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The Consumer Connection

... linking consumers with health care news and information

Michigan Consumer Health Care Coalition
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The Consumer Connection is a publication of the Michigan Consumer Health Care Coalition with the Michigan League for Human Services

Mental Health:
Care and Consequences Update

Mental illness is the second leading cause of disability and premature death in the United States. A recent Substance Abuse and Mental Health Services Administration (SAMHSA) study found that people with serious mental illnesses die an average of 25 years sooner than other Americans. The SAMHSA data appears to reveal the highest mortality rates for any sub-population in the U.S. public health system.

In an international collaboration, the World Health Organization (WHO), the World Bank, and Harvard University gathered a large amount of data in the Global Burden of Disease study and found that mental illness accounts for more than 15 percent of the disease burden—more than cancer—in established market economies like the United States.

According to the National Institute of Mental Health (NIMH), one in four Americans 18 and older suffer from a diagnosable mental disorder. Mental disorders are also the leading cause of disability in the United States for ages 15–44.

In spite of the data, while outlays in every other sector of health care are increasing, mental health services funding is decreasing.

Michigan Mental Health Services

The state system for mental health care was designed to meet the needs of two very different client populations:

- the *developmentally disabled*—people with mental retardation, autism, cerebral palsy, or epilepsy, and
- the *mentally ill*—adults and children diagnosed with such conditions as schizophrenia, bipolar disorder, serious depression, and substance abuse.

Originally, treatment and care for mental health patients took place primarily in state hospitals and centers. In the first half of the twentieth century the number of patients admitted to state institutions grew dramatically. By the 1960s, however, attitudes toward care changed. Mental health professionals, the public, and policymakers concurred that the needs of most mental health patients could be met in community programs located as close to a patient's family as possible. In 1974, Michigan state law was changed to transfer the authority and funding for the care and treatment of adults and children with mental illness and developmental disabilities from the state to community mental health services programs (CMHSPs).

Public mental health services are provided primarily by 46 CMHSPs. Eighteen pre-paid inpatient health plans (PIHPs) manage the Medicaid mental health and substance abuse services called "specialty supports and services."

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Supports and services in Michigan are predominantly community based, but inpatient care, when needed, can be purchased by the CMHSPs and PIHPs from psychiatric inpatient units in local community hospitals or from one of the five state-operated facilities. Information about eligibility for, descriptions of, and provider qualifications for the Medicaid supports and services are available in the Mental Health and Substance Abuse chapter of the Medicaid Provider Manual.

Today the CMHSPs offer a variety of services that may include

- inpatient/outpatient services,
- psychosocial rehab,
- day programs,
- special services for children/teens,
- drug control and substance abuse,
- crisis services, and
- supported employment.

A list of CMHSP service sites can be found at http://www.michigan.gov/documents/cmh_8_1_02_37492_7.PDF.

Since 1999, the Michigan Department of Community Health (MDCH) has operated a managed-care specialty-services program for the Medicaid population. Under this program, the MDCH has contracted with each CMHSP to operate as a specialty prepaid health plan (SPHP) responsible for providing Medicaid-covered mental health and developmental disability services in its geographic area.

Public and Private Facilities

The state has closed 25 state mental health institutions since 1981, 17 of them since 1990. Currently, five state-operated hospitals and centers serve mentally ill adults and children and people with developmental disabilities. They are

- the Caro Center, Kalamazoo Psychiatric Hospital, and Walter Reuther Psychiatric Hospital, which serve mentally ill adults;
- the Hawthorn Center, which serves mentally ill children; and
- the Mt. Pleasant Center, which serves developmentally disabled clients. *The FY2010 Executive budget recommends the closure of this facility and the transfer of its 80 residents to community placements or other institutions.*

In July 2003, the Northville Psychiatric Hospital was closed more than two years earlier than expected. Several reasons are cited for the closures: (1) the belief that the mentally ill and developmentally disabled population should not be locked up but allowed to live and receive care in their community; (2) growth of the community mental health system; (3) development of psychotropic drugs that help manage mental illness; and (4) last but not least, budget priorities and constraints.

The remaining public hospitals are supplemented by a system of private hospital care, providing short-term care for the mentally ill, that people can access through private health insurance or out-of-pocket payment. According to the MDCH, in 2001 there were 61 private psychiatric hospitals/units in Michigan, with the capacity to serve 2,038 adults and 394 minors. But the number of private units is decreasing, due mainly to financial considerations.

Opponents of the state facility closures argue that the institutional beds being lost are not being replaced by enough beds in private general and psychiatric hospitals in the state. They contend that people in psychiatric hospitals are there because they cannot be properly treated in a community setting or in a regular hospital, where stays usually are limited and unsuited for people with long-term mental illness. They also maintain that many patients who are displaced from institutions will end up in a homeless shelter or jail instead of in a community program or general hospital.

Health Care by the Numbers

57.7 Estimated number (in millions) of U.S. adults that experience a mental health disorder in a given year. *National Alliance of Mental Illness 2007.*

6.7 Percentage of adults affected by a major depressive disorder, or about 14.8 million American adults according to the *2004 World Health Report.*

79 Billion dollars, the annual economic, indirect cost of mental illnesses in the U.S. Most of that amount—approximately $63 billion—reflects the loss of productivity as a result of illnesses according to the *U.S. Department of Health and Human Services.*

Work in Progress

Mental health advocates are concerned that (1) mental health resources in Michigan are insufficient, (2) the closure of so many state institutions means that some people with mental health needs are being deprived of a continuum of care.

We want to hear from you—suggestions for improvements and topics, questions, even encouragement!

Please contact us in care of Carol Barish, Consultant for Health Policy, Public Sector Consultants, 600 West St. Joseph Street, Suite 10, Lansing, MI 48933 (517) 484-4954. E-mail: cbarish@pscinc.com

Pharmaceutical coverage has been and remains a contentious issue. Michigan's Medicaid prescription drug formulary in February 2002, denied Medicaid recipients access to certain mental health drugs. However, in July 2004, the governor signed legislation that prohibited the Department of Community Health from requiring prior authorization through the Pharmaceutical Best Practice Initiative for medications prescribed to patients with mental disorders, HIV/AIDS, cancer, organ replacement, and epilepsy or seizure disorders, and maintains other exemptions from prior authorization that are in current policy. Since then numerous policies have been proposed, the most recent in the FY2010 Executive Budget recommendation to implement a preferred provider drug list for behavioral health drugs. This policy, if adopted, will apply to new Medicaid-eligible individuals; current recipients will continue to receive their current drugs.

Half of the health care services provided come from public sources (Medicare and Medicaid); half come through employers. All provide a certain level of mental health care benefits; usually an insurance company or health care plan administers the benefit the employer provides. Coverage levels vary considerably. Some employer sponsored insurance covers 52 mental health care visits per year, while others limit their coverage to 20–25 visits. There are also differences in co-pays, depending on what benefit the employer provides.

Observers generally argue that private insurance coverage for mental health services is inadequate. In addition, in recent years, a large percentage of overall spending in Michigan on mental health services has taken care of the needs of low-income Medicaid beneficiaries. But only half of Michiganians with mental health service needs are eligible under the low financial guidelines for participation. Thus, there is need for other sources to cover mental health services for the non-Medicaid population.

Parity

With enactment of the federal Mental Health Parity Act in 1996, insurers were required to provide the same aggregate lifetime and annual limits for mental health coverage that they provide for medical and surgical coverage. However, the law did allow employers and insurers to limit the number of inpatient days, outpatient visits, and prescription drugs. The 1996 law applied to treatment for mental illness, but it did not *require* employers and insurers to provide mental health services at all; it only specified that *if* these services were provided, there must be parity in coverage.

In October 2008, the president signed the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) that requires employers to provide mental health coverage comparable to the physical health care coverage they offer. The mental health parity bill was tacked on to the financial bailout package. It will provide parity in insurance benefits for 113 million Americans. Employers with 50 workers or less are exempted. Employers with 50 or fewer employees are exempt from the law. The law also provides protections from caps on services and high copayments. Key changes made by MHPAEA, which is generally effective for plan years beginning after October 3, 2009, include the following:

- If a group health plan includes medical/surgical benefits and mental health benefits, the financial requirements (e.g., deductibles and co-payments) and treatment limitations (e.g., number of visits or days of coverage) that apply to mental health benefits must be no more restrictive than the predominant financial requirements or treatment limitations that apply to substantially all medical/surgical benefits;
- If a group health plan includes medical/surgical benefits and substance use disorder benefits, the financial requirements and treatment limitations that apply to substance use disorder benefits must be no more restrictive than the predominant financial requirements or treatment limitations that apply to substantially all medical/surgical benefits;
- Mental health benefits and substance use disorder benefits may not be subject to any separate cost sharing requirements or treatment limitations that only apply to such benefits;

- If a group health plan includes medical/surgical benefits and mental health benefits, and the plan provides for out-of-network medical/surgical benefits, it must provide for out-of-network mental health benefits;
- If a group health plan includes medical/surgical benefits and substance use disorder benefits, and the plan provides for out-of-network medical/surgical benefits, it must provide for out-of-network substance use disorder benefits;
- Standards for medical necessity determinations and reasons for any denial of benefits relating to mental health benefits and substance use disorder benefits must be made available upon request to plan participants;
- The parity requirements for the existing law (regarding annual and lifetime dollar limits) will continue and will be extended to substance use disorder benefits.

To date, Michigan has been unsuccessful in passing mental health parity legislation. (And even if it succeeded, this legislation would *not* apply to anyone who is covered by an employer's self-funded benefit plan—more than half of the people carrying a Blue Cross card.)

Parity opponents argue that it could be costly for health insurers and employers. Supporters counter that providing mental health coverage actually will lower the overall costs of treating mental illness because with early treatment, the amount of care needed is far less than when the illness becomes chronic due to a lack of care. Parity supporters also maintain that employers would receive a net benefit from paying the additional costs of mental health coverage because absenteeism caused by mental illness would be greatly reduced and job productivity increased.

The impacts in other states that have enacted parity laws, according to a Cooper & Lybrand actuarial analysis, show that there have either been decreases in the cost of health insurance premiums or an increase of less than 1 percent. In Minnesota, after one year of experience with parity, Blue Cross/Blue Shield reduced insurance premiums for small businesses by 5–6 percent.

Paying One Way or Another

The Congressional Budget Office, in 2006, reported that nationally full parity would increase premiums less than 1 percent, costing a typical plan $1.32 per person per month. This cost, however, may be offset by savings in other areas when employees and their families have access to treatment for mental illness and addictive diseases.

Many studies and other materials document the minimal costs and substantial benefits associated with implementing mental health parity.

- **Businesses benefit from mental health parity.** The cost to businesses of absenteeism, lost productivity, and claims for disability and unemployment insurance due to untreated mental illness is **greater** than the cost of mental health parity. In 1999, the U.S. Surgeon General reported that the indirect costs of mental illness imposed an estimated $79 billion loss on the U.S. economy in 1990. According to the U.S. Department of Labor, the $79 billion would be worth more than **$123 billion** today.
- **Parity reduces costs to society.** Mental health parity will help reduce social costs such as imprisonment, homelessness, hospitalization, and public assistance.
- Since January 2001, mental health parity has been provided to about nine million employees of the federal government. According to Ronald Bachman, a nationally recognized health care actuary, "…the cost of the FEHBP implementation of mental health parity only ranges between 0.24 percent and 0.87 percent." (*Evaluation of Parity in the FEHBP: Final Report*, Ronald Bachman, FSA, MAAA, Healthcare Visions, Inc., November 2005.)
- Workers with depression "have been found to lose 5.6 hours a week of productivity as compared to 1.5 for workers without depression." (Institute of Medicine, *Improving the Quality of Health Care for Mental Health and Substance-Use Conditions: Quality Chasm Series*, 2006, p. 33.)
- "**The cost of effective depression treatment is more than outweighed by the benefits of reduced disability**. Across several studies, the added cost of effective depression care is typically $300 to $600 over six to twelve months. More recent studies find that this increased cost is balanced by medical care savings over 18 to 24 months. The cost is also balanced against increased employment, decreased absenteeism, and

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increased productivity while at work. Estimates of these savings and benefits range from $50 to $100 per month—equal to or greater than the cost of improved depression treatment.'' (Dr. Greg Simon, *Business Case for Mental Health Parity*, January 18, 2007.)

When treatment of mental illness and addictive disorders is not available, the costs for other medical services increase significantly.

- Medical complaints that originate from psychological factors account for 50–70 percent of visits to primary care physicians.
- General medical health care costs are two to three times greater among people with untreated mental illness or addictive disorders. They visit their primary care physicians twice as often as other people.

The Health Care Happenings...

At the state level…

In February 2009, officials at Blue Cross Blue Shield of Michigan (BCBSM) formally requested double-digit average rate increases on many of the company's individual health insurance policy lines. Additionally, the firm plans to lay off up to 1,000 people as part of a range of cutbacks.

The rate increases requested include: 31 percent for Medicare ''Medigap'' plans, 42 percent for group conversion plans, and 56 percent in the key market of individual insurance plans. It is estimated that these increases will affect 400,000 BCBSM customers. BCBSM serves nearly five million people in Michigan. The proposed BCBSM rate increases have to be approved yet by the Insurance Bureau.

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BCBSM officials said the increases are needed to reduce losses estimated to total $1 billion over the next three years.

Other cost-cutting actions include:

- A freeze on salaries for nonunionized workers
- A request of BCBSM workers who are members of the United Auto Workers to delay a 3 percent pay increase
- A 25 percent reduction in discretionary spending
- Cuts to programs funded by BCBSM in local communities across Michigan

According to BCBSM officials, the layoffs and rate increase proposals are directly related to the failure of the Michigan Legislature to act on two bills in December to reform the individual health insurance market.