Options
for independent
living inc

SEP 30 2003

September 29, 2003

Senator Carol Roessler
Room 8 South
State Capitol
PO Box 7882
Madison, WI 53707-7882

Dear Senator Roessler,

I am writing to thank you for your support of Senate Bill 71 and Senate Bill 72. As a Benefits Specialist at *Options* for Independent Living in Green Bay, WI, I meet many people with mental health disabilities who are struggling to meet their medical needs on a limited budget. SB 71 and SB 72 are important pieces of legislation that can help people with mental health disabilities get the services they need to survive.

Once again, thank you for your support of SB 71 and SB 72. Should you have any questions, please feel free to call me at 1-888-465-1515 ext. 106 or (920) 490-8270 ext. 106.

Sincerely,

Karin Zuleger

Karin Zuleger
Benefits Specialist

555 Country Club Road • PO Box 11967 • Green Bay, WI 54307-1967
920-490-0500 • toll free 888-465-1515 • fax 920-490-0700 • tty 920-490-0600 • www.optionsil.com

Halbur, Jennifer

From: Louis Schubert [lschubert@tds.net]
Sent: Tuesday, September 23, 2003 10:34 AM
To: 'Halbur, Jennifer'
Subject: RE: Touchpoint and mental health

Jennifer,

Why don't I have Carol talk to Jay directly. This answer might not be as simple as we think and this way Carol can ask follow up questions if necessary.

The number is (920) 735-6300 and she should ask for Jay Fulkerson.

Thanks,

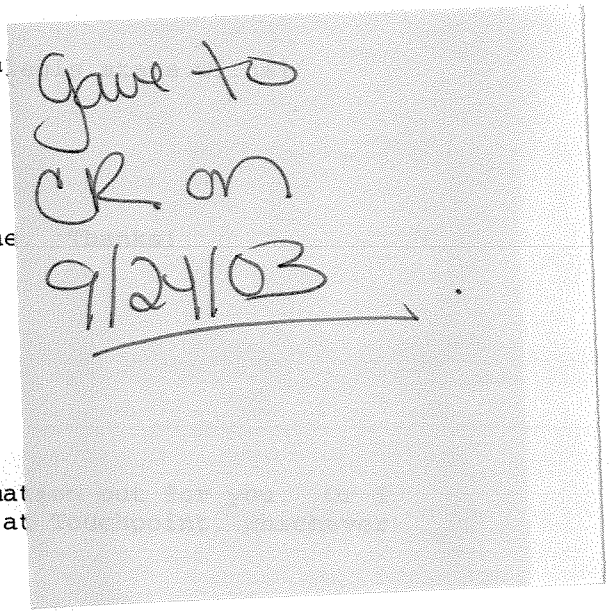
Louie

-----Original Message-----
From: Halbur, Jennifer [mailto:Jennifer.Halbur@
Sent: Tuesday, September 23, 2003 10:35 AM
To: 'lschubert@tds.net'
Subject: RE: Touchpoint and mental health

Louie, whichever is easier for you would be fine

-----Original Message-----
From: Louis Schubert [mailto:lschubert@tds.net]
Sent: Tuesday, September 23, 2003 9:06 AM
To: 'Halbur, Jennifer'
Subject: RE: Touchpoint and mental health

Jennifer - I can either try to find that informat
could get Carol in touch with Jay Fulkerson up at
you prefer.



-----Original Message-----
From: Halbur, Jennifer [mailto:Jennifer.Halbur@legis.state.wi.us]
Sent: Monday, September 22, 2003 4:52 PM
To: 'lschubert@tds.net'
Subject: Touchpoint and mental health

Hi Louie,

Senator Roessler is wondering if Touchpoint covers mental health treatment beyond what is minimally required by state law. Do you have this information?

Thanks!

Jennifer

INSIGHT

Volume 25, Number 6 September 2003

Inside This Issue . . .

On The Back . . .

Order Your 2003-04 WMC Legislative Directory Today!

The easiest way to get the information you need to make a difference is in the WMC Legislative Directory. WMC's Legislative Directory is a who's who of government officials complete with pictures, addresses, committee assignments and abbreviated biographies for state officers, members of Congress and the Wisconsin State Legislature.

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To order the 2003-04 edition, contact Janie Ritter at WMC, 608/258-3400.

Health Care Costs Still On the Rise

R. J. Pirlot, Director, Legislative Relations

Wisconsin Manufacturers and Commerce recognizes that rising health care insurance costs are a major concern for Wisconsin businesses, big and small, as they strive to stay competitive, whether doing business regionally, nationally or globally. Rising health care insurance costs are taking an ever-increasing bite out of employer revenues and employee paychecks, sapping economic development and job creation. In a recent member survey, 50 percent of WMC members saw health care insurance premiums increase over 20 percent and 8 percent saw health care insurance premiums increase over 40 percent. When asked how they will respond to increased health care insurance premiums, 65 percent said they will increase employee contributions and 28 percent said they will cut benefits.

Employers bearing an increasing burden of skyrocketing health care insurance costs is not the solution, nor is simply passing those costs along to employees. The average private sector employee is already paying 20 percent of his or her health care premium. Unfortunately, the state legislature is awash in proposals to create new mandates which would further drive up health care costs for Wisconsin businesses and workers. Now is not the time to pile on additional government health care insurance mandates which would lead to higher health care costs and decreased access to the health care system for Wisconsin workers.

New State Mandates Would Exacerbate Costs

These legislative proposals to enact new insurance mandates on Wisconsin employers are moving in the state legislature. Senate Bill 72, a slimmed-down form of "mental health parity," as well as two Assembly bills which would require expanded health care insurance coverage for drugs prescribed to treat diabetes and cancer, respectively, have received hearings and, in the case of Senate Bill 72, a committee vote.

Government health care insurance mandates inevitably lead to higher health care insurance costs and jeopardize employee access to affordable health care. A basic rule of economics is the more expensive a product, the fewer people who can afford it. Health care insurance is no different. As such, WMC aggressively opposes imposition of new government health care insurance mandates on Wisconsin businesses.

"WMC aggressively opposes imposition of new government health care insurance mandates on Wisconsin businesses."

Rather than inflict new health insurance mandates on Wisconsin's fragile manufacturing economy, WMC proposes allowing fully insured (non-self funded) employers to pick which of the currently mandated health care insurance benefits they will provide and for which they and their employees will pay. By allowing Wisconsin businesses the flexibility to choose which health care insurance benefits they will help purchase for their employees, health care insurance would be more affordable and more accessible.

Rising health care costs are hurting Wisconsin businesses and their employees and are costing the state good-paying jobs. Now is not the time to further drive up costs by enacting new state health care insurance mandates. Contact your legislators today, and tell them "enough is enough," new insurance mandates will undermine your efforts to create and retain good-paying jobs here in Wisconsin.

Halbur, Jennifer

From: Seaquist, Sara
Sent: Wednesday, September 24, 2003 12:32
To: Halbur, Jennifer
Subject: FW: SB71 & SB72
Importance: High

CR email...not a constit

-----Original Message-----
From: Penny Yakes [mailto:pyakes@pressenter.com]
Sent: Wednesday, September 24, 2003 12:23 PM
To: Sen.foti@legis.state.wi.us
Cc: sen.welch@legis.state.wi.us; sen.schultz@legis.state.wi.us; sen.robson@legis.state.wi.us; sen.kanavas@legis.state.wi.us; sen.jauch@legis.state.wi.us; sen.carpenter@legis.state.wi.us; sen.chvala@legis.state.wi.us; sen.roessler@legis.state.wi.us; sen.erpenbach@legis.state.wi.us; sen.risser@legis.state.wi.us; sen.erpenbach@legis.state.wi.us; sen.fitzgerald@legis.state.wi.us
Subject: SB71 & SB72
Importance: High

Dear Senators, As you are all aware I have been a relentless mother and strong advocate for my daughter regarding treatment for her eating disorder for the past 12 years. I know from our years of experience with her illness that mental health should be addressed with the same urgency as physical health. Focusing on early diagnosis and treatment in the patients own communities offers a high expectation of recovery. *This is the opposite of what we have now. A*bout 5 to 7 percent of adults have serious mental illnesses and 5 to 9 percent of children suffer emotional disturbances, according to The President's New Freedom Commission on Mental Health, a 22 member group formed in April 2002.

I am urging all of you to schedule,support, vote yes and pass bills B71 and SB72 during next week's floor session.

SB71 does not change current practice, *it merely codifies into law* practices that are already the standard for insurance companies.

SB72 *Is not a parity bill. It is a major compromise*. The Joint Legislative Council Committee endorsed the proposals as a bi-partisan compromise. As you know SB72 would not become law until 2005, but with the economy on the upswing and with my daughter's life and hundreds of other WI children's lives hanging by a tread I believe there is no excuse for delaying the implementation of this compromised proposal. The time has arrived for WI children and their working families to receive a cost-of-living increase in insurance coverage, which has remained the same since 1985.

Please help us help our children and our families. Thank you for you time and your support in my very personal life-saving advocacy.

Inpatient hospital treatment from $7,000 to $16,800, outpatient treatment from $2,000 to $3,100 and transitional treatment from $3,000 to $4,600. My daughter's life.....priceless.

Sincerely, Penny Yakes

1315 Wilson Street
Eau Claire, WI 54701
715.835.5410
pyakes@pressenter.com

State of Wisconsin / OFFICE OF THE COMMISSIONER OF INSURANCE

Jim Doyle, Governor
Jorge Gomez, Commissioner

Wisconsin.gov

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June 27, 2003

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

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

RE: Social and financial impact report – Senate Bill 72

Dear Senator Panzer and Representative Gard:

SB 72 increases the minimum dollar amounts that must be covered for inpatient, outpatient, transitional treatment related to mental health and AODA treatment in group health insurance plans and certain individual health benefit plans. As required in, s. 601.423, Wis. Stats., I am submitting a social and financial report on the proposed health insurance mandate.

Current Wisconsin Law

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

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

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

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

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

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

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

Proposed Coverage Changes

SB 72 increases the minimum coverage amounts for inpatient, outpatient, and transitional treatment as well as the overall minimum coverage amount for a group health insurance policy.

More specifically, SB 72 would:

a. Increase the minimum for inpatient treatment of nervous and mental disorders and alcohol and other drug abuse (NM/AODA) from $7,000 annually to $16,800 minus applicable cost sharing or $15,100 with no cost sharing.

b. Increase the minimum for outpatient treatment of NM/AODA from $2,000 annually to $3,100 minus applicable cost sharing or $2,800 with no cost sharing.

c. Increase the minimum for transitional treatment of NM/AODA from $3,000 annually to $4,600 minus applicable cost sharing or $4,100 with no cost sharing.

d. Increase the minimum for all treatment of NM/AODA from $7,000 annually to $16,800 minus applicable cost sharing or $15,100 with no cost sharing.

e. Require the Department of Health and Family Services to annually report the change in the coverage limits necessary to conform to the change in the federal consumer price index for medical costs.

Impact of Mandates

Wisconsin has long benefited from a healthy and competitive insurance market. The state currently has the lowest uninsured rate in the country, according to the U.S. Census Bureau. Increasing the amount of mandated coverage for NM/AODA could have an adverse effect on our current health insurance market. Traditionally, as the number of benefit mandates increase the cost of coverage rises, and as costs rise, fewer and fewer individuals and businesses can afford to insure.

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

- **The mandate will add approximately $9.2 to $30.8 million per year to premium costs for group health insurance consumers, borne mostly by small businesses.**

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

- **The increase in costs could increase the disparity between insured plans and non-state regulated self-insured plans, decreasing the effectiveness and protections afforded by state regulation.**

Social Impact Factors

Fully insured group health insurance products cover approximately 2.5 million state residents. This mandate will expand coverage for those individuals. However, individuals who are members of groups whose benefit plans are self-funded are exempt from state regulation by the Employee Retirement and Income Security Act of 1974 (ERISA) and will not be affected by the mandates.

Because self-funded plans do not have to offer state-mandated benefits, this option offers self-funded plans the opportunity to save as much as 10% to 15% on premium costs, or choose which benefits to offer. Anytime mandates are added to insurance products, it will increase the propensity of employer groups to switch to self-funding.

Self-funding of health benefits has historically been used mostly by larger employers, however; over the last decade, the number of medium employers shifting from fully insured to self-funded products has increased. Larger employers are able to spread these costs over a larger base when self-funding and typically do not experience the same impact.

Increasing the disparity between insured and self-funded plans costs could increase the incidence of such switching. The potential of this occurring through mandated mental health treatment is very possible.

According to testimony before the 2002 Study Committee on Mental Health Parity, as many as 1.2 million Wisconsin residents are diagnosed with either a mental disorder or a substance abuse problem which is roughly 22% of the population of the state. The number of these residents with group health insurance coverage that would be covered under SB 72 is unknown at this time.

There is no risk of employers dropping MH/AODA coverage under SB 72 and since the mandate itself is not new, there would be no effect on the number of people who would be eligible nor would there be any effect on availability of coverage without the mandate. However, with the increase in health care costs being experienced by employers in Wisconsin during the previous years and the movement toward more consumer directed types of health care benefits being offered by employers, more of these increases will be shifted to the employees, possibly making the coverage unaffordable (even though it is available) for the employee.

Financial Impact Factors

In estimating the costs of the coverage proposed in SB 72, OCI reviewed data from states that have implemented parity legislation and the results of state employee health plans that have instituted mental health parity for state employees. This information was contained in reports compiled by PriceWaterhouseCoopers, LLP and the University of South Florida. Additionally, Data from the OCI 2001 Study of Certain Mandated Benefits in Insurance Policies and the

testimony of Roland Sturm PhD, Senior Economist from RAND Health, to the Health Insurance Committee, National Conference of Insurance Legislators were used in preparing this statement.

- **.15% to .50%, or $9.2 to $30.8 million, increase in insurance premiums resulting from the modifications to existing mental health requirements.**

The above mentioned increase is based on the following assumptions:

- OCI's Survey of Certain Mandated Benefits in Insurance Policies collected data from insurers regarding the level of benefits paid in excess of the mandated benefits for MH/AODA. Eight of the insurers surveyed indicated that they paid out MH/AODA benefits in excess of the mandate. These insurers indicated that the additional cost of those benefits ranged from .01% to .47% of total benefits paid under their group health plan. The insurers did not indicate if the benefit levels were the cost of full parity or of a benefit level less than full but more than the mandate requires. SB 72 does not require full parity. Premium data used in the calculation was obtained from the 2001 Wisconsin Insurance report which indicated that group health insurers $6.1 billion in premiums for that year.

- Several insurers indicated that they did not include prescription drug costs in the calculation of the minimum coverage amounts as a matter of policy. It is not determinable at this time if those insurers may choose to begin including those costs against the limits once they are raised to the levels described in SB 72.

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

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

- These studies and others have established a link between the level of managed care market penetration and the level of increases in premium costs for mental health and substance abuse (MHSA). In the examples above, states that have high levels of managed care market penetration experienced low levels of premium increases, or even premium decreases, due to MHSA. In states where there was less managed care market penetration, premium increases were greater. Also, other factors, such as minimal or inadequate regulation of MHSA in the examples of Vermont and Connecticut also contributed to higher premium increases. Wisconsin has substantial market penetration by managed care insurance plans. Nearly 70% of employees and their dependants are enrolled in managed care plans in 2001.

- The Ohio State Employee Health Insurance Program established full parity benefits in 1991. After 10 years, the program has not experienced a significant growth in MH/AODA costs and the level of benefits has stayed constant. The Ohio employee program is significant in its reliance on managed care.

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

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

SB 72 requires the Department of Health and Family Services to annually adjust the minimum limits to increase with the change in the federal consumer price index for medical costs. For 2002 the CPI-Medical increased 4.69%. This would increase the minimum coverage amount for all services by $787.92 and increase the minimum amount to over $17,500 in the second year of the mandate should the CPI-Medical trend continue. The CPI Medical has a five and ten year average increase of just over 4% annually. An attachment showing monthly changes to the CPI medical is included for your information.

Impact on the Uninsured

According to Congressional Budget Office estimates - for every 1% increase in premiums, approximately 200,000 persons nationally could become uninsured. While it would be difficult to predict the number of persons affected, it is reasonable to assume that an increase in premium costs to small and medium-sized employers certainly will have a negative impact on the number of people insured in Wisconsin.

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

Sincerely,

Jorge Gomez
Commissioner

MERITER

To: Carol Roessler, Chair
Health Committee
Wisconsin State Senate

RE: SB 72 on Mental Health Parity
Testimony for Hearing of July 22, 2003

- Good morning, Chairwoman Roessler and members of the Committee. I want to thank you very much for giving me the opportunity to speak this morning in support of Senate Bill 72.

- My name is Dr. Michael Miller. I have practiced medicine in Wisconsin for over 20 years, an Associate Clinical Professor in the UW Medical School, am Board Certified in General Psychiatry and Addiction Psychiatry, and I recently completed my second term as Secretary of the American Society of Addiction Medicine, a 3000-member national medical specialty society. Today, in support of SB 72, I am representing Meriter Health Services, a Madison-based, **non-profit** community health system that employs some 3,300 taxpayers and is a major provider of mental health services. I have served as Medical Director of Meriter's NewStart Alcohol/Drug Treatment Program since 1989.

- As Senator Roessler and members of this Committee are well aware, the debate surrounding mental health parity has been going on for several years, and for several legislative sessions.

- Meriter believes that the compromise included in SB 72 is reasonable and prudent at this time, and provides an important first step in bringing help to the many thousands of Wisconsin adults and children who suffer from chronic and acute mental illnesses.

- The debate over mental health parity has been far from easy, and in the past, Meriter Health Services has remained neutral on the various bills and proposals before the Legislature.

- On the one hand, mental illness is a pervasive issue in our state. It is the leading cause of inpatient hospitalization for children and adolescents. But effective treatments – while they can be expensive and lengthy – do exist to help prevent these illnesses from destroying individuals and their families. From a medical perspective, illnesses of the brain can and should be approached just like other illnesses: they should be diagnosed and treated properly.

- Meriter is a major provider of mental health services. In fact, we recently broke ground on a new freestanding child and adolescent psychiatry facility on Madison's southwest side, which is one of only three such programs in the entire state. We view it as a tragedy when people cannot or do not get the mental health services they need simply because of payment issues.

- On the other hand, Meriter understands that there have been economic and ideological reasons offered by those who oppose full mental health parity. Health care providers and insurers are very reluctant to endorse more coverage mandates. Small businesses are concerned that new mandates will drive up the cost of insurance, forcing them to increase co-pays for their employees or drop coverage entirely. While I testified before the Legislative Council committee on mental health and addiction parity that the data clearly show that there is no economic argument when can be made against parity—since the increase in premium would be roughly 0.9% for full parity and only 0.3% for addiction parity--the point that there

would be any measurable increase in health insurance premiums does resonate in the current environment of rapidly-rising health costs.

- Thus, we have the political football of mental health parity. A bill is introduced every session. Hearings bring heart-breaking stories of families in crisis due to a lack of treatment. Businesses sympathize but worry about cost pressures and new mandates. And in the end, parity stalls yet again.

- As I said, Meriter believes that SB 72 is an important step in bringing renewed hope to the lives of people whose families have been tragically affected by the realities of mental illness.

- Increasing the mental health coverage floor – which essentially serves as a ceiling – from the arcane level of $7,000 to $15,000 is a positive and prudent step in the right direction. It's a fair compromise. It will not materially affect health premiums or small employers. But it will bring access to more mental health services to people who are truly in need in our state.

- In assessing this compromise, I think it's fair to ask: Have you gone without a raise during the past 25 years? Has the price of health care – or for that matter, anything else – remained flat for the past 25 years? Whether we're talking about teachers or retirees or working class men and women, everyone needs adjustments to keep up with the cost of living. Recipients of mental health services are no different. The cost and scope of treatment for them has changed in the past quarter-century. Our state policies need to change with the time as well. A true 'indexing of inflation' of the caps in mental health/addiction insurance coverage since the passage of the original Wisconsin mandated benefits over 25 years ago would more than triple the current outdated $7000 cap; but if a raise of the cap to $15,000 is what is before you for action in this session, I strongly encourage your vote in favor of such a change.

- Unfortunately, mental illness is still very much shrouded in stigma. Many people are afraid of it. We don't like to talk about it. Some people even deny that mental illness is really an "illness," and still discuss the issue in the context of moral shortfalls or lack of self-control.

- But as a professional psychiatrist and addictionologist for over two decades, I can tell you that mental illness is a very real physical condition. It should be treated like any other physical ailment. And addiction, while a complex bio-psycho-social-spiritual illness, clearly has roots in brain function and genetics, and is a medical condition not vastly different from other brain diseases.

- People with mental illnesses are our friends, neighbors, family members and co-workers. They raise families, hold jobs, pay taxes, love the Packers and Badgers, and want the same chance at life as everyone else. They deserve that hope. They deserve passage of SB 72.

- Thank you very much. I would be happy to take any questions you might have.

Department of Health and Family Services
Presentation to the Legislative Council Study Committee on Mental Health Parity
Oct. 24, 2002

Mental Health and Substance Abuse Parity
Text of PowerPoint Presentation with Notes

Keith Lang, MSW, Interim Director, Bureau of Substance Abuse Services
Dan Zimmerman, Bureau of Community Mental Health

Public Sector: Funding Sources

- Community Aids
- County Match and Overmatch
- Medicaid
- Medicare
- Mental Health Block Grant
- Substance Abuse Block Grant
- Specialized Grant Programs
- Projects for Assistance in Transition for Homelessness (PATH)
- Intoxicated Driver Program Surcharge
- GPR Funding - Forensic/IMD
- Temporary Assistance for Needy Families
- Drug Abuse Program Improvement Surcharge

"Public sector" refers to:

•services directly operated by government agencies (e.g., state and county mental hospitals) and to

•services financed with government resources (e.g., Medicaid, a Federal-state program for financing health care services for people who are low-income and disabled, and Medicare, a Federal health insurance program primarily for older Americans and people who retire early due to disability).

Private Sector

- Funding Sources
  - Private Insurance (Employer-Provided)
  - Self-Pay
  - Services operated directly by Private Agencies

Public Sector Target Population

- Mental Health
  - Persons with Serious Mental Illness
  - Persons with Severe and Persistent Mental Illness
  - Children with Severe Emotional Disturbances
- Substance Abuse
  - General Population of Adults and Adolescents

Serious Mental Illness refers to persons ages 18 and over who, at any time during an index year, had a diagnosable mental, behavioral or emotional disorder that met DSM criteria and "that resulted in a functional impairment which substantially interferes with or limits on more major lifetime activities" (Federal Substance Abuse and Mental Health Services Administration-SAMHSA).

Severe and Persistent Mental Illness: estimated at 2.7% of the population by SAMHSA. WI Statute 51.01 states "Chronic mental illness" means a mental illness which is severe in degree and persistent in duration, which causes a substantially diminished level of functioning in the primary aspects of daily living and an inability to cope with the ordinary demands of life, which may lead to an inability to maintain stable adjustment and independent functioning without long-term treatment and support and which may be of lifelong duration. Includes schizophrenia as well as a wide spectrum of psychotic and other severely disabling psychiatric diagnostic categories, but does not include infirmities of aging or a primary diagnosis of mental retardation or of alcohol or drug dependence.

Severe Emotional Disturbance in persons under age 21 is defined by a mental or emotional disturbance listed in the APA diagnostic categories for children and adolescents. It results in functional symptoms and impairments and must have persisted 6 months and be expected to persist. (Center for Mental Health Services)

Mental Illness Prevalence Rate

- Mental Health Disorders Overall 19% or 889,227 individuals.
- Adults with Serious Mental Illness (SMI) is 5.7% or 227,710 individuals.
- Adults with Severe Persistent Mental Illness (SPMI) is 2.7% or 144,819 individuals.
- Children ages 5-18 with Severe Emotional Disturbance (SED) is estimated between 36,362 to 65,452.

•Prevalence rate percentages are from Mental Health: A Report of the Surgeon General, 1999, and applied to the WI population numbers from the 2000 census.
•Mental illness affects one in every five American families.
•23% of American adults suffer from a diagnosable mental disorder in a given year.
•People with mental illness fill more hospital beds than those with cancer, lung, and heart disease combined.
•4 of the 10 leading causes of disability in the United States are mental disorders. They included major depression, bipolar disorder, schizophrenia, and obsessive-compulsive disorder.
•1 in 5 children have a diagnosable mental, emotional, or behavioral disorder.
Seventy percent of all children, however, do not receive mental health services.

Substance Use Disorder Prevalence Rate

- Adults in need of treatment for alcohol and drug use disorders is 9.8% or 409,700 individuals.
- Adolescents in need of treatment for alcohol or other drug use disorders is 8.3% or 40,350 adolescents.

A 2000 update of a 1997 Wisconsin household survey that checked the alcohol and drug health of 8,460 adults and 1,075 adolescents found that 9.8 percent of the adults and 8.3 percent of the adolescents were in need of treatment for alcohol or other drug disorders. This means that there are 409,700 adults and 40,350 adolescents in need of treatment statewide.

A 1998 study published in the Journal of American Medical Association entitled "The Epidemiological Catchment Study" showed that 55% of persons with a substance use disorder has some type of mental illness. (While the rate of co-occurring disorders may vary by gender and specific diagnosis, the minimum rate is 55%).

Overview of Mental Health and Substance Abuse Client Services

- Detoxification
- Inpatient/IMD
- Hospitalization
- Crisis Intervention
- Residential Treatment
- Day Treatment
- Outpatient Counseling
- Community Support and Case Management
- Medication Management
- Symptom Management
- Disease Awareness and Education

- Vocational Supports
- Housing Assistance
- Prevention
- Peer Support/Mutual Support
- Other Rehabilitation Services

The Mental Health Act, Chapter 51, and HFS 75 outline the requirements for local mental health and substance abuse services, but county boards have considerable autonomy in designing and operating programs that meet the needs of their individual counties. The boards are overseen and funded by the Division of Supported Living of the Department of Health and Family Services (DHFS). The array of services provided by the boards may include the Prevention, Early Intervention and Education Programs; clubhouses and vocational alternatives for older persons; consumer operated and controlled self help and peer support options; social and recreational opportunities, including drop-in services; sheltered workshops; jail diversion; and other additional services.

Certified Treatment Providers

- There are 1126 (July 2002 report) mental health and substance abuse programs certified by DHFS in the state.
- Includes private and publicly funded service providers.

The mental health and substance abuse programs certified by the DHFS provide services to individuals who are able to pay for their services as well as people who receive publicly funded mental health/substance abuse services. Services are provided on a continuum of care in the least restrictive environment. Certified programs include

- outpatient clinics,
- community support programs,
- adolescent day treatment programs,
- adult day treatment programs,
- medically monitored residential treatment,
- transitional residential treatment,
- narcotic treatment,
- detoxification services,
- methadone detoxification services,
- emergency outpatient programs,
- emergency inpatient programs,
- adolescent inpatient programs,
- adult inpatient programs.

Referral and Access Points to Public Treatment

- Mental Health and Substance Abuse Treatment Providers
- Primary Care Service Providers
- Crisis Services
- Hospitals
- Indian Health Centers
- Law Enforcement, Courts, and Corrections
- Other Human Services Providers and Public Agencies
- Schools
- Employee Assistance Programs

How Do People Obtain Publicly-Funded Mental Health and Substance Abuse Services?

- Medicaid-Eligible Individuals: Through Providers
- Individuals Not Medicaid-Eligible: Through County Human Service Systems

Medicaid-Eligible Individuals

- Entitlement
- Individuals Try to Find Providers
- Low Reimbursement Rates for MA Providers
- Many Private Providers Refuse to Provide MA-funded Services

Individuals Not Medicaid-Eligible: County Human Service Systems

- No Entitlement
- Voluntary Services
  - Limited County Funding Results in Waiting Lists
- Involuntary Services
  - Chapter 51-Involuntary Commitment
  - Chapter 55-Protective Services
  - Child Welfare
  - Other Court-Ordered Services

Medicaid is a federal/state program that pays health care providers to deliver medically necessary health care services to aged, blind or disabled individuals, members of low-income families with dependent children and certain other children, and pregnant women.

In FY 2001, Medicaid enrolled an average of 496,116 Wisconsin residents per month and provided medical services through fee-for-service providers. Wisconsin Medicaid contracts with 13 HMOs in 68 counties to provide services to its enrollees. Wisconsin Medicaid also administers special managed care programs for selected recipients, for instance, children with severe emotional disturbance, and the elderly enrolled in PACE, and Partnership.

However, most individuals with a primary substance abuse diagnosis are usually not eligible for Wisconsin Medicaid. An exception is a low-income parent with a dependent child, or low-income pregnant woman.

Low-income uninsured families who are not eligible for Medicaid qualify for BadgerCare if family income is at or below 185% of the federal poverty level. Families remain eligible until their income exceeds 200% of the poverty level.

2001 Clients and Expenditures: Inpatient and Outpatient Services
Data from County Human Services Reporting System (HSRS)

- Mental Health
  - 94,722 Clients and
  - $319,806,437 Expenditures
- Substance Abuse
  - 58,063 Clients and
  - $70,408,609 Expenditures

Preliminary 2001 Medicaid Expenditures
Inpatient and Outpatient Services

- Mental Health
  - 41,764 Clients and
  - $106,126,996 Expenditures
- Substance Abuse
  - 2,965 Clients and
  - $6,322,333 Expenditures

Historically, outpatient mental health/substance abuse services have been the traditional Medicaid mental health/substance abuse benefit. Access to these services has been declining. Aside from the HMO population being removed from fee-for-service, there continues to be a decline in the number of recipients receiving outpatient mental health clinic services.

How Do Insurance Limitations Affect the Individual?

- Limitations Result In:
  - Limited, Inadequate or No Treatment
  - Rationed Treatment
  - Increased Symptomatology
  - Increased Acuteness of Illness
  - Exhausted Private Insurance Benefits
  - Cost Shifted from Private to Public Sector
  - Increased Public Sector Usage

When privately insured individuals exhaust their benefits they may turn to the public sector for treatment, which increases costs to federal, state and local governments. One study estimated that 20% of public reimbursements are for clients who have had private health insurance. (Lewin-VHI, 1994).

Caps on coverage are skewed to favor inpatient services. This causes use of more expensive care rather than best practice: the use of earlier outpatient intervention, which is less expensive.

Public System Access Issues

- Limitations Result In:
  - Insufficient Funding for Levels of Care
  - Disrupted Continuity of Care
  - Waiting Lists
  - Restrictions on Available Appropriate Care Include
    - Services Based on Severity of Diagnosis
    - Number of Public Sector Clients Accepted by Providers
    - Inadequate Reimbursement Levels for Providers
    - Detoxification (Not Billed as a Medical/Surgical Benefit)
    - Number of Treatment Visits

A 2000 survey conducted by the Bureau of Substance Abuse Services (BSAS) in cooperation with UW CHIPPE identified that 686 individuals were put on a waiting list for services at some

point during the calendar year. An individual must have been waiting for services at least two-weeks prior to being placed on the waiting list.

Outpatient Medicaid rates are one-fourth or less of customary charges within the healthcare industry; there has been no rate reform since the beginning of this benefit. Allied health professionals (i.e., Ph.D. psychologists and masters level therapists) are paid 40-50% less than the Medicaid physician rate. With another Medicaid benefit, allied health professionals (physician assistants) are paid 90% of the physician rate.

Compared with the other Medicaid mental health/substance abuse benefits, professional levels are paid less than 50-55% of the rates.

In addition, due to old, historical department rate settings, county mental health/substance abuse clinics are paid differently than private mental health clinics. **(632.89 to 51.42)**

Untreated Disorders Result In

- Loss of Productivity in the Workplace
- Family Problems
- Primary Care Costs
- Long-term Care Costs
- Impacts on the Criminal Justice System
- Impacts on the Educational System
- Homelessness
- Death

WORKPLACE PRODUCTIVITY:

The World Health Organization (WHO) publication entitled "The Burden of Disease" determined that mental disorders are the second leading health related reason for lost productivity in all market economy countries. In the same study WHO study, alcohol abuse was identified as 5th and drug abuse as the 7th leading cause of lost productivity.

Many studies have shown a direct correlation between untreated mental health problems and absenteeism and increased use of sick leave. One study showed that depressed workers have between 1.5 and 3.2 more short-term disability days in a given 30-day period than other workers. The average salary equivalent disability costs of these days range between $182 and $395 per depressed worker . (Kessler et al , Depression in the Workplace, Health Affairs, Volume 18, Number 5; 1999).

FAMILY PROBLEMS:

Nationally in the last five years, the Division of Family Services has seen a significant increase in the number of children entering foster care because of parental substance abuse. Parental substance abuse is now a factor in more than 50% of the children coming into care and foster care costs for these children constitute over 70% of total foster care costs. Parental substance abuse is a factor in 60 to 85% of the cases receiving child protective treatment services.

PRIMARY CARE COSTS

Studies have shown that those persons not receiving mental health services visited a medical doctor twice as often for unnecessary care than persons who receive treatment. (Lechnyr, R. , 1992 , Cost savings and effectiveness of mental health services; Journal of the Oregon Psychological Assn, 38, 8-12). The APA estimates that 50-70% of visits to primary care physicians are due to conditions that are caused or exacerbated by mental or emotional problems.

Healthcare costs of untreated persons who suffer from alcoholic and drug addiction are 100% higher than those for those who received treatment. Of all hospital admissions, at least 25% of those admitted suffer from alcoholism-related complications, and 65% of emergency room visits are for alcohol or other drug-related disorders (Join Together, 1998; Hazelden Foundation, Testimony Before the House Committee on Government Reform, 1999).

LONG TERM DISABILITY

Health plans with the highest financial barriers to mental health services have higher rates of long-term disability (LTD) claims, and companies with easier access to mental health services see a reduced incidence of LTD claims (Salkever et al, Millbank Quarterly, March 2000).

CRIMINAL JUSTICE

"Untreated persons with mental illnesses end up in the juvenile court, the jail system, in the public sector and on disability." National Advisory Mental Health Council (May, 1998).

Some studies put the rate for mental health disorders among adolescents in detentional or correctional facilities as high as 60% and estimate that 20% of these youth have severe mental disorders. It is also estimated that 60% of detained youth in juvenile facilities in America may have substance abuse disorders while the percentage of co-occurring mental health and substance abuse disorders is placed as high as 50%. (Parent, D., Leiter, U., Kennedy, S. "Conditions of Confinement": Juvenile Detention and Corrections Facilities: Research Report, Washington, D.C., Office of Juvenile Justice and Delinquency Prevention 1994.)

Nationwide, nearly 700,000 persons with active symptoms of a serious mental illness are admitted to jails each year. They make up about 7 percent of the jail population. Persons with serious mental illness are over-represented in jail and prison populations; many do not receive treatment. (Morris, S.M.; Steadman, H.J.; Veysey, B.M. Mental health services in United States jails: A Survey of Innovative Practices. Criminal Justice and Behavior 24:3-19, 1997).

A 1996 study by the Wisconsin Department of Corrections indicated that 32% of offenders booked into jail and nearly 65% of prison admissions have substance abuse problems.

From 1985 – 1995, the proportion of drug offenders in state prisons increased from 9% to 23% of all state prisoners.

EDUCATIONAL SYSTEM

When a serious emotional disturbance in a child or adolescent goes untreated, it can have grave personal, social, and economic impacts on the child and his or her family. The child may experience major problems interacting with others, fail in school, act out or show violent behavior, or have additional or more severe mental health problems as an adult. (CMHS, Children's and Adolescents' Mental Health, 2000)

Forty two percent of youth with SED earn a high school diploma as opposed to 76% of similarly aged youth in the general population. Students with behavioral problems and severe emotional disturbance are often removed from regular schools and general education settings. Placements out of the neighborhood schools and communities are often very costly to communities and disruptive to families. (US Dept of Education National Agenda for Achieving Better Results for Children with Serious Emotional Disturbance, Sept. 1994)

Commissioned by the NIAAA Task Force on College Drinking, the study reveals that drinking by college students age 18-24 contributes to an estimated 1,400 student deaths, 500,000 injuries, and 70,000 cases of sexual assault or date rape each year. It also estimates that more than one-fourth of college students that age have driven in the past year while under the influence of alcohol. (College Drinking Hazardous to Campus Communities, NIAAA 4/9/2002).

HOMELESSNESS

Approximately 600,000 Americans are homeless on any given night. An estimated one-third of these people have serious mental illness, and more than one-half also have an alcohol and/or drug problem. (The Center for Mental Health Services, Homeless Programs Branch.)

A study by the University of California at San Francisco determined that almost three-quarters of homeless individuals suffered from either a mental-health problem or addiction.

DEATH:

Suicide is the 2nd leading cause of death of young people in Wisconsin ages 15-34. In addition, 90-95% of those who commit suicide have a diagnosable mental disorder or substance use disorder.

Alcoholism is the 4th leading cause of death in Wisconsin (301 die annually in alcohol-related traffic crashes, and 839 die annually from alcohol poisoning and 363 from drug poisoning.) *Peterson, Dan (1988), Alcohol-Related Disease Impact in Wisconsin, Wisconsin Division of Health. Remington, Patrick (1994), Preventable Causes of Death in Wisconsin, Wisconsin Division of Health.

Examples of Benefits of Comprehensive Treatment

- According to the National Institute of Mental Health, the current success rate for the treatment of clinical depression is 80-90%.
  - In comparison, the overall success rate for cardiovascular disease is 45-50%.
- Substance abuse treatment is as effective as treatments for illnesses such as hypertension, diabetes, and asthma.
  - About 30-50% complete regimens of treatment and 30-80% suffer a reoccurrence of the illness (relapse).

Due to the widespread impact of untreated/undertreated mental health and substance use disorders, a holistic approach to treatment provides comprehensive benefits.

In the public sector, Wisconsin provides alcohol and other drug abuse services to some 55,600 persons each year spending about $63 million dollars; 40,000 of these receive treatment or rehab services. The economic benefit from these services is estimated to be over $443 million dollars in savings on welfare, criminal justice system costs, property damage and loss, unemployment, industry costs, medical care, injury, and early death. (2000 Bureau of Substance Abuse Services Annual Report).

The National Mental Health Association's Labor Day 2001 Report states that the economy could cut its losses by half - or by $56.5 billion - with an increased investment in the prevention and treatment of mental illness. Untreated and mistreated mental illness costs $105 billion in lost productivity, and $8 billion in costs from crime and welfare. Mental health treatment costs $92 billion, less than half of that. According to various cost-benefit studies, an additional 5.5 percent investment of $5 billion the country could yield between a two and 10 times savings rate by reducing absenteeism, unemployment, welfare and other factors.

Additional Data:

Wisconsin Health Care Information WITHIN for the Health Data Specialist:
Inpatient Costs: Total charges by Payer 2000

	Total	Medicare	Medical Assistance	Other Government	Private Insurance	Self Pay	Other or Unknown
MH	$292,225,666.65	$94,629,620.71	$51,327,071.31	$15,293,758.65	$89,386,503.67	$41,008,615.26	$580,097.05
AODA	$70,360,408.63	$13,813,274.73	$10,728,008.01	$7,467,185.51	$26,745,199.01	$11,564,048.47	$42,692.90
CS	$1,652,882,530.69	$1,007,846,678.37	$66,644,878.83	$18,613,348.25	$534,580,120.00	$24,965,438.57	$232,066.67
Trauma	$46,849,142.97	$4,266,879.88	$4,000,873.03	$486,789.11	$33,401,895.62	$4,415,698.30	$277,007.03

Inpatient Hospitalizations Average Charge by Payer

	Total	Medicare	Medical Assistance	Other Government	Private Insurance	Self Pay	Other or Unknown
MH	$8,447.78	$10,251.29	$8,580.25	$6,214.45	$6,381.10	$14,809.90	$4,114.16
AODA	$4,254.98	$5,286.37	$5,041.36	$3,133.52	$4,237.20	$3,742.41	$4,269.29
CS	$16,407.57	$15,955.78	$17,757.76	$17,107.86	$17,393.77	$12,666.38	$8,288.10
Trauma	$37,965.27	$28,071.58	$42,114.45	$40,565.76	$39,716.88	$35,045.22	$34,625.88

MH: Mental Diseases and Disorders
AODA: Alcohol/Drug Use & Alcohol/Drug-Induced Mental Disorders
CS: Circulatory System
Trauma: Multiple Significant Trauma