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Case Example Illustrations in Support of SB 308 Mental Health/Substance Abuse Parity Legislation

Illustration Number One:

Susan, who is a 33-year-old woman, was previously married to an alcoholic. After being severely beaten for several years, she and her four children took temporary refuge in a shelter for battered women. The shelter referred her to counseling and job training. She returned home, received job training, and is now employed in a clerical position. Her husband is out of the home. The oldest child, a boy who is 14, has started to batter the younger siblings, ages 11, 9, and 5, and the mother.

The shelter referred her and the children to a counseling agency where she attended multiple therapy appointments per week - for herself and with her children. Therapy required to address Susan's depression and family alcohol problems requires at least 9 to 12 months of weekly or bi-weekly treatment (minimum of 18 sessions). In responding to the needs of battery victims, it can be assumed that there is a 90% probability that her spouse is chemically dependent; that the children will exhibit battering and/or alcoholic behavior; and that Susan will need extensive psychotherapy to regain a sense of self-esteem and to acquire the basic skills necessary to care for herself and to redirect the behavior of her children. Existing insurance coverage under the current mandated program runs out long before Susan's counseling needs end.

Without access to more extensive treatment, at least one of her children is very likely to continue the battery pattern in the family - either by becoming the batterer or being a battery victim. Without mental health services Susan will experience related physical symptoms and will utilize medical care facilities (inappropriately) to treat her emotional problems. Family stability would be greatly enhanced, as would the likelihood of successfully developing a non-battering relationship if she and her children would have access to more intensive treatment programs.

Illustration Number Two:

Mark, who is between the age of 6-12 years, as likely to be female as male, as likely to be black or Hispanic as white, is the victim of sexual abuse. Mark has been repeatedly, sexually abused by an adult - someone he knows - and has experienced psychological and social problems related

to being a sexually abused child. If Mark does not receive counseling as a victim of sexual abuse, it is likely that he will "act out" as a teenager. This "acting out" may result in delinquency behavior such as thefts, drug use, truancy, involvement in a teenage pregnancy, or being socially or scholastically withdrawn.

Children such as Mark who have been sexually abused, are reluctant to talk about their experiences and have difficulty building a positive self image because of their experiences. Treatment with these children usually needs to go well beyond one year. If their treatment needs are not addressed as youths, it is likely that their maladjusted behavior will intensify as the reach adulthood, and they will need more intensive and more costly treatment later. As Mark reaches adulthood it is likely that the quality of his family life and work productivity will be limited until he addresses the psychological affects of his sexual abuse experience. Early intervention for children like Mark cannot be completely achieved without expanded coverage for outpatient counseling services.

Illustration Number Three:

Alan, a 30-year-old man, married in his teens and divorced in his early twenties. He has one child that he pays support for - the child lives out of state. Alan has a $20,000 income and health insurance coverage which includes alcohol counseling benefits. He has been an alcoholic since his teens and is now aware that alcohol affected his first marriage and his subsequent relationships.

He received alcoholism treatment five years ago, remained dry for 1 1/2 years and started drinking again.

He entered an outpatient treatment program, sponsored by a local hospital for two months. His therapy was terminated as his health care benefits ran out. A few months later, he and his girlfriend came to couples counseling. Alcohol became a major concern in the counseling. At this point Alan has maintained sobriety for six months.

In order to stabilize his life Alan will require outpatient treatment for at least one year to get him beyond that "magic year-and-a-half" time in which he previously remained dry, and then started drinking again. If Alan does not have access to long-term treatment, it will be difficult for him to maintain sobriety and to be productive in his job. Long-term therapy would allow Alan to significantly change his alcohol related behavior and to become connected to long-term support programs such as Alcoholics Anonymous.

He has agreed to enter a specialized therapy program, which focuses on group therapy and involvement of family members in the therapy period. His parents will enter the program with him. However, given his income and his child support payments, he is able to pay only a portion of the fee for the program. An increase in the benefits coverage to meet his therapy needs would significantly enhance the likelihood of his completing a long-term therapy program, his chances of remaining sober, and keeping his job.

Addiction:
A Brain Disease

IN THE LAST DECADE, we've revolutionized our fundamental understanding of the nature of addiction. "Contrary to popular belief, addiction is not just a lot of drug use," says Alan Leshner, director of the National Institute on Drug Abuse. "It's literally a disease of the brain."

"Drugs hijack the mind by hijacking the brain," he explains. "Scientists have identified molecules in the brain associated with every major drug of abuse." They've also found that all drugs have common effects on dopamine, a neurotransmitter involved in the experience of pleasure. "Alcohol, heroin, cocaine, nicotine, marijuana—all modify dopamine function in similar ways," says Leshner. "Initially, people take drugs because they like what it does to their brains, but over time something happens. All of a sudden, you're taking drugs not because you like them but because you must. This compulsion is the essence of all addiction."

Prettyman/Photo Edit

All drugs—from alcohol to cocaine—change the brain in profound ways.

Symptoms can be treated, but Leshner warns, "Addiction is not like strep throat. It doesn't go away. Drugs change brain cells in profound, long-lasting ways."

NFIB Wisconsin

NFIB
The Voice of Small Business

Statement Before the Senate
Committee on Health, Utilities, Veterans and Military Affairs

By

Bill G. Smith
State Director
National Federation of Independent Business
Wisconsin Chapter

Wednesday, February 9, 2000
Senate Bill 308: Health Insurance Mandates

Mr. Chairman, and members of the Committee, my name is Bill G. Smith, and I am State Director for the Wisconsin Chapter of the National Federation of Independent Business.

Mr. Chairman, I would like to suggest that the subject of today's hearing – Senate Bill 308 – has nothing to do with mental health or substance abuse. The public policy debate is not over whether there is a need or whether there are societal benefits derived from government requiring certain coverages for mental health and substance abuse.

The public policy debate is over whether government should interfere with health purchasing decisions made in the private sector. The public policy debate should be over whether government should in its collective wisdom --- be making decisions that we believe are best left to those who pay the premiums.

That's why small business owners oppose insurance coverage mandates. According to survey studies by NFIB's Research Foundation, 90 percent of our members are strongly opposed to all insurance coverage mandates: because they increase small business insurance premiums, reduce coverage, and set the undesirable precedent that government should dictate benefits offered and paid for by the private sector.

INCREASE COST

The cost of health insurance has increased dramatically for small business owners --- nearly one-quarter of Wisconsin small businesses that purchase health insurance coverage were clobbered by premium hikes of more than 20 percent in 1998.

One small business owner testified before the Assembly Small Business Committee that his firm's rates were going up 33 percent in 1999.

Even a study conducted by the Hays/Huggins Company, and paid for by the National Institute of Mental Health, concluded that mental health parity will increase the cost of the traditional fee for service plan (which are purchased by the majority of Wisconsin small businesses) by 4-5 percent, a point of service plan by 3 percent, and HMO less than 1 percent.

And the Congressional Budget Office reports that for every one percent increase in premiums, 200,000 fewer individuals have health insurance coverage.

In fact, according to one recent study, one in five to as many as one in four uninsured people lack coverage due to benefit mandates.

The actuarial firm of Milliman and Robertson, estimates mental health parity will increase premiums, on the average, by 5-10 percent per year. (Small business owners almost always pay more than average.)

And, a study by Watson Wyatt Worldwide, a Maryland benefits consulting firm, estimated that full mental parity would increase the cost of a typical health plan by 8.8% to 11%.

To put the Watson Wyatt study in a perspective of dollars: "If employers responded to mental health parity by reducing coverage for other health care services, the study found that either co-payments would increase from $10 to $30.50 or a **new** comprehensive deductible of between $150 and $198 would need to be imposed.

So whatever the public purpose of these mandates, whether they be to reduce premium rates, or improve health care, whenever government mandates coverage of certain procedures, services, products or diseases, mandates, such as the one before you for consideration today, are at cross-purposes with their mission if they actually lead to less coverage or no coverage rather than more coverage, and regardless whether that mandate relates to physical or mental health.

So the only debate is over how much will the cost go up and how many small business owners, their employees, and their families, will lose their health insurance coverage due to mandates.

REDUCE COVERAGE

While government mandates specific coverages, workers actually pay for those mandated coverages by sometimes reducing coverage in other areas, and, of course, as premiums increase it may also be necessary to reduce wages so employers can continue to make a plan available.

A 1990 survey by the National Bureau of Research found that the cost of mandated benefits is usually borne by employees in the form of reduced wages, reduced work hours, or loss of employment.

The bottom line, Mr. Chairman, is while mandates enhance coverage and some argue they improve the quality of health care for a few, mandates actually increase costs for everyone, and the cost of mandates falls disproportionately on workers in smaller firms --- those least able to bear this burden.

Larger firms have the option to self-fund their insurance plans and are, therefore, generally exempt from this proposal and all other mandated coverage proposals. In fact, this mandate will apply to only about, on average, a third of the state's population covered by a private group plan.

Of course, this legislation will also increase insurance costs for all taxpayers since it applies to health plans of state and local units of government.

Mr. Chairman, and members of the Committee, as you know few organizations have worked as hard as the members of NFIB for health care reforms that will not only improve access, but also reduce and contain the cost of health insurance.

The legislature deserves our gratitude for enacting market reforms and cost saving options, such as deductability of premiums, and the creation of a medical savings accounts, health care data collection, and a statewide health care purchasing alliance for small business.

Yet, I would ask that members of this committee and members of the Senate, reject proposals that will add millions of dollars to the cost of health insurance for thousands of Wisconsin small business owners, and for those individuals employed by our smaller firms.

According to one study for every one-percent increase in the cost of health insurance, there is a three-percent loss of coverage for small business.

While the proponents of this proposal may argue the increased costs associated with any one mandate are minimal – it is critical for members of the committee, to recognize that a mere 1 percent in the cost of a health insurance plan equals a $36 million increase in premium cost for Wisconsin employers purchasing commercial health insurance. And when you add up the cost of all the mandated coverage's, you are soon

looking at 15-30 percent increase in the cost of health insurance for Wisconsin's small business owners and their workers.

Meanwhile, remember because the federal ERISA law preempts self-insured plans from state mandates, big businesses that self-insure their plans are not affectd by this mandate or any other mandate.

Therefore, those firms least able to afford the higher cost get hit --- small businesses --- in a direct hit on target for higher premiums on Main Street.

Small businesses cannot ignore the mandates.

- They will pay higher premiums.
- They will reduce coverage.
- They will cancel coverage.
- They will reduce their workforce to help them spread limited benefit dollars around.
- Or they will raise prices, placing them at a competitive disadvantage.

In closing, I urge members of the committee to keep focused on the target --- reducing the number of uninsured and containing the cost of health insurance. This proposal and other mandate proposals take us in the wrong direction --- more uninsured and higher insurance costs. I hope that you will vote for more affordable health insurance for small businesses and their workers, and that you will vote against recommending Senate Bill 308 for passage.

Senate Bill 308 Statement

Senate Committee on Health, Utilities, Veterans and Military Affairs
February 9, 2000
Testimony in support of Senate Bill 308
Presented on behalf of the Wisconsin Psychiatric Association
Harold Harsch, M.D.

Thank you Senator Moen and Health Committee members for the opportunity to testify in support of Senate Bill 308. My name is Dr. Harold Harsch. I am a psychiatrist representing the Wisconsin Psychiatric Association. Professionally I am an Associate Professor of Psychiatry and Medicine at the Medical College of Wisconsin. I am currently based at Froedtert Memorial Lutheran Hospital in Milwaukee. I have spent most of by professional career as the Medical Director of a medical psychiatry unit in Milwaukee. A unit that was specifically designed to care for patients requiring hospitalization who have both medical and psychiatric conditions.

I would like to begin by describing some of the historical influences that have led to the unequal treatment of what are now called psychiatric illnesses from so-called physical illnesses. This distinction dates backs to early Greece where psychiatric illnesses, which included seizure disorders, were considered states of possession by the gods. In fact it was Hypocrates who very accurately described major psychiatric illnesses such as schizophrenia, severe depression and anxiety disorders. He campaigned to change the view of his colleagues and the Greek people, at the time, to view the symptoms such as seizures and abnormal behavior as illnesses of the brain and not possession by a god. During the middle ages, individuals with severe psychiatric illnesses were often persecuted and put to death because they were viewed, at that time, not to be possessed by God, but now to be possessed by the devil. It was the late 19th Century when Dr. Alzheimer studied and described what we now know as Alzheimer's disease; his colleague Dr. Kreplin studied and described what we now know as schizophrenia and manic depressive illness. Both of these researchers knew they were studying brain illnesses. Yet, in the United States today Alzheimer's disease is considered a physical illness while schizophrenia and manic depressive illness are classified as, "psychiatric illnesses" which results in significantly restricted insurance coverage for the management and treatment of these illnesses.
Even 40 to 50 years ago in the United States and Western Europe, there were prominent psychiatrists and psychologists who ascribed etiologies to major psychiatric illnesses such as

childhood autism and schizophrenia to the child rearing and behavioral practices of mothers. Today this sounds foolish to most of us. Perhaps there may be less stigma and misunderstanding than several decades ago, the problems of accepting psychiatric problems or illnesses persist and are pervasive in our society.

Numerous times in which I have treated patients who have sustained dramatic recovery where they tell me that they would rather have "cancer" than share with others their diagnosis of a psychiatric illness.

Over the years when I was Medical Director of the Medical Psychiatry Unit – at what was Milwaukee County Medical Complex – I took over the care of dozens of individuals who were transferred to the Milwaukee County facility because their mental health insurance benefits were exhausted. For many of those years, we were able to provide, what I considered to be, excellent treatment with good outcomes for the majority of our patients. That safety net, however, is gone. There is no Milwaukee County Medical Complex and the majority of psychiatric hospitals and psychiatric programs in the state limit the amount of charity care that they will provide.

Many psychiatric illnesses, ranging from obsessive/compulsive disorder to schizophrenia, do have effective treatments. Most of these treatments did not exist before 1950 when the most common approach to these severe illnesses would be to institutionalize the individual for months even years at a time. If aggressive and appropriate treatment does not occur, many of these conditions lead to partial or full disability. Even if some psychiatric conditions do not lead to disability in the workplace, many lead to interpersonal and social disability. I recently received a letter from an individual who suffered from panic disorder with a fear of open places (called agoraphobia). He has been housebound for the past decade and unable to work. What is sad is that treatment for panic disorder is not difficult and often very successful.

Senate Bill 308 Testimony
Harold Harsch, M.D.
February 9, 2000

Let me share an example of how the current cap of outpatient services at $2,000 per year handicaps treatment in a case of obsessive/compulsive disorder (OCD). Again, from my own caseload, an individual suffered from and obsessions about cleanliness, and could not tolerate perceived germ contamination that led to termination from his job. After treatment the symptoms were controlled fairly well with Prozac and he once again became employable. The cost of the Prozac to control his obsessive/compulsive disorder was $3,000 per year. His insurance included the psychiatric drug cost within the $2,000 cap. This is only one example of how effective treatments exist that keep people in the workforce. However, in this case because OCD is considered a "mental illness" or "psychiatric disorder" the insurance health benefits did not even cover the prescription, much less any outpatient physician visits or psychotherapy that occurred.

Manic depressive illness, or bipolar disorder as it is sometimes called, affects one to three percent (1% - 3%) of the population. All credible researchers consider this a brain illness. Over the last few years, research has shown that the more uncontrolled episodes that occur, the more difficult it becomes to control the disorder. Since bipolar disorder usually begins in the 20's, my goal as a physician would be to carefully control this individual's disorder with one or more of the available so-called mood stabilizers. Depending upon which mood stabilizer is used, there are blood tests, there are mandatory physician visits and there are prescription drug costs that easily exceed the $2,000 per year outpatient mandate. However, this is still less expensive than the treatment and medication costs associated with the case of one insulin dependent diabetic over a year. Both the diabetic and the individual with bipolar disorder deserve good medical care.

What we need to ask ourselves as a society in the year 2000 is why does the discrepancy in coverage for mental illness and psychiatric disorders still exist? Are we still haunted by centuries of stigma and misbeliefs? I urge you to support Senate Bill 308 "Mental Health Parity" because parity is both medically and socially correct.

Thank you for allowing me to testify before you today.

4/jse/D:\\Psych-FEH\Doctors\Harsch\Senate Testimony

By substance related disorders, I mean **substance use disorders**, including alcohol, nicotine, and other drug dependencies; **substance-induced mental disorders** such as dementia, psychosis, depression and other substance-induced psychiatric conditions; **substance induced medical conditions** such as cirrhosis, emphysema, hepatitis, and substance-related trauma; and conditions of **intoxication and withdrawal** from alcohol, nicotine, prescription drugs, and other legal and illegal drugs. When I say alcoholism, I mean the same thing as alcohol dependence. When I say nicotine or other drug addiction, I mean the same thing as nicotine dependence or other drug dependence.

My **main points** today are these:

Substance use is a significant public health issue.

Substance dependence is a chronic medical illness.

Substance dependence is a treatable medical illness.

Treatment for substance related disorders is fiscally affordable.

Access to treatment for substance related disorders has diminished in Wisconsin even as the condition remains prevalent: benefit levels are effectively lower than before, and treatment providers have been unable to maintain treatment slots for patients, especially for insured patients.

Parity in insurance benefits for substance related disorders is not untried or dangerous.

Parity in insurance benefits for substance related disorders is the right thing to do.

Parity in insurance benefits for substance related disorders is the smart thing to do.

It is time to pass the current legislation and make parity for insurance benefits for mental disorders and substance related disorders a reality in Wisconsin.

WISCONSIN COALITION FOR ADVOCACY

THE PROTECTION AND ADVOCACY SYSTEM FOR PEOPLE WITH DISABILITIES

February 9, 2000

To: Members of the Senate Committee on Health, Utilities, Veterans and Military Affairs

From: Dianne Greenley
Wisconsin Coalition for Advocacy
Survival Coalition

Re: Senate Bill 308 – Parity for Mental Health and Substance Abuse Treatment

The Wisconsin Coalition for Advocacy, the state's protection and advocacy agency for persons with disabilities, and the Survival Coalition, representing 25 statewide disability organizations, urge your support for Senate Bill 308.

For too many years persons with mental illness and persons with substance abuse problems have suffered from discrimination in insurance coverage. While one's neighbor could receive full coverage for treatment for diabetes, cancer, or heart disease, the individual coping with schizophrenia, depression, or bipolar disorder could receive only very minimal coverage. According to the recent U. S. Surgeon General's report on mental illness, this resulted in an enormous financial burden for families : "For a family with mental health treatment expenses of $35,000 a year, the average out-of-pocket burden is $12,000; for those with $60,000 in mental health expenses in a year, the burden averages $27,000. This is in stark contrast to the out-of-pocket expense of only $1,500 and $1,800, respectively, that a family would pay for medical/surgical treatment." Mental Health: A Report of the Surgeon General (2000), p. 427.

It is time for Wisconsin to follow the lead of 28 other states and the federal government in ending this fundamental unfairness for persons with mental illness and persons with substance abuse problems. By enacting parity legislation we will be enabling persons to get back to work, helping families pay for quality services for children with serious emotional and/or substance abuse problems, and saving money in other health care costs.

However, for years the insurance industry and others have argued that the cost is too high. Fortunately the data are now available to rebut this assertion. The federal government published two reports in 1998 that provide excellent information about the implementation of parity legislation in other states. A study by the Substance Abuse and Mental Health Services Administration (SAMHSA) examined the experience of 5 states that had implemented parity laws for at least one year. Based on their findings they estimate that full parity could result in an average premium increase of 3.6%; however, the amount of increase depends heavily on the type of insurance plan involved. Thus, in HMOs that tightly manage care the increase would be only

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0.6%. In point of service plans the increase may be 3.5%; while in fee for service plans the increase may be 5%. This study also found that employers did not shift from insurance plans to self-funded plans following parity and that costs did not shift from the public sector to the private sector. (Sing, Hill, Smolkin and Heiser, The Costs and Effects of Parity for Mental Health and Substance Abuse Insurance Benefits, U. S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (1998).

The second study, by the National Advisory Mental Health Council, found that there was an interesting interactive effect between parity and managed care. They examined three states with parity legislation and found that the adoption of parity spurred the development of managed care for mental health and substance abuse services with the result that costs actually decreased. Texas and North Carolina initially adopted parity for only state employees and simultaneously adopted a managed care approach. In Texas the per member per month costs decreased 50% and in North Carolina they decreased 32%. In Maryland where the legislation covered all insurance plans costs increased slightly in the first year after the adoption of parity (about 1%), stabilized in the second year and then decreased slightly in the third year. National Institute of Mental Health, Parity in Financing Mental Health Services: Managed Care Effects on Cost, Access, and Quality: An Interim Report to Congress by the National Advisory Mental Health Council (1998).

The strong influence of managed care on the costs associated with parity should mean very modest cost increases, if any, in Wisconsin. According to The Office of the Commissioner of Insurance in 1999 50% of individuals in group insurance plans were in HMOs, 19% in point of service plans, 20% in preferred provider organizations, and only 11% in indemnity plans. Thus, the vast majority of Wisconsin citizens are receiving their group insurance through a managed care plan. Office of Commissioner of Insurance, Health Insurance in Wisconsin (1999). In addition, the news is even better for state employees since almost 90% of them receive coverage under an HMO. Employee Trust Funds, It's Your Choice: 1999, p. B-10.

The time has come for Wisconsin to finally eliminate discrimination against persons with mental illness and substance abuse problems in insurance coverage. We can afford it; it's the right thing to do; and it will mean better health and productivity for thousands of Wisconsin citizens.

WISCONSIN CATHOLIC CONFERENCE

TESTIMONY IN SUPPORT OF SENATE BILL 308
February 9, 2000
Presented by John Huebscher, Executive Director

On behalf of the Wisconsin Catholic Conference, the public policy voice of Wisconsin's Roman Catholic bishops, I urge you to support Senate Bill 308, to provide "parity" between health insurance coverage for mental illness and substance abuse and that provided for physical illnesses.

The human person is more than a physical body. Rather our human nature blends the physical with the intellectual and spiritual. The latter two may be harder to quantify but are no less deserving of our attention. Further, each of us possesses an innate dignity with which, in the words of the Founders, we are endowed by the Creator. This human dignity is present even when one is physically, mentally or emotionally afflicted.

Since all of us suffer when illness robs our neighbor of his or her ability to contribute to the community, we have a shared responsibility to support those who find themselves in a condition of serious mental illness. The mental health needs of our neighbors, no less than their physical well being are a proper concern of public policy. It is, therefore, appropriate for laws and policies to foster parity in how we deal with mental and physical illness.

Parity is appropriate not only because it structures access to health care in accordance with the true aspects of human nature. There are also more pragmatic reasons for doing so.

Over the past few years the Wisconsin Catholic Conference has studied in-depth the issues of welfare reform and criminal justice. That work suggests that mental health needs of people are important factors in both areas.

In the context of welfare reform, a WCC-sponsored study of low-income women participating in W-2 found that, in addition to the economic barriers they faced, a significant number also suffered from depression. In the context of our corrections system, our WCC task force on criminal justice and corrections found that many in the corrections system suffer from mental health and substance abuse. Others have noted that mental suffering and depression is also a concern among those who are the victims of crime.

In light of these facts, Senate Bill 308 offers an improvement in our approach to health care that will serve the health care needs of people but the common good of a society looking for better ways to deal with obstacles to employment and rehabilitation.

Your support of Senate Bill 308 will be appreciated.

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Mental Health Parity Legislation Hearing SB 308
Feb. 8, 2000
Testimony of Phyllis Mensh Brostoff

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1. I am co-owner of two small businesses for the past 16 years, and employ almost 150 people (Stowell Associates and SelectStaff Services, Inc.)
2. I have health insurance as a benefit for my employees
3. I want parity for treatment of mental disorders
4. I am a parent of a son with bi-polar (manic-depressive) disorder **and** a pituitary gland malfunction
5. Both of these conditions are **treatable brain disorders**
6. One of these brain disorders is covered by the health insurance carrier based on what the physician recommends as appropriate
7. The other brain disorder is covered only up to a very restrictive limit based not on what the physician recommends but an arbitrary "minimum" that is in fact an arbitrary maximum for coverage each year, a maximum which was used up by July in the year 1999.
8. Does it make sense to you that the **treatable brain disorder of the pituitary gland** is covered as per doctor orders but not the **treatable brain disorder called bi-polar disorder**?

WISCONSIN COUNCIL ON DEVELOPMENTAL DISABILITIES

WCDD

Promoting Independence and Equality

Date: February 9, 2000

To: Senator Rod Moen, Chair
Members
Senate Committee on Health, Utilities, Veterans and Military Affairs

From: Jim Strachota, Chair

Re: Support for SB 308, relating to health insurance coverage of nervous and mental disorders, alcoholism, and other drug abuse problems

The Wisconsin Council on Developmental Disabilities strongly supports the passage of SB 308, which would end health insurance discrimination against people with mental illness or substance abuse disorders. SB 308 will not only help individuals with mental illness and abuse problems receive the treatment they need to lead productive lives, according to a wealth of data it will actually reduce total health care costs.

Mental illness or substance abuse disorders strikes more than 50 million adults across the nation, nearly 25% of the U.S. adult population each year. More than 18 million Americans are affected by depression each year. Depression is associated with more disability and interruption of daily functioning than hypertension, diabetes, lung diseases, and arthritis. Fortunately, treatment for mental illnesses can be highly successful, for instance, depression is treated successfully in 65-80% of cases, schizophrenia in 60% of cases, and panic disorder in 70-90% of cases. The treatment rates for mental illnesses surpass the rates for other disorders, such as heart diseases, which are routinely adequately covered by health insurance. (Data from the American Psychiatric Association.)

Parity legislation such as SB 308 does not "substantially" raise health care costs and increase premiums for enrollees. According to the National Mental Health Advisory Council, parity results in increases of less than 1%, and substance abuse adds 0.2%. Total health care costs, however, could be reduced under SB 308. The National Mental Health Advisory Council estimates that nation-wide parity legislation would save $2.2 billion a year, because of reductions in the "enormous but often hidden costs of untreated or undertreated severe mental illnesses which are now borne by the general health care system and society at large."

Discrimination in health care insurance coverage of mental illness and alcoholism and other drug abuse disorders is the result of outdated misconceptions and the stigma surrounding mental illness. Please eliminate this discrimination by supporting SB 308.

Thank you very much for your consideration. If you have any questions, please feel free to contact Jennifer Ondrejka, Executive Director, at (608) 266-1166.

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PEGGY
ROSENZWEIG

State Senator, 5th Senate District

TESTIMONY

Thank you very much for the opportunity to testify before you this afternoon to the merits of Senate Bill 308 related to mental health parity.

There has been an evolution in the way we perceive, diagnose and treat mental illness. Science has taught us that many mental illnesses have a biological basis just like physical illnesses that can be successfully treated with medication. But as you know, many health plans offered by employers typically provide less coverage for mental health and substance abuse treatment than for general medical and surgical services. Given the biological nature of both mental and physical illnesses, we must ask ourselves why insurers see fit to treat them differently.

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Early fears were that insurance coverage of mental illnesses would drastically drive up costs of insurance for everyone but these fears have not been borne out. Twenty-six states have put a version of mental health parity law to the test and have found that the cost to consumers has been very low. For example, Allina Health Systems in Minnesota reported that the parity law would add just 26 cents per member/per month to its cost for its 460,000 enrollees. New Hampshire insurance carriers reported no concerns over implementation of the state's parity law and attributed no premium change to the parity law. North Carolina, which has had mental health parity since 1992, saw mental health payments, as a portion of total health payments, decrease from 6.4 percent to 3.4 percent as of fiscal year 1996.

The businesses in these states have been quick to learn that mental health parity laws can mean an improved bottom line. They have found that by providing insurance coverage to individuals with mental illnesses they have been able to reduce sick leave for physical ailments and increase productivity.

Senate Bill 308, if enacted, would produce the positive outcomes that the 28 other states have garnered through their mental health parity laws. It's our turn, in Wisconsin, to step up to the plate and treat those individuals suffering with a mental illness just as we would any one else suffering through a health care crisis. I strongly encourage you to support this legislation.

— Personal story — Brother — Stabilizing evidence that when he is not treated there is evidence of physical deterioration

Thank you for your time. I would be happy to entertain questions at this point, if there are any.

MARY E. PANZER
20TH DISTRICT STATE SENATOR

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MENTAL HEALTH PARITY

SB 308

Senator Mary Panzer

We are here today to talk about the need for and importance of parity in mental health insurance coverage. Current public policy on required insurance coverage is based on information that dates back to the 50's and 60's. It does not reflect the advances that have been made in the diagnosis and treatment of mental and nervous disorders. We know today that most of these diseases are biological in nature and can be treated with medication. It is past time to change the law to reflect that reality.

Current law sets minimum coverage levels for nervous and mental disorders and alcoholism and other drug abuse. These minimum levels become ceilings in practice. SB 308 removes these minimum levels and requires insurance policies to cover nervous and mental disorders and alcoholism and other drug abuse in the same manner that they cover physical illnesses. The bill applies to all types of group health benefit plans, including managed care plans, insurance plans offered by the state and self-insured plans of the state and municipalities.

The requirement that coverage be the same for nervous and mental disorders as for physical disorders applies to components such as deductibles, copayments, annual and lifetime limits and medical necessity definitions.

SB 308 is similar to the federal Mental Health Parity Act in many ways, but it includes a couple of important provisions that the federal act does not. SB 308 removes the annual dollar maxims for AODA treatment and it eliminates the 30-day inpatient limit for mental health services that are present under the federal act.

The issue ultimately returns to one of fairness. Given the biological nature of both mental and physical illnesses, why do we treat them differently from an insurance coverage standpoint?

Let me next address the issue of costs. When we first began discussing this issue several years ago, fears were expressed that mental health parity would lead to double digit or worse increases in insurance premiums. These fears have not been borne out in any of the states which have passed parity legislation.

Minnesota is a good example, both because of their geographic proximity and because their mental health parity law is quite comparable to what is proposed in SB 308. Minnesota's parity law has been in place since 1995. Allina Health System in Minnesota reported that the parity requirement would add 26 cents per member per month for each of its 460,000 enrollees. The insurance plan for Minnesota state employees was

estimated to increase premiums in the range of 1 to 2 percent. Blue Cross/Blue Shield was able to lower premiums 5 to 6 percent even after implementation of parity.

Some samples of data from other states show similar trends. Maryland found that the proportion of the total medical premium attributable to the mental health parity benefit **decreased** by 0.2 percent after implementation of full parity. Rhode Island has seen an increase of 0.33 percent in mental health benefit costs since parity was implemented in 1994. North Carolina, which has had parity since 1992, has seen mental health payments as a percentage of total health payments decrease from 6.4 percent to 3.4 percent as of fiscal year 1996.

The other side of the cost issue is the societal cost. A study by the National Institute of Mental Health found that mental and addictive disorders cost $300 billion annually: productivity losses of $150 billion, health care costs of $70 billion, and other costs – such as criminal justice – of $80 billion. A 1995 study by the MIT Sloan School of Management found that clinical depression alone costs American businesses $28.8 billion each year in lost productivity and absenteeism.

There are several reasons why mental health parity makes sense:

- Treatment is highly effective.
- Cost of coverage is minimal
- Overall cost produce a net benefit when increased productivity and reduced sick leave is factored into the equation.

- Exclusion of mental illness coverage is arbitrary and not a decision driven by cost.

To conclude, lack of insurance coverage for mental illness is a serious problem that has real impact on Wisconsin families. SB 308 makes good economic sense, and it's the right thing to do. I would encourage your support of this legislation.

Background For Committee Hearing Today:

SB 331: Cable Bill – Did Bruce give you background?

SB 313: This is a Risser bill that provides state agent status to psychiatrists who contract directly with counties to provide publicly funded psychiatric services. In other words, they would enjoy the same protections as psychiatrists who are employed by the state/county.

We passed this bill 5 to 1 last session. (Fitzgerald voted no).

SB 308: Under current law, a group health insurance policy that provides coverage of any inpatient hospital services must provide at least $7000 in coverage for nervous and mental disorders and drug and alcohol treatment. Senate Bill 308 would remove this minimum coverage amount and require health insurance policies to provide the same coverage for nervous and mental disorders and alcoholism and drug abuse problems as it does for physical ailments. The bill also provides that the same deductibles or copayments that apply to physical ailments would apply to mental health treatment.

Obviously, mental health advocates love this bill. The problem is, it will increase the cost of health insurance premiums. It's very difficult to underwrite mental health coverage because it's not black and white – as a broken leg or heart surgery might be.

Executive Session:

We noticed an exec on SB 288 (military honors funerals for veterans) and SB 290. You also told members you'd take executive action on the personal care issues. In addition, you may wish to exec the appointment we heard today and SB 313 if it's non-controversial. The motions are as follows:

Appointee

- Confirmation of Pamela Maxson Cooper as a member of the Board of Nursing.

Senate Bill 313??

Passage of Senate Bill 313

SB 288:

- Intro and adoption of Senate Amendment 1 (LRB a1295). David can explain – it's the same amendment adopted by the Assembly.

- Passage of Senate Bill 288 as amended.

SB 290: Senator Plache worked with SMS on the amendments – they are a compromise. A leg council memo has been distributed to members explaining the amendments.

- Intro and adoption of Senate Amendment 1 (LRB a1300)

- Intro and adoption of Senate Amendment 2 (LRB a1329)

- Passage of Senate Bill ~~288~~ 290 as amended.

Personal Care Audits:

- Moved that the committee send a letter to Representative Underheim urging him to schedule a public hearing on Assembly Bill 630.
- Moved that the committee send a letter to Secretary Leean asking him to establish a blue ribbon task force on personal care services.
- Moved that the committee send a letter to the Joint Committee on Audit requesting an audit of MA personal care services and the DHFS audits of personal care providers.
- Moved that the committee introduce LRB 4497 (a companion to Representative Meyer's Assembly Bill 630)
- Moved that the committee send a letter to the Joint Legislative Council requesting the establishment of a special committee to study personal care services in Wisconsin.

February 8, 2000

Senator Rodney Moen
P. O. Box 7882
Madison, WI 53707-7882

Dear Senator Moen:

Per your Committee's request, the panel of providers that testified last week at the hearing on issues related to Medical Assistance Personal Care (MAPC) has developed a list of questions, comments and recommendations to be addressed to/by the Department of Health and Family Services (DHFS). This panel included representatives from Society's Assets (Racine, WI), Independence First (Milwaukee, WI), Community Living Alliance (Madison, WI), Bethel Home and Services (Vernon County), and Lori Knapp, Inc. (Prairie du Chien). We would like to extend our thanks for this Committee's time and attention to the issues surrounding Personal Care.

Comments
In response to the testimony from DHFS, the provider panel presents the following facts for your information and review:

1. DHFS testified that their auditing efforts have uncovered a number of instances where Personal Care (PC) Providers have committed fraud, and that these findings have led to criminal convictions of said PC Providers who are now serving time for those crimes. Response: An email from the Wisconsin Home Care Organization (WHO) was issued on 2/4/00 to providers regarding a discussion the Director WHO had with the Department of Justice. Per this discussion, there have been no convictions of any Medical Assistance (MAPC) Provider, not one Home Health Provider is currently serving time for Medicaid fraud and not one Wisconsin Home Health Provider, of any classification, ever served a day of prison time, state or federal, for Medicaid fraud.

2. DHFS also implied that the audits were conducted at least in part as a response to rapidly rising costs of Personal Care. DHFS stated that the cost for operating MAPC was currently $93 million and in 2001 that cost would rise to $99 million. Response: According to a state fiscal bureau memo dated January 28, 2000, the cost to operate the Personal Care Program for FY 2000 was approximately $80 million ALL FUNDS (This is after $.75 rate increase is implemented): $48 million in Federal Medicaid funds and $32 million in State GPR.

3. DHFS also noted that the increased amount of money spent on personal care increased when the consumer numbers remained the same and that was a red flag for audits as well. Response: Medical Assistance Personal Care is only 2.4% of the total Wisconsin Medical Assistance expenditures according to a report issued

by the Legislative Fiscal Bureau issued January 1999 for services provided in fiscal year 1997-98. The reasons for units of services per recipient increasing at a rate grater than the total number of persons served under MAPC are many:

- A significant portion of the units of which were formerly described as Home Health Aide hours were shifted into the MAPC service category since the change in regulations came about in 1992 (in an effort to save funds);
- The Federal Balanced Budget Act of 1997 has caused a cost shift from Medicare to MAPC Services with patients being discharged from hospitals and nursing homes much earlier and much sicker (needing much more intensive and higher levels of care). The MAPC population of recipients seen by personal care providers is chronically ill, getting older and sicker as the disability progresses, and as a result requiring more services;
- Some counties have such high waiting lists for county funded personal care services, which has led to greater efforts to maximize MAPC services;
- Counties have expanded MAPC services to group homes and CBRF's the last couple of years. Most of these individuals have already been in the Medical Assistance system.
- Agencies and counties have attempted to maximize the use of family members to provide increased services needed to existing cases. Agencies have difficulty opening new cases due to serious staff shorages in all parts of the State.

Recommendations

The providers recommend the following in working with DHFS to resolve the issues and problems regarding the MA Personal Care audits:

1. We would like to see the Senate Health Committee recommend that the Legislative Audit Bureau audit the Bureau of Program Integrity for the following items:

    a. Methods of the audits;
    b. Consistency (or lack of) between each audit. Discover what sort of precedent and past procedure exist on these audits. What audit methods were used and were these methods applied consistently from provider to provider;
    c. What audit tool was being used and how was it applied;
    d. We would also like to request that the Legislative Audit Bureau, prior to auditing the Bureau of Program Integrity, interview providers for their individual accounts of the audit process.

2. We would also like to see the following items for the future:

    a. An annual review of the Providers (as noted in the Administrative Code for Personal Care Services) to educate providers on areas of

documentation that may be lacking. DHFS should provide a certain amount of time to providers in order for them to correct these practices before auditing. A review or audit process should be done in a more timely fashion so if there is a problem the provider can correct it and go forward, not hang in limbo waiting for audit results for over a year.

b. A published, consistent handbook that is properly developed within the formal rules making process that includes public hearings that will produce documentation of provider and consumer input before publishing and enforcing it. Also require the Department to provide adequate training to providers on the changes in the handbook.

c. A clear and standard audit tool. Wisconsin Personal Services Alternative, Inc. (WPSA) has worked with DHFS in the past on the development of an audit tool and would be willing to assist in this process.

3. We would not like to see a discontinuation of any further audit proceedings on non-traditional repayments (traditional repayments involve duplicate billing, billing errors, services not provided, etc.) until the above items have been provided or clarified. Audit proceedings based on a suggested lack of adequate or consistent documentation that is the direct result of a lack of clear consistent direction from the Department and the absence of a handbook need to stop. MAPC Providers are in favor of audits that are reasonable and fair and that eliminate fraud. We need a MA Personal Care Handbook that works. We need an audit tool that is clear. Then we can go through the audit process in a reasonable manner. Then the Department of Health and Family Services can go forward with audits that will truly monitor and improve the services provided.

Questions

It is our hope that many of the following questions in reference to MAPC audits would be answered with an audit of the Bureau of Program Integrity by the Legislative Audit Bureau:

1. What is your definition of fraud? Is this fraud or inadvertence?
2. Is this a failure to provide services or to provide documentation?
3. Are all MA providers audited? If not, how were those that have been audited selected?
4. Is MA the only funding for personal care services? Does anyone else pay for this service?
5. Explain/discuss the difference between personal care only agencies and home health agencies doing personal care services.
6. Have providers been advised as to how to document blended funding cases?
7. How does DHFS help agencies accommodate different funding?
8. Travel time seems to be an audit problem, why is that?
9. Why was there no handbook for 12 years?

10. In regards to problems with Dr. orders not documented correctly, is there any question that the Dr. ordered the service? Do you take back money when cares were provided?
11. Of the audits completed, what amount of $$ could you potentially recoup?
12. What agreements have you come to with providers on these audit issues?
13. What percentage of the Personal Care Agencies would you estimate are actually involved in committing fraud as you define it?
14. Do you see any relationship between the activities of DHFS and the fact that 90 of these Personal Care Agencies have permanently closed their operations in the last two years?
15. When DHFS freezes payments to agencies when they initiate a claim, do the effected agencies, as a practical matter, ordinarily have any realistic means of financially surviving more than a few weeks or months?
16. What are the personal implications to the welfare of Wisconsin residents who require Personal Care Services to live independently when a Personal Care Agency terminates services?
17. What are the possible financial ramifications to Wisconsin taxpayers if a substantial percentage of the Personal Care Agencies are closed?
18. Audits should help agencies improve their practices. What kind of educational/instructional feedback do you have with providers with this audit process?

Sincerely yours,

Jean Rumachik

Jean Rumachik
Legislative Chairperson
Wisconsin Personal Services Alternative, Inc. (WPSA)

Cc: Senator Brian Rude

STATE BAR of WISCONSIN
YOUR PARTNER IN PRACTICE

MEMORANDUM

TO: Senate Committee on Health, Utilities, Veterans and Military Affairs

FROM: Family Law Section, State Bar of Wisconsin

DATE: February 9, 2000

RE: Support Senate Bill 308

The State Bar of Wisconsin's Family Law Section supports Senate Bill 308, which provides expanded health insurance coverage for mental health and alcohol and other drug abuse problems.

As attorneys who practice family law, Section members are frequently involved in cases where either the client, their spouse or their children are suffering from emotional issues, perhaps as a result of a family breakup, that benefit from therapy. Under current law, only nominal coverage for mental health is mandated and is often inadequate to assist with such problems.

It is often the case that divorce actions occur in families where there is mental illness, drug or alcohol abuse or spousal abuse. These problems require mental health treatment, which is often not available or the coverage is inadequate.

Under Senate Bill 308, families may be helped in dealing with these serious issues, perhaps averting divorces. Even where the divorce cannot be avoided, families would benefit from the additional treatment. In addition, the bill provides for more appropriate and fair coverage for inpatient hospitalization for cases where a parent or child suffers from severe mental illness.

The Family Law Section supports Senate Bill 308 because it would assist the clients and families we serve in our practice. The Section urges your support for Senate Bill 308.

If you have any questions, please contact State Bar Public Affairs Director Linda Barth at 250-6140 or lbarth@wisbar.org.

P.O. BOX 7158
MADISON, WI 53707-7158
5302 EASTPARK BLVD.
MADISON, WI 53718-2101

(608) 257-3838
FAX (608) 257-5502

JON ERPENBACH

STATE SENATOR

TO: Committee Members
Senate Committee on Health, Utilities, Veterans and Military Affairs

FR: Senator Jon Erpenbach

DA: February 9, 2000

RE: Constituent testimony regarding Senate Bill 308

Enclosed for your consideration is a copy of testimony from a constituent of mine who wishes to remain anonymous. To honor her request, I am distributing her testimony.

I feel her testimony is very important in this discussion, as she has worked as a nurse within the mental health community, as well as eventually being diagnosed with a mental illness.

Thank you for considering her comments.

20 South, Wisconsin State Capitol, P. O. Box 7882, Madison, WI 53707-7882 ■ 608-266-6670 ■ sen.erpenbach@legis.state.wi.us

Oregon, Ohio
2/7/2000

The current law that establishes minimum coverage for nervous and mental disorders, alcoholism and other drugs abuse problems definitely needs to be the same as for treatment of physical conditions or greater!

I have been a disabled nurse, homemaker that has been involved with the System since 1968. At this time I was disabled with S.S. Coverage in 1982. While an R.N in 1970's - 1980's in the Nursing Home-Hospital scenes I have cared for both nervous and mental disorders. Then as a patient myself I've associated with many people who have neglected health care because they were unemployed, with no insurance available in fact with no place to call home. In fact one newspaper was my husband & daughter and her husband & my

Church Madison, Wi.

With a professional Husband, who is good Provider, a former State employee with expensive ~~unit~~ "Physicians plus" insurance on monthly basis. & Myself an assured quality care with Medicare as the primary provider; however as a former R.N. and a Care caller for an Oregon Church I continue to serve mankind. If my friend lacks a warm Coat? You'll assist her to purchase one or will go to Good Will? It's same with nursing and Medical services for the Mentally ill we need Coverage for these related disorders. (Increased)

2/1/2000
Wheeler

Wisconsin Association of Health Underwriters

Madison Office: 6441 Enterprise Lane Suite 101B, Madison, WI 53744-5046
Phone: (608) 277-1896 Fax: (608) 271-4520
Milwaukee Office: 1123 N. Water Street, Milwaukee, WI 53202
Phone: (414)276-7377 Fax: (414)276-7704

Statement of Jo Anne Burris
Legislative Chair, WAHU
Opposition to Senate Bill 308, relating to mental health coverage
February 9, 2000

The Wisconsin Association of Health Underwriters (WAHU) and its 400 health-insurance-profession members have no disagreement with the intent of SB 308; more mental health benefits may be appropriate for certain groups or individuals. Nonetheless, we must oppose SB 308 and offer a better alternative to SB 308 and all other benefit mandates.

We ask the Legislature to give groups and individuals the freedom of choice in the benefits they want in their health plans. The Legislature should let employers and employees decide what coverage they want to purchase for themselves. Insurance companies should be mandated to offer the benefits, and employers and employees should be able to choose from them, just like they choose what they want with cafeteria-type benefits.

SB 308 and similar bills to mandate health-insurance benefits have a direct negative impact on overall consumer access to health-care coverage.

Mandated benefits take away freedom of choice.

In the real world, employers and employees in small businesses work together to create health-insurance plans that fit their financial and physical health. Mandated benefits rob employers and employees of the opportunity to choose the type and quality of health plan they want. Instead, the Legislature says, "You will buy this benefit, whether you want or not, whether you need it or not."

Mandated benefits are not a free lunch.

Mandated benefits cost money. Proponents of every mandate argue that their mandate will reduce the cost of health insurance. The facts do not support the argument. Twelve of the most common state-mandated benefits increase the cost of a family health insurance by as much as 15% to 30% a year, according to a study by Milliman and Robertson, one of the nation's largest and most respected actuarial firms. A mere 1% increase in the cost of a health insurance plan equals approximately a $36 million increase in premium costs for Wisconsin employers and employees.

Mandated benefits are a stealth tax on businesses and employees.

Instead of taxing and spending directly, mandated benefits allow the government to spend consumers' dollars without having to justify the costs. While employees and employers bear the brunt of the mandate's cost, it is never identified as a cost imposed by government. Even if consumers are not aware of this new mandate, they will likely see their health insurance bills rise.

Mandated benefits can reduce coverage.

In order to hold down the cost of a health plan when mandated befits push costs higher, some employers and employees reduce other benefits or increase co-pays and deductibles. By increasing the cost of health insurance, employers and employees operating on the margins may choose to drop coverage altogether.

Mandated benefits increase utilization.

Once the Legislature mandates coverage of a treatment or condition, the incentive for careful treatment disappears. If a procedure or condition must be covered, then why not use it? And why not use it as much as you want? That's exactly what happens. Utilization jumps dramatically -- whether it's cost-effective or safe.

February 9, 2000

Committee on Health, Utilities, Veterans and Military Affairs
State Capitol
Madison WI 53702

RE: 1999 Senate Bill 308 Insurance Parity for Mental Illness and/or Substance Abuse Treatment - written summary of testimony provided by Karen Avery

Members of the Committee:

First, I want to thank you for the opportunity to express my support of Senate Bill 308, a bill that seeks to end discrimination in health care against persons with mental illness and/or substance abuse issues. I am hopeful that Wisconsin is ready to support this bill.

I am addressing this issue wearing three hats: 1) as a person who was raised by a woman with schizophrenia; 2) as a woman with a mental illness called "Obsessive - Compulsive Disorder;" and 3) as an employee of Independence*First*, an independent living center which serves persons with disabilities in the four county metropolitan Milwaukee area.

As you are probably well aware, group health insurance providers are allowed to limit the services received by persons with mental health and substance abuse issues. Not only is this blatantly discriminatory, but it is bad policy as well. Persons who do not have access to treatment do not "go away." Symptoms become exasperated, families fall apart, jobs are lost and the costs to our state swell in the form of income assistance, Medicaid dollars, incarceration expenses, etc. Insurance parity is not just the RIGHT thing to do, it is the prudent thing to do! Taxpayers should not bear the costs that insurance companies refuse to pay.

My mother, who had schizophrenia, was never provided the care she needed. This was during the '60's & '70's and the understanding of, and treatment for, mental illness was still evolving. Mom was often hospitalized and then released with little to no aftercare or follow-up services. Medication was sporadic, expensive, and constantly changing. Because she continued to bounce back and forth in the system, my sisters and I were often placed in foster care. Our family was extremely fragmented and dysfunctional. This is not necessarily due to the fact that my mother had a mental illness, but rather, that she never received the medication and services that she needed. Again, not only did this affect three young girls and their mother, but it also affected taxpayers as my mother ended up on SSI with no real hope of becoming employed. There were also costs for foster care, Medical Assistance, and numerous family intervention services.

Times are a little different now. Treatment is effective and people with mental health and/or substance abuse issues can be productive members of our community. I know this because I, too, have struggled with mental health issues, both as a child and as an adult. In the early 1990's I had a complete breakdown that resulted in my children and I living in a homeless shelter. Prior to my breakdown, I was employed full-time as an investigator/paralegal in a law firm. I had health insurance, but I had very limited mental health services. I tried to get the help I knew I needed, but it was not forthcoming and

eventually I completely broke down. I lost my job, I lost my home, I lost my car and worst of all, I lost my self-respect. Once I was homeless and poor I qualified for Medical Assistance, which paid for inpatient treatment, medication, and follow-up services. I applied for Social Security Disability Insurance and received those benefits as well. Eventually, after a couple of years, I was able to return to work. Little by little I worked my way back to independence, employment, family relationships and self-respect.

I am now employed full-time as the Associate Director of Independence*First*. I have health insurance but have found that the insurance policies severely limit my access to medication and the therapy I need at times. I made the difficult decision to pay for my own treatment. This costs our family approximately $5,000 per year **in addition** to the $300 per month we pay for our family health insurance premiums. My family is paying almost $10,000 annually for health care! Do I have any other choice? I don't believe I do. If I do not maintain the care I need for my mental illness, I would most likely spiral down and out again. I do not intend for that to happen if I can prevent it. I am very fortunate to have this option because I have the financial resources to do so; however, many, if not most, do not.

Why is this okay? Why is it that those of us with a mental illness cannot get the same level of care and services that persons with "traditional" illnesses or disabilities receive? I am a taxpayer, I am a professionally employed person, I contribute to society and I also happen to have a mental illness. It is time that Wisconsin makes the statement, "This is wrong and we won't allow the insurance companies to discriminate against our citizens anymore!"

Thank you for your time and attention to this important subject.

Sincerely,

Karen Avery

Karen Avery
2454 North Sherman Blvd
Milwaukee WI 53210

CC: Senator Gary George
Representative Antonio Riley

IndependenceFirst
The Resource For People With Disabilities

February 8, 2000

Committee on Health, Utilities, Veterans and Military Affairs
State Capitol
Madison, WI 53702

Dear Committee Members:

I am writing in support of Senate Bill 308 which was introduced by Senator Panzer on December 22, 1999. Under current Wisconsin law, insurance companies can limit the amount and type of care that people with mental health disabilities receive, yet services for people with other disabilities are not limited. This bill would require that the coverage under group health benefit plans for the treatment of people with mental health disabilities be the same as the coverage for the treatment of people with physical disabilities.

On December 17, 1999, President Clinton signed the Ticket to Work and Work Incentive Improvement Act of 1999. One of the key provisions of this piece of legislation is health care coverage. All Americans should have equal access to affordable health care, including people in Wisconsin. Wisconsin has always been a leader on issues for people with disabilities. However, twenty-two other states have enacted parity laws and Wisconsin is not among them.

Please support Senate Bill 308, it can help put an end to the discrimination that people with mental health disabilities continue to face.

Sincerely,

Kathleen Meisner
Benefits Specialist

600 West Virginia, Suite 301, Milwaukee, Wisconsin 53204-1516
Voice/TTY: 414-291-7520 FAX: 291-7510 E-Mail info@independencefirst.org
Website: http://www.independencefirst.org

Wednesday, February 09, 2000

To: Committee on Health, Utilities, Veterans & Military Affairs

I am writing to indicate my support of Senate Bill 308 calling for parity in insurance coverage.

I strongly believe that insurance companies should offer the same level of services to persons with mental illness and/or substance abuse as that which is provided to others. Limitations on coverage and services are unfair and discriminatory!

Sincerely,

Lora Ott

Lora Ott
328 Birch Court
Oregon, WI 53575

To: Members of Senate Committee
of Health, Utilities, Veterans & Military Affairs
From: Molly Cisco
Date: 2-9-00
Re: SB308

Dear Senators,

My name is Molly Cisco and I have a mental illness. Having a mental illness is not the easiest thing to live with in our society. There are people who fear me, people who pity me, and people who see me less than a whole person. Certainly nobody wants to talk about it. But I am writing to you today in hopes that you will understand who I am and what I need.

I have lived with my mental illness all of my life. I was 12 when I first tried to kill myself. My parents were too ashamed to seek professional help, as a matter of fact I was forbidden to tell anyone what was wrong. I spent most of my teenage and young adult life using drugs to medicate myself. Drugs made me feel better for the moment, but that moment would always wear off.

At the age of 21, I attempted suicide again. I knew that I had depression and finally decided to seek help. I saw a therapist and a psychiatrist. I took medication and talked about the things that caused me such pain. Things started to feel better. But this came to an abrupt halt. My insurance would no longer pay for these services. At the time I was making very little money so I could not afford to continue on my own. Once the insurance stopped so did my recovery. I sank right down to where I had been before.

The process of starting and stopping therapy went on for several years until I gave up - I felt defeated. After that, I lived for many years wanting to die. In your wildest dreams you can't imagine what it is like to wish for death. Contemplating suicide became a powerful secret.

I found passive ways to die- I starved myself. I would go for days without food. I lost weight (I am 5'5" and weighed 98 pounds) but still felt the need to continue. Obviously this caused a lot of medical problems. Medical

problems were easily treated. I saw all sorts of doctors for these problems and every dime was covered by my insurance.

5 years ago, after my last suicide attempt, I finally decided to get the help I really needed. I began to see a therapist and the process of my recovery began. It has been a slow process. My insurance would pay for about 6 months of therapy, the rest I paid out of pocket ($80.00 per week). I also began seeing a psychiatrist for medication ($150.00 per month). Luckily the medication was covered by my insurance, but in order to get the prescription I had to see my therapist and psychiatrist. I am not a rich person and this has been extremely expensive for me. For the past 2 years, I have been self- employed and without insurance. I have continued therapy and medication because it has become my lifeline. Now I am beginning a full time job. I know that having my new insurance coverage pay for 6 months of my bills will be helpful, but there is still the other 6 months.

My recovery is forever and I will take medication all of my life. Mental illness doesn't go away just because the HMO stops paying.

Now that I want to live please help me afford to.

Molly Cisco
925 N 70th
Wauwatosa, WI 53213
(414) 607-9721

February 8, 2000

Senator Rodney Moen
P. O. Box 7882
Madison, WI 53707-7882

Dear Senator Moen:

Per your Committee's request, the panel of providers that testified last week at the hearing on issues related to Medical Assistance Personal Care (MAPC) has developed a list of questions, comments and recommendations to be addressed to/by the Department of Health and Family Services (DHFS). This panel included representatives from Society's Assets (Racine, WI), Independence First (Milwaukee, WI), Community Living Alliance (Madison, WI), Bethel Home and Services (Vernon County), and Lori Knapp, Inc. (Prairie du Chien). We would like to extend our thanks for this Committee's time and attention to the issues surrounding Personal Care.

Comments
In response to the testimony from DHFS, the provider panel presents the following facts for your information and review:

1. DHFS testified that their auditing efforts have uncovered a number of instances where Personal Care (PC) Providers have committed fraud, and that these findings have led to criminal convictions of said PC Providers who are now serving time for those crimes. Response: An email from the Wisconsin Home Care Organization (WHO) was issued on 2/4/00 to providers regarding a discussion the Director WHO had with the Department of Justice. Per this discussion, there have been no convictions of any Medical Assistance (MAPC) Provider, not one Home Health Provider is currently serving time for Medicaid fraud and not one Wisconsin Home Health Provider, of any classification, ever served a day of prison time, state or federal, for Medicaid fraud.

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by the Legislative Fiscal Bureau issued January 1999 for services provided in fiscal year 1997-98. The reasons for units of services per recipient increasing at a rate grater than the total number of persons served under MAPC are many:

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- Some counties have such high waiting lists for county funded personal care services, which has led to greater efforts to maximize MAPC services;
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Recommendations

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1. We would like to see the Senate Health Committee recommend that the Legislative Audit Bureau audit the Bureau of Program Integrity for the following items:

    a. Methods of the audits;
    b. Consistency (or lack of) between each audit. Discover what sort of precedent and past procedure exist on these audits. What audit methods were used and were these methods applied consistently from provider to provider;
    c. What audit tool was being used and how was it applied;
    d. We would also like to request that the Legislative Audit Bureau, prior to auditing the Bureau of Program Integrity, interview providers for their individual accounts of the audit process.

2. We would also like to see the following items for the future:

    a. An annual review of the Providers (as noted in the Administrative Code for Personal Care Services) to educate providers on areas of

documentation that may be lacking. DHFS should provide a certain amount of time to providers in order for them to correct these practices before auditing. A review or audit process should be done in a more timely fashion so if there is a problem the provider can correct it and go forward, not hang in limbo waiting for audit results for over a year.

b. A published, consistent handbook that is properly developed within the formal rules making process that includes public hearings that will produce documentation of provider and consumer input before publishing and enforcing it. Also require the Department to provide adequate training to providers on the changes in the handbook.

c. A clear and standard audit tool. Wisconsin Personal Services Alternative, Inc. (WPSA) has worked with DHFS in the past on the development of an audit tool and would be willing to assist in this process.

3. We would not like to see a discontinuation of any further audit proceedings on non-traditional repayments (traditional repayments involve duplicate billing, billing errors, services not provided, etc.) until the above items have been provided or clarified. Audit proceedings based on a suggested lack of adequate or consistent documentation that is the direct result of a lack of clear consistent direction from the Department and the absence of a handbook need to stop. MAPC Providers are in favor of audits that are reasonable and fair and that eliminate fraud. We need a MA Personal Care Handbook that works. We need an audit tool that is clear. Then we can go through the audit process in a reasonable manner. Then the Department of Health and Family Services can go forward with audits that will truly monitor and improve the services provided.

Questions

It is our hope that many of the following questions in reference to MAPC audits would be answered with an audit of the Bureau of Program Integrity by the Legislative Audit Bureau:

1. What is your definition of fraud? Is this fraud or inadvertence?
2. Is this a failure to provide services or to provide documentation?
3. Are all MA providers audited? If not, how were those that have been audited selected?
4. Is MA the only funding for personal care services? Does anyone else pay for this service?
5. Explain/discuss the difference between personal care only agencies and home health agencies doing personal care services.
6. Have providers been advised as to how to document blended funding cases?
7. How does DHFS help agencies accommodate different funding?
8. Travel time seems to be an audit problem, why is that?
9. Why was there no handbook for 12 years?

10. In regards to problems with Dr. orders not documented correctly, is there any question that the Dr. ordered the service? Do you take back money when cares were provided?
11. Of the audits completed, what amount of $$ could you potentially recoup?
12. What agreements have you come to with providers on these audit issues?
13. What percentage of the Personal Care Agencies would you estimate are actually involved in committing fraud as you define it?
14. Do you see any relationship between the activities of DHFS and the fact that 90 of these Personal Care Agencies have permanently closed their operations in the last two years?
15. When DHFS freezes payments to agencies when they initiate a claim, do the effected agencies, as a practical matter, ordinarily have any realistic means of financially surviving more than a few weeks or months?
16. What are the personal implications to the welfare of Wisconsin residents who require Personal Care Services to live independently when a Personal Care Agency terminates services?
17. What are the possible financial ramifications to Wisconsin taxpayers if a substantial percentage of the Personal Care Agencies are closed?
18. Audits should help agencies improve their practices. What kind of educational/instructional feedback do you have with providers with this audit process?

Sincerely yours,

Jean Rumachik

Jean Rumachik
Legislative Chairperson
Wisconsin Personal Services Alternative, Inc. (WPSA)

Cc: Senator Brian Rude

WMC
REPRESENTING WISCONSIN BUSINESS

Wisconsin Manufacturers & Commerce

Memo

February 9, 2000

TO: Members of the Senate Committee on Health, Utilities, Veterans and Military Affairs

FROM: Eric Borgerding -- Director of Legislative Relations

RE: Written Comments Opposing SB 308

Senator Moen and members of the Committee, my name is Eric Borgerding and I represent Wisconsin Manufacturers & Commerce on various issues, including health care. Due to a long-standing commitment, I am unable to appear today in person, but appreciate the opportunity to submit my testimony in writing.

Our members are growing increasingly concerned with the direction of health care in Wisconsin and the country. Health care costs are increasing at a tremendous rate. At the same time, Congress and the state legislature are proposing numerous new mandates that will only exacerbate this situation. Given this climate, WMC must oppose SB 308 in its current form, and I wish to submit, for your consideration, the following comments regarding our position.

Health Care Costs Are Again On the Rise

It is no secret that health care costs for employers, and employees, are once again accelerating at a rapid pace. For many employers, the year 2000 will mark the third straight year of double-digit percentage increases in their insurance premiums. Indeed, it is estimated that premiums paid for the state employees' health insurance plan will increase by 12.4% this year, and will likely cost taxpayers in excess of $30 million GPR more over the biennium. In the private sector, where similar and higher increases are being delivered, employers and employees must bare these increases directly -- GPR is not available to offset their cost increases.

There are numerous reasons for the resurgence of double-digit premium increases, all of which could be the subject of their own legislative hearing. But there is no doubt that the collective and ongoing impact of the individual benefit mandates, that continue to be enacted by the legislature, is contributing to escalating health care costs, and will ultimately jeopardize access to employer-sponsored coverage.

Flood of Benefit Mandates:

From a broader perspective, the ability, or willingness, of employers to provide health care benefits is an increasingly difficult balancing act.

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More and more, cost must be weighed against the employer's ability to afford that coverage, the share of premium that the employee pays, and the level of benefits that can be offered.

Unfortunately, the host of costly benefit mandates that have been enacted prior to the introduction of SB 308, has created an environment that forces this debate to be as much about cost as it is about care. Considered on a piecemeal basis, the larger collective impact of benefit mandates on the cost of providing health coverage is often lost in the studies and rhetoric.

In just the last two legislative sessions, several new benefit mandates have been enacted, including new laws that force employers to pay for coverage of temporomandibular joint disorder (TMJ), and another that requires employers to provide a "Point of Service" coverage option to their employees. Neither of these new mandates will do anything to moderate the cost of health care, or maintain access to insurance coverage -- and there is no end in sight. There are at least 10 benefit mandates bills that have either been introduced, or are currently being circulated, for co-sponsorship. These include:

- AB 4 - Mandating coverage of treatment by an acupuncturist.
- AB 264/SB 115 - Mandating coverage of smoking cessation treatment and medications.
- AB 362/SB 182 - Mandating coverage of contraceptive articles and services.
- AB 430 - Mandating access to OB/GYNs without a referral (part of Act 9).
- AB 565 - Mandating coverage of infertility services.
- AB 672 - Mandating coverage of clinical cancer trials.
- SB 258 - Mandating grievance procedures, access to specialist providers and allowing managed care plans to be sued.
- SB 308 - Mandating the same level of coverage for mental health/AODA as other illnesses.
- LRB 3394/1 - Mandating managed care to cover driver safety education for convicted drunk drivers.
- LRB 4193 - Mandating coverage for hearing aids.

Perhaps, before the enactment of any more benefit mandates, the legislature could reconsider those that have been enacted in the past, and the impact they have on finite health care budgets. One option would be to allow employers, and ultimately their employees, greater flexibility when choosing which mandated benefits they (not the health care providers) actually want, and will jointly pay for. This approach would minimize the broad cost impact of benefit mandates, while giving employers and employees the ability to better target scarce health care dollars at those services they truly want or need. A proposal similar to this was included in the Assembly version of the 1999-2000 state budget, but was removed in the Conference Committee.

The Economics of Benefit Mandates

While the debate over benefit mandates is about more than just dollars, mandate proponents frequently cite the economic benefits to employers as the reason why those employers should be forced, by law, to provide this or that benefit mandate. Proponents of virtually all benefit mandates, including mental health/AODA parity, often site various studies that show: (1) the impact on premiums will be "minor" (with SB 308, one study tabs the increase at between 1-3% increase, while some industry estimates show the increase to be between at least 3% and 8%); or (2) that over the

long-run, employers will save money as they will eventually have a healthier, more productive work force as a result of the new, or in the case of SB 308, expanded benefit.

First, it must be noted that the variation between employers, and thus their ability to "afford" mandates, is massive. For instance, using large, self-funded employers to show that mandates are cost-effective is misleading for the following reasons:

- Larger employers tend to retain their employees for longer periods of time, thus making the "investment" in benefits more certain.

- Smaller, fully insured employers, who are subject to state law, and thus required to provide every current and future benefit mandate passed by the legislature, generally have much higher rates of turnover in their workforce. As a result, it is much less likely that these employers will realize the long-term economic benefits mandate proponents claim.

- Also, due to their self-funded status, larger employers are not subject to the patchwork of state-by-state benefit mandates. As a result, they are better able to target their health dollars to those services that are in greatest demand/need. Unfortunately, fully insured employers are not allowed this type of flexibility under current Wisconsin law - **they are forced to either offer all mandated benefits, or offer no insurance at all.**

Finally, it must be noted that under current law, Wisconsin employers are already required to provide a minimum amount of benefits for mental health disorders and alcohol and drug abuse. Employers that have the resources and flexibility to target their health care dollars, and provide benefits that will "save" them dollars in the long run, can and will do so under current law.

Impact on BadgerCare

As I stated above, there are numerous reasons why the cost of health care is increasing for private sector employers, including health benefit mandates enacted by the legislature. With the enactment of BadgerCare, perhaps never before have state taxpayers had as great a stake in the cost the private sector pays for health care -- and the role of the legislature plays in influencing that cost.

Among other criteria, eligibility for BadgerCare is based upon the availability of employer-sponsored coverage and the percentage of premium the employer pays. As health care costs go up, due to legislative actions and other factors, more employers will be forced to either: reduce the amount of their premium contribution and increase the employees share; or drop coverage all together. Both of these actions will inadvertently result in more people becoming eligible for BadgerCare, and higher costs for taxpayers.

We appreciate the delicate balance between cost and needed services that is required when providing health benefits. To that end, WMC is willing to work with the authors of SB 308 to advance health care policy that allows people to obtain the services they truly need, while preserving affordable and accessible health care for employees and their families.

Again, thank you for the opportunity to submit written comments, and please do not hesitate to contact me if you any questions.

LOCAL
WISCONSIN STATE JOURNAL
Wednesday, February 9, 2000 •

Jensen addresses BadgerCare concerns

■ The Assembly speaker says the state health program needs fixing.

By Jeff Mayers
Capitol Bureau Chief

Soon after Gov. Tommy Thompson praised the state's BadgerCare program, Assembly Speaker Scott Jensen declared Tuesday that the health-care program will have to be "reconstructed."

Jensen, R-Waukesha, responded to a question at a business conference that was critical of the health-care plan for the working poor. Enrollments in the 6-month-old program have soared, posing potential big-money problems in this and future budgets, HMO executives and some business-people are warning. Some HMOs have threatened to bolt the program.

"The market always works. If the state is going to offer (health care insurance) at reduced prices, somebody's going to take advantage of that over time," said Jensen, referring to reports that people are dumping higher-priced insurance for the cheaper, state-provided insurance.

"I think we are about to see some of the problems that are inevitable with this program."

Later, Jensen said big changes in the program are "inevitable" but he predicted the governor first would look to administrative changes to curb costs. Thompson has asked the Legislature to use about $11 million of the state's $380 million surplus to handle the rapidly growing program, but critics warn that wouldn't be enough.

"Concerns about BadgerCare are going to be building," added Assembly Democratic Leader Shirley Krug, D-Milwaukee, who was part of a general panel discussion at the Monona Terrace Convention Center.

The panel discussion was part of Wisconsin Manufacturers & Commerce's "annual legislative dialogue."

Earlier, Thompson spoke to the audience on a number of issues, including BadgerCare. He credited the program with helping to lower the number of uninsured in Wisconsin.

BadgerCare enrollments are predicted to grow to more than 82,000 by the end of the budget cycle in mid-2001, legislative fiscal analysts say. Initial estimates were for more than 67,500 children and their parents.

That means Thompson's request for $11 million to support the new health insurance program would fall short by at least $2.3 million.

A memo from the Legislative Fiscal Bureau last week also warned "there is a real possibility that HMOs will no longer participate in BadgerCare unless additional funding is provided to increase" government reimbursement rates to health plans.

If health maintenance organizations withdrew, overall BadgerCare costs would rise even more because the price advantage of group health plan coverage would be lost, fiscal analysts warned. About 60 percent of BadgerCare participants are covered by 10 state HMOs.

Letting Workers Control Health Benefits

Medical Vouchers

Health-Benefits Trend: Give Workers Money, Let Them Buy a Plan

Advocates Say Pluses Include More Choice for Patient, Less Hassle for Employer

A Reaction to Managed Care

By Ron Winslow
And Carol Gentry
Staff Reporters of The Wall Street Journal

After long relying on managed-care companies as their weapon against health costs, U.S. employers are considering a fundamental change in strategy: turning the fight over to their employees.

While most health-benefits decisions now are negotiated between companies and health plans, a growing number of employers are looking for ways to retreat from their middleman role and let workers make their own benefits decisions – and bear more responsibility.

The idea is driven by a confluence of forces: the backlash against managed care, the popularity of 401(k) retirement plans, the rise of Web sites that help consumers make decisions – plus a recent resurgence in health costs despite the efforts of managed care. Behind the trend, too, is a growing feeling that the nation's vast health-care market won't work with full accountability until patients themselves hold the purse strings. "Let the consumers be the gatekeepers," says the health-benefits director at Honeywell International Inc., Brian Marcotte. "Long term, it has to be the consumer who drives efficiencies."

Obstacles Remain

Putting employees in the driver's seat won't happen overnight. Policy makers and companies will have to wrestle with daunting questions on such issues as tax-code changes, shortcomings in data on quality of care, and affordable coverage for high-risk patients.

But some of the obstacles are wearing away. One that is fading is the long-held view that health-benefits decisions are just too complex to be left to consumers. In addition, it's possible that Congress or a court ruling will expose employers to legal liability in malpractice cases, something that could spur some companies to look for an exit strategy from the health-benefits business. The bottom line: Some employers have now embarked on an experiment that, while still in its early stages, is likely to change the health-care system as radically in the coming decade as managed care did in the last.

In one new strategy, employers provide a set amount of money for each employee's health benefits, thus capping the company's costs. Employees use the amount to purchase a health-insurance plan, picking from a wide menu ranging from no-frills managed care to a traditional fee-for-service plan. Those who want more-generous coverage than can be bought with the company contribution can pay the difference themselves. By analogy with pensions, this approach is known as a "defined contribution" health-benefits system.

Quick Response

Xerox Corp. is already using it, with an added twist: If employees spend less than their allowance, they can use what's left over to enhance a related benefit, such as disability or dental insurance. The market effects have been striking. After a health-maintenance organization in the Southwestern U.S. raised rates significantly last year, 65% of its 1,100 Xerox enrollees switched to different plans. "People migrated out of the high-cost HMO on their own," says Cathy Diamond, health and welfare manager at Xerox.

The case suggests one of the advantages for consumers: a generally much wider range of choices in health plans. At Carlson Cos., a travel and food-service company in Minneapolis, workers have nearly 30 doctor groups and hospital groups to choose from. Carlson employees receive a health-care allowance, which they can spend to enroll in any of the groups. Carlson benefits director Charles Montreuil notes with satisfaction that when one such group raised its rates steeply, "our employees flooded that care system with phone calls – they didn't put the burden on me."

The Xerox and Carlson approaches are similar to a voucher-style program that federal workers have long used to choose their health plans and that some politicians, most prominently Bill Bradley, would like to expand. For employees, the downside of choice, of course, is that they may choose badly. But they have help. Carlson uses a buyers' coalition to select the plans and medical groups, negotiate rates and provide data on quality to help employees make their choices. Xerox contracts such chores to outside companies that set up a virtual market where employees, armed with their health-care allowance, shop for plans. In addition, if the 401(k) experience is any indication, helpful Web sites are sure to pop up. Some already have.

Out of Pocket

Ingersoll-Rand Co. takes a different approach to promoting consumer choice. One option it offered employees for the current year was a low-cost catastrophic-illness insurance plan that kicks in when a family's one-year medical expenses reach $5,000. The plan comes with a $500 use-it-or-lose-it medical-spending account to encourage checkups, but the $4,500 gap between the cash and the insurance means that workers are responsible for the cost of their routine care.

The idea is that if a doctor recommends, say, an MRI exam to check out an ankle injury, an employee paying out of his or her own pocket will consider whether it's worth it. "If the plan pays for everything, people are going to consume everything," says the company's human-resources director, Beth Powers. "People don't pay attention to stuff unless they have some stake in it."

Just 4% of Ingersoll-Rand's 25,000 U.S. employees chose this plan. Ms. Powers thinks many of the rest missed a bargain. For those who spend less than $1,000 a year on medical care—more than half of employees—the plan is cheaper than the more popular "preferred provider" plan, she says. More employees eventually will go for the new approach, Ms. Powers believes: "We put this in as the product of the future."

Not everyone applauds this trend, though. Some fear that employers just want to wash their hands of health benefits and push more costs onto employees. And even some supporters worry it could go too far. Kenneth Abramowitz, a Sanford C. Bernstein analyst who is an ardent advocate of consumer choice, blanches at what he calls the "Yellow Pages" approach: telling an employee, "Here's $5,000 and the Yellow Pages. You figure it out."

Moreover, a similar movement fizzled once before, says Charles Blanksteen, vice chairman of Active Health Management Inc., a Web-based company in New York. As a consultant in the 1980s, he designed defined-contribution systems for several companies. But health-care costs rose faster than company contributions and became too much to bear for lower-income employees, who eventually dropped their insurance. At that point, Mr. Blanksteen says, "The companies blinked—and had to pony up more money."

Employers on the leading edge of this movement say they have no intention of taking a cut-and-run policy.

For one thing, with the labor market tight, employers are loath to tamper too much with their benefit programs. Xerox met a storm of employee protest after news reports suggested it was planning a Yellow Pages strategy. The company says it doesn't plan to change health benefits further until there is "something that would offer employees more flexibility and more value."

For another, many companies known for innovation in health-care purchasing remain convinced that their clout is crucial to changing the market, and they want to keep their hands in, not only to control costs, but also to pressure doctors and hospitals to improve the quality of care.

The 401(k) Model

Still, some employers are inspired by the success of 401(k) plans, which let employees control investment of their retirement funds. There were concerns that employees lacked the knowledge and judgment to do this, but firms sprang up to help employees manage money, and 401(k) accounts have proved highly popular.

Some health-benefits managers are convinced the same will happen with health care. A key reason: the Internet.

Many companies already use Web sites to help employees make health-benefits decisions and sign up for plans. Now, entrepreneurs are developing Web-based services that would greatly reduce the need for a hands-on role for employers and provide consumers with new tools to navigate the health-care system and take decisions into their own hands.

Take eBenX Inc. The Minneapolis firm is developing an Internet health mart where consumers would be able to pick from among competing insurers, spending vouchers from their employers plus some of their own money, if they choose.

Relative Value

In a critical feature of the program, eBenX plans to sort participants according to 10 levels of health risk: the young and healthy in category 1, and older people with chronic ailments in 9 or 10. It will assign vouchers different values according to a person's risk and invite insurers to bid for consumers in each category.

Assuming it can sell the idea, the firm believes its health mart will squelch the usual objections to individual purchase of insurance: Prices are high because there's no group clout and it's only the sick who want to buy. Health insurers no longer would have an incentive to compete just for the good risks, but would have a financial incentive to take on the chronically ill.

This particular system hasn't been tested in real market conditions yet, but investors are enthusiastic. The company went public eight weeks ago at $20 a share and the stock has more than tripled.

Another kind of cyber-mart is under development by Hewitt Associates, a Lincolnshire, Ill., benefits consultant. In September, it staged an eBay-style online auction in which 50 health-maintenance organizations competed for three employer accounts on price and quality indicators. On average, says Tom Beauregard, who developed Hewitt's concept, employers saved 2% in the pilot test over rates they would have been charged after traditional negotiations. Hewitt's long-range plan is to expand its auctions to include patients, who would be able to purchase not just benefits packages but also individual services from doctors and hospitals.

Through another Web service, soon to be launched by Franklin Health Inc. in Upper Saddle River, N.J., consumers will be able to build a customized health record and gain access to data on the quality of providers that is now generally available only to insurers. Other software products will let consumers perform "what if" calculations, plugging in different premium payments, deductibles and anticipated medical expenses to find out what level of benefits to buy—much the way financial-planning software aids investors. These and other emerging services offer some assurance to employers that they could turn health-benefits decisions over to employees without leaving them stranded.

Employees' Experience

It's hard to know what consumers would think of such an approach. But one Xerox employee who says she benefited from the company's defined-contribution system is Charlene Stephens, a 33-year-old editorial assistant in Rochester, N.Y. When her HMO raised its rates, she found another plan that saved her $600 a year in premiums and eliminated the hassles of getting written referrals from a "gatekeeper" doctor before seeing a specialist.

Ms. Stephens had to switch doctors, but her daughter and husband were able to keep theirs. "You really don't give up anything unless you have a real strong relationship with your doctor," she says.

At Carlson, Dave Hinze, an accounting manager, values the freedom of choice his plan offers. His and about 30 other Twin Cities employers contract with numerous "care systems"—doctor and hospital groups—and publish a booklet that rates them on customer service and puts them in one of three price groups.

Liability Issue

Mr. Hinze chose a care system that was close by, in the midrange on costs and top-rated in customer service. His monthly allowance didn't quite cover it, but he got it by paying an extra $50. As he sees it, "To save $50 a month, no one is going to put up with inordinately long waits and doctors who don't treat them with respect."

The budding trend to let employees handle their health-care benefits just as they do their retirement money comes as consumers' role in their own health care is growing anyway. For instance, drug companies, to dodge managed care's attempts to curb use of expensive medicines, increasingly advertise directly to patients. And within managed care, employers have had to offer employees more choices because of resistance to restrictions. "Patients have a lot more to say about their health," says Ingersoll-Rand's Ms. Powers. "Whether we want it or not, this is how the market is going."

Still, most people see only a gradual transition to greater consumer control—perhaps over the next decade—as policy makers, the market and employees themselves get used to the idea. One major hurdle is the tax code. Many experts believe that shifting the tax deduction for medical costs to employees from employers is a prerequisite for a fully consumer-driven system.

Another legal issue could accelerate the idea: Legislation or a court decision that would allow employers to be sued over the consequences of their health-plan decisions. Congress is weighing such a measure, and a related issue is pending before the Supreme Court.

Adding new liability for companies could prompt some to scuttle their health-benefits programs and send employees into the market to fend for themselves. Says Margaret O'Kane, head of a managed-care accrediting organization called the National Committee for Quality Assurance: "If employers find themselves in the path of the trial lawyers, I think you can expect a massive bailout."

Wisconsin Counties Association

MEMORANDUM

TO: Honorable Members of the Senate Committee on Health, Utilities, Veterans and Military Affairs

FROM: Sarah Diedrick-Kasdorf, Legislative Associate

DATE: February 9, 2000

SUBJECT: Senate Bill 308 – Testimony for Information Only

The Wisconsin Counties Association (WCA) would like to make a few brief comments regarding Senate Bill 308 relating to health insurance coverage of nervous and mental disorders, alcoholism and other drug abuse problems.

Specifically, WCA has concerns regarding the cost implementation of Senate Bill 308 will have on county government as an employer. Removing the caps on coverage for nervous and mental disorders and alcoholism and other drug abuse problems will increase insurance company costs. The increased costs will be passed on to employer groups through higher health insurance premiums.

The cost county governments pay for insurance premiums increases dramatically on an annual basis as the cost of health care continues to rise. In some counties, the cost to continue health coverage for employees can increase 25% annually. Mandating additional services as part of an employee health care plan will only exacerbate already increasing health care costs.

WCA would like to suggest the following amendments to Senate Bill 308 which will assist in easing the cost impact implementation of the bill will have on county governments:

1. Amend the legislation to allow plans to establish limits on inpatient days, outpatient visits, etc. (similar to the limits included in many benefit plans).

2. Amend the legislation to allow plans to pay a lesser percentage for each visit for mental health care and/or requiring a higher deductible for mental health care.

WCA asks that as you debate the merits of Senate Bill 308, the cost to local government and the state's taxpayers receives well-deserved discussion.

Thank you for considering our comments.

100 River Place, Suite 101 ◆ Monona, Wisconsin 53716 ◆ 608/224–5330 ◆ 800/922–1993 ◆ Fax 608/224–5325

Mark M. Rogacki, Executive Director

Mark D. O'Connell, Chief of Staff
Craig M. Thompson, Legislative Director

Darla M. Hium, Deputy Director
Lynda L. Bradstreet, Administrative Director

EAP
• ASSOCIATION •

SOUTH CENTRAL WISCONSIN CHAPTER

P.O. Box 252
Madison, WI 53701-0252

February 8, 2000

The Honorable Rodney Moen
Wisconsin State Senator
Chairperson, Health, Utilities, Veterans and Military Affairs Committee

cc: Members of the Health, Utilities, Veterans and Military Affairs Committee

Re: SB 308

Dear Senator Moen:

This letter is being sent on behalf of the members of the International Employee Assistance Professional Association (IEAPA), South Central Wisconsin Chapter. We are highly supportive of SB 308.

In our EA profession, we have repeatedly seen and been frustrated when the clinical need for mental health and alcohol and other drug abuse treatment could not be met due to insurance benefit exhaustion. When these benefits are exhausted, the only recourse available is accessing community resources. Many employees are unable to pay for these services themselves, so they seek "no cost" or "sliding fee" community services. Over the years, these community services have been seriously depleted and may not be available. Because of these treatment limitations, we are very concerned about the overall health and wellness of our communities.

The impact of not providing these services to our citizens is great! The ramifications are felt not only by employees and family members but also our employers and the community as a whole. Early intervention and treatment is very important. When this service is not available and treatment benefits are limited, the employee or family member is much more apt to relapse and if their condition is left untreated, it could result in serious illness or death. In addition, because this illness has been allowed to progress, Wisconsin employers and the community are subject to staggering medical and other societal costs. The employer also incurs recruitment and training costs associated with replacing the employee.

We feel that parity is essential because these illnesses are no less devastating to all of us than any other illness. Often the impact is greater. It would be much more beneficial and fair to our citizens to provide these benefits initially rather than endure the financial and human cost of relapse and associated illnesses due to inadequate treatment.

Thank you for your deliberation on this highly important issue affecting all of us. Please feel free to contact Bob Seidner, chairperson, Legislative and Public Policy Committee, IEAPA South Central Wisconsin Chapter at 608/267-6293.

Sincerely,

The International Employee Assistance Professional Association, South Central Wisconsin Chapter

To: The Health, Utilities, and Veteran's and Military Affairs Committee
From: Lori A. Kinnard 2606 Balboa Ct., #12, Madison, WI 53713
(608)280-9001
Date: February 9, 2000
RE: **Speaking in favor of passing Bill 308, Mental Health Parity**

People with psychiatric disabilities who want to work are having to choose not to in order to receive S.S.I.-Disability. Why? Because the health insurance companies have belittled their therapeutic needs by denying them the same coverage as people with physical disabilities.

I am a college-educated person with several psychiatric diagnoses who works full-time without any assistance from S.S.I. or other government programs for the disabled. I am currently doing well with my depression and obsessive-compulsive disorders thanks to being on the right medications and counseling. However, even though I pay the same costs as fellow employees with physical disabilities for health insurance coverage, I do not receive the same benefits due to discriminatory practices by insurance companies against people with psychiatric disabilities.

I need to take my medications daily to function the same as someone with epilepsy or diabetes; without my medications, I suffer from severe insomnia, unhealthy weight loss down into the 90s, and suicidal behaviors. I need to see my psychiatric therapist on a regular basis in order to cope and be involved in the community the same as someone who needs a physical therapist on a regular basis for the same reasons. Yet, I can only see a counselor twenty times a year, while someone who's blind or in a wheelchair has no yearly limit set on their physical therapy sessions. Someone who's physically ill can stay as long as they medically need to in a hospital, and health insurance will mostly cover it. But, a limit has been set to greatly curtail how long insurance will pay for me to receive in-patient treatment if I have another setback and need to be re-hospitalized on a psychiatric ward.

My nine-year-old daughter also has psychiatric health issues. Right now, she's in foster care with Medical Assistance paying for her medications, counseling, and in-patient care for the past eight months at a children's care institute. There have been times when she's needed to see her therapist twice a week; if she'd been on my health insurance, she would have used up her twenty yearly sessions in ten weeks (two months)! After which, she would have been left to flounder, the same as other children and adults who fall through the cracks. This is especially wrong - children who cannot receive the psychiatric care they need to do well in school and society as high-functioning, productive citizens. In part because health insurance refuses them the same coverage as children with physical disabilities, sending the parents deeper into debt and/or to the government for financial assistance or foster care.

This is not right. Please, pass Bill 308. Thank you.

Sincerely, Lori A. Kinnard

FISCAL ESTIMATE FORM — 1999 Session

☒ ORIGINAL ☐ UPDATED — **LRB # 2896/1**

CORRECTED ☐ SUPPLEMENTAL — **INTRODUCTION # SB 308**

Admin. Rule #

Subject
Mental health insurance parity

Fiscal Effect

State: ☐ No State Fiscal Effect

Check columns below only if bill makes a direct appropriation
Or affects a sum sufficient appropriation.

☐ Increase Existing Appropriation ☐ Increase Existing Revenues
☐ Decrease Existing Appropriation ☐ Decrease Existing Revenues
☐ Create New Appropriation

☒ Increase Costs - May be possible to Absorb Within Agency's Budget ☐ Yes ☒ No

☐ Decrease Costs

Local: ☒ No local government costs

1. ☐ Increase Costs ☐ Permissive ☐ Mandatory
2. ☐ Decrease Costs ☐ Permissive ☐ Mandatory
3. ☐ Increase Revenues ☐ Permissive ☐ Mandatory
4. ☐ Decrease Revenues ☐ Permissive ☐ Mandatory
5. Types of Local Governmental Units Affected: ☐ Towns ☐ Villages ☐ Cities ☐ Counties ☐ Others ____ ☐ School Districts ☐ WTCS Districts

Fund Sources Affected
☐ GPR ☐ FED ☐ PRO ☐ PRS ☒ SEG ☐ SEG-S

Affected Ch. 20 Appropriations
20.435 (4) (v)

Assumptions Used in Arriving at Fiscal Estimate:

This bill removes the specified minimum amounts of coverage that a group health insurance policy must provide for the treatment of nervous and mental disorders and alcoholism and other drug abuse problems but retains the requirement with respect to providing the coverage. In addition, the bill imposes a new requirement that the coverage under group health benefit plans and self-insured health plans for the treatment of nervous and mental disorders and alcoholism and other drug abuse problems must be the same as the coverage under those plans for the treatment of physical conditions. The bill specifies that if an individual health insurance plan does provide coverage for mental health and AODA treatment, the individual insurance plan must provide the same coverage for that treatment that it provides for the treatment of physical conditions. The bill further specifies that the requirements apply to all coverage-related components, including deductibles; coinsurance; copayments; out-of-pocket limits, or appointment limits, etc.

This bill would affect DHFS's Health Insurance Risk Sharing Plan (HIRSP) program. Funding for the HIRSP program is provided by state GPR, policyholder premiums, assessments to the insurance industry, and assessments to health-care providers in the form of provider discounts. Because the level of state GPR support for the program is fixed, policyholders, the insurance industry and health-care providers support any additional cost to the program in a 60/20/20 split, respectively.

The HIRSP program currently provides coverage for mental health and AODA treatment with the following limits: inpatient AODA treatment is limited to 30 days per calendar year; inpatient mental health treatment is limited to 60 days per calendar year; and outpatient AODA and mental health treatment is limited to a total of $3,000 per calendar year. The proposed bill would force the HIRSP program to remove the limits on the number of days or annual expenditures for these treatments.

In 1999, 145 claims for a total of $32,400 were denied for exceeding the annual limits for mental health coverage provided by the HIRSP program. This is the estimated fiscal effect of the proposed bill. It is possible that additional claims were not submitted because policyholders knew that these claims would have been denied due to coverage limitations. It is not possible to estimate the number of claims or the cost of services provided. However, they could increase the estimated cost of the proposal.

Prepared By: / Phone # / Agency Name	Authorized Signature / Telephone No.	Date
Richard T. Chao / 267-0356 DHFS.OSF	John Kiesow John Kiesow, 266-9622	2-9-00

FISCAL ESTIMATE WORKSHEET Detailed Estimate of Annual Fiscal Effect **1999 Session**

☒ ORIGINAL ☐ UPDATED
CORRECTED ☐ SUPPLEMENTAL

LRB # 2896/1 | Admin. Rule
INTRODUCTION # SB 308

Subject

Mental health insurance parity

I. One-time Costs or Revenue Impacts for State and/or Local Government (do not include in annualized fiscal effect):

II. Annualized Costs:	**Annualized Fiscal impact on State funds from:**	
	Increased Costs	**Decreased Costs**
A. State Costs by Category		
State Operations – Salaries and Fringes	$	$ -
(FTE Position Changes)	(FTE)	(- FTE)
State Operations - Other Costs		-
Local Assistance		-
Aids to Individuals or Organizations	32,400	-
TOTAL State Costs by Category	$ 32,400	$ -
B. State Costs by Source of Funds	**Increased Costs**	**Decreased Costs**
GPR	$	$ -
FED		-
PRO/PRS		-
SEG/SEG-S	32,400	-
State Revenues Complete this only when proposal will increase or decrease state revenues (e.g., tax increase, decrease in license fee, etc.)	**Increased Rev.**	**Decreased Rev.**
GPR Taxes	$	$ -
GPR Earned		-
FED		-
PRO/PRS		-
SEG/SEG-S		-
TOTAL State Revenues	$	$ -

NET ANNUALIZED FISCAL IMPACT

	STATE	LOCAL
NET CHANGE IN COSTS	$ 32,400	$0
NET CHANGE IN REVENUES	$0	$0

Prepared By: / Phone # / Agency Name	**Authorized Signature/Telephone No.**	**Date**
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