

**Testimony to the Assembly Committee on Health and Healthcare Reform
AB 512
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Thank you, Chairman Richards and members of the committee for holding this first ever public hearing in the Assembly on mental health and substance abuse (MH/SA) parity.

It sometimes seems that those of us advocating for MH/SA parity are held to an impossible standard: we need to prove that requiring coverage of these disorders that is no more restrictive than coverage of other medical conditions will not result in any increase in cost for the provision of these services. Of course, it will. The provision of any medical service costs money. If we held every service to this standard then the result would be that we simply would not pay for any health care services. Some people would argue that this is exactly the approach that some health insurers are trying to take.

The important question is whether the provision of that service is cost effective. Every study of actual implementation of MH/SA parity demonstrates that MH/SA treatment cost increases are modest at most. Additionally, we know from the Center for Disease Control and Prevention that unaddressed mental disorders increase the morbidity and costs to treat other chronic conditions such as diabetes and heart disease. And organizations such as the National Business Health Care group have endorsed findings that mental illness and substance abuse disorders are a major cause of absenteeism, lost productivity and increased disability costs for businesses. All these things suggest cost effectiveness.

But we are confronted with an accident of history: because our understanding of mental illnesses and substance abuse disorder came later than our understanding of other medical conditions MH/SA consumers and advocates have a higher bar to get over in “proving” the value of their services. Wouldn’t it be nice if we could just start over; if we could say based on what we know today which services are the most cost effective?

Well, fortunately we don’t have to do the math. The Oregon Health Plan has done that for us; and I believe it is instructive. The Oregon Legislature charged the Oregon Health Services Commission to rank medical services in a way that represents the comparative benefits (i.e., clinical effectiveness and cost-effectiveness) and the rank order them from most cost-effective to least cost effective. You can find the entire list at: <http://www.oregon.gov/DHS/healthplan/priorlist/main.shtml> Every year when the Oregon Legislature decides how much money to allocate for the health plan the analysts go down the list and decide how many of the conditions they can cover. Starting Oct. 1, 2009 they will cover 503 of the 680 conditions.

Here are some lines that speak to the relative value of MH/SA treatments:

Line 5 is Medical/Psychotherapy for Abuse or Dependence of Psychoactive Substance

The only treatments ahead of this are maternity care, newborn care, prevention services for birth-10 and prevention services for those over 10.

Line 9 is Medical/psychotherapy for Major Depression, Recurrent

Both of these come ahead of Medical Therapies for Type I Diabetes, Asthma and Hypertension, which are lines 10, 11 and 12, respectively.

So treatment for basic substance abuse or dependence and depression were found to be more cost effective than treatment for diabetes, asthma and heart disease. And yet who would even consider limiting the treatments for diabetes, asthma and heart disease?

Medical Psychotherapy for Schizophrenic Disorders is at line 27; and treatment for Bipolar Disorders is at line 32. These come ahead of treatment for Epilepsy (line 36), rheumatoid arthritis (line 52) and acute and subacute ischemic heart disease, myocardial infarction (76).

All of these are well above the cut line. There are mental health conditions for which the treatments currently fall below the cut line, as there are medical treatments below that line. But nothing prevents insurers from requiring medical necessity determinations for treatments of questionable value.

I think in summation the question I want to pose to the committee is this: given what we know about the cost effectiveness of treatments for MH/SA disorders, why wouldn't we want them covered in a manner no more restrictive than the coverage for other conditions?