State of Wisconsin / OFFICE OF THE COMMISSIONER OF INSURANCE

Jim Doyle, Governor
Sean Dilweg, Commissioner

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April 12, 2010

Assembly Speaker Michael Sheridan
Room 211 West
State Capitol
P.O. Box 7882
Madison, WI 53707-7882

Senate Majority Leader Russ Decker
Room 211 South
State Capitol
P.O. Box 7882
Madison, WI 53707-7882

Dear Speaker Sheridan and Senator Decker,

Pursuant to s. 601.423 Wis. Stats., I am submitting a social and financial report on Assembly Bill 512 (AB512), relating to health insurance coverage of nervous and mental disorders, alcoholism, and other drug abuse problems.

Current State and Federal Law

Practical application of current state and federal law:

- As a result of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (federal parity law), large group health insurance policies providing coverage for medical and surgical benefits in Wisconsin must equally provide coverage for mental health and substance use disorder treatment. Self funded businesses choosing to offer coverage for mental health and/or substance abuse treatment, must also provide such coverage at a parity level.

- Under the federal parity law, providing coverage for mental health and substance use disorder treatment is optional. However, because s. 632.89 Wis. Stats. mandates coverage of mental health and alcohol and other drug abuse treatment, health insurance plans in Wisconsin cannot forgo mental health and substance use disorder treatment benefits. Therefore, WI large group health insurance plans are required to provide parity coverage for mental health and substance abuse treatment, unless a permissible exception under the federal parity law is met.

- Small group (2-50 employees) health insurance policies are not subject to the federal mental health parity requirements but are subject to the minimum coverage amounts for mental health and AODA services provided in s. 632.89 Wis. Stats.

- See Attachments I and II for summaries of current state and federal law.

Assembly Bill 512

Assembly Bill 512 (AB 512), as amended by the Assembly committee on Health and Healthcare Reform, amends s. 632.89 Wis. Stats. to remove the specified minimum amounts of mental health and AODA coverage that large and small group health insurance policies must provide and also extends parity coverage to individual health plans choosing to provide mental health/AODA treatment benefits. The mandate to provide coverage remains with respect to large and small group plans. In other words, a large or small group health plan cannot opt out of providing a mental health/AODA treatment benefit. Conversely, an individual health plan can choose whether to provide mental health/AODA treatment benefits.

The bill prohibits deductibles, copayments, out-of-pocket limits, limitations regarding referrals to nonphysicians and other treatment limitations from being more restrictive for mental health/AODA coverage than the most common or frequent type of treatment limitations that apply to substantially all other coverage under the plan. The bill also requires that expenses incurred for the treatment of mental health and substance abuse problems be included in any overall deductible amount, annual or lifetime limit or out-or-pocket limit under the plan.

AB 512 requires an individual health plan providing coverage of treatment for mental health or AODA problems, group health benefit plans, or governmental self-insured health plans to make available to an insured upon request:

- The plan's criteria for determining medical necessity for coverage of that treatment; and
- The reason for any denial of coverage for services for that treatment.

Large and small group employers can elect for their plans to be exempt from the coverage requirements if a 2% increase in cost is experienced the first plan year, due to the new coverage requirements. A 1% increase must be demonstrated for each year thereafter.

Small employers with fewer than 10 employees may opt out of the parity coverage requirements.

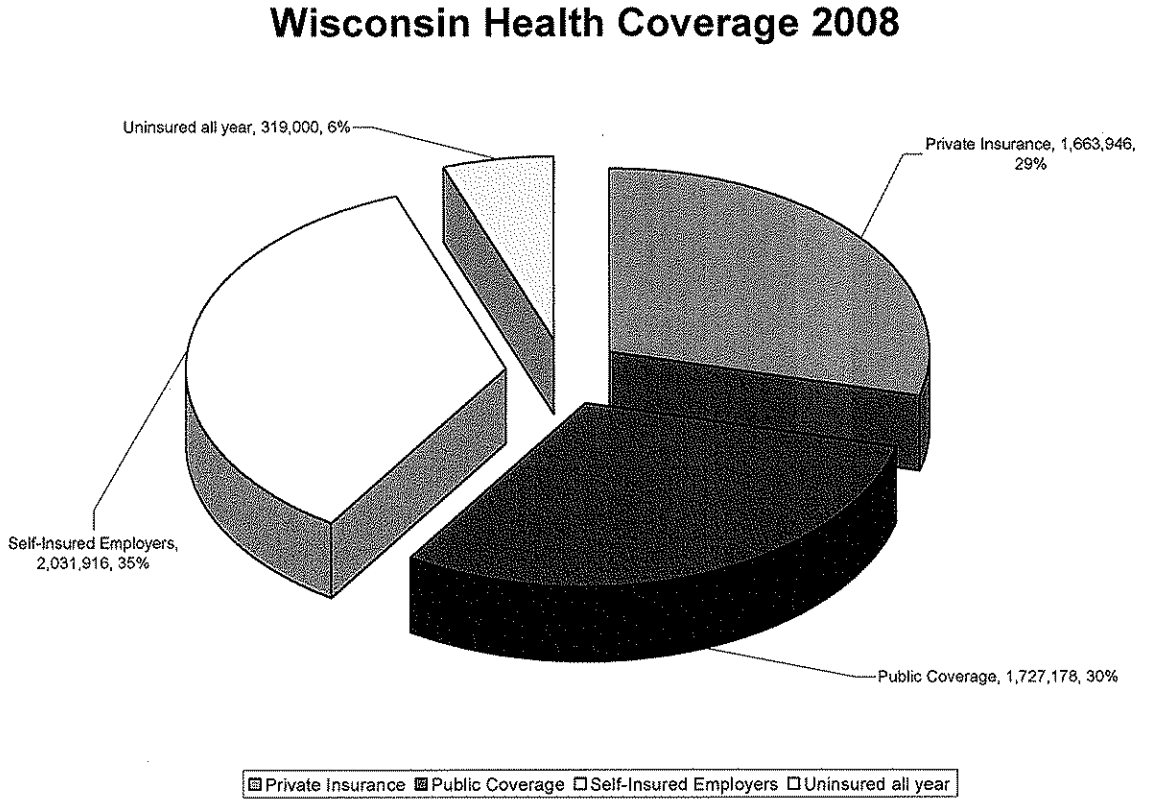
Any employer meeting state or federal parity exemption criteria remains responsible for providing treatment required under s. 632.89 Wis. Stats.

AB 512 clarifies that the parity requirements do not apply to coverage for the treatment of autism spectrum disorder. However, due to federal parity law, large groups must cover autism treatment services at a parity level. Federal parity requirements will pre-empt the autism treatment exemption in AB 512, as it applies to large groups. Therefore, if AB 512 becomes law, small group and individual coverage remain subject to the autism coverage requirements under s. 632.895(12m) Wis. Stats., which requires a minimum of $50,000 in coverage for intensive level treatment and $25,000 for non-intensive level treatment.

Private Insurance Coverage

Privately insured health insurance products cover approximately 1.7 million state residents[1], representing approximately 29% of the state population. This mandate expands coverage for those individuals.

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 AB 512. This exception does not apply to self-insured health plans of the state or a county, city, village, town or school district.



Social Impact

According to the 2008 National Institute of Mental Health report, *The Numbers Count: Mental Disorders in America*, approximately 26.2 percent of Americans over age 18- about one in four adults-suffer from a diagnosable mental disorder in a given year. Such mental disorders include: mood disorder, major depressive disorder, bipolar disorder, schizophrenia, anxiety disorders, panic disorder, obsessive compulsive disorder (OCD) and post-traumatic stress disorder.[2]

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[1] Office of the Commissioner of Insurance

[2] National Institute of Mental Health Website: http://www.nimh.nih.gov/health/publications/the-numbers-count-mental-disorders-in-america/index.shtml#Intro

Nationally, an estimated one in five children is affected by a mental illness.[3]

These statistics suggest that approximately 1.4 million adults and children in Wisconsin have some form of mental illness.[4] Using the estimate that 29 percent of the state population has commercial insurance, it is projected that 406,000 Wisconsin residents have both a mental illness and commercial insurance coverage.

AB 512 provides those covered by a small group health insurance plan or an individual plan offering mental health coverage, greater access to mental health and AODA treatment services. For the period January 2008 through December 2008, there were 343,471 covered lives in the Wisconsin small group market.[5] Such access may be limited for those employed by a business with fewer than ten employees given the "opt out" provision in the bill which allows those employers to offer mental health and AODA benefits below a parity level. It is important to note that those employers remain responsible for providing the minimum coverage amounts outlined in current law, s. 632.895 Wis. stats.

Although AB 512 places parity requirements on large group health insurance plans, these are largely duplicative to those currently required under federal law. Exempt from the federal parity law but required to provide parity coverage under AB 512 are the non-federal governmental self-funded employers. The number of individuals employed by such entities is difficult to assess, however, the Department of Employee Trust Funds indicates there are approximately 181,000 local government employees enrolled in the Wisconsin Retirement System.[6] Most of this population is anticipated to be self funded, however, some may have coverage through private insurance. Those employees with self funded coverage and their families would have greater access to mental health/AODA benefits under AB 512.

In addition to mental health coverage, AB 512 requires parity coverage for AODA treatment. A 2001 report, *Wisconsin alcohol and other drug abuse prevalence,* estimates 403,000 adults in Wisconsin have substance abuse treatment needs.[7] Applying the estimate that 29 percent of the state population has commercial insurance provides an estimate that approximately 116,870 residents with substance abuse treatment needs also have private insurance.

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[3] U.S. Department of Health and Human Services. 1999. Mental Health: A Report of the Surgeon General. Washington, DC: Author.

[4] To calculate the estimate for the number of WI residents with some form of mental illness, the national statistics were applied to the WI population for adults and children, then aggregated. Methodology: 20 percent was multiplied by 1,314,412 (population of persons under 18 in WI.) to get 262,882 children. 26 percent was multiplied by 4,313,555 (adults 18 and over in WI.) to get 1,121,524 adults. The two totals were added to arrive at 1.4 million. Population estimates were taken from U.S. Census data (2008).

[5] Information from OCI Small Employer Rate Change Data.

[6] The WI. Department of Employee Trust Funds indicates there were 193,556 local government employees enrolled in the WI. Retirement System. However, 12,432 of those employees were covered by the WI. Public Employee Group Health Program (health insurance for local governments).

[7] Enders, C., Moskowitz, R., Pancook, M., Schneck, C. (2007) Does Mental Health Parity Make Economic Sense for Wisconsin? *Robert M. La Follette School of Public Affairs; University of Wisconsin-Madison, 4.* This report cites a Welch, Quirke & Moberg (2001) report entitled, Wisconsin alcohol and other drug abuse prevalence estimates.

The number of people impacted by this bill may be reduced given the cost exemptions in AB 512 (and in the federal parity law) and the "opt out" provision.

A survey conducted by OCI of health insurers serving 67% of the large group health insurance market indicates that 8.7%, 9.5% and 9.5% of insureds in the large group market utilized mental health/AODA services in 2007, 2008 and 2009, respectively. Of those utilizing mental health and AODA treatment services, the following percentages (average of all three years) of enrollees hit the minimum coverage amounts required in Section 632.89, Wis. Stat.:

- Inpatient: .7%
- Outpatient: 5.0%
- Transitional: .5%

The survey indicates that 8.2%, 9.3% and 10.4% of insureds in the small group market utilized mental health/AODA services in 2007, 2008 and 2009 respectively. Of those utilizing mental health and AODA treatment services, the following percentages (average of all three years) of enrollees hit the minimum coverage amounts required in Section 632.89, Wis. Stat.:

- Inpatient: .6%
- Outpatient: 4.0%
- Transitional: .6%

Attachment III details the survey findings. These individuals as well as those who previously chose to forgo treatment due to current coverage limits, will benefit from AB 512.

Financial Impact

Mental Health/Substance Abuse Parity Cost Estimate Examples

This section presents estimates from several reports reflecting the cost impact of parity for mental health/substance abuse treatment.

The figures provided do not differentiate between large and small group health plans. An exception are 2007 estimates of S. 558, the Paul Wellstone Mental Health Parity and Addiction Equity Act of 2008. These estimates reflect coverage for large groups since the federal parity law only impacts that population.

Given the federal parity law already requires parity for the large group plans, AB 512 largely impacts the small group plans. As indicated earlier in this report, there were 343,471 covered lives in the Wisconsin small group market in 2008. Health plans in Wisconsin will provide parity coverage for both large and small groups, if AB 512 becomes law. **Therefore, the cost estimate examples in this paper can be used to understand the total potential cost impact of providing full parity to both groups. Adequate data, however, is not available to determine the extent to which parity coverage for small groups impacts available estimates.** In other words, information is unavailable to determine the cost parity coverage for small

groups adds over and above what health plans will incur through providing parity to large groups.

Following is a list of parity cost estimates pulled from various reports:

- The Congressional Budget Office's (CBO) 2007 actuarial study of the proposed comprehensive parity legislation (S. 558) predicted that premiums for group health insurance would increase by an average of about .4 percent.[8]

- A 2007 brief by Milliman of the Paul Wellstone Mental Health and Addiction Equity Act of 2007 estimates insurance premiums will increase by .6% if no increase in utilization management activities occurs in response to parity. The report estimates an actual cost increase of between less than 0.1% and 0.6%, given some plans will implement utilization management.[9]

- A study of the Federal Employees Health Benefits Program estimates the potential increase in health insurance premiums at less than .5%.[10]

- An OCI 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 mental health/substance abuse treatment services. The insurers indicating they paid out benefits in excess of the mandate experienced an additional cost ranging from .01% to .47% of total benefits paid under their group health plan.[11] The report does not indicate the level of excess benefits provided.

- A 2001 study published in "Psychiatric Services," a peer reviewed interdisciplinary journal published by the American Psychiatric Association, estimates the following cost increases associated with full parity, based on figures from the National Mental Health Information Center:[12]
    - PPO and indemnity plans: 5.1% and 5%;
    - HMOs: .6%
    - POS: 3.5%

Wisconsin Specific Information

Taking into account the research reviewed on the fiscal impact of mental health parity, it is determined that estimates are relatively low and typically demonstrate an average of .5% increase in premium, or $40.0 million. This figure is in relation to the

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[8] De Sa, Jeanne; Suzuki, Shinobu; Lex, Leo; Hagen, Stuart. (2007). *Congressional Budget Office Cost Estimate S. 558: Mental Health Parity Act of 2007*

[9] Milliman, An Actuarial Analysis of the Impact of HR 1424, "The Paul Wellstone Mental Health and Addiction Equity Act of 2007." July 5, 2007.

[10] New England Journal of Medicine. (March 2006). *Federal Employees Health Benefits Program.*

[11] Office of the Commissioner of Insurance. (2002). *Study of Costs of Certain Mandated Benefits in Insurance Policies 2001* . IP 37-2002.

[12] Psychiatric Services. (2001). *The Costs of Parity Mandates for Mental Health and Substance Abuse Insurance Benefits.*

approximate $8.0 billion in health insurance premium collected by insurers annually in this state. **Using the established figure of 1.7 million privately insured Wisconsin residents, we can estimate that parity will cost approximately $1.96 per privately insured person, per month. Only a portion of this cost would be new to Wisconsin insurers since they offered at least $7,000 in mental health/AODA coverage per insured for past years. Also note that insurers will incur a large portion of this expense regardless of AB 512 due to the federal parity requirements. While utilization may increase due to availability of coverage, figures from the OCI survey indicate a relatively small population exceeded their mental health/AODA benefit in previous years. The OCI survey asked for the per member/per month cost increase as a result of the new federal parity requirements. Example of plan responses include: $2.40; $2.33; $1.38; $0.91; $0.66 and $2.95.**

Treatment costs for mental illness vary dramatically between disorders. While many mental illnesses require a combination of inpatient, outpatient and transitional services, the table below highlights the average costs of inpatient treatment for various disorders in Wisconsin hospitals.[13]

Price Point Information (July 2008-June 2009)[14]

Condition	Number of Discharges	Median Age	Avg Length of Stay (days)	Average Charge	Charges not covered under WI's Mandated coverage
Schizophrenia	5,289	41	18.8	$21,307	$14,307
Depression	4,234	30	4.5	$6,806	0
Childhood Disorders	1,597	14	11.3	$14,588	$7,588
Psychosis	9,478	39	6.8	$11,021	$4,021
Neuroses other than depression	2,726	26	4.7	$5,982	$0
Organic Disturbances & Mental Retardation	1,193	77	14.3	$19,966	$12,966

[13] Enders, C., Moskowitz, R., Pancook, M., Schneck, C. (2007) Does Mental Health Parity Make Economic Sense for Wisconsin? *Robert M. La Follette School of Public Affairs; University of Wisconsin-Madison, 4.* This report cites a Welch, Quirke & Moberg (2001) report entitled, Wisconsin alcohol and other drug abuse prevalence estimates.
The table is modeled after the one included in the La Follette report but is updated with 2008-09 figures and includes additional disorders.

[14] Calculations completed by the author using data from WI PricePoint. www.pricepoint.org "Charges not Covered" calculations determined by subtracting $7,000 from the "Average Charge."

Condition	Number of Discharges	Median Age	Avg Length of Stay (days)	Average Charge	Charges not covered under WI's Mandated coverage
Other Mental Disorders	412	40	19.1	$34,053	$27,053
Substance Abuse/Dependence, Left Facility Against Medical Advice	762	41	2	$6,502	$0
Alcohol Abuse/Dependence	9,601	46	4	$8,513	$1,513
Other Substance Abuse/Dependence	1,006	$43	9	$12,424	$5,424
Average	3,666.17	39.33	8.75	14,636.08	6,562.92

Seven of the nine disorders had inpatient costs for one inpatient stay higher than the coverage required by state law and, on average, in patient hospital services were $6,562.92 higher than Wisconsin's mandated coverage level of $7,000. In light of the federal parity law, individuals covered by large group health plans are no longer limited to $7,000 in coverage. The data helps illustrate the expenditures individuals insured by a small group health plan, a non-federal, governmental self insured plan or an individual plan without mental health coverage may expect to pay.

Other States: General

There are nineteen states with parity laws that apply to small groups.[15]Some of these states have laws where parity applies to both mental health and substance abuse while others apply only to one. Some only require parity coverage for certain kinds of mental illness, for example, "severe" or "biologically based."

[15] Determined 18 states apply mandate to small groups from a review of the National Conference of State Legislatures table of states with laws mandating or regulating mental health benefits. http://www.ncsl.org/default.aspx?tabid=14352 The 19th state, WA, is not on the NCSL chart but, as of 2008, requires small groups to adhere to parity mandate.

Other States: Vermont

Vermont has a comprehensive mental health/substance abuse parity law which includes coverage of small groups. Data is available regarding pm/pm cost experience of major VT insurers as well as the impact the mandate has had on small employers. VT's experience provides insight into what insurers and employers in WI. may experience if AB 512 is enacted.

Highlights from the Vermont law are as follows:

- Impacts large and small groups as well as individual.
- "Mental health condition" means: any condition or disorder involving mental illness or alcohol or 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.
- A health insurance plan shall provide coverage for treatment of a mental health condition and shall not establish any rate, term or condition than for access to treatment for a physical health condition.
- Any deductible, or out-of-pocket limits required under a health insurance plan shall be comprehensive for coverage of both mental health and physical health conditions.

A 2009 Vermont Department of Insurance report indicates pm/pm in Vermont in 2007 for mental health/substance abuse services ranged from a low of $7.24 for TVHP (utilizes managed care) to a high of $10.41 for Blue Cross Blue Shield VT's (BCBSVT) non-managed care products.[16] Attachment IV to this report contains two tables which break out the pm/pm cost experienced by these insurers for inpatient and outpatient mental health and substance abuse treatment services.

It is important to note that the pm/pm totals referenced above reflect the average amount spent per member per month on mental health/substance abuse services. The figures do not represent a cost increase as a result of parity. Prior to the parity laws, these plans provided some level of coverage for mental health/substance abuse services. Spending by BCBSVT for mental health and substance abuse services, for example, increased by 19 cents pm/pm following implementation of parity. Relative to BCBSVT spending for all services, mental health and substance abuse services accounted for 2.47 percent of the total after parity, up from 2.30 percent pre-parity.[17]

More people received outpatient mental health services following implementation of parity. The percentage of users per 1,000 members increased 6 to 8 percent across two VT health plans (BCBSVT and Kaiser/Community Health Plan).[18]

When Vermont employers were asked to assess the effect of the parity law on any changes they reported in coverage such as cost, 46.5 percent indicated they did not

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[16] State of Vermont Department of Banking, Insurance, Securities&Health Care Administration Legislative Report. (2009). *2009 Insurer Mental Health and Substance Abuse Report Card.*

[17] Rosenbach, M., Lake T., Young C. et.al. (2003). Effects of the Vermont Mental Health and Substance Abuse Parity Law. DHHS Pub. No. (SMA) 03-3822. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration.

[18] Ibid.

know, 32.3 percent said it was not a reason at all, 11.8 percent indicated it was a main or important reason and 9.4 percent said it was one of many reasons. Only 0.3 percent of Vermont employers reported they dropped health coverage for their employees mainly because of the parity law. 0.1 percent of employers reported that parity played a role in the decision to self-insure.[19]

Workplace

According to the U.S. Department of Health and Human Services, 28 million workers in the U.S. workforce experience a mental or substance use disorder. The most prevalent illnesses in the workplace are[20]:

- Alcohol dependence (9%);
- Major depression (8%); and
- Social phobia, an anxiety disorder (7%).

For workers suffering from depression, the disorder may manifest itself as increased health care use, high absence rates, more accidents and increased disability. There is growing evidence that productivity improvements occur as a consequence of effective depression treatment, and those improvements may offset the cost of treatment.[21]

Increasing access to mental health services may produce an associate decrease in physical health claims and acute care services.[22] Depressed patients typically come into a doctor's office with multiple physical ailments—3 times the number of symptoms compared with non-depressed patients.[23] A Health Enhancement Research Organization (HERO) study analyzed medical claims and health risk data for about 46,000 private and public employees to determine the relative importance of 10 modifiable health risk factors in terms of their impact on employee medical costs. The risk factor predicting the largest medical cost increase was depression. Employees who reported being depressed were 70% more expensive than their non-depressed counterparts.[24]

Another benefit to employers is the potential for increased safety and fewer occupational accidents. With treatment, employees with a mental illness should be more focused, which should reduce the number of workplace accidents that occur. Employers may therefore see a reduction in workers' compensation costs.[25] One study

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[19] Ibid.

[20] Substance Abuse and Mental Health Services Administration. Workplaces that Thrive: A Resource for Creating Mental Health-Friendly Work Environments. SAMHSA Pub. No. P040478M. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2004.

[21] Goetzel, R., Ozminkowski, R., Sederer L., Mark, T., (2002). *The Business Case for Quality Mental Health Services: Why Employers Should Care About the Mental Health and Well-Being of Their .Employees.*

[22] Enders, C., Moskowitz, R., Pancook, M., Schneck, C. (2007) Does Mental Health Parity Make Economic Sense for Wisconsin? *Robert M. La Follette School of Public Affairs; University of Wisconsin-Madison, 4.*

[23] Goetzel, R., Ozminkowski, R., Sederer L., Mark, T., (2002). *The Business Case for Quality Mental Health Services: Why Employers Should Care About the Mental Health and Well-Being of Their .Employees.*

[24] Ibid.

[25] Enders, C., Moskowitz, R., Pancook, M., Schneck, C. (2007) Does Mental Health Parity Make Economic Sense for Wisconsin? *Robert M. La Follette School of Public Affairs; University of Wisconsin-Madison, 4.*

found that people with substance abuse disorders are 3.5 times more likely to experience an accident in the workplace and 5 times more likely to file for workers' compensation.[26]

Self funded testimonials

A number of U.S. workplaces offer mental health benefits on par with their medical plans and have done so for many years.[27]

Aurora testified to the Wisconsin Assembly Committee on Health and Health Care Reform that it has been a provider of mental health benefits to its employees at parity since 2002. The testimony further stated, "Since 2002 our costs and claims have been statistically unchanged before and after parity, averaging between 2.5 and 2.9 percent of all claims annually."

The Partnership for Workplace Mental Health talked with several employers to learn more about their experiences with offering parity benefits.[28] Below are a few excerpts:

- Houston Chronicle
  - The Chronicle's total health care costs remained flat, and they experienced a number of additional benefits. The parity effort and increased attention on mental health has helped improve worker performance, enhanced communication between managers and employees, and reduced the stigma or accessing treatment.

- Houston Texans
  - Instituted parity in 2002. Employees did use the mental health benefits, but total costs did not increase. The base rate and premiums stayed the same.

- DuPont
  - Has had mental health parity since 1991. Paul Heck, EAP Director, indicates that "people with mental health conditions that are unaddressed will often act out in the workplace in ways that employers don't consider, e.g. by excessive emotionality and confrontation that leads to work team disruptions, presenteeism, lawsuits, loss of intellectual property, increased turnover rates, etc."

- State of Ohio
  - Gary Hall, benefit manager, said, "Mental Health Parity is still saving us money." In 1995, coverage increased from 23,000 lives to 134,000 lives. The state still paid less then what it paid in 1990 for 23,000 employees.

- Polk County, Florida

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[26] Brumbaugh, A. (1998). *The cost of untreated alcohol and other drug problems.*
[27] Research Works: Partnership for Workplace Mental Health. (2009). *Successful Employer Implementation of the Federal Mental Health Parity and Addiction Equity Act.*
[28] Ibid.

- Starting in 2008, there is no distinction between mental health and medical visits. There are no limits on the number of psychiatric outpatient visits, residential visits for drug addiction are covered, depression screening is utilized, etc. The County has seen utilization overall increase slightly but costs have not increased.

Potential Impact on State Corrections Expenses

Expenditures for inmate mental health care totaled approximately $59.8 million in fiscal year 2007-08.[29] In June 2008, the number of inmates with mental illnesses within DOC's inmate population was 6,957.[30] According to the Department of Corrections, approximately 72% of inmates have AODA needs, however, these can range from being involved in an educational program for those with addiction related problems to those needing serious intensive treatment.

The federal parity law coupled with AB 512 may result in future state correctional system savings as more individuals obtain greater access to mental health and AODA services.

Please contact **Eileen Mallow at 266-7843** or **Jennifer Stegall at 267-7911** if you have any questions regarding this report.

Sincerely,

Sean Dilweg
Commissioner

[29] McCully, S., Drilias, E., Fontaine, J., Regan, M., Sommerfield, R. and Steiner Timothy (2009). *Inmate Mental Health Care* . State of Wisconsin Legislative Audit Bureau http://www.legis.wisconsin.gov/lab/reports/09-4Full.pdf

[30] Ibid

Attachment I

Summary of Wisconsin State Law

Under Current state law, s. 632.89 Wis. Stats.:

- A group health insurance policy providing coverage of any inpatient hospital services must cover those services for the treatment of nervous and mental disorders (mental health) and alcoholism and other drug abuse problems (AODA) in the minimum amount of:
  - 30 days of inpatient services; or
  - $7,000 minus applicable cost sharing; or
  - If no cost sharing applies, $6,300.

- A group health insurance policy providing coverage of any outpatient hospital services, must cover those services for the treatment of mental health and AODA in the minimum amount of:
  - $2,000 minus applicable cost sharing; or
  - If no cost sharing applies, $1,800

- A group health insurance policy providing coverage of any inpatient or outpatient hospital services must cover the cost of transitional treatment arrangements for the treatment of mental health or AODA in the minimum amount of:
  - $3,000 minus applicable cost sharing; or
  - If no cost sharing applies, $2,700

- A group health insurance policy providing coverage for both inpatient and outpatient hospital services, the total coverage for all types of treatment for mental health and AODA problems is not required to exceed $7,000.

Attachment II

Summary of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008

Federal Law Requirements:

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (federal parity law) applies to plan years beginning after October 9, 2009 or for calendar year plans, January 1, 2010.

Financial Requirements and Treatment Limitations

The federal parity law prohibits large group health plans providing medical, surgical and mental health or substance use disorder benefits from applying more restrictive financial requirements to mental health or substance use disorder benefits than the predominant financial requirements applied to substantially all medical and surgical benefits covered by the plan. This prohibition also applies to treatment limitations. Note that large employers can choose to offer health coverage without mental health and/or substance use disorder benefits. (Note: Large groups in Wisconsin cannot choose to forgo a mental health/substance use disorder benefit due to the state mental health/AODA mandate).

Financial requirement includes deductibles, co-payments, coinsurance and out of pocket expenses, but excludes an aggregate lifetime limit and annual limit.

Treatment limitations include limits on the frequency of treatment, number of visits, days of coverage, or other similar limits on the scope or duration of treatment.

Predominant means a financial requirement or treatment limit that is the most common or frequent of such type of limit or requirement.

No separate cost-sharing requirements can be applied to the mental health or substance use disorder benefits.

Small Employer Exemption

Small employer means 2-50 employees.

The parity requirements do not apply to any group health plan for any plan year of a small employer.

Availability of Plan Information

Upon request, the criteria for medical necessity determinations made under the plan with respect to mental health and substance use disorder treatment must be provided to any current or potential beneficiary, participant or contracting provider.

Upon request, information must be provided regarding the reason for any denial under the plan with respect to mental health and substance use disorder treatment.

Out of Network Providers

If the plan provides coverage for out of network medical and surgical benefits, it must provide coverage for mental health or substance use disorder benefits provided by out of network providers (in a manner that is consistent with the requirements of this section).

Cost Exemption

A group health plan is exempt from parity if application of the parity requirement results in an increase of the actual total costs of coverage with respect to medical/surgical benefits and mental health substance use disorder benefits under the plan.

A plan must apply the parity requirements for at least 6 months before determining it has experienced an increase in actual total costs of coverage with respect to medical and surgical benefits and mental health and substance use disorder benefits.

The total increase in cost must be 2% in the first plan year to qualify for the cost exemption. The exemption is applied to the following plan year and is in effect for 1 year. NOTE: An employer may elect to continue to apply the parity requirements.

A plan experiencing at least a 1% increase in costs for each subsequent plan year (after the first plan year where it was determined costs increased by at least 2%), is exempt from the parity requirements.

Increases in actual costs under a plan are made by and certified by a qualified and licensed actuary who is a member in good standing with the American Academy of Actuaries.

The determinations by actuaries shall be in a written report, which must be maintained by the group health plan (or health insurance issuer) for 6 years.

A group health plan must notify the following after it is determined it qualifies for a cost exemption:

- The Department of Labor Secretary
- The appropriate state agencies
- Participants and beneficiaries in the plan

Per Member Per Month Allowed Amounts By Insurer and Third Party						
	All BCBSVT		Magellan Managed		Non-Managed	
BCBSVT Allowed Amounts PMPM	2006	2007	2006	2007	2006	2007
Inpatient Mental Health PMPM	$1.42	$2.01	$1.40	$1.89	$1.53	$0.55
Inpatient Substance Abuse PMPM	$1.79	$0.55	$1.75	$0.52	$1.08	$0.27
Outpatient Mental Health PMPM	$5.32	$5.04	$4.98	$4.80	$9.17	$9.18
Outpatient Substance Abuse PMPM	$0.40	$0.51	$0.40	$0.52	$0.42	$0.41
Total PMPM (sum)	$8.93	$8.11	$8.53	$7.73	$12.20	$10.41

	All TVHP		Magellan Managed	
TVHP Allowed Amounts PMPM	2006	2007	2006	2007
Inpatient Mental Health PMPM	$1.14	$1.56	$0.99	$1.56
Inpatient Substance Abuse PMPM	$1.99	$0.63	$1.87	$0.63
Outpatient Mental Health PMPM	$4.53	$4.39	$4.35	$4.39
Outpatient Substance Abuse PMPM	$0.52	$0.66	$0.52	$0.66
Total PMPM (sum)	$8.18	$7.24	$7.73	$7.24

Survey Responses

I. Question: What percentage of large group health plan enrollees in calendar years 2007, 2008 and 2009 utilized mental health and/or alcohol and other drug (AODA) services? Of those enrollees who utilized services, what percentage hit the minimum coverage amounts required in Section 632.89, Wis. Stat. for outpatient services, inpatient hospital services and transitional treatment arrangements? If complete data for calendar year 2009 is not available by the due date of this survey, provide information for the last month data is available. Indicate the timeframe for which the data applies.

Table 1- Large Group Health Plan Enrollees Utilizing Mental Health/AODA Services

Year	Co. 1	Co. 2	Co. 3	Co. 4	Co. 5	Co. 6	Co. 7	Co. 8	Co. 9	Co. 10	Co. 11	Average
2007	7.4%	7.0%	9.9%	8.2%	8.9%	6.6%	12.1%	9.8%	6.9%	9.6%	9.2%	8.7%
2008	7.4%	6.7%	10.6%	7.6%	10.2%	11.5%	12.1%	11.4%	8.4%	8.9%	9.3%	9.5%
2009	6.9% (thru 10/31)	7.3%	10.3%	8.3%	10.8%	10.7%	12.3%	11.0%	8.2%	9.6%	9.3%	9.5%

Table 2- Percentage of Large Group Members Utilizing Mental Health/AODA Services that hit the Minimum Inpatient Hospital Services Coverage Amounts in Section 632.89, Wis. Stat.

Year	Co. 1	Co. 2	Co. 3	Co. 4	Co. 5	Co. 6	Co. 7	Co. 8	Co. 9	Co. 10	Co. 11	Average*
2007	1.0%	0.1%	0.1%	0.2%	0.7%	0.1%	0.7%	0.4%	Data Unavailable	1.8%	0.8%	0.6%
2008	1.2%	0.1%	0.1%	0.2%	0.8%	0.3%	0.7%	0.9%		1.8%	0.8%	0.7%
2009	1.2% (thru 10/31)	0.1%	0.1%	0.2%	1.0%	0.3%	0.6%	0.9%		1.8%	0.9%	0.7%

Table 3- Percentage of Large Group Members Utilizing Mental Health/AODA Services that hit the Minimum Outpatient Services Coverage Amounts in Section 632.89, Wis. Stat.

Year	Co. 1	Co. 2	Co. 3	Co. 4	Co. 5	Co. 6	Co. 7	Co. 8	Co. 9	Co. 10	Co. 11	Average*
2007	9.1%	1.0%	0.9%	8.2%	2.8%	1.4%	12.0%	2.1%	Data Unavailable	1.2%	5.9%	4.5%
2008	9.3%	1.0%	0.7%	7.6%	3.0%	2.6%	11.5%	4.9%		1.2%	6.7%	4.9%
2009	8.3% (thru 10/31)	1.1%	0.6%	8.3%	3.5%	1.7%	12.4%	4.9%		1.6%	6.8%	4.9%

Table 4- Percentage of Large Group Members Utilizing Mental Health/AODA Services that hit the Minimum Transitional Services Coverage Amounts in Section 632.89, Wis. Stat.

Year	Co. 1	Co. 2	Co. 3	Co. 4	Co. 5	Co. 6	Co. 7	Co. 8	Co. 9	Co. 10	Co. 11	Average*
2007	0.6%	0.0%	0.1%	0.0%	0.6%	0.0%	0.4%	0.1%	Data Unavailable	2.8%	0.2%	0.5%
2008	0.7%	0.1%	0.1%	0.0%	0.3%	0.0%	0.3%	0.1%		2.8%	0.2%	0.5%
2009	1.0% (thru 10/31)	0.1%	0.2%	0.0%	0.5%	0.0%	0.3%	0.0%		2.5%	0.2%	0.5%

*Average of Available Data.

II. Question: What percentage of small group health plan enrollees in calendar years 2007, 2008 and 2009 utilized mental health/and or AODA services? Of those enrollees who utilized services, what percentage hit the minimum coverage amounts required in Section 632.89, Wis. Stat. for outpatient services, inpatient hospital services and transitional treatment arrangements? If complete data for calendar year 2009 is not available by the due date of this survey, provide information for the last month data is available. Indicate the timeframe for which the data applies.

Table 5- Small Group Health Plan Enrollees Utilizing Mental Health/AODA Services

Year	Co. 1	Co. 2	Co. 3	Co. 4	Co. 5	Co. 6	Co. 7	Co. 8	Co. 9	Co. 10	Co. 11	Average
2007	8.5%	5.9%	8.1%	7.9%	11.4%	5.9%	9.1%	11.0%	7.8%	8.7%	6.3%	8.2%
2008	8.5%	5.6%	8.8%	8.1%	21.1%	6.2%	9.0%	12.2%	8.0%	8.5%	6.3%	9.3%
2009	7.6% (thru 10/31)	5.2%	8.4%	6.6%	37.0%	6.4%	8.6%	12.2%	7.9%	8.5%	6.1%	10.4%

Table 6- Percentage of Small Group Members Utilizing Mental Health/AODA Services that hit the Minimum Inpatient Hospital Services Coverage Amounts in Section 632.89, Wis. Stat.

Year	Co. 1	Co. 2	Co. 3	Co. 4	Co. 5	Co. 6	Co. 7	Co. 8	Co. 9	Co. 10	Co. 11	Average*
2007	1.7%	0.1%	0.2%	0.0%	0.3%	0.4%	0.6%	0.2%	Data Unavailable	1.8%	1.0%	0.6%
2008	1.8%	0.1%	0.2%	0.0%	0.4%	0.1%	0.4%	0.5%		1.1%	0.9%	0.6%
2009	2.1% (thru 10/31)	0.1%	0.2%	0.2%	0.2%	0.3%	0.6%	0.4%		1.3%	0.9%	0.6%

Table 7- Percentage of Small Group Members Utilizing Mental Health/AODA Services that hit the Minimum Outpatient Services Coverage Amounts in Section 632.89, Wis. Stat.

Year	Co. 1	Co. 2	Co. 3	Co. 4	Co. 5	Co. 6	Co. 7	Co. 8	Co. 9	Co. 10	Co. 11	Average*
2007	9.9%	0.8%	1.2%	7.9%	1.4%	3.8%	9.1%	4.0%	Data Unavailable	0.7%	5.1%	4.4%
2008	6.5%	0.7%	1.2%	8.1%	1.2%	3.1%	7.7%	2.9%		1.0%	5.3%	3.8%
2009	8.2% (thru 10/31)	0.8%	0.7%	6.6%	1.4%	3.2%	8.8%	2.3%		0.9%	6.5%	3.9%

Table 8- Percentage of Small Group Members Utilizing Mental Health/AODA Services that hit the Minimum Transitional Services Coverage Amounts in Section 632.89, Wis. Stat.

Year	Co. 1	Co. 2	Co. 3	Co. 4	Co. 5	Co. 6	Co. 7	Co. 8	Co. 9	Co. 10	Co. 11	Average*
2007	0.5%	0.0%	0.0%	0.0%	0.5%	0.0%	0.4%	0.0%	Data Unavailable	3.5%	0.1%	0.5%
2008	1.0%	0.1%	0.0%	0.0%	0.3%	0.0%	0.4%	0.0%		4.1%	0.4%	0.6%
2009	1.2% (thru 10/31)	0.0%	0.0%	0.0%	0.3%	0.0%	0.2%	0.1%		4.7%	0.4%	0.7%

*Average of Available Data.

III. Question: Prior to the effective date of The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), did your group plans cover more than the state minimums required in Section 632.89, Wis. Stat.? If yes, for calendar years 2007, 2008 and 2009 indicate the total coverage amount for outpatient services, inpatient hospital services and transitional treatment arrangements for large group plans. Indicate the same for small group plans. If different coverage amounts apply to mental health and AODA treatment, specify the coverage amount for each.

Table 9- Plans that Exceeded State Minimums and Descriptions of Benefits.

	Co. 1	Co. 2	Co. 3	Co. 4	Co. 5
Cover More than State Minimum?	Yes. Prior to the effective date of The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), all [our] group plans exceeded state minimum requirements of s. 632.89, Wis. Stat.	Yes, for nearly all small and large group clients [our] mental health and AODA coverage is more generous than the state-mandated benefit amounts.	No.	No.	No.
Description of Benefit	Generally, coverage options available to plan participants provided a minimum of 50% coverage beyond state minimums and ranged upward to include a plan benefit option that provided 90% coverage (up to $50,000 and 100% thereafter). Our plan options did not vary between large and small groups and did not include any internal caps on MH/AODA coverage.	Below is our most popular small and large group plan design for mental health and AODA: Outpatient -- Greater of 25 outpatient visits or $1,800 paid Inpatient -- Greater of 15 inpatient days or $6,300 paid Transitional -- Greater of 15 transitional days or $2,700 paid	NA	NA	NA

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Table 9 (Cont.)- Plans that Exceeded State Minimums and Descriptions of Benefits.

	Co. 6	Co. 7	Co. 8	Co. 9	Co. 10	Co. 11
Cover More than State Minimum?	No.	Yes, we provided benefits beyond the minimum required in section 632.89, Wis. Stat.	Yes.	As the original Mental Health Parity Law prohibited flat dollar amounts, [we provide] "day limits" or "visit limits", which are in excess of the state mandate. These apply to all groups regardless of size.	No.	No.
Description of Benefit	NA		The policies that exceeded the required minimum covered amounts had unlimited coverage [...]	[W]e have translated the "day limits"/"visit limits" benefit into total dollars. Inpatient- $25,560 Outpatient- $5,800 Transitional- $4,305	NA	NA

Respond to the following question if the answer to part I of is "yes."
Of those enrollees who utilized mental health and/or AODA services in calendar years 2007, 2008 and 2009, what percentage hit the maximum coverage amount allowed for such services under their plan? Provide this information for enrollees covered by large group health plans and those covered by small group health plans. If complete data for calendar year 2009 is not available by the due date of this survey, provide information for the last month data is available. Indicate the timeframe for which the data applies.

Table 10- Percentage of Large and Small Group Members Utilizing Mental Health and/or AODA Services that Met or Exceeded the Maximum Coverage Amount Allowed Under their Plan.

	Co. 1	Co. 2			Co. 3	Co. 4	Co. 5
Large Group Plans	[T]here were no internal caps placed on MH/AODA services under [our] plans in any of the years listed above.	Type	Year	Percent Maximizing Benefit	NA	NA	NA
		Inpatient	2007	0.02%			
			2008	0.02%			
			2009	0.02%			
		Outpatient	2007	0.09%			
			2008	0.09%			
			2009	0.10%			
		Transitional	2007	0.02%			
			2008	0.02%			
			2009	0.02%			
Small Group Plans		Type	Year	Percent Maximizing Benefit			
		Inpatient	2007	0.03%			
			2008	0.04%			
			2009	0.04%			
		Outpatient	2007	0.27%			
			2008	0.17%			
			2009	0.17%			
		Transitional	2007	0.03%			
			2008	0.04%			
			2009	0.04%			

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Table 10 (Cont.)- Percentage of Large and Small Group Members Utilizing Mental Health and/or AODA Services that Met or Exceeded the Maximum Coverage Amount Allowed Under their Plan.

	Co. 6	Co. 7		Co. 8	Co. 9		Co. 10	Co. 11
Large Group Plans	NA	Year	Percent Maximizing Benefit	The policies that exceeded the required minimum covered amounts had unlimited coverage, so no members met a maximum.	Year	Percent Maximizing Benefit	NA	NA
		2007	8.4%		2007	0.02%		
		2008	9.1%		2008	0.01%		
		2009	9.5%		2009	0.01%		
Small Group Plans		Year	Percent Maximizing Benefit		Year	Percent Maximizing Benefit		
		2007	9.9%		2007	0.04%		
		2008	8.1%		2008	0.01%		
		2009	9.6%		2009	0.01%		

IV. Question: The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) impacts plan years beginning after October 3, 2009 (for calendar year plans, January 1, 2010). Indicate the percentage of plans subject to MHPAEA requirements in October 2009, November 2009 and December 2009. For plans subject to MHPAEA requirements in 2009, what was the pm/pm increase as a result of the MHPAEA requirements? For plans subject to MHPAEA beginning on January 1, 2010, what is the pm/pm increase as a result of the MHPAEA requirements?

Table 11- Percentage of Plans Subject to MHPAEA Requirements from October 2009-December 2009.

	Co. 1	Co. 2	Co. 3	Co. 4	Co. 5	Co. 6	Co. 7	Co. 8	Co. 9	Co. 10	Co. 11	Average
Percent of Plans Subject to MHPAEA requirements Oct 09-Dec 09	0%	4%	0%	3%	7%	4%	17%	3%	4%	4%	4%	5%

Table 12- Per Member/ Per Month Increase in Premium as a Result of MHPAEA Requirements for Plans Subject to MHPAEA Requirements in 2009.

Plan	Co. 1	Co. 2	Co. 3	Co. 4	Co. 5	Co. 6	Co. 7	Co. 8	Co. 9	Co. 10	Co. 11	Average*
pm/pm Increase	None, requirements already built into policies.	-0.2% to 0.8% (no dollar value available)	No Explicit pm/pm given.	$2.40	$2.29	$1.38	$5.82	$6.35	$0.80	$0.05	$2.74	$2.43

Table 13- Per Member/ Per Month Increase in Premium as a Result of MHPAEA Requirements for Plans Subject to MHPAEA Requirements beginning January 1, 2010.

Plan	Co. 1	Co. 2	Co. 3	Co. 4	Co. 5	Co. 6	Co. 7	Co. 8	Co. 9	Co. 10	Co. 11	Average*
pm/pm Increase	None, requirements already built into policies.	-0.2% to 0.8% (no dollar value available)	No Explicit pm/pm given.	$2.40	$2.33	$1.38	$5.82	$5.91	$0.91	$0.66	$2.95	$2.48

*Averages are of Available Data given in dollar amounts. Company 1 is not included as all of their plans already adhered to MHPAEA requirements.