## MENTAL ILLNESS AND SUBSTANCE ABUSE

### Problems in the Current Market

Today's insurance market creates barriers to treatment for mental illness through lifetime day or dollar limits and through preexisting condition exclusions.

- 84% of health plans in the current market report day or dollar limits on psychiatric inpatient care (Hay/Huggins 1993).
- Of those reporting day limits, 61% allow 30 or fewer days (Hay/Huggins 1993).
- 95% of medium and large firms report visit or dollar limits on outpatient treatment for mental illness (Bureau of Labor Statistics (BLS) 1991).
- 48% provided 30 or fewer outpatient visits (BLS 1991).

Current coverage for substance abuse treatment is even more limited.

- Many people have no insurance coverage for substance abuse treatment. 21% of people receiving health insurance through large and medium-sized firms have no insurance coverage for substance abuse inpatient rehabilitation or outpatient care (BLS 1991).
- Those who do have coverage face severe restrictions. 10% of participants in the BLS survey reported lifetime day limits, 14% reported limits on the number of treatments, and 22% reported lifetime dollar limits.

### Comprehensive Coverage Through the Health Security Act: The Mental Illness and Substance Abuse Benefit

The Health Security Act covers a broad range of treatment options and eliminates preexisting condition exclusions and lifetime limits that today restrict access of individuals with mental or substance abuse disorders to needed services.

The mental illness and substance abuse benefit in the Health Security Act includes inpatient and residential treatment, intensive nonresidential treatment, and outpatient services, including screening and assessment, diagnosis, medical management, psychotherapy, crisis services, collateral services and case management. Significantly, medical management (even for the severely ill), diagnosis, screening and assessment, and crisis services are not subject to annual day and visit limits.

By January 1, 2001, the Health Security Act replaces current insurance market strategies of annual day limits on inpatient, residential and intensive nonresidential treatment, psychotherapy and substance abuse counseling and relapse prevention with a managed benefit. In addition, higher copayments and coinsurance for psychotherapy, collateral services and some intensive nonresidential treatment days are reduced, and limitations on applying certain expenses to the annual out-of-pocket maximum on cost sharing are eliminated.

Until January 1, 2001, the Act emphasizes a wide range of innovative treatment options, such as case management, partial hospitalization, day treatment programs, and home-based and behavioral aide services -- including services that are important to the treatment of seriously emotionally disturbed children. Providing coverage for this array of treatment options represents a new direction for the delivery of mental illness and substance abuse services and creates incentives for the development of needed capacity.

Health plans are encouraged to utilize the wide array of treatment options to provide individuals with a continuum of care -- that is both appropriate for an individual's needs and cost effective -- through substitution of inpatient and residential days for treatment in other settings. Thirty days of inpatient and residential treatment may be reduced by one day for every two days of intensive nonresidential treatment or by one day for every four outpatient visits for psychotherapy or substance abuse counseling and relapse prevention.

Beyond the services covered through substitution, additional treatments are covered to provide ongoing and appropriate support. A maximum of thirty additional inpatient days are covered for particularly vulnerable individuals. A maximum of 60 additional days of intensive nonresidential treatment are available. Again without substitution, thirty visits of psychotherapy and collateral services are covered for an individual, and 30 visits in group therapy are covered for substance abuse counseling and relapse prevention for individuals who have received other treatment within 12 months.

Through universal coverage, larger numbers of individuals with severe disorders will obtain access to services. While there is promising experience in the private sector with a flexible managed mental health and substance abuse benefit, there is less experience and data on the use of this approach for individuals with severe mental illness or chronic drug and alcohol addiction. Given this uncertainty and consistent with our conservative approach in all of our estimates, we have included protections like a one-day deductible in order to remain conservative in estimating the cost of the benefit. Within this framework, we have developed a benefit structure that encourages flexibility and management so that by January 1, 2001 the benefit no longer needs to rely on specific day and visit limits.

**Initiatives for Improving Access to Mental Illness and Substance Abuse Services**

In addition to the mental illness and substance abuse benefit, the Health Security Act includes initiatives for improving access to mental illness and substance abuse services.

The Act provides funding for services to remove barriers to treatment for mental illness and substance abuse, including community and patient outreach, transportation and translation services.

The Health Security Act requires states to submit a plan by October 1, 1998 to demonstrate how they will integrate state and local mental illness and substance abuse services with the mental illness and substance abuse services included in the comprehensive benefit package.

The Secretary of Health and Human Services is authorized to make grants for the development of school health service sites. Criteria for grant awards include the provision of health and social services, counseling services, and necessary referrals, including referrals regarding mental illness and substance abuse. Other school-based programs focus on educating school children about substance abuse, including tobacco and alcohol use.

# DEPARTMENT OF HEALTH AND HUMAN SERVICES
## ASSISTANT SECRETARY FOR PLANNING AND EVALUATION
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Number of Pages (Including Cover): 4

Comments: When you have a chance I would like to talk with you about the response to this. On the Medicare issue the concern relates to HSA use of Medicare hospital & psychiatric hospital definition.

DANIEL K. INOUYE
HAWAII

APPROPRIATIONS
Chairman, Subcommittee on Defense

COMMERCE, SCIENCE AND TRANSPORTATION
Chairman, Subcommittee on Communications

Chairman, COMMITTEE ON INDIAN AFFAIRS

Chairman, DEMOCRATIC STEERING COMMITTEE

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March 7, 1994

file - Psychologists
Mental Health

Ms. Judy Feder
Office of the Assistant Secretary
for Planning and Evaluation
Department of Health and Human Services
200 Independence Ave., S.W., Rm. 415-F
Washington, D.C. 20201

Dear Ms. Feder:

Following up on our recent discussion, I have enclosed for your files a copy of a memorandum we recently requested from Dr. Russ Newman, of the American Psychological Association, indicating specifically where, in his judgment, the Administration's bill would inadvertently be of considerable "harm" to psychologists. Your continued assistance would be deeply appreciated.

We would also point out that the various health manpower training initiatives do not seem to allow psychology to apply.

Aloha,

P. de L.

PATRICK H. DE LEON
Administrative Assistant

PHD:blw
Enclosure

cc: Dr. Russ Newman
Dr. Ellen Caringer

AMERICAN PSYCHOLOGICAL ASSOCIATION

Ask Lisa Rovin re general insurance practice.

# MEMORANDUM

To: Pat DeLeon, Ph.D., J.D.

From: Russ Newman, Ph.D., J.D.

Subject: Health Care Reform/Health Security Act

Date: February 17, 1994

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As we discussed, there are at least two instances related to health care reform, in general, and the proposed Health Security Act, in particular, where psychologists appear inadvertently restricted or omitted. Ironically, in one instance certain Medicare restrictions on psychologists' practice are incorporated in the Health Security Act while in the other instance psychologists are authorized for certain practices under Medicare, but not so authorized by the proposed Health Security Act.

## Medicare Conditions of Participation

Since the OBRA 1989 amendment to the Medicare program, psychologists have been authorized to perform services consistent with state law and to receive direct reimbursement in all settings. A number of states, including California and the District of Columbia (as well as nine other jurisdictions), permit psychologists to be appointed to the medical staff of hospitals, and allow psychologists to independently admit, diagnose, treat, and discharge patients with psychological problems. This practice is, of course, contingent upon a physician examining the patient upon admission and administering any drug regime or related medical care the patient may need. The Medicare Conditions of Participation for psychiatric hospitals, however, are being interpreted in a fashion that will not permit psychologists the full range of practice allowed by state law.

In particular, 42 CFR sec. 482.60 provides special conditions of participation for psychiatric hospitals, and incorporates the requirement of section 482.12(c)(4) that a doctor of medicine or osteopathy must be "responsible for the care of each patient with respect to any medical or psychiatric problem that is present on admission or develops during hospitalization." This provision, among others, is intended to implement the statutory requirement of section 1861(e)(4) of the Social Security Act (42 U.S.C. Sec. 1395(e)(4)) that every Medicare patient be "under the care of" a physician. As a result,

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Russ Newman, Ph.D., J.D.
*Executive Director*
*Practice Directorate*

restrictions on psychologists' practice in hospitals have remained, although we continue our efforts to resolve these issues.

Unfortunately, the Health Security Act, Title I, Section III (c)(1), incorporates by reference the aforementioned Medicare provisions which have been restrictively interpreted against psychologists. The result, then, is likely to be restrictions on psychologists' ability to independently treat non-Medicare beneficiaries in hospitals. This would be true even in states which expressly authorize independent hospital practice, and in conflict with the Health Security Act's intent to support the ability of non-physician providers to practice to the full extent of their licensure.

Rehabilitation Services

While the above described restrictive Medicare provisions are incorporated into the proposed Health Security Act, the authorization of psychologists in Medicare to provide rehabilitation services is not expressly incorporated. Section 1123(a) of the Health Security Act describes coverage for outpatient rehabilitation services to include occupational therapy, physical therapy, and speech pathology services for the purpose of attaining or restoring speech.

As you know, we are concerned that the absence of explicit mention of psychological/neuropsychological services in this section may work to prevent psychologists from providing the very same services in a reformed health system that they have been providing for years under the Medicare program. Should this occur, it would most certainly have a damaging effect – albeit unintentional – on both patients and psychologists. This could be easily remedied by amending section 1123(a) by deleting the word "and" immediately preceding "(3)" and adding the following at the end of the subsection but before the period:

> "; and, (4) outpatient psychological and neuropsychological services for the purpose of restoring functional capacity or minimizing limitations to functional capacity associated with cognitive or psychological consequences or physical illness or injury."

If you have any additional questions concerning these issues please do not hesitate to contact me.

cc: Donna Daley

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Comments: Medicare statute + regs requiring patient to under physician care.

Please call once you look at psychologist's letter + this stuff to talk about how we should respond.

## Hospital

(e) The term "hospital" (except for purposes of sections 1814(d), 1814(f), and 1835(b), subsection (a)(2) of this section, paragraph (7) of this subsection, and subsection (i) of this section[661]) means an institution which—

(1) is primarily engaged in providing, by or under the supervision of physicians, to inpatients (A) diagnostic services and therapeutic services for medical diagnosis, treatment, and care of injured, disabled, or sick persons, or (B) rehabilitation services for the rehabilitation of injured, disabled, or sick persons;

(2) maintains clinical records on all patients;

(3) has bylaws in effect with respect to its staff of physicians;

(4) has a requirement that every patient with respect to whom payment may be made under this title must be under the care of a physician;

(5) provides 24-hour nursing service rendered or supervised by a registered professional nurse, and has a licensed practical nurse or registered professional nurse on duty at all times; except that until January 1, 1979, the Secretary is authorized to waive the requirement of this paragraph for any one-year period with respect to any institution, insofar as such requirement relates to the provision of twenty-four-hour nursing service rendered or supervised by a registered professional nurse (except that in any event a registered professional nurse must be present on the premises to render or supervise the nursing service provided, during at least the regular daytime shift), where immediately preceding such one-year period he finds that—

(A) such institution is located in a rural area and the supply of hospital services in such area is not sufficient to meet the needs of individuals residing therein,

(B) the failure of such institution to qualify as a hospital would seriously reduce the availability of such services to such individuals, and

(C) such institution has made and continues to make a good faith effort to comply with this paragraph, but such compliance is impeded by the lack of qualified nursing personnel in such area;

(6)(A) has in effect a hospital utilization review plan which meets the requirements of subsection (k) and (B) has in place a discharge planning process that meets the requirements of subsection (ee);

(7) in the case of an institution in any State in which State or applicable local law provides for the licensing of hospitals, (A) is licensed pursuant to such law or (B) is approved, by the agency of such State or locality responsible for licensing hospitals, as meeting the standards established for such licensing;

(8) has in effect an overall plan and budget that meets the requirements of subsection (z); and

(9) meets such other requirements as the Secretary finds necessary in the interest of the health and safety of individuals who are furnished services in the institution.

[661] P.L. 101-234, §101(a)(1), struck out "and paragraph (7) of this subsection" and substituted "paragraph (7) of this subsection, and subsection (i) of this section", effective January 1, 1990. For the applicability of this amendment, see Vol. II, P.L. 100-360, §104(a).

# SUBCHAPTER E—STANDARDS AND CERTIFICATION

## PART 482—CONDITIONS OF PARTICIPATION FOR HOSPITALS

### Subpart A—General Provisions



### Subpart B—Administration



### Subpart C—Basic Hospital Functions



### Subpart D—Optional Hospital Services



### Subpart E—Requirements for Specialty Hospitals



AUTHORITY: Secs. 1102, 1135, 1138, 1861(e), (f), (k), (r), (v)(1)(G), (z), and 1864, 1871, 1883, 1886, 1902(a)(30), and 1905 of the Social Security Act (42 U.S.C. 1302, 6, 1338, 1395f(a)(6), 1395x (e), (f), (k), (v)(1)(G), (z), and (ee), 1395aa, 1395hh, 1395ww, 1396a(a)(30), and 1396(a)).

SOURCE: 51 FR 22042, June 17, 1986, unless otherwise noted.

## Subpart A—General Provisions

### § 482.1 Basis and scope.

(a) *Basis in legislation.* (1) Section 1861(e) of the Act provides that—

(i) Hospitals participating in Medicare must meet certain specified requirements; and

(ii) The Secretary may impose additional requirements if they are found necessary in the interest of the health and safety of the individuals who are furnished services in hospitals.

(2) Section 1861(f) of the Act provides that an institution participating in Medicare as a psychiatric hospital must meet certain specified requirements imposed on hospitals under section 1861(e), must be primarily engaged in providing, by or under the supervision of a physician, psychiatric services for the diagnosis and treatment of mentally ill persons, must maintain clinical records and other records that the Secretary finds necessary, and must meet staffing requirements that the Secretary finds necessary to carry out an active program of treatment for individuals who are furnished services in the hospital. A distinct part of an institution can participate as a psychiatric hospital if the institution meets the specified 1861(e) requirements and is primarily engaged in providing psychiatric services, and if the distinct part meets the records and

staffing requirements that the Secretary finds necessary.

(3) Section 1905(a) of the Act provides that "medical assistance" (Medicaid) payments may be applied to various hospital services. Regulations interpreting those provisions specify that hospitals receiving payment under Medicaid must meet the requirements for participation in Medicare (except in the case of medical supervision of nurse-midwife services. See §§440.10 and 440.165 of this chpater.).

(b) *Scope.* Except as provided in subpart S of part 405 of this chapter, the provisions of this part serve as the basis of survey activities for the purpose of determining whether a hospital qualifies for a provider agreement under Medicare and Medicaid.

### §482.2 Provision of emergency services by nonparticipating hospitals.

(a) The services of an institution that does not have an agreement to participate in the Medicare program may, nevertheless, be reimbursed under the program if—

(1) The services are emergency services; and

(2) The institution meets the requirements of section 1861(e) (1) through (5) and (7) of the Act. Rules applicable to emergency services furnished by nonparticipating hospitals are set forth in subpart G of part 424 of this chapter.

(b) Secton 440.170(e) of this chapter defines emergency hospital services for purposes of Medicaid reimbursement.

[51 FR 22042, June 17, 1986, as amended at 53 FR 6648, Mar. 2, 1988]

## Subpart B—Administration

### §482.11 Condition of participation: Compliance with Federal, State and local laws.

(a) The hospital must be in compliance with applicable Federal laws related to the health and safety of patients.

(b) The hospital must be—

(1) Licensed; or

(2) Approved as meeting standards for licensing established by the agency of the State or locality responsible for licensing hospitals.

(c) The hospital must assure that personnel are licensed or meet other applicable standards that are required by State or local laws.

### §482.12 Condition of participation: Governing body.

The hospital must have an effective governing body legally responsible for the conduct of the hospital as an institution. However, if a hospital does not have an organized governing body, the persons legally responsible for the conduct of the hospital must carry out the functions specified in this Part that pertain to the governing body.

(a) *Standard: Medical staff.* The governing body must:

(1) Determine, in accordance with State law, which categories of practitioners are eligible candidates for appointment to the medical staff;

(2) Appoint members of the medical staff after considering the recommendations of the existing members of the medical staff;

(3) Assure that the medical staff has bylaws;

(4) Approve medical staff bylaws and other medical staff rules and regulations;

(5) Ensure that the medical staff is accountable to the governing body for the quality of care provided to patients;

(6) Ensure the criteria for selection are individual character, competence, training, experience, and judgment; and

(7) Ensure that under no circumstances is the accordance of staff membership or professional privileges in the hospital dependent solely upon certification, fellowship, or membership in a specialty body or society.

(b) *Standard: Chief executive officer.* The governing body must appoint a chief executive officer who is responsible for managing the hospital.

(c) *Standard: Care of patients.* In accordance with hospital policy, the governing body must ensure that the following requirements are met:

(1) Every Medicare patient is under the care of:

(i) A doctor of medicine or osteopathy (This provision is not to be construed to limit the authority of a doctor of medicine or osteopathy to delegate tasks to other qualified health care personnel to the extent recognized

under State law or a State's regulatory mechanism.);

(ii) A doctor of dental surgery or dental medicine who is legally authorized to practice dentistry by the State and who is acting within the scope of his or her license;

(iii) A doctor of podiatric medicine, but only with respect to functions which he or she is legally authorized by the State to perform;

(iv) A doctor of optometry who is legally authorized to practice optometry by the State in which he or she practices;

(v) A chiropractor who is licensed by the State or legally authorized to perform the services of a chiropractor, but only with respect to treatment by means of manual manipulation of the spine to correct a subluxation demonstrated by x-ray to exist.

(2) Patients are admitted to the hospital only on the recommendation of a licensed practitioner permitted by the State to admit patients to a hospital. If a Medicare patient is admitted by a practitioner not specified in paragraph (c)(1) of this section, that patient is under the care of a doctor of medicine or osteopathy.

(3) A doctor of medicine or osteopathy is on duty or on call at all times.

(4) A doctor of medicine or osteopathy is responsible for the care of each Medicare patient with respect to any medical or psychiatric problem that—

(i) Is present on admission or develops during hospitalization; and

(ii) Is not specifically within the scope of practice of a doctor of dental surgery, dental medicine, podiatric medicine or optometry, or a chiropractor, as that scope is—

(A) Defined by the medical staff;

(B) Permitted by State law; and

(C) Limited, under paragraph (c)(1)(v) of this section, with respect to chiropractors.

(5)(i) To identify potential organ donors as defined in §485.302 of this chapter, the hospital has written protocols that—

(A) Assure that the family of each potential organ donor knows of its option either to donate organs or tissues or to decline to donate;

(B) Encourage discretion and sensitivity with respect to the circumstances, views and beliefs of families of potential donors; and

(C) Require that an organ procurement organization designated by the Secretary under §485.308 of this chapter be notified of potential organ donors.

(ii) In the case of a hospital in which organ transplants are performed, the hospital must be a member of the Organ Procurement and Transplantation Network established under section 372 of the Public Health Service Act and abide by its rules and requirements.

(iii) For purposes of this subparagraph, the term "organ" means human kidney, liver, heart, lung, pancreas.

(d) *Standard: Institutional plan and budget.* The institution must have an overall institutional plan that meets the following conditions:

(1) The plan must include an annual operating budget that is prepared according to generally accepted accounting principles.

(2) The budget must include all anticipated income and expenses. This provision does not require that the budget identify item by item the components of each anticipated income or expense.

(3) The plan must provide for capital expenditures for at least a 3-year period, including the year in which the operating budget specified in subparagraph (d)(2) of this section is applicable.

(4) The plan must include and identify in detail the objective of, and anticipated sources of financing for, each anticipated capital expenditure in excess of $600,000 (or a lesser amount that is established, in accordance with section 1122(g)(1) of the Act, by the State in which the hospital is located) that relates to any of the following:

(i) Acquisition of land;

(ii) Improvement of land, buildings and equipment; or

(iii) The replacement, modernization and expansion of buildings and equipment.

(5) The plan must be submitted for review to the planning agency designated in accordance with section 1122(b) of the Act, or if an agency is not designated, to the appropriate health planning agency in the State. (See p.

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**Number of Pages (Including Cover):** 1

**Comments:**

BLS

Medium and Large Firms (1991)

--1% no mental health hospital care
--2% no mental health outpatient care
--Less than 0.5% no inpatient detox
--21% no inpatient alcohol rehab
--21% no outpatient alcohol
--22% no inpatient drug
--23% no outpatient drug

Small Establishments (1990)

--2% no mental health hospital care
--3% no mental health outpatient care
--1% no inpatient detox
--20% no inpatient alcohol rehab
--26% no outpatient alcohol
--23% no inpatient drug rehab
--29% no outpatient drug

State and local governments (1990)

--1% no mental health hospital care
--4% no mental health outpaitnet care
--less than 0.5% no inpatient detox
--17% no inpatient alcohol rehab
--23% no outpatient alcohol
--19% no inpatient drug rehab
--24% no outpatient drug

# Substance Abuse Provisions in the Health Security Act

## Description of Substance Abuse Benefit

- The Health Security Act takes serious steps toward creating a comprehensive alcohol and drug abuse benefit by covering a broad range of treatment options and by eliminating pre-existing condition exclusions and lifetime limits that today restrict the access of individuals with substance abuse disorders to needed services.

- Currently, many Americans have no insurance coverage for substance abuse treatment. Twenty-one percent of people receiving coverage through medium and large firms have no coverage for inpatient rehabilitation or outpatient care for substance abuse (BLS 1991).

- By January 1, 2001, the Health Security Act replaces current insurance market strategies of annual day limits with a managed benefit. In addition, higher copayments and coinsurance that apply initially for certain services are reduced, and limitations on applying certain expenses to the annual out-of-pocket maximum on cost sharing are eliminated.

- Until January 1, 2001, the Act emphasizes a wide range of innovative treatment options, such as day treatment programs, partial hospitalization, ambulatory detoxification, and relapse prevention.

- Health plans are encouraged to use the wide array of treatment options to provide individuals with a continuum of care -- that is both appropriate for an individual's needs and cost effective -- through substitution of inpatient and residential days for treatment in other settings.

    - Thirty days of inpatient and residential treatment may be reduced by one day for every two days of intensive nonresidential treatment or by one day for every four days of substance abuse counseling and relapse prevention.

    - An additional 30 days of inpatient days and 60 days of intensive nonresidential days are available in certain circumstances. Thirty visits of group therapy for substance abuse counseling and relapse prevention are covered for individuals who have received other treatment within 12 months.

    - Significantly, no day or visit limits apply to medical management, diagnosis, screening and assessment, and crisis services.

Other Substance Abuse Services

- In addition to the substance abuse services in the comprehensive benefit package, the Health Security Act includes initiatives for improving access to substance abuse services.
    - The Act provides funding for services to remove barriers to care, such as community and patient outreach, transportation and translation services.
    - The Secretary of Health and Human Services is authorized to make grants for the development of school health service sites. Criteria for grant awards include the provision of health and social services, counseling services and necessary referrals, including referrals regarding substance abuse.
    - Other school-based programs focus on educating school children about substance abuse, including tobacco and alcohol use.
- Funding is increased for the National Institutes of Health prevention research, including substance abuse prevention research.
- We understand, however, that the Health Security Act will not meet all of the needs of hard-core drug users. Therefore, the President's 1995 budget includes $355 million for treatment of hard-core users. This is the largest increase ever proposed.

# The Health Security Act

## Summary of The Mental Illness and Substance Abuse Provisions

Mental illness and substance abuse disorders will affect more than 50 million Americans this year. Left untreated, these illnesses are responsible for countless numbers of lost lives and billions of dollars in lost work days and productivity. The Health Security Act recognizes the economic and personal impact of mental illness and substance abuse disorders and makes treatment for them an integral part of health care in America.

The goal of the Health Security Act's mental illness and substance abuse benefit is to provide full and flexible coverage. The benefit encourages the use of proven, cost-effective, treatment alternatives.

Coverage for mental illness and substance abuse disorders includes screening and assessment, crisis services, inpatient and residential treatment, intensive non-residential treatment, outpatient treatment, case management and collateral services. And, unlike today, there are no lifetime limits on these services.

**By January 1, 2001, day and visit limits, deductible days specific to this benefit and higher cost sharing are eliminated. Expenses not initially counting toward annual out-of-pocket limits will apply toward annual out-of-pocket limits.**

### INPATIENT

Under the Health Security Act, coverage for inpatient services, hospital and residential, are to be provided in the least restrictive setting that is effective and appropriate for the individual and if less restrictive intensive non-residential or outpatient treatment would not be effective or appropriate.

#### HOSPITAL

Mental Illness: Before January 1, 2001, the comprehensive benefit package provides for 30 days annually of inpatient or residential treatment. Cost sharing depends on the option selected.[1] An additional 30 days of inpatient or residential treatment may be approved, if a health professional designated by the health plan in which an individual is enrolled determines either that:

1) the individual poses a threat to his or her own life or that of another; or

2) that the medical condition of the individual requires inpatient hospitalization in order to initiate, alter, or adjust pharmacological or somatic therapy.

Under plans which have a higher cost sharing, the individual must pay a one day deductible for each inpatient admission.

Substance Abuse: Before January 1, 2001, the substance abuse provision of the comprehensive benefit limits hospitalization to medical detoxification associated with withdrawal from alcohol or drugs that involves psychiatric complications. Hospitalization for medical detoxification that does not involve psychiatric treatment is covered under the general benefit and the days do not count against the annual day limit for treatment of mental illness and substance abuse disorders. Under the plans with a higher cost sharing schedule, a one day deductible applies.

**RESIDENTIAL**

**Mental Illness and Substance Abuse:** Residential treatment options include treatment centers, detoxification centers, crisis programs, therapeutic family or group treatment homes, community residential treatment or recovery centers for substance abuse. Before January 1, 2001, the same limits and cost sharing apply to residential treatment as apply to hospitalization.

**INTENSIVE NON-RESIDENTIAL TREATMENT**

**Mental Illness and Substance Abuse:** Intensive non-residential treatments include partial hospitalization, day treatment, psychiatric rehabilitation, home-based services, ambulatory detoxification and behavioral aide services.

These treatments are provided only for the purpose of averting the need for, or as an alternative to, treatment in hospitals or residential inpatient settings; to facilitate the earlier discharge of an individual receiving inpatient or residential care; to restore the functioning of an individual receiving inpatient or residential care; to restore the functioning of an individual with a diagnosable mental or substance abuse disorder; or to assist the individual to develop the skill and gain access to the support services the individual needs to achieve the maximum level of functioning of the individual within the community.

Intensive non-residential treatment services will be provided by health plans if a health professional designated by the health plan determines an individual should receive such services.

Before January 1, 2001, intensive non-residential services are covered as a substitution for inpatient days at the rate of two intensive non-residential days for one inpatient day, until the 30 day annual aggregate inpatient day limit is reached. Individuals may receive up to sixty days of treatment using the substitution formula.

For example, an individual who has been hospitalized for seven days may convert his or her remaining 23 inpatient days to intensive 46 non-residential days. For those who select a higher cost sharing plan, a one-day deductible per episode applies.

An additional 60 days of non-residential treatment may be provided if a health care professional designated by the health plan determines additional treatment is medically necessary or appropriate. The exchange of inpatient days does not apply to this second 60 days. However, these days are subject to a 50% coinsurance payment in higher cost sharing plans and $25 per visit payment for lower cost sharing plans. These cost sharing and other expenses do not count toward the annual out-of-pocket limit on cost sharing. Under higher cost sharing plans, a one-day deductible applies.

## OUTPATIENT

**Other Outpatient Services for Mental Illness and Substance Abuse:** Based on an individual's need, the following outpatient services are available: screening and assessment, diagnosis, medical management, crisis services and somatic treatment services. These are covered following the standard cost sharing schedule but cost sharing for these services does not count toward the annual out-of-pocket limit.

**Outpatient Psychotherapy and Collateral Services:** Before January 1, 2001, 30 psychotherapy or collateral services visits are covered annually. For psychotherapy and collateral sessions there is a 50% coinsurance payment in higher cost sharing plans and a $25 per visit payment for lower cost sharing plans. These cost sharing and other expenses do not count toward the annual out-of-pocket limit on cost sharing.

In order to prevent hospitalization or to facilitate earlier hospital release, additional visits may be made available by exchanging, at a 1 to 4 rate, inpatient days for outpatient psychotherapy visits following the same cost sharing schedule as the first 30 visits. Again, cost sharing for these services does not count toward the annual out-of-pocket cap.

Outpatient Substance Abuse Counseling and Relapse Prevention: Before January 1, 2001, at the discretion of the health plan, an individual may receive substance abuse counseling and relapse prevention treatments by exchanging inpatient/residential days for outpatient visits on a 1 to 4 basis until the 30 day inpatient/residential annual limit is reached.

Within 12 months after an individual receives residential or intensive non-residential treatment, 30 group therapy session are covered for substance abuse counseling and relapse prevention.

Intensive non-residential and outpatient detoxification may only be provided in the context of a treatment program.

Cost sharing for these services does not count the toward annual out-of-pocket limit.

## Case Management

Case management services are to be offered by health plans. However, health plans have the discretion to determine if a specific individual enrolled in a health plan should receive such services. These services include those that assist individuals in gaining access to needed medical, social, educational and other services.

## Other Provisions Related to Mental Illness and Substance Abuse

**Financial Assistance for State Mental Illness and Substance Abuse Activities:** Section 3501 of The Health Security Act authorizes the Secretary of Health and Human Services to use funds from the Public Health Service Initiatives Fund to award grants to States for activities related to mental illness and substance abuse including those:

o To increase the access of individuals to transportation, community and patient outreach, patient education, translation services, and such other services as the Secretary of Health and Human Services determines to be appropriate.

o To improve the capacity of State and local service systems to coordinate and monitor mental illness and substance abuse services, including improvement of management information systems, and establishment of linkages between providers of mental illness and substance abuse services and primary care providers and health plans.

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

In fiscal year 1995, $100 million is authorized to be appropriated; in fiscal year 1996, $150 million is authorized and for fiscal years 1997 through 2000, the authorization is $250 million for each year.

**State Plans for Mental Health and Substance Abuse Integration:** Section 3511 of the Health Security Act states that in order to qualify to participate in the overall health care plan, by October 1, 1998 each state must submit a plan to the Secretary of Health and Human Services. The plan must show how the state will achieve the integration of the state and local mental illness and substance abuse services with the mental illness and substance abuse services included in the comprehensive benefit package.

Pilot programs to demonstrate model methods for achieving the integration of the mental illness and substance abuse services of states with the services included in the comprehensive benefit package will be established by the Secretary of Health and Human Services.

**Financial Assistance For School Health Service Sites:** Sections 3684 and 3685 of the Health Security Act empower the Secretary of Health and Human Services to make grants to State health agencies or to local community partnerships to develop school health services sites. Criteria for grant awards will include provision of health and social services, counseling services, and necessary referrals, including referrals regarding mental illness and substance abuse.

**Privacy Of Information:** Section 5120 of the Health Security Act details the overall health information system privacy standards. No "individually identifiable health information" shall be disclosed unless it is authorized by the individual to whom the information pertains. Section 5123 of the Act specifically includes "the past, present, or future physical or mental health of the enrollees" in the definition of "individually identifiable information".

[1] **Cost Sharing** - Individuals may choose the level of cost sharing most appropriate for them. The three cost sharing options are:

> **Higher Cost Sharing** (Fee For Service) - Patients pay 20% of the cost of each visit after the $200 individual deductible or $400 family deductible is reached. They pay nothing after they reach the annual out-of-pocket maximum of $1,500 for an individual or $3,000 for a family.
>
> **Combination Cost Sharing** (Doctor Network/Preferred Provider Organization) - This plan offers low co-payments ($10)- with no deductible - if patients use the doctors within the network ("preferred providers"). If patients choose doctors outside the network, they have higher co-payments (20% of each visit) - once they've paid the $200 individual deductible or the $400 family deductible. They pay nothing once they've reached their out-of-pocket maximum (see above).
>
> **Lower Cost Sharing** (Health Maintenance Organization) Patients pay no more than $10 for each doctor visit. There are no co-payments for hospital and no deductible has to be met.

## MENTAL ILLNESS AND SUBSTANCE ABUSE

### Problems in the Current Market

Today's insurance market creates barriers to treatment for mental illness through lifetime day or dollar limits and through preexisting condition exclusions.

- 84% of health plans in the current market report day or dollar limits on psychiatric inpatient care (Hay/Huggins 1993).
- Of those reporting day limits, 61% allow 30 or fewer days (Hay/Huggins 1993).
- 95% of medium and large firms report visit or dollar limits on outpatient treatment for mental illness (Bureau of Labor Statistics (BLS) 1991).
- 48% provided 30 or fewer outpatient visits (BLS 1991).

Current coverage for substance abuse treatment is even more limited.

- Many people have no insurance coverage for substance abuse treatment. 21% of people receiving health insurance through large and medium-sized firms have no insurance coverage for substance abuse inpatient rehabilitation or outpatient care (BLS 1991).
- Those who do have coverage face severe restrictions. 10% of participants in the BLS survey reported lifetime day limits, 14% reported limits on the number of treatments, and 22% reported lifetime dollar limits.

### Comprehensive Coverage Through the Health Security Act: The Mental Illness and Substance Abuse Benefit

The Health Security Act covers a broad range of treatment options and eliminates preexisting condition exclusions and lifetime limits that today restrict access of individuals with mental or substance abuse disorders to needed services.

The mental illness and substance abuse benefit in the Health Security Act includes inpatient and residential treatment, intensive nonresidential treatment, and outpatient services, including screening and assessment, diagnosis, medical management, psychotherapy, crisis services, collateral services and case management. Significantly, medical management (even for the severely ill), diagnosis, screening and assessment, and crisis services are not subject to annual day and visit limits.

By January 1, 2001, the Health Security Act replaces current insurance market strategies of annual day limits on inpatient, residential and intensive nonresidential treatment, psychotherapy and substance abuse counseling and relapse prevention with a managed benefit. In addition, higher copayments and coinsurance for psychotherapy, collateral services and some intensive nonresidential treatment days are reduced, and limitations on applying certain expenses to the annual out-of-pocket maximum on cost sharing are eliminated.

Until January 1, 2001, the Act emphasizes a wide range of innovative treatment options, such as case management, partial hospitalization, day treatment programs, and home-based and behavioral aide services -- including services that are important to the treatment of seriously emotionally disturbed children. Providing coverage for this array of treatment options represents a new direction for the delivery of mental illness and substance abuse services and creates incentives for the development of needed capacity.

Health plans are encouraged to utilize the wide array of treatment options to provide individuals with a continuum of care -- that is both appropriate for an individual's needs and cost effective -- through substitution of inpatient and residential days for treatment in other settings. Thirty days of inpatient and residential treatment may be reduced by one day for every two days of intensive nonresidential treatment or by one day for every four outpatient visits for psychotherapy or substance abuse counseling and relapse prevention.

Beyond the services covered through substitution, additional treatments are covered to provide ongoing and appropriate support. A maximum of thirty additional inpatient days are covered for particularly vulnerable individuals. A maximum of 60 additional days of intensive nonresidential treatment are available. Again without substitution, thirty visits of psychotherapy and collateral services are covered for an individual, and 30 visits in group therapy are covered for substance abuse counseling and relapse prevention for individuals who have received other treatment within 12 months.

Through universal coverage, larger numbers of individuals with severe disorders will obtain access to services. While there is promising experience in the private sector with a flexible managed mental health and substance abuse benefit, there is less experience and data on the use of this approach for individuals with severe mental illness or chronic drug and alcohol addiction. Given this uncertainty and consistent with our conservative approach in all of our estimates, we have included protections like a one-day deductible in order to remain conservative in estimating the cost of the benefit. Within this framework, we have developed a benefit structure that encourages flexibility and management so that by January 1, 2001 the benefit no longer needs to rely on specific day and visit limits.

**Initiatives for Improving Access to Mental Illness and Substance Abuse Services**

In addition to the mental illness and substance abuse benefit, the Health Security Act includes initiatives for improving access to mental illness and substance abuse services.

The Act provides funding for services to remove barriers to treatment for mental illness and substance abuse, including community and patient outreach, transportation and translation services.

The Health Security Act requires states to submit a plan by October 1, 1998 to demonstrate how they will integrate state and local mental illness and substance abuse services with the mental illness and substance abuse services included in the comprehensive benefit package.

The Secretary of Health and Human Services is authorized to make grants for the development of school health service sites. Criteria for grant awards include the provision of health and social services, counseling services, and necessary referrals, including referrals regarding mental illness and substance abuse. Other school-based programs focus on educating school children about substance abuse, including tobacco and alcohol use.

November 23, 1993

Dear Senator Kennedy:

The Administration shares your goal of creating a comprehensive and flexible mental illness and substance abuse benefit. The provisions in the introduced version of the Health Security Act take serious steps toward this goal by covering a broad range of treatment options and by eliminating pre-existing condition exclusions and lifetime limits that today restrict the access of individuals with mental or substance abuse disorders to needed services.

The mental illness and substance abuse benefit in the Health Security Act includes inpatient and residential treatment, intensive nonresidential treatment, and outpatient services, including screening and assessment, diagnosis, medical management, psychotherapy, crisis services, collateral services and case management. Significantly, medical management even for the severely ill, diagnosis, screening and assessment, and crisis services are not subject to annual day and visit limits.

By January 1, 2001, the Health Security Act replaces current insurance market strategies of annual day limits on inpatient, residential and intensive nonresidential treatment, psychotherapy and substance abuse counseling and relapse prevention with a managed benefit. In addition, higher copayments and coinsurance for psychotherapy and collateral services are reduced.

Until that time, the Act emphasizes a wide range of innovative treatment options, including case management, partial hospitalization, day treatment programs, and home-based and behavioral aide services that are important to the treatment of seriously emotionally disturbed children. Providing coverage for this array of treatment options represents a new direction for the delivery of mental illness and substance abuse services and creates incentives for the development of needed capacity.

Health plans are encouraged to utilize the wide array of treatment options to provide individuals with a continuum of care -- that is both appropriate for an individual's needs and cost effective -- through substitution of inpatient and residential days for treatment in other settings. Thirty days of inpatient and residential treatment may be reduced by one day for every two days of intensive nonresidential treatment or by one day for every four outpatient visits for psychotherapy or substance abuse

counseling and relapse prevention.

Beyond the services covered through substitution, additional treatments are covered to provide ongoing and appropriate support. A maximum of thirty additional inpatient days are covered for particularly vulnerable individuals. A maximum of 60 additional days of intensive nonresidential treatment are available. Again without substitution, thirty visits of psychotherapy and collateral services are covered, and 30 visits in group therapy are covered for substance abuse counseling and relapse prevention for individuals who have received other treatment within 12 months.

Through universal coverage, larger numbers of individuals with severe disorders will obtain access to services. While there is promising experience in the private sector with a flexible managed mental health and substance abuse benefit, there is less experience and data on the use of this approach for individuals with severe mental illness or chronic drug and alcohol addiction. Given this uncertainty and consistent with our conservative approach in all of our estimates, we have included protections like a one-day deductible in order to remain conservative in estimating the cost of the benefit. Within this framework, we have developed a benefit structure that encourages flexibility and management so that by January 1, 2001 the benefit no longer needs to rely on specific day and visit limits.

In your letter, you asked for clarification in the provisions on the benefit on the following issues:

1. There are no deductibles in the lower cost sharing option.

2. The Act includes no provisions regarding means-testing for mental illness and substance abuse benefits. Of course, individuals may receive premium discounts, and those on AFDC or SSI pay only $2 copayments in lower cost sharing plans.

3. Lower cost sharing plans do not require a copayment for the first 60 days of intensive nonresidential treatment for mental illness and substance abuse and do not require the payment of a one-day deductible. Higher cost sharing plans require the payment of 20% coinsurance for the first 60 days and the payment of a one-day deductible. Expenses for the first 60 days of intensive nonresidential mental illness treatment that an individual incurs prior to satisfying an applicable deductible and copayments and coinsurance may be applied toward the out-of-pocket limit on cost sharing.

4. The Act does not define the terms "somatic treatment services" or "somatic therapies", which are used in section 1115(c) and (e). These terms are not defined

in the Act in order to accomodate changes in future technology and treatment patterns.

In addition to the mental illness and substance abuse benefit, the Health Security Act also provides funding for services to remove barriers to treatment for mental illness and substance abuse, including community and patient outreach, transportation and translation services. Other initiatives include school-based programs aimed at educating school children about substance abuse, including tobacco and alcohol use. In addition, the National Institutes of Health will fund mental illness and substance abuse prevention research.

I appreciate your concern and look forward to working with you on these issues in the future.

Regards,

Ira C. Magaziner
Senior Advisor for Policy Development

# United States Senate

WASHINGTON, DC 20510

November 17, 1993

Ira Magaziner
Senior Adviser for Policy Development
The White House
Washington, D.C. 20500

Dear Ira,

We have reviewed the 11/14/93 release of changes in the Mental Illness and Substance Abuse Provisions in the Health Security Act.

As you are aware, the Senate Working Group on Mental Health believes that comprehensive and flexible benefits provided under a well-managed system are very achievable, and would be more effective and more cost efficient than the plan presented in the Health Security Act. The enclosed testimony and summary of the November 8 hearing before the Senate Committee on Labor and Human Resources highlight our case for such benefits.

In addition, we are concerned that there are a number of problems with the Health Security Act that must be addressed, even in the context of a traditional benefits plan that relies on day limits, heavy deductibles and co-payments to restrict utilization. While we recognize your serious attempt to deal with difficult issues in the 11/14 document, we still have concerns with the revised model. Several significant aspects of the plan should be changed in order to meet the Administration's own goals of security and simplicity.

We would appreciate your consideration of the following issues and questions:

INPATIENT SERVICES

1. Meeting the criteria for additional days: The revised benefits provide 30 days of inpatient treatment. An additional 30 days may be approved if a health professional determines that the patient either poses a threat to his or her own life or that of another, or requires hospitalization to initiate, alter or adjust pharmacological or somatic therapy.

Many situations exist where patients may be seriously disturbed with a medical or psychological necessity for inpatient care but would be unable to meet the stated definition and access the additional 30 days.

2. Deductible: The revised plan continues to require a one-day deductible for inpatient care.

As Hewitt Associates strongly stated at the November 8 hearing, they know of no plan that now uses the one-day deductible as a way to keep costs down. The one-day deductible is likely to save $5 per covered life, yet would put an unconscionable burden on those who can least afford it -- emotionally or financially.

INTENSIVE NON-RESIDENTIAL SERVICES

1. Differential treatment costs: The types of treatment listed are not actuarially equivalent yet are made so by the 2 for 1 substitution. The listed treatments vary greatly in actual cost. For example, partial hospitalization, day treatment, and psychiatric rehabilitation services are likely to be more expensive than a second group of non-residential services, namely the home-based, ambulatory detoxification and behavioral aide services. If the equivalent cost of services is the basis for this trade-off, we would suggest that for this second group, 1 inpatient day should be equal to 4 days of alternative care.

2. Deductible and co-insurance: The 1-day deductible and the 50% co-payment for the second 60 days continue the assumption that the plan must hit people hard at the beginning of treatment and at points during treatment in order to keep costs down. This model perpetuates the concept that people are frivolous in seeking help through these therapies. It also negates the entire concept of good, high quality managed care that provides the best treatment for the patient at that time in the patient's life.

Patients will be financially forced into choosing a type of treatment because of its co-payment or out-of-pocket cap rather than basing such serious decisions on what will help them get well.

OUTPATIENT SERVICES

1. Reduced number of visits: We are seriously concerned that the number of visits for outpatient psychotherapy and collateral services has been cut in half. The original plan allowed for 30 visits for each treatment modality. This reduction is a serious attack on a low-cost and yet highly effective plan benefit. Given the actuarial data concerning outpatient psychotherapy, moving to an increased benefit would make more fiscal and preventive sense than this reduction to a total of 30 visits.

2. Limits and co-insurance: We are dismayed by the Administration's apparent unwillingness to recognize the wealth of data that show the financial advantages of an open outpatient benefit and the unreasonableness of a limited 30-visit outpatient benefit and a 50% co-insurance. The data speak both to the very low cost of removing the day limit and to the administrative nightmare that these limits and the collection of co-payments would create in exchange for little or no cost savings.

3. Out-of-pocket cap: For both the outpatient benefits and the intensive non-residential benefits, we feel strongly that not counting these expenses toward the out-of-pocket cap works adversely on those who need these benefits to improve their lives, perhaps, even to save their lives.

We do have several specific questions raised by the 11/14/93 memo we hope you will answer for us.

QUESTIONS/CLARIFICATIONS

1. In-patient deductible: What would be the deductible for the low cost-sharing option? Would it apply to each admission?

2. Means-testing for benefits: Is there any plan to means-test any of the mental health and substance abuse benefits?

3. Intensive non-residential co-payment: Do the deductible and co-payment paid by the patient during the first 60 days count toward their out-of-pocket cap? Is there a difference between the high and low cost-sharing plans in terms of the one-day deductible and/or co-payment during the first 60 days?

4. How does the plan define "somatic illnesses" and "somatic treatments"? These are central to both the inpatient extension of days and to outpatient psychotherapy.

SUMMARY

We are very concerned that the mental health and substance abuse benefits as now presented will not gain the support of the American people for two primary reasons:

(a) It would be less than many people now have; and, (b) it would create such additional bureaucracy that cost savings in the first three years would be difficult to achieve. That would endanger the phase in of additional benefits in 2001.

We ask that the health plan reflect the large research base that shows the importance of using psychological criteria as well as medical criteria for establishing treatment necessity.

We urge you to re-examine this subject with an openness to new, more recent data, and with a willingness to take issue with those who encourage more administrative restrictions that add to the costs when the goal is to save money. We know that the idea behind the inclusion of mental health and substance abuse benefits is a good one. We fear, however, that the amended plan encourages treatment that may not be in the best interest of the patient and does it by artificially manipulating the patient's cost of obtaining care.

Thank you for your consideration of these important issues. We look forward to hearing from you.

Sincerely,

Paul D. Wellstone

Edward M. Kennedy

Daniel K. Inouye

Pete V. Domenici

Paul Simon

Alan K. Simpson

TO: Melanne Verveer
FROM: Jennifer Klein
DATE: 12/22/93

Attached please find a summary of mental illness and substance abuse provisions of the bill. This should give you all of the information in one place. Christine Heenan is using this summary to write separate talking points on mental illness and substance abuse.

Also, I asked Jason Solomon to send you the Q and A segments from the Washington Post. He left me an extra copy, so let me know if you did not receive it.

# The Health Security Act
# DRAFT * DRAFT * DRAFT * DRAFT
# Summary of The
# Mental Illness and Substance Abuse Provisions

Mental illness and substance abuse disorders will affect more than 50 million Americans this year. Left untreated, these illnesses are responsible for countless numbers of lives and billions of dollars in lost work days and productivity. The Health Security Act recognizes the economic and personal impact of mental illness and substance abuse disorders and makes treatment for them an integral part of health care in America.

The goal of the Health Security Act's mental illness and substance abuse benefit is to provide full and flexible coverage. The benefit encourages the use of proven, cost-effective, innovative treatment alternatives. And, unlike today, there are no lifetime limits on these services.

By the year 2001, all day and visit limits, and cost sharing and day deductibles specific to mental illness and substance abuse treatment, will be eliminated.

Coverage includes: screening and assessment; crisis services; inpatient and residential mental illness and substance abuse treatments; intensive non-residential mental illness and substance abuse treatment; outpatient mental illness and substance abuse treatment; case management and collateral services.

## INPATIENT

Coverage for inpatient services, hospital and residential, are provided in the least restrictive setting that is effective and appropriate for the individual; and, if less restrictive intensive non-residential or outpatient treatment would be ineffective or inappropriate.

### HOSPITAL

Mental Illness: Before January 1, 2001, the comprehensive benefit package provides for 30 days per calendar year of inpatient or residential treatment following the standard cost sharing schedule. An additional 30 days of inpatient or residential treatment may be approved, if a health professional designated by the health plan in which an individual is enrolled determines either that:

1) the individual poses a threat to his own life or that of another; or

2) that the medical condition of the individual requires inpatient hospitalization in order to initiate, alter, or adjust pharmacological or somatic therapy.

Under some plans which have a higher cost sharing schedule, the individual must pay a one day deductible for each inpatient admission.

Substance Abuse: Before January 1, 2001, the substance abuse provision of the comprehensive benefit limits hospitalization to medical detoxification associated with withdrawal from alcohol or drugs that involves psychiatric complications. Hospitalization for medical detoxification that does not involve psychiatric treatment is covered under the general benefit and the days do not count against the annual day limit. Under the plans with a higher cost sharing schedule, a one day deductible applies.

**RESIDENTIAL**

**Mental Illness and Substance Abuse:** Residential treatment options include residential treatment centers, residential detoxification centers, crisis residential programs, mental illness residential treatment programs, therapeutic family or group treatment homes, community residential treatment, or recovery centers for substance abuse. Before January 1, 2001, the same limits and cost sharing apply to residential treatment as apply to hospitalization.

## INTENSIVE NON-RESIDENTIAL TREATMENT

**Mental Illness and Substance Abuse:** Intensive non-residential treatments include partial hospitalization, day treatment, psychiatric rehabilitation, home-based services, ambulatory detoxification and behavioral aide services.

These treatments are provided only for the purpose of averting the need for - or as an alternative to - treatment in hospitals or residential inpatient settings; to facilitate the earlier discharge of an individual receiving inpatient or residential care; to restore the functioning of an individual receiving inpatient or residential care; to restore the functioning of an individual with a diagnosable mental or substance abuse disorder; or to assist the individual to develop the skill and gain access to the support services the individual needs to achieve the maximum level of functioning of the individual within the community.

Intensive non-residential treatment services will be provided by health plans if a health professional designated by the health plan determines an individual should receive such services.

Before January 1, 2001, intensive non-residential services are covered as a substitution for inpatient days at the rate of two intensive non-residential days for one inpatient day, until the 30 day annual aggregate inpatient day limit is reached. Individuals may receive up to sixty days of treatment using the substitution formula.

For example, an individual who has been hospitalized for seven days may convert his or her remaining inpatient days to intensive non-residential days. Therefore 23 inpatient days would be available to convert to 46 intensive non-residential days. For those who have selected the higher cost sharing plan, a one-day deductible per episode applies.

An additional 60 days of non-residential treatment may be provided if a health care professional designated by the health plan determines additional treatment is medically necessary or appropriate. This second 60 days is subject to a 50% coinsurance payment in the higher cost sharing plans and $25 per visit payment for the lower cost sharing plans. These cost sharing and other expenses do not count toward an individual's annual out-of-pocket limit on cost sharing. Under the higher cost sharing schedule, a one-day deductible applies.

## OUTPATIENT

**Other Outpatient Services for Mental Illness and Substance Abuse:** Based on an individual's need, the following outpatient services are available: screening and assessment, diagnosis, medical management, crisis services and somatic treatment services. These are covered following the standard cost sharing schedule, but cost sharing for these services does not count toward an individual's annual out-of-pocket limit.

**Outpatient Psychotherapy and Collateral Services:** Before January 1, 2001, 30 psychotherapy or collateral services visits are covered annually. For psychotherapy and collateral sessions there is a 50% coinsurance payment in the higher cost sharing schedule and a $25 per visit payment for the lower cost sharing schedule. These cost sharing and other expenses do not count toward an individual's annual out-of-pocket limit on cost sharing.

In order to prevent hospitalization or to facilitate earlier hospital release, additional visits may be made available, at the discretion of the health plans, by exchanging, at a 1 to 4 rate, inpatient days for outpatient psychotherapy visits following the same cost sharing schedule as the first 30 visits. Again, cost sharing for these services does not count toward the annual out-of-pocket cap.

**Outpatient Substance Abuse Counseling and Relapse Prevention:** Before January 1, 2001, at the discretion of the health plan, an individual may receive substance abuse counseling and relapse prevention treatments by exchanging inpatient/residential days for outpatient visits on a 1 to 4 basis until the 30 day inpatient/residential annual limit is reached.

Within 12 months after an individual receives residential or intensive non-residential treatment, 30 group therapy sessions are covered for substance abuse counseling and relapse prevention.

Intensive non-residential and outpatient detoxification may only be provided in the context of a treatment program.

Cost sharing for these services does not count the toward annual out-of-pocket limit.

## Case Management

Case management services are to be offered by health plans. However, health plans have the discretion to determine if a specific individual enrolled in a health plan should receive such services. These services include those that assist individuals in gaining access to needed medical, social, educational and other services.

## Other Provisions Related to Mental Illness and Substance Abuse

**Financial Assistance for State Mental Illness and Substance Abuse Activities:** Section 3501 of The Health Security Act authorizes the Secretary of Health and Human Services to use funds from the Public Health Service Initiatives Fund to award grants to States for activities related to mental illness and substance abuse including those:

o To increase the access of individuals to transportation, community and patient outreach, patient education, translation services, and such other services as the Secretary of Health and Human Services determines to be appropriate.

o To improve the capacity of state and local service systems to coordinate and monitor mental illness and substance abuse services, including upgrading of management information systems, and establishment of linkages between providers of mental illness and substance abuse services and primary care providers and health plans.

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

In fiscal year 1995, $100 million is authorized to be appropriated; in fiscal year 1996, $150 million is authorized; and for fiscal years 1997 through 2000, the authorization is $250 million for each year.

**State Plans for Mental Illness and Substance Abuse Integration:** Section 3511 of the Health Security Act states that in order to qualify to participate in the overall health care plan, by October 1, 1998 each state must submit a plan to the Secretary of Health and Human Services. The plan must show how the state will achieve the integration of the state and local mental illness and substance abuse services with the mental illness and substance abuse services included in the comprehensive benefit package.

The Secretary of Health and Human Services will establish pilot programs to demonstrate model methods for achieving the integration of the mental illness and substance abuse services of states with the services included in the comprehensive benefit package.

**Financial Assistance For School Health Service Sites:** Sections 3684 and 3685 of the Health Security Act empower the Secretary of Health and Human Services to make grants to state health agencies or to local community partnerships to develop school health services sites. Criteria for grant awards will include the provision of health and social services, counseling services, and necessary referrals, including referrals regarding mental illness and substance abuse.

**Information Privacy:** Section 5120 of the Health Security Act details the overall health information system privacy standards. No "individually identifiable health information" shall be disclosed unless it is authorized by the individual to whom the information pertains. Section 5123 of the Act specifically includes "the past, present, or future physical or mental health of the enrollees" in the definition of "individually identifiable information".

# SUBSTANCE ABUSE TALKING POINTS

- The structure of the benefit is designed to offer a flexible, continuum of care that allows health plans to tailor treatment programs to an individual's special needs.

## PROBLEMS IN THE CURRENT MARKET

- For the first time Americans will have coverage for substance abuse treatment. For example, based on data from the 1991 Bureau of Labor Statistics (BLS), 21% of participants in medium and large health plans had no insurance coverage for substance inpatient rehabilitation or out patient care.

- A large number of insurance policies place severe restrictions on substance abuse coverage. For example, 10% of participants in the BLS survey had lifetime day limits, another 14% had limits on the number of treatments, and 22% had lifetime dollar limitations.

## PRESIDENT'S PLAN

- The President's Health Security Act, as presented to Congress, immediately addresses these most discriminatory practices within the current insurance systems. The Health Security Act uses no life time limits or prior existing condition exclusions.

- The initial benefit continues to use day and visit limits similar to current insurance policies. At the same time, the benefit is an improvement over current policies in that it provides coverage for a wider range of services than in typical insurance today, using trades against the inpatient/residential benefit to encourage flexibility, use of lower cost effective alternative, and care management.

- For example, the innovative day treatment program models are included as one of the intensive non-residential treatment settings. Visits for the purpose medication management are treated as any other health visit for the same purpose.

- The substitution provisions of a 4 for 1 trade against the inpatient residential benefit provide for an outpatient substance abuse counseling and relapse prevention benefit that is considerably more generous than available in today's insurance market.

- There is provision for continuing care on an outpatient basis for individuals treated either in residential or intensive non-residential settings.

- Clarifications, changes and corrections have been made to various sections in the draft bill . . .the mental illness and substance abuse benefit has not been singled out. We want to make absolutely sure the language is clear and consistent with out policy goals in every area. When the initial of the mental illness and substance abuse benefit legislative language was made public it became clear that different interpretations were causing confusion about the policy intent. In addition, actuarial review of the benefit was continuing and some changes were made in response to the actuarial findings. The basic benefits are now, in fact, more flexible because of more precise language and clear exceptions.

- The Health Security Act demonstrates the Administration's commitment to making substance abuse coverage part of the nation's comprehensive health coverage. This commitment is demonstrated by proposing a benefit structure which will eliminate all differences in insurance coverage by January 1, 2001.

### c. Psychiatric Care Room and Board Coverage

**Chart 5.18**
**Psychiatric Care Room and Board Level of Coverage**

| Coverage | Industrial No. | Industrial % | Financial No. | Financial % | Service No. | Service % | Total No. | Total % |
|---|---|---|---|---|---|---|---|---|
| 100% of R&C (Same Maximum as Other Confinement) | 23 | 5% | 13 | 8% | 25 | 7% | 61 | 6% |
| 100% of R&C (Separate Maximum) | 125 | 28% | 43 | 25% | 177 | 46% | 345 | 34% |
| Less than 100% of R&C (Same Maximum) | 61 | 13% | 12 | 7% | 24 | 6% | 97 | 10% |
| Less than 100% of R&C (Separate Maximum) | 241 | 54% | 104 | 60% | 160 | 41% | 505 | 50% |
| Total | 450 | 100% | 172 | 100% | 386 | 100% | 1008 | 100% |
| No Response | 3 | | 2 | | 8 | | 13 | |
| Total Plans | 453 | | 174 | | 394 | | 1021 | |

**Chart 5.19**
**Psychiatric Treatment Maximum Number of Days for Room and Board Coverage**

| Days | Industrial No. | Industrial % | Financial No. | Financial % | Service No. | Service % | Total No. | Total % |
|---|---|---|---|---|---|---|---|---|
| Fewer than 30 | 6 | 3% | 6 | 6% | 18 | 8% | 30 | 6% |
| 30 | 109 | 52% | 53 | 55% | 140 | 58% | 302 | 55% |
| 31–59 | 43 | 21% | 17 | 18% | 43 | 18% | 103 | 19% |
| 60 | 33 | 16% | 14 | 14% | 30 | 13% | 77 | 14% |
| 61–119 | 8 | 4% | 3 | 3% | 9 | 3% | 20 | 4% |
| 120 | 7 | 3% | 1 | 1% | — | — | 8 | 1% |
| More than 120 | 3 | 1% | 3 | 3% | — | — | 6 | 1% |
| Total | 209 | 100% | 97 | 100% | 240 | 100% | 546 | 100% |

### b. Home Health Care/Hospice Care

Another cost-effective alternative is hospice care. The prevalence of this practice has grown in recent years and is being covered by 88% of organizations in 1993.

**Chart 5.28**
**Home Health Care/Hospice Care Amount of Coverage**

| | Home Health Care | | Hospice Care | |
|---|---|---|---|---|
| Coverage | No. | % | No. | % |
| 100% of R&C | 392 | 40% | 375 | 41% |
| Less than 100% of R&C | 571 | 58% | 424 | 47% |
| Not Covered | 24 | 2% | 110 | 12% |
| Total | 987 | 100% | 909 | 100% |
| No Response | 34 | | 112 | |
| Total Plans | 1021 | | 1021 | |

Of 704 respondents, 21% have no limit on home health care, 55% use a maximum number of days, 20% use the medical plan maximum, 2% use a maximum dollar amount per day, and 2% use a lifetime maximum.

Of 313 respondents, 37% have no limit on hospice care, 11% have an annual limit, 35% have a lifetime limit, 13% have a maximum number of days, and 4% use the medical plan maximum.

## 10. Outpatient Psychiatric Coverage

### a. Prevalence

Ninety-nine percent of respondents provide some level of outpatient psychiatric coverage.

### b. Amount of Coverage

**Chart 5.29**
**Percentage of Reasonable and Customary Charges Paid for Outpatient Psychiatric Care**

| | Industrial | | Financial | | Service | | Total | |
|---|---|---|---|---|---|---|---|---|
| Percent | No. | % | No. | % | No. | % | No. | % |
| 50 | 201 | 46% | 69 | 42% | 150 | 41% | 420 | 44% |
| 51–60 | 4 | 1% | 3 | 2% | 5 | 2% | 12 | 1% |
| 61–70 | 8 | 2% | — | — | 4 | 1% | 12 | 1% |
| 71–99 | 153 | 35% | 56 | 34% | 96 | 26% | 305 | 32% |
| 100 | 69 | 16% | 36 | 22% | 109 | 30% | 214 | 22% |
| Total | 435 | 100% | 164 | 100% | 364 | 100% | 963 | 100% |

### c. Dollar Maximum Per Visit

**Chart 5.30**
**Outpatient Psychiatric Care Maximum Benefit Per Visit**
**(After Application of Coinsurance)**

| | Industrial | | Financial | | Service | | Total | |
|---|---|---|---|---|---|---|---|---|
| Maximum | No. | % | No. | % | No. | % | No. | % |
| Less than $20 | 5 | 5% | 1 | 3% | 2 | 3% | 8 | 4% |
| $20–$29 | 26 | 25% | 7 | 19% | 18 | 25% | 51 | 24% |
| $30–$39 | 17 | 17% | 4 | 11% | 16 | 22% | 37 | 17% |
| $40–$49 | 9 | 9% | 11 | 29% | 13 | 18% | 33 | 15% |
| $50–$59 | 23 | 22% | 9 | 24% | 12 | 16% | 44 | 21% |
| $60–$69 | 4 | 4% | 1 | 3% | 6 | 8% | 11 | 5% |
| $70 or Greater | 19 | 18% | 4 | 11% | 6 | 8% | 29 | 14% |
| Total | 103 | 100% | 37 | 100% | 73 | 100% | 213 | 100% |
| No Response | 6 | | — | | — | | 6 | |
| Total Plans with Dollar Limit Per Visit | 109 | | 37 | | 73 | | 219 | |

### d. Maximum Number of Visits

Thirty-nine percent of 973 respondents have a maximum number of visits per year for outpatient psychiatric care.

**Chart 5.31**
**Maximum Number of Visits Per Year for**
**Outpatient Psychiatric Care**

| | Industrial | | Financial | | Service | | Total | |
|---|---|---|---|---|---|---|---|---|
| Visits | No. | % | No. | % | No. | % | No. | % |
| Fewer than 30 | 40 | 27% | 24 | 33% | 73 | 45% | 137 | 36% |
| 30 | 26 | 18% | 9 | 12% | 29 | 18% | 64 | 17% |
| 31–49 | 11 | 8% | 7 | 10% | 15 | 9% | 33 | 9% |
| 50 | 43 | 29% | 20 | 27% | 33 | 20% | 96 | 25% |
| 51–75 | 24 | 16% | 11 | 15% | 11 | 7% | 46 | 12% |
| 76 or More | 2 | 2% | 2 | 3% | 1 | 1% | 5 | 1% |
| Total | 146 | 100% | 73 | 100% | 162 | 100% | 381 | 100% |
| No Response | 2 | | — | | 2 | | 4 | |
| Total Plans with Maximum Number of Visits | 148 | | 73 | | 164 | | 385 | |

### e. Dollar Maximum Per Year or Lifetime

Of 985 respondents, 26% have no dollar maximum other than the overall comprehensive major medical plan maximum. Of those plans that have a maximum, 39% have an annual maximum only, 20% have a lifetime maximum only, and the remaining 41% have a combination of both annual and lifetime maximums. Chart 5.32 represents the dollar maximums of plans with annual maximums only.

**Chart 5.32**
**Outpatient Psychiatric Care Separate Dollar Maximum Per Year**

| | Industrial | | Financial | | Service | | Total | |
|---|---|---|---|---|---|---|---|---|
| Maximum | No. | % | No. | % | No. | % | No. | % |
| Less than $1,000 | 11 | 6% | 7 | 9% | 15 | 10% | 33 | 8% |
| $1,000 | 32 | 17% | 23 | 30% | 35 | 23% | 90 | 21% |
| $1,001–$1,499 | 5 | 3% | 2 | 3% | 3 | 2% | 10 | 2% |
| $1,500–$1,999 | 49 | 25% | 9 | 12% | 39 | 25% | 97 | 23% |
| $2,000–$2,499 | 34 | 18% | 14 | 18% | 30 | 20% | 78 | 19% |
| $2,500–$2,999 | 16 | 8% | 6 | 8% | 14 | 9% | 36 | 9% |
| $3,000–$4,999 | 16 | 8% | 8 | 10% | 9 | 6% | 33 | 8% |
| $5,000 or Greater | 28 | 15% | 8 | 10% | 8 | 5% | 44 | 10% |
| Total | 191 | 100% | 77 | 100% | 153 | 100% | 421 | 100% |

For the 76 plans with a separate dollar maximum per lifetime for outpatient psychiatric coverage, the common maximums are $10,000 (28%), $25,000 (16%) $50,000 (19%), and less than $10,000 (23%).

Three hundred sixty-two plans have a combination inpatient/outpatient maximum; of these, 40% are $50,000, 24% are $25,000, and 14% are greater than $50,000.

## 11. Emergency Illness and Accident Benefits

Of 1012 respondents, 39% (36% of Industrial, 38% of Financial, and 43% of Service organizations) have separate provisions for emergency accident or emergency illness expenses. Of these participants, 73% do not require a deductible, and 27% do require a deductible, as shown in Chart 5.33 below.

**Chart 5.33**
**Percentage of Reasonable and Customary Charges Paid for Emergency Illness and Accident Benefits**

| | No Deductible | | Subject to Deductible | | Total | |
|---|---|---|---|---|---|---|
| Percent | No. | % | No. | % | No. | % |
| 80 | 10 | 3% | 8 | 7% | 18 | 4% |
| 81–99 | 8 | 3% | 15 | 14% | 23 | 6% |
| 100 | 272 | 94% | 84 | 79% | 356 | 90% |
| Total | 290 | 100% | 107 | 100% | 397 | 100% |

Fifty-seven percent of plans have no maximum for emergency illness and accident benefits, while 39% have a maximum per occurrence, and 4% have an annual maximum.

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**Table 52. Medical care benefits: Percent of full-time participants in plans with mental health benefits by extent of benefits, medium and large private establishments, 1991**

| Coverage limitation | All participants | | Professional, technical, and related participants | | Clerical and sales participants | | Production and service participants | |
|---|---|---|---|---|---|---|---|---|
| | Hospital care[1] | Outpatient care[2] | Hospital care[1] | Outpatient care[2] | Hospital care[1] | Outpatient care[2] | Hospital care[1] | Outpatient care[2] |
| Total | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 |
| With coverage | 99 | 98 | 99 | 97 | 98 | 97 | 99 | 96 |
| Covered the same as other illnesses | 18 | 2 | 18 | 2 | 15 | 2 | 19 | 3 |
| Subject to separate limitations[3] | 81 | 95 | 81 | 95 | 83 | 95 | 80 | 95 |
| Limit on days | 54 | 35 | 55 | 35 | 57 | 36 | 51 | 35 |
| Per year | 45 | 35 | 45 | 33 | 49 | 35 | 42 | 35 |
| Per confinement | 9 | 1 | 10 | 1 | 8 | 1 | 9 | (4) |
| Per lifetime | 2 | (4) | 2 | (4) | 2 | (4) | 3 | (4) |
| Limit on number of treatments | 1 | (4) | (4) | (4) | (4) | (4) | 1 | (4) |
| Limit on dollars | 39 | 68 | 36 | 66 | 44 | 67 | 39 | 70 |
| Per day | 1 | 21 | 1 | 21 | 1 | 18 | 1 | 24 |
| Per year | 9 | 48 | 8 | 47 | 9 | 47 | 10 | 48 |
| Per lifetime | 33 | 32 | 32 | 31 | 38 | 36 | 32 | 30 |
| Per other period | 1 | (4) | 1 | (4) | 1 | (4) | 1 | 1 |
| Coinsurance limit | 10 | 56 | 9 | 50 | 11 | 54 | 10 | 61 |
| 50 percent | 3 | 42 | 2 | 36 | 3 | 41 | 4 | 46 |
| Other[5] | 7 | 14 | 7 | 14 | 8 | 14 | 6 | 14 |
| Ceiling on out-of-pocket expenses does not apply | 16 | 39 | 15 | 38 | 20 | 40 | 15 | 40 |
| Separate copayment or deductible | 3 | 12 | 3 | 14 | 4 | 15 | 2 | 9 |
| Other limitations | 1 | 1 | 1 | (4) | 1 | 1 | 1 | 2 |
| Without coverage | 1 | 2 | 1 | 3 | 2 | 3 | 1 | 2 |

[1] Excludes doctor's charges in the hospital.

[2] Includes treatment in one or more of the following: Outpatient department of a hospital, residential treatment center, organized outpatient clinic, day-night treatment center, or doctor's office. If benefits differed by location of treatment, doctor's office care was tabulated.

[3] Separate limitations indicate that mental health care benefits are more restrictive than benefits for other treatments. For example, if a plan limits inpatient mental health care to 30 days per year, but the limit on inpatient care for any other type of illness is greater than 30 days per year, that plan contains separate limits. The total is less than the sum of the individual items because many plans had more than one type of limitation on mental health coverage.

[4] Less than 0.5 percent.

[5] Includes plans with reduced coinsurance other than 50 percent and plans where the rate of reimbursement varied during the treatment period.

NOTE: Because of rounding, sums of individual items may not equal totals. Where applicable, dash indicates no employees in this category.

**Table 53. Medical care benefits: Percent of full-time participants in plans with substance abuse benefits by uniformity in coverage, medium and large private establishments, 1991**

| Coverage limitation | All participants | Professional, technical, and related participants | Clerical and sales participants | Production and service participants |
|---|---|---|---|---|
| Total | 100 | 100 | 100 | 100 |
| With alcohol abuse treatment benefits | 100 | 100 | 100 | 100 |
| Drug abuse treatment covered in the same manner | 92 | 93 | 92 | 91 |
| Drug abuse treatment covered differently | 7 | 6 | 7 | 7 |
| Drug abuse treatment benefits not provided | 1 | (1) | 1 | 2 |

[1] Less than 0.5 percent.

NOTE: Because of rounding, sums of individual items may not equal totals. Where applicable, dash indicates no employees in this category.

**Table 54. Medical care benefits: Percent of full-time participants in plans with alcohol abuse treatment benefits by extent of benefits, medium and large private establishments, 1991**

| Coverage limitation | All participants | | | Professional, technical, and related participants | | | Clerical and sales participants | | | Production and service participants | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Inpatient detoxification[1] | Inpatient rehabilitation[2] | Outpatient care[3] | Inpatient detoxification[1] | Inpatient rehabilitation[2] | Outpatient care[3] | Inpatient detoxification[1] | Inpatient rehabilitation[2] | Outpatient care[3] | Inpatient detoxification[1] | Inpatient rehabilitation[2] | Outpatient care[3] |
| Total | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 |
| With coverage | 100 | 79 | 79 | 100 | 76 | 80 | 100 | 79 | 79 | 100 | 81 | 78 |
| Covered the same as other illnesses | 31 | 9 | 7 | 33 | 9 | 6 | 31 | 9 | 8 | 29 | 8 | 8 |
| Subject to separate limitations[4] | 69 | 70 | 72 | 67 | 67 | 74 | 69 | 69 | 71 | 70 | 73 | 71 |
| Limit on days | 52 | 54 | 37 | 51 | 53 | 39 | 52 | 52 | 35 | 52 | 55 | 37 |
| Per year | 31 | 32 | 30 | 33 | 33 | 32 | 33 | 33 | 28 | 28 | 30 | 29 |
| Per confinement | 15 | 14 | 1 | 14 | 13 | 2 | 14 | 13 | 1 | 18 | 15 | 1 |
| Per lifetime | 7 | 10 | 7 | 7 | 10 | 7 | 6 | 8 | 4 | 8 | 10 | 10 |
| Limit on number of treatments | 11 | 14 | 7 | 10 | 11 | 5 | 8 | 12 | 5 | 13 | 16 | 8 |
| Limit on dollars | 28 | 27 | 41 | 23 | 22 | 39 | 32 | 32 | 42 | 28 | 27 | 42 |
| Per day | 1 | 1 | 10 | 1 | (5) | 7 | 1 | 1 | 9 | 1 | 1 | 12 |
| Per year | 7 | 7 | 26 | 6 | 6 | 26 | 8 | 8 | 27 | 7 | 7 | 24 |
| Per lifetime | 23 | 22 | 24 | 20 | 19 | 23 | 27 | 27 | 26 | 23 | 22 | 23 |
| Per other period | 2 | 2 | 2 | 1 | 1 | 1 | 2 | 2 | 2 | 3 | 3 | 2 |
| Coinsurance limit[6] | 9 | 10 | 27 | 9 | 10 | 26 | 8 | 9 | 29 | 9 | 10 | 26 |
| Ceiling on out-of-pocket expenses does not apply | 12 | 13 | 23 | 13 | 13 | 23 | 16 | 16 | 25 | 9 | 11 | 22 |
| Separate copayment or deductible | 2 | 3 | 4 | 3 | 3 | 5 | 3 | 3 | 5 | 2 | 3 | 3 |
| Other limitations | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| Without coverage | (5) | 21 | 21 | (5) | 24 | 20 | (5) | 21 | 21 | (5) | 19 | 22 |

[1] Detoxification is the systematic use of medication and other methods under medical supervision to reduce or eliminate the effects of substance abuse.

[2] Rehabilitation is designed to alter abusive behavior in patients once they are free of acute physical and mental complications.

[3] Includes treatment in one or more of the following: Outpatient department of a hospital, residential treatment center, organized outpatient clinic, day-night treatment center, or doctor's office. If benefits differed by location of treatment, doctor's office care was tabulated.

[4] Separate limitations indicate that alcohol abuse treatment benefits are more restrictive than benefits for other treatments. For example, if a plan limits inpatient rehabilitation care to 30 days per year, but the limit on inpatient care for any other type of illness is greater than 30 days per year, that plan contains separate limits. The total is less than the sum of the individual items because many plans had more than one type of limitation.

[5] Less than 0.5 percent.

[6] Coinsurance rate is lower than that applying to other medical services. In such cases, outpatient rehabilitation care is generally at a coinsurance rate of 50 percent.

NOTE: Because of rounding, sums of individual items may not equal totals. Where applicable, dash indicates no employees in this category.

**Table 55. Medical care benefits: Percent of full-time participants in plans with drug abuse treatment benefits by extent of benefits, medium and large private establishments, 1991**

| Coverage limitation | All participants | | | Professional, technical, and related participants | | | Clerical and sales participants | | | Production and service participants | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Inpatient detoxification[1] | Inpatient rehabilitation[2] | Outpatient care[3] | Inpatient detoxification[1] | Inpatient rehabilitation[2] | Outpatient care[3] | Inpatient detoxification[1] | Inpatient rehabilitation[2] | Outpatient care[3] | Inpatient detoxification[1] | Inpatient rehabilitation[2] | Outpatient care[3] |
| Total | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 |
| With coverage | 100 | 78 | 77 | 100 | 75 | 79 | 100 | 78 | 78 | 100 | 80 | 76 |
| Covered the same as other illnesses | 30 | 7 | 6 | 33 | 8 | 6 | 29 | 7 | 7 | 28 | 7 | 6 |
| Subject to separate limitations[4] | 70 | 71 | 71 | 67 | 67 | 73 | 70 | 71 | 72 | 71 | 74 | 70 |
| Limit on days | 52 | 54 | 36 | 52 | 53 | 38 | 53 | 53 | 35 | 52 | 55 | 35 |
| Per year | 31 | 31 | 28 | 33 | 33 | 31 | 35 | 35 | 28 | 28 | 29 | 26 |
| Per confinement | 15 | 14 | 1 | 14 | 13 | 2 | 13 | 12 | 1 | 17 | 16 | 1 |
| Per lifetime | 7 | 9 | 7 | 7 | 9 | 5 | 6 | 6 | 4 | 7 | 10 | 9 |
| Limit on number of treatments | 11 | 14 | 7 | 9 | 11 | 5 | 8 | 12 | 5 | 13 | 16 | 9 |
| Limit on dollars | 29 | 28 | 43 | 24 | 23 | 40 | 33 | 33 | 45 | 29 | 28 | 43 |
| Per day | 1 | 1 | 10 | 1 | (5) | 7 | 1 | 1 | 10 | 1 | 1 | 12 |
| Per year | 7 | 7 | 27 | 6 | 6 | 27 | 8 | 8 | 29 | 8 | 7 | 26 |
| Per lifetime | 24 | 23 | 24 | 20 | 20 | 23 | 28 | 28 | 26 | 24 | 23 | 23 |
| Per other period | 2 | 2 | 2 | 1 | 1 | 1 | 2 | 2 | 2 | 3 | 3 | 2 |
| Coinsurance limit[6] | 9 | 10 | 28 | 9 | 10 | 27 | 9 | 10 | 31 | 9 | 10 | 27 |
| Ceiling on out-of-pocket expenses does not apply | 12 | 13 | 24 | 13 | 13 | 24 | 16 | 16 | 26 | 10 | 11 | 23 |
| Separate copayment or deductible | 3 | 3 | 4 | 3 | 3 | 5 | 3 | 3 | 6 | 2 | 3 | 4 |
| Other limitations | (5) | (5) | 1 | (5) | (5) | (5) | (5) | (5) | (5) | 1 | 1 | 1 |
| Without coverage | (5) | 22 | 23 | (5) | 25 | 21 | (5) | 22 | 22 | (5) | 20 | 24 |

[1] Detoxification is the systematic use of medication and other methods under medical supervision to reduce or eliminate the effects of substance abuse.

[2] Rehabilitation is designed to alter abusive behavior in patients once they are free of acute physical and mental complications.

[3] Includes treatment in one or more of the following: Outpatient department of a hospital, residential treatment center, organized outpatient clinic, day-night treatment center, or doctor's office. If benefits differed by location of treatment, doctor's office care was tabulated.

[4] Separate limitations indicate that drug abuse treatment benefits are more restrictive than benefits for other treatments. For example, if a plan limits inpatient rehabilitation care to 30 days per year, but the limit on inpatient care for any other type of illness is greater than 30 days per year, that plan contains separate limits. The total is less than the sum of the individual items because many plans had more than one type of limitation.

[5] Less than 0.5 percent.

[6] Coinsurance rate is lower than that applying to other medical services. In such cases, outpatient rehabilitation care is generally at a coinsurance rate of 50 percent.

NOTE: Because of rounding, sums of individual items may not equal totals. Where applicable, dash indicates no employees in this category.

# MENTAL HEALTH AND SUBSTANCE ABUSE: DATA ON CURRENT MARKET COVERAGE

## INPATIENT

HAY/HUGGINS 1993

Of 1,008 plans reporting, 84% report a separate maximum confinement limitation (days or dollars) for psychiatric inpatient care.

Of 546 plans reporting day limits, 61% use 30 or fewer days. (It is not clear what the status of the other 450 plans is.)

BLS MEDIUM AND LARGE FIRMS

81% of participants in plans are subject to separate limitations (days, dollars, lifetime) that are different from hospital coverage for other health problems. (1991)

Of plans using day limitations about 52% provided 31 or fewer days. (1989)

## OUTPATIENT - Mental Health

HAY / HUGGINS 1993

Of 973 respondents 39% use visit limits. 53% of those that use a visit limitation provide 30 or fewer visits.

Of 985 respondents, 74% use either annual dollar or lifetime maximums or both. Of those using dollar maximums, 39% use only annual, 20% use lifetime, and 41% use both. Of those with an annual dollar maximum 73% are for $2500 or less.

Of 963 plans reporting, 44% use a 50% coinsurance, 32% use 30% or less, and 22% have on coinsurance.

BLS MEDIUM AND LARGE FIRMS

95% of participants report limitations (either visits or dollars). (1991)

1989 BLS analysis found 48% provided 30 or fewer visits.

**SUBSTANCE ABUSE**

BLS Medium and Large Firms 1991 (except where noted)

All plans reported coverage for detoxification.

79% of plans reported coverage for inpatient rehabilitation and outpatient care (i.e., 21% do not provide coverage).

Inpatient rehabilitation - 10% report lifetime day limits, 14% report limits on number of treatments, 22% report lifetime dollar limits.

Analysis of 1989 data found that of those with rehabilitation limits 70% had 30 days.

Outpatient - 7% report lifetime day limits, 7% report limits on numbers of treatments, 24% report lifetime dollar limits.

Distribution of Utilization – Mental Health (5K).

Approximately 78% of people have inpatient stays 30 days or less. This compares to approximately 92% at 60 days or less.

Approximately 92% of people have 30 or fewer visits. If we look at those only seen by mental health or substance abuse specialists the number is 88%.

URGENT

**EXECUTIVE OFFICE OF THE PRESIDENT**
**OFFICE OF MANAGEMENT AND BUDGET**
**Washington, D.C. 20503**

**November 4, 1993**

**LEGISLATIVE REFERRAL MEMORANDUM**

**LRM #D-480**
**DRAFT #421**

TO: Legislative Liaison Officer -

COMMERCE - Michael A. Levitt - (202)482-3086 - 324
DEFENSE - Samuel T. Brick, Jr. - (703)697-1305 - 325
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VA - Robert Coy - (202)535-8113 - 229
CEA - Francine Obermiller - (202)395-5036 - 242
NEC - Sonyia Matthews - (202)456-6722 - 429
SBA

FROM: JANET R. FORSGREN (for) Janet R. Forsgren
Assistant Director for Legislative Reference

**OMB CONTACT: Robert PELLICCI (395-4871)**
**Secretary's line (for simple responses): 395-7362**

SUBJECT: HHS Proposed Testimony on EOP Draft Bill
Health Security Act of 1993

**DEADLINE: 10:00 A.M. November 5, 1993**

**COMMENTS: Hearing is before the Senate Committee on Labor and Human Resources on Monday, November 8, 1993.**

OMB requests the views of your agency on the above subject before advising on its relationship to the program of the President, in accordance with OMB Circular A-19.

**Please advise us if this item will affect direct spending or receipts for purposes of the the "Pay-As-You-Go" provisions of Title XIII of the Omnibus Budget Reconciliation Act of 1990.**

CC:
Nancy-Ann Min
Bob Boorstin
Jason Solomon
Jack Lew
Chris Jennings
Melanne Verveer
Greg Lawler
Ira Magaziner
Carolyn Gatz
Howard Paster
Clarissa Cerda
Joe Minarik
Bob Anderson
Randy Lyon
Bob Damus
Bill Dorotinsky
Jill Blickstein
Shannah Koss
Janet Forsgren

LRM #D-480

**RESPONSE TO LEGISLATIVE REFERRAL MEMORANDUM**

If your response to this request for views is **simple** (e.g., concur/no comment) we prefer that you respond by **faxing** us this response sheet. If the response is **simple** and you prefer to call, please **call the branch-wide line** shown below (NOT the analyst's line) to leave a message with a secretary.

You may **also respond** by (1) calling the analyst/attorney's direct line (you will be connected to voice mail if the analyst does not answer); (2) sending us a memo or letter; or (3) if you are an OASIS user in the Executive Office of the President, sending an E-mail message. Please **include** the LRM number shown above, and the **subject** shown below.

TO: Robert PELLICCI
Office of Management and Budget
Fax Number: (202) 395-6148
Analyst/Attorney's Direct Number: (202) 395-4871
Branch-Wide Line (to reach secretary): (202) 395-7362

FROM: _____ (Date)

_____ (Name)

_____ (Agency)

_____ (Telephone)

SUBJECT: HHS Proposed Testimony on EOP Draft Bill
Health Security Act of 1993

The following is the response of our agency to your request for views on the above-captioned subject:

_____ Concur

_____ No objection

_____ No comment

_____ See proposed edits on pages _____

_____ Other: _____

_____ FAX RETURN of _____ pages, attached to this response sheet

DRAFT

Testimony

for

Dr. Bernard Arons

Director, Center for Mental Health Services
Substance Abuse and Mental Health Services Administration
Public Health Service
Department of Health and Human Services

before

Senate Committee on Labor and Human Resources

november 8, 1993

DRAFT

Draft Testimony

Dr. Bernard Arons

Senate Committee on Labor and Human Resources

Monday, November 8, 1993

Good afternoon, Mr. Chairman, and Members of the Committee. I am Dr. Bernard Arons, a psychiatrist and the Acting Director of the Center for Mental Health Services, a part of the Substance Abuse and Mental Health Services Administration in the Public Health Service. Recently, it was my privilege to serve as the Chair of the Mental Health and Substance Abuse Working Cluster of the President's Task Force on National Health Care Reform.

I am pleased to be here today to discuss one of the most important aspects of the President's Health Security Plan -- the availability of coverage for all Americans for mental health and substance abuse treatment services. Mental illness and substance abuse disorders are common problems, affecting more than 50 million Americans this year. Estimates put the 1988 annual economic cost to society of mental illness and substance abuse at $273 billion, including direct care, lost productivity, social welfare and the criminal justice system.

<u>The Need for Mental Health Coverage in Health Care Reform</u>

Despite the obvious importance of including mental health and substance abuse services in health care reform, we must

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acknowledge that some have questioned this, believing that we cannot afford such coverage. There are several strong arguments for providing these services. First, we now have cost-effective treatments for mental health and substance abuse (MH/SA) disorders, and high rates of efficacy are being achieved across the spectrum of MH/SA diagnoses. For example, over 80 percent of individuals with depression respond to treatment. Second, mental illness and substance abuse often result in physical illness, inability to work, impaired relationships, and at times, crime and homelessness. Persons receiving MH/SA use less medical care and work more effectively. Thus, much of the savings thought to result from excluding MH/SA services are false, since additional, inappropriate medical care could result. Finally, MH/SA services already are part of health care delivery in the United States. Nearly all medium and large firms include some MH/SA coverage in their health insurance plans, and insurance coverage for MH/SA disorders is seen as an essential component of health insurance. Benefits for MH/SA disorders, as an integral part of a health insurance package, are a wise investment in America's future.

Problems with Existing Coverage

Although many health insurance plans provide coverage for mental illness and substance abuse, they often have serious flaws. Private insurance coverage of mental health and substance abuse care differs substantially in structure from general medical care. They discriminate between MH/SA care and general medical

care by limiting the number of visits or days of treatment, by establishing lifetime limits for MH/SA benefits, and by excluding preexisting conditions. Thus, even when plans cover such services, individuals may be effectively barred from needed treatment.

Limits on access to care have resulted in shifting both the responsibility and cost of care onto the public MH/SA system. For children and adolescents, the burden and cost of care also have been shifted to the child welfare, education, and juvenile justice systems. Even worse, sometimes these overburdened systems are not able to provide needed services, and the individual goes without treatment. Eventually, we all bear the cost of delays or gaps in service provision.

Another consequence of the current benefit structure has been the creation of excess inpatient capacity in many areas of the country, despite the fact that effective technologies exist for treating mental illness and substance abuse in community based settings. A comprehensive array of services, along with the flexibility to provide such services to individuals based upon medical necessity, produces better outcomes than those experienced with traditional benefits. There is also evidence that capitated approaches result in less costly provision of health care services. Increasingly, both the public and private sectors have been developing systems of care that emphasize these elements.

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The Health Security Plan

The President's Health Security Plan will emphasize these desirable elements and make mental health and subetance abuse services an integral part of a national system of health care. The President's proposal represents a meaningful improvement over today's typical insurance policy that covers only a narrow range of services, and that encourages expensive inpatient care over more cost-effective alternatives.

The mental health and substance abuse benefit proposed by the President meets the following goals:

- It ensures that all persons of all ages with mental and substance abuse disorders and their families have access to specialized services.

- It ensures that health plans have the flexibility to provide the appropriate types, mix, level, and duration of services for each individual consumer.

- It encourages the development and use of alternatives to hospitalization, to ensure that services are delivered in the least restrictive environment appropriate to the needs of the individual.

- It reduces the shifting of costs and responsibilities

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to the public sector and encourages the integration of the public and private delivery systems.

MH/SA Benefits Under the Plan

The President's benefit proposal covers services that are important both to reforming the system and to caring for Americans with mental or substance abuse disorders. Distinctly different from typical insurance policies of today, the proposal does not limit intensive treatment to inpatient coverage in hospitals, but broadens it to other residential settings and intensive nonresidential care, such as partial hospitalization and intensive day treatment programs. These services will discourage expensive inpatient hospital care and encourage community-based care. The benefit design also provides incentives for health plans to move to a managed benefit, and in fact requires all plans to have a comprehensive array of benefits.

Initially, for mental illness, up to 30 days per episode of hospitalization are covered per calendar year. An additional 30 days are available if they are determined to be required by a health care provider, for an annual aggregate limit of 60 days. For substance abuse, hospitalization is limited to medical detoxification associated with withdrawal from alcohol or drugs.

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To encourage cost-effective care, residential treatment may be substituted for hospitalization. These services include residential treatment centers, residential detoxification centers, crisis residential programs, mental health residential treatment programs, therapeutic family or group treatment homes, community residential treatment, or recovery centers for substance abuse.

Intensive nonresidential treatment will be offered as an alternative to inpatient or residential care. These services include partial hospitalization, day treatment, psychiatric rehabilitation, home-based services, ambulatory detoxification, and behavioral aide services. Intensive nonresidential treatment is covered as a substitution for inpatient care at the rate of two intensive nonresidential days for one inpatient day. This substitution option is available at the discretion of the health plan.

These treatments are provided only for the purpose of averting the need for, or as an alternative to, treatment in hospitals or residential inpatient settings; to facilitate the earlier discharge of an individual receiving inpatient or residential care; to restore the functioning of an individual receiving inpatient or residential care, to restore the functioning of an individual with a diagnosable mental or substance abuse disorder; or to assist the individual to develop the skill and gain access to the support services the individual needs to achieve the

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maximum level of functioning of the individual within the community.

Outpatient services are also available. These include screening and assessment, diagnosis, medical management, case management, crisis services and somatic treatment services. Initially, 30 visits each for both psychotherapy sessions and collateral services are covered annually. For psychotherapy sessions, there are 50% co-payments in the higher cost sharing plans and $25 per visit for the lower cost sharing plans. These co-payments and other expenses do not count toward annual out-of-pocket limit on cost sharing. Additional outpatient psychotherapy visits may be available, by exchanging, at a 1 to 4 rate, inpatient days for outpatient psychotherapy visits following the same copayment schedule as the first 30 visits.

For substance abuse, outpatient services include screening and assessment, diagnosis, medical management, substance abuse counseling and relapse prevention, crisis services, somatic treatment services, case management and collateral services. An individual may receive these outpatient substance abuse treatments by exchanging inpatient days for outpatient visits on a 1 to 4 basis.

Within 12 months after an individual receives residential or intensive nonresidential treatment, 30 visits in group therapy shall be covered for substance abuse counseling and relapse

prevention. For individuals who do not initially receive residential or intensive nonresidential treatment, group visits will be covered based on an exchange of one day of inpatient treatment for four visits.

Outpatient detoxification may be provided in conjunction with a treatment program. If the first detoxification treatment is unsuccessful, subsequent treatments are covered if the health plan determines there is a substantial chance of success.

Health plans may offer case management services if they determine an individual should receive such services. These services include those that assist individuals in gaining access to needed medical, social and educational services.

Copayments and limits on services are to be eliminated by January 1, 2001, at which time individuals may receive all medically necessary care, regardless of its type, scope or duration. At this time, expenses for intensive nonresidential and outpatient services will apply toward annual out-of-pocket limits. The proposal for comprehensive coverage in 2001 represents a dramatic step toward eliminating the historic discrimination against mental illness and substance abuse.

Summary

This Administration is committed to making mental health and

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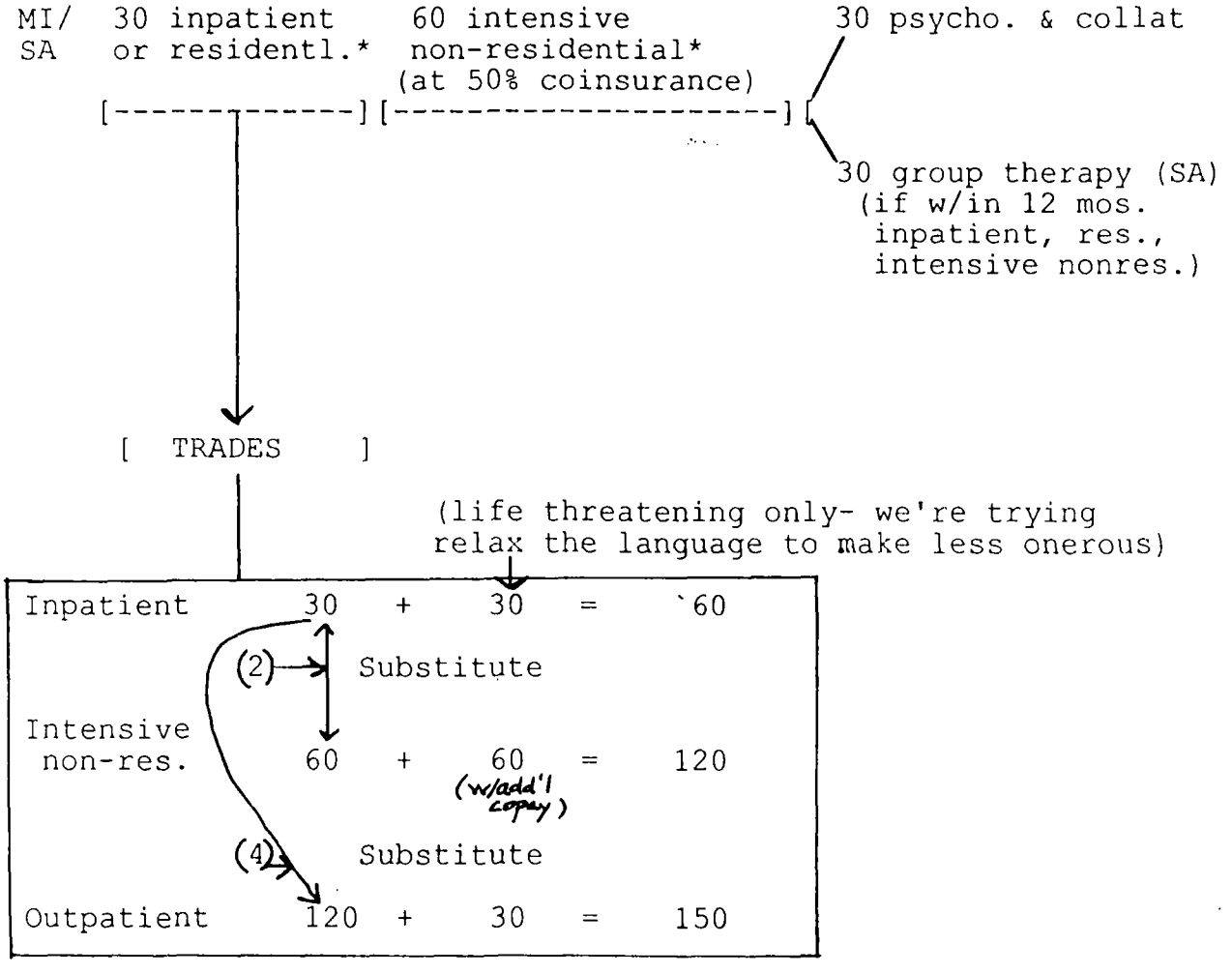
substance abuse services an integral part of a national system of health care. The President's benefit proposal represents a meaningful improvement from today's typical insurance policy that covers only a narrow range of services. And the 2001 benefit takes the essential step of eliminating the historic discrimination against mental illness and substance abuse. To meet this goal we must create a quality delivery system grounded in care management and collaboration between States and health plans to integrate public and private delivery and financing structures. We wish to work with you to make sure that we can meet this objective.

Thank you.

# MENTAL HEALTH AND SUBSTANCE ABUSE BENEFIT




* = Discretionary by plan who receives the service

Broadening range of treatment options

(*) A very imp thing we've done that is dev. innovative treatment options.

Med. man. for the severely ill — no day limits is treated the same as med. man. for any other health condition. Diagnostic and emergency/crisis services are handled similarly.

↓

Similar to emergency services in rest of plan

For ex. . . . partial hosp., home-based and beh. and services that are imp. to the treatment of seriously emot. disturbed children, case management.

covered services.

Health plans are encouraged to utilize the wide array of treatment options to provide individuals with a continuum of care -- that is appropriate for each individual's needs and cost effective for the plan -- by allowing substitution of inpatient and residential days for treatment in other settings. Thirty days of inpatient and residential treatment may be reduced by one day for every two days of intensive nonresidential treatment or by one day for every four outpatient visits for psychotherapy or substance abuse counseling and relapse prevention.

Beyond the services covered through substitution, ~~additional~~ treatments are covered to provide ongoing and appropriate support. A maximum of thirty additional inpatient or residential days are covered if a health professional designated by the health plan determines that the individual poses a threat to his own life or the life of another or if the individual's medical condition requires inpatient treatment in order to begin or adjust pharmacological or somatic therapy. There is considerable consensus around the need for inpatient or residential care in these circumstances. **BERNIE** A maximum of 60 additional days of intensive nonresidential treatment are available. In addition, 30 ~~additional~~ visits of psychotherapy and collateral services are covered each year, and 30 visits in group therapy are covered for substance abuse counseling and relapse prevention for individuals who have received inpatient, residential or intensive nonresidential treatment within 12 months.

Answers to Specific Questions Raised. In your letter, you asked for clarification on the following issues:

1. There are no deductibles in the lower cost sharing option.

2. The Act includes no provisions regarding means-testing for mental illness and substance abuse benefits.

3. Lower cost sharing plans do not require a copayment for the first 60 days of intensive nonresidential treatment for mental illness and substance abuse and do not require the payment of a one-day deductible. Higher cost sharing plans require the payment of 20% coinsurance for the first 60 days and the payment of a one-day deductible. Expenses for the first 60 days of intensive nonresidential mental illness treatment that an individual incurs prior to satisfying an applicable deductible and copayments and coinsurance may be applied toward the out-of-pocket limit on cost sharing.

4. The Act does not define the terms "somatic treatment services" or "somatic therapies", which are used in section 1115(c) and (e). These terms are not defined in the Act in order to accomodate changes in future technology and treatment patterns. **BERNIE???**

# DEPARTMENT OF HEALTH AND HUMAN SERVICES
## ASSISTANT SECRETARY FOR PLANNING AND EVALUATION
### OFFICE OF HEALTH POLICY

PHONE: (202) 690-6870 FAX: (202) 401-7321

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**Date:**

**From:** Sharman Stephens **To:** Jennifer Kline

**Phone:** (202) 690- _____ **Phone:** _____
(202) 690-6870
**FAX:** (202) 401-7321 **Fax:** _____

**Number of Pages (Including Cover):** 9

**Comments:**

## SUBSTANCE ABUSE COVERAGE AND THE HEALTH SECURITY ACT

Today's insurance market creates a number of barriers to substance abuse treatment and addiction recovery, and excludes many Americans with a history of substance abuse from buying fairly priced insurance.

- Fewer than one in five Americans have no insurance coverage for substance abuse inpatient rehabilitation or outpatient care.[1]

- The few who do have some coverage for substance abuse treatment face severe restrictions and limitations-- limits on how long and how often they can seek treatment, and how much that treatment can cost:

  - 1 in 10 have policies that limit the total number of days treatment is covered; so-called "lifetime limits"

  - 14% have limits on the number of treatments covered by insurance

  - 22% have lifetime dollar limitations, after which their insurance pays nothing for treatment.[2]

- And millions of Americans with a history of abuse find themselves locked out of the health insurance market; excluded due to "pre-existing conditions", dropped from coverage when they lose a job, or denied insurance altogether.

### The Health Security Act-- Comprehensive Coverage for All, Unprecedented Coverage of Substance Abuse Services

The Health Security Act provides comprehensive coverage for all Americans, ending the discrimination and exclusion that exists today. It provides broad-based coverage of substance abuse and mental health services, and broadens that coverage by the year 2001. At that time, when the benefit is fully-phased in, treatment of mental health and substance abuse with be parallel to coverage of other illnesses, with no day limits.

- The Health Security Act guarantees all Americans a comprehensive set of health benefits that can never be taken away, regardless of history of illness.

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[1]Bureau of Labor Statistics, 1991. Based on sampling of participants in large and medium health plans.

[2] Ibid.

- The comprehensive benefits package has no "lifetime limit" -- assuring that needed care will be covered throughout each person's lifetime, regardless of total cost.

- The mental health and substance abuse benefit is designed to promote individual tailoring based on need, and to cover a wide variety of settings for needed substance abuse services. The benefit covers:

  - 30 group therapy sessions for substance abuse treatment to build upon previous inpatient or residential care; AND

  - 30 days inpatient or residential treatment for mental illness or substance abuse treatment; OR

  - 60 days intensive non-residential treatment, such as care and counseling in home or community-based settings, including day hospital treatment programs; OR

  - 120 days of outpatient substance abuse services, such as counseling programs and relapse prevention programs.

  - Services designed to help remove barriers to treatment for substance abusers, including community outreach, transportation and translation services.

  Additional coverage for non-residential treatment is also covered, up to 60 additional days, with higher co-payments.

  Within this set of options, there is built-in flexibility to tailor a combination of treatment settings, for example drawing from each category listed above, so that care is as appropriate and responsive as possible for each episode, illness, or individual circumstance.

- In addition to substance abuse coverage through the comprehensive benefits package, the Health Security Act includes new school-based initiatives aimed at educating school children about substance abuse prevention, including tobacco and alcohol, and increased support for existing school-based programs such as the Prevention, Treatment, and Rehabilitation Model Projects for High-Risk Youth.

- The National Institutes of Health will be provided increased funding for medical and behavioral research projects, giving priority to substance abuse as a target for new research dollars.

Note to Jennifer Klein

From: Sharman Stephens

In response to your request I have given some thought to how the benefit package for mental illness and substance abuse might be simplified. From my perspective the simpliest approach would be to move to a straight 45 day inpatient, with a 2 for 1 trade on the intensive non-residential. I would also continue to allow the outpatient services to trade away only 30 days of inpatient, thus leaving a 15 day cushion for emergencies. I picked the 45 day interval because the actuaries priced the inpatient at halfway between 30 and 60.

I recognize that moving to a 45 day benefit can be criticized as cutting the 60 day benefit. However, I believe that the uncertainty around the 30/60 structure as now set up creates the potential for a lot of abuse on the part of health plans as well as the creation of an environment in which there will be considerable jockeying/fighting between health plans and state public mental health and substance abuse authorities -- with considerable time and effort wasted and not to the benefit of patients.

I frankly believe that in real implementation the 45 day, 2 for 1 approach creates a basic benefit that is better than under the current drafting.

cc. Ken Thorpe
Judy Feder

Note Bernie would prefer to have INR as is so that there is always a 15 day inpatient cushion. See attached.

1. Basic change is to use a straight 45 day inpatient benefit.

2. For intensive non-residential two possible approaches: (1) leave as currently drafted (60/60); or (2) do straight 2 for 1 trade so could get up to 90 days. Alternative (1) keeps 15 days of inpatient always available, but only has 60 days at parity cost sharing. Alternative (2) has larger number of days at parity cost sharing, but runs the risk of using up inpatient benefit.

3. Outpatient services leave as drafted so can trade up to 30 inpatient days, thus always leaving 15 days of inpatient available.

| **SERVICE** | **COVERAGE ALTERNATIVE 1** | **COVERAGE ALTERNATIVE 2** |
|---|---|---|
| Inpatient hospital and residential services | straight 45 days annual maximum | straight 45 days annual maximum |
| Intensive Nonresidential treatment | no change (so 60 through substitution, with additional 60) | straight 2 for 1 trade (i.e., up to a 90 day maximum) |
| Psychotherapy | no change (keep 30 visits with 4 for 1 trade up to 30 days of inpatient) | same as Alternative 1 |
| Substance abuse counseling | no change (keep 30 visits after care in other settings and current trade up to 30 inpatient days) | same as Alternative 1 |
| Other outpatient | no change | no change |

Changes on pages: alternative 2

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(j) CLINICIAN VISIT.—For purposes of this section, the term "clinician visit" includes the following health professional services (as defined in section 1112(c)):

(1) A complete medical history.

(2) An appropriate physical examination.

(3) Risk assessment.

(4) Targeted health advice and counseling, including nutrition counseling.

(5) The administration of age-appropriate immunizations and tests specified in subsections (b) through (h).

(k) IMMUNIZATIONS AND TESTS NOT ADMINISTERED DURING CLINICIAN VISIT.—Notwithstanding subsection (i)(5), the clinical preventive services described in this section include an immunization or test described in this section that is administered to an individual consistent with any periodicity schedule for the immunization or test during the age range specified for the immunization or test, and any administration fee for such immunization or test, even if the immunization or test is not administered during a clinician visit.

**SEC. 1115. MENTAL ILLNESS AND SUBSTANCE ABUSE SERVICES.**

(a) COVERAGE.—The mental illness and substance abuse services that are described in this section are the

following items and services for eligible individuals, as defined in section 1001(c), who satisfy the eligibility requirements in subsection (b):

(1) Inpatient and residential mental illness and substance abuse treatment (described in subsection (c)).

(2) Intensive nonresidential mental illness and substance abuse treatment (described in subsection (d)).

(3) Outpatient mental illness and substance abuse treatment (described in subsection (e)), including case management, screening and assessment, crisis services, and collateral services.

(b) ELIGIBILITY.—The eligibility requirements referred to in subsection (a) are as follows:

(1) INPATIENT, RESIDENTIAL, NONRESIDENTIAL, AND OUTPATIENT TREATMENT.—An eligible individual is eligible to receive coverage for inpatient and residential mental illness and substance abuse treatment, intensive nonresidential mental illness and substance abuse treatment, or outpatient mental illness and substance abuse treatment (except case management and collateral services) if the individual—

(A) has, or has had during the 1-year period preceding the date of such treatment, a diagnosable mental disorder or a diagnosable substance abuse disorder; and

(B) is experiencing, or is at significant risk of experiencing, functional impairment in family, work, school, or community activities.

For purposes of this paragraph, an individual who has a diagnosable mental disorder or a diagnosable substance abuse disorder, is receiving treatment for such disorder, but does not satisfy the functional impairment criterion in subparagraph (B) shall be treated as satisfying such criterion if the individual would satisfy such criterion without such treatment.

(2) CASE MANAGEMENT.—An eligible individual is eligible to receive coverage for case management if—

(A) a health professional designated by the health plan in which the individual is enrolled determines that the individual should receive such services; and

(B) the individual is eligible to receive coverage for, and is receiving, outpatient mental illness and substance abuse treatment with re-

spect to a diagnosable mental disorder or a diagnosable substance abuse disorder.

(3) SCREENING AND ASSESSMENT AND CRISIS SERVICES.—All eligible individuals enrolled under a health plan are eligible to receive coverage for outpatient mental illness and substance abuse treatment consisting of screening and assessment and crisis services.

(4) COLLATERAL SERVICES.—An eligible individual is eligible to receive coverage for outpatient mental illness and substance abuse treatment consisting of collateral services if the individual is a family member (described in section 1011(b)) of an individual who is receiving inpatient and residential mental illness and substance abuse treatment, intensive nonresidential mental illness and substance abuse treatment, or outpatient mental illness and substance abuse treatment.

(c) INPATIENT AND RESIDENTIAL TREATMENT.—

(1) DEFINITION.—For purposes of this subtitle, the term "inpatient and residential mental illness and substance abuse treatment" means the items and services described in paragraphs (1) through (3) of section 1861(b) of the Social Security Act when

provided with respect to a diagnosable mental disorder or a diagnosable substance abuse disorder to—

(A) an inpatient of a hospital, psychiatric hospital, residential treatment center, residential detoxification center, crisis residential program, or mental illness residential treatment program; or

(B) a resident of a therapeutic family or group treatment home or community residential treatment and recovery center for substance abuse.

The National Health Board shall specify those health professional services described in section 1112 that shall be treated as inpatient and residential mental illness and substance abuse treatment when provided to such an inpatient or resident.

(2) LIMITATIONS.—Coverage for inpatient and residential mental illness and substance abuse treatment is subject to the following limitations:

(A) RESIDENTIAL MENTAL ILLNESS TREATMENT.—Such treatment, when provided with respect to a diagnosable mental disorder in a setting that is not a hospital or a psychiatric hospital, is covered only to avert the need for, or as an alternative to, treatment in a hospital

or a psychiatric hospital, as determined by a health professional designated by the health plan in which the individual receiving such treatment is enrolled.

(B) RESIDENTIAL SUBSTANCE ABUSE TREATMENT.—Such treatment, when provided with respect to a diagnosable substance abuse disorder in a setting that is not a hospital or a psychiatric hospital, is covered only if a health professional designated by the health plan in which the individual receiving such treatment is enrolled determines (based on criteria that the plan may choose to employ) that the individual should receive such treatment.

(C) LEAST RESTRICTIVE SETTING.—Such treatment is covered only when—

(i) provided to an individual in the least restrictive inpatient or residential setting that is effective and appropriate for the individual; and

(ii) less restrictive intensive nonresidential or outpatient treatment would be ineffective or inappropriate.

(D) ANNUAL LIMIT.—Prior to January 1, 2001, such treatment is subject to an aggregate

annual limit of ~~30~~ days. ~~A maximum of 30 additional days of such treatment shall be covered for an individual if a health professional designated by the health plan in which the individual is enrolled determines in advance that—~~

~~(i) the individual poses a threat to his or her own life or the life of another individual; or~~

~~(ii) the medical condition of the individual requires inpatient treatment in a hospital or a psychiatric hospital in order to initiate, change, or adjust pharmacological or somatic therapy.~~

(E) INPATIENT HOSPITAL TREATMENT FOR SUBSTANCE ABUSE.—Such treatment, when provided in a hospital or a psychiatric hospital with respect to a diagnosable substance abuse disorder, is covered under this section only for detoxification requiring the management of psychiatric conditions associated with withdrawal from alcohol or drugs. The items and services described in this section do not include medical detoxification as required for the management of medical conditions associated

with withdrawal from alcohol or drugs (which is covered under section 1111).

(d) INTENSIVE NONRESIDENTIAL TREATMENT.—

(1) DEFINITION.—For purposes of this subtitle, the term "intensive nonresidential mental illness and substance abuse treatment" means diagnostic or therapeutic items or services provided with respect to a diagnosable mental disorder or a diagnosable substance abuse disorder to an individual—

(A) participating in a partial hospitalization program, a day treatment program, a psychiatric rehabilitation program, or an ambulatory detoxification program; or

(B) receiving home-based mental illness services or behavioral aide mental illness services.

The National Health Board shall specify those health professional services described in section 1112 that shall be treated as intensive nonresidential mental illness and substance abuse treatment when provided to such an individual.

(2) LIMITATIONS.—Coverage for intensive nonresidential mental illness and substance abuse treatment is subject to the following limitations:

(A) DISCRETION OF PLAN.—An individual shall receive coverage for such treatment if a health professional designated by the health plan in which the individual is enrolled determines (based on reasonable standards of medical practice criteria that the plan may choose to employ) that the individual should receive such treatment.

(B) TREATMENT PURPOSES.—Such treatment is covered only when provided—

(i) to avert the need for, or as an alternative to, treatment in residential or inpatient settings;

(ii) to facilitate the earlier discharge of an individual receiving inpatient or residential care;

(iii) to restore the functioning of an individual with a diagnosable mental disorder or a diagnosable substance abuse disorder; or

(iv) to assist such an individual to develop the skills and gain access to the support services the individual needs to achieve the maximum level of functioning of the individual within the community.

(C) ANNUAL LIMIT.—

change

Alternative 2

Alternative 1 would make no changes

(i) IN GENERAL.—Prior to January 1, 2001, the number of covered days of inpatient and residential mental illness and substance abuse treatment that are available to an individual under the ~~30~~ 45-day limit described in the first sentence of subsection (c)(2)(D) shall be reduced by 1 day for each 2 covered days of intensive nonresidential mental illness and substance abuse treatment that are provided to the individual, until such number is reduced to zero.

(ii) ADDITIONAL DAYS.—After the number of covered days referred to in clause (i) has been reduced to zero with respect to an individual, the individual shall receive coverage for a maximum of 60 days of intensive nonresidential mental illness and substance abuse treatment if a health professional designated by the health plan in which the individual is enrolled determines that the individual should receive such treatment.

(D) DETOXIFICATION.—Intensive nonresidential mental illness and substance

abuse treatment consisting of detoxification is covered only if it is provided in the context of a treatment program.

(E) OUT-OF-POCKET MAXIMUM.—Prior to January 1, 2001, expenses for intensive nonresidential mental illness and substance abuse treatment that an individual incurs prior to satisfying a deductible applicable to such treatment, and copayments and coinsurance paid by or on behalf of the individual for such treatment, may not be applied toward any annual out-of-pocket limit on cost sharing under any cost sharing schedule described in part 3 of this subtitle if such treatment is provided—

(i) with respect to a diagnosable substance abuse disorder; or

(ii) pursuant to subparagraph (C)(ii).

(e) OUTPATIENT TREATMENT.—

(1) DEFINITION.—For purposes of this subtitle, the term "outpatient mental illness and substance abuse treatment" means the following services provided with respect to a diagnosable mental disorder or a diagnosable substance abuse disorder in an outpatient setting:

(A) Screening and assessment.

(B) Diagnosis.

(C) Medical management.

(D) Substance abuse counseling and relapse prevention.

(E) Crisis services.

(F) Somatic treatment services.

(G) Psychotherapy.

(H) Case management.

(I) Collateral services.

(2) LIMITATIONS.—Coverage for outpatient mental illness and substance abuse treatment is subject to the following limitations:

(A) HEALTH PROFESSIONAL SERVICES.—Such treatment is covered only when it constitutes health professional services (as defined in section 1112(c)(2)), or when provided by a health facility that is legally authorized to provide the services in the State in which they are provided.

(B) DISCRETION OF PLAN.—An individual shall receive coverage for outpatient mental illness and substance abuse treatment consisting of substance abuse counseling and relapse prevention if a health professional designated by the health plan in which the individual is enrolled determines (based on reasonable standards of Medical Practice criteria that the plan may choose to employ) that the individual should receive such treatment. This subpara-

graph does not apply to group therapy covered pursuant to subparagraph (C)(ii)(II).

(C) ANNUAL LIMITS.—

(i) PSYCHOTHERAPY AND COLLATERAL SERVICES.—Prior to January 1, 2001, psychotherapy and collateral services are subject to an aggregate annual limit of 30 visits per individual. Additional visits may be covered, at the discretion of the health plan in which the individual receiving treatment is enrolled, to prevent hospitalization or to facilitate earlier hospital release, for which the number of covered days of inpatient and residential mental illness and substance abuse treatment that are available to an individual under the ~~30~~ 45-day limit described in the first sentence of subsection (c)(2)(D) shall be reduced by 1 day for each 4 visits. After such number has been reduced to ~~zero~~ 15, no additional visits under the preceding sentence may be covered.

(ii) SUBSTANCE ABUSE COUNSELING AND RELAPSE PREVENTION.—

(I) IN GENERAL.—Except as provided in subclause (II), the number of covered days of inpatient and residential mental illness and substance abuse treatment that are available to an individual under the ~~30~~ 45-day limit described in the first sentence of subsection (c)(2)(D) shall be reduced by 1 day for each 4 visits for substance abuse counseling and relapse prevention that are covered for the individual under subparagraph (B). After such number has been reduced to ~~zero~~ 15, no visits for substance abuse counseling and relapse prevention may be covered, except as provided in subclause (II).

(II) GROUP THERAPY.—Prior to January 1, 2001, substance abuse counseling and relapse prevention consisting of group therapy is subject to a separate aggregate annual limit of 30 visits, if such therapy occurs within 12 months after the individual has received, with respect to a diagnosable

substance abuse disorder, inpatient and residential mental illness and substance abuse treatment or intensive nonresidential mental illness and substance abuse treatment. The provisions of clause (i) and subclause (I) do not apply to therapy that is described in the preceding sentence.

(D) DETOXIFICATION.—Outpatient mental illness and substance abuse treatment consisting of detoxification is covered only if it is provided in the context of a treatment program.

(E) OUT-OF-POCKET MAXIMUM.—Prior to January 1, 2001, expenses for outpatient mental illness and substance abuse treatment that an individual incurs prior to satisfying a deductible applicable to such treatment, and copayments and coinsurance paid by or on behalf of the individual for such treatment, may not be applied toward any annual out-of-pocket limit on cost sharing under any cost sharing schedule described in part 3 of this subtitle.

(f) OTHER DEFINITIONS.—For purposes of this subtitle:

(1) CASE MANAGEMENT.—The term "case management" means services that assist individuals in gaining access to needed medical, social, educational, and other services.

(2) DIAGNOSABLE MENTAL DISORDER AND DIAGNOSABLE SUBSTANCE ABUSE DISORDER.—The terms "diagnosable mental disorder" and "diagnosable substance abuse disorder" mean a disorder that—

(A) is listed in the Diagnostic and Statistical Manual of Mental Disorders, Third Edition, Revised or a revised version of such manual (except V Codes for Conditions Not Attributable to a Mental Disorder That Are a Focus of Attention or Treatment);

(B) is the equivalent of a disorder described in subparagraph (A), but is listed in the International Classification of Diseases, 9th Revision, Clinical Modification, Third Edition or a revised version of such text; or

(C) is listed in any authoritative text specifying diagnostic criteria for mental disorders or substance abuse disorders that is identified by the National Health Board.

(3) PSYCHIATRIC HOSPITAL.—The term "psychiatric hospital" has the meaning given such term in section 1861(f) of the Social Security Act, except that such term shall include—

(A) in the case of an item or service provided to an individual whose applicable health plan is specified pursuant to section 1004(b)(1), a facility of the uniformed services under title 10, United States Code, that is engaged in providing services to inpatients that are equivalent to the services provided by a psychiatric hospital;

(B) in the case of an item or service provided to an individual whose applicable health plan is specified pursuant to section 1004(b)(2), a facility operated by the Department of Veterans Affairs that is engaged in providing services to inpatients that are equivalent to the services provided by a psychiatric hospital; and

(C) in the case of an item or service provided to an individual whose applicable health plan is specified pursuant to section 1004(b)(3), a facility operated by the Indian Health Service that is engaged in providing services to inpa-

tients that are equivalent to the services provided by a psychiatric hospital.

**SEC. 1116. FAMILY PLANNING SERVICES AND SERVICES FOR PREGNANT WOMEN.**

The services described in this section are the following items and services:

(1) Voluntary family planning services.

(2) Contraceptive devices that—

(A) may only be dispensed upon prescription; and

(B) are subject to approval by the Secretary of Health and Human Services under the Federal Food, Drug, and Cosmetic Act.

(3) Services for pregnant women.

**SEC. 1117. HOSPICE CARE.**

The hospice care described in this section is the items and services described in paragraph (1) of section 1861(dd) of the Social Security Act, as defined in paragraphs (2), (3), and (4)(A) of such section (with the exception of paragraph (2)(A)(iii)), except that all references to the Secretary of Health and Human Services in such paragraphs shall be treated as references to the National Health Board.

**SEC. 1133. HIGHER COST SHARING.**

(a) IN GENERAL.—The higher cost sharing schedule referred to in section 1131 that is offered by a health plan—

(1) shall have an annual individual general deductible of $200 and an annual family general deductible of $400 that apply with respect to expenses incurred for all items and services in the comprehensive benefit package except—

(A) an item or service with respect to which a separate individual deductible applies under paragraph (2), (3), or (4); or

(B) an item or service described in paragraph (5), (6), or (7) with respect to which a deductible does not apply;

(2) prior to January 1, 2001 shall require an individual to incur expenses during each episode of inpatient and residential mental illness and substance abuse treatment (described in section 1115(c)) equal to the cost of one day of such treatment before the plan provides benefits for such treatment to the individual;

(3) prior to January 1, 2001 shall require an individual to incur expenses during each episode of intensive nonresidential mental illness and substance abuse treatment (described in section 1115(d)) equal to the cost of one day of

such treatment before the plan provides benefits for such treatment to the individual;

(4) shall require an individual to incur expenses in a year for outpatient prescription drugs and biologicals (described in section 1122) equal to $250 before the plan provides benefits for such items to the individual;

(5) shall require an individual to incur expenses in a year for dental care described in section 1126, except the items and services for prevention and diagnosis of dental disease described in section 1126(a)(2), equal to $50 before the plan provides benefits for such care to the individual;

(6) may not require any deductible for clinical preventive services (described in section 1114);

(7) may not require any deductible for clinician visits and associated services related to prenatal care or 1 post-partum visit under section 1116;

(8) may not require any deductible for the items and services for prevention and diagnosis of dental disease described in section 1126(a)(2);

(9) shall have—

(A) an annual individual out-of-pocket limit on cost sharing of $1500; and

**Copayments and Coinsurance for Items and Services**—Continued

| Benefit | Section | Lower Cost Sharing Schedule | Higher Cost Sharing Schedule |
|---|---|---|---|
| Hospital emergency room services | 1111 | $25 per visit (unless patient has an emergency medical condition as defined in section 1867(e)(1) of the Social Security Act) | 20 percent of applicable payment rate |
| Services of health professionals | 1112 | $10 per visit | 20 percent of applicable payment rate |
| Emergency services other than hospital emergency room services | 1113 | $25 per visit (unless patient has an emergency medical condition as defined in section 1867(e)(1) of the Social Security Act) | 20 percent of applicable payment rate |
| Ambulatory medical and surgical services | 1113 | $10 per visit | 20 percent of applicable payment rate |
| Clinical preventive services | 1114 | No copayment | No coinsurance |
| Inpatient and residential mental illness and substance abuse treatment | 1115 | No copayment | 20 percent of applicable payment rate |
| Intensive nonresidential mental illness and substance abuse treatment (except treatment provided pursuant to section 1115(d)(2)(C)(ii)) | 1115 | No copayment | 20 percent of applicable payment rate |
| Intensive nonresidential mental illness and substance abuse treatment provided pursuant to section 1115(d)(2)(C)(ii) | 1115 | $25 per visit until January 1, 2001, and $10 per visit thereafter | 50 percent of applicable payment rate until January 1, 2001, and 20 percent thereafter |
| Outpatient mental illness and substance abuse treatment (except psychotherapy, collateral services, and case management) | 1115 | $10 per visit | 20 percent of applicable payment rate |
| Outpatient psychotherapy and collateral services | 1115 | $25 per visit until January 1, 2001, and $10 per visit thereafter | 50 percent of applicable payment rate until January 1, 2001, and 20 percent thereafter |