ALASKA LEGISLATURE COMMITTEE FILES 1985-1986 8672

3487 HLAB HB 313

303

RECORDS CERTIFICATION

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Signature of Camera Operator

9/5/89
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02-519 (REV 8/79)

HB

313

COMMITTEE REPORT

HOUSE

HEALTH, EDUCATION AND SOCIAL SERVICES

(7)

FURTHER: FINANCE

3/22/85

Date: _____

The Committee on LABOR & COMMERCE has had HB 313

"An Act requiring certain health insurance policies to cover the treatment of a mental or nervous condition."

under consideration and recommends:

[ ] do pass [ ] do not pass

[ ] do pass with attached amendments(s)

[ ] replace with CS for _____ [ ] same title [ ] new title

and recommends _____

[ ] AND attaches a "Letter of Intent" [ ] New Fiscal Note Sept 24

[ ] Zero Fiscal Note Attached

[ ] reports it back without recommendation

[ ] referred to the _____ Committee

MEMBERS SIGNING
DO PASS

_____

_____

_____

_____

_____

_____

_____

_____

MEMBERS HAVING
OTHER RECOMMENDATIONS:

_____

_____

_____

_____

NO PASS

_____

_____

CHAIRMAN

HB 313 File Contents

April 10, 1985 Wednesday

1) Bill Summary -- Legislative Reporting Service

2) Overview -- R. Poppe, Committee Staff

3) Fiscal Note -- Division of Insurance, DCED -- April 9, 85

4) Fiscal Note -- Dept. of Administration, Division of Retirement and Benefits -- April 10, 85

5) Alaska Statutes -- AS 21.42

6) Memo -- Theresa Bannister, Legislative Legal Counsel, April 4, 85

7) House Research Agency Report -- April 10, 85

8) "Dispelling Myths About Mental Health Benefits," from Business and Health, October, 1984, pp. 7-11

9) "Health Insurance Coverage for Psychiatric Illness: Current Trends and the Private Hospital Response," White Paper by the National Association of Private Psychiatric Hospitals, pp. 1-20, plus two additional articles in the appendix.

April 25, 1985 Thursday Meeting

10) New Fiscal -- Dept. of Administration -- 4/17/85

11) Fiscal Note Analysis -- Dept. of Administration 4/17/85

12) Letter from John George to Rep. Davis -- April 12, 85

13) Letter from Ron Hauenstein to Rep. Davis -- April 10, 85

STATE OF ALASKA 1985 LEGISLATIVE SESSION
FISCAL NOTE

Revision Date:

REQUEST
Bill/Resolution No.: HB 313
Title: An Act requiring ins. policies to cover mental & nervous conditions
Sponsor: Davis
Requestor:
Date of Request:

FISCAL DETAIL
Agency Affected:
Program Category Affected: Labor & Services
BRU, Program or Subprogram(s) Affected:

EXPENDITURES/REVENUES: (Thousands of Dollars)

Operating	FY 85	FY 86	FY 87	FY 88	FY 89	FY 90
100 Personal Svcs		421.3	455.0	491.4	530.7	573.2
100 Rtmnt & Bnfts		706.5	763.0	824.0	889.9	961.2
200 Travel						
300 Contractual						
400 Supplies						
500 Equipment						
600 Land & Struct						
700 Grants, Claims						
700 TRS Match		312.2	337.2	364.2	393.3	424.8
TOTAL OPERATING	-0-	1440.0	1555.2	1679.6	1813.9	1959.2
CAPITAL						
REVENUE						

FUNDING: (Thousands of Dollars)

GENERAL FUND		1336.9	1443.9	1559.4	1684.1	1818.8
FEDERAL FUNDS		49.4	53.3	57.6	62.2	67.3
OTHER		53.7	58.0	62.6	67.6	73.1
TOTAL	-0-	1440.0	1555.2	1679.6	1813.9	1959.2
POSITIONS:	-0-	-0-	-0-	-0-	-0-	-0-
FULL-TIME						
PART-TIME						
TEMPORARY						

ANALYSIS: (Attach a separate page if necessary)

J. K. Humphreys

Prepared By: J. K. Humphreys Phone: 465-4460
Division: Retirement & Benefits Date: April 10, 1985

Approved by Commissioner: Lisa Rudd Date: 4/17/85
Agency: Department of Administration

Distribution (by Agency preparing fiscal note):
Legislative Finance
Legislative Sponsor
Requestor
Office of Management and Budget
Impacted Agency(ies)

Rev. 7/1/84

House Bill 313
Fiscal Note Analysis
Prepared by Division of Retirement & Benefits
Department of Administration

April 10, 1985

IV Analysis: This bill would require increased limits of coverage for mental, emotional, or nervous disorders under the State's health plans for active employees of the state and all retirees. The estimated cost to the state shown on the attached fiscal note is in addition to the estimated cost of $900.500 to other employers participating in the state's retirement and group health plans.

This bill is estimated to result in a $2.66 per month increase in Health Insurance costs of an estimated 13,200 state employees. It is also estimated to result in a .12% increase in the PERS employer contribution rate and a .075% increase in the TRS employer contribution rate and a .075% increase in the TRS State Match contribution rate. The PERS state salaries for FY 86 are estimated to be $544,046,592 and the TRS state salaries for FY 86 are estimated to be $416,297,654. Costs are estimated to increase at a rate of 8% each year.

The FY 86 estimated state cost of $1,440,000 is calculated as follows:

The increase of $2.66 per month health cost times the number of state employees (13,200) times 12 months equals	$421,300
The change in the PERS employer contribution rate (.12%) times the estimated FY 86 State PERS salaries ($544,046,592) equals	$652,900
The change in the TRS employer contribution rate (.075%) times the estimated FY 86 State TRS salaries ($71,490,744) equals	$ 53,600
The change in the TRS State Match contribution rate (.075%) times the estimated FY 86 TRS system salaries ($416,297,654) equals	$312,200
TOTAL	$1,440,000

House Bill 313
Fiscal Note Analysis
Prepared by Division of Retirement & Benefits
Department of Administration

April 10, 1985

IV Analysis: The present value of the cost of this bill in PERS is $7,411,000 resulting in a .6% decrease in the funding ratio. The present value of the cost of this bill in TRS is $3,916,000 resulting in a .4% decrease in the funding ratio.

STATE OF ALASKA

BILL SHEFFIELD, GOVERNOR

DEPARTMENT OF COMMERCE &
ECONOMIC DEVELOPMENT

DIVISION OF INSURANCE

POUCH D
JUNEAU, ALASKA 99811
PHONE: 465-2515

April 12, 1985

Honorable Mike Davis
Vice Chairman
House Labor & Commerce
Committee
Pouch V
Juneau, Alaska 99811

Dear Representative Davis:

Re: HB 313

I appreciated the opportunity to testify on HB 313 before your committee. You have asked me to provide the committee with a summary of the points of my testimony so that the technical problems could be addressed.

HB 313 should include a provision to amend AS 21.87 in order to make Hospital Medical Service Corporations (Blue Cross) subject to the provisions of AS 21.42.365.

The definition of "cost" in the bill is not the normal formula for usual customary and reasonable used by insurers. We would prefer to have this rewritten to more closely match the current UCR definition.

The definition of inpatient treatment limits coverage to hospitals and facilities in Alaska. The definition should be broadened to include facilities outside Alaska as well.

By providing different specific time limits for three categories of treatment, the bill may force providers to admit a patient to a hospital for treatment after outpatient benefits have run out. Hospital treatment is usually very expensive due to the high hospital overhead and the total care treatment.

Health insurance is a voluntary type of insurance. A person or employer is free to decide whether to purchase it for himself or his employees. If mandated coverages are added to voluntarily procured coverage and costs are increased, we have rewarded those who save even more by not having any coverage and penalized those who voluntarily purchase it.

Employers who self-insure health programs are not affected by the bill so they will have a cost advantage. Employers who currently insure may switch to self-insurance to save money. Many may not be financially able to meet this commitment.

Employers who procure coverage out-of-state will get policies not subject to the mandated coverage, thus giving them a cost of doing business advantage.

Employees and employers may negotiate for group health coverages. Mandating coverages supersedes the bargaining right of both parties.

Anytime coverage is mandated, the cost will be passed on to the purchaser of insurance. To the extent that health insurance affordability is limited and costs are increased, some persons will fall out of the insurance system. Testimony before your committee demonstrated individual high cost of treatment and the long duration required. For the same reasons that these persons testified as to the need for coverage, the costs of providing it will be high. Not only insured persons need the treatment. Treatment for mental health should not be denied for lack of insurance. It seems clear that the ultimate spread of cost for this type of treatment should not be limited to insurers and participants in voluntary insurance plans.

Very truly yours,

John L. George
Director

JLG/sa0754s
41285a

Solutions

April 10, 1985

Rep. Mike Davis
Alaska State Legislature
Pouch V
Juneau, Alaska 99801

Dear Rep. Davis:

The Legislative Committee of the Fairbanks Life Underwriters Association has voted to oppose HB 313 in its present form.

Although the committee acknowledged the objective of the proposed legislation, we believe the bill would decrease rather than increase the level of coverage now provided for mental and nervous disorders. The committee anticipates that the following events would occur if this legislation is enacted:

(1) The cost of individual and group health insurance in Alaska will increase.

(2) Because of the higher cost, small employers would be discouraged from providing group health benefits. Existing plans might be cancelled, and other employers would be slow to add this employee benefit.

(3) Increasing the limits for mental and nervous disorders may lead to additional abuse of this benefit, which would cause further price increases.

(4) Some insurance carriers may decide not to do business in Alaska. The best situation for the consumer is to have many, not few, insurance carriers to choose from.

The committee is willing to work with you and Rep. Koponen to see if we can develop other solutions to the problem you have identified.

Sincerely,

Ron Hauenstein

Ron Hauenstein
Legislative Committee
Fairbanks Life Underwriters Association
PO Box 75429
Fairbanks AK 99707

HB 313 File Contents

April 10, 1985 Wednesday

1) Bill Summary -- Legislative Reporting Service

2) Overview -- R. Poppe, Committee Staff

3) Fiscal Note -- Division of Insurance, DCED -- April 9, 85

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6) Memo -- Theresa Bannister, Legislative Legal Counsel, April 4, 85

7) House Research Agency Report -- April 10, 85

8) "Dispelling Myths About Mental Health Benefits," from Business and Health, October, 1984, pp. 7-11

9) "Health Insurance Coverage for Psychiatric Illness: Current Trends and the Private Hospital Response," White Paper by the National Association of Private Psychiatric Hospitals, pp. 1-20, plus two additional articles in the appendix.

Sexual Assault (spousal defense)

HOUSE BILL NO. 310, by Reps. Koponen, Goll, Navarre and Uehling. In a prosecution for sexual assault in the first or second degree, it would not be a defense that the victim was, at any time, the legal spouse of the defendant (adds new language to AS 11.41, Offenses Against the Person).

Repeals AS 11.41.445(a), "(a) In a prosecution under AS 11.41.410 - 11.41.440 it is an affirmative defense that, at the time of the alleged offense, the victim was the legal spouse of the defendant unless (1) the spouses were living apart; or (2) the defendant caused physical injury to the victim."

Does not provide effective date (takes effect 90 days after Governor signs bill).

Introduced March 22 and referred to Health, Education & Social Services, Judiciary.

Appropriation (special) (vaccine to health care providers)

HOUSE BILL NO. 311, by Reps. Rieger, Gruenberg, Koponen, Uehling, Pignalberi, Hanley, Taylor, Furnace, Martin, Phillips, and Hurley. Makes a special appropriation in the amount of $250,000 to the Division of Public Health to provide vaccine to health care providers including private health care providers. The unexpended and unobligated portion of the appropriation lapses into the general fund June 30, 1986. Provides Act takes effect July 1, 1985.

Introduced March 22 and referred to Health, Education & Social Services, Finance.

Dude Creek Critical Habitat (designating)

HOUSE BILL NO. 312, by Reps. Goll, Duncan, M. M. Miller and Binkley. Designates 4,100 acres of state-owned land in the community of Gustavus as the Dude Creek critical habitat area. The purpose of the area is "...the protection and enhancement of the wet meadow habitat that is the key roosting area for migrating lesser sandhill cranes, for the protection of the cranes, and for the continued public use and enjoyment of the area."

The area is to be managed under a management plan prepared by the Department of Fish and Game in consultation with the community of Gustavus and approved by the Board of Game. The Dept. of Fish and Game would be responsible for management of hunting, fishing and trapping in the area. Fish and Game would be required to allow public access, grazing, firewood harvesting, wildlife viewing, hiking and berry picking to the extent the activities are consistent with the habitat area. Does not provide effective date (takes effect 90 days after Governor signs bill).

Introduced March 22 and referred to Resources, Finance.

Health Insurance (mental/nervous conditions)

HOUSE BILL NO. 313, by Reps. Davis and Koponen. Amends AS 21.42 (Insurance. The Insurance Contract) by adding a new section that would require a health insurance policy to provide certain amounts of coverage for mental or nervous conditions

HB 313 (cont'd)

for the insured or member of the insured's immediate family. The policy would have to provide 60 days a year of inpatient treatment, 90 days a year of partial hospitalization, 30 visits a year of outpatient treatment, and the option of the insured to exchange a maximum of 45 days of inpatient treatment for additional days of partial hospitalization. The policy could impose reasonable contract limitations, but could not require the insured to pay a higher deductible or co-payment for a cost for treatment of a mental or nervous condition than for a cost for treatment of another condition or illness. Does not provide effective date (takes effect 90 days after Governor signs bill).

Introduced March 22 and referred to Labor & Commerce, Health, Education & Social Services, Finance.

Public Utilities Commission (extending)

HOUSE BILL NO. 314, by Rep. Davis. Would extend the Alaska Public Utilities Commission until June 30, 1989 (currently set to terminate June 30, 1985. Provides Act takes effect immediately.

Introduced March 22 and referred to Labor & Commerce, Finance.

Price Disclosure

HOUSE BILL NO. 315, by Reps. Davis, Koponen and Clocksin. Amends the Weights and Measures Act (AS 45.75) by adding a new section relating to unit pricing of consumer commodities. Would require a person offering a consumer commodity to disclose the unit price to the consumer. The disclosure would have to be made by attaching a stamp, tag or label on the shelf directly under the product. If the product is not on display, the seller would have to post a sign near the point of procurement, or put the unit price on the product. Lists type of items to which the law would not apply.

Violations of the law would be punishable as a misdemeanor, but before taking action the Director of Weights and Measures would be required to notify the person of the violation and give 30 days to correct it. If the violation is corrected within 30 days no further action may be taken.

Amends Weights and Measures Act by requiring products sold in stores with automatic checkout systems to have on the outside of the package a clear declaration of the price for that package. Lists items which would not fall under provisions. Local law, ordinance, rule or regulations relating to price labeling area required to be consistent with this section. Before taking action, the Director of Weights and Measures would be required to notify the store and give 30 days to correct the violation. If violation is corrected no further action will be taken.

Violation would be a misdemeanor charge, as for unit pricing section, punishable upon a first conviction by a fine of not less than $20 nor more than $200, or by imprisonment for not more than three months, or both. Does not provide effective date (takes effect 90 days after Governor signs bill).

M E M O R A N D U M

To: All Members, House Labor and Commerce Committee

From: Roger Poppe, Committee Aide

Date: April 10, 1985

Subject: Overview, HB 313

On Wednesday, April 10, 1985, the House Labor and Commerce Committee met in Room 102 of the Capitol on HB 313, "An Act requiring certain mental health insurance policies to cover the treatment of a mental or nervous condition."

This bill appeared in similar form last year in the Senate as SB 457 by Senator Faiks, but it never got passed out of Senate HESS. The Senator has circulated similar draft legislation this year, but so far has not introduced it on the Senate side.

The DCED fiscal note on this bill is zero. While the DCED is taking a neutral position on the bill, there have been some concerns raised by Theresa Bannister, legislative legal counsel, which the Committee may want to consider as possible amendments to the bill. They involve legal issues that may be worthy of consideration. Ms. Bannister will be present to answer any questions along this line.

Approximately 92% of the American working force have some form of employer-sponsored health insurance for psychiatric care at present (see item # 9 in your file, p. 3), and twenty-wtwo states have a legislative provision that demands a certain level of mental health benefits be written into every employer sponsored health insurance policy (p. 5). However, many companies have moved to a self-insuring program that as a side-effect allows them to sidestep the legislative mandates in many of these states. Reluctance to include in psychiatric care in health insurance programs include fears that it costs too much or can go on too long, that diagnosis is suspect, that mental illness is percieved as an emotional and personal problem rather than a health problem (pp. 7-8). Statistics provided in the rest of this report refute these fears.

Another problem area is that while most health plans have some kind of coverage for mental illness, 51% of those plans provide coverage at a reduced level, according to one study, and only 10% got equal coverage according to another study. The end result is tht psychiatrists have approximately twice as many patients with no health coverage as other physicians (see p. 1 of item # 8 in your file). This article goes on to refute the major objections usually cited against such insurance; including 1) "uncontrollable costs,", 2) "moral hazard" myths, 3) the cost-effectiveness problem; and 4) the accountability issue.

Additional research on this issue is forthcoming from the House Research Agency, to be presented at the committee hearings.

STATE OF ALASKA
THE LEGISLATURE

LEGISLATIVE AFFAIRS AGENCY

POUCH Y STATE CAPITOL
JUNEAU, ALASKA 99811
907 465 3800

M E M O R A N D U M April 4, 1985

SUBJECT: HB 313 (Mandatory mental health insurance coverage)

TO: Representative Mike Davis

FROM: Theresa L. Bannister TB
Legislative Counsel

You have asked me to indicate what is covered by the term "health insurance policy" in HB 313.

HB 313 covers all health insurance policies issued or delivered in Alaska and nonprofit health care plans that operate in this state.

Nonprofit health care plans are regulated by AS 21.87. They differ from insurance policies because they actually provide the health care services and don't just reimburse medical expenses. Requiring these plans to add mental health services may place a burden on existing plans. For this reason you may want to delete the reference to these plans from HB 313.

The following are two issues that bear on the coverage of HB 313.

1. ERISA preemption. The federal Employee Retirement and Income Security Act (ERISA) of 1974 covers all employee health insurance plans. Governmental employee health insurance plans are not covered by ERISA. The question of how much ERISA prevents states from regulating employee health plans is now before the U.S. Supreme Court. There appears to be a real division in the Federal Appellate Court cases on this issue, so I cannot predict what the Supreme Court will do. HB 313 covers employee health plans.

2. Preemption by the Labor Management Relations Act (LMRA). Also before the U.S. Supreme Court is the question

whether the ERISA preempts state coverage of health insurance plans that are connected with a collective bargaining agreement. According to Mr. Ambrose of the National Mental Health Association (one of the publishers of "For Ayes Only"), this issue is not as strong as the ERISA issue. HB 313 covers employee plans that are connected with collective bargaining agreements.

If I can be of further assistance, please advise.

TLB:ojb
J13/064

ALASKA STATE LEGISLATURE
HOUSE OF REPRESENTATIVES
RESEARCH AGENCY

Pouch Y, State Capitol
Juneau, Alaska 99811
(907) 465-3991

April 10, 1985

MEMORANDUM

TO: Representative Mike Davis

ATTN: Tom Moyer

FROM: Jay Livey and Jonathan Sherwood
Legislative Analysts

RE: Mandatory Mental Health Insurance Coverage Under House Bill 313
Research Request 85-263

You requested that we provide information on the experience of other states with mandatory mental health insurance and discuss the costs and possible effects of implementing such a requirement, as contained in House Bill 313, in Alaska. This memorandum summarizes our findings to date. The first section of this memorandum provides a summary of other states' experience with mandatory mental health insurance. In the second section of the memorandum, the potential costs of HB 313 and the reaction of several major employers and insurers in the state to the proposal are presented.

MANDATED MENTAL HEALTH INSURANCE IN OTHER STATES

Currently, twenty-six states have mandated some type of mental health insurance coverage. Fourteen of these states have enacted minimum benefit packages that must be included by insurers in group and/or individual insurance plans that are offered in the state. Twelve states have passed mandated availability laws that require insurers to make available a minimum benefit package to purchasers of insurance. Under the laws that mandate minimum coverage, a group and/or individual insurance policy must include mental health insurance while the mandated option requires that the policyholder be given the option to purchase mental health insurance. In most of the states that either mandate coverage or availability, state law defines the minimum coverage that must be offered.

During the past five years, the number of states that have passed some type of mandatory mental health insurance has increased from twenty to twenty-six. Also within the past five years, three states, Oregon, Montana and Maine have replaced availability statutes with statutes

mandating minimum benefits. According to the National Institute of Mental Health, no states rescinded or weakened their mental health mandates.

Minimum Benefit Packages Required by States

Fourteen states have passed legislation requiring insurance companies to include mental health insurance in their coverage as a condition of writing insurance in the state. These state laws generally specify the level of mental health coverage that must be provided. Table 1 summarizes these mandated benefits and identifies the mandated coverage proposed by HB 313.

As the table shows, not all the states mandate the same categories of benefits. Three states, Colorado, Connecticut and Alaska offer distinct outpatient, inpatient and partial hospitalization benefits. Maine and Oregon combine partial hospitalization and inpatient into one benefit. Six states do not identify partial hospitalization as a separate benefit. All the states mandate inpatient benefits and only North Dakota does not mandate outpatient benefits.

The levels of mandated coverage also vary considerably. Ten states require a minimum number of inpatient days that must be included in health policies. North Dakota mandates 70 inpatient days while Connecticut, Montana, Virginia and Wisconsin each mandate 60 days. Colorado mandates 45 days and Montana, Virginia and Wisconsin require 30 days. In comparison, the inpatient requirement proposed in HB 313 is 60 days. Several states do not quantify the required coverage, but require the benefit to be comparable to other types of coverage.

Coverage for partial hospitalization provides benefits for those instances in which the patient is receiving continuous treatment over a specified portion of each 24-hour period. Three states quantify a benefit level for partial hospitalization while other states either do not specify a partial hospitalization benefit or include this benefit as part of inpatient coverage. If inpatient and partial hospital benefits are combined, only North Dakota and Connecticut require benefits that exceed those proposed in HB 313.

All the states except North Dakota require outpatient benefits to be provided. Maine and New Hampshire quantify outpatient benefits based on the number of visits per year while all of the other states quantify these benefits based on a dollar limit. House Bill 313 requires mental health coverage to include a minimum of 30 outpatient visits per year compared the 40 visits required by Maine and the 15 hours of outpatient services mandated by New Hampshire. Minimum dollar benefits range from $2,000 per year in Oregon to $500 per year Massachusettes and Wisconsin.

TABLE 1 -- SUMMARY OF STATE MANDATED MENTAL HEALTH COVERAGE

State	Inpatient Benefit	Partial Hospitalization	Outpatient Benefit	Other
Colorado (1975)	45 days per year	90 days per year	$1,000 limit/year	
Connecticut (1971)	60 days per year	120 days per year	$1,000 limit/year	
Maine (1983)	60 days per year	with inpatient	40 visits/year	
Maryland (1976)	30 days per year	optional coverage	At least 50% of other types of coverage	
Massachusettes (1973)	60 days	none	$ 500 outpatient	
Minnesota (1975)	equal to other coverage	none	80% of $750	
Montana (1983)	30 days per year	none	$1,000/year (includes drug abuse)	
New Hampshire (1975)	equal to other coverage	none	15 hours/year	$ 3,000 limit per year $10,000 lifetime benefit
North Dakota (1975)	70 days per year	140 days per year	none	
Ohio (1982)	not specified	not specified	$ 550 per year	
Oregon (1983)	$7,500 per year	with inpatient	$2,000 per year	$9,000 total/year
Virginia (1976)	30 days per year	none	$1,000 per year	
Wisconsin (1975)	30 days per year	none	$ 500 per year	
Alaska	60 days per year	90 days per year	30 visits/year	

Prepared by the House Research Agency, April 1985.

State statutes that mandate minimum mental health coverage generally define the providers that are eligible to provide the mandated services. Table 2 identifies the providers that are eligible to receive reimbursement for mandated services. Because it is assumed that licensed physicians and psychiatrists are eligible for reimbursemnent, the table identifies only other types of mental health professionals. Table 2 also indicates whether or not the mandated mental health services apply to group or individual insurance policies.

As the table indicates, eleven of the thirteen states that mandate mental health coverage identify psychologists as providers that are eligible for reimbursement. Clinical social workers are eligible providers in seven states and psychological nurses are eligible in one state. Two states--North Dakota and Wisconsin--do not identify eligible providers.

Mandated Availability

Statutes in thirteen states require insurance providers to offer mental health insurance to consumers in the state. In these cases, the insurer must make mental health insurance available to the consumer, but the consumer has the option of purchasing the coverage. Generally, the statutes that mandate the availablity of this insurance also define the minimum coverage that must be made available. Table 3 summarizes this coverage.

TABLE 2

MANDATED MENTAL HEALTH INSURANCE
(Providers eligible for reimbursement and type of policy covered)

	Type of Policy		Reimbursement eligibility			
State	Group	Individual	Psychologists	Clinical Social Worker	Psychological Nurse	Other
Colorado	x		x			
Connecticut	x		x	x		
Maine	x		x	x	x	
Maryland	x	x	x	x		
Massachusettes	x	x	x	x		licensed psychotherapist
Minnesota	x		x			
Montana	x		x	x		
New Hampshire	x		x			licensed pastoral counselors
North Dakota	x					
Ohio	x		x			
Oregon	x		x	x		nurse practitioners
Virginia	x	x	x	x		
Wisconsin	x					
Alaska	x		x			

Prepared by the House Research Agency, April 1985.

TABLE 3

SUMMARY OF MANDATED AVAILABILITY FOR MENTAL HEALTH INSURANCE

State	Inpatient Benefit	Partial Hospitalization	Outpatient Benefit
California	Terms and conditions to be agreed on by policyholder and insurer.		
Florida	30 days per year	With inpatient	$1,000 per year
Georgia	Benefits on par with those of other illnesses.		
Illinois	Annual benefit up to $10,000 or 25% of the lifetime policy limit.		
Kansas	30 days per yar	none	$ 600 per year
Louisiana	Benefits on par with those of other illnesses.		
Missouri	30 days per year	none	$1,500 per year
New York	30 days per year	none	$ 700 per year
Tennessee	none specified	none	30 visits per year
Vermont	45 days per year	with inpatient	$ 500 per year
Washington	Coverage provided for treatment at usual and customary rates.		
West Virginia	45 days per year	none	$ 500 per year or 50 treatment sessions with physchologist.

Prepared by the House Research Agency, April 1985.

REACTIONS TO MANDATORY MENTAL HEALTH COVERAGE IN ALASKA

You requested that we contact major insurers and employers in the state to determine the possible effects of House Bill 313. We contacted Blue Cross of Washington and Alaska, the Alaska Teamsters Employer Services Corporation, William M. Mercer, Inc.--insurance consultants for many of the largest employers in the state--the State of Alaska Division of Retirement and Benefits, the Municipality of Anchorage, and the University of Alaska. In addition, we also discussed the proposed legislation with the directors of the Alaska Division of Insurance and the Alaska Division of Mental Health.

Costs

Most of the individuals we contacted believed that the proposed legislation would result in an increase in the cost of mental health coverage. Although many plans have coverage for inpatient treatment similar to that mandated in HB 313, coverage of partial hospitalization and outpatient treatment is generally less than would be mandated by the bill. The most common difference is a higher copayment requirement for outpatient treatment. In addition, many plans have annual and lifetime limits to the amount of benefits that may be paid under the plan. Several individuals stated that the greatest cost increases would result from the provision of outpatient benefits.

I received estimates of the increased cost of the mandated coverage from three sources, Blue Cross of Washington and Alaska, the State of Alaska Division of Retirement and Benefits, and the University of Alaska. These are summarized below:

Plan	Number of Covered Families	Average Monthly Cost per Family	Total Annual Cost (thousand)
Blue Cross	21,000	$3.54	$892,000
State of Alaska[1]	19,250	$6.06	$1,400,000
University of Alaska	3,200	$3.13	$120,000

The cost shown for the State is significantly higher than for Blue Cross and the University. According to Mike Coughlin, this high cost results from the fact that the State must provide coverage to individuals after they retire. Therefore, individuals must accumulate sufficient funds

[1]According to Michael Coughlin, Deputy Director of Retirement and Benefits, estimates for the State of Alaska are preliminary and subject to revision.

to pay for this future expense while they are still working. The number of covered families shown for the State of Alaska includes 13,200 active employees and 6,050 retired employees.

Rick Rubin, with the Alaska Teamster Employer Service Corporation, stated that when the union reduced its outpatient mental health benefits from 100 percent coverage to 50 percent coverage with a $700 annual limit, costs decreased by a factor of 5. This dramatic change might suggest that utilization of outpatient mental health services could be higher under coverage more comparable to other forms of outpatient coverage.

However, several individuals noted that a significant portion of medical expenses incurred under existing health insurance coverage is probably for the indirect treatment of mental or nervous conditions. According to this view, a number of people seek the treatment of a physician for a complaint that is psychological in nature or as a means of obtaining a sympathetic listener. Providing mental health coverage might reduce this use of often expensive medical treatment.

Another potential savings from the bill could result from the requirement that outpatient mental health treatment be reimbursed at the same rate as other treatment. Much of the mental health coverage that now exists excludes outpatient care or covers it at a lower rate than inpatient care. As a result, inpatient treatment may sometimes be more affordable for the patient than outpatient treatment, even if the latter is more appropriate and cost-effective. If coverage of outpatient care were comparable to inpatient coverage, individuals might be more likely to seek the most cost-effective treatment.

It should also be recognized that to the extent mandatory mental health insurance is used to pay for treatment that would be obtained regardless of coverage provisions, the increased cost of mental health coverage does not represent a new cost. Instead, costs that would otherwise be paid by the individual, by the government, or by some other party are paid through premiums collected from the insurance group.

Concerns about Cost Containment

A number of the individuals with whom we spoke stated that the proposed legislation could limit cost containment efforts. First, there was a general concern that mandating specific levels of benefits would reduce the flexibility of insurers and employers to implement cost containment measures. Second, some individuals argued that determining the medical necessity of treatment of nervous and mental disorders is more difficult for insurers than determining the medical necessity of other types of coverage. Requiring higher copayments for mental health coverage is

perceived as a method of discouraging individuals from obtaining unnecessary care.

In addition, a number of insurers and employers expressed a preference for imposing coverage minimums in terms of dollars instead of service units. Dollar limits are perceived as a means of improving the predictability of the coverage risk and encouraging more cost-discriminating choices of treatment alternatives.

General Opposition to Mandatory Coverage

Some of the individuals we contacted expressed opposition to most types of mandatory coverage, including mandatory mental health coverage. One concern is that by raising the price of insurance, mandated coverage may price some consumers out of the market or force them to forego other kinds of coverage which they find more attractive. Mary Carlson of the University of Alaska stated that if mandatory mental health coverage is imposed on the University, some other benefit may have to be reduced.

Another objection is that too many mandatory coverage requirements may eventually reduce the profitability of the Alaska market and could lead some insurers to withdraw from the market. However, no one suggested that this outcome would result from the enactment of HB 313 alone, only that any mandatory coverage worsens the business climate for the insurance industry in Alaska.

Finally, some employers expressed the opinion that employee benefits should be determined through collective bargaining, and not mandated by law. Currently, there is a case before the U.S. Supreme Court in which the right of states to mandate coverage for collectively bargained benefits is being challenged.

Possible Alternatives

It should be noted that none of the insurers with whom we spoke expressed any opposition to requiring insurers to make mental health coverage available as a group plan option. In this way, consumers would have some access to mental health insurance but would be able to choose whether to spend money for mental health coverage.

* * *

This memorandum is a brief summary of our findings; we have collected several relevant publications and comments not discussed in this document. Should you wish, we will include these materials in a later, more comprehensive report. If you have any questions, please do not hesitate to contact us.

JL:JS

Dispelling Myths About Mental Health Benefits

BY STEVEN S. SHARFSTEIN, SAM MUSZYNSKI AND GRACE-MARIE ARNETT

The case is made that mental health coverage is cost-effective and controllable.

MENTAL HEALTH REPORT

Insurance coverage for mental health care always has lagged behind that of coverage for other medical care, and today, private insurance coverage for psychiatric illness is only half as available as coverage for other medical problems.

The American Psychiatric Association, in 1983, surveyed health insurance benefits provided by a cross section of major private sector employers. The 300 plans in the study sample covered 33 million workers and dependents employed in such corporations as IBM, General Motors and Exxon plus numerous mid-sized and smaller companies. The survey showed all of the plans provided some level of inpatient coverage for mental illness, but only 49 percent of the insured were protected for mental illness expenses on the same basis as any other illness. The remaining 51 percent of insured individuals were covered at a reduced level. Ninety-eight percent of the plans had some coverage for outpatient expenses for mental illness treatment. But, again, only 10 percent of the plans provided these benefits on the same basis as outpatient coverage for other medical conditions.[1]

An earlier study of 455 major insurance programs, conducted in 1980 by Hewitt Associates, a benefits consulting firm, also found equal outpatient coverage for mental disorders in only 10 percent of the plans.

This discrimination is bad for patients, for business, for mental health providers and, ultimately, for the community and taxpayers. Unequal coverage of psychiatric treatment has evolved primarily because of several prevalent myths about mental health benefits and care. In business' role as a formulator of health care policy, accurate information is essential to assure that employers make wise economic decisions about health care coverage for employees while providing for quality health care.

The 1960s and 1970s were decades of tremendous growth for mental health services, fueled by ever expanding public and private third party financial resources. From 1955 to 1977, the number of patients treated in inpatient and outpatient mental health facilities almost quadrupled, from 1.7 million to 6.4 million.

There also was a major shift in the type of care delivered, with inpatient care declining sharply while outpatient care increased tenfold, primarily because of federal funding of community mental health centers.

The emergence of an accessible mental health treatment system in the U.S. depended upon joint private and public financing. Through these investments, the private and the public sectors have demonstrated over the last two decades the importance of mental health care. But concerns over the costs of this care have arisen in tandem with alarm over the nation's soaring total health care bill. As a result, a last in-first out policy is being adopted by health insurers with regard to psychiatric coverage, whose growth traditionally has lagged behind that of other medical coverage.

Restricting Benefits

Today, psychiatrists have approximately twice the number of patients with no health insurance as other physicians, and those patients with insurance have greater limits on their psychiatric benefits than for medical care. Mental health coverage has been curtailed in a number of plans, including those under the Federal Employees Health Benefits Program (FEHBP). Some carriers, beginning in 1981, imposed strict limitations on the amount of mental health care federal employees and their dependents may receive under the plans. The Blue Cross-Blue Shield federal employees plan, for example, in 1982 imposed a 50-visit limit on outpatient mental health treat-

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ment and a 60-day limit on inpatient care annually, whereas in the past treatment was limited only by medical necessity.

Decades of clinical experience and research have proven, however, that mental and physical illness cannot be separated without impeding effective treatment. Psychiatric problems often are presented as physical complaints while somatic diseases initially may be experienced as emotional symptoms. Restrictions on mental care coverage cannot prevent individuals from obtaining some kind of care, although that care may not be the most appropriate for their illness. There is good evidence that attempting to establish a false dichotomy between mental and physical illness leads to a false economy in insurance coverage.

"Restrictions on mental care coverage cannot prevent individuals from obtaining some kind of care, although that care may not be the most appropriate for their illness. There is good evidence that attempting to establish a false dichotomy between mental and physical illness leads to false economy in insurance coverage."

For example, an executive under great stress may experience headaches, abdominal pain, fatigue and depression. Unless accessible psychiatric diagnosis and care are available, this executive might have to undergo costly medical and diagnostic testing and specialty consultations. It is cost-effective to treat this person with psychiatric interventions.

In addition, because of the essentially cognitive nature of psychiatry, especially as it involves psychotherapy, because psychiatrists can treat only a limited number of patients each day, and because fewer of their patients are insured, psychiatrists' earnings are near the bottom of the income scale compared with other physicians. So while psychiatrists contribute little to soaring health care costs, insurance coverage for their patients, nonetheless, is often the first to be cut.[2]

The Uncontrollable Costs Myth

Psychiatric care will not be reimbursed equally along with other medical treatments, however, until some of the myths considered unique to psychiatry are addressed. There are four commonly held myths that may account for discriminatory treatment of psychiatric coverage.

The first such myth is that costs of psychiatric treatment are uncontrollable and unpredictable. Opponents of comprehensive psychiatric coverage suggest that providing benefits with no limits on the number of days for inpatient treatment or the number of visits for outpatient care would bankrupt an insurance carrier because of the influx of new patients who would seek these services. Actual experience shows these concerns to be invalid.

Data from the Blue Cross-Blue Shield federal employee health plan, for example, which had no artificial limits on mental health coverage from 1967 to 1981, aside from the same deductibles and copayments for general medical care, indicate that mental health costs are stable over time. After an initial jump in costs immediately following the introduction of broader psychiatric benefits between 1967 and 1969, mental health care accounted for 7.2 percent to 7.7 percent of the total benefits paid from 1970 to 1981.

In 1971, the Rand Corporation began a health insurance study that enrolled 7,500 persons at six sites across the country in 14 different insurance plans having patient copayments ranging up to 95 percent, with a maximum dollar expenditure of $1,000 per family. The Rand study found that expenditures for mental health care constituted only about 5 percent of the total health care costs for all insurance plan enrollees.

It was further determined that when insurance pays more of the bill and the patient less, people use extra psychiatric care at about the same rate as they use extra care from other medical specialists. The researchers found that between 7.1 and 9.6 percent of the population studied used mental benefits; this calculation embraces visits to general practitioners and internists whenever a psychotropic medication or a mental health reason was involved in the visit. Only a small percentage of the individuals (0.4) saw clinicians more than 40 times a year. The Rand study underscores the stability over time of costs for mental health care under insurance.[3]

Health economist John Krizay has done studies that also suggest that costs level out over time or show a plateau effect. In a 1982 study, for instance, he analyzed the experiences of the two insurers participating in the FEHBP — Blue Cross-Blue Shield and Aetna — on a state-by-state basis and translated these data into per capita utilization rates and costs in constant dollars. He noted that in almost all states the total percentage of enrollees who received psychiatric benefits under these plans was around 1.5 percent of total enrollment, indicating that the availability of insurance financing does not cause excessive utilization.[4]

Many of the restrictions on insurance coverage for psychiatric care appear to stem largely from concern about the costs of long-term custodial care or intensive psychotherapy. The standard treatment regimen for intensive psychotherapies involves a minimum of three therapy sessions a week. Experience with the FEHBP, which placed no annual restrictions on the number of outpatient visits for more than a decade, has shown that the number of persons receiving intensive psychotherapeutic treatment ranged from 0.9 percent of all psychiatric outpatients treated in 1971 to 1.1 percent in 1973. The cost for treatment for this population during the same time period ranged from 8.7 percent to 10.3 percent of the total cost of physicians' treatment of mental disorders.[5]

The availability of coverage limited only by medical necessity for intensive psychotherapy during the early

1970s did not seem to cause any appreciable increase in the number of people using this form of treatment. It is clear that in this system, which offered a comprehensive benefit — the full range of mental health services — that the number of people utilizing intensive psychotherapy remained consistently low. This seems a self-stabilizing factor mitigating against threats of exorbitant overutilization of the benefit.

Still, misconceptions about the excessive duration and costs for all psychiatric care have prevailed, and unwarranted discriminations against both inpatient and outpatient psychiatric care in general have persisted. The growing body of data and coverage experience suggests that these concerns and resultant discriminations need to be reviewed. A look at the larger picture of utilization of mental health benefits in comparison to use of other medical services indicates, too, that even with unlimited access to psychiatric care, use is predictable and the portion of the total health dollar consumed is modest.

The "Moral Hazard" Myth

Another myth is that mental health care costs are unstable because of the "moral hazard" which is especially applicable to psychiatric coverage. "Moral hazard" describes the case in which the services demanded for treatment of an illness depend, in part, on the price of these services. Since insurance lowers the price to consumers, more services may be used than if the consumer were required to pay the entire medical bill.

Arguments for restricting mental health benefits focus on the assumption that liberal coverage encourages unnecessary and excessive use. Supporters of this view cite data such as this: Among outpatient users of mental health care in the federal employees Blue Cross-Blue Shield plan, 9 percent accounted for 45 percent of the total cost. Likewise, in the Michigan Blue Cross plans, the highest utilization group of persons, consisting of 10 percent of the users with mental disorders, accounted for over 60 percent of the charges.

But that someone with insurance may be more likely to initiate medical care, and once under care, be likelier to opt for more extensive treatment is not a phenomenon exclusively found in the mental health area. General medical literature also has documented the fact that insurance encourages utilization of physician services. The 1981 Rand study, for example, reported that 1 percent of utilizers of medical care in the 7,500 sample accounted for 28 percent of the total expenditures.

Another study, "Insurance Effects on Employer Group Dental Expenditures," published in the June 1984 issue of *Medical Care*, further illustrates this point. The study found consumers spend more on dental care when they have dental insurance, and 81 million Americans have this type of coverage. Specifically, the study's findings indicate that total outlays for covered dental service are 36 percent higher for employees whose group insurance requires no cost sharing than for workers whose group insurance covers only 80 percent of the costs of basic dental services.

There is no established consensus about the extent of the impact of insurance on use of psychiatric services. Nonetheless, it is unwarranted to assume that this is a phenomenon unique to mental health care and, therefore, that specific benefit limitations to control for moral hazard are justified. The distribution of higher users of mental health benefits seems, if anything, to be less extreme.

According to a National Center for Health Statistics survey of ambulatory care conducted between May 1973 and April 1974, less than 20 percent of all physician visits are for problems considered "serious" or "very serious" by physicians. Nonetheless, 61 percent of all visits concerned problems for which the same patient had been seen by the same physician before, and, in roughly the same percentage of cases, the patient was instructed to return for yet another visit.

The demand for medical services, in other words, has little to do with "seriousness" in terms of clinical judgment. Relief from discomfort or anxiety is the most common motive for seeking medical advice. Thus it is both impossible to design a health insurance program around a concept of "seriousness," and illogical to apply a "seriousness" doctrine to coverage of psychiatric services alone. In that same vein, it is inappropriate for carriers to provide open-ended coverage for various nonpsychiatric conditions while restricting coverage for mental disorders. Yet, a recent study by Roche Products, Inc. showed more than 90 percent of psychiatrists stated they seldom or never see patients who primarily are seeking self-improvement.[6]

"There is no established consensus about the extent of the impact of insurance on the use of psychiatric services. Nonetheless, it is unwarranted to assume that this is a phenomenon unique to mental health care. . . . The distribution of higher users of mental health benefits seems, if anything, to be less extreme."

Lengthy inpatient care and intensive outpatient treatments are important and valid approaches in psychiatric care, just as open heart surgery is an important and valid method of treatment for cardiac patients.

The Cost-Effectiveness Debate

A third myth is that mental health care is not cost-effective. When benefits for mental health care are expanded and the stigma associated with receiving treatment for mental conditions decreases, an initial increase in insurers' costs attributable to psychiatric care is likely to occur. However, with psychiatric problems no longer masked under other diagnoses, and with early detection and ap-

propriate treatment of these conditions, it also is probable that such costs will be offset partly by reduced expenditures for care of other illnesses.

Over the past few years there has emerged a body of evidence that spending for psychotherapy produces savings elsewhere through increased employee productivity, reduced absenteeism and lower costs for other medical care. There is wide and growing acceptance in private industry that it is worthwhile to invest in providing mental health services to employees as corporations can recoup some of the costs of this coverage in other areas.

Increasing medical care expenditures has made evidence of cost-effectiveness essential. In psychiatric treatment, however, results are not as quantifiable as in other medical disciplines. What is the dollar value of relief from incapacitating depression or anxiety, for instance? How can one measure the benefits to a child who is no longer beaten by an alcoholic father or calculate the advantages of a patient's increased capacity for intimate relationships?

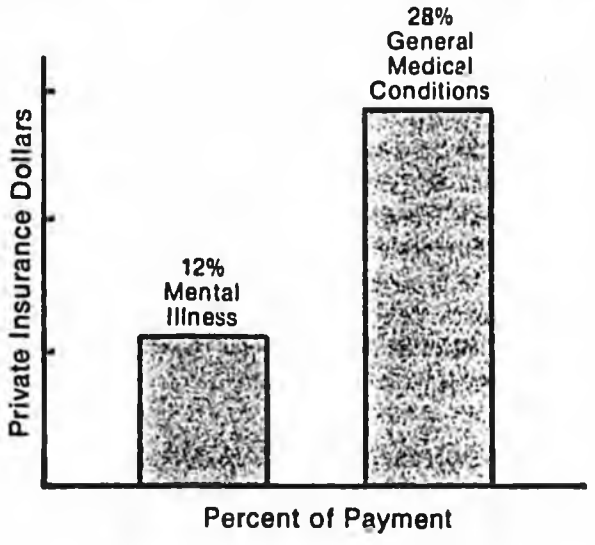
Yet some notable studies have been done which document the cost-effectiveness of psychiatric care in quantifiable terms. Among these was an extensive, three-part study reported in 1980 which found that the use of community based programs for the chronically disabled psychiatric patients greatly reduced the need for hospitalization, lengthened community tenure and enhanced community adjustment. A rigorous cost-benefit analysis determined that benefits outweighed costs by about $400 per individual.[7]

"...As companies look for areas to trim costs, psychiatric benefits often are the first to go, further eroding the real insurance provisions of their coverage. This is especially true where psychiatric benefits for catastrophic illness are eliminated to provide for more predictable routine dental care, for example."

A 1980 study looked at the issue of costs and benefits from a broad societal perspective. The focus was on the impact of the psychoactive medication lithium on the costs generated by manic depressive psychoses. Their conservative estimate of the 10-year savings was $4.2 billion, that is, $2.9 billion in unexpended treatment costs plus $1.3 billion in productivity gains.[8]

Further, a 1983 study involving the Blue Cross-Blue Shield federal employees health plan showed a group of patients who began outpatient psychotherapy following diagnosis of chronic medical disease used 56 percent fewer medical services during the third year after diagnosis than a group with the same diseases who received no outpatient psychotherapy.[9]

These studies clearly show that treatment for mental illness is cost-effective and can be measured directly in terms of savings from nonutilization of other medical services.



The Accountability Issue

A final myth is that psychiatric treatment is not accountable to insurance carriers. Utilization review in the form of peer review has become the cornerstone of organized psychiatry's accountability to payers and consumers. The goal of utilization review is to monitor the necessity and appropriateness of care, while peer review is intended to improve the quality of care. Psychiatric peer review is carried out by psychiatrists and it is concerned with utilization review, quality review, continuing education, advocacy with third party payers for improved care and cost control.

Unfortunately, many insurance carriers have chosen to put strict limits on psychiatric care rather than implement peer review procedures.

The American Psychiatric Association has developed peer review services to give employers the option of providing psychiatric care limited only by medical necessity, thereby enhancing their opportunity to achieve savings through cost avoidance in other areas of medical care. The APA's peer review program was established in the early 1970s and expanded in 1976 at the behest of the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), the health insurance program for military families. Panels of psychiatrists are organized in each of the APA's district branches or chapters.

More than 400 psychiatrists nationwide now review mental health benefits claims for a total of 24 national and local insurers. Three psychiatrists review each case, basing their evaluations on guidelines in the *Manual of Psychiatric Peer Review*, which is regularly revised by the APA. In 1982, the APA conducted 5,000 reviews for CHAMPUS and 965 reviews for other third party payers.

The reported cost savings resulting from use of the APA program are impressive. Aetna Life and Casualty's peer review costs in 1981 were about $20,000, and its

estimated savings were $2.4 million. Mutual of Omaha Insurance Company estimated a savings of about $300,000 during its first year of participation in the program. CHAMPUS reports that peer review has led to "outright savings" of $5 million a year since it began participating three years ago. In addition, savings in costs of medical care avoided as a result of peer review may be three to four times greater than the direct savings. Peer review has been effective in assuring that necessary and appropriate care is delivered.

The APA program is recognized by many third party payers as a responsible effort by the psychiatric community to deal with significant issues of accountability. Mental health benefits require special attention by claims reviewers because of the essential task of protecting patient confidentiality in order for the treatment process to work. The APA's peer review program makes this service available by utilizing careful, professional reviewers in a system that assures accountability and confidentiality.

Business Leadership Needed

It has been predicted that 90 percent of health care services in 1990 will be delivered through contract arrangements between providers and third party payers and their intermediaries. Already systems are evolving to change the economics of health care delivery. There is increased cost sharing to heighten consumers' awareness of cost, and there is more competition between plans for premium dollars. Diagnosis related groups (DRGs) are altering dramatically medical services paid through Medicare and are being adopted rapidly by numerous other all-payer systems.

The extent to which business takes the lead in making choices and helping the medical and other health professions to set the course for health care delivery may well determine the success or failure of the evolving systems to provide quality care at reasonable prices to employers and employees. Some crucial issues must be addressed in this process. One is that as more and more people are covered by insurance the original definition of insurance is weakening. Increasing limits on psychiatric coverage mean that employees are less likely to be protected against the onset of a catastrophic mental illness. Also, as companies look for areas to trim costs, psychiatric benefits often are the first to go, further eroding the real insurance provisions of their coverage. This is especially true when psychiatric benefits for catastrophic illness are eliminated to provide for more predictable routine dental care, for example.

A second issue is that because of prevalent myths about mental health benefits, access to private psychiatric insurance coverage is limited and, consequently, more of the burden for this care falls to the public sector, especially state mental health programs. Only 12 percent of the payment for treatment of mental illness comes from private insurance dollars, compared with 28 percent of the payment for treatment of general medical conditions. States pay almost 50 percent of the cost of mental health care while paying less than 15 percent of the cost of other medical treatments.

This shift in the financial burden of mental health care to the public sector creates especially serious problems for the mentally ill in times of budget cutbacks by all levels of government. Patients receive less care and sometimes no care at all. The untreated show up on the streets as the homeless and in the jails and courts.

The public sector has a responsiblity to care for the 28 million Americans who reported in a 1982 Robert Wood Johnson Foundation survey that they had serious trouble obtaining medical treatment. An estimated one million of these people were refused treatment for financial reasons and had no where else to turn but to public facilities. If these facilities are crowded with employees and their dependents whose employers have eliminated catastrophic psychiatric care from their health insurance packages, then the poor and near-poor are left with no place to go for mental health care.

It is imperative that business stand up to this challenge to provide insurance coverage in its truest sense for its employees to obtain private psychiatric treatment so that the state can provide adequate care to those with no other alternatives.

With accurate information to dispel myths about whether psychiatric costs are controllable, the need for psychiatric treatment, the cost-effectiveness of such care and accountability to carriers, business should be prepared to lead the revolution into the next century to assure employees receive full, affordable and high quality health care. ■

The opinions expressed in this article are those of the authors and do not reflect the official position of the American Psychiatric Association.

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The National Association of Private Psychiatric Hospitals

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Health Insurance Coverage for Psychiatric Illness: Current Trends and the Private Hospital Response

CONTENTS

Americans spent $287 billion on health care in 1981, accounting for almost 10 percent of the total gross national product in the United States. Over 41 percent of that was spent on hospital care.

Most Americans do not pay for their own hospitalization. On the national average, only 4.7 percent of the patients in private psychiatric hospitals pay their own bills. Sixty eight percent of patients have commercial insurance, with the majority being employer-sponsored.

Twenty nine cents of every dollar spent on health care in this country is spent by business in the form of health insurance premiums or health care bills. This portion has been growing, pushed by the rising costs of medical care. Last year, the consumer price index rose only 3.9 percent, while health costs rose 11 percent. One national employer says that in 1982 its inflation rate for mental health services was 19 percent.

Business has begun to look for ways to cut its share of the health care bill. Recent developments and trends in the provision of insurance for psychiatric illness have diminished the ability of many Americans to receive adequate mental illness treatment and care. As a sampling:

* In 1982, Business Insurance, a weekly financial magazine, reported that businesses are adding the benefit of profit sharing and new retirement savings plans but noted that employers ". . . are more likely to cut the health care benefits they provide."

* in 1981, the federal government slashed its psychiatric benefits for employees covered by Blue Cross / Blue Shield, a program that had been seen as a model of mental illness coverage nationwide.

* in 1982, a major U.S. heavy industry eliminated its widely publicized and praised in-house psychiatric and psychological counseling and referral program because the company no longer could afford the costs of psychiatric services charged by providers in the community.

The National Association of Private Psychiatric Hospitals is implementing a strategy to inform corporate leaders, insurance carriers and benefit consultants of the need for and benefit of employer-sponsored insurance for psychiatric care. This information campaign hopes to give these decision makers an understanding of the true costs of having -- and not having -- mental illness care. Additionally, NAPPH will stress the role of the private psychiatric hospital in the provision of high quality, cost effective treatment for the psychiatrically ill employee. Our ultimate purpose is to prevent any erosion of mental health benefits by large national employers and to acknowlege the good that has come through and to employers who offer adequate mental health coverage to employees and their families.

As an integral part of your community's health care system, your hospital plays an important role in the decision of your community's employers to choose -- or not to choose -- adequate coverage for mental illness for employees. Although many issues will be determined on a national scale, your hospital has a voice and a stake in the decisions made locally concerning insurance coverage for your community's employed.

The purpose of this statement is to review the background affecting today's insurance coverage climate and to provide you with the impetus for involvement. It is not a complete picture, nor is it a document that will answer every question concerning psychiatric insurance coverage. We hope that it will spark your hospital to a greater understanding of the serious nature of the debate about psychiatric insurance coverage and to greater involvement.

Robert L. Thomas
Executive Director

Robert V. Sanders
President

The Business Perspective: Methods of Health Care Cost Containment

"Benefits covering treatment of psychiatric disorders seem the least concrete and least manageable and ... represent the most rapidly growing cost." (Industry medical director to the American Psychiatric Association, 1982)

While approximately 92 percent of working Americans have some form of employer-sponsored health insurance for psychiatric care which includes some reimbursement for hospitalization, many employers do not regard the benefit as a desirable or necessary one. At a time of deep recession, high unemployment, and emphasis on cost cutting, many businesses view mental health benefits as a prime area for substantial cost savings.

Cost control of psychiatric insurance benefits is not a new phenomenon. Most businesses provide some form of control through arbitrary limitations in their health policies. Common limitations include maximums on the total number of inpatient days covered and on total dollar reimbursement for inpatient stays and outpatient services; restrictions on the type of setting or provider for which the carrier will reimburse the patient; separate and higher deductibles than provided for other health costs; and higher copayments and stricter lifetime or yearly benefit maximums for psychiatric care than for other medical care.

The difficult economy of the 1980s is placing great pressure on corporate benefit managers, consultants and insurance carriers to decrease employee health insurance premium costs and reduce health spending. The arbitrary limits already set on mental health insurance make the benefit a prime target for other cost control mechanisms and reductions. It should be noted, however, that cost cutting methods are being used on all types of health care insurance. Containment of health costs is a primary agenda item for many corporate benefit managers.

Recent trends to cut health care costs show that increasing copayments is a popular mechanism for cost containment. In 1981, 13 percent of the nation's businesses increased out of pocket costs for care. Business is also asking employees to

pay part of the insurance premiums for their coverage. In 1981, seven percent increased the employee's share of the premium bill. The figures for 1982 are expected to be higher.

The rise in Employee Assistance Programs (EAP) has also been a result of concern over rising health care costs. Originally a method of rehabilitating the alcoholic employee, the EAP has come to encompass such diverse elements as marital and family counseling, drug rehabilitation, psychological screening, and referral to private therapists. A 1979 survey of the Fortune 500 companies found that 56.7 percent operated employee assistance programs.

Screening and treating workers through the company EAP has become a preferable alternative to the expense of firing a problem employee. While EAPs have been a positive force in employee mental health, there is a danger that employers, in their search for cost cutting mechanisms, will attempt to use the in-house EAP as a substitute for more comprehensive mental illness benefits.

The health maintenance organization (HMO) also has been seen as a cost saving mechanism. An HMO is a pre-paid plan that emphasizes total, one-stop health care on a routine basis. HMOs, it is believed, stop unnecessary usage of more expensive means of treatment. Many HMOs do not provide for private psychiatric hospitalization unless the employer specifically requests this service.

Employee mental wellness programs are being developed for similar reasons. These programs, funded totally by the employer, offer emotional, psychological, social and sometimes physiological support services to help the employee on and off the job. The program also alerts the employee to any potential mental health risks or problems at their very early stages. Again, business hopes that this preventive care will eliminate some of the high costs of hospitalization, as well as provide for more productive, healthy employees.

Some proposals for health benefit cost cutting have come from the "competition" models being proposed by the current federal administration. The most dominant of the proposals is the one that calls for a limit on the income tax exclusion for health insurance provided to employees. This "tax cap" may force employers to offer only a limited selection of employer-sponsored benefits, with a menu of optional benefits paid for by the employee. The net effect is that workers will have to choose from among mental health, dental and maternity benefits; laboratory and x-ray services; emergency room treatment, and the like for their health care.

Twenty two states have a legislative provision that demands that a certain level of mental health benefits be written into every employer sponsored health insurance policy. This mandate does not guarantee, however, that every employer provides mental health coverage. Many companies have learned that self-insuring employee health benefits not only provides a better cash management situation for the company, but also offers a mechanism for avoiding the mandate. The concept of self-insuring is gaining in popularity as an effective management tool. This is not to say that all self-insured employers do not provide mental health benefits. It is not safe to assume, however, that mandated benefits cover all employees.

As a direct result of the concern over employee health benefit costs, businesses around the country are forming coalitions on health. The main objective of these coalitions is to stop the rise in health care costs, especially in hospitalization. In some cases, coalition membership is limited to businesses, and providers are not included in their discussions.

The least desirable but most effective method of cost control for business is benefits reduction. Direct reduction of benefits cuts premium costs. But reducing benefits is not that easy. Employees are used to having certain benefits; in fact, employees often want additional benefits each year. How does a company cut benefit costs while increasing benefits?

The easiest way is to find a benefit that is, in the employer and employee viewpoint, the least needed and least demanded, and which can be quietly reduced or discarded. In too many cases, that benefit is the mental health benefit.

To offer new services to employees without increasing costs, businesses have begun to trade off one type of benefit for another. Most notably, dental benefits are taking the place of extensive mental illness coverage. The argument proffered is that these benefits can be used by more workers and thus are more equitable to all workers. In fact, these benefits are also generally less expensive in premiums and total dollar expense for the carrier and the business. The costs and usage of these benefits are more predictable than those of mental health benefits. That mental health benefits have no vocal constituency helps the reduction process.

While there has not been a national trend to slash mental health benefits, it is true that many employers are opting for other types of less expensive, more "popular" benefits in place of mental health. Data from new group health insurance policies written during the five years from 1976 to 1981 show that while the percentage of employees receiving dental insurance rose from 17 percent to 35 percent, the percentage receiving full hospital benefits for psychiatric care remained much the same, moving only from 64 percent to 66 percent. (See Appendix A)

The Business Perspective: Problems with Insurance Benefits For Mental Illness

"Insurers look at psychiatric treatment as open-ended and that scares them. If you have cancer, they'll pay you, but usually you'll either be dead in two years or on your way to being cured. Psychiatry can go on for 10 or 13 years." (Insurance association executive to the Wall Street Journal)

The image of psychiatric treatment held by some business executives and insurance carriers can be summed up succinctly: Treatment costs are uncontrollable and the conditions are not serious enough to warrant extensive medical attention or lengthy hospitalization. Psychiatric illness is viewed as a condition from which there can be no substantial recovery and for which a carrier must pay for an indefinite period of time. Diagnosis is often suspect, as are the providers of care and setting of treatment. Finally, the costs of psychiatric care, especially as related to the potential benefits to the individual, his family and society, are suspect.

A letter written in 1981 to the American Hospital Association by a senior Blue Cross / Blue Shield official reflects this opinion:

"Coverage of basic hospitalization and related medical, surgical and diagnostic services generally hold stronger account and member loyalties than mental health coverages [sic] since they are viewed as involving high-cost services for life threatening conditions. They [sic] also seem to think the end product of non-mental coverages is more tangible and measurable than the end product of mental health coverages. Consequently, some mental health benefits programs have been reduced by accounts [employers] either as one way to reduce overall costs or to find monies for new coverages of greater preference."

Psychiatric benefits also suffer in comparison to other health benefits because they have no active constituency. The New York Times reported that some 15 percent of those who have mental illness coverage do not use it; rather they pay for treatment out of their own pockets because of fear of reprisals from their employers. Thirty one percent of Americans believe that mental illness is a form of emotional weakness and a personal -- rather than a health -- problem.

Because of this stigma, and the fact that mentally ill employees are generally not regarded with the understanding and sympathy of other ill employees, employers can cut psychiatric care benefits with little worry about employee complaint.

Insurance carriers often cite overutilization of psychiatric insurance benefits as a major reason for not having extensive coverage for employees. Carriers often state that a small number of employees will use a large pool of mental health dollars; that dollars for mental illness are used disproportionately to other health coverages; and that any extension of mental health coverage creates a rush of "worried well" to psychiatric facilities and providers.

Finally, businesses often are concerned about the use of the most intensive type of psychiatric care: hospitalization. While it is generally recognized by most major employers that a mental illness can be severe enough to require hospitalization, employers worry that hospital benefits can be abused by employees, physicians and hospitals. The internal and external mechanisms that insure that only those patients who require hospitalization actually receive it are not well understood. Business fears that a lack of control over the actual need for hospitalization increases costs significantly.

> "Peer review, an important cost and quality review tool program as well as a mechanism to deal with subjectivity in the mental health field is insufficient at this time to safeguard against overutilization. This means other control mechanisms (coinsurance, limits, deductibles) are still needed." (Washington, D.C. office of Blue Cross/Blue Shield, internal memo, 1983.)

The Hospital Response: Facts About Insurance for Mental Health

> Most public business and labor leaders do not know the fundamental facts concerning private psychiatric hospitalization and other treatments for mental illness. (Edward Sodaro, Jr., M.D. and Pasquale Carone, M.D., The Psychiatric Hospital, Spring, 1983)

The biggest fear expressed by business about health insurance benefits for psychiatric care is that these benefits are too expensive. The cost to any company for insurance covering mental illness depends on the company's particular carrier and situation, but one fact is clear: Insurance for mental health is not expensive. For example, a survey of 79 major corporations showed that the annual per capita costs of psychiatric insurance benefits were $29.47. In 1979, the costs of the generous federal government package for mental health was about 50 cents a week per person, or $1.30 for a weekly family cost. Even in today's dollars, insurance for inpatient psychiatric care is not expensive. According to information collected by Hay Associates, a benefit consulting firm, today's employer spends $2000 annually for employee health benefits; if the employer provides 365 day coverage for inpatient psychiatric care, it costs only $100.

The only comprehensive study done on insurance for psychiatric disorders also disproves the notion that a small number of employees use a large pool of health insurance dollars. In the mid-1970s, a study was done on the costs and usage patterns of mental health benefits in the federal government program for employees. This included full coverage for psychiatric hospitalization for up to 365 days.

The study showed that only 4 percent of all hospital admissions under the health insurance plan were for mental disorders, which represented 6 percent of the total basic hospital benefits paid. Mental illness represented only 9 percent of the hospital days provided for all conditions.

The claims that mental health usage is dominated by a few users disproportionately to other types of health care also seems to be without solid basis. In a study done by Blue

Cross, 10 percent of the persons with a mental disorder accounted for 60 percent of the psychiatric charges. In isolation, that may sound staggering. But the same study showed that 5 percent of the users with other medical diagnoses accounted for 52 percent of other medical charges.

The business fear that hospitalization for psychiatric illness will be abused by patients or facilities shows a lack of adequate information about the review processes available to employers and insurance carriers.

The National Association of Private Psychiatric Hospitals endorses the objectives and functions of the Peer Review system of the American Psychiatric Association. That system uses independent reviewers to examine medical necessity, appropriateness of treatment modalities, lengths of stay and other factors. Seventeen nationwide insurance companies and CHAMPUS have contracted with APA for its peer review services. One company reports a 3 percent yearly savings in its total mental health bill through APA Peer Review.

In hard economic times, business needs to know more than the raw costs of any benefit. A business wants some benefit to the company for the dollars it provides. An excellent case for mental health benefits can be made on the basis of what is good for the company, not merely the employee.

According to the Washington Business Group on Health, a voluntary association of 200 national businesses representing 55 million workers:

* A three year study of absenteeism at Weirton Steel Company demonstrated that psychiatric illness was the principal reason for the absence of 61 percent of those examined.

* Kimberly Clark found that participants in its employee assistance program reduced their on the job accidents by 70 percent.

* Kelsey Hayes tracked 58 plant workers involved in the company's mental health counseling program and documented an average recovery of 316 hours per employee in the program.

* The Equitable Life Assurance Society found that for every $1 of treatment cost incurred by the emotional health program, there was a $3 return in increased productivity.

Many of the nation's largest companies have learned that

mental health benefits save the company costs by lessening absenteeism, increasing productivity and decreasing the number of on-the-job accidents. Some have found that medical--surgical benefit costs decrease when mental health benefits are used.

The Business Group concluded: "...insured mental health benefits prove a very effective cost-containment tool since they seem to cause reduced utilization of hospital-medical--surgical benefits which are more expensive." (See Appendix B)

The Hospital Response: Answers to Common Questions

Misconceptions about mental health insurance benefits are as common as the myths surrounding mental illness. Presented here are some of the most frequent concerns posed by employers and benefit consultants. You may find these answers helpful in your community. You may also strengthen the validity of this information with examples and data from your hospital.

Q: My company has never had extensive mental health benefits. Why should we change now?

A: Take a good look at your current employee usage of regular medical-surgical benefits. Compare them to the regional and national average for your industry. You may find some startling statistics.

Often, employees who do not have mental health benefits and who suffer from a mental illness use their medical-surgical benefits to cover but not treat their diseases. According to the medical director of IBM, almost one-half of all patients seen in the corporation's medical departments have some complaint that is emotional or psychiatric in nature. A high rate of medical office visits, prescriptions for blood pressure and tension pills, backache and migraine pain, and an unusual number of personal accidents are all covered by medical-surgical insurance benefits -- and are all symptoms of mental illness.

Q: My company offers 30 days of inpatient coverage for mental illness. That's not as good as our coverage for physical illness, but 30 days is a lot of time in the hospital, isn't it?

A: While a 30 day limit on psychiatric care may seem reasonable for many adult diagnoses, this limit can place a substantial burden on an employee or his family when his particular diagnosis requires more intensive care. For /a 7

instance, 30 days of inpatient treatment per year effectively eliminates adequate treatment for children and adolescents. On the average, children and adolescents require 128 days of care in the private psychiatric hospital. The limit of 30 days, while it may be adequate for many adults, does not provide for unusual situations.

Q: Why shouldn't my company give a benefit everyone uses, like dental or eye care, instead of expanded mental health coverage?

A: Providing the costs of routine care for any specialty is one sign of a generous employee benefit package.

Health insurance is there to help the employee who may need financial assistance with an extraordinary cost to keep himself or his family healthy. That is what mental health insurance should do: cover the extraordinary medical costs. No employee should be given the costs of routine care and give up assistance with the tremendous financial burden that goes with any hospitaliation.

Health benefits are not given on the basis of proclivity to use them. After all, your employees are protected from cancer, heart disease and respiratory ailments -- whether or not they have these conditions. For the very few who do require these benefits, they are life savers. It is the same with mental health benefits.

Q: Do my workers really need these benefits? I've never heard of anyone using or asking for psychiatric care in my office.

A: That may be true. According to the New York Times, 15% of Americans who have mental health insurance benefits pay for their psychiatric care out of their pockets because they fear work reprisals or do not want their coworkers to find out about their illnesses.

No employee should have to pay for the total cost of necessary hospitalization because his disorder is an unpopular one. Insurance benefits are designed to cover extraordinary medical costs, regardless of the stigma attached to the illness.

Q: My business offers an employee assistance program. Doesn't that take care of my employees' psychiatric needs? Why do we need insurance coverage?

A: Progressive companies support employee assistance programs as an additional benefit for their employees. The EAP provides on-site counseling and consultation for a variety of psychological and personal problems, including marital and family difficulties, financial concerns, and drug and alcohol problems. An EAP, however, is usually a time limited consultation. No company's EAP counselor can be expected to handle a serious psychiatric disorder. The EAP counselor is well equipped to pinpoint psychiatric illness, and is the right person to refer the employee for further treatment.

If it is necessary for the employee to seek further treatment for psychiatric illness, insurance benefits are a must. Your employee will know there is no reprisal from the company for his illness and that he will not have to carry the financial burden alone.

Providing an EAP without appropriate inpatient psychiatric benefits is like providing an aerobics class for your employees but no benefit to the employee who suffers a heart attack.

Q: How often will the same employee need psychiatric hospitalization?

A: While some psychiatric illnesses can be chronic, the most prevalent of all adult psychiatric illnesses are not. Usually, one hospital stay with appropriate follow-up care is all that is necessary.

Unfortunately, the popular image of psychiatric care is the treatment of the schizophrenic. A chronic disorder, schizophrenia is one of the most studied but still most mysterious, disorders; however it is not the most common, and is certainly one of the most rare in America's employed population. Only 15 percent of those persons treated in private psychiatric hospitals in 1981 were diagnosed as schizophrenic.

Q: If coverage for psychiatric illness is such a cost effective investment, why aren't more companies offering it?

A: Many of the nation's leading employers are! In the 1981

Hay Huggins study of 663 national employers, 66.2 percent offered the same coverage for inpatient mental illness care as for physical care. Only 16 firms had coverage of less than 60 days. In a 1982 survey by the American Psychiatric Association of 100 major companies, 42 offered at least 90 days of inpatient psychiatric treatment per year. The nation's largest employers have acknowleged the difference insurance against mental illness can make, and provide extensive inpatient benefits for their employees.

Q: How much does a typical mental health benefit cost?

A: The cost of the benefit depends on the specifics of the group being insured. Some generalizations can be made, however. A survey of 79 major corporations in 1980 showed that the average annual per capita cost of the mental health benefit was $29.47, with a range of $4.34 to $78.00 per year. Obviously, the range in benefits offered was also great.

In 1979, the cost of the generous federal government program, which included full inpatient coverage for 365 days a year, was about 50 cents a week per person, or $1.30 for a family. According to figures for 1982, inpatient coverage of 365 days would cost $100 per year per worker.

Q: I've heard that psychiatric hospitals keep patients until their health insurance benefits run out. Can insurance be abused like that?

A: Hospitals are in the business of patient care and recovery, not of using up insurance dollars.

By the third day of every patient's hospital stay, the hospital is already planning for the patient's discharge. The hospital establishes criteria that will determine when the patient can return home based on the patient's condition and diagnosis. The hospital also looks at alternatives to hospitalization.

Private psychiatric hospitals have as their primary concern the welfare of the patient. That is what determines when the patient is ready to leave the hospital.

Q: Isn't any discussion of mental health insurance benefits by psychiatric hospitals a little too self-serving? Aren't you just trying to raise your occupancy levels?

A: No. The point of the discussion is patient care. Employers should know that the benefits they provide for the mental health care of their employees are important not only for employee health, but for the health of the company. Employers should know that they can expect high quality service from the private hospital.

Most importantly, employers must understand that employees will not express their mental health needs. There is still a great stigma on the person who seeks psychiatric care. Discussions with employers about the need and benefits of this care will help the mentally ill.

(It may be pointed out that the national average daily occupancy rate for private psychiatric hospitals is 86.3 percent.)

The Hospital Response

> It is clear that the employer will have increasing involvement with treatment for mental illness and its outcome with working people. The employer is the middle man for his workers. He will be the prudent buyer of the best services for the available dollars and will be in the role of negotiating with the psychiatric hospital to supply these services. The key to the success of this venture lies in the willingness of the hospital to meet the employer halfway. (Lawrence S. Brody, M.D., The Psychiatric Hospital, Summer, 1982)

The National Association of Private Psychiatric Hospitals (NAPPH) has developed a national campaign to inform corporate leaders, benefit consultants and insurance carriers of the need for and benefits of health insurance coverage for psychiatric illness. This message needs to be brought to the business leaders in your community. Your hospital serves as the model of private psychiatric hospitalization for your community. By including in your discussions with business leaders a dialogue on the need for insurance coverage for hospitalization for psychiatric illnesses, you will safeguard your community's future health.

Included here are samples of actions already being taken by private psychiatric hospitals. Many other ideas will come to mind as you discuss with your staff your community's special interests and needs.

Your hospital should consider taking some of these actions, if they are not already a part of your community relations or marketing efforts.

1. Develop a mailing list of local businesses and include the titles of vice president or manager of employee benefits, the chief executive and chief financial officers, the medical director or occupational health director and the employee asssistance director. Use this list for your external newsletter, new clinical program information or brochures and special educational programs. The Chamber of Commerce can provide you with the names of major employers in your area.

Some newspapers or regional magazines also keep this information.

2. Become familiar with the main business groups in your community, including the Chamber of Commerce. Get a top administrative or clinical staff member to join these groups. Try to secure speaking engagements during the organizations' meetings. Work on program planning committees where your mental health expertise can offer a fresh perspective to business topics. The Kiwanis, the Rotary and the Lions Club are examples of voluntary groups whose leadership is predominantly business executives. A good relationship with these decision-makers gives your hospital the opportunity to show how valuable mental health services are.

3. Become involved with your local or regional business coalition on health. (The NAPPH Department of Socio-Economics can give you the name of your nearest coalition.) Learn the coalition's objectives and work with the group. These coalitions are forums for business discussion on health care costs. Your hospital should provide information about psychiatric services to the coalition members, and work with them on gathering new data, examining problems and finding opportunities. While it is too early in their development to know whether coalitions will become a major force in the provision of health care options, they are definitely an opportunity to learn about the business perspective of psychiatric care and to educate business leaders.

4. Consider making clinical staff available to area businesses on a consultative or educational basis. At least 80 NAPPH member hospitals are offering educational workshops tailored to business in areas covering occupational stress, management development, confronting the alcoholic employee and retirement planning, to name just a few. Seventy NAPPH members are providing on-site consulation to businesses either by direct counseling of employees or by services to management. These services include management education in motivation, team building and effective communications.

Your hospital may wish to charge for these services, or provide them gratis to area business. This depends on your particular situation and the business climate in your community. Member hospitals have offered some management consultation and one or two training sessions without compensation in order to establish strong ties to the business. Then, if more services are needed, a fee arrangement is devised. Other hospitals feel very strongly that business is used to paying for services and does not value services it receives for free.

Some hospitals have developed their industrial and business relationships into hospital-sponsored employee assistance programs. (See Appendix C)

Whatever the extent of your hospital's involvement, it is essential that your hospital become familiar with the employers who provide health insurance for workers in your community.

5. If your hospital offers alcoholism treatment, involve your clinical or administrative staff in the Association of Labor-Management Administrators and Consultants on Alcoholism, Inc. (ALMACA). ALMACA, a national organization, offers many opportunities to discuss with business and labor the problems employees are experiencing, including those psychiatric problems that go beyond alcoholism. The group understands the need for treatment of mental disorders and is an excellent resource.

6. If your area businesses are unionized, talk to the business agents of the major locals. Explain your hospital's services to them and to their members. According to national union offices, the unions' primary concern is patient confidentiality. Explain the systems that are in place to assure confidentiality for all patients. Remember that union leadership has long supported mental health insurance benefits and has a good understanding of the need for psychiatric care.

7. Don't forget that your hospital is a business, too. Your administration can speak with business executives as business managers. You can understand the business need to maintain a level of high quality production. Your hospital shares many of the same problems that face business: absenteeism, morale difficulties, on-the-job accidents. You can also explain that providing mental health services to employees in need is a way of cutting the costs of many of these problems. Being regarded as a business by other business executives puts the hospital in an advantageous position.

8. Be responsive. Treat local businesses as you would a valued referral source. When a local business requests a service, offer what you are able in a timely manner and be prepared to suggest another source if your hospital cannot handle the request. When you begin to develop a liaison with an area business, be prepared to maintain the contact. It may be helpful to think of your contacts with business in the same manner a salesman thinks of clients.

In an NAPPH telephone survey of businesses chosen at random around the country, the primary complaint about private psychiatric hospitals was that clinical staff, especially physicians, do not return telephone calls. This complaint was cited more frequently than the cost or length of care, difficulty with medical records or after-care provisions, yet it is the simplest to correct. Understanding what is valuable to business in your community will help your staff be more responsive, without creating an unworkable system.

Some NAPPH member hospitals have assigned one staff person, often the after care coordinator, as the key contact with businesses that refer patients. This system seems to work well. The contact takes all calls from business regarding the hospital or the care of an individual patient. The contact also routinely calls on business executives and handles any difficulties they may be having with the hospital, from obtaining information to working with third party carriers.

Establishing and maintaining good relationships with business is not an option for your hospital to consider in a long range plan. You must make your hospital an active participant with business <u>now</u>, so that inpatient psychiatric care remains a viable part of every employee's health care coverage. This is a task that no one else can do. Only your hospital can create a full and accurate understanding of the high quality care you provide. Your hospital probably has already completed this task with the medical community, mental health professionals, school systems, clergy and other traditional referral groups. Now it is time to take this message to the people who play such a significant role in the provision of health care insurance, an act that allows many people in your area to receive private psychiatric care: the businesses of your community.

If you have any questions, need additional infomation or desire assistance in beginning your contacts with business contact:

Eileen Dutka Demko, Director of Public Relations, National Association of Private Psychiatric Hospitals, 1319 F Street, N.W., Suite 1000, Washington, D.C. 20004, telephone number (202)393-6700.

APPENDIX A

TRENDS IN NEW GROUP INSURANCE PLANS 1976-1981

(Groups with 25-499 Employees)

Data taken from the 1981 survey of New Group Health Insurance Policies issued by insurance companies, done by the Health Insurance Association of America. The survey covers 4,120 new cases written between January 1 and March 31, 1981, by 33 companies, accounting for more than 63% of insurance company group health insurance premiums written in 1980. It includes 1,134,788 insured persons.

The analysis given below focuses on employees in groups of 25 to 499 in order to guard against distortions that could result if any one survey period included either too many small cases or one or two extremely large cases.

A "new case" is defined as one underwritten for the first time or if previously issued, one that has had hospital-medical, dental, major medical or disability income benefits added.

Coverage	Percentage of Employees	
	1976	1981
Dental, combination or comprehensive	17%	35%
Maternity	65	97
Short term disability income insurance	25	47
Long term disability income insurance (with monthly maximum of $2000 or more)	21	72
"All reasonable and customary" surgical charges	12	53
Full hospital charges for "mental and nervous disorders"	64	66

Psychiatry and Industry: A Business View

Willis B. Goldbeck

Introduction

Throughout the history of employee health benefits, the human mind has been treated as a second class citizen. Management and labor attitudes, insurance design, and provider behavior have compounded the more general social stigma that places a false distinction between problems of the mind and those of the body.

Since the mid-1970s, major U.S. employers have become increasingly aware of the need to give greater priority to emotional problems. This recognition has resulted from a convergence of concern for the overall escalation of medical care costs with growing evidence that well designed mental health benefits can contribute to cost management while improving quality of care.

During the next decade, it can be reasonably predicted that mental health will receive unprecedented attention. Insurance is expanding; model programs are increasingly available; research is confirming an expanded number of benefits that can derive from the prevention and treatment of emotional problems; scientific, academic, and anecdotal evaluations are demonstrating the cost and quality effectiveness of various programs; and demographic and economic pressures clearly are increasing the emotional stress with which millions of Americans are trying to cope. Finally, the individual and collective consumers are becoming increasingly demanding of provider accountability and increasingly sophisticated about the need for well designed and managed health benefits that do not discriminate against mental health.

Mr. Goldbeck is executive director of the Washington Business Group on Health, Washington, D.C.

Holism, A Positive Trend

For some, the holistic health movement is derisively characterized as fruit, nuts, carob, yoga, and meditation. For many, and for an increasingly large number of employers, the philosophy inherent in holism and, yes, even those same elements mentioned above, are gaining greater acceptance. For psychiatrists, psychologists, and social workers, the holistic approach is an extremely beneficial development as it is predicated on the body-mind, rather than the body and the mind.

Not surprisingly, this development, viewed as beneficial for many, also is threatening for some more traditional providers. What was once the protected province of psychiatrists is now an increasingly open field with players from the ranks of psychologists, social workers, healers, experts in biofeedback and transcendental meditation, and other wellness practitioners.

Nonetheless, the holistic trend does appear positive. The sorting out that undoubtedly will occur in the next decade will itself be a healthy response to the long overdue recognition of the need to come to grips with emotional problems at all points on the illness-wellness continuum.

New Directions in Mental Health Benefits

Contrary to some reports, the new directions are not in traditional insurance, although the scope of coverage there also is increasing.

"The image of the worker as 'Macho Man,' able to cope with any problem, is being drowned in a sea of alcoholism, drug abuse, legal, marital, and financial problems that are, at best, detrimental to productivity, and, at worst, destructive of life itself."

Innovations of lasting importance are taking place in: *a)* new definitions of benefits, *b)* new insurance designs, *c)* new structures for corporate programs, and *d)* new recognition of the various ways the work setting can contribute to both the cause of and recovery from emotional problems. For mental health programs offered by employers to be genuinely successful, both management and labor must accept some new definitions of health which challenge long held values.

The image of the worker as "Macho Man," able to cope with any problem, is being drowned in a sea of alcoholism, drug abuse, legal, marital, and financial problems that are, at best, detrimental to productivity, and, at worst, destructive of life itself. Between these two lie a plethora of wasted days off from work, wasted medical care utilization, and wasted compensation that should be applied to real needs. Inherent in this new awareness of personal problems is the risk of blaming the victim when, in fact, the working conditions or, more broadly stated, the corporate culture may well be a contributing factor.

Corporate programs are moving in-house through the employment of staff psychiatrists, psychologists, and social workers. Simultaneously, insurance is starting to focus on the front, or prevention, end of the scale through the provision of innovative plans such as that designed by John Armer in California. There, easy access to appropriate levels of counseling and an educational program are combined with peer review and a system of economic incentives to achieve a balance between the need for care and the need to avoid abuse. Not only has the program been successful, it also has reduced dramatically the utilization of costly hospital and surgical care.

An often overlooked aspect of the relationship between mental health and industry is the provision of job programs specifically designed for the mentally restored. As the pressures of deinstitutionalization have mounted, the value of an association between a mental wellness support system and participating employers is made more evident.

Fountain House, in New York City, is an example of a successful transitional employment center that matches industry's employment needs with the productive skills of the mentally restored. Companies such as Sears and American Express, and unions such as the AFL-CIO have found that these programs provide them with workers who experience lower rates of turnover and higher levels of productivity than did the so-called normal workers doing the same tasks.

Finally, corporate medical plans are being redesigned to reflect the latest research. For example, the *American Journal of Public Health* reported in February (1) that "13 studies showed, on the average for surgical and coronary patients, psychological intervention reduced hospitalization approximately two days below the control group's average."

The Bottom Line

For those who desire to reduce the discrimination against mental health problems, the issue of escalating health care costs is a positive development. At the very time when employers' attention to the cost problems is at its peak, the value of providing well designed mental health benefits is becoming more evident.

Most of the leading corporate programs were started without any hard evidence of the possible return on investment. They were started because it was common sense to do so. Walter Wriston, chief executive of Citicorp and former chairman of the Business Roundtable Task Force on Health, speaking to a WGBH/Boston University conference said:

> When a manager sees absenteeism rising or coronary events increasing, he or she knows that it is not only a human problem but a business challenge. Setting up mental health services to remedy these human problems and restore these employees to full productivity is a rational and legitimate business decision. The more sensitive such programs are to early detection, the better—for the employee, the company, and the whole society.

Further, there were increasing accounts of the cost to industry for alcoholism (now in excess of $50 billion annually) and stress. The National Institute of Occupational Safety and Health (NIOHS) published a provocative estimate for the cost of executive stress (Table I).

Today's corporate manager has much more evidence to go on:

- Weirton Steel reports that 61 percent of its absenteeism is due to psychiatric problems.
- Kennecott Copper Company's "Insight" counseling program reports a 53 percent reduction in absenteeism and 55 percent hospital/surgical/medical reduction.

- The California Psychological Health Plan, a benefit plan added to some insurance policies, reports that users have a 20-24 percent reduction in hospital/surgical/medical utilization.
- Blue Cross of Western Pennsylvania reports that for 136 persons who used insured outpatient psychiatric benefits, medical costs dropped from $16.47 to $7.06 per month.
- Group Health Association (a Washington, D.C., health maintenance organization) reports that users of mental health counseling benefits reduced their non-psychiatric physician visits by 30.7 percent and lab/x-ray services by 29.8 percent.
- General Motors' alcoholism program reports a 49 percent reduction in lost work hours and a 29 percent reduction in disability costs.
- Bethlehem Steel has a 60 percent rehabilitation rate in its alcoholism program.
- Kimberly Clark's employee assistance program showed a 70 percent reduction in accidents for the year after participation as compared with the year before.

Stress management in industry also is developing a fine track record. Although research is needed, stress management techniques have shown promising results related to productivity in the following areas:

- Improved clarity of thinking,
- Improved concentration,
- More appropriate reactivity (e.g. reduced irritability, anger, and/or anxiety),
- Elimination of writer's (or thinker's) block,
- Decreased turnover,
- Improved self-esteem,
- Increased creativity,
- Increased personal satisfaction.

TABLE I
Cost of Executive Stress

	Conservative Estimate	Ultraconservative Estimate
Cost of executive work loss days (salary)	$2,861,775,800	$1,430,887,850
Cost of executive hospitalization	248,316,864	124,158,432
Cost of executive outpatient care	131,058,235	65,529,117
Cost of executive mortality	16,470,977,439	9,856,064,119
	$19,712,128,338	$11,426,639,518

Source: NIOSH

"Employers will allocate more resources to mental health when the professional societies stop fighting over reimbursement (always in the guise of quality) and start working together for a truly comprehensive system."

Relaxation therapy has its corporate converts:

- *New York Telephone Company* conducted a study of the effectiveness of three types of relaxation responses. One hundred and fifty-four volunteers who experienced symptoms of stress were randomly assigned to four groups: clinically standardized meditation, respiratory-method meditation, progressive muscle relaxation, and a waiting list group that served as a control. After five-and-a half months, all four groups demonstrated a reduction in symptoms. However, employees participating in the meditation relaxation groups showed significantly greater symptom reduction than the control groups.
- *Converse Rubber Company* permitted a study that demonstrated that "relaxation response" breaks were feasible in the course of the work day. These breaks were associated with improvements in general health, performance (physical energy, strength of concentration, ability to handle problems, and overall efficiency), and well being, and with a lowering of blood pressure.

Transcendental meditation (Transco and Bon Ami), biofeedback (Standard Oil of California, Rochester Police Department), and the provision of psychiatric and psychological counseling in conjunction with job selection (Mobil Oil) are just some of the other applications of an increasingly mental wellness approach to work life.

Together, these pioneering programs all point to a few key factors: *a)* Today's world and the pressures of most work environments produce stresses that affect all of us to degrees not previously acknowledged. *b)* For the average employee, help with coping skills is a far greater need than more sophisticated inpatient psychiatric care. *c)* While there is still much to learn, there is no longer any doubt about the imperative need to provide well designed mental health benefits.

Issues

Even in this emerging field, we know enough to identify several key issues that impede the overall effort to meet the priority mental health needs of industry.

- Employers will allocate more resources to mental health when the professional societies stop fighting over

"We must develop and then support a truly societal approach to mental health that makes deinstitutionalization a managed objective, not a fad; that addresses all levels of mental health needs; and that takes a long-term approach to cost effectiveness measures."

reimbursement (always in the guise of quality) and start working together for a truly comprehensive system.

- Employers and psychiatrists of good conscience should oppose all attempts to exempt the profession(s) from the jurisdiction of the Federal Trade Commission. State licensure is not a substitute for the consumer protection responsibilities of the FTC. Granted, the agency can use some reform. Under Chairman James C. Miller, III, reform is assured. No profession should be so presumptuous as to designate itself above the obligation of the federal government to protect the public. And few professions or businesses have ever given consumers so many reasons to need protection as have the medical professions. From the employer's perspective, the FTC is a vital link in the strengthening chain of cost management and pro-competitive forces.
- Employers need to offer programs that involve the whole family. To fail to recognize the interdependency of problems that are manifest at the worksite with their counterparts at home is to fail to understand mental health.
- As government reduces its commitment to mental health, industry will be paying an increasing price through cost shifting and the high cost of neglect. We must develop and then support a truly societal approach to mental health that makes deinstitutionalization a managed objective, not a fad; that addresses all levels of mental health needs; and that takes a long-term approach to cost effectiveness measures.

Conclusion

Let me close by making clear the biases our experience has developed:

a) There is no way to avoid the cost of mental illness.

b) The economic and humane interests are identical for the public and private sectors' employers.

c) Mental health benefits are costly, but not so costly as trying to avoid meeting real needs.

d) Abuse of mental health benefits is primarily the result of poor benefit design.

e) There is no medical, social, political, or economic excuse for sustaining the traditional discrimination against providing care for the unique and most important part of our total person: the mind ■

References

1. Mumford E, Schlesinger H, Glass G: The effects of psychological intervention on recovery from surgery and heart attacks: an analysis of the literature. American Public Health Journal 72(2):141-151, 1982

Working with Industry: A Challenge to Psychiatry

Edward A. Ross

The challenge to psychiatry at this time when industry seems to be shifting its attitude about mental illness is to take advantage of the opportunities, aggressively pursue the mental health programs in which industry and business can relate, and examine itself as a profession. Psychiatry must become a profession in which industry can have confidence and to which it is willing to turn for assistance with difficult people problems. Industry must be able to embrace psychiatry as an ally in its struggle to protect its investment in "human capital."

The attitude of American industry toward its employees clearly seems to be in a period of flux. At one time in our history an employee was considered to be little more than equipment: When it breaks down, replace it. In fact, equipment has been a little better off in that it, at least, has been repaired and maintained for the length of its useful life before being discarded. Employees have not fared quite so well—when productivity lags, they have been cast aside.

Today, however, more companies seem to be willing to consider the costs that are associated with recruitment, training, salary, and benefits as an investment as well as an expense—an investment no different from the equipment purchased for the employees' use. Consequently, more companies are attempting to establish programs to give their employees the same opportunity to serve a full and useful life as they have given their equipment. Since 1970 the percentage of Fortune 500 companies that have programs for this purpose, including the 250 leading banking, insurance, utility, transportation, and financial organizations, has increased from 25.2 to 56.7 (1).

With the attitude of industry in general being one of concern about such issues as productivity, absenteeism, employee morale, and the provision of a generally pleasant working environment for employees, more and more companies are paying attention to the human variable within all of these factors. When the human element comes under scrutiny, the psychiatric profession should be an integral part of the team doing the scrutinizing and making recommendations for change. When the psychiatric profession is *not* a member of that team, the emotional needs of the employees often go unmet or totally ignored. As an example, many companies already have developed and are aggressively marketing "employee fitness programs" in hopes of improving the general health and well being of their employees. Some have gone as far as hiring physical fitness experts to design gymnasiums, tracks, and complete health care facilities within which employees are offered individualized programs. Some also include, as an integral part of the program, stress management seminars and stress testing.

As far as these programs go, their efforts are significant and deserving of a round of applause. However, they are primarily aimed at the physical health of the individual, leaving mental health issues unresolved. Most fitness programs developed thus far ignore the emotional, psychiatric, substance abuse, spouse abuse, and other "personal" problems that can and obviously do debilitate so many people. One notable exception is the program developed by Kimberly Clark, Inc. In this company's program the physical and emotional elements are coordinated under a single umbrella.

Mr. Ross is administrator of Lakeside Hospital in Memphis, Tennessee.

"Psychiatry must become a profession in which industry can have confidence and to which it is willing to turn for asssitance with difficult people problems. Industry must be able to embrace psychiatry as an ally in its struggle to protect its investment in 'human capital.'"

The challenge to psychiatry, then, is to become involved at the initial stages of development of physical fitness programs and to convince the employer to expand the program umbrella from the outset to include the mental health issues that so significantly affect what industry is most concerned about—productivity, absenteeism, employee morale, and loyalty to the company. Most psychiatrists are not particularly interested in becoming medical directors of large corporations; conversely, most corporations are not interested in having a psychiatrist as medical director. Consequently, the psychiatric profession must develop other avenues through which to relate to industry and, indeed, provide exactly what industry is searching for but cannot seem to find. Perhaps the single best vehicle through which psychiatry can establish and maintain workable and useful relationships with industry is through employee assistance programs.

Employee Assistance Programs

The history of employee assistance programs (EAPs) is based solidly in the alcoholism portion of the large "mental health umbrella." As EAPs continue to be developed, however, more and more recognition is being paid to factors other than alcoholism which affect the employee on the job. Innumerable variables affect a person's work performance, and each individual develops his or her own pattern of operation. As the variables in the individual's life change, the patterns of work performance change. If the variables that change happen to be emotional, behavioral, or stress related, industry is ill equipped to deal with the related work performance changes. Often the pattern that develops between a supervisor who is attempting to deal with an "emotionally disturbed" employee through threats, traditional disciplinary procedures, or shade tree counseling serves only to mask the problem for a period of time, after which it will again emerge. The cyclical pattern that evolves becomes an extremely costly one for the employee, the supervisor, and the company. A seemingly logical response to this cycle is intervention by the psychiatric profession at the root of the problem, which is the "emotional disturbance."

The expanded scope of employee assistance programs enables the employee whose work performance is substandard due to problems other than alcoholism or drug abuse to receive appropriate care. However, this expansion is only the first step the psychiatric profession can make toward enhancing its relationship with industry.

The employee assistance concept leads directly to the concept of fitness. The concept of organizational fitness includes traditional organization and development and the newer idea of diagnosis and treatment of organizational problems, which, incidentally, most often fall within the broad scope of communication, employee assistance programs, and employee relations. The psychiatric profession has the expertise necessary to address these difficult issues and to assist industry in developing and maintaining "well" organizations within which "well" employees can work.

When faced with problems in these areas, psychiatry in general and psychiatric hospitals in particular should be the first places to which industry can turn for assistance. Issues such as communication, employee relations, and organizational fitness are all related to people and people problems. No other profession is better equipped to deal with difficult people problems than psychiatry.

In order to protect its investment in "human capital," industry must have the assistance and expertise that psychiatry possesses. However, business has long perceived psychiatry as academic, intellectual, to some degree magical, and often for women only. The onus, then, is on psychiatry to determine whether it wishes to provide that which industry is seeking. In other words, an exchange relationship must exist which requires change on the part of the psychiatric profession. We must be able to commu-

"The challenge to psychiatry...is to become involved at the initial stages of development of physical fitness programs and to convince the employer to expand the program umbrella from the outset to include the mental health issues that so significantly affect what industry is most concerned about—productivity, absenteeism, employee morale, and loyalty to the company."

nicate to industry in a way that illustrates an understanding and acceptance of concern for "the bottom line" and "return on investments," and we must give assurances that we can help accomplish both.

One Hospital's Model

In an attempt to address this specific issue, one private psychiatric hospital, Lakeside Hospital, Inc., in Memphis, Tennessee, has established a subsidiary to develop communication channels for the purpose of describing to industrial employers in that hospital's area how the psychiatric profession can go about helping them increase their bottom line and return on investments. The subsidiary offers a four-pronged approach that consists of *a)* the development and operation of employee assistance programs; *b)* oragnization and development, including training for individuals as well as for groups within the organization; *c)* psychological testing and assessment, including pre-employment screening, career assessment, and career planning; and *d)* relocation counseling.

The four prongs of the program address all of the "people problem" areas with which an industry most often finds itself in difficulty. The EAP obviously addresses the "problem employee"; training and development address communication problems—upward or downward, lateral organizational structure, specific management development, and the general wellness of the organization itself. The psychological testing can operate as an assessment tool for the employee assessment program or as a tool for specific employees. Pre-employment screening, career assessment, and career planning all relate to employee relations and employee development. Relocation counseling relates directly to employee relations and the stress that often is associated with transferring an employee from one city to another. The umbrella of organizational fitness, in the first year of operation of the program, has been extremely well received by the organization and has resulted in a number of contracts for total programs as well as contracts for specific components, i.e. training and development.

Companies that have had employee assistance programs for a number of years often report that their return on investment is as high as 150 to 170 percent. Johns Hopkins University completed a three-year study on 12 companies collectively employing 134,000 persons (1). The results of the study indicated that in the first year the collective investment in employee assistance programs was $230,000 and the collective savings was computed to be a return of $450,000. In the second year the investment remained the same with a return of $600,000; and in the third year, with the same investment, a $1,000,000 savings was projected. Companies that are using the organizational fitness approach are recognizing return on investment at an even higher level. It is not surprising, therefore, that industries in other cities and states are beginning to request services along this line.

"Through aggressive marketing of the organizational fitness program and the provision of a service that is responsive to industry's needs, we have seen the increasing acceptance of psychiatry as a helping profession rather than as a 'suspicious' one."

A significant development resulting directly from the establishment of the Lakeside program has been the increased communication between the psychiatric hospital, psychiatrists, and other mental health professionals with the industrial community. Setting up these programs, however, requires that industrial and psychiatric representatives consider issues involving confidentiality and the transfer of information. Some reporting mechanisms do not require that confidential information be released, while others require a careful review of what information should be released and by whom. The requirements of information exchange differ from company to company, making the face-to-face interaction imperative. The end result is a better mutual understanding. Through aggressive marketing of the organizational fitness program and the provision of a service that is responsive to industry's needs, we have seen the increasing acceptance of psychiatry as a helping profession rather than as a "suspicious" one.

Conclusion

The psychiatric profession must aggressively pursue programs to which industry and business can relate and must establish itself as a profession in which industry can have confidence and can embrace as an ally in the struggle to protect its investment in "human capital." Should psychiatry fail to meet the challenge of pursuing such programs and establishing the all important link with the industrial community, the outlook for a strong and viable profession becomes bleak and discouraging. The challenge is at hand; the time is now; the choice cannot be delayed.

References

1. Roman PM: Executive Caravan Survey. New Orleans, Tulane University, pp 88-90

APPENDIX D

SUPPLEMENTAL INFORMATION

While many articles have been written on the problems and benefits of insurance for mental illness, a few studies often are used as reference. The most common are listed below.

1. Reed, Louis S., Ph.D.: Coverage and Utilization of Care for Mental Conditions Under Health Insurance, American Psychiatric Association, August 1975.*

Includes the study of the federal Blue Cross / Blue Shield plan for federal workers, with costs, utilization experience, summary of benefits paid, etc. This is the study on which many arguments for insurance benefits for psychiatric care are based.

2. Sharfstein, Steven S., M.D., Taube, Carl A.: Reductions in Insurance for Mental Disorders: Adverse Selection, Moral Hazard, and Consumer Demand, American Journal of Psychiatry, Vol. 139, No. 11, November 1982.*

The arguments against insurance for mental illness, including a call for psychiatry to develop more effective approaches to public education on the nature of mental illness and its treatment.

3. Jones, Kenneth R., M.Div., M.A., Vischi, Thomas R., M.A., M.C.P.: Impact of Alcohol, Drug Abuse and Mental Health Treatment on Medical Care Utilization, Alcohol, Drug Abuse and Mental Health Administration, December 1979.

This is an exhaustive compendium of studies done throughout the 1960s and 1970s. This group is most often used to "prove" that medical-surgical costs decrease when psychiatric treatment is available. Private psychiatric hospitals should note that only one of the 25 studies--Blue Cross of Western Pennsylvania--was done outside the confines of a pre-paid plan or health maintenance organization. Emphasis in all studies is on the effect of outpatient psychiatric care.

Reprints can be obtained by writing to the Division of Treatment, Office of Program Planning and Coordination, ADAMHA, 5600 Fishers Lane, Rockville, Maryland 20857.

4. Employee Mental Wellness Programs, Washington Business Group on Health, June 1979.*

A review of the wellness programs sponsored by national businesses and corporations, including utilization, benefits, and problems.

5. McGuire, Thomas G., Montgomery, John T.: "Mandated Mental Health Benefits in Private Health Insurance," Journal of Health Politics, Policy and Law, Vol. 7, No. 2, 1982.*

A comprehensive look at the issue of mandated mental health benefits, including an analysis of the benefits and costs of mandates for psychotherapy.

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*Copies are available from the NAPPH Department of Public Relations.

PO Box 82668
Fairbanks, Alaska 99708

Rep Navarre

Rep. Mike Davis and Members of the
Labor and Commerce Committee
Alaska State Legislature
Juneau, Alaska 98801

Dear Representative Davis and Committee:

I am sorry that there was not time to hear my testimony at today's hearing on HB 313, but I am submitting this as written testimony of the need for the passage of the bill or one similar but more comprehensive.

I have no particular expertise in insurance matters or psychiatry, but I do have the experience of a lifetime of watching my mother juggle the budget and checking coverages on the large number of insurance policies that she paid for to ensure reasonable and human care for my father, who is chronically mentally ill. Now that my mother is dead, I have had to learn of the "lifetime allotments" and the minimal yearly limits of mental health care that these policies allow my father. I also have watched my younger sister struggle with a similar but milder form of the illness, which is thought to be, and apparently is, hereditary. Both my father and sister suffer from manic depression, an illness that is cyclical but chronic. In other words both have been productive and creative individuals, who have worked and paid taxes and for health care insurance. Unfortunately both periodically are in need of intensive medical care and supervision. At these times, our family experiences not only the pain of seeing a loved one in torture, but also a frantic search to be sure that there are means of insuring adequate and appropriate treatment. In my sister's milder case, her savings and ours are used to provide medication, a doctor's supervision, and thus far in-home care. Her health insurance does not pay for those episodic periods of care nor for the interim outpatient consultations that allow her to keep on an even keel or be productive. At these times she must go on leave without pay from her job, so she has always gone to work again with financial stress that she doesn't need in her periods of recovery and that are often alleviated by other family members' contributions.

My father's situation is more severe and complicated by the fact that he is elderly now. In a year that my mother was treated for cancer at a cost of $60,000, all of which was paid for by her insurance policy, my father was hospitalized for severe and psychotic depression, administered shock treatments, and presented for a bill for $40,000. Fortunately the doctors who treated my father could legitimately find physical complications that could justify hospitalization and many of the charges could be presented to his insurance company and Medicare, so we were spared the impossibility of covering all of these enormous bills in the same year that we lost my mother. However, if it had not been the fact that my father was so advanced in age and his depression caused so much physical detrioration, I don't know what we would have done. Because my father does have lengthy lucid periods and can be treated successfully temporarily, we have resisted making him a ward of the state and placing him in a state institution. If we had not been able to have this care in part paid for by insurance, we would have had no choice.

Although all of this took place in another state, I am surprised that Alaska

where most workers have an incredible array of insurance benefits, has not already passed a bill of this nature. Dozens of adult people in Fairbanks that I know are able to straighten their teeth under their employee health insurance policy but none would be covered sufficiently or at all if they were to face a severe mental disease.

Psychiatrists and physicians are increasingly pointing to physical bases for chronic mental illness. A recent book THE BROKEN BRAIN by Nancy Andreasson is a succinct summary of the physical roots of schizophrenia and manic depression. The treatments in current use also are based on the assumption that there is a physical basis for these diseases. Drugs and shock treatments are used, rather than psychoanalysis. There is still not a cure for these conditions but there have been some moderately successful treatments. Comparing my mother's cancer and my father's mental illness and the ways and settings for treatment, I could not see a major difference. There was not a cure for the type of cancer that struck my mother, but she was cared for without regard to cost with the knowledge that the expenses would be covered. My father received lengthy and extensive care also but in his case, we held our collective breaths because we couldn't be sure what his bill would mean for us.

Mental illness is enough of a burden without the additional punishment of having it treated as an "optional" or "second-class" or unrecognized disease by insurance companies. The stigma and fear associated with mental illness has meant that people in the past have not been able to question these unfair policies, but as more is being learned and publicized about these diseases I don't think patients, their families or the general public will be satisfied with this inequity. Someday perhaps a policy without provision for coverage of mental health care will be like one that covers all conditions and illnesses except kidney stones or broken bones. Thank all of you for your careful consideration of this bill.

Sue Sherif

TESTIMONY OF THE OHIO COALITION

For

ALCOHOLISM AND MENTAL HEALTH INSURANCE

Before

THE OHIO SENATE ELECTIONS, FINANCIAL INSTITUTIONS,
AND INSURANCE COMMITTEE

SENATOR PAUL R. MATIA, CHAIRMAN

IN OPPOSITION TO S.B. 365

OCTOBER 13, 1981

I AM JOHN CORRIGAN, VICE PRESIDENT OF THE FRANKLIN COUNTY MENTAL HEALTH BOARD. I AM ALSO THE CHAIRMAN OF THE INSURANCE COMMITTEE OF THE ASSOCIATION OF MENTAL HEALTH ADMINISTRATORS--A NATIONAL ORGANIZATION OF EXECUTIVE DIRECTORS AND ADMINISTRATORS OF MENTAL HEALTH PROGRAMS. IN THIS CAPACITY I AM WORKING WITH SEVERAL OTHER NATIONAL ORGANIZATIONS TO PROMOTE ADEQUATE HEALTH INSURANCE COVERAGE FOR TREATMENT OF MENTAL AND EMOTIONAL DISORDERS. TODAY I AM REPRESENTING THE OHIO COALITION FOR ALCOHOLISM AND MENTAL HEALTH INSURANCE.

IN THE PAST WEEKS AND TODAY YOU HAVE HEARD TESTIMONY ABOUT TWO PIECES OF LEGISLATION, EACH OF WHICH HAS BEEN PRESENTED AS REPLACEMENT FOR S.B. 90, PASSED BY THE 112TH GENERAL ASSEMBLY. I AM TESTIFYING IN OPPOSITION TO ONE OF THESE BILLS, S.B. 365.

UNLIKE S.B. 90, S.B. 365 MANDATES THE AVAILABILITY OF OUTPATIENT MENTAL HEALTH AND ALCOHOLISM SERVICES BUT DOES NOT REQUIRE THAT THESE BENEFITS BE INCLUDED IN HEALTH INSURANCE POLICIES. THE FACT THAT IT IS NECESSARY TO LEGISLATIVELY MANDATE EVEN THE OPTION TO BE COVERED FOR APPROPRIATE MENTAL HEALTH AND ALCOHOLISM TREATMENT IS TESTIMONY TO THE PROBLEMS OF PEOPLE WHO HAVE NEEDED--BUT DID NOT HAVE--THIS COVERAGE. IT IS INAPPROPRIATE TO DISTINGUISH BETWEEN THESE ILLNESSES AND OTHERS FOR WHICH HEALTH INSURANCE IS PROVIDED.

THERE ARE HISTORICAL REASONS WHY EARLY INSURANCE COVERAGE DID NOT INCLUDE SERVICES FOR ALCOHOLISM AND MENTAL ILLNESS. DURING THE 30'S AND 40'S WHEN HEALTH COVERAGE BECAME WIDESPREAD, EXISTING TECHNIQUES FOR THE TREATMENT OF ALCOHOLISM AND MENTAL ILLNESS WERE UNPROVEN. NOW HOWEVER, WITH ADVANCES IN RESEARCH

AND TREATMENT TECHNOLOGIES, THE MEDICAL COMMUNITY HAS RECOGNIZED THAT THESE SERVICES ARE NOT ONLY EFFECTIVE, BUT THAT INTERVENTION WITH THESE ILLNESSES IS CRITICAL TO THE GENERAL HEALTH OF THE POPULATION. UNFORTUNATELY, OUR INSURANCE POLICIES HAVE NOT KEPT PACE WITH THESE CHANGES IN HEALTH CARE.

IT IS ALSO UNFORTUNATE THAT THIS GAP IN HEALTH INSURANCE HAS TO BE BRIDGED BY PUBLIC POLICY. HOWEVER, I WOULD LIKE TO SHARE WITH YOU SOME DATA THAT INDICATES HOW COSTLY IT IS TO THE PUBLIC TO CONTINUE TO DISCRIMINATE BETWEEN TREATMENT FOR OTHER ILLNESSES AND APPROPRIATE TREATMENT FOR MENTAL HEALTH PROBLEMS. IN TESTIMONY FOLLOWING MINE, THE COSTS ASSOCIATED WITH DISCRIMINATING AGAINST ALCOHOLISM WILL BE ADDRESSED.

HOW INADEQUATE COVERAGE COSTS THE PUBLIC

THERE IS NO QUESTION THAT THE PRIMARY COST TO THE PUBLIC WHEN HEALTH INSURANCE DOES NOT ADEQUATELY COVER TREATMENT FOR MENTAL AND EMOTIONAL PROBLEMS IS THE PERSONAL DISTRESS AND DISRUPTION TO THE FAMILY THAT OCCURS WHEN THESE DISORDERS GO UNTREATED. FURTHERMORE, MENTAL HEALTH PROBLEMS TAKE A TOLL IN THE WORK SETTING. THE FEDERAL ALCOHOL, DRUG ABUSE AND MENTAL HEALTH ADMINISTRATION ESTIMATES THAT THE COST OF LOST PRODUCTIVITY ON THE JOB DUE TO MENTAL AND EMOTIONAL PROBLEMS EXCEEDS THE TOTAL EXPENDITURES FOR ALL MENTAL HEALTH TREATMENT. IN 1975, THIS LOST PRODUCTIVITY WAS ESTIMATED TO BE ALMOST 17 BILLION DOLLARS.

THE COST TO THE PUBLIC'S WELL-BEING AND THE COST TO THE ECONOMY ARE SIGNIFICANT. IF THERE WAS NO OTHER EVIDENCE TO SPEAK FOR APPROPRIATE TREATMENT OF MENTAL AND EMOTIONAL

PROBLEMS. THESE COSTS ALONE MIGHT BE SUFFICIENT. HOWEVER, I WOULD LIKE TO TALK ABOUT TWO OTHER WAYS THAT COST SAVINGS RESULT FROM APPROPRIATE TREATMENT.

1) I WOULD LIKE TO TALK ABOUT REDUCED UTILIZATION OF NON-PSYCHIATRIC MEDICAL SERVICES WHEN OUTPATIENT MENTAL HEALTH TREATMENT IS PROVIDED. DATA FROM STUDIES ACROSS THE COUNTRY REVEAL THAT THE COST OF OUTPATIENT TREATMENT IS OFFSET BY REDUCTIONS IN USE OF OTHER MEDICAL SERVICES.

2) I WOULD ALSO LIKE TO SHARE WITH YOU SOME DATA FROM HERE IN OHIO THAT SUGGESTS THE COST SAVINGS THAT OCCUR IF INPATIENT PSYCHIATRIC TREATMENT CAN BE AVERTED THROUGH EARLY INTERVENTION WITH SHORT-TERM OUTPATIENT PSYCHOTHERAPY.

SAVINGS FROM REDUCED UTILIZATION OF OTHER MEDICAL SERVICES

WE ALL KNOW THAT THE LAST DECADE HAS SEEN TREMENDOUS INCREASES IN EXPENDITURES FOR HEALTH CARE, INCREASES CAUSED BY BOTH GREATER COST AND GREATER UTILIZATION. AS A RESULT, PATIENT PATTERNS OF HEALTH CARE USE HAVE BEEN CLOSELY SCRUTINIZED. AS A PART OF THIS RESEARCH, MANY STUDIES HAVE BEEN CONDUCTED TO EXAMINE THE EFFECT OF OUTPATIENT MENTAL HEALTH TREATMENT ON THE USE OF OTHER MEDICAL SERVICES.

THE COST OF TREATING ONLY PHYSICAL SYMPTOMS

REASONS FOR ASKING THIS QUESTION ARE CLEAR. IN 1979, HANKIN AND OKTAY REPORTED THAT BETWEEN 10% AND 20% OF THE TOTAL POPULATION ARE TREATED IN PRIMARY HEALTH CARE SETTINGS FOR PROBLEMS THAT HAVE UNDERLYING PSYCHOLOGICAL CAUSES. FIGURES COLLECTED FOR 1975 BY THE FEDERAL ALCOHOL, DRUG ABUSE AND MENTAL HEALTH ADMINISTRATION INDICATED THAT 73% OF THOSE TREATED FOR MENTAL DISORDERS WERE SEEN IN GENERAL HEALTH CARE SETTINGS ONLY. AND A MORE RECENT STUDY BY RESEARCHERS AT THE UNIVERSITY OF COLORADO INDICATED THAT 54% OF PATIENTS SUFFERING FROM MENTAL ILLNESS WERE TREATED BY PRIMARY CARE PHYSICIANS.

THE REASON THESE FINDINGS ARE DISCONCERTING IS THAT TREMENDOUS ADDITIONAL COSTS OCCUR WHEN A PATIENT WITH AN UNDERLYING MENTAL OR EMOTIONAL PROBLEM IS NOT DIVERTED TO A SPECIALIST. V.R. FUCHS CALLED THIS PHENOMENON THE "TECHNOLOGICAL IMPERATIVE". A GENERAL PRACTIONER WILL DO EVERYTHING HE HAS BEEN TRAINED TO DO TO RULE OUT VARIOUS ILLNESSES BY PRESCRIBING LAB TESTS, X-RAYS,

OTHER EXPENSIVE DIAGNOSTIC PROCEDURES, AS WELL AS THE TRIAL AND ERROR ADMINISTRATION OF MEDICATIONS. THESE PROCEDURES ARE EXTREMELY EXPENSIVE WHEN COMPARED TO THE ALTERNATIVE OF A THOROUGH PHYSICAL EXAM AND REFERRAL FOR OUTPATIENT PSYCHIATRIC EVALUATION AND, PERHAPS, SHORT-TERM TREATMENT.

SAVINGS FROM SHORT-TERM OUTPATIENT TREATMENT

THUS, RESEARCHERS HAVE ASKED WHAT HAPPENS TO THE UTILIZATION OF MEDICAL SERVICES WHEN OUTPATIENT TREATMENT FOR MENTAL AND EMOTIONAL PROBLEMS IS PROVIDED? THE FINDINGS HAVE INDICATED, OVERWHELMINGLY, THAT APPROPRIATE TREATMENT RESULTS IN DECREASES IN PHYSICIAN VISITS, LAB TESTS AND X-RAYS, AND INPATIENT HOSPITALIZATION.

> SCHLESINGER, MUMFORD AND GLASS AGGREGATED RESULTS FROM 11 STUDIES AND FOUND AN OVERALL 25% DECREASE IN LATER USE OF MEDICAL SERVICES WHEN OUTPATIENT PSYCHOTHERAPY WAS PROVIDED.
>
> JONES AND VISCHI REVIEWED 13 STUDIES AND FOUND DECREASED UTILIZATION OCCURRED IN 12 OF THE 13. REDUCTIONS RANGED FROM 5% TO 85%, WITH A MEDIAN OF 20%.

IN THE FOLLOWING TABLE I HAVE PROVIDED A SUMMARY OF THE STUDIES REVIEWED BY DRS. JONES AND VISCHI. BEYOND REDUCTIONS IN DAYS OF HOSPITALIZATION, MEDICAL VISITS, AND LAB AND X-RAY SERVICES, THE REVIEWERS ALSO NOTED THAT:

1) ALL THREE STUDIES THAT EXAMINED LONG TERM IMPACTS FOUND EVEN GREATER REDUCTIONS IN THE YEARS FOLLOWING THE FIRST YEAR AFTER TREATMENT;

2) THE LARGEST REDUCTIONS IN UTILIZATION OCCURRED WITH THOSE PEOPLE WHO HAD PREVIOUSLY BEEN THE HIGHEST UTILIZERS;

3) SHORT-TERM OUTPATIENT TREATMENT OF LESS THAN 20 VISITS WAS AS EFFECTIVE, IF NOT MORE EFFECTIVE, THAN LONG-TERM TREATMENT IN REDUCING UTILIZATION OF OTHER MEDICAL SERVICES;

IMPACT OF MENTAL HEALTH TREATMENT ON UTILIZATION OF OTHER MEDICAL SERVICES

(From K. R. Jones & T. R. Vischi, Medical Care, 1979, Vol. 17 No. 12)

Study	Setting	Time: Before ADM Care	Time: After ADM Care	Study Group Size	Comparison Group: Size	Comparison Group: Psych. Match	Comparison Group: Utiliz. Match	Comparison Group: Demogr. Match	Impact on Medical Utilization (Study Group / Comparison Group)
Mental Health									
1. West German (Duehrssen) (1962)	Clinic	unstated	5 years	845	none	—	—	—	85% reduction in days hospitalization.
2. Kaiser Permanente (Follette) (1967)	HMO	1 year	5 years	152	152	yes	yes	yes	62% decline for all me visits vs. +13%; and decline for all inpati days vs. −6%.
3. HIP (Fink) (1969)	HMO	1 year	2 years	112	106 116 97	yes no yes	no no no	no no no	8% decline for physici services vs. +5%, +3 −6%; and 15% decli lab and x-ray service −25%, −3% and +1
4. GHA (Goldberg) (1970)	HMO	1 year	1 year	256	none	—	—	—	31% decline for physic services and 30% de for lab and x-ray visi
5. Kaiser Oregon (Uris) (1974)	HMO	1 year	1 year	45	45 45	yes no	yes yes	yes yes	11% decline for medic visits vs. −16% and -
6. Puget Sound (Kogan) (1975)	HMO	5 years	2¼ years	148 171	148 165	no no	no no	yes yes	17% and 20% declines i outpatient visits (incl psychotherapy) from before psychotherapy 2nd year after vs. +5 −3%.
7. Blue Cross W. Pennsylvania (Jameson) (1976)	CMHC	about 2 years	about 2 years	136 26	1,500 521	no no	no yes	no no	57% decline in inpatien outpatient medical ex itures; 87% decline fo utilizers vs. −61% for parison high utilizers
8. HIP Medicaid (Fink) (1977)	HMO	1 year	1 year	169	141	yes	no	no	12% decline for all phy services vs. +7%; an decline for lab and x services vs. +28%.
9. Mexican-American (McHugh) (1977)	health center	about 6 months	about 6 months	119	none	—	—	—	72% increase in medic encounters.
10. 4 Settings (Regier) (1977)	HMOs; health center	Mental Health care received at some time during the one year period studied		987 541 258 957	172 379 555 491	yes yes yes yes	no no no no	no no no no	6%, 30%, 28% and 21% medical visits respec by the four study gro
11. GHA (Patterson) (1978)	HMO	3 months 12 months	3 months 12 months	952 426	none none	— —	— —	— —	declines of 19% (medi services), 14% (lab), 30% (x-ray) for 3 mo after; declines of 5% and 33% for 12 month
12. Minority Children (Graves) (1978)	health center	1 year	1 year	21	21 21	yes no	yes no	yes yes	36% decline in medical vs. +30% and −9%.
13. Columbia Medical Plan (Kessler) (1978)	HMO	1 year	1 year	1,155	none	—	—	—	8% decline in medical

4) OF THE 13 STUDIES, THE ONLY ONE WHERE NO REDUCTION IN UTILIZATION OCURRED WAS CONDUCTED IN A NEW NEIGHBORHOOD HEALTH CENTER IN A MEDICALLY UNDERSERVED COMMUNITY.

MOST INSURANCE COMPANIES DO NOT STRUCTURE THEIR DATA IN A WAY THAT ALLOWS THEM TO INSPECT REDUCTIONS IN MEDICAL UTILIZATION THAT RESULT FROM OUTPATIENT TREATMENT OF MENTAL AND EMOTIONAL PROBLEMS. THEREFORE, MOST OF THE ABOVE STUDIES WERE CONDUCTED IN PRE-PAID HEALTH CARE SETTINGS. HOWEVER, A RECENT STUDY FOUND THAT THESE VERY SAME REDUCTIONS IN MEDICAL UTILIZATION ALSO OCCURRED IN THE FEE-FOR-SERVICE INSURANCE PLAN OF THE FEDERAL EMPLOYEE HEALTH BENEFIT PROGRAM.

THESE FINDINGS, AND THOSE FROM STUDIES REVIEWED ABOVE, CLEARLY INDICATE WHY OUTPATIENT MENTAL HEALTH TREATMENT IS COSTLY WHEN IT IS <u>EXCLUDED</u> FROM HEALTH INSURANCE, NOT WHEN IT IS INCLUDED.

IN DESIGNING LEGISLATION TO REPLACE S.B. 90, YOU ARE BEING ASKED TO CONSIDER THE STATUS OF COVERAGE FOR NON-HOSPITAL TREATMENT OF MENTAL AND EMOTIONAL DISORDERS. PRIOR TO S.B. 90 AND IN OTHER STATES, INPATIENT TREATMENT OF THESE ILLNESSES HAS BEEN GENERALLY INCLUDED IN HEALTH INSURANCE POLICIES. HOWEVER, TREATMENT OUTSIDE OF THE HOSPITAL IS NOT. THUS, THE SUBSCRIBER WOULD NOT BE COVERED IF HIS FAMILY PHYSICIAN RECOMMENDED EVALUATION BY A SPECIALIST. THE SUBSCRIBER WOULD NOT BE COVERED IF EARLY INTERVENTION VIA BRIEF PSYCHOTHERAPY WAS NEEDED BEFORE THE PROBLEM DEVELOPED INTO AN ACUTE PSYCHIATRIC EPISODE. THE SUBSCRIBER WOULD NOT BE COVERED IF AFTER A PERIOD OF ACUTE HOSPITALIZATION, LESS INTENSIVE TREATMENT SUCH AS PARTIAL HOSPITALIZATION OR OUTPATIENT SERVICE COULD BE SUBSTITUTED FOR THE 24-HOUR CARE PROVIDED IN THE HOSPITAL.

LESS EXPENSIVE ALTERNATIVES TO HOSPITALIZATION

THERE IS NO QUESTION THAT AT TIMES, INPATIENT TREATMENT IS REQUIRED AND APPROPRIATE. BUT, AS DR. BERNARD KUHR OF THE OHIO PSYCHIATRIC ASSOCIATION TESTIFIED SEVERAL WEEKS AGO, ALTERNATE FORMS OF TREATMENT ARE IMPORTANT WEAPONS IN THE ARSENAL OF PSYCHIATRIC CARE. IF INPATIENT HOSPITALIZATION IS ALL THAT IS COVERED BY ONE'S INSURANCE AND, THUS, ALL THAT CAN BE AFFORDED, TREATMENT NOT ONLY BECOMES MORE DISRUPTIVE TO THE PATIENT'S LIFE, IT BECOMES CONSIDERABLY MORE EXPENSIVE.

IN THE FOLLOWING TABLE, INPATIENT AND OUTPATIENT SERVICES ARE COMPARED FOR THE AVERAGE PAYMENT PER CLAIM PAYED IN 1980.

AVERAGE PAYMENT PER CLAIM IN 1980 FOR MENTAL AND EMOTIONAL DISORDERS

	Outpatient	Inpatient
Blue Cross Plans		
Central Ohio	$49	$2,373
Northeast Ohio	$152	$4,524
Northwest	$38	$2,643
Cincinnati—all regions	$53	$2,529
Blue Shield		
OMIM	$43	$278

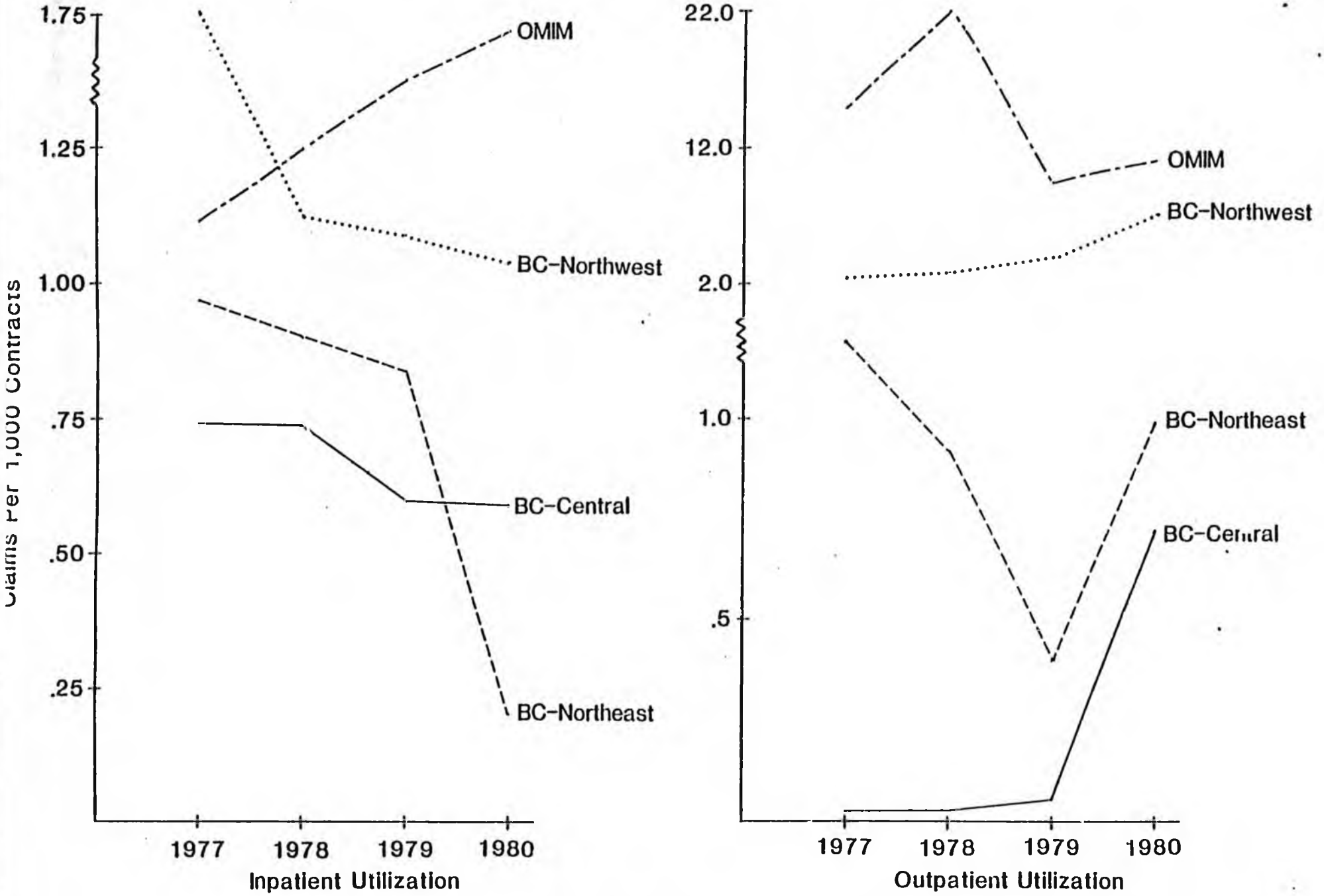
(From information presented to Senator Paul R. Matia and Representative Michael Stinziano by Leo A. Simpson, Chairman, Ohio Blue Cross and Blue Shield Plans S.B. 90 Task Force.)

THESE FIGURES WERE PROVIDED BY BLUE CROSS AND BLUE SHIELD PLANS IN OHIO IN RESPONSE TO A QUESTIONNAIRE DISTRIBUTED BY SENATOR MATIA AND REPRESENTATIVE STINZIANO. AS YOU CAN SEE, THE EXPERIENCE FOR BLUE CROSS PLANS WAS THAT THE AVERAGE INPATIENT CLAIM WAS 40 TIMES AS EXPENSIVE AS THE AVERAGE OUTPATIENT CLAIM. WHEN PRACTIONER COSTS ARE INCLUDED (AS REPORTED BY THE ONE BLUE SHIELD PLAN THAT RESPONDED TO THE QUESTIONNAIRE), THE AVERAGE COST OF AN INPATIENT CLAIM BECOMES ALMOST 50 TIMES THAT OF OUTPATIENT.

I AM NOT SUGGESTING THAT OUTPATIENT TREATMENT REPLACES THE NECESSITY FOR INPATIENT. HOWEVER, EARLY INTERVENTION AND TREATMENT CAN SOMETIMES PREVENT FURTHER DETERIORATION SO THAT INPATIENT CARE IS NOT NEEDED. THE FIGURES REPORTED HERE INDICATE THAT IF INPATIENT CARE WERE AVERTED ONE TIME IN 40 OR 50 CASES, THE INSURANCE COMPANY WOULD BREAK EVEN. OBVIOUSLY, THE PATIENTS INVOLVED COME OUT FAR AHEAD.

HAVE HOSPITALIZATIONS DECREASED IN OHIO?

SINCE OHIO HAS HAD S.B. 90 FOR 2 YEARS, IT MIGHT BE ASKED WHETHER THERE IS DATA TO SUGGEST THAT OUTPATIENT TREATMENT HAS AVERTED ANY INPATIENT CARE. THERE IS NO DEFINITIVE DATA. AS WITH THE OFFSET OF MEDICAL UTILIZATION, INSURANCE COMPANIES DO NOT NORMALLY COMPILE THEIR DATA IN SUCH A WAY THAT ALLOWS THIS COMPARISON. HOWEVER, AGAIN FROM FIGURES PROVIDED TO SENATOR MATIA BY BLUE CROSS AND BLUE SHIELD PLANS, IT APPEARS THAT TRENDS TOWARD DECREASING INPATIENT UTILIZATION HAVE OCCURRED OVER THE SAME PERIOD THAT THERE HAS BEEN INCREASING UTILIZATION OF OUTPATIENT TREATMENT. THOUGH I HAVE SOME CONCERNS ABOUT THE



MENTAL AND EMOTIONAL DISORDERS

(From information presented to Senator Paul R. Matia and Representative Michael Stinziano by Leo A. Simpson Chairman, Ohio Blue Cross and Blue Shield Plans S.B. 90 Task Force.)

VALIDITY OF THIS DATA, I THINK THE COMMITTEE SHOULD EXAMINE THE UTILIZATION REPORTED HERE IN OHIO. THESE FIGURES ARE SHOWN ON THE PRECEDING GRAPHS.

FIRST, I WOULD NOTE THAT DATA FOR BLUE CROSS SERVING CINCINNATI AND OTHER REGIONS IS NOT INCLUDED BECAUSE IT APPEARED THAT THEY REPORTED DIFFERENT GEOGRAPHIC AREAS IN DIFFERENT YEARS. HOWEVER, FOR THE 3 BLUE CROSS PLANS FOR WHICH DATA IS AVAILABLE, SIGNIFICANT INCREASES IN OUTPATIENT UTILIZATION OCCURRED IN 1979 AND 1980 AFTER IMPLEMENTATION OF S.B. 90. ALL 3 PLANS ALSO SHOWED SIGNIFICANT DECREASES IN INPATIENT UTILIZATION, WITH 2 OF THE 3 SHOWING THEIR LARGEST DECREASES IN THE YEARS FOLLOWING S.B. 90. IN CONSTRAST, OHIO MEDICAL INDEMNITY MUTUAL (OMIM; THE ONE BLUE SHIELD PLAN THAT RESPONDED TO THE QUESTIONNAIRE) HAS SHOWN AN INCREASE IN INPATIENT CLAIMS OVER THE FOUR-YEAR PERIOD. HOWEVER, THEY ALSO HAVE SHOWN A DECREASE IN OUTPATIENT CLAIMS.

ONCE AGAIN, THIS DATA DOES NOT CONSTITUTE DEFINITIVE PROOF THAT OUTPATIENT UTILIZATION RESULTS IN DECREASES OF INPATIENT USE. AND, AS WAS THE SITUATION WHEN CONSIDERING REDUCED MEDICAL UTILIZATION, THE KIND OF DATA REQUIRED FOR DEFINITIVE ANSWERS ARE NOT READILY AVAILABLE FROM THE INSURANCE COMPANIES. (OTHER INSURANCE COMPANIES RESPONDING TO THE SURVEY INDICATED THEY WERE NOT EVEN ABLE TO PROVIDE THE VERY GENERAL FIGURES SHOWN HERE FOR BLUE CROSS AND BLUE SHIELD PLANS.)

THOUGH BASED ON THESE GRAPHS I WOULD NOT SAY THAT OUTPATIENT CARE REGULARLY AVERTS INPATIENT CARE, I WOULD BE WILLING TO BET THAT IN ONE OF 40 TO 50 CASES OF TREATMENT IT DOES.

IF THIS BET IS ACCURATE, THE COST OF OUTPATIENT CARE IN THE OTHER 39 TO 49 CLAIMS HAS BEEN RECOVERED. IF INPATIENT CARE IS AVERTED MORE OFTEN THAN ONE OUT OF 40 TO 50 CASES, THEN IT COSTS THE SUBSCRIBER MONEY WHEN HIS GROUP IS NOT COVERED FOR NON-HOSPITAL TREATMENT OF MENTAL AND EMOTIONAL DISORDERS.

SUMMARY

I HAVE BEEN TALKING ABOUT COST SAVINGS THAT OCCUR WITH APPROPRIATE TREATMENT OF MENTAL AND EMOTIONAL DISORDERS. THOSE WHO OPPOSE REQUIREMENTS FOR INCLUDING COVERAGE OF THIS TREATMENT IN HEALTH INSURANCE POLICIES OFTEN ARGUE THAT RUNAWAY UTILIZATION OF OUTPATIENT SERVICES DRIVES UP THE COST OF INSURANCE. FIRST, THIS ASSERTION DOES NOT TAKE INTO ACCOUNT SAVINGS THROUGH REDUCED USE OF OTHER MEDICAL SERVICES OR AVERTED INPATIENT PSYCHIATRIC VISITS. IT MAY BE THAT RUNAWAY UTILIZATION WOULD DRIVE DOWN THE COST OF HEALTH INSURANCE. UNFORTUNATELY, WE DON'T KNOW IF THIS IS THE CASE, BECAUSE RUNAWAY UTILIZATION JUST HAS NOT OCCURRED WHEN OUTPATIENT COVERAGE WAS PROVIDED.

ON THE FOLLOWING TABLE IS LISTED THE UTILIZATION EXPERIENCE OF SEVERAL LARGE INSURANCE PLANS. THE HIGHEST PERCENTAGE OF THE POPULATION WITH CLAIMS FOR OUTPATIENT TREATMENT IS 2.2%. THE HIGHEST AVERAGE NUMBER OF VISITS IS 18.8, IN A PLAN THAT HAD NO UPPER LIMIT ON THE NUMBER OF SESSIONS. A MUCH LOWER AVERAGE NUMBER OF SESSIONS WAS MUCH MORE COMMON. THE WEIGHTED AVERAGE FOR ALL 12 PLANS LISTED HERE WAS 9 1/2 VISITS PER 100 SUBSCRIBERS. WITH THIS UTILIZATION RATE, AND USING A COST OF $45 PER VISIT, EACH SUBSCRIBER WOULD PAY $4.26 PER YEAR OR 8¢ PER WEEK TO HAVE HIS INSURANCE COVER THE <u>FULL COST</u> OF TREATMENT. WITH 80% CO-INSURANCE, THE SUBSCRIBER PAYS $3.40 PER YEAR OR 6 1/2¢ PER WEEK. THESE FIGURES DO NOT SUGGEST THAT OUTPATIENT MENTAL HEALTH TREATMENT RUNS UP THE COST OF HEALTH INSURANCE. FURTHERMORE, IN A GROUP OF 1,000 SUBSCRIBERS, THE TOTAL COST WOULD BE MORE THAN OFFSET IF 17 DIAGNOSTIC EVALUATIONS WERE NOT PRESCRIBED OR IF 2 INPATIENT PSYCHIATRIC CLAIMS WERE AVERTED.

UTILIZATION RATES OF OUTPATIENT MENTAL HEALTH SERVICES
FOR POPULATIONS INSURED FOR
OUTPATIENT TREATMENT OF MENTAL DISORDERS

Insured Population	Year	Percent With a Mental Disorder Claim in a Year	Number of Visits in a Year Per Person Using Services	
Michigan Auto Workers, Blue Cross and Blue Shield	1968	1.1%	7.0	a
Maryland Auto Workers, Blue Cross and Blue Shield	1970	1.4%	7.5	a
Kaiser Foundation Plans				
N. Calif Federal employees	1968	1.9%	6.4	a
S. Calif Federal employees	1968	2.2	7.7	a
S. Calif Auto Workers	1969	1.8	6.1	a
Oregon Federal employees	1968	1.4	6.0	a
Hawaii Federal employees	1968	0.6	9.3	a
Group Health Association, Washington, D. C.				
Federal Employees	1969	2.0%	4.2	a
Transit Workers	1969	0.6	5.6	a
Community Health Assoc. Detroit Federal employees	1970	1.4%	6.2	a
Health Insurance Plan New York Federal employees	1969	0.8%	18.8	a
Blue Cross of Western Penn.	1973	1.1%	5.3	b

Source: a) Reed et al, 1972 (2)
b) Jameson et al, 1978 (3)

(Prepared by M. R. Von Korff & M. Kramer, 1979, National Institute of Mental Health)

IN CONSIDERING LEGISLATION TO REPLACE S.B. 90 I URGE YOU TO TAKE INTO ACCOUNT THE TOTAL COST TO THE PUBLIC, PERSONAL AND FINANCIAL, WHEN NON-HOSPITAL TREATMENT OF MENTAL AND EMOTIONAL DISORDERS ARE NOT COVERED BY HEALTH INSURANCE. THE CONCEPT OF EMPLOYERS AND EMPLOYEES DECIDING WHETHER SUCH COVERAGE SHOULD BE PROVIDED IS PHILOSOPHICALLY ATTRACTIVE; HOWEVER, PRAGMATICALLY, THE DECK IS STACKED AGAINST A GOOD DECISION.

MENTAL AND EMOTIONAL DISORDERS CARRY CONSIDERABLE STIGMA IN OUR SOCIETY. SOMEONE WHO NEEDS PSYCHIATRIC HELP IS CONSIDERED WEAK, UNABLE TO HANDLE HIS OWN PROBLEMS. FURTHERMORE, THE PUBLIC HOLDS UNREALISTIC FEELINGS OF IMMUNITY FROM MENTAL AND EMOTIONAL PROBLEMS. WE JUST DON'T THINK WE WILL EVER NEED THE COVERAGE.

THE DECK IS FURTHER STACKED BY THE RATE STRUCTURE OF THE INSURANCE INDUSTRY. AS AN OPTION IN A HEALTH INSURANCE POLICY, NON-HOSPITAL TREATMENT OF MENTAL AND EMOTIONAL PROBLEMS CARRIES A SEPARATE PRICE TAG. HOWEVER, GIVEN COST OFFSETS VIA REDUCED UTILIZATION OF OTHER MEDICAL SERVICES AND AVERTED INPATIENT PSYCHIATRIC CARE, THE CHOICE TO NOT INCLUDE THE ADDITIONAL BENEFITS MAY BE COSTLY. WHAT LOOKS CHEAPER IS ACTUALLY MORE EXPENSIVE.

THUS, I URGE YOU NOT TO MAKE NON-HOSPITAL TREATMENT OF MENTAL AND EMOTIONAL DISORDERS OPTIONAL. FURTHERMORE, I WOULD RECOMMEND THAT YOU REQUIRE THE MINIMUM BENEFIT PACKAGE SPECIFIED IN S.B. 336. THIS BENEFIT PACKAGE PROTECTS COVERAGE AGAINST INFLATIONARY DETERIORATION BY SPECIFYING MINIMUM TREATMENT RATHER THAN MINIMUM DOLLARS. IT PROVIDES PARTIAL HOSPITALIZATION SERVICES AS AN ALTERNATIVE TO INPATIENT CARE. A DAY OF PARTIAL HOSPITALIZATION IS A FRACTION OF THE COST OF A DAY OF INPATIENT. PARTIAL

HOSPITALIZATIOI ALLOWS INTENSIVE TREATMENT TO BE SPREAD OUT OVER A LONGER TIME FRAME TO REDUCE THE POSSIBILITY OF RE-HOSPITALIZATION. BY "TRADING-OFF" THIS TREATMENT ALTERNATIVE FOR DAYS OF INPATIENT PSYCHIATRIC CARE, IT CAN BE PROVIDED WITHOUT INCREASING THE TOTAL LIABILITY OF THE INSURER.

S.B. 336 ALSO INCLUDES AN OUTPATIENT BENEFIT STRUCTURE THAT REDUCES THE BARRIERS TO EARLY INTERVENTION BUT DISCOURAGES A PROTRACTED NUMBER OF VISITS. THE SUBSCRIBER'S RESPONSIBILITY FOR OUTPATIENT FEES INCREASES AS THERAPY CONTINUES. THE BENEFIT PACKAGE IN S.B. 336 IS DESIGNED TO ENHANCE THE COST SAVINGS I HAVE DESCRIBED IN THIS TESTIMONY. EARLY INTERVENTION AND ALTERNATIVES TO INPATIENT CARE ARE ENCOURAGED WHILE PROLONGED TREATMENT AND EXPENSIVE PROCEDURES ARE DISCOURAGED.

PROPONENTS OF S.B. 365 WILL ARGUE THAT THE BILL GIVES THE PUBLIC FREEDOM OF CHOICE. I WOULD ARGUE THAT BY REQUIRING MINIMUM MENTAL HEALTH BENEFITS, YOU WILL BE PROTECTING THEIR FREEDOM IN A FAR MORE CRITICAL CHOICE--THE DECISION TO SEEK THE MOST APPROPRIATE TREATMENT OF A MENTAL OR EMOTIONAL PROBLEM. PEOPLE NEED TO BE ABLE TO CHOOSE EARLY TREATMENT AND NON-HOSPITAL CARE WITHOUT THE THREAT OF FINANCIAL HARDSHIP. I URGE YOU TO PROTECT THEIR FREEDOM OF CHOICE BY REPLACING S.B. 90 WITH S.B. 336, NOT S.B. 365.

604-4th Street, Suite 1
Juneau AK 99801
April 11, 1985

Honorable Mike Navarre
Representative
Alaska State Legislature
Pouch V
Juneau AK 99811

Dear Representative Navarre:

I am writing in support of HB 313, which is currently being reviewed by the House Labor and Commerce committee. This act would require insurance providers to increase coverage to include mental illness and nervous disorders. Currently, thirteen states have improved coverage for the mentally ill, and several others are considering legislation similar to HB 313, which will upgrade and provide the needed coverage for individuals affected.

Thank you for your time and consideration

Sincerely,

Marjorie W. Thomson

Marjorie W. Thomson