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WISCONSIN STATE LEGISLATURE ...
PUBLIC HEARING - COMMITTEE RECORDS

2009-10
(session year)

Senate
(Assembly, Senate or Joint)

Committee on ... Health, Health Insurance, Privacy, Property Tax Relief, and Revenue (SC-HHIPPTRR)

COMMITTEE NOTICES ...

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INFORMATION COLLECTED BY COMMITTEE FOR AND AGAINST PROPOSAL

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- Hearing Records ... bills and resolutions (w/Record of Comm. Proceedings)
  (**ab** = Assembly Bill) (**ar** = Assembly Resolution) (**ajr** = Assembly Joint Resolution)
  (**sb** = Senate Bill) (**sr** = Senate Resolution) (**sjr** = Senate Joint Resolution)
- Miscellaneous ... **Misc**

* Contents organized for archiving by: Stefanie Rose (LRB) (June 2012)

To the Honorable Members of the Committee on Health, Health Insurance, Privacy, Property Tax Relief, and Revenue.

My name is Sandy Bernier, and I live at 831 Minnesota Ave in North Fond du Lac WI. I am providing written testimony to you today in support of SB 362 for Mental Health Parity. I am the mother of four children and a certified social worker. I met my youngest daughter Samantha when she was only five-years-old. I was married to her biological father for only a year when her biological mother was found dead in her apartment from an intentional overdose of drugs. Samantha was only six-years-old at the time of her mother's suicide. Samantha lost her mother due to persistent mental illness that her mother struggled with during her teens and in into her adult life.

My husband, Samantha's biological father had joint custody of Samantha and so it only made sense that she would come and live with us. With three children of my own it was not difficult to make the transition to a blended family. I did suggest that Samantha continue counseling with the same therapist she was seeing since age five due to some behavior issues and to deal with the severe trauma of losing a mother.

Even adults have questions about death, heaven, and why people die. Watching a child grieve the loss of a parent was one of the most difficult situations I have ever encountered. Even prior to Samantha's mother's death, I found her behavior difficult and challenging. The regular boundaries and positive reinforcement that most children responded to never seemed to change her acting out behavior.

Over a period of time Samantha's behavior became very troubling from refusing to go to bed, to throwing tantrums that would last hours, continual lying, and refusing to do homework. Samantha remained in counseling from age five off and on until age of nine when she was finally diagnosed with non specific depression and conduct disorder and was admitted to Winnebago Mental Health Hospital after threatening to kill her father and herself.

After several issues with law enforcement, and the families' inability to keep her safe Samantha's therapist informed us things would continue to spiral out of control if we did not seek a serious intervention.

The multiple issues that our families faced while seeking help for our daughter were many; lose of sleep due to worry, missing work to attend therapy appointments, denial of services because our deductible for our insurance has not been met and we had no cash on hand. For months we made the trip from Fond du Lac to Milwaukee to seek the help of a child psychologist because of a shortage of child psychologist in the area.

Time after time, we were turned away from programs because our daughter was not as they say "in the system", meaning she had not had legal consequences severe enough to get the interventions that she so desperately needed". Desperate, we sought a program out of state. Our insurance would not cover the cost. The only alternative left was to take out an out a $40,000 dollar loan in hopes of getting her the help she needed before she ended up in jail or dead. After a year in a holistic program, Samantha seemed to be getting better and returned home.

The success was short lived, and once again Samantha struggled with her mental health issues. After a period of time with her on the run, we filed uncontrollable child papers with the Department of Social Services. We worked with a social worker, the school system, a therapist all in hopes of getting Samantha back on track literally trying

to save her life. It was clear she, like her mother was struggling with serious mental health issues. After Samantha ran again and was missing for weeks at a time, the court placed her in a treatment facility due to our inability to keep her safe from herself.

What many people do not know, including psychiatrists, counselors and many other professionals is this: when you are a middle class family forced to file out of control papers on your child, and the child is placed out of the home, the court garnishes your wages. I had legally adopted Samantha when she was seven. The court took 17% of my income and 17% of my husband's income, so 34% of our family income was taken from of each month.

It seems to be more of a punitive system. Have you ever heard of taking 34% of a family's income when their child was stricken with cancer? The amount of money that was taken out of each paycheck was the equivalent of two mortgage payments for use. This amount does not include, the attorney fees for your child, the shelter care charges of eighty-five dollars a day while your child is waiting to be placed in a program, and the cost for therapists.

There has always been a stigma with mental illness, but there seems to be an attitude that parents who have children with mental health issues are just a defective family, can't really teach their children how to behave, get them under control. After the third placement in a treatment facility Samantha returned home just after her sixteenth birthday, started medication that helped her gain control. One medication alone was $400 dollars, are insurance did not cover it. The insurance company told us to look on the bright side, "we would meet our deductable in no time".

At this point in our lives we owe well over $45,000 dollars for our daughter's treatment. If you added up lost time from work, illness due to the stress, the constant battle with lack of coverage for treatment, the true cost would be hard to calculate. At one point Winnebago Mental Health called and informed me we still owed them $2,000 dollars and I responded "after I put a kidney up for sale on E-bay I will mail you the check.

My message to you is very simple. Investing in adequate and timely treatment increases the ability for those with mental illness to live meaningful, and product lives. As a Social Worker, I see this inequity impact the lives of the consumers we serve, the co-workers I work with, and countless families who have no place to turn. As a mother I can tell you that even with insurance the road is difficult, without it, it is near impossible. Please support SB362 so that those with mental health and AODA issues can get timely and appropriate treatment so no one has to endure the financial hardship and obstacles that our family has endured in order to get our daughter the help she so desperately needed.

Thank you for your time,

Sandy Bernier CSW
831 Minnesota Ave
North Fond du Lac WI 54937


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Chairman Erpenbach, and members of the Committee. Thank you for this opportunity to testify in support of the Wisconsin Mental Health and Substance Abuse Parity Act, LRB 09-3406/2-LRB 09-3614/1.

I am Bruce Kruger, Executive Vice President of the Medical Society of Milwaukee County (MSMC), an organization established for over 165 years and representing over 3,000 practicing physicians, residents and medical students. MSMC has been very active in improving the delivery of mental health services in Milwaukee County and is currently a partner in conducting an analysis of the current public and private delivery systems, following which a redesign of the delivery systems will be undertaken. We have also been advocates for an expansion of the continuum of mental health services including expanding outpatient services access, increased supportive housing, and increased access to psychiatric medication management services.

It has been the experience of our physician members that patients experiencing medical issues also have a high incidence of underlying depression or other mental health or substance abuse issues. Due to various factors, including limited or no mental health insurance benefits, the primary medical physician is confronted with having to prescribe or manage psychotropic medications with little to no consultative access to psychiatric medication management due to patients having little to no coverage in their employer based health insurance.

A recent study conducted and published by Peter J. Cunningham and published in ***Health Affairs*** in April, 2009 documented that about two-thirds of primary care physicians (PCPs) reported in 2004–05 that they could not get outpatient mental health services for patients—a rate that was at least twice as high as that for other services. Shortages of mental health care providers, health plan barriers, and lack of coverage or inadequate coverage were all cited by PCPs as important barriers to mental health care access. The probability of having mental health access problems for patients varied by physician practice, health system, and policy factors. The results suggest that implementing mental health parity nationally will reduce some but not all of the barriers to mental health care.

Key Findings

1 Two-thirds (67%) of physicians responding to the study said they were unable to obtain quality mental health services for their patients; more than double the rate for other common services, including specialist consultations, nonemergent hospital admissions, and imaging services.
2 Physicians reporting difficulty in securing services for their patients cited a lack of insurance coverage, or having inadequate coverage, as a very important reason 59 percent of the time, while a similar proportion cited a lack of providers as very important. Fifty-one percent of doctors cited barriers posed by health plan provider networks and administrative requirements as very important.
3 When compared by specialty, pediatricians were more likely than other primary care physicians to respond that lack of providers was an obstacle. Inadequate coverage was not as much of a cause for children as it was for adults.
4 Primary care physicians with a larger number of charity care patients were more likely to have difficulty receiving outpatient mental health services than those who

provided less charity care. The number of Medicaid patients did not have a major affect on access.

5 In states that have enacted mental health parity legislation, physicians were slightly less likely to report plan barriers and inadequate coverage as challenges than in states where there were no parity laws.

MSMC believes that continued prescribing of medications by primary care physicians is a continued reality for our health care delivery. The inability, however, for patients to obtain psychotherapy, medication consultation by a psychiatrist, intensity of treatment, and treatment consistent with evidence-based guidelines, does not optimize clinical outcomes and can result in increased hospitalizations, costs, and sub optimal quality of life.

We appreciate Representative Pasch and Senator Hansen introducing this important legislation and strongly urge the committee to support the bill. MSMC believes that this legislation, if passed, will provide access and support to primary care physicians who are challenged by increased demand for services, dwindling interest in increasing manpower, and unable to obtain necessary consultative and management due to insurance benefit limitations. It is time that we recognize the inequity that exists for insured individuals who have coverage for medical conditions but limited to no coverage for significant underlying mental health conditions. This bill will level that playing field!
Thank you for the opportunity to present this testimony.


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Mental Health America of Wisconsin

Testimony to the Senate Committee on Health, Health Insurance, Privacy, Property Tax Relief and Revenue
SB 362
Shel Gross, Director of Public Policy

Thank you, Chairman Erpenbach and members of the committee for holding this hearing on mental health and substance abuse (MH/SA) parity.

It sometimes seems that those of us advocating for MH/SA parity are held to an impossible standard: we need to prove that requiring coverage of these disorders that is no more restrictive than coverage of other medical conditions will not result in any increase in cost for the provision of these services. It very well may, although provision of timely and adequate services could actually reduce costs by avoiding costly hospitalizations. The provision of any medical service costs money. If we held every service to this standard then the result would be that we simply would not pay for any health care services. Some people would argue that this is exactly the approach that some health insurers are trying to take.

The important question is whether the provision of that service is cost effective. Every study of actual implementation of MH/SA parity demonstrates that MH/SA treatment cost increases are modest at most. Additionally, we know from the Center for Disease Control and Prevention that unaddressed mental disorders increase the morbidity and costs to treat other chronic conditions such as diabetes and heart disease. And organizations such as the National Business Health Care group have endorsed findings that mental illness and substance abuse disorders are a major cause of absenteeism, lost productivity and increased disability costs for businesses. All these things suggest cost effectiveness.

But we are confronted with an accident of history: because our understanding of mental illnesses and substance abuse disorder came later than our understanding of other medical conditions MH/SA consumers and advocates have a higher bar to get over in "proving" the value of their services. Wouldn't it be nice if we could just start over; if we could say based on what we know today which services are the most cost effective?

Well, fortunately we don't have to do the math. The Oregon Health Plan has done that for us; and I believe it is instructive. The Oregon Legislature charged the Oregon Health Services Commission to rank medical services in a way that represents the comparative benefits (i.e., clinical effectiveness and cost-effectiveness) and the rank order them from most cost-effective to least cost effective. You can find the entire list at: http://www.oregon.gov/DHS/healthplan/priorlist/main.shtml

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Every year when the Oregon Legislature decides how much money to allocate for the health plan the analysts go down the list and decide how many of the conditions they can cover. Starting Oct. 1, 2009 they will cover 503 of the 680 conditions.

Here are some lines that speak to the relative value of MH/SA treatments:

Line 5 is Medical/Psychotherapy for Abuse or Dependence of Psychoactive Substance

The only treatments ahead of this are maternity care, newborn care, prevention services for birth-10 and prevention services for those over 10.

Line 9 is Medical/psychotherapy for Major Depression, Recurrent

Both of these come ahead of Medical Therapies for Type I Diabetes, Asthma and Hypertension, which are lines 10, 11 and 12, respectively.

So treatment for basic substance abuse or dependence and depression were found to be more cost effective than treatment for diabetes, asthma and heart disease. And yet who would even consider limiting the treatments for diabetes, asthma and heart disease?

Medical Psychotherapy for Schizophrenic Disorders is at line 27; and treatment for Bipolar Disorders is at line 32. These come ahead of treatment for Epilepsy (line 36), rheumatoid arthritis (line 52) and acute and subacute ischemic heart disease, myocardial infarction (76).

All of these are well above the cut line. There are mental health conditions for which the treatments currently fall below the cut line, as there are medical treatments below that line. But nothing prevents insurers from requiring medical necessity determinations for treatments of questionable value.

I think in summation the question I want to pose to the committee is this: given what we know about the cost effectiveness of treatments for MH/SA disorders, why wouldn't we want them covered in a manner no more restrictive than the coverage for other conditions?


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TESTIMONY SUBMITTED BY THE NATIONAL ASSOCIATION OF SOCIAL WORKERS, WISCONSIN CHAPTER IN SUPPORT OF SENATE BILL 362 BEFORE THE SENATE COMMITTEE ON HEALTH ON NOVEMBER 10, 2009

The National Association of Social Workers, Wisconsin Chapter, strongly supports Senate Bill 362.

This bill would close the gap in coverage in Wisconsin that results from the national Wellstone Dominici Mental health/substance abuse parity bill. Senate Bill 362 would ensure that employees of small as well as large employers will be covered equally for mental health and substance abuse conditions.

The Wellstone Dominici bill, which went into effect on October 3rd 2009, requires that all group health plans of 51 or more employees that provide mental health and substance abuse coverage must provide this coverage at the same level as the coverage for medical and surgical coverage.

Senate Bill 362 would extend the coverage of the Wellstone Dominici bill to employers with 50 or less employees that provide coverage for mental health and substance abuse problems. Approximately 700,000 individuals who work at companies with 50 or less employees would benefit from this bill.

The New Day Coalition has been working to pass full mental health and substance abuse parity in Wisconsin for over ten years. One of the biggest concerns raised over the years by opponents of this bill has been regarding possible increases in premiums. After ten years of working on this bill we now have a wealth of information from states that have implemented full mental health and substance abuse parity, as well as from the federal government and private industry that show that the implementation of full mental health and substance abuse parity, at worst results in a 1% increase in premiums.

The nine states of California, Maine, Maryland, Minnesota, North Carolina, Pennsylvania, Rhode Island, South Carolina and Vermont have documented experience that implementing parity increased insurance premiums by less than one percent.1 This positive experience has led a number of states to expand their coverage of mental illness and substance abuse. Most recently the state of Washington expanded its parity law in 2007 to include small groups and individual plans. In addition to Washington at least six other states, Connecticut, Maryland, Minnesota, New Mexico, Rhode Island and Vermont have implemented parity laws for small business. There is no research from these or other states that parity results in employers having to drop coverage because of increased premium costs.

The largest study of parity to date was a four year study of the Federal Employees Health Benefits Program, which has had parity since 2001 and covers nine million employees.

The study concluded that when parity mental health and substance abuse were implemented and managed, total healthcare costs for most of the plans did not increase beyond the increases over the same period that were observed in a matched group of health plans that did not have a parity benefit. 2

In addition to information we now have about the minimal if any increases in premiums as a result of parity, we also have much information about the effectiveness of treatment. Between 70 and 90 percent of individuals with serious mental illness have significant reductions of symptoms and improved quality of life with a combination of pharmacological and psychosocial treatments and supports.3 More than 80% of people with clinical depression can be successfully treated. 4 A recent study demonstrated a reduction in alcohol and drug use (52 percent and 69 percent, respectively) one year after treatment.5 These figures compare to a success rate for heart disease of 45 to 50 percent.6

Finally untreated mental illness and substance abuse has a huge impact on the workplace. In a 2007 survey of more than 500 human resource and employee benefit managers from companies of all sizes across the country, respondents reported that mental illness had more effect on loss productivity, increased absenteeism and other indirect costs than any other health issue. Nearly one-third (31 percent) ranked it first; this is more than twice the number that selected "back problems" which came in second at 14 percent. Substance abuse, asthma/allergies and smoking followed closely behind at 10 percent or less.7

Please vote to support Senate Bill 362.

1. Washington Coalition for Insurance Parity, *Mental Health Parity: Summary of Costs and Savings,* by Randy Revelle and Chelene Alkire, January 30, 2007

2. Finch RA. Phillips K. Center for Prevention and Health Services. Am Employer's Guide to Behavioral Health Services: A Roadmap and Recommendations for Evaluating, Designing, and Implementing Behavioral Health Services. Washington, DC: National Business Group on Health; 2005. Available at http://www.businessgrouphealth.org/pdfs/fullreport_behavioralhealthservices.pdf

3. National Alliance on Mental Illness. Found at: www.nami.org/Content/NavigationMenu/Inform_Yourself/About_Mental_Illness/About_Mental_Illness.htm

4. Mental Health America. Factsheet: Depression in the Workplace. Found at: http://www.nmha.org/index.cfm?objectid=C7DF951E-1372-4D20-C88B7DC5A2AE586D

5. Open Society Institute-Baltimore. Tackling Drug Addiction. Found at: www.soros.org/initiatives/baltimore/focus_areas/drug_addiction

6. Alexander, Stanford J., Chairman, Weingarten Realty Investors, *Statement before the Subcommittee on Employer-Employee Relations,* U.S. Congress, March 13, 2002

7. *Employee Benefit News*, "Innerworkings: A Look at Mental Health in Today's Workplace" May 2007


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Closing the Mental Health and Substance Abuse Insurance Parity Gap

Federal parity does not provide protections to over 700,000 Wisconsin residents.

The *Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, P.L. 110-343 (*the *Wellstone-Domenici Act)* became law on Oct. 3, 2008. It applies to most group health plans for plan years beginning on Oct. 3, 2009, or, in the case of a group health plan that is part of a collective bargaining agreement, by no later than Jan. 1, 2010.

This federal law applies to group health plans offered by employers of 51 or more employees. It does not mandate that such businesses provide mental health and substance abuse coverage as part of their group health plan coverage. However, if a plan does provide either mental health or substance abuse coverage, then the treatment limitations and financial requirements of such coverage must be no more restrictive than those applied to the plan's medical and surgical coverage. This is called "parity."

Small employers with 50 or fewer employees and individual health plans are exempt from the Act's provisions. For more than 700,000[1] Wisconsin residents, the *Wellstone-Domenici Act* offers no protection.

The *Wellstone-Domenici Act* will improve insurance coverage and treatment for many people facing mental health and substance abuse issues. Yet, many others whose lives are disrupted by addiction and mental health challenges remain without adequate insurance coverage. In too many cases, those in need forego treatment simply because they are unable to afford it.

The *Wisconsin Mental Health and Substance Abuse Parity Act, LRB 3406 / 3614/1,* will address this gap in the federal law.

The *Wisconsin Mental Health and Substance Abuse Parity Act* closes part of the mental health and substance abuse insurance parity gap. It requires all group health plans—typically purchased by smaller employers not covered by the *Wellstone-Domenici Act*—to provide mental health and substance abuse disorder benefits at parity.

While such coverage is not required for individual plans, if mental health and substance abuse benefits are included in the individual plan coverage, then the treatment limitations and financial requirements applicable to this coverage must be at parity.

[1] Agency for Healthcare Research and Quality, Center for Financing, Access and Cost Trends. 2008 Medical Expenditure Panel Survey-Insurance Component, 2008.

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Summary of Provisions of the *Wisconsin Mental Health and Substance Abuse Parity Act LRB 3406 / 3614/1*

Existing Law

- In Wisconsin, any group health insurance policy that provides inpatient or outpatient hospital services must cover mental health and substance abuse treatment.

- Currently, mental health and substance abuse treatment must cover, at a minimum, $7,000 for inpatient and $2,000 for outpatient services, minus applicable cost-sharing under the policy. Existing law also requires transitional treatment services up to a minimum of $3,000, minus any applicable cost sharing. In total, any group policy must cover up to $7,000, or the equivalent benefits measured in services, per year.

Changes Proposed by the *Wisconsin Mental Health and Substance Abuse Parity Act*

- While continuing the requirement that group health plans provide mental health and substance abuse treatment coverage, this legislation would remove the specified minimum amounts of coverage.

- The bill instead requires of group health plans and government self-insured plans that deductibles, co-pays, out-of-pocket limits, limitations regarding referrals to non-physicians and other treatment limitations for mental health and substance abuse treatment may be no more restrictive than the most common or frequent treatment limitations that apply to substantially all other coverage under the plan.

- The bill would apply the new requirements to all types of group health benefit plans, including defined network plans, insurance plans offered by the state, and self-insured health plans of the state and municipalities.

- This parity requirement would also apply to individual plans if they provide mental health or substance abuse coverage.

- If a group, government self-insured or individual health plan covers mental health and substance abuse treatment and provides for at least one annual physical examination, then such plans would now be required to provide at least one annual screening to determine the need for mental health and substance abuse treatment. Coverage for additional screenings associated with pregnancy would be required.

—more—

- Expenses incurred for the treatment of mental health and substance abuse must be included in the overall deductible, annual or lifetime limit, or out-of-pocket limit under the plan.

- Group health plans, government self-insured plans and individual plans providing mental health and substance abuse treatment must provide to the insured or plan participant, upon request: 1) the plan's criteria for determining medical necessity for coverage of that treatment; and 2) the reason for any denial of coverage for services for that treatment.

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Parity Will Save Money and Improve Health

Parity's return on investment: reduced costs, improved outcomes.

- Parity reduces the need for costly medical services (such as emergency room services) and improves health outcomes for people with heart disease, diabetes, cancer and other chronic diseases. A cost-benefit analysis from a range of industries found for every $1 invested in more thorough mental health treatment, employers gained a minimum return of $1.20 in the form of increased productivity and attendance.[1] Additionally, actuaries at PriceWaterhouseCoopers built a model of integrated mental health and primary and acute care that indicated that after five years the payer would realize $5 in savings for every $1 spent on behavioral health services.[2]

Parity means minimal premium increases.

- With appropriate care management, parity results in improved protection with an increase in premium costs of less than 1 percent.[3] This according to numerous case studies, from a recent study by the University of Maryland School of Medicine to state studies in Alaska, Maryland, Minnesota, New Hampshire, North Carolina, Rhode Island, South Carolina, Texas and Vermont.

- A study of privately insured employers who adopted comprehensive parity plans with unlimited benefits found that even in the worst case, premiums increased by less than 1 percent due to parity.[4]

- Parity has worked in Ohio and Minnesota. Following Ohio's implementation of mental health parity for state employees, there was an overall savings in healthcare costs.[5] Minnesota has had comprehensive parity since 1995. Medica, an independent consulting organization, found that costs rose just 26 cents per member per month.[6]

Parity works for small business.

- Six states—Connecticut, Maryland, Minnesota, New Mexico, Rhode Island and Vermont—have implemented parity laws for small businesses. Result: no significant cost increases, no significant rise in small businesses dropping health coverage.[7] In fact, the costs to business of absenteeism, lost productivity, and disability and unemployed insurance claims due to mental illness and addiction are greater than the cost of mental health parity.[8]

—more—

Long-term study shows that parity does not increase costs.

- The largest study of parity to date was a four-year study of the Federal Employees Health Benefits Program which has had parity since 2001. The study concluded that when parity mental health and substance abuse were implemented and managed, total healthcare costs for most of the plans did not increase beyond the increases over the same period that were observed in a matched group of health plans that did not have a parity benefit. The federal study is the largest evaluation of the addition of behavioral health parity benefit ever conducted—with 9 million employees, the federal government is the largest employer in the United States—and one of the few studies in behavioral healthcare utilization that compared parity plans with similar non-parity plans over a defined period of time. The fact that this study was conducted with the largest employer in the United States gives even greater significance to its findings.[9]

Parity works for the corporate bottom line.

- Parity is provided to employees of national corporations including American Airlines, Black & Decker, Boeing, Compaq, Dell Computers, Delta Airlines, DuPont, Eastman Kodak, Exxon, FedEx, IBM, Pepsico, Sun Microsystems, Texas Instruments and Xerox. Employers provide generous mental and substance abuse benefits to their employees and families because they are convinced that doing so is essential to the corporate bottom line.[10]

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[1] A. Lo Sasso et al, Modeling the impact of enhanced depression treatment on workplace functioning and costs. Medical Care, 2006.
[2] Managed Behavioral Health News, January 2000.
[3] Satcher, David, M.D., Ph.D. Mental Health: A Report of the Surgeon General, 1999.
[4] Rand Health, 2001
[5] Mandated Health Benefits Advisory Commission, 2005.
[6] National Conference of State Legislatures, 2002.
[7] R. Revelle. Sr. Vice President, WA State Hospital Assn. Mental Health Parity: Summary of Costs and Savings, 2007.
[8] Schual-Berke, Shay. Pat Thibaudeau and Randy Revelle. Pro: End discrimination against the mentally ill. In the Seattle Times, Feb. 10, 2005. Found at: http://seattletimes.nwsource.com/html/opinion/2002175525_revelle10.html
[9] Finch RA. Phillips K. Center for Prevention and Health Services. An Employer's Guide to Behavioral Health Services: A Roadmap and Recommendations for Evaluating, Designing, and Implementing Behavioral Health Services. Washington, DC: National Business Group on Health; 2005. Available at http://www.businessgrouphealth.org/pdfs/fullreport_behavioralhealthservices.pdf
[10] Report to the Office of Personnel Management, Washington Business Group on Health, 2000.

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Addiction and Mental Illness Are Chronic Diseases That Are Effectively Treated

Addiction

- Scientific evidence has shown addiction to be a chronic, relapse-prone disease which literally changes brain chemistry. Addiction is recognized as a disease by the American Medical Association.

- Addiction is an equal-opportunity disease. Prevalent and costly, it disrupts the well-being and health care of individuals in every age, income and ethnic group. Yet, only a small percentage of persons with alcohol and drug addiction get treatment, unlike those living with other chronic diseases such as diabetes, hypertension or asthma.

- For the past 30 years, federally sponsored research has repeatedly confirmed the efficacy and cost-effectiveness of treatment to counteract the powerful effects of addiction and help patients regain control of their lives. For example, a recent study demonstrated a reduction in alcohol and drug use (52 percent and 69 percent, respectively) one year after treatment.[1]

- Millions of people with addictions have been successfully treated. Strong motivation can facilitate the treatment process. Sanctions or enticements in the family, employment setting or criminal justice system can increase both treatment entry and retention rates and the success of drug treatment interventions.[2]

Mental Illness

- Mental illnesses are serious medical illnesses. They cannot be overcome through "will power" and are not related to a person's "character" or intelligence. The National Institute of Mental Health reports that one in four adults—approximately 57.7 million Americans—experience a mental health disorder in a given year.[3]

- The best treatments for serious mental illnesses today are highly effective; between 70 and 90 percent of individuals have significant reduction of symptoms and improved quality of life with a combination of pharmacological and psychosocial treatments and supports.[4]

—more—

- Depression tends to affect people in their prime working years and may last a lifetime if untreated. More than 80 percent of people with clinical depression can be successfully treated. With early recognition, intervention, and support, most employees can overcome clinical depression and pick up where they left off. [5]

- Without treatment the consequences of mental illness for the individual and society are staggering: unnecessary disability, unemployment, substance abuse, homelessness, inappropriate incarceration, suicide and wasted lives.[6]

- **The economic cost of untreated mental illness is more than $100 billion each year in the United States.**[7]

- With appropriate effective medication and a wide range of services tailored to their needs, most people who live with serious mental illnesses can significantly reduce the impact of their illness and find a satisfying measure of achievement and independence. A key concept is to develop expertise in developing strategies to manage the illness process.[8]

- Early identification and treatment is of vital importance. By ensuring access to the treatment and recovery supports that have both proven effective, recovery is accelerated and the further harm related to the course of illness is minimized.[9]

- Chronic drug abusers who also live with mental illness can be treated. Researchers currently are investigating the most effective way to treat drug abusers with mental illness, and especially whether or not treating both conditions simultaneously leads to better recovery. Currently, the two conditions often are treated separately or without regard to each other. As a result, many individuals with co-occurring disorders are sent back and forth between substance abuse and mental health treatment settings.[10]

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[1] Open Society Institute-Baltimore. Tackling Drug Addiction. Found at: www.soros.org/initiatives/baltimore/focus_areas/drug_addiction

[2] National Institute on Drug Abuse. Principles of Drug Addiction Treatment: A Research Based Guide. Found at: http://www.nida.nih.gov/PDF/PODAT/PODAT.pdf

[3] National Alliance on Mental Illness. Found at: www.nami.org/Content/NavigationMenu/Inform_Yourself/About_Mental_Illness/About_Mental_Illness.htm

[4] National Alliance on Mental Illness.

[5] Mental Health America. Factsheet: Depression in the Workplace. Found at: http://www.nmha.org/index.cfm?objectid=C7DF951E-1372-4D20-C88B7DC5A2AE586D

[6] Mental Health America.

[7] National Alliance on Mental Illness.

[8] National Alliance on Mental Illness.

[9] National Alliance on Mental Illness.

[10] National Drug Intelligence Center, a component of the U.S. Department of Justice. Drug Abuse and Mental Illness Fast Facts. Found at: http://www.usdoj.gov/ndic/pubs7/7343/7343p.pdf

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Cost to Business of Not Treating Mental Illness and Addiction

Not treating mental illness and addiction costs money and lives.

- According to Helen Darling, president of the National Business Group on Health, "Mental health and substance abuse disorders currently cost U.S. employers billions of dollars annually in lost worker productivity."[1] The National Business Group on Health recently recommended equalizing mental health and addiction benefits with other medical benefits.[2]

Leading cause of disability.

- Mental illness and substance disorders account for the two leading causes of disability in the U.S., nearly 37 percent of all disability. Growing evidence indicates that limiting mental health and substance disorder benefits increases the overall cost of healthcare.

- More than half of U.S. adults have a mental or physical condition that influences their ability to work or carry out usual activities.[3]

Reduced productivity.

- In 1999, the U.S. Surgeon General reported that the indirect costs of mental illness imposed an estimated $79 billion loss on the U.S. economy in 1990, or more than $123 billion today.[4]

- More than 1.3 billion days are lost each year due to mental disorders, roughly half the number of days (2.4 billion) associated with all chronic physical conditions combined, including cancer, heart attacks, ulcers and vision loss[5]. Individuals with chronic conditions took an average of 32 sick days a year,[6] costing employers billions of dollars annually.[7]

Workers' compensation claims.

- Workers with substance abuse disorders are 3.5 times more likely to experience a costly accident in the workplace and five times more likely to file for workers' compensation.

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[1] L. Carlson Shepard, Employee Benefit News, February 2006.

[2] Finch RA. Phillips K. Center for Prevention and Health Services. An Employer's Guide to Behavioral Health Services: A Roadmap and Recommendations for Evaluating, Designing, and Implementing Behavioral Health Services. Washington, DC: National Business Group on Health; 2005. Available at http://www.businessgrouphealth.org/pdfs/fullreport_behavioralhealthservices.pdf

[3] K. Merikangas, R. Kessler, et al. The Impact of Comorbidity of Mental and Physical Conditions on Role Disability in the US Adult Household Population. Archives of General Psychiatry. October 2007.

—more—

[4] Mental Health: A Report of the Surgeon General. Found at:
http://www.surgeongeneral.gov/library/mentalhealth/chapter6/sec2.html
[5] Merikangas, R.
[6] Merikangas, R.
[7] National Business Group on Health, 2005.

New Day Coalition

Promoting integration of health care for the mind and body.

126 S. Franklin St., Madison WI 53703 • 608-251-1450 • wispsych@execpc.com

Support for Addiction / Mental Health Treatment in Wisconsin

- Support for including addiction treatment in health care reform unites Wisconsinites across party lines, income and demographic groups. A recent poll conducted by the Washington, D.C. firm Lake Research Partners shows that 74 percent of Milwaukeeans support increased access to addiction treatment as part of health care reform, including majorities of Democrats, Independents and Republicans.

  In addition, 65 percent said that they would pay an increased monthly health care premium—an extra $2 per month—to ensure everyone had improved access. This broad, bi-partisan support in Milwaukee mirrors national trends: 77 percent of Americans support including addiction treatment in health reform, 56 percent strongly; and 69 percent of Americans support paying two dollars more per month in health insurance premiums to make addiction treatment more accessible and affordable.[1]

- Expanding and enhancing drug and alcohol treatment programs received unanimous support by the Wisconsin Assembly in its passage of Assembly Bill 283 on Sept. 17, 2009. The Senate is expected to vote on the bill this fall.

- In 2001, the Wisconsin Senate passed SB-157—legislation that, among other provisions, also removed the specified minimum amounts of coverage that a group health insurance policy must provide for the treatment of drug and alcohol addiction and mental illness.

- All five Committee versions of national health care reform currently under consideration by the United States Senate and House of Representatives include parity provisions that must comply with the *Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, P.L. 110-343* [2].

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[1] Milwaukee Addiction Treatment Initiative. Milwaukeeans Support Increasing Access to Drug, Alcohol Addiction Treatment, New Poll Shows. Found at: http://www.ca-ppi.org/solutions/mati/documents/News_Release_Milwaukeeans_Support_Increasing_Access_to_Drug_Alcohol_Addiction_Treatment_New_.pdf

[2] Legal Action Center (www.lac.org/), a non-profit, public-interest law firm and policy organization located in Washington, D.C. and New York City that specializes in fighting discrimination against and protecting the rights of people with alcohol or drug problems, HIV/AIDS or criminal records.


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State of Wisconsin / OFFICE OF THE COMMISSIONER OF INSURANCE

Jim Doyle, Governor
Sean Dilweg, Commissioner

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December 4, 2009

Sen. Jon Erpenbach, Chair
Senate Health, Health Insurance, Privacy,
Property Tax Relief, and Revenue Committee
Room 8-South, State Capitol
Madison, WI 53702

Dear Chairman Erpenbach,

During the public hearing on Senate Bill 362, the mental health parity legislation, several Committee Members raised questions that I have responded to below.

1. Why did the federal government limit the scope of mental health parity to those employers with more than 50 employees?

   Our research has determined this was a policy decision by Congress.

2. How many other states have mandated full parity, and how do those benefits compare among the states?

   I am enclosing information obtained from the National Conference of State Legislatures outlining mental health benefits among the states. This information, last updated November 5, 2009, provides a summary of how this benefit is treated by the various states.

3. When do we expect the social and financial impact report to be completed on Senate Bill 362?

   My staff is currently compiling information to complete the social and financial impact report on this legislation, and will provide that report as soon as the work on the report has been completed.

4. Does the Office of the Commissioner of Insurance have any idea how much this will cost each insurer?

   Enclosed is a copy of the Social and Financial Impact Report that was completed by our office on 2005 Senate Bill 128/Assembly Bill 252. This legislation, which was similar to the current proposal, estimated an increase of .15 to .50 percent in total insurance

premiums collected in Wisconsin which results in an approximate individual monthly increase of $0.64 to $2.17 in premium.

5. In light of the fact that medical costs are increasing at a much higher rate than the Consumer Price Index (CPI), what other alternative does the Office of the Commissioner of Insurance feel would be fair to take into consideration when looking at raising the rates for mental health parity coverage, IF full parity is not offered?

   Commissioner Dilweg's written testimony included a suggestion that the Legislature consider linking the required benefit level for mental health services to the CPI. For clarification, the Commissioner was referring to the Medical CPI, which can be more than twice the rate or higher than the standard CPI. This would set the current level of benefits at approximately $23,000.

I hope this information is helpful. As always, if you would like additional information, please let me know.

Sincerely,

Kimberly Shaul
Deputy Insurance Commissioner

cc: Members
Sean Dilweg, Commissioner

Enclosures

NCSL
NATIONAL CONFERENCE of STATE LEGISLATURES

GO

State Laws Mandating or Regulating Mental Health Benefits

Updated: February 2009; reposted with additions November 5, 2009. NEW

Mental health services have been one significant part of medical care for a number of years. However, the costs, coverage and availability of such services have been the object of policy discussions and a variety of state legislation. There is not a general consensus that state government should require coverage for mental health. 46 states currently have some type of enacted law but these laws vary considerably and can be divided roughly into three categories:

1. **mental health "parity" or equal coverage laws**
2. **minimum mandated mental health benefit laws**
3. **mandated mental health "offering laws".**

Note that some laws apply primarily to "serious mental illness" and may not assure coverage for particular individual diagnoses or circumstances. Many private market health plans include some type of mental health benefits on a voluntary commercial basis, not necessarily required by state or federal laws. Note that grief counseling may not be considered a covered benefit under some state laws, although it may be offered by insurers as part of a standard mental health benefit package. Laws in at least 38 states include coverage for substance abuse, alcohol or drug addiction.

CMS Guidance Regarding Mental Health Parity Requirements In CHIPRA, Medicaid and Group Insurance NEW

The federal Centers for Medicare & Medicaid Services (CMS) issued a State Health Official letter on November 4, 2009 regarding the mental health parity requirements under the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA). The letter provides general guidance on implementation of section 502 of CHIPRA, Public Law 111-3, which imposes mental health and substance use disorder parity requirements on all Children's Health Insurance Program (CHIP) State plans under title XXI of the Social Security Act (the Act). This letter also provides preliminary guidance to the extent that mental health and substance use disorder parity requirements apply to State Medicaid programs under title XIX of the Act.

In summary the letter addresses specific requirements in the measure as follows:

1. Qualifying financial requirements and treatment limitations applied to mental health or substance use disorder benefits may be no more restrictive than those applied to medical surgical benefits.
2. No separate qualifying criteria may be applied to mental health or substance use disorder benefits.
3. When out-of-network coverage is available for medical surgical benefits, it must also be available for mental health or substance use disorder benefits.

Medicaid and Group Health Insurance:

Requirements from the Paul Wellstone and Pete Dominici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) became effective for group health insurance plans on October 3rd of 2009. These same requirements will only apply to Medicaid insofar as the state's Medicaid agency contracts with one or more managed care organizations (MCOs) or Prepaid Inpatient Health Plans (PIHPs). In these cases the MCOs or PIHPs must be in compliance. A state Medicaid plan is not subject to these requirements otherwise. The MHPAEA applies to all CHIP programs and became effective April 1 of 2009. State CHIP plans are deemed in compliance if they provide coverage of Early and Periodic, Screening, Diagnosis and Treatment (EPSDT) benefits.

States Requiring Legislative Action for Compliance

The letter also specifies that if a state requires legislation in order to be in compliance with the requirements, a state will not be found to be in violation before its next legislative session as long as it notifies the Secretary of HHS and she concurs that legislation is needed. They ask that states in the circumstances submit a letter to the Center for Medicaid and State Operations to that effect as soon as possible and include information as follows:

1. the provisions in question,
2. the reason the state requires legislative action for compliance, and
3. the date the state will begin implementing the provision.

2008 Federal Law Requiring Parity in Some Circumstances

On October 3, 2008, the Emergency Economic Stabilization Act (HR 1424) passed Congress and was signed into law. It included a major mental health provision - known as the *"Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act,"* which was attached to the economic bill and also became law. This federal mental health law requires health insurance plans that offer mental health coverage to provide the same financial and treatment coverage offered for other physical illnesses. It does not mandate that group plans must provide mental health coverage. [Parity Section 512 full text]

This legislation expands parity by requiring equality for deductibles, co-payments, out-of-pocket expenses, coinsurance, covered hospital days, and covered out-patient visits. The measure also includes a small business exemption for companies with fewer than 50 employees, as well as a cost exemption for all businesses if it will result in a cost increase of 2% in the first year and 1% in each subsequent year. The bill builds on the current 1996 federal parity law, which already requires parity coverage for annual and lifetime dollar limits. The current HIPAA preemption standard applies. This standard is extremely protective of state law. Only a state law that "prevents the application" of this Act will be preempted, which means that stronger state parity and other consumer protection laws remain in place. It will require the Comptroller General to inform Congress on health plans' and health insurers' coverage and exclusion rates, patterns, and trends of mental health and substance use disorder diagnoses. The new law exempts businesses with 50 or fewer employees from its mental health parity requirements. Most provisions go into effect on a delayed basis, in 2010.
Sources: Press Release from the Office of U.S. Senator Pete Domenici; Press Release from the Office of U.S. Senator Edward Kennedy.
News Article: "Lawful Boost to Mental Health Coverage" Los Angeles Times, October 13, 2008.

Recent State Law History

- In **2002** laws were added in **Alabama, Colorado, Kentucky, New Hampshire** and **New Jersey**.
- In **2003**, "barebones" laws allowing exceptions to mandated coverage, were enacted in **Colorado, Montana and Texas. Maine** expanded categories of illnesses covered; **Hawaii** and **Kansas** extended dates of existing coverage laws.
- In **2005, Washington** enacted a full mental health parity law, applying to health insurance, but exempting policies for individuals and small group employers with 50 or fewer employees. It will take effect in phases between 2006 and 2010. **Oregon** also enacted a full parity law that took effect January 1, 2007.
- In **2006-07**, four additional states passed variations of full parity laws. **Idaho's** law provides parity, but only for state employee and family insurance policies. **New York's** former Gov. George Pataki signed Timothy's Law, named for a 12-year-old boy who committed suicide in 2001. The law requires that all private insurance policies have the same deductibles, number of office visits, number of inpatient visits and co-payments for mental health disorders as for other illnesses. The statute also requires that private plans provide at least 30 days of inpatient and 20 days of outpatient mental health care per year. In **Ohio**, outgoing Gov. Bob Taft signed his state's first mental health parity law (SB 116) on Dec. 29, 2006. The Mental Health Parity Act mandates that coverage provided for seven "biologically based mental illnesses," such as schizophrenia and bipolar disorder be on par with those for physical conditions. In July 2007 The **North Carolina** legislature enacted a measure covering nine conditions.
  See "TWO MORE STATES ENACT PARITY LAWS," State Health Notes, 1/22/07.

State Laws and Federal Limits: The state laws noted below generally do not apply to federally funded public programs such as Medicaid, Medicare, the Veterans Administration, etc. In addition, "self-funded" health insurance plans, often sponsored by the largest employers, usually are entirely exempt from state regulation because they are preempted by the federal ERISA law.

All of the state laws listed in this report were written and applied prior to the October 2008 passage of the Mental Health Parity and Addiction Equity Act, so coordination and interpretation of how state and federal laws combine or potentially conflict is a likely task for 2009. NEW
> See ERISA and the States, a 2008 online resource guide by NCSL.

A Comment from the Commercial Sector
"Every client that I work with will have to make some plan-design changes to conform to the [new behavioral health parity provisions signed into law on Oct. 3]."
— Chip Kirby, an employee benefits attorney with Liberte Group LLC in Washington, D.C., told AIS's Health Plan Week., 10/24/2008 NEW

Mental Health Parity Laws
Parity, as it relates to mental health and substance abuse, prohibits insurers or health care service plans from discriminating between coverage offered for mental illness, serious mental illness, substance abuse, and other physical disorders and diseases. In short, parity requires insurers to provide the same level of benefits for mental illness, serious mental illness or substance abuse as for other physical disorders and diseases. These benefits include visit limits, deductibles, copayments, and lifetime and annual limits.

Parity laws contain many variables that affect the level of coverage required under the law. Some state parity laws--such as Arkansas'--provide broad coverage for all mental illnesses. Other state parity laws limit the coverage to a specific list of biologically based or serious mental illnesses. The state laws labeled full parity below provide equal benefits, to varying degrees, for the treatment of mental illness, serious mental illness and biologically based mental illness, and may include treatment for substance abuse. The newly enacted federal parity law affects insurance policies that already provide some mental health coverage; there is no federal law directly mandating parity to the same extent as state laws; also see background on unsuccessful federal parity legislation below the state table.

Minimum Mandated Benefit Laws
Many state laws require that some level of coverage be provided for mental illness, serious mental illness, substance abuse or a combination thereof. They are not considered full parity because they allow discrepancies in the level of benefits provided between mental illnesses and physical illnesses. These discrepancies can be in the form of different visit limits, copayments, deductibles, and annual and lifetime limits. Some mental health advocates believe these laws offer a compromise to full parity that at least provides some level of care. Others feel that anything other than full parity is discrimination against the mentally ill. Some of these laws specify that copayments and deductibles must be equal to those for physical illness up to the required level of benefits provided. If a law does not specify, the copayment could be as much as 50 percent of the cost of the visit and require a separate deductible to be met before mental health visits will be covered.

Mandated Offering Laws
Mandated offering laws differ from the other two types of laws in that they do not require (or mandate) benefits be provided at all. A mandated offering law can do two things. First, it can require that an option of coverage for mental illness, serious mental illness, substance abuse or a combination thereof, be provided to the insured. This option of coverage can be accepted or rejected and, if accepted, will usually require an additional or higher premium. Second, a mandated offering law can require that **if** benefits are offered **then** they must be equal.

Full Parity, Mandated Benefit and Mandated Offering State Laws

State	Eff. Date Law citation/ web link.	Insurance Policies Affected by Law.	Illnesses Covered. (1)	Type of Benefit/	Co-pays and Co-insurance
AL	2001: H.677 of 2000	Individual and group with a small employer exemption of 50 or less.	Mental illness.	Mandated offering.	Must be equal.
AL	2002: S. 293	Adds health care service plans and health maintenance organizations (signed 4/26/02)	Mental illness	Mandated offering	Must be equal
AK	1997; ----- 2006 HB 289	Group - 5 employees or less exempt; 20 or less must offer coverage. ------ Limited to large employer group markets, and does not apply if it would result in an increase in the cost of the plan of 1% or more.	Alcoholism and Drug Use. ------ Mental Illness.	Minimum Mandated ------- Mandated Benefit.	Must be equal ------ Must be Equal.
AZ	1998: Ariz. Rev. Stat. Ann. 20-2322	Group with small employer exemption 50 or less, or cost increase of 1% or more.	Mental illness.	Mandate for plans that offer benefits.	Can be different.
AR	1987 ------ 1997: §23-00-506 [Act 1020 of '97] ------- 2001 HB 1562	Group and HMO. ------ Group: small employer exemption 50 or less; cost increase 1.5% or more exempted. ------ Not applicable to employers with 50 or fewer employees and to plans covering state employees. Exempts health benefit plans if it will result in cost increase of 1.5% or more.	Alcoholism and drug dependency. ------- Mental illnesses and developmental disorders. ------- Mental Illness.	Mandated Offering ------ Full parity. ------- Minimum Mandated	Not less favorable generally. ------ Must be equal. ------ Must be equal.
CA	1974:	Group.	Mental or nervous	Mandated	Not specified.

	Cal. Ins. Code § 10125		disorders.	offering.	
CA	2000: Cal. Ins. Code § 10144.5	Group, individual and HMO.	Severe mental illness.	Full parity.	Must be equal.
CO	1992: Colo. Rev. Stat. § 10-16-104(5) --- 1994	Group. --- Group	Mental illness excluding autism. --- Alcoholism	Mandated benefits. --- Mandated Offering	Shall not exceed 50% of the payment. Deductible shall not differ. --- Shall not exceed 50% of the payment. Deductible shall not differ.
CO	1998: §10-16-104(5.5)	Group.	Biologically based mental illness.	Full parity.	Must be equal.
CO	2002: Chapter 208 of 2002	Provide coverage for substance abuse treatment regardless of whether the treatment is voluntary or court-ordered. (signed 5/28/02)	Substance abuse	Clarification of earlier laws	
CO	2003: H 1164	Allows exceptions for barebones policies		Exceptions	
CT	2000: Conn. Gen. Stat. §38a-488a; §38a-514a	Group and individual.	Mental or nervous conditions; alcoholism and drug addiction.	Full parity.	Must be equal.
DE	1999: Del. Code Ann. Tit. 18 § 3343 Tit. 18 § 3566 --- 2001 H 100	Group and individual. --- Group, HMO, individual and state employee plans.	Serious mental illnesses. --- Drug and Alcohol Dependencies.	Full parity. --- Parity	Must be equal. --- Must be equal.
FL	1992: Fla. Stat. § 627.668 --- 1993	Group and HMO. --- Group and HMO.	Mental and nervous disorders. --- Substance Abuse.	Mandated offering. --- Mandated offering.	May be different after minimum benefits are met. --- Not Specified.
GA	1998: Ga. Code §33-24-29; §33-24-28.1 (SB 620, 1998)	Group and individual.	Mental disorders including substance abuse.	Mandated offering.	Must be equal.
HI	1999: Hawaii Rev. Stat. §431M-5 --- 2000 HB 2392	Group and individual with small employer exemption- 25 or less employees. --- Deletes exemptions for employers with 25 or fewer employees & for government employee health benefit plans.	Serious mental illness. ---	Full parity. ---	Must be equal. ---
HI	1988: Hawaii Rev. Stat. §431M-1 ~7	Individual, group and HMO.	Mental illness.	Mandated benefits.	Must be comparable.
HI	2003:	Makes law permanent, deleting	Mental illness.	Full parity	

	HB 1321 --- 2005: SB 761	sunset dates. --- Expands definition of 'serious mental disorders' in current law to include delusional disorders, major depression, obsessive-compulsive disorders, and dissociative disorders.	---	---	---
ID	2006 HB 615 (ID Stat.: §67-5761A)	Health Insurance Plans for State Employees and their family members only.	Serious Mental Illness as defined in the APA's DSM-IV-TR.	Parity	Must be Equal.
IL	1991: Ill. Rev. Stat. Ch. 215 §5/370c --- 1995 --- 2001 SB 1341 --- 2005 HB 59 --- 2006 HB 4125	Group. --- Group --- Exempts employers with 50 or fewer employees. --- Eliminates sunset provision in existing mental health parity law. --- Makes HMOs subject to existing mental health coverage requirements.	Mental, emotional or nervous disorders. --- Alcoholism --- Serious Mental Illness --- N/A --- Increased number of visits for treatment of pervasive developmental disorders.	Full parity 2005 [See co-payment exceptions] Mandated offering, 1991-2004 --- Mandated benefits --- Parity for Serious mental illness; Mandated offering for other mental illness. --- N/A --- N/A	Insured may be required to pay up to 50% of the expenses incurred. --- Not Specified. --- Must be equal for serious illness. --- N/A --- N/A
IN	1997 HB 1400 --- 2000: *H.1108 of '99*; Ind. Code § 27-13-7-14.8 Ind. Code § 5-10-8-9 (state)	Private Insurance Policies offering mental health benefits. Exempts employers with fewer than 50 employees and any business whose rates would increase over 1% as a result of legislation. --- Group, individual and state employees with a small employer exemption 50 or less, or cost increase of 4% or more.	Mental Illness --- Mental illness.	Parity --- Mandate for plans that offer benefits. Full parity for state employee plans.	Not specified. --- Must be equal for plans that offer coverage. Full parity for state employee plans.
IN	2003: H 1135	Adds substance abuse benefit for those with mental illnesses	Substance abuse	Mandate for those with mental illnesses	
IA	2005 HF 420; IA Code 514C.22 (2005)	Group policies to companies with more than 50 employees, public employees and small businesses that currently have mental health coverage.	Substance abuse, eating disorders, ADD not included.	Mandated Benefit.	Must be Equal.
KS	1998: § 40-2.105 2001: *H.2033 of '01* H 2071 of 2003 ---	Group, individual, HMO and state employee plans. H. 2071 extended sunset to Dec. 31, 2003.	Alcoholism or drug abuse or mental conditions.	Mandated benefits.	Not specified. ---

	2006 HB 2691	------ Group. If a policy does not have aggregate lifetime or annual limits on other medical benefits, then it may not impose them on mental health benefits.	------- Mental Illness	------ Minimum Mandated Benefits.	Not Specified.
KY	1980 ------ 1986: Ky. Rev. Stat. §§ 304.17-318 [group] §§304.38-193 [HMO]	Group ------ Group.	Alcoholism ------- Mental illness.	Mandated Offering. ------- Mandated offering.	Not Specified. ------ To the same extent as coverage for physical illness.
KY	2000: HB 268	Group with small employer exemption of 50 or less.	Mental illness and alcohol and other drug abuse.	Mandate for plans that offer benefits.	Equal if offered.
KY	2002: H 391 of '02	Small employer exemption raised to 51.			
LA	2000: La. Rev. Stat. Ann. § 22:669(1)	Group, HMO and state employee benefit plans.	Serious mental illness.	Mandated benefits.	Must be equal.
LA	1982: § 22:669(2)	Group, self-insured and state employee plans.	Mental illness.	Mandated offering.	Must be equal.
LA	1982: §22:215.5	Group.	Alcoholism and drug abuse.	Mandated offering.	Not specified.
ME	1984 ------ 1996: Me. Rev. Stat. Tit. 24 § 2325-A	Group with a small employer exemption for 20 employees or less. ------ Group with a small employer exemption for 20 or less.	Alcoholism and drug dependency. ------ Mental illness.	Mandated Benefit. ------ Full parity.	May place a maximum limit on benefits as long as they are consistent with the law. ----- Must be equal.
ME	1996: Me. Rev. Stat. tit. 24 § 2325-A(5-D)	Individual plans must offer coverage.	Mental illness.	Mandated offering.	Must be equal.
ME	2003: H 973	Group of 21 or more, including HMOs, adds substance abuse-related disorders and other illness categories.	Substance abuse, etc.	Full parity	
MD	1994: Md. Ins. Code Ann. § 15-802 (click 'code folder', then 'Insurance', title 15, section 802)	Individual and group.	Mental illness, emotional disorder, drug abuse or alcohol abuse disorder.	Full parity [See co-payment exceptions]	Must be equal. Except outpatient: 80% -visits 1-5; 65% - visits 6-30; 50% visits over 30.
MD	2002: Chapter 394 of '02 (eff. 10/1/02)	Requires individual and group insurers, nonprofit health service plans, and HMOs to provide coverage for medically necessary residential crisis services.	Residential crisis services		
MA	1991 ------ 1996: Mass. Gen. Laws Ch. 175:47B	Individual, group, HMO. ------ Individual, group and HMO.	Alcoholism. ------ Mental or nervous conditions.	Mandated Benefits. ------ Mandated benefits.	Not specified. ------ Not specified.

MA	2001: *S.2036/ Ch. 80 of '00*	Individual, group and HMO. [Pro and Con testimony on costs of expansion]	Biologically-based mental illness.	Full Parity for bio-based; mandated benefits of mental illness and substance abuse.	Must be equal.
MI	1988 --- 2001: *S.1209 of '00, see §3501*	Group for Inpatient; Group and Individual for other levels. Exemption for cost increases of 3% or more. --- HMO's only, group and individual contracts, with a cost exemption of 3%.	Mental health and substance abuse --- Mental health and substance abuse	Minimum mandated benefits. --- Minimum mandated benefits.	Charges, conditions for services shall not be less favorable than the maximum for any other comparable service. --- Charges, conditions for services shall not be less favorable than the maximum for any other comparable service.
MN	1986 --- 1995; 2000: Minn. Stat. § 62A.152	Group and Individual. --- Group, individual and HMO's (full parity for HMO's).	Alcoholism, chemical dependency, or drug addiction. --- Mental health and chemical dependency.	Mandated Benefit. --- Full parity for plans that offer coverage and HMO's.	Not Specified. --- Must be equal.
MS	1975: Miss. Code Ann. § 83-9-39 to 41	Group.	Alcoholism.	Mandated benefit.	Not specified.
MS	2002: Miss. Code Ann. § 83-9-41; H667 of '01	Group and individual with an exemption if costs of implementation are 1% or more of overall costs.	Mental illness.	Mandated offering for small employers of 100 or less. Minimum mandated benefits for others.	Must be equal for inpatient and partial, however, payment for outpatient visits shall be a minimum of fifty percent (50%) of covered expenses.
MO	1997: §§ 376.825; § 376.811	Group, individual and HMO.	Mental disorders and chemical dependency.	Mandated offering.	Must be equal.
MO	2000: § 376.825 *H.191 of '99* --- *2004*	Group and individual. --- Group	Mental illness including alcohol and drug abuse. --- Mental Illness	Mandate for plans that offer benefits. --- Parity	Shall not be unreason-able in relation to the cost of services provided for mental illness. --- Must be equal.
MT	2000:	Group and individual.	Severe mental	Full parity.	Must be equal.

	Mont. Code Ann. § 33-22-706		illness.		
MT	1997; 2001 Mont. Code Ann. § 33-22-701 to 705	Group.	Mental illness alcoholism and drug addiction.	Mandated benefits.	No less favorable up to maximums.
MT	2003: H 384	12 month pilot allows exceptions for barebones policies.		Exceptions	
NE	1989 ------ 2000: §§ 44-791 to 44-795	Group and HMO ------ Group and HMO with a small employer exemption of 15 or less.	Alcoholism ------ Serious mental illness.	Mandated Offering. ------ Mandate for plans that offer coverage.	No less favorable generally than for physical illness. ------ May be different.
NV	1997 ------- 2000: Nev. Rev. Stat. §§ 689A.0455; 689B.0359; 695B.1938; 695C.1738	Group, individual, and HMO. ------ Group and individual with a small employer exemption 25 or less, or cost increases of 2% or more.	Abuse of alcohol or drugs. ------- Severe mental illness.	Mandated benefits. ------- Mandated benefits.	Must be paid in the same manner. ------- Not more than 150% of out-of-pocket expenses required for medical and surgical.
NH	1993: N.H. Rev. Stat. Ann. §§ 415:18-a	Group, individual and HMO. Specifies different benefits for mental illness under major medical and non-major medical plans.	Mental or nervous conditions.	Mandated benefits.	Ratio of benefits shall be substantially the same as benefits for other illnesses.
NH	1995: § 417:E-1	Group.	Biologically-based mental illnesses	Full parity.	Must be equal.
NH	2002: H 762; Chapter 204 of 2002	Any policy of group or blanket accident or health insurance.	Parity for bio-based illnesses, mandated benefits for other MI's and substance abuse		
NJ	1985 ------ 1999: §§ 17:48-6v; 17-48A-7u; 17B:26-2.1s ------- 2000 ------ 2002	Group and individual. ------ Group and individual ------ State Employee Plans. ------ Individual Health Plans.	Alcoholism ------- Biologically based mental illness. ------- Biologically based mental illness. ------ Biologically based mental illness; alcohol and substance abuse.	Mandated benefits for care prescribed by a doctor. ------ Full parity. ------ Parity. ------ Mandated Offering.	Must be equal. ------ Must be equal. ------ Must be equal. ------ Bio based mental illness: No coinsurance but $500 copayment per inpatient stay. 30% coinsurance for outpatient

					stay. Alcohol and substance abuse: 30% coinsurance.
NM	1987 --- 2000: N.M. Stat. Ann. §59A-23E-18	Group. --- Group with different exemptions for small and large employers.	Alcoholism --- Mental health benefits.	Mandated Offering. --- Full parity.	Consistent with those imposed on other benefits. --- Must be equal.
NY	1998: Ins. Law § 3221 (1)(5)(A) --- 2004 --- 2006	Group. --- Group --- All private insurance policies. See: Timothy's Law web site, 2007.	Mental, nervous, or emotional disorders and alcoholism and substance abuse. --- Eating Disorders --- Mental health disorders	Mandated Offering. --- Minimum Mandated Benefit. --- Full parity	As deemed appropriate and are consistent with those for other benefits --- Not Specified. --- Must be equal. State to foot the bill for additional costs incurred by businesses with fewer than 50 employees; the Legislature allocated some $50 million to cover those costs
NC	1985 --- 1991 HB 279 --- 1997: N.C. Gen. Stat. § 58-51-55 --- 2007	Group --- State Employees Health Plan. --- State Employees Health Plan --- Health Insurers	Chemical Dependency. --- Mental Illness --- Mental illness and chemical dependency. --- Mental Illness	Mandated Offering. --- Parity --- Full parity. --- Parity	$8,000 per year and $16,000 per lifetime. --- Must be equal --- Must be equal. --- Must be equal.
ND	1995: N.D. Cent. Code § 26.1-36-09 *[page 431]*	Group and HMO.	Mental disorders, alcoholism and drug addiction.	Mandated benefits.	No deductible or copay for first 5 hours not to exceed 20% for remaining hours.
ND	2003: H 2210	Adds that inpatient treatment and partial hospitalization, or alternative treatment must be provided by an addiction treatment program licensed under chapter 50-31.	Substance abuse	Clarification	
OH	2006: SB 116	Law signed 12/29/06; effective	7 "biologically based mental illnesses," such	Full Parity	

	--- 1985: Ohio Rev. Code Ann.§ 3923.30	--- Group and self-insured.	as schizophrenia and bipolar disorder --- - Mental or nervous disorders and alcoholism.	--- Mandate for plans that offer mental health coverage. Mandated benefits for alcoholism.	--- Subject to reasonable deductibles and coinsurance.
OK	2000: Okla. Stat. tit. 36 §6060.11 to §6060.12 (SB 2, 1999)	Group with a small employer exemption 50 or less, or cost increase of 2% or more.	Severe mental illness.	Full parity.	Must be equal.
OR	1981 --- 2000: Or. Rev. Stat § 743.556 --- 2005: SB 913	Individual --- Group and HMO. --- Group.	Alcoholism --- Mental or nervous conditions including alcoholism and chemical dependency. --- Mental, nervous conditions including alcoholism and chemical dependency.	Mandated Offering. --- Mandated benefits. --- 2007: Full parity NEW	Coverage must be no less than 80% of total. --- Shall be no greater than those for other illnesses. ---
PA	1989 --- 1999 H.366 of 1998, (see § 634)	Group and HMO. --- Group and HMO-small employer exemption 50 or less.	Alcoholism or drug addiction. --- Serious mental illness.	Mandated benefits. --- Mandated benefits.	For the first course of treatment shall be no greater than those for other illnesses. --- Must not prohibit access to care.
RI	1995 --- 1995 R.I. Gen. Laws § 27-38-2.1	Individual, group, self-insured and HMO. --- Individual, group, self-insured and HMO. *(in effect through 12/31/2001)*	Substance dependency and abuse. --- Serious mental illness.	Mandated benefits. --- Full parity.	Not Specified. --- Must be equal.
RI	1/1/2002 H.5478/ S.832 of 2001	Expands the state mental health parity law to include coverage for all mental illnesses and substance abuse disorders. *(replaces § 27-38.2-1 above)*	All mental illnesses & substance abuse disorders.	Full parity	Must be equal
SC	1994 S.C. Code Ann. § 38-71-737	Group.	Psychiatric conditions, including substance abuse.	Mandated offering.	May be different.
SC	2000 SB 1041 (repealed Jan 1, 2005) --- 2005 SB 49	State employee insurance plan with cost increase exemptions. --- Health Plan Insurers. Individual and small group policies are exempt.	Mental health condition or alcohol or substance abuse. --- Psychiatric illnesses as	Full parity. --- Parity.	Must be equal. --- Must be equal.

			defined by DSM-IV published by the APA.		
SD	1979 --- 1998 § 58-17-98 (HB 1262, 1998) --- 1999 HB 1264 --- 2003 HB 1236	Group, individual and HMO. --- Group, individual and HMO. --- Group, individual and HMO. --- Group, individual and HMO.	Alcoholism. --- Biologically-based mental illness. --- Clarifies biologically based mental illness as: schizophrenia, other psychotic disorders, bipolar disorder, major depression, and obsessive-compulsive disorder. --- Offers exclusion of coverage for specified mental illness.	Mandated Offering. --- Full parity. --- Parity --- n/a	Must be equal. --- Must be equal. --- Must be equal. --- n/a
TN	1982 --- 2000 § 56-7-2360; § 56-7-2601	Groups with exemptions for employers with 50 or fewer employees or it plan results in cost increases of 1% or more. --- Group with a small employer exemption 25 or less, or cost increase of 1% or more.	Alcohol and Drug Dependency. --- Mental or nervous conditions.	Mandated Offering. --- Mandated benefits.	Must be equal. --- Must be equal.
TX	1981 --- 1991	Group and self-insured with an exemption for self-insured plans of 250 or less. --- State employee plans.	Chemical Dependency. --- Biologically-based mental illness.	Mandated Benefit. --- Full parity.	Must be sufficient to provide appropriate care. --- Must be equal.
TX	1997 Ins. art. 3.51-14	Group and HMO, with a small employer exemption of 50 or less.	Serious mental illness.	Mandated benefits with a mandated offering for small groups of 50 or less.	Must be equal.
TX	2003: SB 541	Allows insurers and HMOs to offer policies without mandates for the treatment of mental illness and chemical dependency, with an exception for serious mental illnesses.		Exceptions	
UT	2001 Utah Code Ann. 31A-22-625 (HB 35, 2000)	Group (as of 7/1/01) and HMO's (as of 1/1/01)	Mental illness as defined by the DSM.	Mandated offering.	May include a restriction.
VT	1997 Vt. Stat. Ann. tit. 8 §4089b (HB 57, 1997) --- 2006	Group and individual. --- Amends the 1998 statute to add an "any willing provider"	Mental health condition including alcohol and substance abuse. ---	Full parity. ---	Must be equal. ---

	HB 40.	amendment. The law prohibits an insurer from excluding from its network or list of authorized providers any licensed mental health or substance abuse provider located within the geographic coverage area of the health benefit plan if the provider is willing to meet the terms and conditions for participation established by the health insurer.			
VA	2000 thru 7/1/2004 & indefinitely. Va. Code, § 38.2-3412.1	Group and individual with a small group exemption 25 or less. (Note: Extended without sunset date by S 44, see below)	Biologically-based mental illness including drug and alcohol addiction.	Full parity.	Must be equal to achieve the same outcome as treatment for any other illness.
VA	Effective 7/1/2004. § 38.2-3412.1	Group, individual and HMO. (See 2004 change, below)	Mental health and substance abuse.	Mandated benefits.	Co-insurance for outpatient can be no more than 50% after 5th visit. All others must be equal.
VA	S 44 of '04	Repeals sunset date of 7/1/04, above. (enacted 3/19/04)	Mental health and substance abuse.		
VA	S 212 of '04 *§§ 37.1-255*	Establishes Inspector General for Mental Health	Mental health & substance abuse		
WA	1987 Wash. Rev. Code § 48.21.241 -------- 2005 HB 1154 (effective 2006-10) -------- 2006 HB 2501	Group and HMO. ------- State's Basic Health Plan and businesses with 51 or more employees, excluding those that are self-insured. ------ Clarifies that mental health coverage applies to all group health plans for groups other than small groups as defined in existing state law. Provides that the copayment or coinsurance for mental health services be no more than the co-payment or coinsurance for medical and surgical services otherwise provided under the health benefit plan.	Mental health treatment. ------ Mental Health Services except substance related disorders, life transition problems, skilled nursing services, home health care, or court ordered treatment. Court ordered treatment allowed if deemed medically necessary. ------- Requires prescription drugs to treat mental illness be covered as are other prescription drugs.	Mandated offering. ------ Mandated offering. --------- ---	Reasonable deductible amounts and co-payments. ----- Not Specified. ---
WV	1998 § 33-16-3a	Group and individual with a cost increase exemption of 1%.	Mental or nervous conditions.	Mandated offering.	Not specified.
WV	2002 HB 4039	Insurance plans and HMOs. Law allows insurer to apply "whatever	Serious Mental Illness as defined	Full parity	Not specified.

	------ 2004 HB 4286	cost containment measures may be necessary" to maintain costs below 2% of the total costs for the plan. ------- Repeals a section in previous statute relating to coverage for alcohol dependency since it is superseded by a section that explicitly mentions substance abuse treatment.	in the APA DSM. --------	----------	---------
WI	Wis. Stat. § 632.89 ------ 2004 SB 71	Group (with "at least specified minimum benefits in every group contract") ------ Group Insurance	Mental or nervous disorders ------ Exempts prescription drugs and diagnostic tests from minimum coverage limits.	Mandated offering ----- Mandated Offering.	Comparable deductibles and copays ------ Not specified.

NOTES for state mental health statute table:
A) The *Diagnostic and Statistics Manual of the American Psychiatric Association* (DSM) includes universally accepted definitions and descriptions of mental illnesses and conditions. There are 13 DSM diagnoses commonly referred to as biologically-based mental illnesses by mental health providers and consumer organizations. Between 3 and 13 of these diagnoses are referred to in various state parity laws. For example, in Alabama, mental illness is defined as: 1) schizophrenia, schizophrenia form disorder, schizo-affective disorder; 2) bipolar disorder; 3) panic disorder; 4) obsessive-compulsive disorder; 5) major depressive disorder; 6) anxiety disorders; 7) mood disorders; 8) Any condition or disorder involving mental illness, excluding alcohol and substance abuse, that falls under any of the diagnostic categories listed in the mental disorders section of the International Classification of Disease, as periodically revised.

B) **Examples of "Barebones" exception laws:**

- **Colorado H 1164**
- **Texas S 541 of 2003**
- **Montana H 384of 2003**

of 2003 allows small employers to purchase a basic health benefit plan that does not include mental health and substance abuse treatment mandates. allows insurers and HMOs to offer policies without mandates for the treatment of mental illness and chemical dependency, with an exception for serious mental illnesses if the plan is issued to a large employer. An insurer that offers such policy must also offer at least one policy with state-mandated health benefits. allows for a 12-month demonstration project that in some cases, permits a limited coverage plan or managed care plan without mandates for mental illness

Federal Parity Amendment
In 1996 a federal parity amendment was signed into law as part of the VA-HUD appropriations bill. The law, otherwise known as the Mental Health Parity Act of 1996 (Public Law 104-204, see text online), prohibits group health plans that offer mental health benefits from imposing more restrictive annual or lifetime limits on spending for mental illness than are imposed on coverage of physical illnesses. This law expired on September 30, 2001 due to a "sunset" provision, but was extended through December 31, 2002 when President Bush signed Public Law 107-116. The Mental Health Parity Act of 1996 offers limited parity for the treatment of mental health disorders. The statute does not require insurers to offer mental health benefits, but states that if mental health coverage is offered, the benefits must be equal to the annual or lifetime limits offered for physical health care. It also does not apply to substance use disorders, and businesses with fewer than 26 employees are exempt..

On October 30, 2001 the U.S. Senate passed a broader parity bill, which was sent to the House. On December 18, in a House-Senate negotiating meeting, the House members rejected the Senate bill by a 10n-7y vote. The *New York Times* reported that sponsors Senators Domenici and Wellstone "said they wanted to requires health plans and insurance companies to provide equivalent coverage, or parity for mental and physical illness. House Republicans, employers and insurance companies objected to the proposal, saying it would increase costs for employers in a recession, when many businesses are already cutting health benefits because of a resurgence in medical inflation."[6]

9-11: Terrorism Impacts on Mental Health

The events of September 11, 2001 and related bio-terrorism scares had a profound effect on Americans in every part of the United States. In 2003, the war with Iraq brought the potential for new psychological and mental health concerns, according to the American Psychological Association. Yet the issues raised have been a part of health

policy for more than two decades.

The nation, through the actions of federal, state and local governments, and citizens in innumerable roles, united and moved forward. However, the medical traumatic effects of those events impacted many people, for months or even years. *USA Today* reported it this way: "The terrorist strikes and their devastating aftermath are triggering the largest mental health challenge ever faced by employers and straining the USA's army of grief counselors, not just at the attack sites but in workplaces across the country. The emotional fallout was expected to be so widespread that some health insurers are loosening restrictions on employees' use of mental health services." [1] The impact could be far larger than the numbers directly affected. For example, just in Arlington County, Virginia, "some 20,000 to 40,000 of the county's 200,000 residents could experience a traumatic stress reaction from the attacks, officials estimate, pointing to an earlier Surgeon General's report on mental health and disasters." [2]

Mental Health Benefits and Hurricane Katrina Victims

The widespread harm inflicted by Hurricane Katrina includes health impacts and longer-term mental and emotional harm. People who are displaced, injured, have lost loved ones, homes, property, belongings, jobs, family stability, pets, and those with friends, relatives or coworkers affected, may need or seek counseling and medical help. Some, but not all, of the varying state health insurance mandate laws may require coverage of either emergency or longer-term mental health services.

The list below is a general survey of these laws. It provides a quick comparison among states, but it is not intended as a consumer guide to services, since coverage varies even further based on employer and individual contracts, including services offered above or beyond the minimum required by state law. Also public programs including Medicaid, Medicare, local health departments have separate standards of coverage - sometimes more extensive -- than private market health policies.

Expert Sources and Reports

1. U.S. General Accounting Office, *"Mental Health Parity Act: Despite Federal Standards, Mental Health Benefits Remain Limited"* GAO/HEHS-00-95 (Washington, D.C., May 2000) [includes state charts]
2. U.S. General Accounting Office, "*Health Insurance Regulation: Varying State Requirements Affect Cost of Insurance,* GAO/HEHS-96-161 (Washington, D.C: August 1996).
3. U.S. Department of Health and Human Services, Public Health Service, "The Costs and Effects of Parity for Mental Health" (Merrille Sing, Mathematica, 2001)
4. National Center for Policy Analysis, *An Easy Way to Make Health Insurance More Expensive,* February 21, 1997. (Obtained from http://www.ncpa.org/pub/ba/pdf/ba224.pdf; Internet.)
5. Gail A. Jensen and Dr. Michael A. Morrisey, *Mandated Benefit Laws and Employer- Sponsored Health Insurance,* (Health Insurance Association of America: January 1999).
6. "*Drive for More Mental Health Coverage Fails in Congress*", New York Times, December 18, 2001.

For related news stories and resources see:

- "Hurricane Katrina Survivors Lack Access to Mental Health Services" The majority of Hurricane Katrina survivors who developed mental disorders after the disaster are not receiving the mental health services they need, and many who were receiving mental health care prior to the hurricane were not able to continue with treatment, according to an NIMH-funded study published online in the American Journal of Psychiatry. National Institutes of Health (NIH) 12/17/07.
- "TWO MORE STATES ENACT PARITY LAWS," State Health Notes, 1/22/07
- Resilience in the Time of War - articles by American Psychological Association (APA) including tips for assisting children and adults. - March 2003.
- Communities Gear Up for Long-Term Effects of Disaster - Health Intelligence Network- October 8, 2001 [2]
- Psychiatric Dimensions of Disaster a resource list by The American Psychiatric Association, Sept. 2001
- Resources for Responding to Trauma and Terrorism - web page by the National Assoc. Mental Illness
- Disaster Mental Health: Dealing with the Aftereffects of Terrorism - resources from the National Center for Post Traumatic Stress Disorder (PTSD)
  - What are the Traumatic Stress Effects of Terrorism? - fact sheet from NCPTSD, September 2001
  - Recommendations for Pharmaceutical Treatment of Acute Stress Reactions - Sept. 26. 2001
- HHS Makes $35 M in Emergency Funds Available to Entities that Suffered Losses from September Attacks - competitive grants for public and not-for-profit health entities. These grants target NY, CT, NJ, VA, PA and D.C. - news release October 9, 2001
- Nation in shock seeks counseling, consoling - USA Today, September 20, 2001 [1]
- Public Health Preparedness - web updates from CDC, August 2002
- Mental Health menu page - NCSL resources, updated regularly, 2004
- Mental Health Parity: A State Lawmaker's Digest, NCSL, 2001

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September 16, 2005

Senator Dale Schultz
Senate Majority Leader
Room 211 South, State Capitol
P.O. Box 7882
Madison, WI 53707-7882

Representative John Gard
Speaker of the Assembly
Room 211 West, State Capitol
P.O. Box 8952
Madison, WI 53708

RE: Social and financial impact report – Senate Bill 128/Assembly Bill 252

Dear Senator Schultz and Representative Gard:

SB 128/AB 252 increases the minimum dollar amounts that must be covered for inpatient, outpatient, and transitional treatment related to mental health and AODA treatment in group health insurance plans and certain individual health benefit plans. As required in, s. 601.423, Wis. Stats., I am submitting a social and financial report on the proposed health insurance mandate.

Current Wisconsin Law

Wisconsin's current mental health mandated benefits law applies only to group health insurance policies. The services covered under current law are; inpatient services, outpatient services and transitional services.

There are certain minimum coverage amounts for each of the three previously mentioned services.

A group policy that provides coverage for inpatient hospital services must annually cover:

- At least expenses for the first 30 days as an inpatient in a hospital; or
- At least $7,000 minus a co-payment of up to 10% or actuarially equivalent benefits measured in services rendered.
- At least $3,000 minus a co-payment of up to 10% for transitional treatment or actuarially equivalent benefits measured in services rendered.

A group policy that provides coverage for outpatient services must annually cover:

- At least $2,000 of services minus a co-payment for up to 10% or equivalent benefits measured in services rendered.
- At least $3,000 minus a co-payment of up to 10% for transitional treatment or equivalent benefits measured in services rendered.

** However, total coverage for inpatient, outpatient, and transitional treatment services need not exceed $7,000 or equivalent benefits per year.

Additionally, 2003 Act 178 specifically excludes costs incurred for prescription drugs or diagnostic testing from the minimum required coverage.

Proposed Coverage Changes

SB 128/AB 252 increases the minimum coverage amounts for inpatient, outpatient, and transitional treatment as well as the overall minimum coverage amount for a group health insurance policy.

More specifically, SB 128/AB 252 would:

a. Increase the minimum for inpatient treatment of nervous and mental disorders and alcohol and other drug abuse (NM/AODA) from $7,000 annually to $18,300 minus applicable cost sharing or $16,500 with no cost sharing.
b. Increase the minimum for outpatient treatment of NM/AODA from $3,100 annually to $3,100 minus applicable cost sharing or $2,800 with no cost sharing.
c. Increase the minimum for transitional treatment of NM/AODA from $4,700 annually to $4,600 minus applicable cost sharing or $4,200 with no cost sharing.
d. Increase the minimum for all treatment of NM/AODA from $7,000 annually to $18,300.
e. Require the Department of Health and Family Services to annually report to the governor and the legislature on revising the limits based on the change in the federal consumer price index for medical costs. The Legislature is not required to change the required coverage based on this report.

Impact of Mandates

Wisconsin has long benefited from a healthy and competitive insurance market. The state currently has one of the lowest uninsured rates (48 of 51) in the country, according to the U.S. Census Bureau[1]. Increasing the amount of mandated coverage for NM/AODA would raise premium costs which could make insurance coverage more expensive for businesses. A bi-product of increased costs could be the shifting of premium increases to employees in the form of greater cost sharing arrangements.

It is difficult to project the actual impact of any mandate because of the factors involved. The structure of a benefit will affect, either positively or negatively, the level of consumer demand or utilization of service. For example, a limited benefit may lead consumers to decide not to seek treatment that is not vitally necessary. On the other hand, a broader set of benefits could lead to additional utilization for a specific treatments not previously covered. Taking these two limited factors into account, OCI's survey and analysis projects the following impacts of this mandate.

- **The mandate could add approximately $10.9 to $36.6 million per year to premium costs for group health insurance consumers, mostly small and medium sized businesses and potentially employees through cost shifting mechanisms including but not limited to new co-pays, deductibles and coinsurance amounts. This would represent a .15 to .50 %increase of the total premium collected in Wisconsin of $7.3 billion.**

- **Individuals who remain covered under group policies will have an increased access to care for certain treatments as specified.**

[1]DeNavas-Walt, Carmen; Bernadette D. Proctor; and Robert J. Mills, U.S. Census Bureau, Current Population Reports, P60-226, *Income, Poverty, and Health Insurance Coverage in the United States: 2003*, U.S. Government Printing Office, Washington, DC, 2004.

Social Impact Factors

Fully insured group health insurance products cover approximately 1.4 million state residents[2]. This is a dramatic decrease over the past decade in the number of Wisconsin residents who are insured under a group health insurance policy, representing less than 30% of Wisconsin's population. This mandate will expand coverage for those individuals. It is unclear whether there would be any indirect impact with unregulated self-funded plans as such plans are not required to submit for review benefit packages offered to employees with OCI.

People with individual health insurance policies are not covered by Wisconsin's NM/AODA mandate. By extension, this means that they would not be covered by SB 128/AB 252. In 2004 there were approximately 134,769 people in Wisconsin with individual health insurance policies.[3]

Individuals who are members of groups whose benefit plans are self-funded are exempt from state regulation by the Employee Retirement and Income Security Act of 1974 (ERISA) and will not be affected by SB 128/AB 252. Because self-funded plans do not have to offer state-mandated benefits, this option offers self-funded plans the opportunity to limit benefits provided to employees and save on premium costs. Some self-funded plans may, however, choose to provide comparable NM/AODA coverage.

Self-funding of health benefits has historically been used mostly by larger employers, however; over the last decade, the number of medium employers shifting from fully insured to self-funded products has increased. It is unclear to what extent either large or medium size employers are experiencing success in reducing premium costs associated directly to the avoidance of providing employees state mandated coverage.

Figure 1 below demonstrates this occurrence. While commercial insurance coverage has declined in Wisconsin since 2000, enrollment in self-funded health plans has grown by nearly 40 percent. Movement from commercially insured plans into public insurance programs has also increased 24% since 2000; however, it is less certain that health insurance mandates were the main factor in this shift. Wisconsin's ailing economy in 2000 and 2001 and the high cost of health care in general may have had more of an impact than mandates specifically.

According to testimony before the 2002 Study Committee on Mental Health Parity, as many as 1.3 million Wisconsin residents are diagnosed with either a mental disorder or a substance abuse problem which is roughly 22% of the population of Wisconsin. The number of these residents with group health insurance coverage that would be covered under SB 128/AB 252 is unknown at this time.[4]

There is no risk of employers dropping MH/AODA coverage under SB 128/AB 252 and since the mandate itself is not new, there would be no effect on the number of people who would be eligible nor would there be any effect on availability of coverage without the mandate. However, with the increase in health care costs being experienced by employers in Wisconsin during the previous years and the movement toward more consumer directed types of health care benefits being offered by employers, more of these increases will be shifted to the employees, possibly making the coverage unaffordable (even though it is available) for the employee.

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[2] Office of the Commissioner of Insurance (June 2005). *Health Insurance Coverage in Wisconsin* (PI-094 R 06/2005) p. 14. Madison, WI.

[3] Id.

[4] Lang, K. and Zimmerman, D. (October 24, 2002). *Department of Health and Family Services Presentation to the Legislative Council Study Committee on Mental Health Parity.* Madison, WI

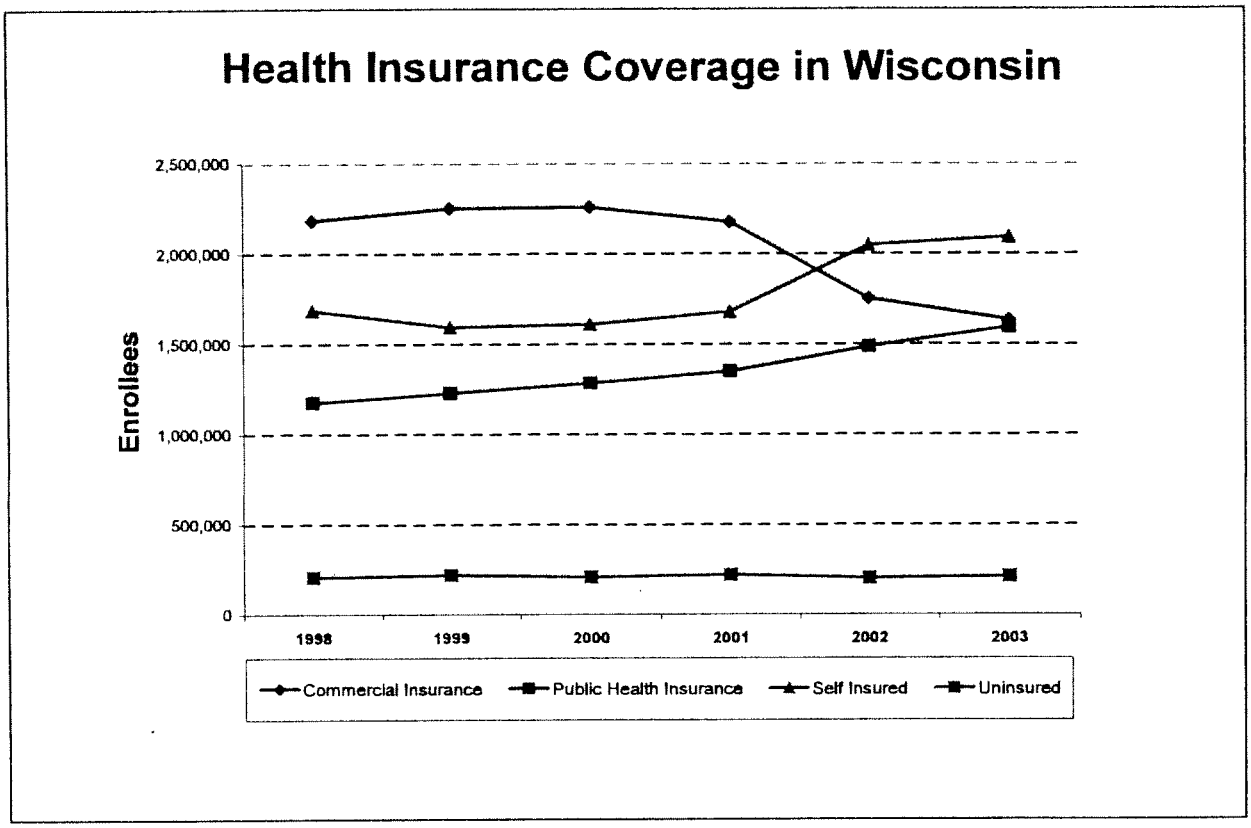

Figure 1. Health Insurance Coverage in Wisconsin 1998-2003.

(Source: OCI, DOA, DHFS)

Financial Impact Factors

In estimating the costs of the coverage proposed in SB 128/AB 252, OCI reviewed the Social and Financial Impact report that was submitted to the Wisconsin Legislature on July 8, 2003 for Senate Bill 72 which contained the same language as 2005 SB 128/AB 252 (although the minimum amounts were different).[5] The report for 2003 SB 72 contained data from states that have implemented parity legislation and the results of state employee health plans that have instituted mental health parity for state employees. This information was contained in reports compiled by PriceWaterhouseCoopers, LLP[6] and the University of South Florida[7]. Additionally, data from the OCI 2001 Study of Certain Mandated Benefits in Insurance Policies[8] and the testimony of Roland Sturm PhD, Senior Economist from RAND Health, to the Health Insurance Committee, National Conference of Insurance Legislators were used in preparing this statement. Subsequent to the Report for 2003 SB 72, additional studies were made available on the

[5] Gomez, J. (July 8, 2003). *Social and Financial Impact Report to Senator Mary Panzer and Representative John Gard.* Madison, WI. Office of the Commissioner of Insurance.

[6] Bachman, Ronald E. (2000). *Mental Health Parity: "Just the Facts" -- Actual Data and Experience Reports.* Prepared for the American Psychological Association, 2000 State Leadership Conference (Atlanta, GA: PriceWaterHouseCoopers).

[7] Levin, B.L., Hanson, A. & Coe, R.D., (2001), *Mental Health Parity; National and State Perspectives 2001: A report to the Florida Legislature*, Tampa, Flaorida; The Louis de la Parte Florida Mental Health Institute

[8] Office of the Commisisoner of Insurance (October 2001). *Study of Costs of Certain Mandated Benefits in Insurance Policies 2001.* Madison, WI.

cost of changes in mental health coverage legislation in Missouri[9], New Jersey[10] and Utah[11]. The information contained in these new surveys has not caused OCI to alter the financial impact estimate that was proposed in 2003 SB 72 for 2005 SB 128/AB 252.

- **Insurance premiums would increase .15% to .50%, or $10.9 to $36.6 million, as a result of the modifications to existing mental health requirements. Again, this represents .15 to .50% of total premium or a per individual monthly increase of $0.64 to $2.17 in increased premium costs**

The above mentioned increase is based on the following assumptions:

- OCI's Survey of Certain Mandated Benefits in Insurance Policies collected data from insurers regarding the level of benefits paid in excess of the mandated benefits for MH/AODA. Eight of the insurers surveyed indicated that they paid out MH/AODA benefits in excess of the mandate. These insurers indicated that the additional cost of those benefits ranged from .01% to .47% of total benefits paid under their group health plan. The insurers did not indicate if the benefit levels were the cost of full parity or of a benefit level less than full but more than the mandate requires. SB 128/AB 252 does not require full parity. Premium data used in the calculation was obtained from the 2003 Wisconsin Insurance Report which indicated that group health insurers $7.3 billion in premiums for that year.

- Several insurers in the OCI survey indicated that they did not include prescription drug costs in the calculation of the minimum coverage amounts as a matter of policy. Wisconsin Act 178, which became effective on April 21, 2004, prohibited the inclusion of prescription drug costs or diagnostic costs in the calculation of mandated costs. However, Act 178 did not apply to policies in force until those policies became renewable, which means Act 178 was not fully in effect until April 20, 2005. Health insurance policies are typically one year contracts. It is too early to tell what type of impact Act 178 has had on the current mandate. However, because mental health and substance abuse treatments have a strong pharmaceutical component, it would be reasonable to assume that Wisconsin Act 178 could serve to dampen cost increases experienced as a result of SB 128/AB 252.

- While the number of people in Wisconsin with commercial health insurance coverage has decreased dramatically, the cost of health care in Wisconsin has increased just as dramatically. With this in mind, greater weight was given to percentage estimates of cost rather than increases estimated on a per member/per month basis as this latter method may underestimate the potential increases applicable to SB 128/AB 252. This is due to the decrease in the number of covered lives which limit the ability to spread increases over a larger pool.

- The states listed in the studies showed per member/per month premium costs increased from a low of $.06 in Maryland and California to $.33 per member/per month in Rhode Island. Other states list percentage increases rather than per member/per month costs. For those states the percentage changes in premium costs vary from .08 percent in Maine to 3% in Vermont and Connecticut.

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[9] Missouri Department of Insurance (2004). *Study to Assess the Impact of the Mental Health and Substance Abuse Insurance Act* (HB 191). Jefferson City, MO.

[10] Mandated Health Benefits Advisory Commission (February 2005). *A Study of Assembly Bill A-333-A Report to the New Jersey State Assembly*. Trenton, NJ.

[11] Hawley, J.E. (February 2004). *2004 Catastrophic Mental Health Report.* Salt Lake City, UT. Utah Insurance Department

- Other states such as Colorado, North Carolina and the Texas State Employee health plan experienced declines in premium costs related to mental health parity. Also, individual insurers in Maryland, Minnesota and New Hampshire also experienced declines in premium costs related to mental health parity.

- These studies and others have established a link between the level of managed care market penetration and the level of increases in premium costs for mental health and substance abuse (MHSA). In the examples above, states that have high levels of managed care market penetration experienced low levels of premium increases, or even premium decreases, due to MHSA. In states where there was less managed care market penetration, premium increases were greater. Also, other factors, such as minimal or inadequate regulation of MHSA in the examples of Vermont and Connecticut also contributed to higher premium increases. Wisconsin has substantial market penetration by managed care insurance plans. For 2004, 1,307,094 employees and their dependants are enrolled in commercial managed care products (Health Maintenance Organization, Preferred Provider Plan or Point of Service Plan).[12]

- The Ohio State Employee Health Insurance Program established full parity benefits in 1991. After 13 years, the program has not experienced a significant growth in MH/AODA costs and the level of benefits has stayed constant. The Ohio employee program is significant in its reliance on managed care.

- Characteristics of managed care for MHSA include declines in average inpatient stays, decreased outpatient visits and decreases in costs for both inpatient and outpatient visits. This trend is evident in a survey of Wisconsin insurers that was compiled by OCI in January 2001. That survey showed decreases in outpatient utilization of .2% and decreases in costs per service of 9.2%. Together these factors contributed to a –1.3% effect on overall insurance premiums for the period surveyed. Increases in other elements, however, outweighed the decline in MHSA and no actual decrease in health insurance premiums was experienced. These characteristics were also evident in Maryland and Minnesota. Both states implemented parity laws in 1995 and experienced neither large cost explosions or flight of employers to ERISA sponsored plans. Cost increases in both states averaged 1-2%.

- Most estimates of mandating full parity in mental health coverage as defined in S. 543, the Paul Wellstone Mental Health Parity Act range from .9% (CBO) to 1%.

Another financial impact factor that OCI is not able to quantify is the amount of productivity gains would be realized by the passage of this bill. It is known that once employees are able to get help for their mental health and/or substance abuse conditions, productivity will increase and related medical costs associated with untreated mental health and substance abuse that goes untreated will decrease. According to the final report of the President's New Freedom Commission on Mental Health, indirect cost of mental illness is $79 billion, with $63 billion of that amount related to lost productivity[13]. There are too many variables that are unknown for OCI to provide a credible estimate that would apply to the State of Wisconsin. Such variables would include the number of patients in group health insurance plans that are also being treated for mental health or substance abuse conditions; what the amount of lost productivity is caused by those patients; or what is the eventual medical cost if these people went untreated. It is possible that an actuarial study could provide a credible estimate of that opportunity cost.

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[12] Office of the Commissioner of Insurance (June 2005). *Health Insurance Coverage in Wisconsin* (PI-094 (R 06/2005) p. 14. Madison, WI.

[13] New Freedom Commission on Mental Health, *Achieving the Promise: Transforming Mental Health Care in America. Final Report.* DHHS Pub. No. SMA-03-3832. Rockville, MD: 2003.

Social and Financial Impact
SB 128/AB 252
September 16, 2005

Impact on the Uninsured

There are many factors that go into an employer's decision to discontinue offering health insurance benefits. As indicated earlier, the number of those with commercial insurance coverage in Wisconsin has decreased dramatically over the past 5 years, while the number of uninsured has remained fairly static. At the same time, however, fewer mandates have been passed by the legislature. It is difficult to estimate what the effect of an additional .15% to .5% increase in health care premiums would be to an employer who would has experienced yearly double digit premium increase without the mandate.

Please contact Eileen Mallow at 266-7843 or Jim Guidry at 264-6239 if you have any questions regarding this report.

Sincerely,

Jorge Gomez
Commissioner

JAG/jrg