TOWARD EQUAL ACCESS:

FINANCING OF MENTAL HEALTH SERVICES BY THIRD PARTY PAYERS

Report of the Third Party Reimbursement Committee

STATE ADVISORY COUNCIL ON MENTAL HEALTH
SUBCOMMITTEE ON CHILDREN'S MENTAL HEALTH

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I. EXECUTIVE SUMMARY

This report provides an overview of the investigations of the State Advisory Council on Mental Health and the Children's Mental Health Subcommittee. The Advisory Council formed a Third Party Reimbursement Committee in October 1989 to review and make recommendations regarding access and availability of mental health care financed through third-party payment sources.

In forming the Committee, the Council and Subcommittee had determined, largely through public hearings and written and oral communications, that difficulties in accessing mental health care increased in recent years. The Committee sought to develop an understanding of the forces influencing the financing of mental health care by third-party payers and to make recommendations related to its findings.

In addition, the Committee was initiated in response to a concern that the Advisory Council and Subcommittee needed to develop and maintain an ability to participate in broader health policy developments at both the state and federal levels. This report, with its accompanying recommendations, is intended in part as a record of the Advisory Council's learning process and represents an effort to inform others of the unique aspects of the financing of mental health care by third-party payers.

SUMMARY OF FINDINGS AND RECOMMENDATIONS

Problems expressed to the Advisory Council and Children's Subcommittee by the public include:

1. **finding adequate coverage for serious mental illness, particularly once a person has been diagnosed;**

2. **accessing mental illness services even though such services generally are covered in a particular plan; and**

3. **receiving the appropriate amounts and types of services once care has been authorized.**

In responding to these expressed problems, the Committee adopted a series of **guiding principles**:

1. **limited resources should be targeted upon those with the most serious need for mental illness services;**

2. **public policy should not be designed to encourage or allow private payers to choose not to cover mental illness services for these persons;**

3. **health plan management processes should apply to the provision of mental illness services on the same basis as other services in the overall benefits package.**

Recommendations regarding <u>how</u> access to mental illness services should be provided and maintained include:

1. **for those with employer-sponsored health benefits, mental illness benefits should be required through tax code mechanisms;**

2. **for those who are employed but have no employer-sponsored coverage, employers should be required to provide coverage or contribute to a risk pool;**

3. **for those who are unemployed, mental illness benefits should be made a part of unemployment benefits;**

4. **for those who otherwise have no access to private-pay health insurance or unemployment benefits, existing public programs should be expanded to accommodate them.**

Recommendations regarding <u>which</u> mental illness services persons should have access to include:

Rather than managing the amount or types of care all individuals are eligible for, resources should be managed by targeting resources on a smaller population with greater needs. Persons with at least the following conditions should have access to an array of services appropriate to their needs:

+ **schizophrenia**
+ **schizo-affective disorder**
+ **bipolar and delusional depression**
+ **pervasive developmental disorder.**

The service package should include both acute/emergency care and maintenance

(support) services. Those with less acute or chronic conditions (those in need of counseling for life adjustment or stress) would receive few services under this recommendation.

Recommendations regarding **how** mental illness services should be administratively managed include:

Coverage for mental illness services should be subject to the same terms and conditions as those applied to other illnesses.

In practical terms, this means that

provider network arrangements;

prior authorization requirements;

prospective/concurrent/retrospective review processes; and

any copayments or deductibles

should apply to mental illness services on the same basis as applied to other services in the health benefits package.

II. INTRODUCTION

Since 1985, Minnesota has pursued a renewed effort to provide access to a coordinated array of quality mental health services. Despite the existence of 21 separate commissions and studies preceding it,[1] in 1985 Governor Perpich created the Governor's Mental Health Commission, and charged it with the responsibility of making recommendations about Minnesota's mental health care system. The Commission's February 1986 report, Mandate for Action, outlined a series of steps needed to put Minnesota at the forefront of the provision of quality mental health care.

The Commission's recommendations were coupled with other reports critical of Minnesota's mental health system[2] and resulted in the passage in 1987 of the Comprehensive Mental Health Act, which required each county or region of the state to make available an array of mental health services under a policy of targeting inevitably limited services on those persons with the most serious and persistent mental illnesses.[3]

The Commission also recommended a number of changes to Minnesota statutes regulating coverage of mental health services by third-party payers*, much of it approved in subsequent legislative sessions.[4] Of concern was the relationship of the availability and access to care to the frequency of acute episodes of mental illness and the use of resource-intensive types of care.

Even with statutory changes, the concern over appropriate access has not abated. Ironically, while the Mental Health Commission concerned itself with availability of and access to care, the broader health care arena was focusing its efforts on gaining control over rapidly rising health care costs, with stronger management of access one method of doing so. Thus, in many ways the Mental Health Commission was swimming against the tide of health care policy in the 1980s, identifying unmet needs and recommending financing strategies to meet those needs, while the balance of the health care arena focused on cost.

Only relatively recently has the attention of the broader health policy arena returned to access issues. Estimates that over thirty million Americans - including an estimated 400,000 Minnesotans - lack affordable health insurance have highlighted the

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* For purposes of this report, "third-party payers" includes any entity financing health coverage besides the individual patient, including public programs such as Medical Assistance. "Private" third-party payers would include indemnity insurers, HMOs, PPOs, and other health service plan corporations.

interrelationships and tradeoffs of rising costs (which make health insurance unaffordable) and efforts to control those costs (which can make certain types of care more difficult to access).

The successors to the Governor's Commission, the State Advisory Council on Mental Health and the Subcommittee on Children's Mental Health, determined in October 1989 to once again focus on health insurance issues. The genesis of the effort was essentially two-fold:

1. **Discussions and policy developments in the broad sector of health care financing dictated that the Advisory Council maintain an awareness of such developments; and**

2. **The Council had received (and continues to receive) information, particularly from consumers of services and their family members and relatives, indicating that access to mental health care is increasingly difficult under third-party payers.[5]**

Information the Council received about the types of problems experienced by consumers of services and their families can be summarized into three categories:

1. **Finding adequate coverage for serious mental illness, particularly once a person has been diagnosed (e.g. person is uninsured, or limitations on coverage for pre-existing conditions);**

2. **Accessing mental health services even though such services generally are covered in a particular plan (e.g. prior authorization requirements or concurrent reviews of inpatient stays); and**

3. **Receiving the appropriate amounts and types of services once initial services have been authorized (e.g. limits on numbers of visits or days; lifetime coverage limits).**

In addition to pressures caused by rising costs, the Committee identified several issues unique to the nature of mental illness affects the availability of health insurance for it. These include:

1. **Skepticism about the efficacy of treatment and an ability to determine completion of a treatment episode;**

2. **Consumer preferences, i.e. consumers choose other types of insurance coverage;**

3. **Subjective definitions of mental health which lead to difficulties in targeting care to those most in need; and**

4. **A lack of professional consensus regarding the definition of appropriate care and the treatment roles played by various professionals.**

Despite these concerns, there is widespread agreement that mental health insurance benefits at some level are appropriate. Minnesota statutes, reviewed above, are one example. Recent health care policy efforts at the federal level - including the federal Pepper Commission and the various versions of the Basic Health Care Benefits for All Americans Act - have included coverage for mental health care.[6] Finally, most employers who self-insure their employee benefits offer coverage similar to that required by state mandates.[7]

Historical arguments in favor of mental health coverage identified by the Committee include:

1. **Access to mental health care assists individuals to overcome reluctance to seek needed services;**

2. **Support for public policies which provide all with minimum coverage;**

3. **Concern for adverse selection which may occur when only one third-party payer provides coverage (i.e. individuals will choose the payer that offers services they know they will use. Such payers can then find themselves with a greater-than-average share of persons who use costly services. Requiring all third-party payers to offer benefits may avoid this problem); and**

4. **The appropriate use of mental health services which may reduce other health expenditures.**

These items serve as background to the discussion which follows.

III. ECONOMICS OF HEALTH CARE

The trend toward management of health care costs is probably irreversible. U.S. health spending reached $500 billion in 1986, or 11.1% of GNP.[8] The federal Health Care Financing Administration estimates that these figures will increase to $1.5 trillion and 15% respectively by the turn of the century.[9] All in all, support for closely scrutinizing the value of health care has greatly increased.

At the same time, estimates are that from 31 to 37 million Americans are without health insurance of any kind. The Minnesota Department of Health estimates that Minnesotans without health insurance at any one time amount to approximately 342,000.[10]

In the U.S., health insurance was initiated on a large scale with the advent of Blue Cross hospital plans in the 1930s. In part because insurance increases access to health care by facilitating payment and relieving beneficiaries of excessive costs, eligibility for Social Security and veterans programs were expanded and the Great Society programs of the 1960s were enacted.[11]

While these programs were enacted principally to facilitate access to care, concern for cost was not absent. Health care, particularly care that is paid for by someone other than the patient, is a unique commodity in that it does not generally respond in predictable ways to economic pressures. For example, increased costs not borne by the patient may not inhibit their desire to access care. Unlike other "products" in the marketplace, potentially unlimited amounts of health care can be used to bring increasing levels of satisfaction with one's health (or decreasing levels of concern over one's health).

The increasing cost of health care has been attributed in part to the advent of health insurance and its insulating effects from the true cost of care. Other postulated causes include general inflation, aging of the population, expanded use of medical technology, state-mandated benefits,[12] and duplicative administrative functions of competing third-party payers.[13]

There is little consensus regarding the extent to which the availability of insurance for mental health care contributes to cost. While some studies have gathered evidence of a direct relationship between the availability of mental health insurance and the demand for such services, others have found that this relationship is no stronger than that for general health services[14] or may decrease expenditures for other health services.[15]

At any price, however, an increase in the utilization of services usually increases expenditures. Similarly, at any level of utilization, an increase in price increases

expenditures. Thus, attempts to control expenditures have inevitably focused on controlling either price or utilization, particularly in areas where the relationship between the provision of care and decreased longer-term costs is tenuous.

Price has been shown to be extremely difficult to control; witness the recent history of cost increases. In addition, providers of care generally are attracted to the marketplace only if reimbursements are sufficiently more attractive than alternative methods of earning an income. For example, many providers are increasingly reluctant to serve Medical Assistance (MA)-eligible persons since the reimbursement rate under MA is low relative to other sources of income.[16] Similarly, providers will tend to congregate in geographic areas where patient flow and reimbursement are relatively generous.

Controlling utilization has its difficulties as well. Health care, as an inexact science, is not amenable to definable amounts of care for a given condition. Underlying causes of a condition, as well as the degree of severity, differ from person to person. The U.S. health care system has generally recognized the complexity of illness by assigning primary responsibility for its treatment to providers who have received high levels of education and training.

Identifying "appropriate" levels of utilization of mental health care on an aggregate level is said to be particularly difficult. Mental illness diagnoses were exempted from the DRG (Diagnosis-Related Groups) payment system due to difficulties in predicting cost or utilization. When mental health care finally was included in the DRG payment system in Minnesota, reimbursement levels for given mental health diagnoses were based upon average lengths of stay in 1981 - called "community norms" - rather than an empirical definition of how much care persons with mental illness "need."

Difficulties in predicting - and thus budgeting for - the cost of health and mental health care have led to efforts to provide predictability in other ways. Efforts by third-party payers to capitate payment levels or numbers of visits are two examples of methods of enhancing the predictability of costs.

IV. HEALTH CARE BENEFITS - THE BUSINESS PERSPECTIVE

Particularly in the 1980s, employers have come to view the provision of health care benefits almost entirely on the basis of cost.[17] As costs have escalated, increasing numbers of employers have attempted to control price and utilization by:

1. **Selectively contracting with health plan companies which promise to charge a discounted rate on care;**

2. **Turning to self-insurance, in which the employer funds the cost of care and thus chooses the types and amounts of care to which employees are entitled;**

3. **Requiring copayments or deductibles to increase employees' economic participation in decisions to seek care; and/or**

4. **Requiring care to be "managed," often through prior authorization or concurrent and retrospective review mechanisms.**

In addition, many small employers have dealt with the rising cost of health care either by dropping or reducing health benefits for their employees or by not offering benefits at all.[18]

State laws which require third-party payers to provide mandated benefits is one factor contributing to employers' movement toward either self-insurance (for which no state mandates apply, under the federal ERISA pre-emption) or the provision of no insurance for employees at all.[19] Other factors include self-insured's exemption from state premium taxes, and an enhanced ability to manage claims payments, particularly if the firm administers its own claims.

There is a lack of information on the extent to which any particular mandated benefit contributes to costs or employers' incentives to self-insure. Generally, employers have been open to providing access to certain mental health services through corporate Employee Assistance Programs (EAPs)[20] and/or specified services in a health benefits package. "Investments" of these types in human capital may increase or decrease depending upon the financial status of an employer or competition for employees in the labor market.

In seeming contrast to these findings are reviews which indicate that third-party payer coverage of mental illness is more restrictive than coverage for other types of care.[21] In fact, legislation recently enacted in California prohibits discrimination in coverage for

mental illness in group insurance plans.[22] One response to this contradiction may be that mental health benefits represent the most constantly-changing part of health benefits, but there is little evidence to support such a conclusion.

As discussed earlier, third-party payers and employers tend to be skeptical of mental health benefits because of difficulties in determining from a lay perspective appropriate amounts of care. They may also be concerned that mental health or chemical dependency issues may be used as a "crutch" for poor employee performance. It seems clear, however, that most employers and third-party payers do provide mental health benefits; often in question is the *extent* of coverage.

Overall, there has been considerable acknowledgement that utilization review and other mechanisms are needed to focus limited resources on persons with the most serious and persistent mental illnesses.[23] However, a debate persists, particularly among providers, regarding the intrusiveness of these mechanisms into the process to providing care.

V. HEALTH CARE BENEFITS - THE CONSUMER'S PERSPECTIVE

Many persons when given a choice will choose health care benefits which cover services they know they will use.[24] Some of these, such as basic vision or dental care, can be adequately budgeted for by a third-party payer. The cost of others may be less predictable. Indeed, the term "moral hazard" refers to the influence of the availability of health benefits on behavior.

Under such conditions, few can be expected to choose health care coverage for serious mental illness when there has been no previous personal or family experience with the illness. In addition, the social stigma of mental illness discourages some from seeking out appropriate services. These issues can contribute to the choosing of so-called "shallow" insurance, which covers less expensive, routine costs of care but limits coverage of catastrophic expenses. Finally, a general expectation that the public sector will serve as a safety net for seriously ill or injured persons limits incentives to purchase or provide coverage in the private sector.

Until recently, most persons attached to the availability of health care coverage the expectation that such coverage would operate in the traditional sense of insurance: premiums are paid as a hedge against catastrophe, and when serious illness or injury strikes, care would be financed. Recently, as individuals have become responsible for a greater share of the cost of health care, the understanding of the true cost of care has increased.[25] This dynamic played a role in Congress' revocation of the Medicare Catastrophic Health Care Act. It can also saddle unfortunate individuals and families with excessive bills, and cause them to qualify for publicly-financed care.

What this will mean for persons with serious mental illness is not clear. Efforts have increased in recent years to enable third-party payers to "carve out" and separately insure high users of care in an effort to lower the cost of coverage for the remainder of the insured population.[26] On the other hand, even if persons with serious mental illness are maintained in broader risk pools, there will likely continue to be efforts to create caps on total expenditures or levels of utilization in an effort to make the cost of high amounts of care bearable for the remaining contributors to the risk pool.

In either case, persons with serious mental and other illnesses may increasingly receive their care via publicly-financed programs. Their desire for user-friendly systems of access to care may conflict with efforts to manage their care with administrative mechanisms. Alternatively, efforts to increase their economic contributions to care, and thus their level of knowledge regarding choice of care, may have the effect of prohibiting access altogether. New systems of third-party reimbursement for mental health care will need to take into account this delicate balance.

VI. HEALTH CARE BENEFITS - THE PUBLIC SYSTEM PERSPECTIVE

As discussed previously, Minnesota has adopted a public policy of requiring third-party payers to provide minimal levels of mental health care. The state has also moved toward creating and improving its comprehensive system of publicly-financed care, with the most intensive services focused upon those with the most serious mental illnesses. These are the two principle vehicles under which the state ensures that mental health services are available and accessible.

Comprehensive data on mental health expenditures by private third-party payers is generally unavailable in Minnesota.[27] Public expenditures for mental health services, including federal, state, and county shares, amounted to approximately $248 million in 1989. Figure 1 illustrates the portion of expenditures paid by each governmental entity, while Figure 2 indicates the services on which state-level funds were spent.

As Figure 2 indicates, the overwhelming majority of public expenditures pay for state and community hospital care and residential services (69% of all expenditures). These costs have risen even as average lengths of stay for publicly-funded clients have decreased.[28] The overall emphasis in recent years has been to provide an expanded array of ambulatory services to persons with serious and persistent mental illness in an effort to reduce inpatient utilization, but the effect of the former on the latter is unclear.

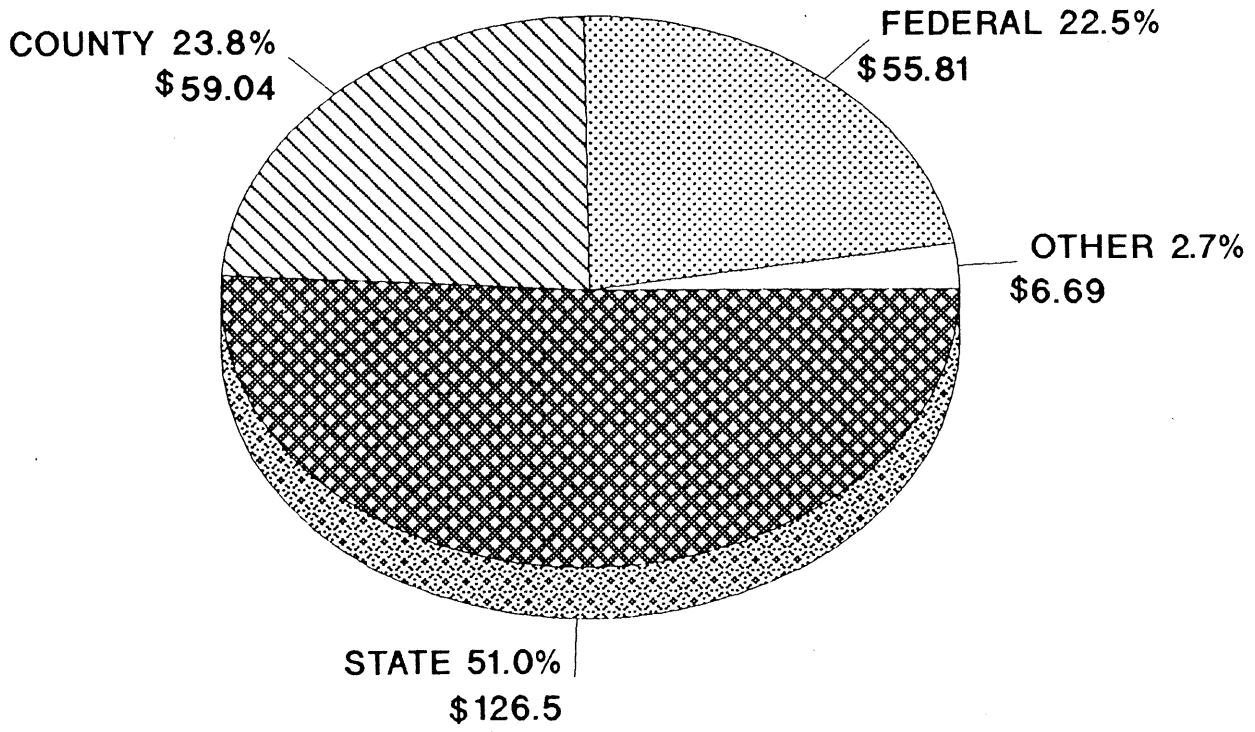
Recent efforts by the Minnesota Department of Human Services to enhance the quality of care in Regional Treatment Centers (RTCs -formerly called state hospitals)[29] indicates a commitment to their role as provider of last resort. Broader state efforts to increase access to care for seriously mentally ill persons has taken place, as discussed above, amidst the development of policies designed to control overall health care costs. As such, neither the Department of Human Services nor the public generally has articulated a clear policy of access to mental health care, leading to a differentiated public perspective in this area.

A subject for further investigation is the extent to which the availability of a comprehensive public system of care creates disincentives toward private-sector financing and provision of care. Of particular interest is the extent to which public systems of care are relied upon for mental health care in comparison with other types of care. While uncompensated care provided by publicly-funded community hospitals has received increased attention recently, it is important to note that the state of Minnesota absorbed approximately 60% of the cost of state hospital care from 1985 through 1988.[30]

Est. DHS Funding for MH Services - CY 1989

by funding source

source: DHS Mental Health Div.



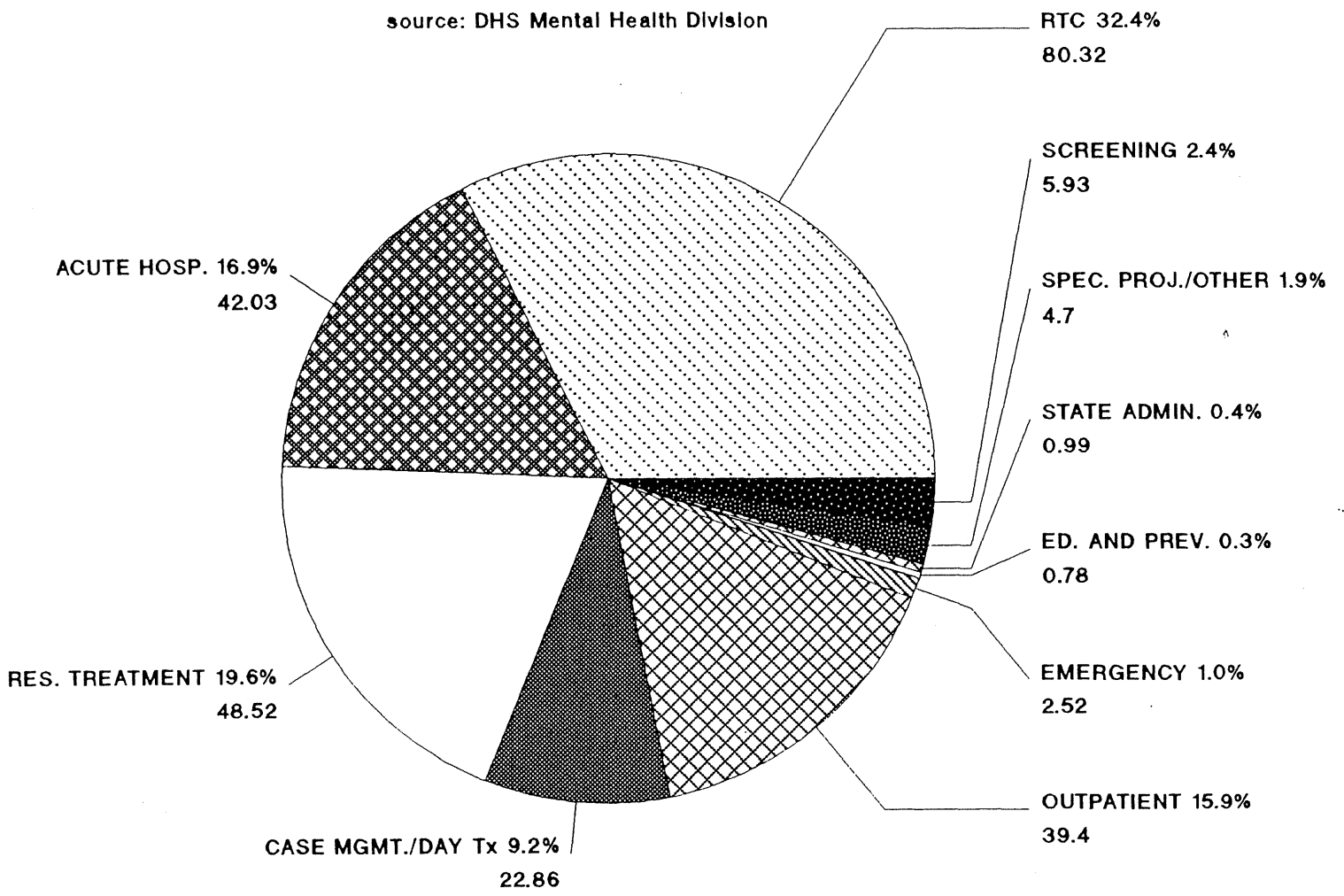
dollars in millions

FIGURE 1

Est. DHS Funding for Mental Health Services – CY 1989

by service category

source: DHS Mental Health Division



Total: $248,032,755

FIGURE 2

In general, long-term and catastrophic care has often been viewed as a public responsibility in the U.S. (despite efforts such as that of the Pepper Commission). While the resulting separate tiers of care can lead to discontinuity in care, it is not within the scope of this report to explore the extent to which such discontinuity affects quality.

VII. ADVISORY COUNCIL RECOMMENDATIONS

In addition to the previous discussion, members of the Third Party Reimbursement Committee brought to the table vast expertise in mental health care financing issues. In developing its recommendations, the Committee started by adopting a series of guiding principles focused upon providing access to care and enhancing the availability of services for persons most in need of mental health care. These principles include:

> **to the extent that services are limited, persons with serious and persistent mental illness or severe emotional disturbance should receive priority in the allocation of care.**

This principle is important because it focuses resources on a narrower subset of the population[31] as the highest priority. For this reason, the term mental "illness" rather than "health" care is used in the balance of recommendations.

A second adopted principle concerns the responsibilities of privately-financed care in relation to publicly-financed care:

> **public policy should not be designed to encourage or allow private payers to choose not to cover mental illness services for these persons.**

A final principle concerns access to mental illness care relative to other types of health care, and addresses inequities in how mental illness care is managed:

> **health plan management processes should apply to the provision of mental illness services on the same basis as other services in the overall benefits package.**

These principles underlie the Committee's recommendations regarding both access to mental illness care and the availability of such care. The Committee was concerned about ensuring access by all citizens to appropriate mental illness care, a population that includes the uninsured, underinsured, and insured (as indicated by the problems identified in the first chapter).

RECOMMENDATIONS: HOW ACCESS TO MENTAL ILLNESS SERVICES SHOULD BE PROVIDED AND MAINTAINED

The Committee first recognized that individuals must be provided access to mental illness care. A primary mechanism for doing so is to provide financial assistance with, or risk protection from, some or all of the costs of care. The Committee thus recommends:

1. **For those with employer-sponsored health benefits, mental illness benefits should be required through tax code mechanisms;**

2. **For those who are employed but have no employer-sponsored coverage, employers should be required to provide coverage or contribute to a risk pool;**

3. **For those who are unemployed, mental illness benefits should be made a part of unemployment benefits;**

4. **For those who otherwise have no access to private-pay health insurance or unemployment benefits, existing public programs should be expanded to accommodate them.**

In arriving at these recommendations, the Committee is aware of legal difficulties relating to the federal ERISA statute, particularly in regard to the first recommendation. After considering several options, it was determined that a court challenge under ERISA to the first recommendation was worth risking if the only alternative were that self-insured employers were not required to provide the same level of benefits as other employers and insurers.

RECOMMENDATION: TO WHICH MENTAL ILLNESS SERVICES PERSONS SHOULD HAVE ACCESS

Once persons could be reasonably assured of access to mental illness care, the Committee recognized that definition was needed of what types of care persons should have access to. A guideline: rather than managing the amount or types of care all individuals are eligible for, the Committee determined that resources should be managed by targeting them on a smaller population with greater needs. Persons with at least the following conditions should have access to an array of services appropriate to their needs:

+ **schizophrenia**
+ **schizo-affective disorder**
+ **bipolar and delusional depression**
+ **pervasive developmental disorder.**

The service package should include both acute/emergency care and maintenance (support) services. Those with less acute or chronic conditions (those in need of counseling for life adjustment or stress) would receive fewer services under this recommendation.

This recommendation is an explicit recognition of limited resources.

RECOMMENDATION: HOW MENTAL ILLNESS SERVICES SHOULD BE ADMINISTRATIVELY MANAGED:

In much of the communications received in the past two years by the Advisory Council, methods of managing mental illness care were identified as a barrier to accessing care. While recognizing that administrative/management mechanisms had grown among third-party payment systems over the last several years, the Committee determined that such processes are necessary in principle to ensure standards of quality and to manage limited resources.

Within these constraints, the Committee decided that such mechanisms ought not to be applied more restrictively to mental illness services than other types of care. More completely, coverage for mental illness services should be subject to the same terms and conditions as those applied to other illnesses.

In practical terms, this means that

provider network arrangements;

prior authorization requirements;

prospective/concurrent/retrospective review processes; and

any copayments or deductibles

should apply to mental illness services on the same basis as applied to other services in the health benefits package.

VIII. SUMMARY

The Committee recognizes the need to balance access to mental illness care with its cost. However, this recognition comes with a realization that for many severely ill or disturbed persons, a public system of care serves as a safety net for those not able to access care through the private third-party payer market. The Committee believes that this is in part due to an inability, through choice or otherwise, of the private market to play a role in providing services for these persons. Any new program to increase access to health care ought not to do so by inappropriately underproviding services for these persons.

ENDNOTES

1. Minnesota State Planning Agency, *Mandate for Action* (St. Paul: February 1986), p. 4.

2. Including Minnesota Office of the Legislative Auditor, *Deinstitutionalization of Mentally Ill People* (St. Paul: February 1986); and
E. Fuller Torrey, M.D. and Sidney Wolfe, M.D., *Care of the Seriously Mentally Ill: A Rating of State Programs* (Washington, D.C.: Public Citizen Health Research Group, 1986).

3. In 1989, the Legislature passed the Comprehensive Children's Mental Health Act. For purposes of this report, references to mental illness include childhood emotional disturbance unless otherwise indicated.

4. The 1987 Legislature amended Minnesota Statutes 62A.152 to allow coverage of 80% of the first ten hours of outpatient treatment, plus at least 75% of any additional hours up to 30. Minn. Stat. 62D.102 was similarly revised, except that copayments not to exceed the greater of $10 or 20% of the applicable charge could be applied.

   The 1988 Legislature amended each statute to reflect that group treatment must be provided at a ratio of no less than two group treatment sessions to one individual treatment hour.

   In addition, the state's Medical Assistance plan has been amended several times to include coverage for case management and other mental health services.

5. Examples include:

   "I have a choice between about six HMOs and the standard 80% (insurance) coverage. I've always gone with the standard 80% coverage -- you don't foresee mental health issues coming up in your life. If you have a physical, say you go to the doctor, you get a one-time office visit, you get a prescription . . . mental health goes on for years. So I have all these bills. I'm trying my best to pay them off." (testimony from parent to Children's Subcommittee, 1/6/89)

   "We are disturbed by the very limited choice of providers of mental health services under the plan . . . as distinct from virtually all other covered services, the plan apparently provides no coverage at all for the services of out-of-

network mental health and chemical dependency care providers . . ." (letter to DOERS Commissioner Nina Rothchild, 12/13/90)

"Mental health agencies are turning more and more to brief therapy policies and practices as payment for services becomes more difficult to obtain from insurance providers . . . when limited to providing brief therapy, one is likely to diagnose a symptom (e.g. adjustment disorder with anxiety) rather than the underlying condition . . ." (letter to DHS Asst. Commissioner Kaufman, 5/9/90)

"I was involved in a case where a child tried to kill himself four times. He was placed in a hospital first for physical treatment and then form treatment because he was emotionally disturbed . . . Because of his insurance coverage he could only be in there six days. So what did they do? . . . ten days later they discharged him from the facility and his out-patient treatment consisted of calling a psychologist in two weeks. Now that's not treatment." (testimony to Children's Subcommittee from attorney, 1/6/89)

"Mental illness is a chronic illness which has required me to use health care yearly, monthly, weekly, or even daily on occasions for the past 20 years, causing considerable expense for my family and the insurance company. We have figured roughly that our family has paid $100,000 over and above any insurance premiums." (testimony to MN Health Care Access Commission, 6/5/90)

6. Regarding the report of the Pepper Commission, remarks by Senator David Durenberger to the National Advisory Committee on Mental Health, Marshall, Minnesota, April 12, 1990.

   Regarding the Benefits for All Americans Act, see S. 168/H.R. 1846, 101st Congress.

7. Office of the Legislative Auditor, *Health Plan Regulation.* St. Paul: author, February 1988, p. 61.

8. World Institute on Disability, *Access to Health Care.* Washington, D.C.: author, December 1988, p. 12.

9. Health Care Financing Administration, "National Health Expenditure Estimates for 1986." *Health Care Financing Review,* vol. 8, no. 4 (Summer 1987).

10. Statement to the Third Party Reimbursement Committee of the Advisory Council by Marianne Miller, Director of Health Economics for the Minnesota Department of Health.

See also Minnesota Health Care Access Commission, *Interim Report to the Legislature,* (St. Paul, February 1990), p. 6.

11. World Institute on Disability, pp. 3 - 11.

12. While the relationship of mandated benefits to premium costs is not completely understood, Blue Cross and Blue Shield of Minnesota estimated that 14% to 20% of its premiums were a result of mandated benefits between 1982 and 1987. Citizens League, *Access, Not More Mandates: A New Focus for Minnesota Health Policy* (Minneapolis, September 1989), pp. 10 - 11.

    Data is generally unavailable regarding the extent to which any single mandate contributes to cost.

13. Susan Sherry, in a statement to the Minnesota Health Care Access Commission. St. Paul: March 22, 1990.

    Also, "private insurance accounts for three times higher administrative costs than the government to deliver almost 25% less personal health care services." Institute on Disability, p. 12.

14. Kenneth B. Wells, et al. *Cost Sharing and the Demand for Ambulatory Mental Health Services.* RAND Corporation, 1982, pp. 13 - 17.

15. Willis B. Goldbeck, "Psychiatry and Industry: A Business View." *The Psychiatric Hospital,* vol. 13, no. 3.

16. Legislative Audit Commission, *Access to Medicaid Services* (St. Paul, February 1989).

17. Elliot Segal and Lisa Garret, "The Employer Perspective," in *The New Economics and Psychiatric Care.* Steven Sharfstein, M.D. and Allan Beigel, M.D. eds. (Washington, D.C.: American Psychiatric Press, 1985), p. 54.

18. "Workers are most likely to lack employment-related insurance if they are self-employed; work in part-time, temporary, or seasonal jobs; work for a small organization; or earn low wages."

    P. Short, A. Monheit, and K. Beauregard, *A Profile of Uninsured Americans.* DHSS Publication no. (PHS) 89-3443, September 1989, as cited in 18. *The Minnesota Health Care Access Commission Interim Report to the Legislature,* February 1990, p. 6.

19. However, while state mandates were rated as a "fairly important" reason by small firms as a reason for self-insuring, it was the least important reason for medium and large firms. *Health Plan Regulation,* p. 62.

In 1987, 27 states regulated mental health benefits provided by insurers or HMOs. "State Mandates for Mental Health, Alcohol, and Substance Abuse Benefits: Implications for HMOs." *GHAA Journal,* Winter 1988, p. 51.

20. "Since 1970 the percentage of Fortune 500 companies that have (EAP) programs . . . has increased from 25.2 to 56.7." Edward A. Ross, "Working with Industry: A Challenge to Psychiatry. *The Psychiatric Hospital,* vol. 13, no. 3.

A recent study of the McDonnell Douglas EAP attributed savings of $5.1 million in health benefits costs to an effectively managed EAP. See "McDonnell Douglas Corporation's EAP Produces Hard Data," *Almacan,* August 1989.

21. For example, see *GHAA Journal,* Winter 1988, p. 48, or American Psychiatric Association Office of Economic Affairs, *The Coverage Catalogue* (Washington, D.C.: American Psychiatric Press, 1986).

22. California Statutes Chapter 743, Section 10123.15.

23. For example, Bassuk and Holland identify the need to develop methods of identifying and targeting persons with long-term illnesses in an effort to manage their return to less costly types of care.

Ellen L. Bassuk and Stephen K. Holland, "Accounting for High Cost Psychiatric Care." *Business and Health* (July 1987), pp. 38 - 41.

24. Segal and Garrett, p. 61.

25. Sherry.

26. John C. Goodman and Gerald L. Musgrave, *Freedom of Choice in Health Insurance.* Dallas: National Center for Policy Analysis, November 1988; and

World Institute on Disability, pp. 58 - 59.

27. Indeed, there is little data on total health expenditures of any type in Minnesota, according to a preliminary report of the Delivery Mechanisms Committee of the Minnesota Health Care Access Commission. St. Paul: Health Care Access Commission, Draft Issue Paper #10, revised June 21, 1990, p. 5.

28. Inpatient days for mental health and chemical dependency treatment provide by Minnesota HMOs have also decreased. See Maureen Shadle and Jon B. Christianson, "The Impact of HMO Development on Mental Health and Chemical Dependency Services." *Hospital and Community Psychiatry,* vol. 40, no. 11, p. 1147.

29. These efforts include the securing of Joint Commission on Accreditation of Health Care Organizations accreditation for all six RTCs; a increase in salaries for psychiatrists as part of an enhanced recruitment effort; and proposals to renovate aging facilities.

30. RTC reimbursement information, mental illness collections summary. St. Paul: Mental Health Division, Department of Human Services. July 6, 1990.

31. Using prevalence estimates for mental disorders developed by the National Institute of Mental Health's Epidemiologic Catchment Area Program:

Mental Disorder	Men				Women			
	Age Group, Years				Age Group, Years			
	18-24	25-44	45-64	65+	18-24	25-44	45-64	65+
Schizophrenia	1.3	0.9	0.6	0.0	1.0	2.0	0.5	0.4
Affective Disorder	4.6	4.9	3.0	1.3	7.4	10.2	7.0	3.8
Personality Disorder	2.4	2.2	0.2	0.4	0.8	0.5	0.0	0.0
Cognitive Impairment (severe)	0.4	0.3	0.8	5.5	0.5	0.2	1.1	4.1
Phobia	4.7	3.9	5.4	2.9	11.3	12.8	7.5	6.3

Rama S. Pandey, Ph. D., "Prevalence Estimates of Mental Disorders for Minnesota Counties." Submitted to the Minnesota Department of Human Services under contract #89255, September 1987.

A separate report estimates that between 3 and 8% (or approximately 2 - 5 million) of American children experience severe emotional disturbances. June M. Tuma, "Mental Health Services for Children: the State of the Art." *American Psychologist,* vol. 44, no. 2, as cited in *What Legislators Need to Know About Children's Mental Health.* Report of the National Conference of State Legislatures. Washington, D.C.: author, April 1990.