☞ **95hr_AC-ISCP_Misc_pt10b**

☞ Details: Mental health parity information

(FORM UPDATED: 08/11/2010)

WISCONSIN STATE LEGISLATURE ...
PUBLIC HEARING - COMMITTEE RECORDS

1995-96

(session year)

Assembly

(Assembly, Senate or Joint)

Committee on Insurance, Securities and Corporate Policy...

COMMITTEE NOTICES ...

- Committee Reports ... **CR**
- Executive Sessions ... **ES**
- Public Hearings ... **PH**

INFORMATION COLLECTED BY COMMITTEE FOR AND AGAINST PROPOSAL

- Appointments ... **Appt** (w/Record of Comm. Proceedings)
- Clearinghouse Rules ... **CRule** (w/Record of Comm. Proceedings)
- Hearing Records ... bills and resolutions (w/Record of Comm. Proceedings)
  (**ab** = Assembly Bill) (**ar** = Assembly Resolution) (**ajr** = Assembly Joint Resolution)
  (**sb** = Senate Bill) (**sr** = Senate Resolution) (**sjr** = Senate Joint Resolution)
- Miscellaneous ... **Misc**

* Contents organized for archiving by: Stefanie Rose (LRB) (October 2012)

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(512) 476-6431

cc: Pat, Har, Cath

November 29, 1994

Jacqueline Shannon
President, TEXAMI
1000 East Seventh Street
Suite 208
Austin, Texas 78702

RE: Serious Mental Illness

Dear Ms. Shannon:

In response to your letter of November 2, 1994, regarding data relative to serious mental illness, we are providing the enclosed information. The data provided is for participants enrolled in the State's self-insured managed care plan, HealthSelect of Texas, administered by Blue Cross and Blue Shield of Texas, Inc. and included claims from network, as well as non-network providers. Corresponding data from Health Maintenance Organizations is not available.

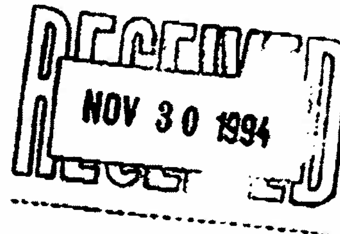
We hope this information will be of use to you. If you have any questions, please let me know.

Sincerely,

Diana Rushing

Diana S. Rushing, Manager
Insurance Programs Section
Group Insurance Division

cc: The Honorable Mike Moncrief



Uniform Group Insurance Program
FY94 Serious Mental Illness Claims
Experience for HealthSelect (1)

ICD*9 Code	Classification of Disease	Amount Paid (2)
290	Senile and Presenile Organic Psychotic Conditions	$ 76,709
291	Alcoholic Psychoses	57,996
292	Drug Psychoses	36,739
293	Transient Organic Psychotic Conditions	90,147
294	Other Organic Psychotic Conditions (Chronic)	45,802
295	Schizophrenic Disorders	327,686
296	Affective Psychoses	6,420,484
297	Paranoid States	20,775
298	Other Nonorganic Psychoses	252,716
299	Psychoses with Origin Specific to Childhood	9,585
	Total Claims	$ 7,338,639
	Average Number of Employees/Retirees (3)	148,656
	Average Annual SMI Claims per Employee (4)	$ 49.37 ←

Footnotes

(1) For purposes of this analysis, Serious Mental Illness (SMI) is defined as International Classification of Diseases (ICD*9) codes 290.0 through 299.9.
(2) SMI claims data incitudes all claims incurred during the period September, 1993 through August, 1994 and paid through October, 1994.
(3) FY94 average number of actiave and retired employees enrolled in HealthSelect.
(4) FY94 claims divided by average enrollment.

FORWARD
PLURIBUS UNUM

NAMI MODEL

AN ACT TO PROVIDE EQUITABLE INSURANCE COVERAGE FOR SEVERE MENTAL ILLNESS

Whereas there is increasing scientific evidence that severe mental illnesses such as Schizophrenia, Bipolar Disorders (Manic-Depressive Illness) and Major Depression are physical disorders just like Cancer, Diabetes, and other serious physical health problems:

Whereas most private health insurance policies provide coverage for severe mental illness at levels far below coverage of other physical disorders;

Whereas limitations in coverage of severe mental illness in private insurance policies has resulted in inadequate treatment for persons with these disorders;

Whereas inadequate treatment facilitates relapse and causes untold suffering for individuals with severe mental illnesses;

Whereas lack of adequate treatment and services for persons with severe mental illness has contributed significantly to homelessness, involvement with criminal justice systems and other significant social problems experienced by individuals with these disorders;

Whereas the failure to provide adequate coverage of severe mental illnesses in private health insurance policies has resulted in significant increased expenditures for state and local governments;

Be it enacted by the People of the State of ____.

For the purpose of prohibiting discrimination in the coverage of severe mental illness in all health insurance contracts offered in the state of ___ which are subject to regulation by the state.

I. All health insurance contracts offered in the state of ____ which are subject to regulation by the state shall provide benefits for treatment of severe mental illness which are equal to benefits for treatment of all other physical diseases and disorders.

II. The non-discrimination requirement set forth in paragraph I pertains to all aspects of health insurance contracts offered in the state of ____ which are subject to regulation by the state, including but not limited to:

- A. Coverage of inpatient hospital services;
- B. Coverage of outpatient services;
- C. Coverage of medication;
- D. Maximum lifetime benefits;

E. Copayments; and
F. Individual and family deductibles.

III. Definitions:

A. For purposes of this Section, "severe mental illness" includes:

1. Schizophrenia;
2. Bipolar Disorder (manic-depressive illness);
3. Major Depression;
4. Panic Disorder;
5. Obsessive-Compulsive Disorder; and
6. Schizoaffective Disorder
7. All other disorders identified currently or in the future as severe, biologically-based mental illness.

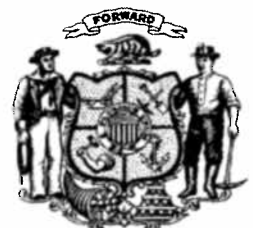
B. For purposes of this Section, "outpatient services" include but are not limited to:

1. Psychiatric rehabilitation;
2. Case Management;
3. Medication management;
4. Day Treatment;
5. Partial Hospitalization; and
6. Outpatient Psychotherapy.

IV. The non-discrimination mandate set forth in Paragraph I applies to all models of health service delivery in the State, including but not limited to fee for service models, Health Maintenance Organizations (HMO's), Preferred Provider Organizations (PPO's), and "Mixed Model" arrangements.

12/16/93

WISCONSIN STATE LEGISLATURE



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94 --

PUBLIC LAWS
CHAPTER
94- 225

STATE OF RHODE ISLAND

JT COMM. LEGISLATIVE SERVICES
LAW REVISION OFFICE

IN GENERAL ASSEMBLY

JANUARY SESSION, A.D. 1994

AN ACT

RELATING TO INSURANCE -- PARITY IN
COVERAGE FOR SERIOUS MENTAL ILLNESS

94 - S 2017 as amended

Introduced By: Senators Fitzpatrick, Perry, Cicilline, York, and Porter

Date Introduced: January 5, 1994

Referred To: Senate Committee on Corporations

It is enacted by the General Assembly as follows:

1 SECTION 1. Title 27 of the General Laws entitled "Insurance" is
2 hereby amended by adding thereto the following chapter:

3 CHAPTER 38.2

4 INSURANCE COVERAGE FOR SERIOUS MENTAL ILLNESS

5 27-38.2-1. Mental illness coverage. -- Every health care insurer
6 shall provide coverage for the medical treatment of serious mental
7 illness under the same terms and conditions as such coverage is pro-
8 vided for other illnesses and diseases. Insurance coverage offered
9 pursuant to this statute must include the same durational limits,
10 amount limits, deductibles, and co-insurance factors for serious
11 mental illness as for other illnesses and diseases.

12 27-38.2-2. Definitions. -- For the purposes of this chapter, the
13 following words and terms shall have the following meanings:

14 (a) "Health insurers" means all persons, firms, corporations, or
15 other organizations offering and assuring health services on a prepaid
16 or primarily expense-incurred basis, including but not limited to
17 policies of accident or sickness insurance, as defined by chapter 18

1 of this title, nonprofit hospital or medical service plans, whether
2 organized under chapter 19 or 20 of this title or under any public law
3 or by special act of the general assembly, health maintenance orga-
4 nizations, or any other entity which insures or reimburses for diag-
5 nostic, therapeutic, or preventive services to a determined population
6 on the basis of a periodic premium, except for supplemental policies
7 which only provide coverage for specified diseases.
8 (b) "Serious mental illness" means any mental disorder that cur-
9 rent medical science affirms is caused by a biological disorder of the
10 brain and that substantially limits the life activities of the person
11 with the illness. The term includes, but is not limited to:
12 (1) schizophrenia
13 (2) schizoaffective disorder
14 (3) delusional disorder
15 (4) bipolar affective disorders
16 (5) major depression
17 (6) obsessive compulsive disorder.

18 (c) "Medical coverage" means inpatient hospitalization and out-
19 patient medication visits.
20 27-38.2-3. Medical necessity and appropriateness of treatment.
21 -- Upon request of the reimbursing health insurers, all providers of
22 treatment of serious mental illness shall furnish medical records or
23 other necessary data which substantiates that initial or continued
24 treatment is at all times medically necessary and appropriate. When
25 the provider cannot so establish the medical necessity and/or appro-
26 priateness of the treatment modality being provided, neither the
27 health insurer nor the patient shall be obligated to reimburse for
28 that period or type of care which was not so established. The excep-
29 tion to the preceding can only be made if the patient has been
30 informed of the above and has agreed in writing to continue to receive
31 treatment at his or her own expense.
32 The health insurers, when making the above determination of medi-
33 cally necessary and appropriate treatment, must do so in a manner con-

1 sistent with that used to make the determination for the treatment of

2 other diseases or injuries covered under the health insurance policy

3 or agreement.

4 27-38.2-4. Limitations of coverage. -- The health care benefits

5 outlined in this chapter apply only to services delivered within the

6 state of Rhode Island.

7 Inpatient coverage in cases where continuous hospitalization is

8 medically necessary shall be limited to ninety (90) consecutive days.

9 SECTION 2. This act shall take effect on ~~July 1, 1994.~~ JANUARY 1, 1995, AND SHALL APPLY TO POLICIES ISSUED, RENEWED OR IN EFFECT ON OR AFTER JANUARY 1, 1995.

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DES1000
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For the committee Senator William V. Irons
4/5/94

FORWARD
E PLURIBUS UNUM

BRIEF DESCRIPTION OF SERIOUS MENTAL ILLNESSES
TREATMENT EFFICACY FOR SERIOUS MENTAL ILLNESSES

the following is excerpted from: ***Health Care Reform for Americans with Severe Mental Illnesses: Report of the National Advisory Mental Health Council****, Department of Health and Human Services, Public Health Services, national Institutes of Health, National Institute of Mental Health, March 1993.*

SCHIZOPHRENIA - is an illness beginning in late adolescence or early adulthood in which psychotic features (hallucinations, delusions, and disordered thinking) and lost capabilities (loss of will, pleasure, and emotional range) are predominant.

Treatment efficacy:

- Standard anti-psychotic medications reduce psychotic symptoms in 60% of patients and in 70-85% of patients experiencing psychotic symptoms for the first time.
- Adding psychosocial treatments can reduce the rehospitalization rate to 25-30% over a 2 year period.
- New medications such as Clozapine have been effective with one third of all patients who were previously unresponsive to all other medications. Other new medications, such as Resperidone, are also now coming to market.

MANIC DEPRESSIVE ILLNESS (BIPOLAR DISORDER) - People with manic depressive illness experience cycling between extreme highs (mania) and extreme lows (depression). Episodes may recur within days, months, or years, with intermittent periods of normal moods.

Treatment efficacy:

- Many treatments now permit effective management of symptoms and enable people to lead essentially normal lives.
- Lithium is well-established as an effective treatment as has been shown to lessen symptoms within the first ten days. Lithium remains the standard of treatment. Patients maintained on lithium are 28 times less likely to relapse than those without medication. Other anti-manic or antidepressant medications have also been shown to be effective.
- The sooner patients are diagnosed and treated the better their chances for recovery. With optimal treatment a person with bipolar disorder can regain approximately 7 years of life, 10 years of effective major activity, and 9 years of normal health, which otherwise would have been lost due to the illness.

Clinical

MAJOR DEPRESSION - Major depression, beyond affecting mood itself, contributes to loss of interest and pleasure, fatigue, feelings of worthlessness,

definitional difficulties

suicidal thoughts, and disturbances of bodily functioning, such as weight loss and insomnia. These symptoms are frequently all-pervasive and may last for long periods of time without treatment.

Treatment efficacy

- Between 60 and 65% of all patients obtain relief from their depression from the initial treatment with antidepressant medication.
- This rate rides to 80-85% with substitutions in medication or the addition of additional psychopharmacological treatments.

PANIC DISORDER - Often first seen in the family physician's office because of the sudden onset of feelings of impending death, people with panic disorder experience discrete periods of intense fear or discomfort, accompanied by shortness of breath, dizziness, palpitations, sweating, choking, and chest pains. Often these symptoms assume such significance that the person experiencing them can do little else.

Treatment efficacy

- The treatment of panic disorder is one of the majaor successes demonstrated through clinical treatment research.
- Response rates of 70-90% have been reported with antidepressant medications as well as antianxiety medications.
- New developments have shown that behavioral approaches have produced enduring positive effects similar to medications over a 2 year period.

OBSESSIVE COMPULSIVE DISORDER (OCD) For many years people with OCD had very little hope of relief from crippling rituals and obsessive thinking patterns. They were besieged by intrusive senseless ideas, and uncontrollable, repetitive behaviors driven by their own minds. Clinical studies report that only about 5% of patients have a spontaneous recovery and that others may recover somewhat with behavioral treatments (up to 75% initially) but as they try to lead normal lives their symptoms more often than not recur.

- For patients with OCD the prospect of improvement has brightened through the recent introduction of the tricyclic antidepressant clomipramine, and other medications. With 80% response of OCD patients showing some response, and 60% at least a moderate response, and with the addition of a new behavior therapy provides some relief from rituals (particularly when additional booster sessions are given), these severely ill individuals have new grounds for hope.

FORWARD

Estimate of Added Cost
of
Covering Biologically-Based
Mental Illnesses
On the Same Basis
As All Other Illnesses

Prepared for:

The Alliance for the Mentally Ill of Maryland

John Krizay
January 5, 1992

EXECUTIVE SUMMARY

The _added_ cost of covering the biologically-based mental illnesses on the same basis as other physical illnesses for residents of the State of Maryland is estimated, at today's prices, at approximately $1.00 per covered person per month. Using the common factor of 2.5 covered lives per employee, the _per employee_ cost would be approximately $2.50 per employee per month. These estimates are based on actual utilization rates in Maryland for the year 1989, adjusted for provider rate increases that have taken place in the interim.

"Added" cost refers to the cost that would accrue to insurance carriers or other types of health plans above what is already required of them by Maryland law or what is normally provided by health plans that are not covered by the Maryland mandate. (The Maryland mandate requires 30 day inpatient coverage on an equal basis with other ailments covered plus unlimited outpatient coverage at an effective average co-pay of 52%.)

Added cost to HMOs, should they be required to provide the same coverage, would be approximately the same for those that do no specifically exclude "chronic mental illnesses." HMOs normally provide 30 days inpatient care plus 20 outpatient visits with nominal or no co-pay. For those HMOs that have chronicity exclusions (to the extent that they are enforceable), added costs

would likely be not more than $0.40 per person higher, i.e. $1.40 per person per month, and, perhaps even less, depending on the particular HMO's rating system.

The so-called "mental and nervous" disorders encompass a wide array of behavioral problems most of which are not believed to reflect brain disfunctioning in a physiological sense. Those that are now widely recognized as stemming from a physical or biological disorder of the brain are listed in the International Classification of Diseases under ICD-9 codes 295.0 through 299.9, making up only one-sixth of all diseases codified as mental disorders. In terms of utilization, these biologically-based diseases account for roughly one-fourth of patients presenting claims for treatment of all mental disorders, about 16% of mental health outpatient visits and about one-third of hospital days related to mental disorders in insured populations where all "mental and nervous disorders" are covered on the same basis as physical ailments.

At one time, victims of these serious mental diseases were more often than not, simply institutionalized, frequently for a lifetime. However, modern medicine has provided effective treatments so that long term hospitalization or institutionalization can be avoided. Indeed, early intervention can result in a functional patient capable of independent living with only minimal support through public funds. Equal coverage of this category of ailments in private health plans makes this kind of early intervention more likely. Families are, naturally,

reluctant to commit a family member to an institution or to rely on public facilities which, many visualize as the first step toward institutional life. They are more likely to seek help in a private setting when early symptoms appear, so that adjustments in family life and rehabilitation efforts can proceed in a timely fashion. Modern psychiatric medicine makes such a scenario feasible at minimal cost and a likely savings of public sector funds.

I. Description of Biologically-based Mental Illnesses

The accepted classification of all diseases is outlined in the International Classification of Diseases, Revision 9. (Revision 10 is expected to be released soon.) Mental disorders are also classified in more detail in the Diagnostic and Statistical Manual of Mental Disorders prepared by the American Psychiatric Association. However, most insurers categorize claims by the ICD-9 code. These appear in three digit rubrics plus two rubric sub-classifications.
The mental disorders begin with ICD-9 290.0 and end with ICD-9 code 319.

The major diseases - the psychoses which encompass those mental disorders now considered to be biologically based - are those that are listed under codes 295.0 through 299.9. They are described as follows in the ICD manual:

Code	Description
295	Schizophrenic Disorders (including simple type, disorganized type, catatonic type, paranoid type, acute, latent, residual, schizo-affective, acute undifferentiated, and unspecified types.
296	Affective psychoses. (including manic disorders, single episode, manic disorders, recurrent episodes, major depressive disorders, single episodes, major depressive disorders, recurrent episodes, bipolar affective disorders (manic), bipolar effective disorders (depressed), bipolar affective disorders, mixed, bipolar affective disorders, unspecified, manic-depressive psychosis, other unspecified affective psychoses.
297	Paranoid states. (including paranoid state/simple, paranoia, paraphrenia. shared paranoid disorder, other paranoid states, unspecified paranoid

states.

298	Other non-organic psychoses (including depressive type psychosis, excitative type psychosis, reactive confusion, acute paranoid reaction, psychogenic paranoid psychosis, other and unspecified reactive psychosis, unspecified psychosis.
299	Psychosis with origin specific to childhood (including infantile autism, disintegrative psychosis, other specified early childhood psychoses, unspecified childhood psychoses.

III. Source of Data Used in Estimate.

The data used in arriving at these estimates, in large measure, reflect actual experience of CHAMPUS (Civilian Health and Medical Program of the Uniformed Services) eligibles seeking treatment for mental disorders in the State of Maryland. CHAMPUS utilization, appropriately adjusted for differences in coverage limits, age distribution, etc. in other states and found to be an accurate reflection of utilization in other populations.

This data base is especially apt as a source of utilization projections in Maryland because the CHAMPUS population here is relatively large. Nearly 200,000 CHAMPUS eligibles under age 65 reside here, i.e., about 4% of the total under 65 Maryland age group. Moreover, most of the CHAMPUS eligibles of Maryland reside in or near the large population centers of the state: Montgomery County, Prince Georges County, and Baltimore County. These are also the highest utilizer populations in Maryland so that estimates derived from this group are likely to overestimate state-wide utilization.

The CHAMPUS population is not an exact reflection of the general population, particularly in terms of age distribution. However, these differences are readily accounted for because CHAMPUS data is available in such complete detail, including utilization by age group and by ICD-9 group, as well as by ICD-9 categories <u>within</u> age groups. It is also one of the few data basis in the entire nation that reports utilization by inpatient care, residential treatment care, outpatient treatment (all by age group), by procedure code (CPT), including number of admissions, average length-of-stay, and type of provider. Additionally, both inpatient and outpatient

utilization are reported in a manner that permits accurate calculations of utilization by utilization group (i.e., the number of claimants using one visit only, the number using 2 visits only, etc. up to 61 visits by single visit increments and by larger increments beyond 61.

For this analysis, Maryland CHAMPUS data were first arrayed by the five diagnostic codes (ICD-9 codes) that represent the biologically-based mental ailments. These results were then further arrayed by age groups within each ICD-9 code and, then, the number of outpatient visits, inpatient visits, and inpatient days were calculated for each age group/ICD-9 code in terms of days or visits per 1,000 eligibles. These were then recalculated in terms of the age group distribution in the under 65 Maryland population; that is the utilization rates per 1,000 persons were applied to non-CHAMPUS Maryland population, thereby producing a projection of non-CHAMPUS utilization rates had this population been blessed with the same coverage as CHAMPUS.

CHAMPUS coverage closely approximates coverage equal to coverage of medical services for illnesses other than mental disorders (60 days inpatient care in acute facilities at nominal co-pay subject to extension upon review, unlimited outpatient coverage at an average co-pay of 22.5%). The utilization data, thus serve as an excellent base to project the limits of utilization under circumstances where the biologically-based mental diseases are treated as other physical ailments. With utilization by visit category and day category included in the data the <u>added</u> cost to typical coverage or coverage already required by law can be calculated. By calculating the current cost to insurers, estimating the additional utilization that would be likely due to the lower cost to the consumer and probable increases in cost over the ensuing two years is feasible.

IV. Calculations

A. Outpatient utilization:

As mentioned in Section III, the major adjustment required in applying CHAMPUS utilization rates is correction for age distribution differences. Use of outpatient care for these ICD-9 categories is highest in the 25-34 age group. At the same, it is this age cohort in the CHAMPUS age distribution that contains the smallest number of eligibles. *But since we can determine the utilization rate per 1,000 covered lives in each age cohort, we can calculate the total utilization per 1,000 for any age distribution.*

The age distribution differences between the Maryland CHAMPUS population (under 65) and the entire Maryland population is as follows:

Age Group	Maryland CHAMPUS	All Maryland
<15	28.2%	23.9%
15 - 24	16.9%	15.2%
25 - 34	9.8%	22.5%
35 - 44	12.6%	16.9%
45 - 64	32.3%	21.6%

The outpatient utilization rates per 1,000 for <u>each</u> age group and <u>each</u> ICD-9 category drawn from CHAMPUS data are as follows:

Age Grp.	295	296	297	298	299	ALL
>15	1.13	14.46	0.02	0.75	1.14	17.21
15 - 24	9.04	61.30	0.39	1.95	0.45	71.70
25 - 34	18.98	112.42	1.70	2.83	0.06	133.29
35 - 44	17.46	124.24	1.93	1.68	0.01	142.32
45 - 64	9.08	50.27	1.18	1.02	0.00	60.34
ALL [Wtd]	8.87	56.13	0.83	1.37	0.42	67.62

When applied to the entire Maryland under 65 population and adjusted for a different age distribution the <u>total</u> rates per thousand increase largely because of the State's larger 25 - 34 population, the highest users of outpatient care in these disease categories. The all Maryland rates are as follows:

ICD Code	Outpatient Visits/1,000
295	10.81
296	69.82
297	30.46
298	1.62
299	0.36
ALL	113.06

In calculating costs (see below), the total visit rate per thousand has been increased by 15% to account to a slow but steady growth in outpatient usage in these disease categories as revealed by a trend analysis covering the past then years.

The inpatient utilization rates per 1,000 for <u>each</u> age group and <u>each</u> ICD-9 category drawn from CHAMPUS data are as follows:

Age Grp.	295	296	297	298	299	ALL
>15	1.23	25.39	0.01	0.76	0.16	29.50
15 - 24	7.65	70.35	0.04	0.99	0.14	82.76
25 - 34	5.73	28.74	0.08	0.71	0.00	36.94
35 - 44	3.90	22.23	0.05	0.32	0.00	27.79
45 - 64	1.91	9.56	0.08	0.24	0.00	12.61
ALL [Wtd]	3.27	29.11	0.30	0.58	0.35	33.00

When applied to the entire Maryland under 65 population and adjusted for a different age distribution the <u>total</u> rates per thousand increase only slightly in the case of inpatient care because the age group with the highest user rates are found in the 15 - 24 age group in these disease categories where the share of total population is practically identical between the Maryland population and the CHAMPUS eligible population. The all Maryland rates are as follows:

ICD Code	Outpatient Visits/1,000
295	3.81
296	29.02
297	0.05
298	0.60
299	0.06
ALL	34.75

Inpatient professional services parallel inpatient day utilization rates so these figures are not repeated here. This service is, in any event, a minor cost, amounting to only $0.06 per person per month. (See below.)

V. Cost Factors

Projected costs per person per month were arrived at by using the projected utilization rates per thousand, multiplying by assumed provider rates and reducing them to per person rates, divided by 12 (months). The provider rates used are as follows:

> Hospital: $500 per day, plus 20% ancillary charges.
> Mental Health Professionals: MDs & Clinical Psychologists, $100 per visit, Support Counselors (MSWs, etc.) $70 per visit.

Outpatient Costs

The data base used in these calculations indicate that about 8% of outpatient visits were of the "medical management" type at a rate of $50 per visit. Also about 18% of the outpatient visits in this disease category were for support counselors. The weighted average outpatient visit rate, thus, is $90.60 per visit.

Since our CHAMPUS data base already reflects a utilization rate at approximately equal coverage (22.5% average co-pay, i.e. 77.5% paid by the health plan), our estimates already show the maximum use rates.

As indicated above, the projections based on 1989 data suggest an outpatient utilization rate of 113 visits per thousand per year. Our trend line analysis suggests a rate for 1992 of 129.5. To calculate the difference between the cost to the insurer under the existing coverage requirements and those that would accrue to him under equal coverage requirements for these disease category, we applied an elasticity co-efficient of 0.6, derived from Rand studies modified by our own observations working with various health plans around the country. The major modification in this function is the exclusion of visits 1 - 3 where, we have noted, cost to the consumer does not seem to have any measurable effect of utilization. Cumulative visits in the 1 - 3 visit categories account for approximately 30% of all visits.

The projections indicate that under the existing system, the health plan, on average, would experience a utilization rate of 97.8 visits per 1,000 per year, and the health plan would be responsible for $45.30 per each visit. For these ICD categories, the cost would be $4.43 per person per year, or $0.37 per person/month. Under equal coverage, total utilization would be 129.5 visits per 1,000, which translates to $9.39 per person/year or $0.78 per month as the health plan's cost. The added cost, then would be the difference: $0.41 per person/month or $1.02 per employee.

Inpatient day Costs

There should be no added utilization in the first thirty days used since this is the required coverage on an equal basis in Maryland. Roughly 75% of all inpatient days are accounted for in the first 30 days. Thus, the health plan's added cost would consist of any days used above 30.

Current inpatient utilization should average around 26.4 days per 1,000 for these disease categories, according to our calculations. With equal coverage (meaning, in this instance, no day limits) only 7.9 days would be added to the health plan's responsibility i.e. 8 1/3 additional days per 1,000. At our projected rate of $600 per day ($500 plus ancillaries), The added cost would be $0.42 per person/month or $1.05 per employee. [$600 x 8.3/1,000/12]

Inpatient professional services

As mentioned earlier, inpatient professional visits closely parallel inpatient day utilization. Projections suggest an additional 7.6 added visits per 1,000 which would be the health plan's responsibility. At a visit rate of $100, this adds $0.06 per month to the health plans cost.

Added cost summary

	per person/month	per employee/month
Outpatient	$0.41	$1.03
Inpatient Days	$0.42	$1.05
Inpatient Visits	$0.06	$0.15
Total	$0.89	$2.23

These cost figures are rounded off to an even $1.00 per person and $2.50 employee in the executive summary, above.

FORWARD

Coopers & Lybrand reported the results of an analysis they conducted for the California Medical Association and the California psychiatric Association. Their study examined the financial implications of extending unlimited coverage (both inpatient and outpatient) for treatment of the biologically-based brain diseases (serious mental illnesses). This extension would put these serious mental illnesses on a par with the other diseases included under the major medical benefits.

Coopers & Lybrand concluded that the cost of extending unlimited coverage for these diseases would total $.78 per month per insured person.

A similar study in Minnesota concluded that for indemnity plans, equal coverage for major mental illness would not likely add more then $.50 per month per covered person, and for HMO's about $1.00 per month. These were high estimates based on the highest utilization rates that have been experienced over some years applied to age distribution of the Minnesota residents.

Fortunately, due largely to revolutionary advances in the brain sciences and important discoveries in psychopharmacology, most serious mental illnesses can be treated effectively.

Why is serious mental illness not covered like other illnesses?

Despite its low incidence, and the high hopes for its successful treatment, serious mental illness is the one disease most discriminated against in public and private health insurance. This discrimination does not reflect sound economics, because *leaving biologically-based mental illness untreated costs much more than it saves*. In fact, the lack of adequate insurance coverage, combined with the downsizing of state mental hospitals, has placed a significant cost for care onto states and communities, as people with serious mental illness are served closer to home in community settings.

Some brief background information may help to explain how this injustice has come about. For many years the nation's mentally ill were treated as wards of the state. Little was known about brain diseases and nothing could be done to ameliorate them, so their victims were simply warehoused, often in deplorable conditions.

In 1955, the first antipsychotic drugs were discovered that controlled the symptoms of severe mental illness. This discovery clearly established that these diseases were biologically-based disorders of the brain. Between then and the next year, the population of our nation's mental hospitals decreased for the first time in history.

Although adequate treatment can help people with mental illness lead productive lives and some serious mental illnesses can be completely controlled, few "miracle cures" can be accomplished. It will always be easier to treat persons with transitory problems in living than to tackle the long-term management of persons with catastrophic disease.

When mental illness was established as a physical disease, especially when it was discovered to be amenable to psychopharmacologic therapy it became rational to treat it within the medical system.

At this point it also became logical to include such treatment in third-party reimbursement systems, both in the private and public sectors.

At the same time, however, the development of psychotherapies and drugs to treat transitory mental health and emotional problems proliferated. A much larger proportion of the total population, who do not suffer from brain diseases, can benefit from these services. To have them included in third-party payment programs, policy makers made a trade-off at the expense of the seriously mentally ill.

Today government and private sector health insurers are required by a myriad of state and federal laws and regulations to give very broad but very shallow coverage for "mental health" benefits dispensed by a variety of providers. Coverage for the treatment of mental illness is included under these benefits. However, the levels of reimbursement are low, the co-payments are high, and the annual and lifetime limits are completely unrealistic to support any kind of real treatment for the seriously mentally ill. These extreme provider and consumer incentives for extended treatment work very well to limit the amount of mental health care that is consumed, and which therefore must be reimbursed under health insurance policies. However, the reason such incentives work for those with only mental or emotional problems is that they can exercise choice about whether to seek and pay for treatment. For persons with serious mental illness, there is no choice. They had nothing to do with the onset of this terrible and debilitating illness. But left alone without treatment, they are powerless to overcome it.

Research conducted by the World Institute on Disability shows that of all the chronic conditions examined, persons with mental illness exceed the annual and lifetime dollar maximums of insurance coverage at a much higher rate than a person with any other disability. *This is not because the treatment of mental illness is so costly. It is because these arbitrary limits are so very low.*

Persons with biologically-based mental illnesses are also particularly hard hit by the practice of most insurance carriers of excluding coverage for preexisting conditions. In most cases, these devastating illnesses first strike in the late teen years or early adulthood. This is the time when many young persons are in "limbo", i.e., becoming too old to continue coverage under their parents' policies, but not well enough established in the work force to afford their own insurance. The current exclusionary practices of insurance carriers therefore make it likely that young persons who develop serious mental illness will never obtain coverage for the treatment of their disease.

Most members of the National and the New Hampshire Alliance for the Mentally Ill are the parents, spouses, or siblings of persons with mental illness. These are families who participate fully in the work force, and who have always paid their insurance premiums. For most of them, the fact that their health care policies did not cover the real cost of treating mental illness came as a complete surprise. They only learned of it when they needed it the most.

Several of the nation's courts have recognized the injustice of health insurers refusing to reimburse for the treatment of biologically-based mental illnesses as physical diseases, and remitting them instead to the lesser levels allocated for the treatment of mental health problems.[2]

Discrimination against the seriously mentally ill by our health insurance system has far reaching consequences for the nation as a whole and for New Hampshire in particular. Far from saving money, this short-sighted approach shifts costs to programs like Medicaid that can least afford it, shifts treatment to crisis intervention and other modalities that are least effective, and shifts service delivery to emergency rooms and other settings that are most expensive.

Two hundred years ago, when little was known about the physical basis of brain diseases, the mentally ill were treated like prisoners instead of like patients. Medical and scientific advances have greatly increased the potential for successful treatment of these diseases. But these advances have not been matched by the full incorporation of these patients into the third-party payment systems that support most of the health care in this country.

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[2] *Arkansas Blue Cross & Blue Shield, Inc. v. Doe,* 733 S.W.2d 429 (Ark. App. 1987), required a health insurer to reimburse the costs of caring for a policyholder's manic-depressive daughter based on the court's conclusion that bipolar illness is a "physical illness rather than a mental condition". In *Kunin v. Benefit Trust Life Insurance Co.*, CV 87-3715-IH (C.D.CA, 1988), a federal district court held that autism was not a "mental illness" within the meaning of and exclusionary clause in a group health and medical insurance policy. And in *Simons v. Blue Cross & Blue Shield of Greater New York*, 144 AD2d28 (1989), the highest state court in New York held that hospitalization of a person for anorexia nervosa did not fall within the insurance policy's coverage limitation for psychiatric care.

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POSITION PAPER

MENTAL HEALTH PARITY BILL

Mental Illnesses and Insurance Coverage

Nationwide, only 21% of all health insurance policies provide coverage for severe mental illnesses that is comparable to coverage for other illnesses. Only 2% have comparable outpatient coverage. Over 60% of health maintenance and preferred provider organizations specifically exclude treatment for people with serious mental illnesses.

Many health insurance plans limit coverage for treatment of severe mental illnesses while imposing no limit on treatment for other conditions. Typically, such limitations are in the number of days allowed for facility care or visits for outpatient care. Plans often call for high copayments for treatment of mental illnesses than they do for treatment of other illnesses or diseases. In some cases, comparable coverage can be purchased, but only with higher premiums for special mental illness "riders".

Several states have already passed laws to provide equitable insurance coverage, including New Hampshire and Rhode Island whose bills are attached, as well as the AMI model legislation.

We would like to see a bill introduced in the Legislature which would require that health insurance policies provide coverage for biological mental illnesses (schizophrenia, bipolar disorder, major depression, obsessive-compulsive disorder and panic disorder) to the same extent that they cover all other physical illnesses.

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Jan 1 '93

AN ACT
RELATIVE TO MENTAL ILLNESS COVERAGE

Analysis: This bill provides for all health insurance policies in the State of NH to provide coverage for certain biologically based mental illness at the same level as coverage for other physical illness.

1. New Chapter; Coverage for Certain Biologically Based Mental Illnesses. Amend [xx] by inserting the following new Chapter:

CHAPTER [xxx]

COVERAGE FOR CERTAIN BIOLOGICALLY-BASED MENTAL ILLNESSES

I. For purposes of this chapter "mental illness" means a clinically significant or psychological syndrome or pattern that occurs in a person that is associated with present distress, a painful symptom or disability, impairment in one or more important areas of functioning, or with a significantly increased risk of suffering, death, pain, disability, or an important loss of freedom.

II. Notwithstanding any other provision to the contrary, each insurer that issues or renews any policy of group or blanket accident or health insurance and each hospital service corporation under RSA [xxx], medical service corporation under RSA [xxx] and health maintenance organization under RSA[xxx] providing benefits for disease or sickness in the state of New Hampshire shall provide benefits for treatment and diagnosis of certain biologically based mental illness under the same terms and conditions and which is no less extensive than coverage provided for any other type of health care for physical illness.

III. The following mental illnesses, as defined in the most current edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association, shall be covered under this section:

1. Schizophrenia
2. Schizoaffective Disorder
3. Major Depressive Disorder
4. Bipolar Disorder
5. Paranoid and other Psychotic Disorders

6. Obsessive-Compulsive Disorder
7. Panic Disorder
8. Pervasive Developmental Disorder, or Autism

IV. The benefits required under this section shall begin when benefits provided under [the current mental health mandate] are exhausted.

2 Applicability. This act shall be applicable to any health insurance contract, policy, certificate, or plan that is issued or renewed on or after January 1, 1995.

3 Effective Date. This act shall take effect January 1,1995.