Committee Name:
Joint Committee on Finance – Budget Hearings (JCF_BH)

Appointments

99hr_JCF_BH_Appoint_pt00

Clearinghouse Rules

99hr_JCF_BH_CRule_99–

Committee Hearings

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Committee Reports

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Executive Sessions

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Hearing Records

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Misc.

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Record of Committee Proceedings

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Multiple Topics

A Response to the 1999-2001 Biennial Budget by Wisconsin's consumers, families, and advocates for MENTAL HEALTH.

Grassroots Empowerment Project, Mental Health Association of Milwaukee, National Alliance for the Mentally Ill of Wisconsin, WeCARE Coalition, Wisconsin Coalition for Advocacy, Wisconsin Council on Mental Health, and Wisconsin Family Ties.

Last year, through the Governor's Blue Ribbon Commission on Mental Health a blueprint for mental health systems revision was developed and approved. Families, consumers, advocates and county representatives and professionals were encouraged that Wisconsin was once again taking a forward step in genuinely responding to the mental health needs of its citizen. Our reputation as being a leader in this arena is well-known.

The new system is described as one that will be community-based, consumer and family-centered in which funding will follow the person and not the services.

With the encouragement of the Governor, DHFS then started workgroups. For months, these workgroups that included consumers, families, advocates, local county representatives and professionals have been busy pulling together the details for the new system as described in the Governor's Blue Ribbon Commission on Mental Health report.

Now the people of Wisconsin are presented with a budget that does very little to support our mental health needs. In many ways, lessens the leadership role that Wisconsin has assumed for many years in the country.

1. Community Aids - Not supported

The recent 17% cut in the federal Social Services Block Grant resulted in a loss of $18 million over the biennium in Community Aids. This cut will produce an unacceptable reduction in services to our most vulnerable citizens. We support that the legislature the replacement of these funds with GPR dollars.

2. Behavioral Health Managed Care Demonstration Projects - Not supported

We are testifying against the proposed budget cut in funding for the Blue Ribbon Commission on Mental Health Demonstration Projects. The drastic reduction from 8 to only 2 sites will seriously affect the ability of the Department of Health and Family Services to test and pilot the carefully crafted reforms for mental health services.

These reforms were the result of the efforts of many consumers, advocates, state administrators, local county representatives, professionals and consultants for the past two years. The Governor received their work with enthusiasm. Then the budget's proposed under-funding of the demonstration pilots is a serious blow to the efforts of so many of our citizens to help improve the mental health services of Wisconsin.

We urge you to restore the budget cuts and allow these carefully planned demonstrations to reach their goals.

3. Governor's Blue Ribbon Commission on Mental Health - Support

In order to initiate the positive changes in the alcohol and drug abuse, developmental disabilities and mental health systems as recommended by the Governor's Blue Ribbon Commission on Mental Health we support the modifications of DHFS's powers and duties.

4. Non-Institutional Rate Increases - Not Supported

Since there have been no increases for years in these rates, we support a 3% rate increase for all community-based, non-institutional mental health MA providers in 2000-01.

5. SSI Caretaker Supplement - Benefit Level - Not supported

Increase the Caretaker Supplement above the Governor's recommendation from $150 a month per dependent child to $250 a month for the first child and $150 a month for each additional child equally $6.65 million of federal TANF dollars. It has been documented that 40% of these mothers are coping with mental illnesses.

Support of the Governor's proposal to expand the child care assistance program to include children ages 12-18 with special needs or chronic health conditions who require supervision after school.

6. Mental Health Institutes - Expanded Services - Support

We support the opportunity for MHIs to expand the scope of services provided that could enhance the provision of community services needed.

7. Health Insurance Risk-Sharing Plan (HIRSP) Not Supported

It is difficult to support a decrease in funds for this program. This program is in desperate need of a legislative audit in order to determine the effectiveness of this program and determine its true costs. Leave GPR support at its current level until the audit is conducted and it can be determined what level of change may or may not be appropriate. This decrease in funds will result in a increase in the premium costs for consumers.

8. School Funding for Special Education - Not Supported

Retain the statutory language directing the state to reimburse local school districts at 63% of the actual costs of special education.
Provide additional funding to increase the Categorical Aids reimbursement rate to local school districts to 40%.

Wendy Kilbey, Parent of children with mental illness, Wisconsin Family Ties, 16 N. Carroll St. #640, Madison, WI 53703, 608/267-6888

Bill Daniel, Consumer, Grassroots Empowerment Project, 106 E. Doty St, #3A, Madison, WI 53703, 608/251-9151

Robert Beilman, M.D., Family member, NAMI Wisconsin, 4510 Woods End, Madison, WI 53711, 608/238-2235.

Position Statement in Opposition to License Fees for Ambulance Providers

The Wisconsin EMS Association opposes the implementation of license fees for Wisconsin ambulance service providers. Many of Wisconsin's ambulance services operate as non-profit, volunteer agencies. Many of these same services continually struggle financially in their operations. They look to community donations and hold fund raisers to purchase needed equipment and supplies, obtain continuing education, and upgrade the level of service that they provide to the community. It was for these reasons that the Funding Assistance Program (FAP) was created in 1990. In this program, the State of Wisconsin provides funding to ambulance services that provide primary emergency response. It is a complete contradiction for the State of Wisconsin to provide funding to an ambulance service and then mandate money be returned to the State of Wisconsin in the form of a provider license fee. This tactic is nothing less than moving money from an expense line of the state budget, to an income line of the state budget, in the form of a fee passed through the ambulance service.

During the past years, The Department of Health and Family Services (DHFS) and the State EMS Board have successfully demonstrated themselves to be friends and supporters of Wisconsin EMS and EMTs. The EMS Board has made it a priority to identify funding for EMS and has charged a committee with working toward this goal. Creating a new fee structure on ambulance providers directly contradicts the efforts of the EMS Board and the population they serve. It also sends a message to the Wisconsin EMS community that the ultimate goal of these two entities is truly not to support and aid Wisconsin's ambulance services.

The Wisconsin EMS Association urges that license fees for Wisconsin ambulance providers not be created. The implementation of an ambulance provider fee contradicts the efforts communities have instituted to generate volunteerism and to control costs associated with providing necessary services to local Wisconsin communities. The funds that might by raised for the State of Wisconsin through such a program are greatly outweighed by the negative impact that will be displayed on Wisconsin ambulance providers and EMTs. The Wisconsin EMS Association requests that this plan be removed immediately from the budget proposal of 1999-2000.

Wisconsin EMS Association

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BUDGET HEARING--LEGISLATIVE JOINT COMMITTEE ON FINANCE
April 15, 1999

The Dane County Elderly Services Network is a coalition of agencies providing social and other services to the elderly in Dane County. It has a core group of the fourteen Focal Points and community centers. I am a member and represent the Dane County SOS Senior Council.

The Elderly Services Network supports the basic concepts underlying the Family Care Program and recommends legislative authorization for implementation. We believe that the pilot projects should continue and that the proposed additional pilot sites in the Governor's Budget be included for funding. ESN has concerns with some basic elements of the Family Care proposal; however, the concepts are sound in that the thrust is to assure community placement planning with reliance on nursing home care whenever indicated through assessment and evaluation.

ESN requests that non-pilot counties not be overlooked insofar as state funding is concerned. Waiting lists for the Community Options Program (COP) exceed 10,000 persons as of December 1998. We suggest that the Legislature consider allocating sufficient funds to reduce the waiting list by fifty percent in the first year of the biennium and an additional 50 percent in the second. We recognize that the cost is considerable; however, we also know the effects of insufficient funding at the local level and the dispair of persons on waiting lists.

Paul H. Kusuda; 200 Tompkins Dr.; Madison WI 53716-3255; 222-2780

1702 N. Page
Stoughton, WI 53589
April 15, 1999

To the Joint Finance Committee:

I am writing to beg you to change your mind about the proposed state Budget freeze. I work with adults with serious and persistent mental illness, as well as am a parent of a child with a developmental disability.

The programs which would be affected by the freeze affect the most vulnerable people in our society. I have no doubt that with the freeze, more money will end up being spent in the long-run due to lack of programs and support. Decompensation of people whose needs are not being met will result.

All programs desperately need every bit of money possible, many needing even more than what's presently available. For example there is at least a 5 year wait for programs like Family Support and Resource Center. This wait is way to long already, let alone more cuts which would result in a reduction of the already too-far-cut-back services. This program is for developmentally disabled children, and a freeze may make a major impact on their development, thus increasing the future need for monies.

Furthermore day treatment/vocational services enable adults with serious and persistent mental illness with needed structure /self-esteem to maintain mental health. They also make it possible for people to become productive members of society. I can't imagine CSP cuts, transportation cuts, or loss of adult family homes options. All these would be purely devastating.

I urge you to restore the cuts which have occurred to the Community Aids in the last two budgets.

Sincerely,

Rebecca H. Kelly

Rebecca H. Kelly

Public Hearing

Provisions in the Budget Bill [1999 Assembly Bill 133]

Relating to

The Health Insurance Risk Sharing Plan (HIRSP)

Reference: s. 20.435 (4) (af)
s. 20.435 (4) (ah)
s. 20.435 (4) (gh)

Sections 417, 418, 2256-2278,and 9123 (2), pp. 427, 1052-1058, and 1406

Place: State Capitol, Room 411 South

Date & Time: April 15, 1999, 10:30 a.m.

Testimony of: Robert T. Wood
Corporate Vice President, Government Relations
Wisconsin Physicians Service Insurance Corporation (WPS)

Member, HIRSP Board of Governors

My name is Robert Wood. I am Corporate Vice President of Government Relations for Wisconsin Physicians Service Insurance Corporation (WPS). I have served on the HIRSP Board of Governors for more than 11 years. I have been responsible at WPS for review of HIRSP operations, administration and legislation since the plan was first enacted nearly twenty years ago as part of the Laws of 1979.

I am speaking on the subject of proposed changes to the HIRSP statutes in the budget. I speak as a member of the HIRSP Board, but I am not speaking for the HIRSP Board.

I am submitting brief written testimony and I will try to be even briefer in speaking here.

In 1997, this Committee restructured HIRSP funding based on agreements reached with insurers, providers, and the Department of Health and Family Services.

The basic agreements were that $6 million GPR in the first half of calendar year 1998 and $12 million in GPR in the current fiscal year would be appropriated to partially fund the HIRSP program. After application of GPR funding, full premium payments would be set to fund 60 percent of program costs and insurers and providers would each fund 20 percent of the remaining unfunded costs. The Department would track and fund financial perform of the plan against budget, and there would be a reconciliation process to balance out any variances from statutory funding shares. You transferred the program from OCI to the Department of Health and Family Services, and asked

DHFS to take care of these tasks.

The new funding arrangements translated into an immediate 15 percent rate cut for the people in the plan. HIRSP rates dropped from 192 percent of a standard risk rate to 150 percent. For many individuals aged 60 or more who make up the largest age group in the plan this meant close to $1,000 in savings on an annual basis.

In the current fiscal year, we were able to keep premiums at 150 percent of a standard risk rate. I'm confident they will remain at 150 percent in the next fiscal year. A rate increase will still be needed, but only to reflect the marketplace increase in the standard risk rate. This means the new funding arrangements are working well for the people in the program who themselves pay the largest share of program costs.

There have been a number of problems in the administration of the HIRSP program since it was transferred to DHFS, particularly with the Department's inability until very recently to provide data on financial operation of the plan against budget, or to provide information on plan enrollments and demographics. I don't want to dwell on these problems, because I believe that some of the most serious problems are close to being fixed.

I raise the subject only because, when you transferred the program to DHFS, you reduced the ability of the HIRSP Board of Governors to effectively oversee the operations of HIRSP and approve policy changes in the program. I believe that if you had kept the HIRSP Board the same strong Board it was for nearly 18 years when the plan was administered at OCI, some of the problems we have had with the plan over the past 15 months might not have happened, and those that couldn't have been avoided might have been paid attention to and fixed earlier.

This said, I have three recommendations for changes to the HIRSP statutes in the current budget bill.

1. My first recommendation is that you make the Board a stronger Board again.

   HIRSP is a partnership between the private sector, and the government. In this partnership, the people enrolled in the plan and the insurers and providers who share in plan costs pay the greatest share of the costs of the HIRSP program. They deserve a stronger voice in how their funding of the program under the statutes is accounted for and reconciled.

   I think I do not have to tell you that the Department wishes the Board to speak in a very small voice and only as an advisory body. I think if the Board is to be limited to a strictly advisory role, you might as well not have a Board at all.

   The Board has historically played a strong role in representing the interests of the people who are enrolled in the plan. To the extent that you have a weak board, it is these people who loose the most in terms of ***not*** having a voice in the operations of the plan.

   A. Feeling as I do, I would recommend that you delete those sections in the budget bill, as originally introduced, that would further weaken the Board.

   B. Next, I would recommend that the Board needs a stronger voice in at least six areas.

      (1) Development and approval of the HIRSP budget.

(2) Oversight of financial management of the plan against budget.

(3) Oversight of changes in HIRSP policy, including proposed changes in HIRSP benefits and other changes to statutes.

(4) Reporting of data in HIRSP monthly reports, and other information of interest to the Board.

(5) Assignment of work and scheduling of meetings of Board committees and sub-committees.

(6) Development and release of reports specified in statutes as reports by the Board to the Legislature and to the Governor.

C. Finally, representation on the Board needs to be adjusted in two areas:

(1) The Secretary of DHFS chairs the Board. Statutes should specify that no appointed member of the Board should be an employee of DHFS.

(2) Statutes should specify that at least one of the consumer representatives on the Board must be a participant in HIRSP.

Planning documents relating to HIRSP are starting to talk about turning HIRSP into a "Medicaid look-alike program," but HIRSP is an insurance program, not a categorical benefits program. As the Department has learned, it is a very different program from Medicaid. I think you should want to keep it that way.

In January 1999, HIRSP costs were running about $38 million on a fiscal year basis. The Department (as of yesterday) now estimates that program costs have increased and will be closer to $46 million at the end of this fiscal year.

The HIRSP population is not a "Medicaid look-alike" population. There were just under 7,000 individuals enrolled in the plan in January. On average close to 60 percent of the HIRSP population is female. More than 60 percent of the people covered under the plan are over age 50. Nearly 30 percent are over age 60. Between 35 and 40 percent of the people insured by HIRSP report annual household incomes under $20,000 and receive subsidies that help them pay premiums and deductibles.

These people could use a stronger Board to speak on their behalf. When problems occur, the Board ought to have sufficient oversight authority to ask for and receive explanations and information and to request action to fix problems, but we don't.

2. My second recommendation speaks to the Department's most recent legislative proposal.

A. The Secretary of DHFS outlined new changes he wishes to make to HIRSP in recent testimony before this Committee. Since then, as I understand it, the Secretary has modified his proposal.

The Secretary reviewed the most recent outlines of his legislative proposal at a meeting of the HIRSP Board yesterday.

At that meeting, the HIRSP Board agreed that new legislative language requested by the Secretary to give the Department greater flexibility in managing and reconciling financial performance of the plan is needed and should be drafted.

The proposed new language, as I understand it, would allow the Department to determine variances in the statutory 60%/20%/20% funding of program costs compared to actual funding on a calendar year basis, and make adjustments to reconcile those variances in the immediately following fiscal year.

The Secretary also discussed proposed changes in processing of prescription drug claims, some of which appear to the Board to be reasonable.

But the Board asked to be provided with more information relating to reductions in benefits, which some members of the Board would oppose.

3. Finally, I do think that I can speak for the Board in asking that you consider restoring the $2,000,000 in GPR funding for HIRSP that was cut in the budget.

   A. If these funds were restored, the appropriation under s. 20.435 (4) (af) would increase from $9,900,000 to $11,900,000 in each of the next two fiscal years.

Thank you for your time and patience.

I would be pleased to try to answer any questions you may have.