MENTAL HEALTH BENEFIT

In Section 1115: Mental Illness and Substance Abuse Services

Amend subsection (d), Intensive Nonresidential Treatment, Part (C), annual limit, so as to provide the following benefit:

- 90 days of Intensive Nonresidential Treatment services
- no trade-off against inpatient care.

OR:

- 120 days of Intensive Nonresidential Treatment services
- Initial 60 days a free-standing benefit; second 60 days subject to a trade- off against inpatient care, as follows:
  - -- two days of partial hospitalization services for one day of inpatient care;
  - -- other Intensive Nonresidential Treatment services at trade-offs based upon actuarial equivalency.

Amend subsection (c), Inpatient and Residential Treatment, paragraph (D), Annual Limit, so as to provide coverage for 30 days of inpatient and residential treatment per year, and a maximum of 15 additional days when found to be medically necessary or appropriate. Delete (D)(i) and (ii), which limits extended stays only to individuals who are dangerous or who need pharmacological or somatic therapy.

In Section 1135: Table of Copayments and Coinsurance

Amend the Lower Cost-Sharing Schedule for Intensive nonresidential mental illness and substance abuse treatment to add "No copayment in the low cost-sharing plans"; and amend the Higher Cost Sharing Schedule for Intensive nonresidential mental health and substance abuse treatment to add "20% of applicable payment rate".

CHILDREN'S MENTAL HEALTH SERVICES

In Section 1115: Mental Illness and Substance Abuse Services

Amend the Health Security Act, to insert the phrase "for individuals over age 21" in each place where annual limits or trade-offs are prescribed for the interim mental health benefit. Similarly, amend language which excludes certain mental health and substance abuse costs from the out-of-pocket maximum so as to insert the phrase "except for individuals under age 22".

In Section 1135: Table of Copayments and Coinsurance

Amend the Lower Cost Sharing Schedule for Intensive nonresidential mental illness and substance abuse treatment to add "No copayment for individuals under age 22"; and amend the Higher Cost Sharing Schedule for Intensive nonresidential mental health and substance abuse treatment to add "20% of applicable payment rate for individuals under age 22".

Effect of These Amendments

These amendments would establish for children a comprehensive benefit of mental health and substance abuse services without arbitrary, statutory limits on care. Essentially, this gives children access to the 2001 mental health and substance abuse benefit of the Health Security Act immediately upon enactment.

Alternative Proposal

Provide the benefit described above only for children in lower cost-sharing plans, since these children's services will be subject to close management either through an HMO or through the health plan's use of a preferred provider network. In addition, make the following amendments to the mental health and substance abuse benefit for children in the higher cost-sharing plans:

- Remove the arbitrary, statutory limits on intensive nonresidential services and outpatient mental health and substance abuse therapy;

- Amend the inpatient/residential limit to raise the ceiling to 90 days, but with reviews required as the necessity of continued care at the following specified intervals: 15 days, 30 days and every 15 days thereafter;

- Amend the cost-sharing requirements for psychotherapy, as follows: 20% co-payment for the first 10 visits, 50% copayment for subsequent 30 visits, 20% copayment for further visits (all psychotherapy should be subject to external review).

$10 copayment in lower cost sharing plan.

MENTAL ILLNESS AND SUBSTANCE ABUSE BENEFIT
ITEMS AND SERVICES COVERED

Inpatient Hospital and Residential Services

Intensive Nonresidential Treatment

Outpatient Treatment

--Screening and Assessment

--Diagnosis

--Crisis services

--Medical Management

--Substance Abuse Counseling and Relapse Prevention

--Somatic treatment services

--Psychotherapy

--Collateral services

--Case Management

MENTAL ILLNESS AND SUBSTANCE ABUSE SERVICES

- All day & visit limitations eliminated by 2001. Before January 1, day & visit limits apply to these services:
  - -- inpatient hospital/residential services
  - -- intensive non-residential services
  - -- psychotherapy and collateral services
  - -- outpatient substance abuse services

- Screening & assessment, diagnosis, medical management, crisis services, somatic treatments covered with no visit limits

- No lifetime limits

- Prescription Drugs Covered

MENTAL ILLNESS AND SUBSTANCE ABUSE
INPATIENT HOSPITAL AND RESIDENTIAL TREATMENT SERVICES

Settings

--hospital
--psychiatric hospital
--residential treatment center
--residential detoxification center
--crisis residential program
--mental illness residential treatment program
--therapeutic family or group treatment home
--community residential treatment and
recovery center for substance abuse

Appropriate Levels of Care

- Treatment covered when provided in least restrictive inpatient or residential setting that is effective and appropriate, and when less restrictive intensive nonresidential or outpatient treatment would be ineffective or inappropriate

MENTAL ILLNESS AND SUBSTANCE ABUSE
INPATIENT HOSPITAL AND RESIDENTIAL TREATMENT SERVICES

Day Limits

- Annual limit of 30 days

- Additional 30 days available if health professional designated by the health plan determines:

  (1) individual danger to self or others

  (2) medical condition requires inpatient hospital care for pharmacological or somatic therapy

MENTAL ILLNESS AND SUBSTANCE ABUSE
INPATIENT HOSPITAL AND RESIDENTIAL TREATMENT SERVICES

Cost Sharing

- Lower Cost Sharing - No copayment
- Higher Cost Sharing - One day deductible per admission and 20 percent coinsurance
- Cost sharing counts toward out-of-pocket maximum

MENTAL ILLNESS AND SUBSTANCE ABUSE
INTENSIVE NONRESIDENTIAL SERVICES

Services

--partial hospitalization

--day treatment program

--psychiatric rehabilitation program

--ambulatory detoxification

--home-based mental illness services

--behavioral aide mental illness services

MENTAL ILLNESS AND SUBSTANCE ABUSE
INTENSIVE NONRESIDENTIAL SERVICES

Day Limits

- Covered as a substitution for inpatient days at the rate of two intensive nonresidential days for one inpatient day until the 30 day inpatient limit is reached (i.e., up to 60 days using substitution)

- Additional 60 days available if health professional designated by the health plan determines additional treatment is medically necessary or appropriate.

MENTAL ILLNESS AND SUBSTANCE ABUSE
INTENSIVE NONRESIDENTIAL SERVICES

Cost Sharing

- Lower Cost Sharing - For first 60 days, no copayment; $25 per visit for second 60 days

- Higher Cost Sharing - Per admission one day deductible; for first 60 days 20 percent coinsurance; 50% coinsurance for second 60 days

- Cost sharing for first 60 days for mental illness counts toward out-of-pocket maximum

MENTAL ILLNESS AND SUBSTANCE ABUSE OUTPATIENT TREATMENT

Services With No Specified Day or Visit Limits

--Screening and assessment

--Diagnosis

--Medical management

--Crisis services

--Somatic treatments

--Case management

MENTAL ILLNESS AND SUBSTANCE ABUSE OUTPATIENT TREATMENT

Cost Sharing on Services Without Limitations

- Lower Cost Sharing - $10 per visit
- Higher Cost Sharing - 20 percent coinsurance
- Cost sharing does not count toward out-of-pocket maximum

MENTAL ILLNESS AND SUBSTANCE ABUSE
OUTPATIENT TREATMENT
PSYCHOTHERAPY AND COLLATERAL SERVICES

Psychotherapy & Collateral Services (services to family member of patient)

--30 visits

--Additional visits available by exchanging, at a 1 to 4 rate, inpatient days for outpatient psychotherapy visits.

Cost Sharing Psychotherapy and Collateral Services

- Lower Cost Sharing - $25 per visit
- Higher Cost Sharing - 50 percent coinsurance
- Cost sharing does not count toward out-of-pocket maximum

MENTAL ILLNESS AND SUBSTANCE ABUSE
OUTPATIENT TREATMENT: SUBSTANCE ABUSE

Substance Abuse Counseling and Relapse Prevention

--Up to 120 sessions available by exchanging, at a 1 to 4 rate, inpatient/residential days for outpatient visits

--Within 12 months after receiving residential or intensive non-residential treatment, 30 group therapy sessions

Cost Sharing Substance Abuse Counseling and Relapse Prevention

- Lower Cost Sharing - $10 per visit
- Higher Cost Sharing - 20 percent coinsurance
- Cost sharing for outpatient treatment does not count toward out-of-pocket maximum

MENTAL ILLNESS AND SUBSTANCE ABUSE
OUTPATIENT TREATMENT

Case Management

- Services that assist individuals in gaining access to needed medical, social, educational and other services

- Health plans have the discretion to determine if a specific individual enrolled in a health plan should receive such services.

Cost Sharing

- Lower Cost Sharing - No copayment

- Higher Cost Sharing -No coinsurance

MENTAL ILLNESS AND SUBSTANCE ABUSE
PUBLIC HEALTH INITIATIVES

- Supplemental Formula Grants to States for Mental Health and Substance Abuse

  --Increase access, capacity to coordinate, and incentives to integrate

- Loan and Loan Guarantee Programs for Capital Costs for Non-Acute Residential Treatment Centers and Community-Based Clinics

MENTAL ILLNESS AND SUBSTANCE ABUSE
INTEGRATION OF PUBLIC AND PRIVATE SYSTEMS

- States expected to integrate mental illness and substance abuse services of the State with the services included in the comprehensive benefit package by January 1, 2001

- By October 1, 1998 participating states required to submit report

- Pilot program to demonstrate model methods of achieving integration

SUPPLEMENTAL TALKING POINTS MENTAL ILLNESS AND SUBSTANCE ABUSE

SLIDE 1 - Items and Services Covered

- For the first time, mental illness and substance abuse treatment services will be a mandatory componenet of national health care, ensuring that individuals with mental illnesses and substance abuse disorders will have access to specialized services.
- IMPROVEMENT from current insurance policies in that broader array of services covered than in typical policy today.
- Emphasis is on encouraging health plans to offer a more flexible managed benefit approach.

SLIDE 2 - MI/SA Services

- Initial benefit continues to use day and visit limits similar to current insurance policies.
- Phase-in period required to develop the service system capacity to deliver this comprehensive benefit, and to integrate the public and private systems.
- Coverage for prescription drugs, including recent advances in psychopharmacology.

SLIDE 3 - Inpatient Hospital and Residential Treatment Services

- Residential treatment for mental illness covered as a hospital alternative.
- Covers residential treatment for substance abuse.
- Hospitalization for medical detoxification from alcohol or drugs is covered under the regular hospital benefit and does not count toward day limitations.
- Under the mental illness and substance abuse benefit inappropriate use of other hospital care for substance abuse is discouraged by providing coverage only for detoxification requiring management of psychiatric conditions.

SLIDE 4 - Inpatient Day Limits, SLIDE 5 - Inpatient Cost Sharing

Self-explanatory

SLIDE 6 - Intensive Nonresidential Services (Services)

- Intensive treatment is not limited to inpatient settings.
- Less restrictive, nonresidential treatment, such as partial hospitalization and day treatment programs, can be provided when appropriate.
- Appropriate utilization of these services will reduce reliance on expensive hospital care and encourage more community-based treatment.
- Treatments purposes:

  - to avert the need for, or as an alternative to treatment in hospitals;

  -to facilitate the earlier discharge of an individual receiving inpatient or residential care;

  -to restore the functioning of such individuals;

  -to assist the individual to develop the skills and gain access to the support services the individual needs to achieve maximum level of functioning within the community.

SLIDE 7 - Intensive Nonresidential Services (Day Limits)

- The substitution structure is similar to the more innovative types of flexible benefit structures developing in the private sector today.
- Individuals may receive up to 60 days of treatment using the substitution formula.
- If health care professional designated by health plan deems medically necessary, an ADDITIONAL 60 days of non-residential treatment may be provided.
- The exchange of inpatient days does not apply to the second 60 days of treatment.

SLIDE 8 - Intensive Nonresidential Services (Cost Sharing)

- The second 60 days cost sharing expenses DO NOT apply to the individuals annual out-of-pocket limit on cost sharing.

SLIDE 9 - Outpatient Treatment

- Different than current insurance today, screening and assessment, diagnosis, somatic treatments, crisis services, and brief office visits to monitor patient psychiatric medication are treated as other physician office visits

- The medical management policy is similar to Medicare.

SLIDE 10 - Outpatient Cost Sharing on Services Without Limitations

Self-explanatory

SLIDE 11 - Outpatient Psychotherapy and Collateral Services

- Family members of individuals receiving mental illness and substance abuse treatment may receive medically related or appropriately related services with the patient.

- Collateral services counted against family member benefit not patient

- Through the 1 for 4 exchange, additional psychotherapy visits (beyond 30) may be available to prevent hospitalization or to facilitate earlier discharge.

- This exchange will follow the same cost sharing schedule as the first 30 visits.

SLIDE 12 - Outpatient Substance Abuse

Self-explanatory

SLIDE 13 - Case Management

- Case management benefit will help to address the special needs of the individuals with severe mental illness or hard core substance abuse.

SLIDE 14 - Public Health Initiatives

- Purposes of Formula Grant

  -- increase access to transportation, community and patient outreach, patient education, translation services, and other appropriate services;

  -- to improve the capacity of State and local service systems to coordinate and monitor mental health and substance abuse services;

-- to improve management information systems and establish linkages between providers of mental illness and substance abuse services with primary care providers and health plans;

-- to provide incentives to integrate public and private systems for the treatment of mental illness and substance abuse disorders.

SLIDE 15 - Integration of Public and Private Systems

- A plan demonstrating the integration of the state and local mental illness and SA services into the overall health system must be submitted by the states.

- The Secretary of HHS will establish pilot programs to demonstrate model methods for achieving the integration of such services into the comprehensive benefit package.

Mental Illness and Substance Abuse

Wouldn't it be more affordable and practical to just do a catastrophic benefit which did not include the extras of mental health, dental, and vision?

Why have there been so many changes to the mental illness and substance abuse benefit?

Why is the benefit so complicated?

Why include services such as behavioral aides, psychiatric rehabilitation, home based services, and case management which are not typically covered by private insurance?

Why are some of the out-of-pocket costs for substance abuse treatment handled differently than mental health?

Why is there a combined substance abuse and mental illness benefit?

Why does the MI/SA benefit use an inpatient deductible when there is not one for the rest of health?

Why does a person have to be functionally impaired or nearly so to get services? Won't this delay treatment until problems reach crisis levels?

How will a long term mental hospital patient exercise his/her rights under the plan, and how will care be coordinated for them?

Won't many mentally ill Medicaid non-cash beneficiaries be adversely impacted by the provisions of the plan?

AMERICAN
PSYCHOLOGICAL
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MENTAL HEALTH AND PSYCHOLOGICAL SERVICES: ESSENTIAL TO HEALTH CARE REFORM

Our nation faces an enormous need for mental health care. Unfortunately, our present mental health delivery system wastes scarce mental health dollars and ignores the value of psychological treatments. Congress should and can provide universal access to basic, affordable mental health and psychological treatment by restructuring the health delivery system to promote cost-effective psychological services.

NEED:

Americans need access to appropriate, high quality mental health care.

- At any point in time, an estimated 15-18% of Americans, including about 14 million children, suffer from a diagnosable mental disorder.
- In any one-month period, nearly 8 million Americans suffer depression. As many as 1 out of 5 Americans will suffer at least one episode of major depression during their lifetime.
- Several studies have indicated that up to 60% of all visits to primary care physicians are by individuals who have no identifiable physical illness but whose complaints stem from psychological factors.

COST AND WASTE IN CURRENT SYSTEM:

Our health care system wastes scarce mental health dollars, primarily by discouraging the use of effective and relatively inexpensive outpatient mental health treatments.

- Mental health benefits typically represent only 5-7% of total medical plan costs. 67-80% of all mental health dollars are spent on inpatient care.
- Rising mental health costs are not due to treatment of the seriously mentally ill or to outpatient care, but are almost entirely due to inpatient alcohol and drug abuse and inpatient adolescent care cost increases. A 1990 study of private health insurance claims found that inpatient substance abuse services increased by 30% and adolescent treatment expenses increased by 65% between 1986 and 1988.
- The present insurance system discourages the use of outpatient mental health care by reimbursing inpatient care often at 100%, with no out-of-pocket costs, while severely restricting coverage and imposing high copayments for outpatient treatment.

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THE SOLUTION

Access to appropriate, high quality mental health care should be made available to all Americans based on necessity and delivered in the most cost-effective manner. President's Clinton's plan, and every other reform proposal, must:

1. **Guarantee universal coverage for comprehensive benefits, including specified mental health benefits which emphasize cost-effective outpatient care.**

- Support the President's outpatient psychotherapy "substitution" mechanism that allows patients to trade inpatient days for cost-effective alternatives. This benefit should be made available to individuals in all health plans who are impaired by their disorders, not just to those averting hospitalization.

- However, the best benefit now would be one with no arbitrary limits and a reduction of the onerous 50% copayment for outpatient psychotherapy, as the President has proposed for 2001. Such a high copayment will likely force people who can't afford it to put off treatment or to enter a more costly inpatient hospital setting at a higher direct cost to the plan.

- Appropriate outpatient coverage should be ensured for people who need intensive outpatient treatment--children who are suffering from abuse or violence, women who have been raped or abused, and people suffering serious and debilitating behavioral and personality disorders which interfere with their ability to work, maintain a stable family, or maintain their physical health.

- Outpatient mental health treatment accounts for only 30% of the total mental health bill, a percentage that has remained stable for over 15 years. Studies have demonstrated that the use of copayments sufficiently controls the demand for utilization of outpatient mental health services without the need to resort to arbitrary session limits. Copayments ideally should be scaled to income to avoid undue financial hardship on families.

2. **Ensure access to psychological services in all health plans and treatment settings.**

- Millions of consumers are helped by psychologists through psychotherapy, diagnosis and assessment, neuropsychological testing, rehabilitation, and other services.

- Managed care plans often have discriminated against psychologists when forming provider panels. Most states have passed statutes giving group health insurance plan enrollees the freedom to choose psychologists, but national health reform must broaden consumer access and choice in all types of plans.

3. **Require managed care to include quality standards which protect the patient.**

- Too many managed care programs have posed serious quality of care problems for patients needing mental health services. The General Accounting Office recently found no conclusive evidence that managed care health plans save money. Lower premiums were attributed to enrollment of younger and healthier people, not the efficiency of managing care.

- Managed care programs should be required to adhere to quality standards which protect the patient; ensure the provision of an adequate range of high quality, individualized services appropriate to the needs of the patient; use reviewers who are licensed or certified in the areas of mental health care under review; make public the review standards and criteria used in evaluating care plans; separate clinical reviews from financial interests; establish arbitration to resolve appeals; ensure patient confidentiality; make decisions quickly; and, maximize patient choice.

- Managed care companies should be held liable to patients for any injury caused by negligent treatment or cost-containment.

March 1994
Government Relations
Practice Directorate

AMERICAN
PSYCHOLOGICAL
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PSYCHOLOGISTS IN THE HEALTH CARE SYSTEM
HIGH QUALITY, AFFORDABLE MENTAL HEALTH CARE

The Training and Credentialing of Psychologists

No other mental health profession requires as high a degree of education and training in mental health as psychology. Accredited doctoral programs in clinical psychology, including practicums and internships at clinics and hospitals, take an average of 7.2 years beyond an undergraduate degree.

Licensure is required for independent practice by approximately 50,000 psychologists in all 50 states. Licensure requirements for psychologists are generally uniform across states, authorizing the psychologist to independently diagnose and treat mental and nervous disorders upon completion of both a doctoral degree in psychology and a minimum of two years of supervised experience in direct clinical service. To further ensure quality of care, an ethical code has been adopted as a part of all state licensing laws.

Psychologists Provide Valuable and Effective Therapy and Testing Services

Practicing psychologists are uniquely trained to provide psychotherapy and testing services, services which have been proven to be effective in the diagnosis and treatment of the full range of mental disorders. Psychotherapy offers individuals a treatment approach which in many cases is equally, if not more, effective than drug therapies. Such behavioral interventions are effective in treating a range of mental and physical disorders. Cognitive and interpersonal psychotherapies are well-suited and effective treatments for depression. Psychotherapy treatments are known to be effective in reducing factors contributing to illness and in enhancing coping strategies and healthy behaviors. Psychotherapy can help people control high blood pressure and manage chronic pain or headaches. These treatments can help people change habits to reduce their risks for cardiovascular disease, cancer and HIV. Breast cancer patients who participate in group psychotherapy are known to survive longer than those who do not. Diabetic adolescents can be helped to maintain the discipline of diet and insulin treatments through psychotherapy. Alternatives to drug therapies are particularly valuable to elderly populations,

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who are often suffering from overdrugging and the numerous side effects of various drugs and drug interactions. This is a problem of such magnitude that the Inspector General of the Department of Health and Human Services called it "our nation's other drug problem."

Diagnostic tests performed by psychologists and neuropsychologists are state-of-the-art tools, usually designed and developed by psychologists. Increasingly, physicians and other health care professionals turn to psychologists for their diagnostic capabilities. These diagnostic services can establish the presence of brain damage, brain disease or developmental abnormality. They can identify the specific area or areas of cerebral dysfunction and assess the prognosis for improvement or deterioration in functioning. Psychologists and neuropsychologists then apply these results toward the development of rehabilitative services for patients, working to assist the patient in becoming as functionaly independent as possible and providing treatment recommendations to facilitate the greatest recovery of neuropsychological functioning.

Since the mid-1980s, psychologists have provided more outpatient psychotherapy and psychological diagnostic evaluations than any other doctorally-trained mental health professional. Psychology has been in the forefront of the leading psychological and biological research on the mind/body interface, including the diagnosis and treatment of stress disorders, neurological impairments, brain disease and psychosomatic illness.

Psychologists are Found in all Settings, but Emphasize Treatment in the Least Restrictive Setting

Psychologists' focus is on the least restrictive setting of treatment, believing that this is the best clinical response to many psychological disorders. Additionally, outpatient treatment, while equally or more effective than inpatient treatment for most individuals, is much more cost-effective.

In addition to outpatient psychotherapy and testing, psychologists are playing an increasing role in other settings, such as hospitals, skilled nursing facilities and partial hospital settings. Psychologists contribute to patient care in a variety of ways, such as: pain management; treatment for sleep and eating disorders; emergency room care/crisis intervention; biofeedback; behavior therapies, including applying behavioral techniques in helping chemotherapy patients better deal with the emotional effects of chemotherapy treatments; and assisting with pre-and post-surgical preparations, including interventions to inform and support patients who have had a heart attack or are facing surgery.

Psychologists are currently recognized as independent providers in federal programs including Medicare, the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), the Veterans Administration, the Federal Employees Health Benefit Plan (FEHBP), HMOs and Medicaid plans.

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The Costs of Failing to Provide Appropriate Mental Health Care

The effects of mental disorders, which strike a substantial portion of Americans, extend far beyond those who are in direct need of services. Mental disorders create a burden on our health care system because patients with untreated psychological disorders are heavy users of medical services. In addition mental disorders have a direct effect on our economy because they result in diminished productivity in the workplace. Providing appropriate mental health care helps those who suffer from psychological disorders, saves valuable health care resources, and restores productivity in the workplace.

Mental disorders affect a substantial portion of Americans including children and older Americans

- Right now, an estimated 15-18% of Americans, including 14 million children, suffer from a diagnosable mental disorder.
- Fifty to 70% of usual visits to primary care physicians are for medical complaints that stem from psychological factors.
- Anxiety and depression are among the six most common conditions seen in family practice.
- In any one-month period, nearly 8 million Americans suffer from depression. As many as one in five Americans will suffer at least one major episode of depression during their lifetimes.
- Twenty-five percent of patients seen by primary care physicians have psychological disorders.
- A random sample of elderly residents in Medicaid facilities found that nearly 80% of the residents had moderate to intense needs for mental health care.

Mental disorders are real and debilitating. They result in lost productivity that affects all Americans.

- In 1990, major depression alone cost an estimated $23 billion in lost work days.
- Minor depression, which affects more people, may account for 51% more disability days than major depression.

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Mental health intervention reduces overall health costs

- A two-year study of the medical use of 300 veterans looked at psychiatric patients who demonstrated excessive use of the health care system. These patients reduced their use of medical services from 5.5 to 3.5 annual outpatient visits after receiving abbreviated mental health treatment. Control groups, who received no psychotherapy, *increased* their use of the health care system.

- A 3-year study of 10,000 Aetna beneficiaries showed that the group's medical costs dropped progressively in the 36 months following introduction of mental health treatment. One group's health costs dropped from $242 per person the year beforeaddition of the mental health benefit to $162 two years after treatment.

- Research of 20,000 Columbia Medical Plan participants (in Maryland), showed that untreated mentally ill patients increased their medical utilization by 61% during a one-year period. The mentally ill who received psychological treatment increased their medical expenditures by only 11%. The treated group's use of medical services was comparable to that of a comparison population with no diagnosable mental disorder, which averaged a 9% increase.

- Modest psychological interventions have been shown to reduce general hospital stays approximately 1.5 days below control group's average 8.7 days.

- Elderly patients who received mental health care averaged 12 fewer hospital days per year than a comparison group who were hospitalized for the same reasons but did not receive mental health care. This savings is important because older Americans are the fast-growing segment of the population. In 1992, people over the age of 50 accounted for less than 26% of the population. By 2050, this number will grow to more than 37%.

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Case Studies Illustrate Cost Savings Resulting From Appropriate Mental Health Intervention

Mental disorders cost America real dollars in health care costs and in lost productivity. The following case studies illustrate how providing appropriate mental health care saves valuable health care resources and restores productivity to the workplace.

Corporations demonstrate significant savings

- In 1989, BellSouth adopted a mental health benefit that encouraged employees to receive care in the least restrictive setting. BellSouth's bill for mental health dropped $6 million in the three following years.

- McDonnell Douglas has used a mental health benefit with no constraints on the type of treatment since 1989. In the first year of this benefit, the company saw a 50% decrease in psychiatric inpatient admission costs, and per capita mental health costs declined by 34%.

- Between 1989 and 1992, the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) expanded its yearly outpatient psychiatric care expenditures from $81 million to $103 million. This decision to devote an additional $22 million to outpatient care resulted in a net savings of $200 million because of reduced psychiatric hospitalization.

- In one year, Chevron saw a 21% decrease in psychiatric hospital admission costs because the company implemented a provider network that covered intermediary services and encouraged outpatient care.

- First National Bank of Chicago saved 30% in mental health and substance abuse costs over four years as a result of implementing a mental health benefit that expanded the range of services covered and reimbursed outpatient costs at 85%.

- In 1987, National Cash Register (NCR) began encouraging employees and their families to use a mental health plan that emphasized early intervention, access to a full range of care, and treatment in the least restrictive setting. NCR saved close to $300,000 in the first year alone. Project savings for expanding the program are close to $2 million.

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American Association for Marriage and Family Therapy
Promoting the Profession and the Practice Since 1942

Part 6 - Additional Provisions of Standards Relating to Health Care Providers

Sect. 1161 Override of Restrictive State Practice Laws.

(A) No State may, through licensure or otherwise, restrict the practice of any class of health professional beyond what is justified by the skills and training of such professionals.

(B) Each State shall institute adequate measures to prohibit the exclusion of or discrimination against any category of licensed health professional by alliances or health plans on the basis of the professional's type of license or scope of practice, except for restrictions limiting service to those functions which are within the professional's licensed scope of practice.

Subtitle E - Health Plans

Sect. 1402 (C) Anti-Discrimination

(2) SELECTION OF PROVIDERS FOR PLAN NETWORK - In selecting among providers of health services for employment or for membership, a health plan, as defined in this Title including but not limited to a self-insured health plan, as defined in this subtitle, may not engage in any practice that has the effect of discriminating against a provider-

(a) based on race, national origin, or gender of the provider;

(b) based on the income, health status, or choice of health services of a patient of the provider; or

(c) based on the type, class or profession of the provider authorized by state law or regulation to provide health care services.

(d) No health plan may exclude entirely, or unreasonably limit, or assign only to its fee-for-service plan, members of a profession which is licensed under state law to provide covered services.

CALIFORNIA
PSYCHOLOGICAL ASSOCIATION
Affiliated with California Chapters and the American Psychological Association

March 14, 1994

4th Cienaga Drive
Fullerton, CA 92635

Ms. Jennifer Klein
2nd Floor, West Wing
The White House
Washington, DC. 20500

Dear Jennifer:

Attached please find the recommended amendments that the American Psychological Association, with California's support, would like to see in the Health Security Act regarding Education and Training. Women, minorities & those individuals who want to be psychologists would need. I have also include a SAMHSA Report to Congress re a Successful Training Program for Psychologists.

In the practice side, we spoke of the co-payment for outpatient psychotherapy. APA actuarial consultants are working on a graduated schedule (ala Maryland's) where parity with physical health care be reached. I'll send these to you when I received them. The substitution language from inpatient to outpatient is an excellent idea since one-inpatient day cost can be about six outpatient visits even at $125.00 an hour and many psychologists have offered daily outpatient visits to help patients through life-threatening crises without inpatient. I am sure you have heard many such stories. I would like to further discussed the role of psychologists as a key member of the primary care team, as a cost-efficient way for quality and preventive health care.

I enjoyed our trio together and please call (213) 738-4605 if you have any questions. Sincerely, Spice Jo Lu, PhD

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PSYCHOLOGY'S NEEDS FOR EDUCATION AND TRAINING

Justification for Psychologists' Need for Federal Funding for Education and Training

- Psychology, as the science of human behavior, serves a unique role in the promotion of health and the prevention of disease:

  Ψ 6 of the 10 leading causes of death are behaviorally based:

  ♦ VIOLENCE ♦ SMOKING ♦ AIDS ♦ ACCIDENTS ♦ SUBSTANCE ABUSE ♦ DIET

  Ψ Successful health care requires intervention at both the biological and the behavioral levels.
  Example: Direct links have been found between psychological interventions and the immune, endocrine and cardiovascular systems

  Ψ Cost effective health care requires increased use of behavior based prevention programs.
  Example: Health enhancing changes in fewer than 10 behavioral risk factors could prevent between 40-70% of all premature deaths, 33% of all cases of acute disability and 66% of all cases of chronic disability.

- Psychology, as the science of human behavior, educates and trains its students to address national needs:

  Ψ Serve in public settings: Community Health Centers and Hospitals, VA Centers and Hospitals, Community Mental Health Centers, Schools

  Ψ Serve in underserved areas: urban and rural poor

  Ψ Serve high risk populations: minorities, infants, youth, elderly, homeless, AIDS, chronically ill

  Ψ Serve in areas of national need: violence, substance abuse, health enhancement, disease prevention, sexual risk behaviors

- Education and training of a doctoral psychologist:

  Ψ Requires an average of 7.5 years beyond the bachelor's degree.

  Ψ Includes advanced knowledge of the theory and research in human behavior; and for health service providers, advanced training in application of the science to therapeutic intervention of individual and group problems.

  Ψ Two thirds of psychology graduates report significant levels of personal debt; debts can range as high as $100,000.

  Ψ Financial support plays a major role in attracting individuals to a particular discipline.

  Ψ Financial support reduces the time required to progress through a program and the cost to the student of doing so.

TITLE III OF THE HEALTH SECURITY ACT

The Field of Psychology Needs:

1.	Definition of Health Professional and all synonyms to explicitly include psychology.	**Subtitle A, B, D, E** 1. Legislation is silent on education and training of psychologists. [Sec 3041 Definitions]
2.	Add Psychology	**Subtitle A** 2. To Training of Underrepresented Minorities and Disadvantaged Persons [Sec3071(c)]
3.	Training provision for psychologists.	**Subtitle A** 3. Legislation does not include training for psychologists who are needed in a health care system. [Sec 3071 (c)]
4.	Add representatives from mental health professions including psychology	**Subtitle A** 4. To the National Institute on Health Care Workforce Development Advisory Board in Subtitle A [Sec 3073(d)(2)(G)]
5.	Psychology's access to Academic Health Center funds.	**Subtitle B** 5. Legislation does not include health professionals who are currently trained with indirect Medicare funding (e.g., psychologists). [Sec 3101(b)(4)]
6.	Add Mental Health Professional Shortage Areas.	**Subtitle E** 6. Legislation does not include Mental Professional Health Shortage Areas (as defined by HHS for under served populations). [Sec 3421(g)]
7.	Training provision for service providers for Mental Health and Substance Abuse.	**Subtitle F** 7. Legislation does not include a training provision for those health professionals providing services for mental health and substance abuse. [Subpart C]
8.	Add Language on "psychological and behavioral interventions" to Purposes - Comprehensive School Health	**Subtitle G** 8. The existing language talks about targeting the risk behaviors but does not go on to say what will be done about them, some language is needed to that effect. [Sec 3601(2)(A) and (5)]

PROPOSED AMENDMENTS FOR TITLE III OF THE HEALTH SECURITY ACT

1.	Definition	Add a definition of health professional and all synonyms including health provider, health care professional, health educator - which includes psychology to Subtitles A, B, D, E [For Subtitle A-Sec 3041 Defs - add health prof]
2.	ADD Psychology to	Training of Underrepresented Minorities and Disadvantaged Persons [Sec 3071 (c)]
3.	New Training Provisions	For "psychologists" in Subtitle A (HHS Programs) [Sec 3071 (e)]
4.	Add respresentatives from mental health professionals including psychology.	To the National Institute on Health Care Workforce Development Advisory Board in Subtitle A [Sec 3073 (d)(2)(G)]
5.	Training of Psychologists in Academics Health Centers	Continue to allow funding for training psychologists and other health professions who have been trained under medicare (1886(d)(5)(B)(ii) of the Social Security Act [Sec 3101 (b)(4)]
6.	Add Mental Health Professional Shortage Areas (as defined by HHS)	To the Health Professional Shortage Areas in Subtitle E [Section 3421 (g)]
7.	Training provision for service providers for Mental Health and Substance Abuse	For "psychology & other health professionals" in Subtitle F (Mental Health and Substance Abuse) [Subpart C]
8.	Add language on psychological and behavioral interventions.	To purposes (Comprehensive school Health Education) in Subtitle G. [Sec 3601 (2)(A) and (5)]

PSYCHOLOGY'S NEEDS FOR EDUCATION AND TRAINING

FEDERAL FUNDING

- Ψ **Psychology DOES NOT have access to appropriate and adequate funding**
- Ψ **The one program (Center for Mental Health Services, Clinical Training Program) that provided funds to educate and train psychologists is to be ELIMINATED.**
- Ψ **New and reauthorized legislation are INADEQUATE for psychology's needs.**
- Ψ **Psychologists serve critical roles in meeting national needs (violence, substance abuse, AIDS, chronic illness, homelessness).**

TITLE VII OF THE PUBLIC HEALTH SERVICE ACT

	Psychology Needs	Reauthorization of Title VII program under the Disadvantaged Minority Health Improvement Act of 1991 (Senate Bill S. 1569; House Bill not yet introduced)
1.	Access to Centers of Excellence.	1. Access by Psychology is currently included but it is not expected in the House Bill.
2.	Access to Loans for Disadvantaged Students.	2. Access by Psychology is not included in legislation; it is not expected to be included.
3.	Access to Scholarships for Students with Exceptional Needs.	3. Access by Psychology is not included in legislation; it is not expected to be included.

PSYCHOLOGY'S NEEDS FOR EDUCATION AND TRAINING

SUMMARY

Ψ Pyschologists can continue to provide such services and make a significant contribution **ONLY IF FEDERAL FUNDS ARE AVAILABLE TO SUPPORT THEIR EDUCATION AND TRAINING.**

Ψ The Health Security Act's provisions on education and training in Title III are silent on which health professions are eligible; however, references are made to Title VII of the Public Health Service Act. **PSYCHOLOGY IS INELIGIBLE OR EXCLUDED FROM PARTICIPATION IN THE MORE SUBSTANTIAL LOAN AND SCHOLARSHIP PROGRAMS AS WELL AS THE INSTITUTIONAL SUPPORT PROGRAMS.**

- ***In Title VII, psychology is ineligible for:***
  - *Health Professions Student Loan Program*
  - *Loans for Disadvantaged Students*
  - *Financial Assistance for Disadvantged Health Professions Students*
  - *Scholarships for Students of Exceptional Need Centers of Excellence*

- ***In Title VII, psychology is eligible for but scarcely participates in:***
  - *Health Education Assistant Loans- only 2% were for psychologists in 1993 (the loans are too costly)*
  - *Scholarships for Disadvantaged Students- only 1 school in 1993*
  - *Health Career Opportunity Program- only 3 schools in 1993*
  - *Area Health Education Centers-as yet no psychologists*

Ψ Psychologists eligibility in the proposed HSA is not adequate. History has demonstrated that eligiblity does not equal participation.

Ψ **FEDERAL SUPPORT OF PSYCHOLOGISTS WORKS.** The only federal program that is currently providing funds for training of psychologists is now slated for **elimination**. The Center for Mental Health Services Clinical Training Program in SAMHSA is highly successful. It has a 93% return on loans. In addition, 85% of those trained, mostly minorities, have remained in underserved areas 5 years after fulfilling their service obligation.

- ***Education and training of a doctoral psychologist:***
  - *Requires an average of 7.5 years beyond the bachelor's degree*
  - *Includes advanced knowledge of the theory and research in human behavior; and for health service providers, advanced training in application of the science to therapeutic intervention of individual and group problems*
  - *Two thirds of psychology graduates report significant levels of personal debt; debts can range as high as $100,000*
  - *Financial support plays a major role in attracting individuals to a particular discipline*
  - *Financial support reduces the time required to progress through a program and the cost to the student of doing so*

SAMHSA REPORT TO CONGRESS: SUMMER 1993

Fact Sheet: The Mental Health Clinical Training Program's Payback Service Requirement

The clinical training program administered from 1948 until 1992 by the National Institute of Mental Health (NIMH) and now by the Center for Mental Health Services (CMHS), was modified in 1981 to require an obligation to pay back one month of service by working seriously mentally ill adults) for each month of Federal financial support as a clinical trainee. The purpose of this requirement was to insure that clinical trainees who receive Federal financial support provide services to underserved mentally ill populations in public facilities. CMHS has reviewed several aspects of the effectiveness of the payback service requirement.

Major findings of this review include:

- Of 6,072 trainees who received support sine 1981 and completed training in psychology, psychiatry, psychiatric nursing, and social work, 5,654 trainees, or 93 percent, have completed or are engaged in the payback service obligation. Of the remaining 7 percent, 2 percent are currently providing information about payback status; 3 percent had the obligation waived due to death or total disability; and 2 percent are engaged in monetary payback.

- The former trainees have completed over 93,000 months of payback service, or over 7,700 years of service. Two-thirds of this payback service was done in inpatient hospital settings or in community-based outpatient settings.

- One-fourth of these trainees worked with children and adolescents, one-sixth with minorities with mental disorders, and another one-sixth with seriously mentally ill adults.

- Since 1981, curriculum modifications in these training programs have become progressively more oriented toward training professionals to provide services to the priority populations.

- Based on responses from a sample of trainees who have completed their payback service obligation, about 49 percent of the trainees continue to work in public mental health settings, and an additional 31 percent continue to work in private nonprofit mental health settings, for a total of 80 percent who are continuing to work in the public or private nonprofit sectors.

The average Federal investment per trainee has been $11,000. Requiring trainees to work in public or private nonprofit settings has frequently resulted in their continuing employment in such agencies.

For further information, please contact CMHS Human Resource Planning and Development Branch (301-443-5850).