



Connecticut

Testimony before the Human Services Committee

February 26, 2008

Support for HB 5617

Good afternoon, Senator Harris, Representative Villano, and members of the Human Services Committee. My name is Allan Atherton, and I am the President of the Connecticut State Chapter of the National Alliance on Mental Illness. I am here today to testify in support of HB 5617, An Act Delaying Implementation and Making Revisions to the Charter Oak Health Plan. This bill will mandate that mental health parity apply to the Charter Oak Plan, as well as fixing other negative aspects of the plan, such as the annual limits on prescription drugs.

The Governor's Charter Oak Health Plan excludes mental health parity and places limits on outpatient and inpatient mental health care services. It does this in the face of Connecticut's strong insurance law that requires all insurance plans in Connecticut to comply with mental health parity – one that is designed to protect all Connecticut insured residents from discrimination in mental health care. The plan also restricts access to prescription drugs and durable medical equipment through the use of annual cost caps.

Connecticut has one of the strongest mental health parity laws in the nation. If the Charter Oak Plan moves forward as is, we will be the only state in the region with a health plan for uninsured residents that does not follow our own law. According to the Commissioner of the Department of Social Services, the reason that mental health parity is excluded is because it will "dramatically increase the target premium." This simply is not true. Studies show that mental health parity has an insignificant impact on cost. A recent Milliman article highlights the fact that estimates of cost increases for mandated mental health parity are at 0.6% or lower today. The Congressional Budget Office agrees and reports a 0.4% estimated cost impact. They also point to the fact that **"none of these analyses consider the effect of cost offsets from savings in other healthcare services, such as the potential for reduced visits to primary-care doctors or emergency rooms."**

The result is an expensive health plan that will meet the needs of only a young and healthy population that is least likely to use it. The young and healthy can get a private insurance policy for less money that includes better coverage for prescription drugs and durable medical equipment, and includes mental health parity coverage.

Moreover, the outcome of the plan design is debatable. With few other options, many people in need of mental health treatment will likely enroll in the plan, and when they encounter the limits to mental health coverage, they will be forced to overuse other services, such as emergency room visits and primary care visits.

State planning documents show that the Charter Oak plan was intentionally designed to reduce the likelihood that people who have serious health conditions, such as mental illness and physical disabilities, would be able to utilize it. A memo from the state's hired consultant expressly states that there should be limits on mental health benefits, durable medical equipment, and prescription drugs "to avoid selection issues associated with the chronic users of those services." He warned that failing to do this would mean taking on "bad risk." Consequently, the state has put itself at risk of a lawsuit by potentially violating Connecticut's anti-discrimination laws, which specifically prohibit discrimination in state programs or services on the basis of mental disability.

What kind of message does it send when the state offers an insurance plan and then exempts itself from a critical consumer protection while requiring all insurers in the state to comply with the hard-won public policy decision that mental health parity is essential? This sets up a two-tier system for mental health coverage – are people enrolling in Charter Oak plan somehow less worthy of mental health parity than the rest of us?

Some have argued that it is not mental health parity that is too costly, but the overall use of high costs services by people with mental illnesses. Well, that is discrimination. There are many serious health conditions, such as cancer, that require high cost treatments and services. Would this legislature justify limits on cancer treatment based on that fact?

The state of Connecticut must not back an insurance plan that treats mental health care differently than other health care treatment, and that systemically attempts to exclude those who are in most need of its services.

Thank you for time and attention to this critical issue.

Cost of Implementing Parity

- “In states in which legislation requires parity of mental health and general coverage, **cost increases are nearly imperceptible** as long as the care is managed.” *Mental Health: A Report of the Surgeon General*. (1999), p.458.
- “Does implementing parity increase the total cost of health benefits? **Recent research supports and expands earlier findings that implementing parity benefits results in minimal if any increase in total health care costs.** A recently updated simulation model estimates an approximately **1.4 percent increase** in total health insurance premium costs when parity is implemented.” Kirschstein, Ruth L., M.D. *Insurance Parity for Mental Health: Cost, Access, and Quality, Final Report to Congress by the National Advisory Mental Health Council*. National Institutes of Health, June 2000, p.3.
- A number of private sector companies are already providing parity, and it's costing about 25 cents a day, at the most. For the FEHB Program, the cost will be even less...with an aggregate program **increase of 1.3%. Per biweekly pay period, those with a self-only enrollment will pay \$0.46 for parity. Family enrollees will pay \$1.02.** *Mental Health and Substance Abuse Parity Frequently Asked Questions*, Office of Personnel Management (2001).
- The amount spent by BlueCross BlueShield of Vermont for mental health and substance abuse services increased **19 cents per member per month following implementation of parity.** Rosenbach, M., Lake, T., Young, C., et al. (2003). *Effects of The Vermont Mental Health and Substance Abuse Parity Law*, DHHS Pub. No. (SMA) 03-3822. Center for Mental Health Services, Substance Abuse and Mental Health Services Administration. p. x and p.57.
- In the first twelve months of implementation, Oregon's Public Employees' Benefit Board's cost to provide parity was **less than half of one percent.** State of Oregon Public Employees' Benefit Board. *Mental Health Parity* (2004).
- In Texas, direct premium costs for treating all serious mental illness on an inpatient and outpatient basis is estimated to account for 2% of the premium. *When health care cost savings estimated to equal 20.5% of the treatment costs are factored in, the resulting indirect premium cost equaled 1.6% of the premium.* Albee, S., Blount, E., Hansen, M., Lee, T., Litow, M., and Sturm, M. *Cost Impact Study of Mandated Benefits in Texas, Report #2*, September 2000.
- ...mandated benefits should be evaluated using specific evaluation categories including level of demand, impact of mandating the benefit, impact of not covering under private insurance, impact of not providing treatment, health status/efficacy, impact of treatment on sick day/disability cost, and direct and net premium cost impacts. Based on these evaluation categories, **chemical dependency and serious mental illness scored first and second place in terms of relative value in a review of thirteen mandated benefits.** Albee, S., Blount, E., Hansen, M., Lee, T., Litow, M., and Sturm, M. *Cost Impact Study of Mandated Benefits in Texas, Report #2*, September 2000
- “**Thus far, there is no evidence that employers—large or small—were dropping health care coverage,** as some had feared prior to the bill's passage.” “As of Fall 2001, health insurance purchasers said that they have not seen ‘earth-shattering’ changes in premium costs related to the mental health parity law. One employer representative referred to the parity law as a ‘non-event.’” Tim Lake and Cheryl Pedersen, *Employers Not Dropping Coverage After Implementation of Mental Health Parity in California*, Mathematica Policy Research, Inc., (2002), p.20-21.
- **Providing insurance coverage for mental illness equal to that for physical illness does not drive up the cost of care,** according to an exhaustive study of health benefits for federal employees. Goldman, Frank, Burnam, Huskamp, Ridgely, Normand, Young, Barry, Azzone, Busch, Azrin, Moran, Lichtenstien, and Blasinsky, *Behavioral Health Insurance Parity for Federal Employees*, N Engl J Med 2006 354: 1378-1386.
- **Most insurers, especially managed care plans, experienced small increases in total premiums.** Two managed care companies in Maryland stated that **premiums increased by 1 percent or less.**

After this initial increase, total premiums generally "leveled out." Sing, Merrile, et al. *The Costs and Effects of Parity for Mental Health and Substance Abuse Insurance Benefits*. Center for Mental Health Services, SAMHSA, Department of Health and Human Services. March 1998.

- The costs of providing appropriate treatment for mental and addictive disorders must be measured in a larger context that also considers disability costs, employee absenteeism and lost productivity. Taking these into consideration, **employers found that traditional benefit limitations were not cost-effective.** Kristen Reasoner Apgar, *Large Employer Experiences and Best Practices in Design, Administration, and Evaluation of Mental Health and Substance Abuse Benefits—A Look at Parity in Employer-Sponsored Health Benefit Programs*, Washington Business Group on Health, Report to the Office of Personnel Management, March 2000.
- "As of January 1, 2001, all of the FEHB plans had complied with the parity policy, two-thirds incurred no added administrative costs, and none reported major problems with implementation. Furthermore, **no plans left the FEHB Program to avoid the parity policy.** The policy change enhanced MH/SA benefits for FEHB Program enrollees." U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, *Evaluation of Parity in the Federal Employees Health Benefit (FEHB) Program: Final Report Executive Summary*, December 31, 2004. Accessed from the Web at <http://aspe.hhs.gov/daltcp/reports/parityves.htm> on January 8, 2008.
- The Congressional Budget Offices estimates that 2007 federal parity legislation (S. 558) **would increase premiums for group health insurance by an average of about 0.4 percent.** Congressional Budget Office Cost Estimate: S. 558 Mental Health Parity Act of 2007, *As ordered reported by the Senate Committee on Health, Education, Labor, and Pensions on February 14, 2007*, March 20, 2007.