Senate Bill 71 Relating to: treatment of prescription drug costs, diagnostic testing, and payments under mandated insurance coverage of treatment for nervous and mental disorders and alcoholism and other drug abuse problems, and granting rule-making authority. (FE)

BILL SPONSORS	Introduced by the JOINT LEGISLATIVE COUNCIL.
BILL HISTORY	Senate Bill 71 was introduced and referred to the Senate Committee on Health, Children, Families, Aging and Long Term Care on March 13, 2003. A public hearing was held on July 22, 2003. An executive session was held on September 15, 2003. **The committee recommended SB 71 for passage on an 8-1 (Welch) vote.**
LRB ANALYSIS	<u>Current Law</u>: Under current law, a group health insurance policy (called a "disability insurance policy" in the statutes) that provides coverage of any inpatient hospital services must cover those services for the treatment of nervous and mental disorders and alcoholism and other drug abuse problems in the minimum amount of the lesser of: 1) the expenses of 30 days of inpatient services; or 2) $7,000 minus the applicable cost sharing under the policy or, if there is no cost sharing under the policy, $6,300 in equivalent benefits measured in services rendered. If a group health insurance policy provides coverage of any outpatient hospital services, it must cover those services for the treatment of nervous and mental disorders and alcoholism and other drug abuse problems in the minimum amount of $2,000 minus the applicable cost sharing under the policy or, if there is no cost sharing under the policy, $1,800 in equivalent benefits measured in services rendered. If a group health insurance policy provides coverage of any inpatient or outpatient hospital services, it must cover the cost of transitional treatment arrangements (services, specified by rule by the commissioner of insurance, that are provided in a less restrictive manner than inpatient services but in a more intensive manner than outpatient services) for the treatment of nervous and mental disorders and alcoholism and other drug abuse problems in the minimum amount of $3,000 minus the applicable cost sharing under the policy or, if there is no cost sharing under the policy, $2,700 in equivalent benefits measured in services rendered. If a group health insurance policy provides coverage for both inpatient and outpatient hospital services, the total coverage for all types of treatment for nervous and mental disorders and alcoholism and other drug abuse problems is not required to exceed $7,000, or the equivalent benefits measured in services rendered, in a policy year. <u>Proposed Changes:</u> This bill specifies that the minimum coverage limits required for the treatment of nervous and mental disorders and alcoholism and other drug abuse problems do not include costs incurred for prescription drugs and diagnostic testing. Diagnostic testing is defined in the bill as procedures used to exclude the existence of conditions other than nervous or mental disorders or alcoholism or other drug abuse problems. The Department of Health and Family Services is authorized to specify, by rule, the diagnostic testing procedures that are not included under the coverage limits. The bill also provides that, if an insurer pays less than the amount that a provider charges, the required minimum coverage limits apply to the amount actually paid by the insurer rather than to the amount charged by the provider.

	Finally, the bill provides that if an insurance policy contains a provision that is inconsistent with the new provisions, the new requirements will first apply on the date the policy is renewed. Major Impact: Senate Bill 71 prohibits diagnostic testing procedures (as determined by DHFS) and prescription drug costs from being included in the minimum coverage limits required for the treatment of nervous and mental disorders and alcoholism and other drug abuse problems.
FISCAL IMPACT	**Department of Health and Family Services**: No Fiscal Effect. HIRSP would be subject to the statutory changes in SB 71. However, HIRSP does not currently include the costs of prescription drugs and diagnostic tests as part of nervous and mental health and AODA treatment limits. **Office of the Commissioner of Insurance:** Indeterminate cost to state. Increase Costs-may be possible to absorb within the agency's budget. Cost to local governments is indeterminate. SB 71 will require OCI to incorporate additional reviews in new policy submissions and develop additional procedures when conducting company examinations. OCI estimates that these increases can be absorbed within the agency's existing budget. The local fiscal effect of SB 71 is more difficult to determine. In 2002 OCI conducted a survey of mandated benefits, one of which was mental health and alcohol and other drug abuse. One finding the study made was that some insurers were not counting prescription medication against the mandatory minimums set by 632.89. Depending on health benefit plan design and the insurer involved, some units of local government will not see any increases in health care costs due to the mandates or they may see decreases from removing these items from the mandatory minimums established in statute. Some cost increases could be assumed by units of local government by individual patients who bump up against the mandatory minimums due to large prescription drug costs of those individuals, however, OCI cannot determine the prevalence of those patients employed by local government. It should be noted, however, that the overall health care costs to local governments would not change dramatically. This bill essentially reclassifies existing costs.
SUPPORT	**The following people appeared in favor of this bill**: • Matt Kiralx, State Independent Living Council, Wausau • Kathryn Shug, Learning Disabilities Association of Wisconsin • Russell Gardners, Jr, Association of Psychiatrists, Mt. Horeb • Mary Lou Burger, Oak Creek • Shel Gross, Mental Health Association, Madison • Frank Ryan, NAMI, Middleton • Catherine Beilman, National Association for the Mentally Ill, Madison • James Curtin, Madison • Jennifer Ondrejka, WI Council on Developmental Disabilities, Madison • Michael Miller, M.D., Wisconsin Medical Society, Madison • John Grace, WI Association of Family and Children's Agencies, Madison

	• Antoinette Burton, Milwaukee • Jeff Pearcy, Brookfield • Dave Hansen, State Senator • Legislative Liaison Gary Radloff, Department of Health and Family Services • Arthur Koch, NAMI, Waukesha • **The following people registered in favor of this bill**: • Secretary Helene Nelson, Department of Health and Family Services • Jeff Spitzen-Resnier, WI. Coalition for Advocacy, Madison • Louie Schubert, WI. Association of Health Plans, Madison • Lisa Maroney, UW Medical Foundation, Madison • Phil Newenfeldt, 5333 West Bluemond Road, Milwaukee • Liz Buchen, Lutheran Social Services, Madison • Michael Blumenfeld, WI. Jewish Conference, Madison • Dianne Greenlay, WI. Coalition for Advocacy, Madison • Clare McArdle, League of Women Voters, WI, Madison • Alice O'Connor, Wisconsin Medical Society, Madison • Sarah Bowen, WI. Psychological Association, Madison • Charity Eleson, WI Council on Children and Families, Madison • Peter DeSantis, Wausau • Representative David Cullen, 13th Assembly District • Representative John Lehman, 62nd Assembly District • Marc Herstand, National Association of Social Workers, WI Chapter, Madison • Reverend Sue Maline Larson, Lutheran Office for Public Policy in WI, Madison • Mickey Beil, Dane County, Madison • Mark Wadium, Outagamie County Board of Supervisors, Appleton • John Huebscher, Wisconsin Catholic Conference, Madison
OPPOSITION	**The following person appeared in opposition to this bill:** • Dan Schwartzer, WI. Association of Health Underwriters, Madison **The following people registered in opposition to this bill:** • Ron Kuehn, Wisconsin Association of Insurance and Financial Advisors, 2 E Mifflin St, Ste 600, Madison, WI • R.J. Pirlot, Wisconsin Manufacturers and Commerce, Madison • Bill Smith, NFIB, Madison • Dan Schwartzer, WI Association of Provider Networks, Madison
CONTACT	**Jennifer Halbur, Senator Carol Roessler, 266-5300**
DATE	**September 29, 2003**

WISCONSIN STATE SENATE

Carol Roessler
STATE SENATOR

April 8, 2004

Marcia Larson
111 Josslyn Street
Oshkosh, WI 54902-3471

Dear Marcia,

Now that the 2003-2004 legislative session is over I am providing you with an update regarding Senate Bill 71.

SB 71, relating to treatment of prescription drug costs, diagnostic testing, and payments under mandated insurance coverage of treatment for mental disorders, was introduced and referred to the Senate Health Committee March 13, 2003. SB 71 passed the Senate March 2, 2004 and passed the Assembly March 11, 2004. The Governor signed SB 71 April 7, 2004.

I have included the bill history for you to review, which details the movement of this bill through the Legislature. This information is also available on the Wisconsin Legislature online database named Folio, accessible by visiting http://folio.legis.state.wi.us

Thank you for contacting me on this issue and I look forward to hearing your comments, questions, or concerns in the future.

Sincerely,

Carol

CAROL ROESSLER
State Senator
18th Senate District

S:\DOCS\Jennifer\End of 03 session update ltrs\4-8-04 sb 71 mental health update ltr..doc

CAPITOL ADDRESS: State Capitol • P.O. Box 7882, Madison, WI 53707-7882 • **PHONE:** 608-266-5300 • **FAX:** 608-266-0423
HOME: 1506 Jackson Street, Oshkosh, WI 54901 • **TOLL-FREE:** 1-888-736-8720
E-MAIL: Sen.Roessler@legis.state.wi.us • **WEBSITE:** http://www.legis.state.wi.us/senate/sen18/news/

SB71
SENATE BILL 71
An Act to create 632.89 (1) (b) and 632.89 (6) and (7) of the statutes; relating to: treatment of prescription drug costs, diagnostic testing, and payments under mandated insurance coverage of treatment for nervous and mental disorders and alcoholism and other drug abuse problems, and granting rule-making authority. (FE)

2003

03-13-03. S. Introduced by JOINT LEGISLATIVE COUNCIL.
03-13-03. S. Read first time and referred to committee on Health, Children, Families, Aging and Long Term Care. **117**
04-16-03. S. Fiscal estimate received.
07-22-03. S. Public hearing held.
08-01-03. S. Fiscal estimate received.
09-04-03. S. Executive action taken.
09-15-03. S. Report passage recommended by committee on Health, Children, Families, Aging and Long Term Care, Ayes 8, Noes 1. . . . . **365**
09-15-03. S. Available for scheduling.

2004

02-26-04. S. Placed on calendar 3-2-2004 by committee on Senate Organization.
03-02-04. S. Read a second time. **652**
03-02-04. S. Ordered to a third reading. **652**
03-02-04. S. Rules suspended. **652**
03-02-04. S. Senator Moore added as a coauthor. **652**
03-02-04. S. Senator Wirch added as a coauthor. **652**
03-02-04. S. Senator Erpenbach added as a coauthor. **652**
03-02-04. S. Senator Hansen added as a coauthor. **652**
03-02-04. S. Senator Carpenter added as a coauthor. **652**
03-02-04. S. Read a third time and **passed**, Ayes 29, Noes 4. . . . . **652**
03-02-04. S. Ordered immediately messaged. **655**
03-08-04. A. Received from Senate. **803**
03-08-04. A. Read first time and referred to committee on Rules. **804**
03-10-04. A. Made a special order of business at 9:11 A.M. on 3-11-2004 pursuant to Assembly Resolution 39. . . . . **860**
03-11-04. A. Read a second time. **877**
03-11-04. A. Ordered to a third reading. **877**
03-11-04. A. Rules suspended. **877**
03-11-04. A. Read a third time and **concurred in**, Ayes 89, Noes 10 . . . . . **877**
03-11-04. A. Ordered immediately messaged. **877**
03-11-04. S. Received from Assembly concurred in. **709**
03-17-04. S. Fiscal estimate received.
03-24-04. S. Report correctly enrolled on 3-23-2004. . . . . **743**
04-07-04. S. Presented to the Governor on 4-5-2004. . . . . **752**
04-07-04. S. Report approved by the Governor on 4-6-2004.
2003 Wisconsin Act 178. . . . . **750**

Contact Detail

Larson, Marcia
111 Josslyn St
Oshkosh, WI 54902-3471

Contact Date: 07/21/2003 **Contact Type:** E-mail

Summary: SB 71

Issue: **Position:**

Description: -----Original Message-----
From: Marcia Larson [mailto:marcia@novaoshkosh.com]
Sent: Monday, July 21, 2003 1:14 PM
To: sen.roessler@legis.state.wi.us
Subject: Senate Bill 71

Hi Carol:

I just learned last Friday of tomorrow's meeting to review Senate Bill 71 regarding mandates for mental health and alcohol and drug treatment. Here's my take on it: obviously a mandate that has been in effect as long as 632.89 needs to be rethought. Insurance rates can't multiply many times over in a given number of years, while providers are forced to live with fixed limits over the same period of time.

One of the possible ramifications of raising the mandated limits, however, is that all levels of care will be managed even more stringently. In many instances we can't access the monies represented by the current mandate. Moreover, employers purchase in good faith what they believe are benefits for their employees, based on 632.89, that exist only on the paper they're written.

While I'm aware of the insurance industry's, as well as the Wisconsin Manufacturer's negative position regarding removal of the internal caps, I still believe that that concept is the key to building fairness into the mandate.

Bill 71 has some interesting, if not threatening, consequences for Nova Treatment Center. Here's the issue: some payers, hoping to save money, who formerly regarded Nova as an inpatient provider, have in the recent past relegated us to transitional living status. We haven't minded that too much because the cost of Nova's care is so reasonable that the existing transitional benefit covers a decent portion of our cost of care. The proposed transitional mandate of Bill 71 for transitional living would obviously cover even more. Vince Ritacca, with the anticipation of Bill 71, is thinking about getting clarification on this matter, as to what status we actually occupy. If Nova is relegated to a par with hospital inpatient status only, I think we could, worst case, be managed out of existence. (Some payers argue since treatment like Nova's is provided in a residential setting, they should be considered residential or transitional status). While Nova is a medically monitored program that meets the standards of clinical hours of HFS 75.11, payers associate anything called hospital inpatient with detox or exorbitant cost, a thing to manage to the nth degree with attention being given primarily to process, rather than actual monies spent/value etc.

Hope this frame of reference is useful for you. Thanks for your consideration in these matters.

Marcia

Status: Done **Closed Date:** 07/28/2003

Assigned: Jermstad, Sara **Owner:** Jermstad, Sara

Note **Note Date:** 07/22/2003

Summary: SJ put on legislative contact list

Contact Type:

Description:

Note **Note Date:** 04/08/2004

Summary: JH sent end of session update letter

Contact Type:

Description:

File: S:\DOCS\Jennifer\End of 03 session update ltrs\4-8-04 sb 71 mental health update ltr..doc

SB71

Jermstad, Sara

From: Asbjornson, Karen
Sent: Monday, July 21, 2003 4:44 PM
To: Jermstad, Sara; Jermstad, Sara
Subject: New Forward Contact Ownership and Assignment

Constituent: Marcia Larson (7422)
111 Josslyn St
Oshkosh, WI 54902-3471

Office: 920-231-0143

Owner: Jermstad, Sara
Assigned: Jermstad, Sara
Summary: SB 71

Issue:
Position:
Status: Pending
Contact Type: E-mail
Description: -----Original Message-----
From: Marcia Larson [mailto:marcia@novaoshkosh.com]
Sent: Monday, July 21, 2003 1:14 PM
To: sen.roessler@legis.state.wi.us
Subject: Senate Bill 71

Hi Carol:

I just learned last Friday of tomorrow's meeting to review Senate Bill 71 regarding mandates for mental health and alcohol and drug treatment. Here's my take on it: obviously a mandate that has been in effect as long as 632.89 needs to be rethought. Insurance rates can't multiply many times over in a given number of years, while providers are forced to live with fixed limits over the same period of time.

One of the possible ramifications of raising the mandated limits, however, is that all levels of care will be managed even more stringently. In many instances we can't access the monies represented by the current mandate. Moreover, employers purchase in good faith what they believe are benefits for their employees, based on 632.89, that exist only on the paper they're written.

While I'm aware of the insurance industry's, as well as the Wisconsin Manufacturer's negative position regarding removal of the internal caps, I still believe that that concept is the key to building fairness into the mandate.

Bill 71 has some interesting, if not threatening, consequences for Nova Treatment Center. Here's the issue: some payers, hoping to save money, who formerly regarded Nova as an inpatient provider, have in the recent past relegated us to transitional living status. We haven't minded that too much because the cost of Nova's care is so reasonable that the existing transitional benefit covers a decent portion of our cost of care. The proposed transitional mandate of Bill 71 for transitional living would

obviously cover even more. Vince Ritacca, with the anticipation of Bill 71, is thinking about getting clarification on this matter, as to what status we actually occupy. If Nova is relegated to a par with hospital inpatient status only, I think we could, worst case, be managed out of existence. (Some payers argue since treatment like Nova's is provided in a residential setting, they should be considered residential or transitional status). While Nova is a medically monitored program that meets the standards of clinical hours of HFS 75.11, payers associate anything called hospital inpatient with detox or exorbitant cost, a thing to manage to the nth degree with attention being given primarily to process, rather than actual monies spent/value etc.

Hope this frame of reference is useful for you. Thanks for your consideration in these matters.

Marcia

Wisconsin Medical Society

Your Doctor. Your Health.

FLOOR DISTRIBUTION
AUTHORIZED BY SENATOR
PANZER

TO: Members, Wisconsin State Senate

FROM: Alice O'Connor & Mark Grapentine

DATE: March 2, 2004

RE: SUPPORT Senate Bill 71

On behalf of more than 10,000 members statewide, the Wisconsin Medical Society urges passage of SB 71 as a modest improvement for individuals who seek mental health services.

This legislation eliminates the diagnostic testing and cost of prescription drugs from being counted against the current insurance caps for mental health services. The Society feels this legislation *minimally* protects the status quo for individuals who seek help by enabling them to spend more of their insurance dollars on treatment as costs associated with testing and pharmaceuticals continue to increase. Currently these non-treatment costs fall inside the insurance cap, leaving less money for actual treatment.

This modest legislation does something for individuals who suffer greatly without addressing the bigger need addressed in separate legislation that would automatically provide a cost of living increase (COLA) to the current spending limits.

The Society is hopeful that after years of this legislation passing one house only to languish in another before adjournment, your action will encourage the Assembly to pass SB 71 and send it to the Governor before adjournment this year.

Thank you for your support of SB 71. Physicians who treat individuals with diseases of the mind are grateful for your efforts on SB 71. They believe it is a step in the right direction in addressing and treating the needs of this complex set of health conditions with their patients.

Please feel free to contact Alice O'Connor (aliceo@wismed.org), Mark Grapentine (markg@wismed.org) or Jeremy Levin (jeremyl@wismed.org).

330 East Lakeside Street • PO Box 1109 • Madison, WI 53701-1109 • wisconsinmedicalsociety.org • Phone 608.442.3800 • Toll Free 866.442.3800 • Fax 608.442.3802

The League of Women Voters of Wisconsin, Inc.

122 State Street, Madison, Wisconsin 53703-2500
608/256-0827 FX: 608/256-2853 EM: genfund@lwvwi.org URL: http://www.lwvwi.org

Statement to the Senate Committee on Health, Children, Families, Aging and Long Term Care in Support of SB 71 and SB 72 Relating to Mental Health Insurance Parity

July 22, 2003

For over fifteen years, the League of Women Voters of Wisconsin (LWVWI) has been advocating for mental health insurance parity. We believe that insurance companies should provide payments for participation in all phases of mental health treatment programs, equally, as they do for other types of in-patient and out-patient treatment.

Despite increased evidence that mental illness symptoms are a result of brain chemistry malfunctions, and that medications can alter symptoms, there remains opposition to including this category of illness in health insurance coverage.

Currently 34 states have some form of health insurance parity. In Minnesota, Blue Cross/Blue Shield reduced its insurance premiums by 5-6% after one year's experience under the state comprehensive parity law (National Mental Health Association www.nmha.org). The NIMH (National Institute of Mental Health) concludes that parity may increase insurance premiums by 1% but would result in decreases in total health care costs. In Texas after the implementation of a 1991 parity law, there was a 47.9% decrease in the cost of mental health and substance abuse care for Texas state employees covered under a Blue Cross/Blue Shield insurance plan. Recent studies in other states show that the cost increase of mental health insurance parity is under 1%. The United States Congress passed a parity law in 2002 that was signed by President Bush.

Both SB-71 and SB-72 address these issues thoroughly. They offer good progress toward the eventual goal of complete parity for mental health care. We urge this committee to recommend that parity be included in your recommendations for ways that Wisconsin can control health insurance costs.

LWVWI Legislative Committee contact for Mental Health Issues -- Clare McArdle

WAFCA
Wisconsin Association of
Family & Children's Agencies

131 W. Wilson Street
Suite 901
Madison, WI 53703

(608) 257-5939
FAX (608) 257-6067

John R. Grace
Executive Director

Testimony on Mental Health Insurance Coverage Requirements
Senate Bills 71 and 72

by John R. Grace
Executive Director
Wisconsin Association of Family and Children's Agencies

Hearing before Senate Committee on Health, Children, Families, Aging and Long Term Care

July 22, 2003

The Wisconsin Association of Family and Children's Agencies (WAFCA) strongly supports passage of Senate Bills 71 and 72 which would modify the mental health insurance coverage requirements.

WAFCA is an organization of 50 agencies that provide mental health, substance abuse, home care and other services to low-income families and their children. The majority of their work with families is supported by public dollars primarily through Community Aids and local tax dollars.

The current mental health insurance coverage requirements offer some assurance that individuals will be able to use their health insurance to access mental health services when they need them. Unfortunately, the requirements which were intended to establish minimum coverage amounts have become viewed as maximums. The $7,000 statutory amount is not enough to cover outpatient therapy, medications and occasional hospitalizations. Although we believe that coverage of mental illnesses should be equal to coverage of other illnesses, SB 71 and SB 72 through exclusion of diagnostic testing and prescription drug costs and indexing of the $7,000 amount to reflect medical inflation would be helpful and would allow more persons access to the care they require.

Increasing the mental health maximums could also reduce reliance on public programs to fill the gaps left by private and employer-sponsored insurance. Using data collected by the Department of Health and Family Services, we have been able to estimate that the fiscal effect of individuals using public programs costs Community Aids approximately $40 million annually. According to HSRS 2001 data, mental health services to county clients were $319.8 million, of which, $200.7 million was paid for by Community Aids. The remaining amounts were paid by Medicare, clients themselves and other funds. Of the $200.7 million it can be

estimated that as much as 20% or $40.1 million was paid for individuals who have had private health insurance that did not meet their needs.[1] This $40.1 million figure represents approximately 10% of the total Community Aids appropriation for 2003. If this level of cost-shifting to public programs was reduced, counties would have money to provide services to clients on waiting lists or to increase services for those whose services have been reduced due to the lack of Community Aids increases over the last decade.

Full coverage of mental illness and substance abuse treatment, is not just about allowing a few people access to "extra" services that they can really get along without. It is about allowing people access to services that will improve their health status, reduce their use of physicians and hospitals for symptoms related to their mental illness, reducing government expenditures, and reducing the number of parents and children who end up in corrections or child welfare because their illnesses remain unaddressed.

While SB 71 and SB 72 will not allow full coverage of mental illness and substance abuse treatment, they will do a great deal to increase individuals' access to these services.

Lin MH & AODA Sub.

[1] Service and payment data from DHFS' Human Services Report System data, 2001. According to Lewin-VHI (1994), 20% of public reimbursements are for clients who have had private health insurance. Some factors in client and public expenditures may have changed since 1994, yet it is very likely that they have changed in ways that would increase, rather than decrease, this 20% figure.

WISCONSIN COUNCIL ON CHILDREN & FAMILIES
Voices for Wisconsin's Children

RESEARCH • EDUCATION • ADVOCACY
16 N. Carroll Street • Suite 600 • Madison, WI 53703 • (608) 284-0580 • FAX (608) 284-0583
1442 N. Farwell • Suite 508 • Milwaukee, WI 53202 • (414) 831-8880 • FAX (414) 298-9127
www.wccf.org
A MEMBER OF THE NATIONAL ASSOCIATION OF CHILD ADVOCATES

August 27, 2003

To: Members of the Senate Committee on Health, Children and Families
and Long-Term Care
Senator Carol Roessler, Chair

From: Linda A. Hall, Senior Health Policy Analyst

The Wisconsin Council on Children and Families urges you to support passage of Senate Bills 71 and 72, which would increase the mental health insurance coverage requirements. Passage of these bills will improve access to mental health services for insured families in your district and will begin to reduce fiscal pressures on public programs that fill the gap when people are denied access by private insurance.

The current mental health insurance coverage requirements provide a limited guarantee that individuals will be able to use their health insurance to access mental health services when they need them. Unfortunately, the requirements, initially intended to establish minimum coverage amounts, have become viewed as maximums. The $7,000 statutory amount is not enough to cover outpatient therapy, medications and occasional hospitalizations. SB 71 and SB 72 through exclusion of diagnostic testing and prescription drug costs and indexing of the $7,000 amount to reflect medical inflation would increase coverage of mental illnesses significantly. Although the new minimums would still not allow coverage of mental illnesses in amounts equal to coverage of other illnesses, it would allow more persons access to the care they require.

Full coverage of mental illness, without dollar limits, continues to be a policy goal that the Council believes is important because children need increased access to mental health care through their parents' health insurance. Statistics from Mental Health: A Report of the Surgeon General on children and mental health demonstrate the critical nature of the need:

- 1 in 5 children have a diagnosable mental, emotional, or behavioral disorder, yet 70% of all children do not receive mental health services;
- mental illness affects 1 in every 5 families in America;
- suicide is the leading cause of death of young people in Wisconsin ages 15-34 and 90-95% of those committing suicide have a diagnosable mental health or substance abuse disorder; and

Children also need their parents to have adequate access to mental health services. The Surgeon General's report documented that 28% of adults had a diagnosable mental or substance

abuse disorder yet less than one-third of them received treatment for their condition. Another study showed that up to 17% of adults experience major depression at some point in their life[1].

Depressed parents are less effective parents. Studies show that children of depressed mothers are at higher risk of suicidal thoughts and behaviors and at higher risk for medical problems and hospitalization. Mothers of abused and neglected children are much more likely to be depressed than are other mothers[2]. Children of depressed parents are more likely to develop problem behaviors and, later in life, their own mental illnesses. While genetics undoubtedly plays some role in the development of mental illness in these children, several studies have shown that environmental factors -- including the parents' energy to parent -- have a significant effect on whether the children develop mental illness.[3]

When parents lack adequate mental health and substance abuse treatment, they are less productive at work, more likely to miss work and more likely to lose their jobs. If parents lose their jobs, children begin to experience all the negative effects of poverty. Numerous studies demonstrate that treatment for mental illness that includes psychotherapy and medication is very effective in improving the measurable effects that depression has on the body.

People who cannot access treatment through health insurance often turn to publicly funded programs. Again, according to the Surgeon General's report, private insurance spent 6% of its health care dollars on mental health care, whereas Medicaid spent 9% and state and local governments spent 18% on mental health care. Another study estimated that 20% of public mental health expenditures are for individuals who have had private health insurance.[4] When private health insurance doesn't pay for care, government does. State and local governments pay through Medicaid, BadgerCare and Community Aids. Increasing access to services through private insurance would reduce reliance on these public programs.

The Council urges you to support SB 71 and SB 72 to reduce reliance on public programs and increase timely access for insured individuals to services for mental illnesses.

---

[1] Mental Health: A Report of the Surgeon General, 1999.

[2] Mental Health and Substance Abuse Parity Presentation by Keith Lang and Dan Zimmerman, Department of Health and Family Services, October 24, 2002.

[3] Depression and Low-Income Women: Challenges for TANF and Welfare-to-Work Policies and Programs, National Center for Children and Poverty, March 2001.

[4] Ibid

SB 71 & 72

Global Vision Community Partnership Award

Deadline August 25

Applications for the Global Vision Community Partnership Awards are due August 25. Contact Ann Lucas for more information, *alucas@wha.org*.

Mental Health Parity Proponents, Opponents Present Views at Hearing

The Senate Committee on Health, Children, Families, Aging and Long Term Care held a hearing July 22 on two bills recommended by a recent Legislative Council study committee on mental health parity.

At the Senate Health Committee hearing, supporters of the Senate Bills 71 and 72 including DHFS, the Wisconsin Medical Society (WMS), the National Alliance for the Mentally Ill (NAMI), and the Wisconsin Psychiatric Association stressed that the proposals are not mental health parity, but said they are a necessary step in that direction.

SB 71 provides that prescription drug and diagnostic testing costs are covered under the general health/drug benefit of an insurance policy, and not under the mandatory mental health and AODA benefit. SB 72 increases the mandated minimum benefit for mental health and AODA treatment based on the change in the consumer price index for medical services since 1985 (when coverage amounts in current law were enacted). In general, coverage increases from $7,000 to $16,800 for inpatient treatment; from $2,000 to $3,100 for outpatient treatment; and from $3,000 to $4,600 for transitional treatment.

According to Sen. Dave Hansen (D-Green Bay) who co-chaired the Legislative Council, "increasing mental health insurance coverage will, in the end, save the state millions of dollars by maximizing worker productivity and reducing worker sick leave, and at the same time, help to ease the financial as well as psychological and emotional burdens faced by those individuals who suffer from mental illness and substance abuse."

Supporters expressed universal agreement on these points and said mental illness and substance abuse should be treated the same as other physical ailments by insurers.

Wisconsin Manufacturers and Commerce (WMC) testified in opposition to SB 72, arguing that it will cause the cost of health insurance to rise, jeopardizing access to health care in Wisconsin as increasing numbers of employers cannot afford to provide health insurance.

How is the employee any better off if insurance becomes so expense employers can't provide any benefit at all?" asked R.J. Pirlot, WMC director of legislative relations. "Isn't what's available today better than that alternative?"

Pirlot said health insurance mandates hit small businesses the hardest, ultimately forcing them to stop providing health benefits to their employees. The Wisconsin Association of Health Underwriters (WAHU) has also expressed opposition to SB 72, but did not testify at the July 22 hearing.

A committee vote on SB 71 and SB 72 has not been scheduled. WHA has not taken a position on either bill. For more information about either hearing, contact Jodi Jensen at 274-1820 or *jjensen@wha.org*.

JCAHO Announces 2004 National Patient Safety Goals

On July 21, 2003 the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) announced its Board of Commissioners approved 2004 National Patient Safety Goals. Beginning January 1, 2004, all JCAHO-accredited health care organizations will be evaluated for compliance with the current six National Patient Safety Goals as well as a new National Patient Safety Goal to reducing the risk of health care-acquired infections. For each of the National Patient Safety Goals there are evidence-based requirements that set clear expectations for health care organizations to address specific types of health care errors. In addition to the new goal, the requirement of the second goal, to "read back" verbal and telephone orders to confirm their accuracy, has been expanded to include the "read back" of critical test results that are communicated verbally.

The 2004 National Patient Safety Goals and Requirements are:

Goal 1: Improve the accuracy of patient identification.
Requirements:

- Use at least two patient identifiers whenever taking blood samples, or administering medications or blood products.
- Prior to the start of any surgical or invasive procedure, conduct a final verification process, like a "time out", to confirm the correct patient, procedure and site using active communication techniques.**

Goal 2: Improve the effectiveness of communication among caregivers.
Requirements:

- Implement a process for taking verbal or telephone orders or critical test results that require a verification "read-back" of the order or test results by the person receiving the order or test results.
- Standardize the abbreviations, acronyms and symbols used throughout the organizations, including a list of abbreviations, acronyms and symbols not to use.**

Goal 3: Improve the safety of using high-alert medications.
Requirements:

- Remove concentrated electrolytes from patient care units.**
- Standardize and limit the number of drug concentrations available in the organization.

Goal 4: Eliminate wrong-site, wrong-patient and wrong-procedure surgery.
Requirements:

- Create a preoperative verification process to confirm that the appropriate documentation is available.
- Implement a process to mark the surgical site involving the patient in the marking process.**

Goal 5: Improve the safety of using infusion pumps.
Requirements:

- Ensure free-flow protection on all general-use and PCA IV pumps used in the organization.**

Goal 6: Improve the effectiveness of clinical alarm systems.
Requirements:

- Implement regular preventive maintenance and testing of alarm systems.
- Assure that alarms are activated with appropriate settings and are sufficiently audible within the unit.

Goal 7: Reduce the risk of health care-acquired infections.
Requirements:

- Comply with the current CDC hand-hygiene guidelines.
- Manage as sentinel events all identified cases of unanticipated death or major permanent loss of function associated with a health care-acquired infection.

** Requirement marked with a double asterisks are included in the WHA Public Reporting Program.

SB 71 & 72

NAMI-Racine

Alliance for the Mentally Ill of Racine County, Inc.
818 Sixth Street Racine WI 53403

Advocacy - Support - Education

Main Phone: 262-637-0582
Fax: 262-637-0376
NAMI-CAT office: 262-637-6200

July 22, 2003

JUL 25 2003

Senator Carol Roessler, Chair
Health, Children, Families, Aging and Long-Term Care Committee
Rm. 8 South State Capitol
P.O. Box 7882
Madison, WI 53707-7882

Dear Senator Roessler and Committee Members,

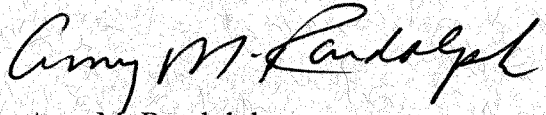
The Racine County NAMI Consumer Advocacy Team would very much like to see Senate Bills 71 and 72 become law. As mental health advocates and also persons living with mental illness, each member of our Consumer Advocacy Team is very concerned about parity in mental health care. Because we each have a mental illness ourselves and are in recovery, we know that treatment works - that persons who receive adequate care for their mental illnesses can live productive and fulfilling lives.

The present mandated minimums on insurance coverage for mental health and addictive disorders are used by many insurance companies as maximums and are preventing many mental health consumers from receiving the care necessary to launch them on the road to recovery. Equally damaging is the stigma and discrimination that the current law promotes. Stigma is one of the greatest roadblocks preventing persons from seeking any amount of mental health services, and the discrimination stands as an example and a precedent allowing others to justify discrimination of the disabled.

Because NAMI-CAT advocates on a daily basis for others living with mental illness, we know first hand what happens to persons who are inadequately treated for their mental illness - uncompleted college education, inability to find employment and loss of employment, billions of dollars a year lost to employers, poverty, alcohol and drug addiction, incarceration in jails and prisons, serious harm to self and others, frequent emergency room visits, increase in other medical ailments and injuries, divorce, homelessness, loss of life, the bankruptcy of caring families and the sacrifice of parental guardianship to insure adequate care for their ill child, and an overall waste of human potential for which any democratic country should be ashamed.

Although far from parity in coverage for mental health and addictive disorders, Senate Bills 71 and 72 should provide some relief to those individuals and families besieged by these devastating illnesses. This compromise moves us one short step closer to equality with health care coverage provided for other brain disorders and for illnesses of all other organs of the body. It is the least our state government can do for some of its most vulnerable citizens. It is the least you can do to promote the end of discrimination in our great Nation.

Sincerely,



Amy M. Randolph
Assistant Program Coordinator
NAMI-Racine County, Consumer Advocacy Team

SB71/72

(414) 964-6449 JUL 21 2003 Fax: (414) 964-9814

Andrew W. Kane & Associates, S.C.
Clinical, Consulting & Forensic Psychology
2815 North Summit Avenue
Milwaukee, Wisconsin 53211-3439

July 18, 2003

Senator Carol Roessler, Chair
Senate Committee on Health, Children, Families, Aging and Long-Term Care
Room 8 South, State Capitol
P.O. Box 7882
Madison, Wisconsin 53707-7882

Dear Senator Roessler,

I'm writing with regard to S.B. 71 and S.B. 72, which I understand will be discussed at a hearing before your Committee next week. I want to ask that both bills be strongly supported by your Committee.

While there is no magic formula that will decrease illness and stress, reduce the cost of medical care and health insurance, increase productivity at work, and generally improve the quality of people's lives, there is something with a proven record of helping in all those areas: psychotherapy. Unfortunately, most people can't afford an adequate amount of psychotherapy, making major life changes difficult or impossible for them. As their stress levels increase, their productivity at work decreases, and their immune systems become less able to fight off disease, according to a large body of research. Part of the problem is the low amount of the state mandate for mental health services.

According to "Mental Health: A Report of the Surgeon General" (1999), at any point in time 28% of the population has a diagnosable mental or substance abuse disorder, while only 8% receive mental health services. The other 20% continue to suffer and to be physically ill more often and to be less productive on the job. That untreated 20% bears some of the responsibility for the high, and rising, cost of medical care and medical insurance, as well as reduced productivity in their jobs.

Research indicates that psychotherapy, particularly cognitive therapy, is at least as effective for depression and anxiety disorders as is medication. In the short-term, there may be little or no cost savings because of the direct cost of treatment. In the long term, making psychotherapy readily accessible is very likely to significantly to reduce overall health care costs. It also gives the individual skills that can be used to address future problems in

the individual's life, decreasing the impact of future sources of stress and improving the quality of life for the individual and his or her family.

A 2002 report by the Robert Wood Johnson Foundation cited a study that found that medical expenditures by people who also had mental health problems were four and a half times higher than for people who had no identifiable mental health problems. The cost for treatment for the mental health problems was included in the total medical cost amount.

In another study, a meta-analysis of 91 published research studies found that 90% reported a decrease in medical care utilization following some type of psychological services. Of 28 studies that reported cost data, 26 indicated that cost savings from reduced medical care utilization exceeded the cost of the psychological services received.

Sending employees to their primary care physicians does not provide a viable alternative. According to the New York Times of July 8, 2003, most primary care physicians do not recognize or diagnose depression or other psychological disorders. Physicians also seldom recommend psychotherapy (the treatment of choice) in cases they do recognize. When they prescribe medication, it is often in doses that are too low, and for too short a time. Relapse after short-term antidepressant utilization is relatively likely.

When the costs associated with lost productivity, sick leave, work-related accidents, and other indirect expenditures are added to the direct cost of medical care, the total cost of mental health problems in the workplace at least doubles. A study reported in the June 18, 2003 issue of the Journal of the American Medical Association indicates that workers with depression indicated nearly four times as many hours of lost productivity as did co-workers without depression. Extrapolating the results to all workers in the U.S.A. "suggests that U.S. workers with depression employed in the previous week cost employers an estimated $44 billion per year in (lost productive time)... [not including] labor costs associated with short- and long-term disability." The President's New Freedom Commission on Mental Health reported in 2002 that the economy's loss of productivity from mental illness amounts to $63 billion annually." A study by MetLife indicated that psychiatric claims were 7% of their short-term disability claims, but nearly double that percentage for white-collar employees. A survey by Employee Benefits Journal [2002] indicated that mental health problems were the second-ranked reason for loss of productivity, accounting for 29% of all loss of productivity. Dow Chemical Company is currently targeting "presenteeism," the situation in which the individual comes to work but is so distracted or dysfunctional that it impacts not only his or her work but the work of other employees as well.

Consumers Union (Consumer Reports) conducted the largest study ever done of mental health care, in 1995. They found that family physicians helped, but that people who saw a mental health professional for at least six months did far better; that psychotherapy alone worked as well as psychotherapy combined with medication; and that the longer people stayed in psychotherapy, on average, the more they improved. A similar "dose-response" result has been reported by more recent research as well [e.g., Clinical Psychology: Science and Practice, 2002; Journal of Consulting and Clinical Psychology, 1999]. Each of these conclusions calls into serious question the common practice of health maintenance organizations and other managed care entities of limiting initial access to mental health care and limiting the number of sessions of psychotherapy permitted. While these practices may have reduced the expenditure of health care dollars in a given year, the long-term impact is very likely to have been an increase in medical care expenditures (and in the cost of health insurance) because mental health problems were approached with a "Band-Aid" mentality rather than with an attempt to control the significant impact of mental health problems on medical care expenditures and health insurance costs.

The Consumers Union study also "found that people got better in three distinct ways, and that all three kinds of improvement increased with additional treatment. First, therapy eased the problems that brought people to treatment. Second, it helped them to function better, improving their ability to relate well to others, to be productive at work, and to cope with everyday stress. And it enhanced what can be called 'personal growth.' People in therapy had more confidence and self-esteem, understood themselves better, and enjoyed life more."

Dozens of research reports annually indicate the impact of psychological problems on people's medical condition. In just the past two years, research reports have indicated that: people who indicate high levels of stress are more likely to experience a fatal stroke than are people who report little or no stress [Stroke, April 2003]; stress is a significant risk factor for most kinds of cardiovascular disease [Behavioral Medicine, 2002; Harvard Mental Health Letter, April 2003]; patients with a Posttraumatic Stress Disorder (PTSD) made 30% more visits for general medical care than did patients without this diagnosis [Psychosomatic Medicine, 2001]; people who show evidence of significant anxiety, depression or hostility have a strong tendency to have compromised immune systems that make them more susceptible to medical problems associated with aging, cardiovascular disease, arthritis, and other medical disorders [Annual Review of Psychology, 2002]; psychological factors play a significant role in delaying the healing of chronic wounds [Psychosomatic Medicine, 2001]; psychotherapy markedly decreased the cost of treating irritable bowel syndrome (cost: $976) compared with Paxil (cost: $1,252) and treatment with neither

psychotherapy nor an antidepressant (cost: $1,663) [Gastroenterology, 2003]. In short, stress, anxiety, depression, and other mental health problems have an adverse impact upon nearly every area of physical functioning, causing costs of medical care and health insurance to increase and markedly decreasing the productivity of workers at every level.

The personal, financial and productivity losses are particularly unfortunate when one considers that most mental health problems are highly treatable. The Consumers Union study, and a great deal of other research, demonstrates that psychotherapy works for most people. Research clearly indicates that incidence and prevalence of medical disorders decrease, costs for medical care are reduced, and workers have fewer sick days and are more productive when they are at work. Yet most managed care plans limit access to psychotherapy, generally permitting at most 20 sessions and making both the patient and the therapist fight for approval of the number of sessions needed if treatment is to be both successful and lasting. This policy hurts both the worker and the employer, the latter by saddling them with higher insurance premiums at the same time that managed care policies regarding psychotherapy cause increases in medical care and decreases in productivity.

An informed public policy requires that sufficient psychotherapy be available to permit individuals to achieve significant benefit, and to have that benefit be substantial in its duration. The Consumers Union and other research strongly indicates that, for the most part, the more psychotherapy one receives the better the effect for the individual and, by implication, for the family, the employer, and society. The optimal number of sessions appears to fall between six months and a year of weekly psychotherapy, approximately 25 to 50 sessions. The current mandated benefit, 90% of the first $2,000, doesn't come close to the minimum number of sessions that should be mandated. The proposal to raise the mandate to $3,100 would greatly help, though a strong case could be made for raising it to $4,000 or more.

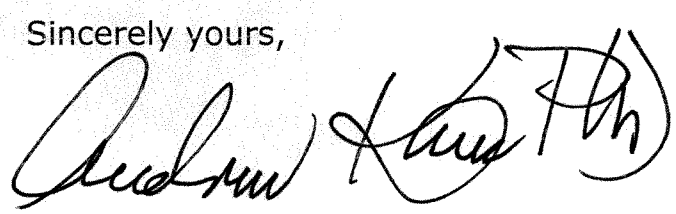
The data further indicate that, of all the actions that could be taken by the legislature to impact the high cost of health insurance, the single most significant one may be a substantial increase in the mandated benefit for psychotherapy. Psychotherapy is an investment, not simply a cost.

Parity for mental and physical health coverage is essential. Given the massive body of evidence that physical health is very strongly affected by mental health problems, it is at best short-sighted to fail to offer equal coverage for all health problems, physical and mental. The Congressional Budget Office estimated in 2001 that the cost of full parity would be less than a 1% increase in insurance premiums. A 1999 study by the Substance

Abuse and Mental Health Services Administration indicated that businesses that brought mental health care benefits into parity with physical health benefits rarely experienced either a cost increase or a need to change other benefit provisions. President Bush supports achieving parity for mental and physical health.

The legislature, through SB 71 and SB 72, has an opportunity to have a strong, long-lasting impact upon the mental health and physical health of the population of this state, upon the productivity of our workers, and upon the rising cost of health insurance. I very much hope that your Committee will spearhead this critically important improvement in services and service accessibility.

Sincerely yours,



Andrew W. Kane, Ph.D.
Clinical, Consulting and Forensic Psychologist

SB71/SB72

JUL 24 2003

Access to Independence, Inc.

Putting the Person Before the Disability

July 23, 2003

Senate Health, Children, Families, Aging
and Long-Term Care Committee

Dear Committee Members:

Thank you for the opportunity to submit written testimony in support of Senate Bills 71 and 72.

Access to Independence is an independent living center that seeks to promote independence and self-determination for people with all types of disabilities. In our daily interactions with consumers, we witness firsthand the frustration people experience trying to obtain needed services. Numerous barriers exist including long waiting lists for community services and inequities in health insurance coverage. It is this latter issue that SB 71 and 72 seek to address.

As you know, in 1985 the state Legislature enacted mandated minimums for mental health and substance abuse health insurance coverage. However, language that would have permitted increases for inflation, were subsequently deleted from the bill. SB 72 will restore indexing for inflation. This action is needed to ensure that coverage remains at the level envisioned in 1985.

Evidence clearly shows that mental illness and addictive disorders can be as effectively treated as physical illnesses. Treatment also saves money in the long run by preventing costly hospitalizations, lost wages and the need for other public benefits. It is a matter of simple fairness that people with mental illness and substance abuse receive comparable coverage. These two bills fall far short of providing full parity but it is a step in the right direction and the least that we can do for people in our community who experience mental illness and substance abuse disabilities.

Sincerely,

Valerie Brown

Valerie Brown
Advocacy Team Coordinator

A United Way and Dane County Human Services funded agency

2345 ATWOOD AVENUE • MADISON, WI • 53704-5602
PHONE: (608) 242-8484 • FAX: (608) 242-0383

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

SB71 & SB72

Coalition for Fairness

in Mental Health and Substance Abuse Insurance

To achieve
mental health and substance abuse parity
in health insurance
in the state of Wisconsin.

121 South Hancock Street, Madison WI 53703 • Phone 608-251-1450 • Fax 608-251-5480 • Email wispsych@execpc.com

BFWG

Mental Health and Substance Abuse Insurance Coverage
SB 71 and SB 72

On March 12, the 22-member Joint Legislative Council endorsed two proposals developed by a Legislative Council Study Committee on Mental Health Parity. The two bills, SB71 and SB72, have been referred to the Senate Health, Children, Families, Aging and Long-Term Care Committee, chaired by Senator Roessler. While the bills stop short of creating parity in coverage of mental health and addictive disorders, they would increase the mandated minimum coverage currently in statute and more clearly define how costs are allocated to these mandated minimums. The bills do not create a new mandate but, rather, provide that mental health and substance abuse coverage would be no worse than it was in 1985, when the mandated minimums were first enacted. We believe it is time to take this important step.

SB 71 clarifies that the costs of medication and diagnostic tests cannot be charged against the mandated minimum coverage. This is current practice in the insurance industry and thus will not cost employers or employees more money. SB 71 also clarifies that any charge against the mandated coverage must be the actual amount an insurer pays and not the amount charged by a provider.

SB 72 increases the mandated minimums for inpatient, transitional and outpatient services based on the consumer price index for medical care costs since1985. It is our understanding that the original intent when the mandated minimums were enacted was for the amount to increase regularly based on inflation; however, the Legislature subsequently removed that requirement. Indexing for inflation is a common practice, and we believe it is time to implement it for mental health and substance abuse coverage.

Evidence continues to increase that mental health and substance abuse disorders can be effectively treated at rates comparable to other illnesses. Advanced brain imaging techniques have begun to allow scientists to see the impact of these disorders on the brain and the real impact of treatment. We know that these disorders are real, we know their impact and we know that treatment is highly effective.

Most individuals who need treatment will not use even the current mandated minimum amount of $7000 in a year. However, families continue to be bankrupted by paying for mental health and substance abuse treatment that is not covered by the current mandated minimums. Families with children with serious emotional disturbances continue to face the choice of giving up custody of their child to ensure they have access to treatment.

SB71 and SB72 recognize that, for a variety of reasons, the Legislature has been reluctant to enact comprehensive insurance parity for mental health and substance abuse disorders. These bills represent a significant compromise and deserve your full support.

Thank you for your time and attention to these important issues. Please feel free to contact us if you have any questions or concerns about these proposals.

Sincerely,

Catherine Beilman
NAMI WI
608-268-6800

Sarah Bowen
WI Psychological Assn
608-251-1450

Bill Stone
WI Assn for Alcohol & Other Drug Abuse
608-276-3400