THE BUSINESS CASE FOR ENLIGHTENED MENTAL HEALTH CARE

HOW VERMONT BUSINESS BENEFITS FROM MENTAL HEALTH PARITY, ACT-129, H.404 AND H.411

A Study Prepared for

THE VERMONT PSYCHOLOGICAL ASSOCIATION

THE VERMONT MENTAL HEALTH COUNSELORS ASSOCIATION

THE VERMONT PSYCHIATRIC ASSOCIATION

THE VERMONT CHAPTER OF THE NATIONAL ASSOCIATION OF SOCIAL WORKERS

VERMONT SUBSTANCE ABUSE WORK TASK COMMITTEE

by
James T. Wrich
J. Wrich & Associates, L.L.C.
Madison, Wisconsin

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Executive Summary

The purpose of this paper is to demonstrate to Vermont's business community and the State Legislature that there is a continued need for enlightened mental health legislation. The main objective is to assure that those suffering from mental and substance use disorders get the right care, the first time at a reasonable cost. It is with considerable thought and research that the Vermont Psychological Association, the Vermont Mental Health Counselors Association, The Vermont Chapter of the National Association of Social Workers and the Vermont Psychiatric Association And The Vermont Substance Abuse Work Task Committee have jointly taken a strong position supporting such legislation. But most important, it is in the interests of other key stakeholders that H.404 and H.411 be enacted.

The stakes are high. Studies show that three people out of ten in the adult population have a current mental or substance use disorder and that roughly half of the population will encounter such a problem during their lifetime. Yet only one in nine with a mental disorder will receive treatment from a professional with a specialty in their illness and, worse yet, only one in twenty-six with a substance use disorder will receive appropriate care. By appropriate care we mean, first of all, care that is delivered by professionals who are trained and experienced in the specific disorder–in other words, a mental health or substance abuse professional. Second, we mean care that is delivered at the appropriate level and for the appropriate duration of time to achieve optimal results considering the patient's condition. The intensity and duration of care will vary depending on the specific disorder and its severity. The earlier the intervention, the more effective and less costly these problems will be, both in terms of treatment expense and by reducing the adverse cost effects of a prolonged, active condition.

Certainly those afflicted with mental and substance use disorders will benefit from H.404 and H.411 because it will remove barriers to care that still exist in spite of the enactment of Vermont's Mental Health Parity, Rule 10, 95-2 and Loss Ratio (Act 129) legislation. Those suffering from these afflictions live day to day not knowing where their depression, anxiety or addiction might lead them. They do not have control of their lives, in spite of often heroic efforts to control their symptoms through will power. The efforts of family and friends are to no avail. Only appropriate care will relieve the symptoms, and more importantly, help them achieve an optimal level of functioning so they can be productive members of society.

In addition to those afflicted are those directly affected. Studies show that unresolved mental and substance use disorders of parents wreak trauma on their children which often is carried into the schools in the form of behavioral and learning problems, and later into adult life in the forms of addiction, depression, and violence.

The general public will benefit from this legislation significantly in other areas. Prisons across the country are populated with inmates who suffer from mental and substance use disorders. According to the Robert Wood Johnson Foundation, 78 percent of inmates nationally are incarcerated either due to an alcohol or drug related offense or because they were under the influence of drugs or alcohol when they committed the crime for which they were convicted. Over half of all unplanned pregnancies occur when at least one of the parties is under the influence. Alcohol is involved in over half of the traffic fatalities. The suicide rate among alcoholics has stood at seven times the national average for years, and depression is involved in the vast majority of these cases. Moreover, on the horizon is a potentially huge problem as Military Service Members return from Iraq and other combat theatres with post traumatic stress disorder (PTSD), addiction and anxiety disorders triggered by combat trauma. Many of them

are going to need care that goes beyond that currently provided to the civilian population or we will all face the consequences for at least thirty years to come.

Taxpayers specifically will benefit because increasingly the burden of paying for health care is becoming so heavy that the business community is providing less coverage to fewer employees. Unless this trend is reversed, increasing numbers of those who become uninsured or under-insured will be shifted to public health care programs.

As much as any of the stakeholders, Vermont's business community stands to benefit from H.404 and H.411. It bears a large portion of the cost of health care and untreated or inappropriately treated mental and substance use disorders have a huge adverse comorbid impact on overall health care costs. Depression alone is involved in more than 40 percent of cancer cases, 23 percent of heart disease, and 15 percent of diabetes. But this is only part of the problem to employers. At least as important is the impact on overall operating costs. Countless studies show that when employees or their families suffer from these problems, the impact on employee productivity, on-the-job accidents, and sick leave burdens employers with enormous costs and frustration. On the other hand, benefit to cost studies of Employee Assistance Programs have demonstrated the financial rewards to employers of providing good mental health coverage.

None of this is news – neither the devastation nor the ability to curb it through appropriate care. In 1995 Kenneth Howard, PhD, Chairman of the Psychology Department at Northwestern University in Evanston, Illinois reported that more than 300 outcome evaluation studies had been conducted to that point which demonstrated the efficacy of appropriate treatment for mental and substance use disorders.

What is not generally known, however, is that managed health programs in Vermont and elsewhere may well be costing employers more than unmanaged care. Both an audit of the Vermont State employees health plan a few years ago and the loss-ratio data generated by Act 129 show that the non managed segments were less expensive to the employers involved and that enrollees received more care as measured in dollars spent. Lower administrative costs and higher loss ratios in the non-managed segment accounted for this outcome.

So, the fundamental question is this: If mental and substance use disorders are so devastating, but effective treatment is available, why is such a large portion of those afflicted not receiving the care they need? This paper addresses that issue and shows how the enactment of H.404 and H.411 can help correct the situation.

The Need for Good Mental Health Services.

Research shows that about 30 percent of the adult population age 15 to 64 has a current (past 12 months) mental or substance use disorder serious enough to be classified in the Diagnostic Statistical Manual of Mental Disorders (DSM IVR). Approximately 50 percent will encounter such a problem during the course of their lives.[1] The costs both in money and human suffering are enormous. When combining Depression, Anxiety, and Substance Use Disorders alone, the social costs may well range from $200 billion to $500 billion annually[2]. This includes lost productivity absenteeism and accidents at work, increased auto and liability insurance, and incarceration of those who committed an alcohol or drug related crime. Trauma, especially if experienced in early childhood can lead to a host of other mental health problems including violence at home and in public, addiction, depression and anxiety. [3] Much of the cost is borne by employers.

That's the bad news. The good news is that good mental health care can reduce this burden, saving dollars and lives at the same time. In fact, many employers, public and private, have discovered how valuable good mental health treatment can be when they conducted benefit to cost studies of their Employee Assistance Programs. Benefit to cost analysis conducted by J. Wrich & Associates, LLC. (JWA) have shown positive a BCR ranging from 3 to 1 to 7 to 1 in five years with a payback period as short as 10 months. All costs of treatment, the time off to get it, and the operating cost of the EAP were included. The only benefit against which these costs were weighed was improvement in use of sick leave after EAP use. Attachment A summarizes these findings.

Such results could not have been possible if the mental and substance abuse treatment had not been effective. Indeed, studies show that "The Effect Size of Therapy" is 80%, which means that 80 percent of those in therapy are better off than an equivalent untreated population. Moreover, none of the companies in these studies enlisted managed behavior health practices which denied necessary care[4]

Yet, short term financial interests of insurers can mitigate against the need for adequate care that is the foundation of such positive benefit to cost results. In addition, the serious cost bind experienced by many companies as they try to provide good health care coverage to their employees can obscure the perception of what effective mental health and substance abuse treatment entails. Equally important is the adverse comorbid impact on overall medical surgical costs when mental and substance use disorders are either left untreated or are treated inappropriately. Finally, there are the huge social consequences of untreated mental and substance use disorders which will be addressed later.

Since this paper is written for the business community, much of the focus is on how it is impacted by the overall problem of health care cost escalation. From that perspective, the positive role effective mental health care can play, and the need for legislation to assure its delivery is more easily understood.

The Problem

[1] National Co-morbidity Study (NCS), Kessler, Ronald, PhD, et al.
[2] Sources: Various including the Robert Wood Johnson Foundation and the Substance Abuse and Mental Health Administration (SAMHSA) of the National Institute of Health.
[3] Vander Kolk, Bessel PH.D. Harvard. "The Compulsion to Reenact the Traumatic Experience"
[4] Source: Scott Miller, Brattleboro Retreat Workshop, January 6, 2006. "Beyond Integration: the Triumph of Outcome over Process in Clinical Practice" Miller, Scott; Duncan, Barry; and Hubble, Mark.

Employers of all descriptions are chaffing under the burden of escalating health care costs. It is difficult to argue that we in the U.S. are getting our money's worth when comparing our health care costs to those in other developed countries.[5] U.S. health care costs are more than twice the median of thirteen other High Income OCED Countries, even though many of them have older and presumably more vulnerable populations.

In examining the causes of U.S. health care cost escalation, one finds that the preponderance of the problem is not in the areas that have received the most attention over the past twenty years. The fees charged by service providers, the demand by consumers, or even the incidence of disease in the general population, while significant, are not the primary forces driving up health care costs. The major issue is in the manner in which health care is financed. The problem is systemic and not relegated to one or a few discrete components. As we have seen time and again, cost containment approaches which serially extract and examine one part at a time while ignoring its relationship to the system as a whole miss the main issue. The solution requires a quantum approach in which the relationships of the components to each other and the effect on the overall system are analyzed and addressed.

Warren Benis, the widely acknowledged leadership guru of the 1990's once remarked:

"Content without context is pretext"

Therefore, significance of mental health legislation must be viewed in the context of the system as a whole and not as just one more cost item. The focus of this paper is two-fold:

1. To understand the health care cost escalation problem and its implications for business concerns, and,
2. To develop an appreciation for the mental health legislation advocated by three of Vermont's major mental health professional associations.

Light must be shed on the background and context of the issue beginning with overall health care costs and how it affects business, and followed with the role mental and substance use disorders play in this problem. This will entail a discussion of the effect of good treatment for mental health and substance use disorders and why certain legislation is necessary in Vermont to assure the delivery of such treatment.

Health Care Costs in Vermont: Today and Looking Ahead.

It is estimated that total health care costs in Vermont, including private and publicly funded programs, have reached $3.0 billion annually, or about $4909 per capita. This compares to $5670 per capita nationally.[6] Traditionally Vermont's per capita costs have been lower than the national average but this gap has gradually narrowed over the past several years. As a percent of Gross State Product, health care represented 14.7 in 2003, the highest level ever recorded. Nationally, health care represented 15.3 percent of the GDP.[7] Without a significant change in

[5] Sources: "World Health Organization Report 2000 – Health Systems: Improving Performance (Geneva: WHO, 2000), and "The U.S. Health Care System: Best in the World or Just the Most Expensive?" University of Maine, Bureau of Labor Education.
[6] Source: BISHCA, "Vermont Annual Health Care Expenditure Analysis and Forecast", March 2005.
[7] Ibid.

the health care system, the total cost in Vermont could grow to $5.0 billion per year by 2010 based on the trend line of the past five years, with per capita costs exceeding $7500.

Regarding insurance coverage, Vermonters fall into three major categories:

1. Roughly 60 percent access health care through private insurance plans, largely provided by employers.
2. Roughly 30 percent receive health care through a publicly funded program.
3. The remainder, 10.1 percent, have no insurance and struggle to get minimal care regardless of how urgent their needs may be.

It is estimated that 62,530 Vermont residents were uninsured during 2003, up 21.8% from 2000 versus a 13.1% increase in the number of uninsured nationally during that period. This group experienced the most dramatic growth change by far of the three major categories. As is true nationally, a large majority (over 70%) of uninsured Vermonters age 18 and over were employed and of those having jobs two-thirds were working full time.[8] More than 6000 children and adolescents were uninsured with most living in households where at least one adult was employed.

Impact on Business and Individuals

Most developed countries have some form of national health care provided through their governments. In contrast, a majority of U.S. citizens have access to health services though an employer health plan. Funding of such plans is usually shared by employers and employees through premium payments with those who actually use the plan generally paying a greater share of the overall cost through co-pays and deductibles. The structure and incentives in this reimbursement system have evolved into a major crisis where the current cost and financing of health care adversely affects nearly everyone, from the largest corporate entity to the smallest child. Let's look at some of the major ramifications:

- Large U.S. corporations have difficulty competing in world markets against foreign competition whose governments provide national health care. This carries over to their vendors and suppliers who are often small businesses.
- Through cost shifting, employers with generous health plans are often charged more for services in order to offset the providers' cost of uncompensated care generated by public programs and private insurance plans with poor benefits.[9] [10] Thus, the employees in these companies face a dilemma: demands for good insurance coverage may jeopardize their jobs or result in lower wages.
- For many families, the biggest threat to financial security is not lack of earning power as much as poor health. Without adequate health insurance coverage, one serious illness or accident can wipe out a lifetime of savings and with it the educational opportunities of the children and the economic security in later years for the adults.[11]

[8] BISHCA: "Profile of the Vermont Uninsured" Issue Brief No.1 September, 2001.
[9] Institute for Policy Innovation: "Issue Backgrounder", Prescription Drug Payola Scam Breaks Wide Open, The Economic Problem With Rebates: *Cost Shifting*, Dr. Merrill Mathews, Jr.
[10] Source: Vermont Association of Hospitals and health Systems "Act 53 of 2003 (18 V.S.A. -9405b), p.3.
[11] "Planning for the Future" The 4th Pillar: Meeting the Cost of Health Care. Harvard Consumer Bankruptcy Project.

- Small employers, the self-employed and farmers often cannot afford to buy health insurance for themselves or their employees.[12] Small group policies are very expensive and premiums can rise suddenly and at a staggering rate. Individual policies are even costlier.[13] High deductibles and pre-existing conditions clauses can leave policyholders with no coverage for the very issues most likely to require medical attention. In Vermont, the better a person's health, the greater the likelihood they have private insurance. Conversely, those who reported fair or poor health were more likely to be uninsured.[14]
- Health providers, in spite of attempts at cost shifting, are saddled with bad debt that exceeds the amount of charity care they can provide. Uncompensated service for Vermont hospitals alone totaled $33 million in 1999, versus $14 million in free care.[15] This expense ends up being borne by the general public in the form of increased fees for service.
- With few exceptions, the cost of health insurance is beyond the means of those who are without it.[16] Many who have coverage are strapped by high co-pays, deductibles, and preexisting condition clauses which can still leave them in dire financial straits.[17]
- As cost, accessibility and quality problems grow, the odds of delivering effective health care at a reasonable cost diminish. When personal health issues are not effectively addressed early in their onset, they become more expensive to treat and the prognosis for recovery is poorer.[18] Both human suffering and the cost of care increases.

At the end of the day, the only reliable way to contain health care expenditures is to assure that people get the right care, the first time, at a reasonable cost.

Considering all of this, it is no wonder that employers often react negatively to any proposal that may remotely appear to potentially increase health care costs. Benefits managers and CEOs across the country nearly all believe that health care is an entitlement but they have difficulty visualizing how their companies can provide it and remain competitive. Many are already strapped for cash in a flat economy. In self-defense, businesses nationally have been forced to increase co-pays and deductibles or reduce benefits. Some have found it impossible to offer employees any health coverage at all.[19]

Business in Vermont is no exception. From 1999 through 2003, private insurance coverage dropped from 62.3% to 58.2% of the population while the publicly funded and the uninsured segments increased. Without a plan to strengthen and improve health coverage while containing costs, Vermont's citizens and employers are likely to pay higher premiums for lower quality and less access, while more citizens are either shifted to publicly funded programs or join the ranks of the uninsured.

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[12] Study: Farmers have hard time getting insurance. Milwaukee Journal Sentinel, November 8, 2002

[13] Kaiser Commission on Key Facts: Medicaid and the Uninsured, "The Uninsured and their Access to Health Care. Jan. 2001.

[14] BISHCA: "Profile of the Vermont Uninsured" Issue Brief No.1 September, 2001.

[15] "Governor's Bipartisan Commission on Health Care Availability and Affordability."

[16] Families USA, *A 10-Foot Rope for a 40-Foot Hole: Tax Credits for the Uninsured,* 2002 Update.

[17] *The Erosion of Employer-Based Health Coverage and the Threat to Workers' Health Care,* The Commonwealth Fund, Issue Brief, August 2002.

[18] *Medical Emergency Live Sicker, Die Younger: The Plight of the Uninsured,* San Francisco Chronicle, April 27, 2003.

[19] *The Erosion of Employer-Based Health Coverage and the Threat to Workers' Health Care,* The Commonwealth Fund, Issue Brief, August 2002.

Key Factors in Health Care Cost Escalation

Getting the right care, the first time at a reasonable cost. Few would argue the merits and necessity of such a goal. Yet, there are major barriers in achieving it.

1. Managed Care Practices that Hinder Delivery of Good Care
2. High Administration Costs
3. Unaddressed Comorbidity

Effectively addressing these barriers constitutes the basis of our contention that it is in the interest of business to support and embrace enlightened mental health legislation. Each of these three problems significantly affect the delivery of all care, particularly mental health care, and are therefore addressed by currently proposed legislation. They are examined in detail in this paper. A fourth barrier – the Plethora of Plans Triggering Anti-Selection – is also a major issue affecting delivery of care, but being broader in scope is not addressed in the proposed mental health legislation and will only be touched upon briefly in this paper.

In the absence of a uniform national or statewide health care plan that covers all Vermont citizens, the huge administrative costs in managing and delivering care through several hundred variations of private plans will not subside. A simple comparison of the administrative costs of Medicare/Medicaid at less than 5% versus the 20% to 35% cost of private plan administration provides a partial view of the issue. When adding in another 10% to 20% of provider administrative costs in directly related responses to managed care practices, the contrast is even greater. Of the $3.0 billion spent in Vermont for health care, a conservative assumption might put the overall administrative cost at 25%. If this was reduced to 10% -- or twice the administrative costs of Medicare/Medicaid -- the savings of $450 million would be sufficient to provide health care coverage to all 62,530 uninsured Vermonters with more than $140 million left over annually after the first 18 months when costs for those who had been without insurance would be higher than average due to morbidity build-up resulting from the absence of adequate care. However, caution is needed here. While the immediate effect of a uniform program covering everyone would likely be lower costs and fewer uninsured, the savings could be short lived due to the adverse comorbid affect on medical costs of unaddressed mental health and substance use disorders. We will address this issue later. Let's first look at administrative costs.

Managed Care and the Rise in Administrative Costs. Underlying the basic concept of managed care is the premise that health care professionals cannot be trusted to provide only the amount of care reasonably needed at a fair price. In the 1970s and 80s, employers came to the conclusion that someone other than the providers had to keep an eye on what was happening and try to control it. In the 1970's independent organizations – HMOs -- were established to fulfill this role. Congress passed a law requiring companies to offer an HMO alternative. It was expected that administrative costs would increase somewhat as more non-clinical oversight tasks were employed in the delivery of health care. It was also expected that overall costs would be kept in check. As experience demonstrates, that has not happened. Now as in the 1970s and '80s, health care costs continue to rise at several times the rate of inflation.

On the medical side, the sheer plethora of plans – HMOs, PPOs, indemnity plans, with dozens of variations in each– not only created an environment in which anti-selection could flourish, but also added significantly to the overall cost of administration. On the mental health side, however, something much different has occurred. The development of managed behavioral health systems a decade or two later took place at the same time as another business phenomena was evolving – the widespread use of mergers and acquisitions to grow companies. As a result, in the mental health arena the problem of excessive administrative costs had a different genesis than on the medical side.

The traditional means by which investors made money -- funding companies that could profitably sell their goods and services to increase market share – gave way to mergers and acquisitions in the 1980's and 90's. This strongly influenced the way Managed Behavioral Health Organizations (MBHOs) delivered care. Throughout that period some of the larger MBHOs hoarded cash or incurred huge debt to finance mergers and acquisitions. This accounted for a major portion of MBHO expense. The result was that loss ratios – the portion of premium spent on direct care – were found to be as low as 38% in performance audits conducted by JWA, LLC and none had a loss ratio in excess of 55%. Meanwhile, medical HMOs had loss ratios in the 75% to 90% range while Medicare/Medicaid was well above 90%. Benefits managers were shocked at these findings and legislation has been passed at the state level requiring MBHOs to disclose their loss ratios. Vermont was the second state nationally to pass such legislation when ACT 129 was enacted in 2001.

Legislation to Correct the Problem and Safeguard Effective Care.

Most people believe that self-monitoring in the interest of the general welfare is preferable to legislation. However, history shows that laws become necessary when individuals or organizations are either unable or unwilling to resist pressure to act in a manner that is contrary to the public well being. The Vermont legislature has recognized this need and acted upon it in the case of mental health services.

Act 129. Transparency lights the pathway to accountability. The effect of ACT 129 has been dramatic. Reported loss ratios for MBHOs have risen from an average of 58.5% in the two years before enactment to 71.5% in the two years immediately following. The Unmanaged Mental Health Services segment shows a significantly higher loss ratio than the MBHO services (85.8% before and 83.5% following) but, in what may be a surprise to many employers who have not closely analyzed their own data, the Unmanaged Mental Health segment provided service at an overall *lower* cost to employers than the managed mental health services. During the years for which data was available to us, mainly 2000 through 2003, the overall average per member per month cost to employers computed to $8.45 for more than 523,000 covered members. Analysis of the data shows that the mean average cost for 371,000 members in *managed* plans computed to $9.61 per member per month versus $7.61 for 152,000 members covered in *non-managed plans*.[20] Amazingly, the managed segment grew by 40% during that time and the unmanaged segment shrunk by 50%.

[20] All computations were based on data provided by BISHCA including data reports collected under ACT 129.

In truth, none of this is a complete surprise. A few years ago our company conducted a study of the Vermont State employee health plans which provided both medical and mental health services. This study showed that the State's self funded, self-administered Choice Plus medical plan cost 3.2% less and provided 10.6% more service as measured by dollars spent, than the HMOs ***when comparing like enrollees***. However, because of anti-selection -- skimming off of lower cost enrollees -- the HMOs appeared to be far less expensive on the surface -- $3910 per family versus $4656.

As for the counterintuitive growth patterns in market share, they can largely be explained by the fact that the marketing muscle of large MBHOs can dwarf the smaller providers regardless of cost or quality of service, particularly when they are enlisted as subcontractors by large medical insurance companies.

Because of ACT 129, employers, employees and Unions in Vermont have a better chance of making a more rational decision when deciding how to provide mental health services to employees. Moreover, MBHOs that are both effective and efficient can now be delineated from those that are not but who simply low-ball their prices to buy into the business while engaging in denial of care after securing the contract. Further, purchasers and consumers of mental health services are not as likely to assume that just because a service purports to be managed, that it will be less expensive.

Need for Further Legislation. Important as it is, simple disclosure of loss ratios will not in itself assure quality mental health care. In order to do that, accessibility to the right care is essential. This means that a large number of practitioners who collectively have expertise across a broad spectrum of disorders must be available to enrollees. The Diagnostic Statistical Manual of Mental Disorders (DSM-IV) covers seventeen major categories with dozens of discrete diagnosis. While research shows[21] that more than half of those having any DSM disorder will be afflicted with one or a combination of the three most prevalent – affective disorders, substance use disorders, or anxiety disorders – the other issues cannot be overlooked. Several studies have shown the existence of a serious adverse co-morbid relationship between untreated mental/substance use disorders and medical costs. Attachment B. shows the relationship of depression to major medical issues while Attachments C and D show the relationship of untreated alcohol abuse and alcoholism to a host of medical and social problems. Attachment D is a detailed index of the potential cost impact of mental and substance use problems across the spectrum of ICD-10 medical categories in the health claims of several JWA, LLC customers.

H.404. Like any other business, MBHOs and insurance companies must make a profit to stay in existence. However, efficiency does not necessarily translate into effectiveness where health care is concerned. Again, the total context of the issue must be considered. If MBHOs or insurance companies restrict the number of practitioners, they may improve their bottom line, but they will also jeopardize the chances of enrollees getting the care they need and this will nearly always comes back to haunt employers on the medical side of the cost issue.

H.404, addresses the issue of limiting accessibility by opening the MBHO panels to any willing and qualified mental health provider just as the HMO panels are open to any willing

[21] National Co-morbidity Study (NCS), Kessler, Ronald, PhD, et al.

and qualified medical practitioner. Testimony on this issue is presented in Attachment F., but a summary is offered here:

1. Closed Panels for Mental Health Providers are Inconsistent with the Open Panels of Most Physical Health Care Systems.

- A significant majority of Vermont physicians are empanelled in the Blue Cross Blue Shield system.
- Only 30% of Vermont's mental and substance abuse providers are empanelled by Magellan, Blue Cross Blue Shield's subcontracted MBHO.

2. Open Panels Provide Greater Choice for Consumers.

- Audits show that Rural Residents can be short changed and Vermont is a largely rural state.
- There is potential for "de facto" restraint of trade inherent in closed panels.
- Closed panels risk losing experienced therapists.

3. Portability of Coverage is jeopardized.

- People are on the move.
- Transition from one therapist to another is costly and can adversely affect clinical outcomes. If a company changes plans, an employee who is already seeing a therapist would have to change therapists if the therapist were not in the network of the new plan.

4. MBHO's Claims of Credentialing Expense are greatly Exaggerated.

- In order to meet NCQA requirements, MBHOs must do primary verification of providers. Estimated cost is about $200 per therapist, or about 16 cents per therapeutic session for a full time therapist that provides 1200 hours of therapy per year.
- This computes to less than .02% of a therapist's fee and even less as a percentage of the MBHO's premium.

The stigma and shame that attends mental and substance use disorders has often allowed discriminatory practices that would be unconscionable in any other area of medical practice. H-404 supports the principle objective of Vermont's Parity Law of assuring that a patient can receive equal treatment for both the mind and body.

Parity.

The Vermont Mental Health Parity act went into effect on January 1, 1998. In keeping with its position as a leader in consumer protection in health care, Vermont was among the first states in the nation to pass such legislation. As such, it became a model how to assure that individuals can secure equal treatment for both the mind and the body. However, as often happens with legislation, those who were regulated by it looked for ways to safeguard profits while complying with the letter of the law. At this point, we wish to state that from a business standpoint, there is nothing immoral about this. Businesses have a fiduciary responsibility to maximize shareholder value. However, from the standpoint of

delivering mental health services in a manner consistent with the intent of the law, some major loopholes were exposed which undermine this objective. H.411 aims to close those loopholes.

H.411. The Vermont Psychological Association, the Vermont Mental Health Counselors Association, and the Vermont Psychiatric Association support this bill because it can eliminate loopholes in the current Parity Act. Experience is showing that there are a number of practices in managed health plans that take advantage of these loopholes at the expense of patients, employers, and the general public.

Specifically our associations wish to eliminate paragraph (d) of Sec. 1. 8 V.S.A. 4089b, (a) (3). This provision states the following:

> "A health insurance plan shall be construed to be in compliance with this section if at least one choice for treatment of mental health conditions provided to the insured within the plan has rates, terms and conditions that place no greater burden, financial or otherwise, on the insured than for access to treatment of physical conditions."

In practice, this provision allows an employer to provide two health plans: one with good coverage for physical health conditions that has no mental health provision, and a second with clearly inferior coverage, which contains a mental health benefit with equally poor coverage. Either way, an employer who chose to engage in such a practice could save money in the short run, but employees would be forced to choose between a plan that offered poor over-all coverage for both physical and mental disorders, and one that provided no mental health coverage at all. The law should not be written in a way that could put a conscientious employer or insurance carrier at a disadvantage in the market place by rewarding its competitor for gaming the system.

There are other loopholes in the Parity Law that also need to be closed. The playing field needs to be leveled.

If a health care plan is managed it should not be permitted to have budget or reimbursement policies for mental and substance use disorders which create discriminatory treatment practices that permit selective denial of care. When insurers use a capitated budget "carve out" for mental health and substance abuse treatment without enforcing the same practice for medical surgical treatment, it is a discriminatory practice and needs to be eliminated. If such a practice were enlisted for oncology or treatment of heart disease, it would not be tolerated. Uniform budgeting policy and payment practices should apply to all care, whether it is for mental, substance use, or medical surgical disorders.

Moreover, charging co-payments or deductibles that are either higher for mental health and substance abuse treatment than for comparable primary care or that represent a higher percentage of the total cost of care, are clearly discriminatory and a serious barrier to those seeking care for these disorders. Again, if a category of physical disorders – Musculoskeletal, for example -- were singled out for this type of discrimination, it would not be tolerated. Equivalent co-payments and deductibles for equivalent levels of care should

be a uniform requirement across all disease categories, including mental and substance use disorders.

In addition, discriminatory administrative practices also need to be eliminated. Managed plans should not be allowed to employ practices in admissions, care authorization or continuation of care for mental and substance use disorders than are not also used for medical surgical problems. At present, enrollees are subjected to rigorous and intrusive review and authorization practices when seeking care for their mental and substance use disorders that they do not encounter when they seek treatment for medical surgical issues. Once again, the playing field needs to be leveled. Uniform administrative practices are needed for all health problems and must be complied with by all insurance companies, HMOs and MBHOs so that those who are the most clever at gaming the system will not have a competitive edge in the market place over those who are most conscientious in delivering good care.

An insurance plan should not be managed in a manner that allows treatment of less severe, episodic issues while neglecting to provide treatment for the more complex, chronic disorders. Therefore, no plan of insurance should be allowed to selectively exclude chronic mental or substance use disorders when chronic physical disorders are covered. As established earlier in this paper, mental health issues that are left untreated significantly impact medical surgical disorders and are a driving factor in escalating health care costs. The proper treatment of chronic illness has long been recognized as an essential component of health care. Consequently, MBHOs that deny care for chronic mental and substance use disorders can enhance their profits without suffering the cost consequences on the medical surgical side of the equation. The result is that everyone else – employers, employees, and public programs – pays for the increase in relapse and comorbid effects while the MBHOs experience no adverse consequences. In the meantime, those who are afflicted, suffer longer.

Social Consequences.

Once again, we return to Benis's quotation and consider the larger context within which this issue must be considered. Looking at it only from the standpoint of mental health and its cost is the narrowest of views. Reviewing the co morbid effect on medical surgical costs broadens the issue somewhat, but not enough. Calculating the impact on employers is broader yet, but still leaves out the most important consideration. Any discussion of treatment for mental and substance use disorders would be incomplete without examining the social consequences of not providing effective treatment.

Currently, half of the traffic accidents nationally involve alcohol. So our insurance rates are higher. In half of the unplanned pregnancies, at least one of the parties was under the influence of alcohol or drugs, so our cost of education, welfare and medical care are greater. An inordinate number of child abuse and neglect cases, drownings, suicides and family violence involve mental or substance use disorders and the cost effects reverberate throughout our society. Often, lack of treatment leads to various types of anti-social or illegal activity.

Looming ominously in the background is the ever-present temptation to advance criminal justice responses in dealing with these issues. A striking example is seen in the trend

towards incarcerating those who's mental or substance use disorders, largely untreated, are a factor in criminal activity. At the same time, some MBHOs will not authorize treatment if the patient is involved in illegal activity or is a court referral. Moreover, many MBHOs specifically exclude authorization for care of youth exhibiting so-called "Conduct Disorders" even if there is no involvement in illegal activity.

While various mental disorders can be involved in anti-social behavior, the figures on substance use disorders alone are astonishing. Cracking down on alcohol and drug abusers has been popular with state legislatures across the country during the past twenty years. But, it comes at a price. The Robert Wood Johnson Foundation estimates that 78 percent of those populating the nation's prisons and jails are incarcerated as a result of a crime that either involved illegal drugs or was committed while under the influence of alcohol.

Vermont does not have a choice in whether it pays for mental and substance use disorders, but it does have a choice in how it pays for them. A stunning contrast in the social policies and use of criminal justice responses can be seen in two states with very similar demographics – Wisconsin and Minnesota. Minnesota has long been a leader in mental health/substance abuse treatment and court diversionary programs while Wisconsin has lagged behind somewhat. Further, Minnesota did not enact the strict truth in sentencing legislation passed by the Wisconsin legislature in the mid 1990s. According to the FBI, Minnesota and Wisconsin have almost identical crime statistics. Minnesota with a population of 5.1 million and a felony crime rate of 3.1 per thousand versus Wisconsin with a population of 5.4 million and a felony crime rate of 2.9 per thousand, each experience roughly 15,000 felony crimes per year. Yet, Wisconsin currently incarcerates approximately 22,000 people at a cost of $2.0 billion per biennium, up from about 7000 incarcerated in 1993 at a cost of $566 million.[22] In contrast, Minnesota has 7500 people incarcerated at a cost of approximately $825 million per biennium.[23] Minnesota leases prison cells to Wisconsin.

To date, Vermont has chosen to follow a route similar to that taken by Minnesota. Wisconsin at 390 incarcerations per 100,000 of population ranks 26th nationally. Minnesota ranks 49th with 171 incarcerations per 100,000 population. Vermont ranks 43rd with 233 incarcerations per 100,000 population.[24]

Conclusion.

The delivery of good treatment for mental and substance use disorders is in everyone's interest: employers, employees, the general public, and government. Effective treatment of these disorders is just as important to individual well–being as treatment for physical afflictions. As the research indicates, one form of care cannot be effective if offered without regard for the other.

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[22] Gross, E., Friese, B., & Bogenschneider, K. (2203) Corrections and Crime in Wisconsin and The Wisconsin Department of Corrections Truth in Sentencing Workgroup, Wisconsin Legislative Council, 2003-04.

[23] Minnesota Department of Corrections.

[24] "2004 Incarceration Rates &(Rank) Per 100,000 Population, prepared by Bob Zapffe, Oklahoma Department of Corrections, October 25, 2005.

In order to assure the delivery of good care for mental and substance use disorders and the benefits it generates to employees and employers, the system of reimbursement and the administrative practices must be fair. This means that it should not discriminate by expending a much lower percentage of premium on mental health than is spent on physical health; by restricting the numbers of qualified mental health practitioners in a way that would be unthinkable in physical health; or by allowing games to be played in the system where an employer or insurance company can comply with the letter of the parity law while evading its intent.

It is important to maintain perspective when considering the bills currently before the Vermont legislature. Less than 5 percent of private sector health care costs nationally are spent on treatment for mental and substance use disorders. We have no reason to believe it is higher in Vermont. If this entire expenditure was eliminated altogether and no treatment whatsoever was provided for these issues, the savings would be offset within a few months through medical cost inflation alone. In view of the adverse co-morbid effects shown in the attachments, medical inflation would be exacerbated and the future increases in overall health costs would likely far exceed those estimated earlier.

In short, not treating mental and substance use disorders or treating them inadequately, results in far greater overall health care costs, not to mention the social consequences which everyone pays for.

The end result of the reimbursement system – whether “managed” or not --should be to allow practitioners the freedom to provide the best care of which they are capable, at a fair price, in response to the nature and severity of the patient’s problem. Most important, it should truly promote the opportunity for those in need to receive the right care, the first time at a reasonable cost. It is just good business.

END.