Approved: February 23, 1999
Date

MINUTES OF THE SENATE COMMITTEE ON FINANCIAL INSTITUTIONS AND INSURANCE .

The meeting was called to order by Chairperson Senator Don Steffes at 9:00 a.m. on February 22, 1999 in Room 529 S of the Capitol.

All members were present except: Senator Rich Becker, Excused

Committee staff present: Dr. Bill Wolff, Research
Ken Wilke, Office of Revisor
Nikki Feuerborn, Committee Secretary

Conferees appearing before the committee:

Others attending: See Attached

Hearing on SB 160 - Requiring mental health coverage to be the same as physical illness coverage

Senator Barone reviewed with the Committee the main points of the bill which addresses discrimination in the level of health insurance coverage involving mental illness. This bill is different from ones in the past as it lists only five brain diseases which would be covered under this proposed legislation:

- schizophrenia
- bipolar and major depression
- obsessive compulsive disorder
- panic disorder
- pervasive developmental disorder, including autism

Kathleen Sebelius, Insurance Commissioner, explained that although she rarely supported mandates, this topic was different due to the discriminatory treatment of mental illness in health insurance policies (Attachment 1). She compared physical diseases which are controlled by drug therapy and other medical interventions but the reluctance of insurance companies to adequately cover brain disorders which can be treated with drug therapy and medical intervention. Commissioner Sebelius explained that 58% of population who had employer-provided health coverage in 1981 had in-patient coverage for mental illness and 10% for outpatient coverage; by 1993 these percentages had dropped to 16 percent for inpatient and 4% for outpatient coverage. The cost increases in health plans will be offset by a reduction in more serious and costly illnesses as well as higher productivity in the workplace. Full parity for mental health would increase premiums by an average of 3.6% (managed care and fee for service plans).

Rochelle Chronister, Secretary of SRS, asked that mental illness receive the same health benefits as physical illness (Attachment 2). She reminded the Committee that mental illness was more common than cancer, heart disease, and diabetes, yet it is not covered by most health insurance plans.

Chip Wheelen, Kansas Mental Health Coalition, said their highest public policy priority is the elimination of discrimination in health insurance coverage (Attachment 3). Accurate diagnosis and appropriate treatment of mental illnesses result in social and economic benefits which far exceed the cost of providing treatment.

Dr. Roy Menninger, Kansas Psychiatric Society, reviewed for the Committee how the benefits far outweigh any costs involved in nondiscriminatory insurance coverage for the mentally ill in testimony which included the following explanations (Attachment 4):

- medical cost effectiveness
- cost offset statistics
  - reduced medical/surgical outpatient visits
  - reduced medical inpatient days
  - reduced psychiatric inpatient days
- cost-benefit analysis

Twenty years also six cents of every insurance premium dollar was spent on mental illness coverage, now only three cents are allotted to mental illness coverage. Coverage should also be extended to include eating disorders, attention deficit disorder, conduct and behavior disorders. Treatment is getting better for the mentally ill and coverage is going down. The mentally ill have been disenfranchised and we need to reverse the trend.

Passage of this bill would impose a simple standard of fairness in health insurance and restore the fundamental premise of insurance: to spread the risk among all who pay premiums.

Jim Cain presented testimony explaining the devastation their family has experienced through the cost of the mental illness of their son and the maximizing of their health insurance benefits (Attachment 5).

Paul Klotz, Association of Community Mental Health Centers of Kansas, Inc., said that in his opinion this is the most important piece of legislation to be placed before the Committee in 20 years (Attachment 6). He related the history of the cause, the attempts at legislation in the past, and presented statistics proving that parity will not "break the bank."

Terry Larson, NAMI, drew attention to the unfairness in insurance coverage for the mentally ill (Attachment 7). She attributed this to the lack of understanding about brain disorders and that the stigma attached to mental illness perpetuates the injustice.

Sherry C. Diel, Deputy Director of Kansas Advocacy and Protective Services, Inc., related her personal story of depression and the huge financial drain her family experienced (Attachment 8). She is now a working productive citizen and stressed that the benefits derived from this mandated coverage will substantially outweigh any costs associated with increased mental illness benefits.

Written testimony supporting the bill was submitted by the Kansas Medical Society (Meg Draper) (Attachment 9).

The hearing was continued until Wednesday, February 24 at 12:30 p.m. in Room 519 South. Meeting was adjourned.

SENATE FINANCIAL INSTITUTIONS AND INSURANCE COMMITTEE GUEST LIST

DATE: Feb. 22, 1999

NAME	REPRESENTING
Linda DeBruesy	KS Insurance Dept.
Kathleen Sebelius	"
Maggie Keating	"
Chip Wheelen	KS Psychiatric Society
Roz Hemmenger	KS Psych. Society
Paul M. Klotz	Assoc. of CMHCs of KS, Inc.
Jim Carr	
Grant Denny	KID
Peter Haxton	
Rochelle Chronister	SRS
Tonya R. Kluffs	Interhab
Wesley Marshall	Interhab
Elizabeth Adams	NAMI Kansas
Bill Sneed	HIMA
John Federico	Humana
Danielle Noe	Governor's Office
Stacy Soldan	Hein + Wein Chtd.
Carrie Ann Brown	KAHP
Amy A. Campbell	KMHC

Kathleen Sebelius
Commissioner of Insurance
Kansas Insurance Department

February 22, 1999

TO: Senate Committee on Financial Institutions and Insurance

FROM: Kathleen Sebelius, Insurance Commissioner

RE: SB 160 – Eliminating discrimination in coverage of specific mental illnesses

Mr. Chairman and members of the Special Committee:

Thank you for the opportunity to discuss with you the very important topic. While I generally support market flexibility rather than "body parts" mandates where legislative bodies develop medical protocol, this particular topic is different. The difference is the discriminatory treatment of mental illness in health insurance policies. Coverage for this disease is a fairness issue.

While coverage for mental health disorders has for existed for some time in Kansas history, it exists differently than coverage for other illnesses, and would lead one has to ask why the difference exists? There is little question that those individuals with "mental disorders" are treated differently from their neighbors who have "physical disorders." It is difficult, if not impossible to obtain insurance coverage for brain diseases, with the same levels of coverage that individuals can obtain for any physical condition. It is difficult to understand why an illness of the body, such as diabetes, is covered while an illness of the mind, such as schizophrenia, is not. Both conditions can be treated and often brought under control by drug therapy and other medical interventions, but the brain disorders are not adequately covered by health insurance. To

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isolate mental illness for minimal protection, while fully covering physical diseases in a major medical policy, seems to be discrimination of the worse kind.

Mandating full health insurance coverage for mental illnesses was "unthinkable" in the past because of the fear of increased costs. The Bureau of Labor Statistics reported that in 1981, 58 percent of the men and women who had some sort of employer-provided health coverage had inpatient coverage for mental illness comparable to that for physical illness, and 10 percent had comparable outpatient coverage. By 1993, those percentages were down to 16 percent and 4 percent , respectively. In 1995-1996, of the 620 large-and medium sized companies surveyed by Watson Wyatt Worldwide only 11 percent of those employers claimed they provided mental health benefit parity.

According to the National Advisory Mental Health Council, a group of experts advising both the National Institute of Mental Health and the Congress, mental disorders, many relatively brief in duration, affect about 22 percent of the adult population in any year; serious mental disorders affect over five million adults in any year, between 2 percent and 3 percent of the adult population. In addition, about 3.2 percent of children and adolescents between the ages of nine to seventeen have a severe mental disorder in any six-month period. Schizophrenia affects 1.5 percent of the adult population; major depression about 1.1 percent; manic depressive illness or bipolar disorder about 1 percent.

When considering the impact of cost and concerns about the economics of these benefits, one must also look at the question of what the cost is of untreated mental health conditions in terms of employee days-off and overall loss of productivity. Studies started showing that workers with severe depression or other mental illnesses were costing large employers heavily in absenteeism, poor productivity, disability benefits, even at-work violence. Companies then began seeking

more extensive treatment of these problems because it might actually save the employers money in the long run. It is quite likely that the cost increases in health plans will be offset by a reduction in more serious and costly illnesses. We need to balance the issue.

In the history of mental health parity, states started choosing to provide parity for public employees only. Now, more and more states have considered and passed parity legislation. By July, 1998, 17 states had passed some kind of parity legislation: Arkansas, California, Colorado, Connecticut, Delaware, Georgia, Indiana, Maine, Maryland, Minnesota, New Hampshire, North Carolina, Rhode Island, South Dakota, Tennessee, Texas and Vermont.

Statistics are now available from states with mental health parity laws. In Maryland, for example, statistics showed a seven percent drop in the length of inpatient psychiatric hospital stays one year after passage of a mental health benefit parity law (National Underwriter). I would also point out that a number of recent studies of state imposed mental health mandates show that costs have risen by an average of 2-5%. A 1997 Rand Corporation study found that raising the typical average dollar limit on the mental health coverage would increase costs by about $1 per managed care enrollee. A mental health study completed for the Department of Health and Human Services found that full parity for mental health, which included substance abuse services, increases premiums by an average of 3.6% (this included both managed care and fee for service plans).

Bringing those statistics closer to home, just last year, the Kansas State Employees Health Care Commission asked insurers to submit bids, with and without mental health parity. The benefits were seen to far outweigh the insignificant cost increases with all the plans. As of January 1, 1999, Kansas State employees will have the option for parity for mental health benefits.

In your deliberations and consideration of the elimination of discrimination for mental health coverage for Kansas citizens, please consider SB 160 favorable for passage and bring fairness to the health insurance market for those Kansas families with mental disorders.

State of Kansas
Department of Social & Rehabilitation Services

Rochelle Chronister, Secretary
Janet Schalansky, Deputy Secretary

For additional information, contact:

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Financial Institutions and Insurance
February 22, 1999

Testimony: Insurance Parity for Mental Health

Secretary of Social and Rehabilitation Services
Rochelle Chronister, Secretary
785.296.3271

Senate Financial Institutions & Insurance

Date 2/22

Attachment # 2

Contents

Kansas Department of Social and Rehabilitation Services
Rochelle Chronister, Secretary

Financial Institutions and Insurance
Insurance Parity for Mental Health

February 22, 1999

Mr. Chairman and members of the Committee, I am Rochelle Chronister, Secretary of the Kansas Department of Social and Rehabilitation Services. It is the position of this administration to not support additional insurance mandates; however, I would like to provide this information on SB 160.

Mental illness can strike anyone. It knows no age limit, economic status, race, creed, or color. People who suffer from or have suffered from mental illness have many obstacles to overcome. Instead of receiving compassion and acceptance, people with mental illnesses may experience hostility, discrimination and intolerance. Most of the intolerance can be attributed to both the lack of knowledge about mental illness and the stigma that accompanies these disorders. As a society, we often perceive all people who have a mental illness as strange, scary, or even dangerous. In fact, when people with mental illnesses are asked to identify the biggest problem they face, most say it is simply a lack of acceptance.

One area in which the consequences of stigma takes a particularly high toll on families is insurance coverage. Health plans offered by employers typically provide less coverage for mental health treatment than for general medical and surgical services. States and the federal government have begun to require that mental health treatment be covered in the same way as other medical care. This concept is known as "parity." Parity simply means that mental illness should receive the same health benefits as physical illnesses. Four of the five illnesses in this bill are believed to be chemical imbalances of the brain which can often be controlled by medication which allows those with the illness to again become working, productive citizens.

Lower benefits for these illnesses result in inadequate care or financial disaster for those afflicted and their families. The main objection to parity is the belief that insurance costs will escalate dramatically. The fact is that it is much more cost effective to diagnose and treat mental illness in the early stages than to allow it to develop into a serious problem that can require long-term hospitalization.

As of today, 19 states have passed laws that, to various degrees, require parity in mental health. This piece of legislation will add Kansas to that list.

Let me leave you with this one last thought - mental illness is more common than cancer, heart disease, and diabetes, yet it is not covered by most health insurance plans.

Thank you for your time and for your attention. I would be happy to entertain any questions you may have.

STUDIES ON THE COST OF PARITY FOR MENTAL HEALTH

A study released in March, 1998, by HHS, estimates that full parity for mental health in private health insurance plans that tightly manage care would increase family insurance premiums less than one percent. The premium increase for a composite of health plans that reflect insurance coverage nationwide (e.g. Fee for Service, Preferred Provider Organization, Health Maintenance Organization) would average 3.6 percent. In this composite, parity for mental health services only would raise premiums by 3.4 percent (see Table 1).

In the study, "full parity" means that insurance benefits for any group of mental health diagnoses are the same as insurance benefits for medical/surgical diagnoses with respect to cost sharing, service limits, and annual or lifetime spending limits. HHS commissioned this study to learn more about the effects of state parity mandates, and to provide improved estimates of the costs of parity, based on recent data and the best advice of actuaries and economists.

Table 1

TYPE OF SERVICE	PARITY IN COST SHARING	PARITY IN SERVICE LIMITS	FULL PARITY
Mental Health	0.3%	1.1%	3.4%

This report was prepared by Mathematica Policy Research, Inc., for HHS. Key findings include:

- Most state parity laws are limited in scope or application. Many are limited to treatment for serious mental illness. Many exempt small employers or only apply to plans for government employees.
- State parity laws have had a small effect on premiums. Cost increases have been lowest in systems with tightly managed care and generous baseline benefits.
- Employers have not attempted to avoid parity laws by becoming self-insured, and they do not tend to pass on the costs of parity to employees.
- Costs have not shifted from the public to the private sector.
- Based on an updated actuarial model, full parity for mental health is estimated to increase premiums by 3.4 percent, on average.
- Projected premium increases do not reflect potential market responses.
- Premium increase are greater for plans that are limited to children.

Other studies show minimal cost impact and that businesses are going ahead with plans to provide parity to their employees:

Rand Corporation Study (November 12, 1997)

- ☐ Equalizing annual limits (typically $25,000) - a key provision of the Mental Health Parity Act of 1996 - will increase costs by only about $1 per employee per year under managed care.

- ☐ An even more comprehensive change required by some state laws (i.e., removing limits on inpatient days and outpatient visits) will increase costs by less than $7 per enrollee per year.

- ☐ The main beneficiaries of parity will be families with children who, under current conditions, are more likely than adult users to exceed their annual benefit limits and go uninsured for the remainder of the year.

Mercer Study (October 23, 1997)

- ☐ 85 percent of American companies are either in compliance or plan to make changes to comply with the Mental Health Parity Act of 1996.

- ☐ Seven out of ten of those same employers agree than mental health parity is a reasonable national policy goal and that parity is important to their employees.

Lewin Study (April 8, 1997)

- ☐ In a survey of New Hampshire insurance providers, no cost increases were reported as a result of a state law requiring health insurance parity for severe mental illnesses.

Kansas Mental Health Coalition

Testimony
to the
Senate Financial Institutions and Insurance Committee
by Charles Wheelen, Vice-Chairman
February 22, 1999

Thank you for the opportunity to testify in support of SB160. The Kansas Mental Health Coalition is comprised principally of statewide organizations representing consumers, families, community service providers, and dedicated individuals as well as community mental health centers, hospitals, nurses, physicians, psychologists, and social workers. We all share a common interest; we are dedicated to improving the lives of Kansans with mental illnesses.

Our highest public policy priority is the elimination of discrimination in health insurance coverage. We believe that because mental illnesses are diagnosable, treatable medical conditions, health insurance coverage should be the same as it is for other illnesses or diseases. Current Kansas law requiring minimum mental health coverage for alcoholism, drug addiction, or mental disorders is extremely important and must be preserved in order to assure necessary treatment. Severe mental illnesses, however, should be categorized as medical conditions with the same health insurance coverage as other medical diagnoses. Such an amendment to Kansas law would benefit patients, their families, employers, taxpayers, and the State of Kansas.

There is abundant research which consistently concludes that accurate diagnosis and appropriate treatment of mental illnesses results in social and economic benefits which far exceed the cost of providing treatment. But that is a secondary reason you should take favorable action on SB160. The principal reason you should recommend passage of SB160 is because it would eliminate discrimination and restore fairness in health insurance coverage.

Thank you for considering our comments in your deliberations.

Kansas Psychiatric Society

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Founded 1942

February 22, 1999

Testimony
to the
Senate Committee on **Financial Institutions and Insurance**
by
Roy W. Menninger, MD, Chairman, KPS Insurance Committee

Thank you for the opportunity to express our support for Senate Bill 160. This legislation would require that health insurance coverage for mental illnesses be equal to coverage for other medical conditions. It would end the discrimination that occurs because of an existing provision in Kansas law (K.S.A. 40-2,105) which allows insurers to set lower limits of coverage for all "nervous or mental conditions" listed in the *Diagnostic and Statistical Manual of Mental Disorders*. The purpose of our testimony today is to emphasize that mental illnesses are diagnosable and treatable, and when accurately diagnosed and treated, the benefits far outweigh any costs.

Medical Cost Effectiveness

The omission of adequate coverage for mental health benefits, especially out-patient services places a major restriction on accessibility of treatment for those in need --

- 28% of adults in the US have a lifetime diagnosis of a mental disorder - Only ¼ of them seek help for their condition. Of those that do, ½ consult with primary care physicians, not psychiatrists. [NIMH 1993]

There is a common assumption that parity coverage would raise the risk of a huge cost-overrun; the belief that everyone would begin to use these services

- Fact: average length of out-patient treatment: <10 sessions
  The problem: keeping people IN treatment! There is no evidence that there would be a mad rush to treatment.

- Western Pennsylvania Blue Cross study: only 1.5% of employees actually used the covered out-patient services in a 1-year period; the average number of psychotherapy visits for that group was 6.1 sessions.

- Rand study [1968]: only 4% of enrollees received outpatient psychotherapy even when it was administered at no cost to the patient. The average client had only 11 visits per year at a cost of approximately $740.

Senate Financial Institutions & Insurance

Date 2/22

Attachment # 4

Cost Offset Statistics

Equal coverage for mental illnesses is cost effective in 4 ways:

1 - REDUCED MEDICAL/SURGICAL OUTPATIENT VISITS:

- Group Health Association of Washington study [1970] noted a 31% reduction in physician visits and 30% reduction in radiology and laboratory services in the first year following initiation of broadly available psychiatric services.

- Psychotherapy resulted in a 10-33% decrease in utilization of medical services and an average reduction of 1.5 days of inpatient care.

- 85% of some 58 studies reported a 45-60% decrease in medical care utilization following use of psychotherapy. [Mumford et al 1984]

- Group therapy with medical patients produced a 50% reduction in subsequent office visits, yielding an average cost savings of $3,900.

- Group therapy for breast cancer patients led to greatly improved mood, 50% decrease in pain, and extended survival by an average of 18 months. Cost: $3000 -- compares favorably to the cost of $100,000 for bone marrow transplant.

2 - REDUCED MEDICAL INPATIENT DAYS

- Kennecott Copper: when mental health counseling for employees was provided, hospital medical and surgical costs decreased 55%:

  • The company's weekly claims costs dropped nearly 75%.

  • For every dollar spent on psychiatric care, the company saved $5.78 in medical costs.

- Patients with multiple symptoms but no apparent physical disease incur costs about nine times greater than average per capita cost, but psychiatric consultation led to a 53% reduction in medical charges.

- Kaiser-Permanente study [1967]: those enrollees who received psychiatric treatment reduced outpatient medical services by 62% and inpatient medical services by 68% over a 5 year period. A matched control group maintained a pattern of high utilization of medical services.

- Poorly adjusted patients cost 75% more than well-adjusted patients.

3 - REDUCED PSYCHIATRIC INPATIENT DAYS

- Borderline Personality treatment study using twice-weekly psychotherapy [Stevenson & Meares 1992] demonstrated:
  - 60% reduction in time away from work
  - 86% reduction in number of visits to medical professionals
  - 75% reduction in number of self-harm episodes
  - decrease in hospital admissions by 59%
  - time spent as an inpatient dropped by 50%
- Depression: Total cost of illness: $43.7 billion: [MIT study]
  - $11.7 from lost work days
  - $12.1 from lost productivity on the job
- Depression is a complication of many medical and surgical problems which commonly prolongs lengths-of-stay (LOS) in general hospitals by 10 days. When adequately treated with antidepressants and psychotherapy (average of 5.5 visits), the mean LOS is 31.8 days shorter than for patients with untreated depression, producing savings of $25,400.

4 - REDUCED INDIRECT EXPENSES ASSOCIATED WITH DIMINISHED WORK PRODUCTIVITY

- 75% of the costs of major depression are attributable to lost social and economic productivity rather than the costs of direct treatment.
- Employees with untreated mental health problems will be absent 15% to 30% more frequently than healthy employees. [NIMH study 1992]

Cost - Benefit Analysis

Mental illness was estimated to cause $74.9 billion in lost productivity in 1990. The total annual costs of mental illness and substance abuse (other than direct treatment) are estimated at over $225 billion. Six of the top ten causes of death are associated with mental illness and substance abuse. A recent M.I.T. study estimates an annual cost of $11.7 billion in lost work days and $12.1 billion in other lost productivity from depression-related mental illness. People who suffer from depression have more social disability (interference with work, family and other functioning) than the eight most common medical illnesses.

The economic benefits include reduced expenses for inpatient mental illness and other medical treatment (both inpatient and outpatient), improved work attendance and productivity, improved family functioning, less antisocial behavior and decreased crime-related costs. The net economic benefit of full coverage for treatment of the most severe mental illness alone has been estimated at over $2 billion per year. The most extensive analysis of medical cost offset data found that outpatient psychotherapy lowers the rate of hospitalization on average by 73.4%, and substantially reduces time spent in the hospital.

Mental illness treatment is often necessary to effectively treat physical illness. For example, intensive psychotherapy to lower distress and disability levels and make necessary life changes is more effective and vastly cheaper than a coronary artery bypass (avg. $40,000+) for angina patients.

Conclusions

The existing Kansas statute governing health insurance coverage for substance abuse as well as nervous or mental conditions is extremely valuable but creates an inadvertent form of discrimination against Kansans who suffer from severe, disabling illnesses. Kansans who have a severe mental illness should receive the same insurance benefits as any other Kansan with a serious medical condition.

We respectfully request that you recommend passage of SB160. It would impose a simple standard of fairness in health insurance and thereby restore the fundamental premise of insurance; to spread the risk among all who pay premiums so that the insured who becomes afflicted with a mental illness will receive adequate health insurance benefits. Thank you.

Supporting data: Numerous studies conclude that a full, non-discriminatory mental health benefit including outpatient psychotherapy, such as formerly provided under the FEHBP, has been cost-effective. The experience of the CHAMPUS military health care system similarly supports full mental health coverage. Other studies (58 are discussed in Mumford, et al., *Am. J. Psychiatry* 141:1145-1158) reinforce the cost-effectiveness data. Sources for this fact sheet include (partial list): Andrews, Private and public psychiatry: a comparison. *Am. J. Psychiatry* 146:881-886; Broadhead et al., *JAMA* 264:2524-2528; Browne et al., *Med. Care* 28:43-58; Duehrssen et al., *Der Nervenarzt* 36:166-169; Frank et al., *Arch. Gen. Psychiatry* 47:1093-1099; Hoke, L.A., Longitudinal Patterns of Behavior in Borderline Personality Disorder, Boston Univ. 1989; Horvath et al., *Arch. Gen. Psychiatry* 49:817-823; Krizay, Is the 20-visit limit an effective cost-control device? *WPS* 1990, and *Am. J. Psychiatry 139:866-871;* Langsley et al., *Am. J. Psychiatry* 127:1391-1394; Lazar et al., *The Long-Term Psychotherapy Needs of Psychiatric Patients* (1993); Linehan et al., *Arch. Gen. Psychiatry* 48:1060-1064, 50:971-974; Ornish et al., *JAMA* 249:54-59; Peele, *Psychiatric News* 21:3, 12/90; Schlesinger et al., *Am. J. Public Health* 73(4):422-429; Sharfstein et al., *Dispelling Myths About Mental Health Benefits,* October 1984; Smith et al., *N. Eng. J. Med.* 314:1407-1413; Spiegel et al., *Lancet,* 1989, 2:888-891; Stoudemire et al., *Gen. Hosp. Psychiatry* 8:387-894; Weissman et al., *J. Affect. Disorders* 29:77-84; Wells et al., "Cost-Sharing and the Demand for Ambulatory Mental Health Services" Rand Corp. 1982; Zients, *Presentation to White House Mental Health Working Group 4/23/93.*

How Expensive Is Unlimited Mental Health Care Coverage Under Managed Care?

Objectives.—To study costs, access, and intensity of mental health care under managed care carve-out plans with generous coverage; compare with assumptions used in policy debates; and simulate the consequences of removing coverage limits for mental health care as required by the Mental Health Parity Act.

Design.—Claims data from 1995 and 1996 for 24 managed care carve-out plans; all plans offered unlimited mental health coverage with minimal co-payments.

Outcome Measures.—Probability of care, intensity of care, and total costs broken down by service type and type of enrollee.

Results.—Assumptions used in last year's policy debate overstate actual managed care costs by a factor of 4 to 8. In the plans studied, costs are lower owing to reduced hospitalization rates, a relative shift to outpatient care, and reduced payments per service. However, access to mental health specialty care increased (7.0% of enrollees) compared with the preceding fee-for-service plans (6.5%) or free care in the RAND Health Insurance Experiment (5.0%). Removing an annual limit of $25 000 for mental health care, which is the average among plans currently imposing limits, will increase insurance payments only by about $1 per enrollee per year. Children are the main beneficiaries of expanded benefits.

Conclusions.—Concerns about costs have stifled many health system reform proposals. However, policy decisions were often based on incorrect assumptions and outdated data that led to dramatic overestimates. For mental health care, the cost consequences of improved coverage under managed care, which by now accounts for most private insurance, are relatively minor.

JAMA. 1997;278:1533-1537

IN 1996, a number of important federal laws affecting health care were passed, including the Mental Health Parity Act of 1996. The Mental Health Parity Act requires employers to increase dollar limits for mental health coverage to limits for medical care, but it does not require employers to offer mental health or medical coverage, nor does it impose any conditions on deductibles, co-payments, or limits on days or visits. The Mental Health Parity Act and related legislation currently considered by over 30 states will affect millions of patients and providers, but their effects depend on how employers perceive the cost consequences of such regulation. Unfortunately, there remains much uncertainty about the impact of such policies, a situation that has not changed much from the Clinton health system reform debate 4 years ago.[1] This uncertainty raises the concern that employers who base their decisions on older data or studies might erroneously decide to drop mental health coverage altogether.

This article provides data on mental health and substance abuse utilization for 24 new managed care plans in 1995 and 1996 and estimates the costs of removing different coverage limits for mental health and substance abuse, including limits not affected by the Mental Health Parity Act, but possibly by state laws enacted in 1997. New data are needed because the delivery system has changed dramatically in the last 10 years as a consequence of therapeutic advances—in particular the development of new medications—and the growth of managed care. By now, about 3 of 4 individuals are enrolled in some form of managed medical care[2] and the managed care penetration in mental health insurance has always been higher. In addition, managed care itself has been changing and now often represents intensive concurrent utilization review of specialty care, whereas managed care in the past was often limited to gatekeeping mechanisms or prospective payments. Particularly important cases of modern managed care are carve-out contracts, in which mental health and substance abuse care are administered separately from medical care. Employers often contract directly with specialized behavioral health companies for such services, but many insurance companies and health maintenance organizations (HMOs) carve out mental health care, either to a subsidiary or to an independent vendor. This article focuses on such managed care carve-out contracts.

Most estimates proposed in policy debates have not taken those changes into account. For example, the influential cost estimates of parity by the Congressional Research Service (CRS) last year did not incorporate any cost distinction between managed care or fee-for-service care and relied on a 1986 report from the National Institute of Mental Health for mental health practice patterns.[3,4] By not considering trends in the health care market or in treatment pattern, such as the substitution of outpatient for inpatient care, these numbers are likely to overestimate the cost effects of parity legislation and bias decisions by employers and policymakers.

DATA AND METHODS

The UCLA/RAND Research Center on Managed Care has extensive utilization and cost data from managed behavioral health firms, including data on over 4000 plans administered by United Behavioral Health (formerly US Behavioral Health). Of those 4000 plans, we selected plans to minimize modeling assumptions to evaluate the effects of the Mental Health Parity Act and required the following: (1) very generous benefits with no limits on coverage (to obtain the distribution of costs without limits); (2) new start-up of the plan (very generous plans are likely to attract higher users over

From RAND, Santa Monica, Calif.
Reprints: Roland Sturm, PhD, RAND, 1700 Main St, Santa Monica, CA 90401 (e-mail Roland_Sturm@rand.org)

Table 1.—Total Annual Cost by Service Type per Enrollee per Year (in Dollars)*

	1995/1996 Utilization Data	Free Care	Hay/Huggins Cost Assumptions
Outpatient	36	42	145
Inpatient	13	13	182
Residential	1	1	46
Total	50	56	373

*Total payments to providers, including insurance payments and patient co-payments. See text regarding the Hay/Huggins Co Inc[3] cost assumptions.

Table 2.—Average Costs, Visits, and Days for Users (12-Month Period, July 1995 Through June 1996)*

	Mean (SD)	Median	99th Percentile
Total payments, $	700 (1928)	300	7723
Co-payment, $	74 (110)	50	390
Insurance payments, $	626 (1875)	250	7434
Outpatient visits, No.	9.5 (12.4)	6	51
Hospital days	1.5 (9.4)	0	43
Residential days	0.12 (0)	0	0

*Based on 8220 users, 7.02% of eligible enrollees.

time unless legislation requires similar benefits); and (3) all employees were covered with the same benefits (to avoid the dramatic selection effects across different plans offered by the same employer). Of 4000 plans, 24 plans with over 140 000 enrollees satisfied these criteria. All providers and provider groups were independent and paid on a fee-for-service basis; United Behavioral Health did not capitate providers or own equity in any provider groups. More detail on the full data set of 4000 plans and utilization management can be found elsewhere.[5]

The 24 plans selected for this article all offered identical benefits that far exceed the benefits typically necessary to achieve parity with medical conditions: $10 co-payment for an outpatient visit, and $100 co-payment for each inpatient admission. Note that the co-payment is per admission, not per inpatient day, and there are individuals with more than 100 inpatient days, but only $100 or $200 co-payments for those stays. There were no deductibles or limits on any type of service and both mental health and substance abuse services were covered. However, patients were required to use network providers and receive prior authorization, their care was reviewed by a case manager, and services were limited to medically necessary care.

The main limitation of the sample is that the policyholder is currently or was formerly employed by a public employer (98% of policyholders are current employees, 2% are eligible for COBRA) and enrollment is heavily concentrated in the Midwest (although there are some observations in all geographic areas). Therefore, the data are not necessarily representative for all industries or for other geographic regions in the country. This group is similar to a national comparison group in terms of income (93% of median family income nationally), housing costs (96% of a median gross rents paid nationally), but it is slightly less educated (4 percentage points fewer college degrees), and has substantially fewer ethnic minorities (7 percentage points less). For sensitivity analyses, I discuss some comparisons with other employers and plans, including a comparison with utilization under the preceding plans. Another data limitation is that some claims may not have been processed. United Behavioral Health estimates that unprocessed claims account for no more than 5%. However, it will be clear that none of the conclusions in this article are sensitive to this.

To compare these new data against the assumption[s] [o]f CRS, which relies on a table of health care cost distribut[ions] assumed to be valid for plans with no cost-sharing,[3] costs need to be inflated to the level of "free care." While the 24 plans studied had minimal cost-sharing, those co-payments may have been sufficient to change demand and I therefore inflated them by the maximum number allowed by the CRS-Hay/Huggins model.[3] This inflation factor assumes that reducing a co-payment by $1 on average increases insurance payments by $2.50. This may overstate the costs of the free managed care plan in Table 1 (column labeled "Free Care").

Because of the demand response to co-payments, the costs of removing limits on coverage depends on coinsurance/co-payment mechanisms. With high co-payments, removing limits will lead to a smaller cost increase than with low co-payments. I therefore used a very generous structure for co-payments in the plans studied ($10 per outpatient visit, $100 per inpatient admission). This is likely to overstate the cost increases associated with removing limits in plans that maintain high co-payments.

UTILIZATION AND THE DISTRIBUTION OF MENTAL HEALTH CARE COSTS

Utilization is commonly decomposed into access (probability of any care) and intensity (number of visits or hospitalizations per user).[6] Among the 24 plans studied, 7.02% (standard error [SE], 0.08%) of enrollees used any formal mental health or substance abuse services in 1 year. The rates were 9.20% (SE, 0.19%) among employees, 6.15% among adult dependents (SE, 0.19%), and 5.12% (SE, 0.15%) among child dependents; thus the access rates differ significantly across the 3 groups ($P<.05$). These access rates to formal mental health care are higher than the 5% rate for enrollees in the free plan in the RAND Health Insurance Experiment.[7,8]

One concern is that employers experiencing the highest utilization switch to managed care and rates in current plans tend to overestimate use under managed care. However, the pattern of increased access under managed care plans is consistent for enrollees in the fee-for-service medical plans for which more detailed mental health data are available before and after the switch to a carve-out plan. Before the switch, 6.7% had any mental health specialty use per year (in 1992 and 1993); after the switch, 11.9% had any specialty use per year. Access rates are not available for the preceding HMO plans, although some HMOs provided average outpatient utilization. For members in those HMOs, the average number of mental health outpatient sessions per 1000 members increased substantially (from 200-300 sessions per 1000 enrollees per year under the HMO plan to over 500 under the carve-out plan). A case study of Pacific Bell, a West Coast telecommunications company with over 100 000 enrollees (not part of this study), showed the same pattern in access rates before and after switching mental health benefits to a carve-out plan, although the increase under the carve-out plan was smaller.[9]

Table 2 provides a breakdown of utilization and costs for individuals with any mental health or substance abuse claims in the 12-month period from July 1, 1995, to June 30, 1996. Total payments averaged about $700 per user with a median of $300. Of those total payments, patients paid an average of $74 with the plan paying the remainder. The mean of outpatient visits is 9 to 10 visits, and the median 6; the average number of inpatient days is around 1.5; the mean of residential days is 0.1

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for all users. Compared with utilization before the carve out, the average number of outpatient visits per user has increased slightly and the average number of inpatient days has decreased dramatically.

Even individuals with hospital stays, who are the most costly users, had on average co-payments of only $180 with a median of $130. However, average total costs were $3800 with a median of $1900. Thus, co-payments averaged to a coinsurance rate of about 10% for all users and less than 5% for users with any type of inpatient care.

Table 3 provides more detail about the total cost distribution and contrasts it to the assumptions underlying the CRS simulations.[4] The column of Table 3 labeled "Free Care" inflated actual costs to make them comparable with a completely free plan. Actual and inflated costs are quite similar, except that costs are shifted slightly upward, particularly in the lowest cost brackets. The proportion of total user costs under $500 is reduced by about 8 percentage points and that mass is primarily shifted into the medium expense brackets ($501-$5000). There is little change for the highest cost brackets.

Both the actual cost and the simulated free care plan costs differ dramatically from the CRS-Hay/Huggins assumptions. The latter has relatively too much weight in both the high (>$5000) and the low tail (<$500) and not enough in the medium cost range. Thus, deflating the CRS-Hay/Huggins distribution to have the same mean as the free care plan is not sufficient to simulate the effects of changed benefits under managed care. The CRS assumption of an access rate of 8.39 also seems high because the rate of formal mental health care was only 5.00 in the free plan in the RAND Health Insurance Experiment.[7,8]

Table 1 distinguishes costs by type of services and shows the change in the proportion between outpatient and inpatient costs. Over the last 10 years, there has been a dramatic shift away from inpatient toward outpatient care, a trend that is not unique to mental health. Some of this has been driven by economic reasons and managed care and some has been due to therapeutic advances, in particular new medications. Under the managed fee-for-service care in the 24 plans studied, inpatient care accounts for only one fourth of total costs and even less under the simulated free managed care plan (Table 1). In contrast, the CRS-Hay/Huggins cost distribution allocates about half to inpatient care and assumes total costs to be about 6 times higher than actual costs under managed care.

Although the new data presented here came from managed care carve-out plans, there are reasons to believe that traditional fee-for-service care has moved in a similar direction. For example, a case study of Pacific Bell found that the share of inpatient mental health costs was falling continuously before Pacific Bell carved out mental health care[9]: in 1988, inpatient costs were 51% of total mental health care costs for enrollees in the fee-for-service medical plan; in 1990, inpatient costs were down to 44% of total mental health care costs. After the switch to a behavioral health carve-out plan in 1991, the share of inpatient costs dropped further to 27%. Similarly, in the unmanaged fee-for-service plans that preceded the managed fee-for-service plans in this study, the share of inpatient mental health care costs was 38% in 1992 and had dropped to 36% in 1994. Managed care then further reduced the inpatient share to 27% in 1995. Thus, even unmanaged fee-for-service plans experienced a trend away from inpatient care, but a switch to managed care substantially accelerated this trend.

Table 3.—Comparison of Total Cost Distributions*

	1995/1996 Utilization Data	Free Care	Hay/Huggins Cost Assumptions
Any use, %	7.02	7.02	8.39
Among users, percentage in each $ bracket			
1-100	20.28	18.67	0.00
101-250	23.12	17.09	47.70
251-500	23.80	24.48	2.86
501-1000	17.74	19.95	0.00
1001-2500	11.02	14.91	21.57
2501-5000	2.24	2.92	11.65
5001-10 000	1.13	1.25	7.48
10 001-25 000	0.51	0.57	2.56
>25 000	0.15	0.15	6.19

*The free care managed care plan inflates actual costs using an induction value of 150. The Hay/Huggins costs use the cost table and the 6% inflation factor suggested for health maintenance organizations (see Hay/Huggins Co Inc).[3]

Table 4.—The Effects of Limits on Average Insurance Payments per Enrollee (in Dollars)*

Type of Limit	All	Employee	Adult Dependent	Child Dependent
No limits	43.9	56.4	36.0	35.5
$50 000 Annual limit	43.8	56.3	36.0	35.2
$25 000 Annual limit	42.9	56.0	35.8	33.2
$10 000 Annual limit	40.1	53.5	34.6	28.7
30 Inpatient days and 20 outpatient visits	37.0	48.1	30.6	28.8

*Only insurance payments, since patient co-payments were excluded.

THE COSTS OF REMOVING LIMITS ON COVERAGE UNDER MANAGED CARE

Table 4 simulates how the annual payments by the insurance carrier are affected by changes in limits. These costs are broken down by type of enrollee because access rates (any use of services) and costs per user differ substantially between employees, adult dependents, and child dependents.

The first row of Table 4 shows actual annual payments by the insurance carrier for services, excluding co-payments or administrative costs; the following rows calculate annual payments after imposing limits on annual coverage. Among 4000 plans, the most commonly found limit was $10 000 and the average limit was $25 000.[5] An annual limit of $50 000 has essentially no effect, but it is also uncommon. Removing the average limit of $25 000 would increase costs by $1 dollar per enrollee per year. Even removing a low, but common, annual limit of $10 000 would increase costs by less than $4 per enrollee per year. Note how the imposition of removal of limits differs by type of enrollee. It has the smallest effect for adult dependents and the largest effect for child dependents, which means that children benefit more from the removal of limits than adult dependents or employees.

Although the Mental Health Parity Act defines limits in terms of dollars, there often are coverage limits expressed in number of inpatient days or outpatient visits. Among plans with such limits, the median (and average) limit on inpatient days was 30, the median limit on outpatient sessions was 20 (the average was 30).[5] Congressional Research Service used limits of 30 inpatient days and 20 outpatient sessions in its simulations for the costs of parity.[4]

The effect of removing those limits depends on the definition of inpatient treatment. Table 4 counts both hospital and residential treatment as inpatient and removing limits on both

types of use will have a larger cost impact than even a $10 000 limit because some high users spent most of the year in a residential facility. As for all limits affecting high-cost users, the largest effects are for child dependents. If a plan only limits hospital days, the effect of removing such a limit will be closer to removing a $25 000 annual cost limit.

COMMENT

This article analyzed the first-year cost and utilization data from 24 managed care behavioral health carve-out plans that offered more generous coverage than discussed during the parity legislation. Most importantly, those plans had no limits on coverage, which make them a unique database to predict the consequences of the Mental Health Parity Act among a privately insured population. Virtually all other existing insurance arrangements impose various types of coverage limits. Thus, this article fills a crucial gap for policy simulations, which so far had to rely on older databases under unmanaged fee-for-service care and assumptions about the effects of managed care.

Comparing the distribution of costs to the assumptions used by CRS, this article found much smaller average mental health care costs. Moreover, even deflating the CRS numbers would not provide unbiased predictions because of the change in practice patterns. This trend may have some economic reasons and may be accelerated by managed care, but it is not limited to managed care and also reflects a change in the practice of psychiatry and therapeutic advances. One of the most visible changes may have been the growth of antidepressant medications. Ten years ago, only a very small group of seriously depressed patients received any antidepressants, even in the mental health specialty sector, and antidepressants were often prescribed at a therapeutically ineffective dosage.[10] Fewer adverse effects of newer antidepressants have reduced the problem of ineffective dosages.

Concerns about costs constitute the continuing major hurdle for parity legislation. Regarding the specific provisions of the Mental Health Parity Act, which focuses only on coverage limits, this article estimates that removing the typical average annual limit of $25 000 would increase mental health care costs by about $1 per enrollee per year under managed care. Even the most costly change (removing a limit of 30 inpatient days and 20 outpatient sessions) would mean a less than $7 per enrollee per year cost increase in a plan without deductibles and minimal co-payments ($10 per outpatient session, $100 per hospitalization). In contrast, the CRS-Hay/Huggins assumptions would imply a cost increase of over $100 per enrollee per year for removing this limit, which is higher than the total mental health care costs under managed care.

The most vulnerable population in the current system are the sickest patients. Under existing policies, they quickly exceed their benefits and generally end up in the public sector. The calculations (Table 4) show that the largest increases in insurance costs as a consequence of the Mental Health Parity Act are for children, which is an important finding that has not yet received sufficient attention. Children generally have lower rates of any use, but children with mental health problems are very expensive users. Therefore, parity regarding limits for mental health or substance abuse care will primarily benefit families with seriously mentally ill children.

The focus of this article is on new managed care plans administered through a carve-out company. All plans were administered by the same company and other carve-out companies may have different use patterns. For example, all plans provide under a fee-for-service arrangement, whereas other managed care plans have combined utilization management with capitation or ownership of provider groups, which may lead to even lower costs. The carve-out company for the 24 plans analyzed was also the insurer, whereas many other carve-out arrangements separate administration and insurance.

Although the most common mental health insurance arrangement at this time, carve-out plans are also not necessarily representative for all managed care. Under carve-out arrangements, patients access mental health specialty care directly through a telephone referral, whereas under traditional managed care, patients have to go through their primary care physician, who serves as the gatekeeper to all specialty care. Although some HMOs now carve out mental health benefits through subcontracts, other HMOs continue to rely on primary care gatekeepers to mental health specialty care. By removing the primary care gatekeeper, carve-out plans are likely to increase access to specialty care and reduce the proportion of patients with mental health problems that are only seen in the general medical sector. This effect may be stronger for mental health than for physical health problems because of the low detection rates of mental health disorders in primary care.[10] In this study, enrollees in HMOs doubled the number of outpatient mental health sessions after mental health care was carved out, although their financial incentives to seek care initially did not change (average co-payments for outpatient sessions were $10 in the HMOs). Managed care plans that rely on primary care gatekeeping may therefore experience lower mental health costs, although some of those differences may simply be a substitution of primary care visits. Some of the increase in utilization may also be due to the extensive advertising and notification of employees of their new benefits.

In this data set, there were fewer high-cost episodes than expected based on previous reports on utilization. This was unlikely to be caused by prior selection effects or exclusionary policies in the plans offered, but it could be caused by denial of care or other attempts to transfer patients to other sectors. However, analyzing actual utilization reveals that utilization patterns are in fact much more consistent with prior reports about cost outliers. The reason is a discrepancy between billed charges and the discounted reimbursement rates. For example, a psychiatrist may bill $150 or $200 for a new patient, although the contractual rate for network providers is $95. Even larger discrepancies exist in bills from facilities. Over 4% of users incur billed amounts of over $10 000 and virtually all services were considered eligible, but evaluating the same services at the contractual rates reduces the proportion of users with costs over $10 000 to about half of a percent (Table 3). Thus, one of the major reasons for the lower costs is not changing care patterns, but contractually fixed reimbursement rates. At the same time, the contracted network structure offers financial protection to patients, who are not responsible for the difference between billed and reimbursed amounts as they are under traditional fee-for-service plans. The average patient responsibility among patients with billed charges of over $10 000 was around $250; the average was under $400 among patients with billed charges of over $50 000.

Physicians may be concerned that the low costs of specialty care under these carve-out contracts are caused by shifting care away from psychiatrists to master's degree level therapists and counselors. We found that 23% of the costs claims

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were attributable to psychiatrists. This may seem low, but it may actually reflect an increase over patterns seen 10 years ago in HMOs. Among depressed outpatients in HMOs, the Medical Outcomes Study found that only 10% were treated by psychiatrists in 1986,[10,11] although these numbers are not directly comparable because of different sampling designs (the Medical Outcomes Study includes patients treated only in primary care).

Another concern is that the low costs reflect an interruption of care when patients are involuntarily switched to managed care. In the plans studied, this was not the case as patients in treatment were covered for continuing care through their existing provider for 3 additional months. Moreover, the carve-out company approached those providers and encouraged them to join its network to improve long-run continuity. In contrast, results from the Medical Outcomes Study showed that continuity was problematic for depressed outpatients in HMOs 10 years ago.[11]

The Mental Health Parity Act of 1996 requires some changes in almost all existing mental health care plans, regardless of whether they are traditional indemnity plans, part of an HMO plan, or separate carve-out plans. This article showed that the effects of removing limits is relatively minor under managed care in carve-out plans even with low co-payments. However, if the cost increase in traditional plans turns out to be as high as predicted by the CRS-Hay/Huggins model, we are likely to see employers trying to compensate for it through higher co-payments or by dropping mental health care coverage. In this case, both mental health specialists and primary care physicians are likely to encounter more uninsured or underinsured patients and have fewer total patients. Another possible effect could be that employers increasingly switch to intensively managed care plans and to single-source carve-out benefits to contain adverse selection.[12] In that case, mental health specialists (including both psychiatrists and nonphysician therapists) would experience a substantial increase in insured patients, but reimbursement rates will be more closely tied to contracts. Nevertheless, this may be preferable than the current situation, in which providers—and especially psychiatrists, who have the sickest and most costly patients—have to make decisions on what to do with patients who exhaust their benefits.

Roland Sturm, PhD

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References

1. Frank RG, McGuire TG. Estimating costs of mental health and substance abuse coverage. *Health Aff (Millwood)*. 1995;14:102-115.
2. Jensen GA, Morrisey MA, Gafney S, Liston DK. The new dominance of managed care: insurance trends in the 1990s. *Health Aff (Millwood)*. 1997;16:125-136.
3. Hay/Huggins Co Inc. *Health Care Benefit Value Comparison Model, HCBVC Version 6.5, PC Model Users Guide Documentation*. Washington, DC: Hay/Huggins Co Inc; 1995.
4. O'Grady MJ. *Mental Health Parity: Issues and Options in Developing Benefits and Premiums*. Washington, DC: Congressional Research Service; 1996. CRS Report for Congress, 96-466 EPW, US Library of Congress.
5. Sturm R, McCulloch J. *Mental Health and Substance Abuse Benefits in Carve-Out Plans and the Mental Health Parity Act of 1996*. Los Angeles: Research Center on Managed Care for Psychiatric Disorders, University of California, Los Angeles; 1997. Working Paper No. 105.
6. Duan N, Manning WG, Morris CN, Newhouse JP. A comparison of alternative models for the demand of medical care. *J Econ Business Statistics*. 1983; 1:115-126.
7. Newhouse JP. *Free for All?* Cambridge, Mass; Harvard University Press; 1993.
8. Wells KB, Manning WG, Duan N, et al. *Cost Sharing and the Demand for Ambulatory Mental Health Services*. Santa Monica, Calif: RAND; 1982. Document R-2960-HHS.
9. Goldman W, McCulloch J, Sturm R. *Costs and Utilization of Mental Health Services Before and After Managed Care*. Los Angeles: Research Center on Managed Care for Psychiatric Disorders, University of California, Los Angeles; 1997. Working Paper No. 108.
10. Wells KB, Sturm R, Sherbourne C, Meredith LS. *Caring for Depression*. Cambridge, Mass: Harvard University Press; 1996.
11. Sturm R, Meredith LS, Wells KB. Provider choice and continuity for the treatment of depression. *Med Care*. 1996;34:723-734.
12. Frank RG, Huskamp HA, McGuire TG, Newhouse JP. Some economics of mental health carve-outs. *Arch Gen Psychiatry*. 1996;53:933-937.

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Committee on Financial Institutions and Insurance
Senate Bill 160
February 22, 1999

Chairperson, Steffes and Members of the Committee, thank you for the opportunity to testify today on this very important bill. My name is James Cain and I am the Superintendent of West Franklin USD 287 in Pomona, Kansas. More importantly, I am the father of a 20 year old who has had a lifetime of mental illness. My wife and I originally accepted David into our home as a foster child when he was 5 ½ months old. We ultimately adopted him when he was 2. David's biological mother abused drugs and alcohol while pregnant with David. Consequently, he entered this world with a brain that simply doesn't function like most of us. To this day, he doesn't always understand right from wrong. In simple terms, his brain is wired backwards. He sees many things just exactly the opposite of reality. Obviously, this makes it difficult to function in our world.

David has received mental health services since he was seven or eight years old. We utilized mental health services through our local mental health center for several years. David had three very expensive in-patient private hospitalizations. These hospitalizations were effective. Each stay was able to provide appropriate medications that allowed David to function in society at a somewhat normal level. However, as he grew he outgrew his medications and it became necessary to re admit him to another hospital. Finally, during the third hospitalization, we maximized our health insurance benefits. During the first two hospitalizations, which lasted approximately 60 days each time, our share of the cost became many thousand dollars. The third hospitalization left us with a bill in excess of $50,000. At the same time, the insurance company had spent $100,000 on the three hospitalizations. In total, we spent something over $100,000 plus the costs of therapy that lasted for years.

Having run out of insurance, we had only one option and that was to give custody of David to SRS so he could access the state hospital system. David was screened at Topeka State Hospital and had long term admissions to Rainbow and Osawatomie State Hospital. The State of Kansas spent hundreds of thousands on his state hospital stays and we were billed for many thousand additional dollars.

To say the least, my family, our insurance company, and the State of Kansas became partners in David's mental health care, whether we wanted to or not. None of the three entities had any options but to participate in his mental health care.

The tragedy is that decisions about David's care were always driven by costs and not by his needs. The insurance company would discontinue paying benefits when he maximized their benefit coverage. I had to discontinue private hospitalizations when the insurance quit paying and when I couldn't generate the funds to keep him in the hospital

any longer. The State of Kansas would discharge him from the State Hospital when they felt he was stabilized to the point that he could receive needed services in a less expensive environment. In all the hospitalizations, both private and state, never was a discharge made on the basis that he no longer needed the service.

I could share with you all the tragedies that we experienced in the mental health system, where the care was inappropriate, where abuse occurred, where he was overmedicated, where he was ridiculed for being mentally ill, where he and his family were deprived of our rights, where my wife and I were consistently treated as second class citizens, where we were seen as the problem rather than the solution, where professionals had no understanding of mental illness at all, where patients are not respected, etc. But that is not the purpose of this hearing.

What you do need to understand from our experience is how unequal medical coverage hurts everyone. I have already explained that unequal coverage prevented us from getting David the care that he needed for years. Those were the formative years of his life and as a society, we failed this young man. There is enough wisdom to know how to treat David's needs, there is not enough available money to do so. I have been told that equal coverage would cause insurance premiums to increase by less than 2%. I don't know if this is true, but if it is, it would certainly be money well spent. You see in David's case the results were that he became uninsurable for life. My family lost our health insurance as we were dropped. We spent our lifetime savings to obtain care for David and ultimately sold our home to raise money to pay his hospital bills. We were genuinely homeless for several months while I earned a healthy living. David's care has cost my family all the luxuries of life that most people take for granted. We can no longer afford to drive a nice vehicle. We never go out to eat or for entertainment. We haven't purchased new furniture or even clothing in years. We still live in a double wide mobile home that is mortgaged far beyond it's worth. In essence David's care and lack of insurance coverage has cost my family a standard of living that anyone in this room takes for granted. That really probably still doesn't concern most of you. What should concern you is that our entire health insurance group was left without insurance because of David's claims. At the time our group consisted of slightly under 40 families. The effect of unequal coverage was that the care was not provided and yet nearly 40 Kansas families were left without health insurance. Since then we have been able to obtain health insurance for our group. However, initially the school district had to spend well over $100,000 to purchase our way into a group. This was a new expense to the school district. At the same time it forced many school employees to change health insurance that did not want to change as our new coverage requires all employees to be in the group.

I could continue for hours or even days to tell you about all the problems that have been created by unequal health insurance coverage. I could tell you that well over 100 Kansans have been negatively effected by one persons mental health not being adequately covered. I could tell you how David's family is still paying bills for his care from years ago. Most importantly I must tell you that unequal coverage is still costing this state thousands and thousands of dollars for David. You see David has now entered

the criminal justice system. We failed to meet his mental health needs during those formative years and he still lives. Unfortunately today he lives in jail. The State of Kansas is still providing his care. By all likelihood our state will continue to take care of David whether it is through the criminal justice system or through the mental health system. Perhaps I am naïve but I still believe had David's needs been met when he was eight, nine, or ten years old, he would not need the level of care that he needs today. Our failure to invest in the future frequently costs us considerably more later. It may be too late to meet David Cain's needs but it isn't too late to meet the needs of the hundreds of others that are just like David only much younger. Equal health coverage is an absolute must for Kansas. Please help your state by supporting Senate Bill 160. It is a good investment in the future.

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Senate Committee on Financial Institutions and Insurance
Testimony on Equal Coverage Insurance
Paul M. Klotz, Executive Director
February 22, 1999

Thank-you for this opportunity to speak in favor of equal health insurance coverage for serious mental illness.

This is a fiscal issue.

Community Mental Health Centers (CMHC's) provide care to over 100,000 citizens per year. Patient loads have generally doubled over the past ten to twelve years largely as a result of deinstitutionalization. During the period from 1970 to 1997, the State Hospital average daily census declined by more than eighty percent. Many of these former hospital patients now rely on CMHC's for mental health services to maintain their ability to live in their own community.

In Kansas, 97 percent of all citizens seeking public mental health care are seen at community mental health centers.

Of the CMHC clientele, 22,000 are serious, at risk patients that require ongoing care and treatment. An estimated 10,000 are seriously emotionally disturbed children that are being served in the community, and over 12,000 are severe and persistently mentally ill adults. Growth of these types of services in the community has been dramatic. Without CMHC's, these seriously mentally ill adults and children would be confined to a hospital.

Private insurance comprises only 7 percent of the funding stream to CMHC's. This is lower than it should be because in the majority of health insurance plans, only the required mandated limits for outpatient and inpatient mental health services are allowed. The lack of parity in mental health and the lack of the recognition on the part of private insurance companies as to the value of "non-traditional" mental health services have necessitated the development of a largely publicly funded mental health system throughout the nation. County, state and federal governments are funding necessary services that private insurance does not cover. According to data from the National Comorbidity Survey, 64 percent of individuals with severe mental disorders have private insurance.

The public supports it.

In June a nationwide poll conducted by Opinion Research Corporation for the National Mental Health Association (NMHA) revealed a major discrepancy between what Americans want in their health insurance and what they actually have.

While, the survey shows the vast majority of Americans -- 93 percent -- think mental illnesses should be treated the same as physical illnesses, the reality is that 96 percent of insurance plans provide inferior coverage for mental illnesses compared to other illnesses.

According to the National Institute of Mental Health (NIMH), one in four Americans will experience a mental illness in a given year.

NMHA's survey of more than 1,000 adults found:

- 61 percent strongly agreed and 32 percent agreed that health care insurance should provide the same coverage for mental health problems as it does for physical health problems.
- Support for mental health parity does not depend on an individual's belief that a family member might need mental health care: 61 percent of respondents strongly supported parity while 28 percent had a strong expectation of a family member's need for mental health treatments.
- Support for mental health parity may relate to an individual's awareness of insurance discrimination against people with mental illnesses. Of those polled, 61 percent (the same percentage that strongly favored mental health parity legislation) had some knowledge of the limits of their health insurance coverage for mental health treatments.
- 30 percent of respondents did not know the extent to which their insurance would cover mental health treatments. In fact, the Bureau of Labor Statistics said last year that 96 percent of insurance plans impose limits on mental health care that they do not place on physical health care.

Since 1994 nearly every state legislature has considered parity for mental health.

The Association attended a session on mental health parity while at the NCSL conference last year. Information was presented that mental health parity is an issue that is receiving a lot attention from state legislatures -- during the 1997-98 legislative sessions 88 bills were introduced in 32 states.

At the NCSL session, we received a comprehensive report from the National Institute of Mental Health, a division of the U.S. Department of Health and Human Services. The reports states that nondiscriminatory mental health care in combination with managed care "results in lowered costs and lower premiums (or at most very modest increases) within the first year of parity implementation." Moreover, NIMH specifically found that its research does not support assertions - made by some -- that "high financial costs" will result from parity because they are using outdated assumptions.

I ask you to review the NIMH study. It is particularly significant because for the first time, a nonpartisan and objective agency (unconnected to mental health advocates or insurance companies) has examined all available data and concluded that parity will in no way break the bank!

It will help reduce the stigma of mental illness.

Contrary, to persistent myth, mental illnesses are both real and definable. Thanks to research advances, the diagnosis and treatment of mental disorders have undergone dramatic improvements in recent years; enabling millions of people to be treated successfully lead productive lives. Furthermore, the great majority of people can now be treated on an outpatient basis. Even those who once would have spent much of their lives disabled and hospitalized can now live successfully in the community if they have access to treatment.

NAMI KANSAS

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Seeking the highest possible quality of life for persons with brain disorders and their families

Testimony

TO: Members, Senate Financial Institutions & Insurance Committee
FROM: Terry Larson, Executive Director, NAMI Kansas
RE: Senate Bill 160, Equal Health Insurance Coverage for Serious Brain Disorders
DATE: February 22, 1999

Thank you for this opportunity to speak here today.

I am testifying on behalf of persons with serious brain disorders (also known as mental illnesses) and their families. Today you have heard solid facts about the overall benefits of equal coverage and about what may happen to families due to the lack of equal coverage. Many of you have heard all of this before. But here we are in 1999 and still no decent health insurance for major brain disorders.

Equal health insurance coverage is about assuring highly effective treatments for mental illnesses. It is about keeping people in the work place, where they are productive taxpayers. It is about reducing general medical visits. Equal coverage is about eliminating unjust discrimination against one of the body's organs. It is about what is fair and what is moral.

Opponents of equal coverage have used every means possible to block fairness from taking place. I ask you to consider why we have health insurance coverage if not to protect families and individuals from catastrophic financial losses when someone becomes seriously ill or injured.

Somehow, policymakers, business owners and the insurance industry itself have decided that illnesses affecting the brain are not worthy of the protection afforded to every other illness, disorder and condition. Why is it acceptable to protect people when heart disease strikes but not when brain disease strikes? Why would the insurance industry deny coverage of brain disorders when the industry's purpose is to provide health insurance coverage?

There can be only one real reason that this inequity exists: The lack of understanding about brain disorders. The stigma perpetuates the injustice and the injustice perpetuates the stigma. Nineteen other states have chosen to end the discrimination. Nineteen other states have declared that this cycle must stop. All the fears that have been thrown to you by the opponents of equal coverage in Kansas are generally unwarranted - 19 other states have shown us that.

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When a state such as South Dakota can recognize this, why can't Kansas? We've been working on this issue for nine years. We have followed all the rules and conditions demanded of us. Yet, we still do not have equal health insurance for mental illnesses, which strike randomly and without respect to how good you are or how respectable your family may be. People are hurting, families are hurting - these people are your constituents. Yet, in 1999, the State of Kansas continues to discriminate!

We were required to produce an impact study. NAMI Kansas sought and received an actuarial study from the Kansas Insurance Department. Then we went one better - we commissioned KU's Institute of Public Policy and Business Research to conduct a system impact study. We were directed to produce a "laundry list" of illnesses to be covered. We developed a list of specific diagnoses to be covered. Yet, in 1999, the State of Kansas continues to discriminate.

Opponents of equal coverage have provided debatable information about this issue. They have referred to brain disorders as "mental health maladies." Everyone has a "mental health malady" from time to time, but mental illnesses are not mental health maladies. They are real biologically-based disorders. But the debatable information continues to be believed by the very people who can make a real difference. We, the supporters of equal health insurance coverage, find our support rooted in accurate scientific research, cost analyses and experience-based outcomes. Maybe, in 1999, the State of Kansas will end the discrimination.

It appears to us that those who oppose equal health insurance coverage for specified brain disorders are playing to public prejudices toward mental illnesses to defeat something that they think will lose business for them. Since we cannot counteract these efforts, we can only come to you and speak to the real barrier to equal coverage - that is, misunderstanding, ignorance, stigma. Consider:

- Until it happens to them or their family member, most people still think brain disorders result from bad parenting, dysfunctional relationships, their own character defects or spiritual deficiencies. Through scientific research, we know that none of these cause mental illness, any more than they cause diabetes, asthma or appendicitis. (We also need to look at all the disorders that are now covered equally but are truly self-imposed - think about diseases caused by cigarettes, alcohol and bad diets. What about pregnancy?)
- The symptoms manifested by many brain disorders are difficult to understand, causing suspicion and discomfort among "regular people." That is because symptoms of mental illness are demonstrated in terms of bizarre behaviors, strange thought processes and inexplicable mood changes. Why can't they just think/act right? Why can't they think positive thoughts? (The answer, of course, is that these symptoms are the illnesses. Would we ask a person with epilepsy to just quit having seizures, the person with Parkinson's Disease to just quit shaking, the person with a spinal cord injury to stand up and walk?)
- The very notion that equal coverage for major mental illnesses needs to be first tested in the state employees' health care plans is reflective of this irrational prejudice against brain disorders. To my knowledge, this test has never been required for other physical disorders - cancer, heart disease, asthma, kidney failure, diabetes, etc.

Look around this room. Chances are that there are several people here who are being treated for brain disorders. See if you can find the "faces of mental illness." Look at me: I am one of them. In fact, the coverage provided by the mandates adequately meets my needs. I will receive no economic benefits from SB 160 - in fact, I will probably lose a few dollars. But what if my illness becomes more severe? Would I have to quit my job and end my ability to be highly productive? Would I have to quit being a substantial taxpayer in order to get the treatment I might need? This could happen. It could happen to you, too, or to someone you love very deeply.

Ending the discrimination against medically treatable mental illnesses means doing what is moral and what is right. It is about protecting hard working families and individuals from financial devastation. It is about easing the burden on the taxpayers. It is about you, me and all of us.

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Memo To: Chairman Steffes and Members of the Senate Financial Institutions and Insurance Committee
From: Sherry C. Diel, Deputy Director
RE: SB-160--Act Eliminating Discrimination In Coverage Of Specified Mental Illnesses
Date: February 22, 1999

What is Kansas Advocacy and Protective Services, Inc.?

Kansas Advocacy and Protective Services, Inc. ("KAPS") is a federally funded non-profit corporation. Our agency serves as the designated Protection and Agency for persons with disabilities in the state of Kansas. Each state and territory in the United States has a similar type of organization. Our role is to advocate for legal rights and services for persons with disabilities. Pursuant to federal law, KAPS has authority to pursue resolution of disputes through use of legal, administrative and other appropriate remedies. Because our funding is limited, KAPS utilizes priorities, developed as a result of public input, to advocate for systemic changes in the public and private sector to benefit Kansans with disabilities.

KAPS supports the amendments proposed by SB-160.

Insurance parity for the mental illnesses specified in this bill has been a goal of many consumers and mental health advocates for many years. The illnesses specified in this bill oftentimes require short-term in-patient hospitalization during periods of crisis to stabilize the person. With the low maximum insurance benefits provided for in current law, persons with serious and persistent mental illness must rely on the public sector for treatment and vital medications. This places a significant drain on finite public dollars. For those persons whose income levels are too high for Medicaid eligibility, those persons oftentimes go with out vital treatment because they cannot afford it. They simply fall through the cracks until their condition becomes too severe to ignore.

Mental illness is not a choice. It can happen to any of us or someone we know. This bill would not only preserve vital public dollars, it would greatly benefit those persons who fall through the cracks. I know, I was one of those persons. After receiving the news that my daughter would not live to reach her 5th birthday. I stayed at home to care for my daughter, so we lived on my husband's income. We could not qualify for any public supports. I

suffered from major depression for a 2-year period of time without treatment because our family's income went to pay for treatments for our daughter that our insurance did not pay for.

If the Senate passes HB-2005 which provides that mandated health coverages would apply on a trial basis to the State health plan for 18 months before a recommendation is made as to whether it should be mandated on the private insurance industry, mental health parity for certain mental illnesses may become a reality.

Advocates for many years have said that raising the maximum limits for mental illnesses to be equal to those of physical illnesses would not have a major impact on health insurance rates. If HB-2005 and SB-160 pass both Houses, we will finally have the data to show that coverage for these specified mental illnesses does not substantially impact insurance rates. Moreover, the benefits derived from this mandated coverage will substantially outweigh any costs associated with increased mental illness benefits.

KAPS respectfully requests the Committee recommend SB-160 favorably for passage. Should you have any questions or concerns, please do not hesitate to contact me at (785) 273-9661.

KMS

KANSAS MEDICAL SOCIETY

February 22, 1999

TO: Financial Institutions and Insurance Committee

FROM: Meg Draper
Director of Government Affairs

SUBJ: Mental Health Insurance Coverage

The Kansas Medical Society appreciates the opportunity to provide written comments today on the issue of insurance coverage for mental illness.

The KMS House of Delegates debated and passed a resolution relating to mental health insurance benefits at the KMS annual meeting in 1997. The resolution concludes by stating:

> "Resolved, that the Kansas Medical Society endorse the principle of third party payors providing mental illness benefits which are equivalent in scope and duration to those benefits provided for other illnesses."

KMS therefore supports the concept of mental health parity and believes that patients are entitled to receive equal benefits for physical and mental illnesses. Thank you very much for considering our comments.

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