



FACT SHEET

The Wisconsin Mental Health and Addiction Parity Act (Senate Substitute Amendment 1 to SB-362)

The Wisconsin Parity Act will provide immediate mental health and substance use disorder insurance benefits at parity levels for 200,000 currently insured employees of Wisconsin’s small businesses—as well as their spouses and dependent children. Under this legislation, 173,000 individuals may also benefit from the increase in mental health and substance use disorder benefit coverage if their individual policies offer this coverage.¹ Ultimately, for many of the 700,000 Wisconsin employees whose companies are exempt from the federal *Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (P.L. 110-343)*,² the *Wisconsin Parity Act*—which is based upon this legislation—will provide them with the opportunity to be insured at increased treatment benefit levels.

The Wisconsin Parity Act will have no state fiscal impact. Because state employee and Medicaid programs must comply with the *Wellstone-Domenici Act* there is no additional fiscal impact on these programs. The one requirement that did create a fiscal impact—the requirement for annual, prepartum and postpartum depression screenings—was removed from the bill.

The Office of the Commissioner of Insurance will be granted authority to promulgate rules to ensure that the Wisconsin Parity Act conforms to requirements of the Wellstone-Domenici Act. The Insurance Commissioner has testified that he can address any potential issues that may arise.

The Wisconsin Parity Act recognizes the concerns of small business. Using language consistent with federal guidelines as outlined in the *Wellstone-Domenici Act*, new amendments to the *Wisconsin Parity Act* will allow employers with fewer than 10 employees to opt out for one plan year at a time of the parity provision. The amendments also permit larger employers who can show that parity has increased their insurance costs by two percent in the first year, and then one percent in later plan years, to opt out for one plan year at a time as well.

Mental illness and drug addiction are physical diseases which can be successfully treated

Addiction / Substance Use Disorders

- Scientific evidence has shown substance use disorders to be chronic, relapse-prone diseases which literally change brain chemistry, and are recognized as such by the American Medical Association. Substance use disorders affect 1 in 11 Americans.³

- For the past 30 years, federally sponsored research has repeatedly confirmed that treatment results in positive outcomes and is cost effective. A recent study showed a reduction in alcohol and drug use (52 percent and 69 percent, respectively) one year after treatment; a 1994 study showed a 64 percent reduction in arrests one year after treatment.⁴

Mental Illness

- Mental illnesses—which affect about one in four adults,⁵ approximately 57.7 million Americans—are serious **medical** illnesses. They are not related to a person’s “character” or intelligence, and cannot be overcome through “willpower.”
- 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.⁶

Parity is good for business and labor

Wisconsin’s small businesses can’t afford the costs of untreated mental illness and substance use disorders. For a minimal investment, parity will save millions of dollars in reduced sick days, increased worker productivity and decreased healthcare and disability costs.

Parity:

- **Will reduce the costs associated with untreated mental illness and substance abuse totaling an estimated \$80-100 billion annually**, including disability and unemployment insurance claims, absenteeism, presenteeism and lost productivity.⁷
- **Will help improve both the mental AND physical health of workers**, which can lead not only to lower healthcare costs, but also improved employee productivity.⁸
- **Will not lead to a dramatic increase in healthcare costs.** In fact, parity will cause health insurance premiums to increase by approximately 0.4 percent,⁹ according to the federal Interim Final Rules implementing the *Wellstone-Domenici Act* released Feb. 2 by the Departments of the Treasury, Labor, and Health and Human Services. This conclusion is based upon a November 2007 cost estimate prepared by the Congressional Budget Office—the most authoritative, independent, expert analysis of parity’s economic impact on private-sector employers.
- **If implemented in the context of medical management and managed care, may, in fact, reduce or have little impact on overall healthcare costs**, which are routinely twice as high for people living with substance use disorders than those without; and even higher for people living with both substance abuse *and* mental health disorders,¹⁰ according to the Departments of the Treasury, Labor, and Health and Human Services citing studies of at least nine states: California, Maine, Maryland, Minnesota, North Carolina, Pennsylvania, Rhode Island, South Carolina and Vermont.¹¹

For example, Blue Cross and Blue Shield of Minnesota, which covers more than two-thirds of the population in the state, was able to reduce its insurance premiums by five percent after one year's experience under the state's comprehensive mental health parity law in 1995 that included mental health and substance abuse.¹²

- **May provide a significant cost benefit to businesses**, according to a dozen critical reviews and meta-analyses that have been conducted in the last 25 years to examine this cost-benefit question. This body of knowledge provides substantial evidence that providing mental health treatment offsets or reduces the subsequent use of medical care services and their associated healthcare and disability costs.¹³
- **Improves health outcomes for people with heart disease, diabetes, cancer and other chronic diseases.** A cost-benefit analysis from a range of industries found that 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.¹⁴ Moreover, actuaries at PriceWaterhouseCoopers built a model of integrated care which indicated that after five years, the payer would realize \$5 in savings for every \$1 spent on behavioral health services.¹⁵
- **Is a civil rights issue.** The Interim Final Rules quote Rep. Patrick Kennedy (D-Rhode Island), one of the chief sponsors of the *Wellstone-Domenici Act*: “[a]ccess to mental health services is one of the most important and most neglected civil rights issues facing the Nation. For too long, persons living with mental disorders have suffered discriminatory treatment at all levels of society.”¹⁶

Eighty percent of employers in the U.S. already sponsor mental health benefits coverage, according to the Society of Human Resource Management's most recent benefits survey in 2009, which is in direct recognition of the tremendous impact that mental health and substance use disorders have on the workforce and the company's bottom line.¹⁷

The *Wellstone-Domenici Act*—upon which the *Wisconsin Parity Act* is based—received support from both the business and insurance communities, with supporters that included the U.S. Chamber of Commerce, the National Retail Federation, the American Benefits Council and America's Health Insurance Plans.¹⁸

Parity works for Wisconsin businesses: Two case studies

- **Journal Communications, Inc.**—a Milwaukee-based media and communications company with 4,000 employees nationally—**experienced decreases in both its behavioral health utilization as well as its behavioral health costs in the first year it offered parity-level mental health and substance use disorder treatment benefits (April 2008-March 2009).**

After one year of parity, the company's behavioral healthcare costs were competitive with other members of the Business Health Care Group (BHCG), a coalition of employers in southeastern Wisconsin, many of whom have not implemented parity. Compared to BHCG normative data, Journal Communications' behavioral health pharmacy costs were nearly equal (\$4.63

pm/pm compared to \$4.53 pm/pm); its outpatient costs were slightly above the average (\$2.75 pm/pm compared to \$2.33 pm/pm); and its inpatient costs were significantly lower (\$.66 pm/pm compared to \$1.09 pm/pm).¹⁹

- In June 2009, KI, a Green Bay-based, international furniture-making corporation with 3,000 employees worldwide—1,400 of whom are currently insured by KI—implemented parity to stem rising disability claims costs, predominately in the mental health category. By providing parity, **KI anticipates a reduction in the indirect and direct costs of untreated mental health and substance use disorders in addition to a cost savings in areas such as increased worker productivity, and reduced absenteeism and disability claims.**²⁰

Labor supports parity—the Wisconsin State AFL-CIO is also a strong supporter of the Wisconsin Parity Act, recognizing that both employees and employers benefit from the provision of mental health and substance use disorder insurance coverage at parity levels—through enhanced employee wellness and productivity resulting in an improved bottom line.²¹

Parity is good for Wisconsin children

- Many Wisconsin children have mental health problems, problems that are real and painful, and can be severe. **Nationally, about 20 percent of children are estimated to have mental disorders** with at least mild functional impairment;²² research shows that half of all lifetime cases of mental illness begin by age 14.²³
- Unfortunately, **only about 20 percent of children and adolescents with psychiatric disorder in the U.S. receive any kind of mental health services,**²⁴ despite the fact that mental health problems can be successfully recognized and treated. Most of the symptoms and distress associated with these disorders can be alleviated with timely and appropriate treatment and supports.²⁵
- **Strong mental health is a crucial component of scholastic achievement for children.** Untreated mental illness leads to higher-than-normal dropout rates, high rates of school absenteeism and tardiness. Referral to a school-based mental health center or to counseling reduces absenteeism by 50 percent and tardiness by 25 percent, according to a 2000 study published in the Journal of School Health.²⁶

¹ The Lewin Group, “The Wisconsin Health Plan (WHP); Estimated Cost and Coverage Impacts,” Final Report, Prepared for the Wisconsin Health Project, June 4, 2007. and U.S. Department of Health and Social Services, Agency for Healthcare Research and Quality, “Medical Expenditure Panel Survey (MEPS),” Table II, State of Wisconsin, Private Sector Data by Firm Size, 2008.

² *The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008* (Division C, Title V, Subtitle B, Secs. 511-512 of The Emergency Economic Stabilization Act, H.R. 1424, P.L. 110-343) effective as of October 3, 2009.

³ National Institute on Drug Abuse Info Facts: Treatment Approaches for Drug Addiction.

<http://www.drugabuse.gov/infofacts/treatmeth.html>

⁴ Open Society Institute-Baltimore. [Tackling Drug Addiction](http://www.soros.org/initiatives/baltimore/focus_areas/drug_addiction). Found at

http://www.soros.org/initiatives/baltimore/focus_areas/drug_addiction

⁵ Kessler RC, Chiu WT, Demler O, Walters EE. Prevalence, severity, and comorbidity of twelve-month DSM-IV disorders in the National Comorbidity Survey Replication (NCS-R). *Archives of General Psychiatry*, 2005 Jun;

62(6):617-27. Per National Institute of Mental Health (<http://www.nimh.nih.gov/health/publications/the-numberscount-mental-disorders-in-america/index.shtml>)

⁶ Mental Health America. Factsheet: Depression in the Workplace. Found at: <http://www.nmha.org/index.cfm?objectid=C7DF951E-1372-4D20-C88B7DC5A2AE586D>

⁷ Research Works, page 14.

⁸ Melek, S. (2009). Preparing for parity: Investing in mental health [White Paper]. Denver, CO: Milliman. Available from: www.milliman.com. As quoted in Research Works: Partnership for Workplace Mental Health (December 2009). Successful Employer Implementation of the Federal Mental Health Parity and Addiction Equity Act, page 13. Available at <http://www.workplacementalhealth.org/pdf/RWParityFinal.pdf>

⁹ Interim Final Rules under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, Federal Register/Vol. 75, No. 21/Tuesday, February 2, 2010/Rules and Regulations, Supplementary Information, Sec. IV, Economic Impact and Paperwork Burden, page 5427.

¹⁰ Druss, B. G., & Rosenheck, R. A. (1999). Patterns of health care costs associated with depression and substance abuse in a national sample. *Psychiatric Services*, 50, 214–218. AND Kathol, R. G., McAlpine, D., Kishi, Y., Speies, R., Meller, W., Bernhardt, T., et al. (2005). General medical and pharmacy claims expenditures in users of behavioral health services. *Journal of General Internal Medicine*, 20, 160-167. Quoted in Research Works (page 14).

¹¹ Interim Final Rules, page 5425.

¹² Bachman, R.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. As quoted in Research Works, page 24.

¹³ A comprehensive list of these studies is available at Research Works, page 21.

¹⁴ A. Lo Sasso et al, Modeling the impact of enhanced depression treatment on workplace functioning and costs. *Medical Care*, 2006.

¹⁵ *Managed Behavioral Health News*, January 2000.

¹⁶ Interim Final Rules, page 5422.

¹⁷ Research Works, page 14.

¹⁸ Research Works, page 3.

¹⁹ Jeff Kluever, “Utilizing Mental Health Parity to Enhance Your Bottom Line.” This webinar, hosted by Workforce Wisconsin, can be viewed at:

<http://hosted.mediasite.com/mediasite/Viewer/?peid=c6872ef3ffa84229b1f012ce920a967b>

²⁰ New Day Coalition, February 17, 2010, Business and Labor Support the Wisconsin Parity Act letter to Members of the Wisconsin State Assembly.

²¹ *Id.*, page 3.

²² U.S. Department of Health and Human Services. *Mental Health: A Report of the Surgeon General—Executive Summary*. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health, 1999. Found at: <http://www.surgeongeneral.gov/library/mentalhealth/summary.html>

²³ Kessler RC, Chiu WT, Demler O, Merikangas KR, Walters EE. “Prevalence, severity, and comorbidity of 12-month DSM-IV disorders in the National Comorbidity Survey Replication.” *Arch Gen Psychiatry*. 2005 Jun; 62(6):617–27. In National Institute of Mental Health, “Treatment of Children with Mental Illness Frequently asked questions about the treatment of mental illness in children.” Found at: <http://www.nimh.nih.gov/health/publications/treatment-of-children-with-mental-disorders/nimh-treatment-childrenmental-illness-faq.pdf>

²⁴ Fritz, G.K., M.D. “The Shortage of Child Psychiatrists in the U.S.: Causes and Solutions.” Presentation to the New York STEPS Roundtable (September 10, 2007). Found at: http://www.scaany.org/collaborations/documents/steps_shortage_caps.ppt

²⁵ Substance Abuse and Mental Health Services Administration, National Mental Health Information Center. “Children’s Mental Health Facts: Children and Adolescents with Mental, Emotional, and Behavioral Disorders.” Found at: <http://mentalhealth.samhsa.gov/publications/allpubs/CA-0006/default.asp>

²⁶ Substance Abuse and Mental Health Services Administration, National Mental Health Information Center. “Children’s Mental Health Facts: Children and Adolescents with Mental, Emotional, and Behavioral Disorders.” Found at: <http://mentalhealth.samhsa.gov/publications/allpubs/CA-0006/default.asp>