

Minnesota Psychiatry in 2001

“It was the best of times, it was the worst of times,
it was the age of wisdom, it was the age of foolishness...”
Dickens (1859)

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ABSTRACT

The systems for financing the diagnosis and treatment of mental health and substance use disorders in Minnesota have evolved to discriminately reduce the percentage of each health care dollar spent on these disorders, much more so than the rest of the country. This paper traces the mechanisms and the extent of these reductions and presents options to restore a fair share of funding for those treatments. The reader is referred to “A Report on the 1999 Public Hearings on Adult and Children’s Mental Health” * and “A Critique of Minnesota’s Managed Mental Health Care” ** for further proof of its accuracy. Although some sections are cumbersome to the reader for their detail, the author deemed it important to document the evidence that supports the most important **final section** which describes **options for improvement**:

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Introduction

The Best of Times

In 2001, the economy of the state of Minnesota has been booming. Unemployment is low, incomes have been rising for a number of years, and interest rates remain low as does inflation. The managed care industry has assumed a greater and greater portion of responsibility for providing medical and mental health care to Minnesotans, and these programs are creating databases that provide information that is available only through such a system.²¹ Thus, the opportunity to learn more about disease processes and the most effective ways of managing or treating them has never been brighter. We already have good cost-benefit analyses of a number of medications and procedures.^{107, 182, 188} Psychopharmacology was named the “Science of the Century” by Science Magazine a few years ago, and in Minnesota we enjoy relatively few restrictions on the availability of psychotropic medications compared to other states. There are new psychotherapies that are proving to be more effective than the old forms, and the ability to learn about them has never been as great as with the advent of electronic information sharing.

We have new developments in the area of functional magnetic resonance imaging that promise to provide us with information as to how a patient’s brain is working without surgery, x-rays, painful diagnostic techniques, or lengthy trials on various medications. Already at several hospitals, it is possible to obtain a single photon emission computerized tomograph (SPECT) image of a working brain, indicating the presence of Alzheimer’s disease or other physical causes for psychiatric syndromes. Positron emission tomography (PET) also offers great promise in determining the function of the brain in the living human being. New genetic tests are available to predict the development of several psychiatric illnesses in symptom-free patients who have family histories of psychiatric disease. The use of quantitative EEG techniques has been refined, and with it we now have the ability to predict treatment response to specific medicines as well as help with diagnosis.

The market conditions for Minnesota psychiatrists have never been better. There are only about 500 clinical psychiatrists in our entire state, according to the Minnesota Psychiatric Society. Yet, there are over 160,000 Minnesotans who suffer with serious and persistent mental illness.¹⁰¹ In addition, 760,000 Minnesotans experience a diagnosable mental or substance abuse disorder in any six-month period. There is a tremendous demand for services from a small supply of providers. The percentage of graduating medical students who choose psychiatry has been generally declining for the last ten years as well, thus ensuring a continuation of this psychiatrist shortage. In 1990, according to the American Psychiatric Association, Minnesota was one of only two states with an adequate number of physicians (per capita) and also a shortage of psychiatrists. The most severe shortages are in the field of child psychiatry, where the demand from Minnesota families is growing rapidly. There are five full-time psychiatrist positions open in our state alone, and there are many other clinics and residential facilities across the region that are seeking psychiatric manpower.

The Worst Of Times

Despite these many reasons to be excited about the future of psychiatric care, there are also some very discouraging trends. As stated so well by Dr. Charles Meyer in 1989, “Mental health don’t get no respect. Mental health lacks respect from federal and state governments, managed care, non-psychiatric physicians, and the public.”⁹⁶ The average income of American psychiatrists has declined to the lowest of any specialty, and there has begun a “brain drain” from the profession. In one recent year, only one graduate from the medical schools of Harvard and Yale combined chose psychiatry as a career.

In part because of cutbacks in the funding of psychiatric care, the overall cost of health insurance did not increase much for many years in the late 1980’s and the early 1990’s. However, recent years have shown major increases in the rates for general health insurance in Minnesota. Despite this and radically altered mental health care delivery systems, it appears as if further decreases in care are still forthcoming.⁶⁶ Nationally, over 72% of Americans are enrolled in managed behavioral care organizations; 86 million people in 1993 and 177 million people in the year 2000. Mental health and substance abuse (MH/SA) benefits have been carved out from most general medical plans, and there has been a consolidation of mental health care to just a few large managed behavioral health care organizations. 58% of these Americans are covered by the top three behavioral healthcare providers,¹¹² and 85% by the top 11. **In Minnesota, consolidation has reached an extreme** with 96% of HMO enrollment held by the three largest plans, and revenues are going up (see Figures 1 & 2).

“The pendulum has swung too far towards mindless cost-cutting without a full evaluation of the impact of such changes on the overall quality of care that patients receive,” Dr. F.A. Manian reports in a recent issue of the *New England Journal of Medicine*.⁸³ The backlash against managed care is growing stronger recently as well, probably in response to perceived decreases in quality by patients and providers both.¹³⁶ As noted by the Minnesota Psychiatric Society in its 1987 white paper on the quality of psychiatric care:¹⁰¹ “Our state, with a long tradition of quality health care and enlightened mental health treatment, has been accused of having a ‘non-system’ for mental health services. We rank low (38th) among the 50 states in providing effective mental health treatment.” Currently, the insurance industry is characterized by its ability to charge and collect for services, pass through its capital costs, and skim off profitable patients - and at the same time to shun its proportionate responsibility for the medically indigent, the chronically ill, the costs of medical education and research, and for meeting community needs.³² As one of the leading neurologists in the Twin Cities noted, “Only the bottom line counts to insurance companies. I would say that almost never is it an enjoyable, satisfying experience working with them.”¹⁵⁰

Mental illness is widespread and at times difficult to treat. Probably no one expects insurance companies to fully cover all 300 psychiatric disorders for all patients. About one-half of these disorders can be handled by non-medical strategies. However, four of the ten leading causes for disability in persons age five and older are mental disorders.¹⁵¹ These are common illnesses. There is a great mythology that MH/SA care is expensive and time-consuming. In reality, eighteen Minnesotans can be provided a 20-session psychotherapy with a doctor for the same

amount of money as is spent on terminal care for the average Minnesotan. The majority of patients with MH/SA illnesses can lead productive, full lives with adequate treatment. This paper will show that the limitations in the funding of MH/SA disorders in Minnesota have become too extreme to be sensible or ethical, and that it is time to restore this vital part of our healthcare system.

Insurance Strategies to Limit Expenditures for MH/SA Treatments

Prepaid group health care began in the 1940's as an insurgent, even radical form of medicine. At the time, few Minnesotans had health insurance. These early programs would later be called group or staff models - closed systems with salaried doctors and an emphasis on prevention. The members of such plans sacrificed freedom of choice of provider for the security and continuity of care offered by these plans. The doctors sacrificed independent, fee-for-service practice for a stable salary, a collegial setting, less after-hours call, and a social mission to limit health care expenditures. Such plans were fiercely resisted by organized medicine at the time, which believed these plans to be socialistic.

The shift in prepaid group health care from an insurgent social movement to a very entrepreneurial and occasionally ruthless part of the health care system represents a stunning reversal. The turning point was in the early 1970's, when then President Richard Nixon renamed prepaid group health care as Health Maintenance Organizations (HMO's), with legislation that provided for federal endorsement, certification, and assistance. Generally, organized medicine has continued to oppose HMO's as representing corporate meddling by non-clinicians. Cost management has been driven over the years jointly by the demands of payers (employers and governments) for lower prices and the response of entrepreneurs trying to gain a larger market share by providing an acceptable product at a lower price. With the huge amounts of money involved in providing health care to Americans, it is understandable that every reduction in expenditures produces profits very quickly, and it is understandable why the creativity of health care managers has been impressive.

➤ Limiting Inpatient Utilization

Since **inpatient** psychiatric and substance abuse care is the most expensive, early efforts addressed the propriety of using the hospital to treat mild and moderate disorders. Admission criteria were first developed by Blue Cross/Blue Shield of Minnesota and by the Foundation For Health Care Evaluation in the late 1970's. At that point, the average length of a psychiatric hospitalization was over 30 days and standard inpatient chemical dependency treatment was 28 days. These treatment programs involved routine diagnostic testing, individual and group psychotherapy, specialized treatment programs for different diagnoses, and family education and therapy. Planning and arrangement for an appropriate level of care following discharge occupied a significant part of these inpatient stays.¹⁰¹ In 1981, Blue Cross/Blue Shield launched its Effective Care '81 program to monitor the appropriateness and cost of inpatient care. In 1983, the Department of Human Services in Minnesota contracted with Blue Cross/Blue Shield to be its medical review agent for Medicaid community-based psychiatric programs, and utilization review criteria were adopted for this project. In 1984, the Minnesota legislature adopted the Diagnosis Related Group (DRG) system for Medicaid inpatient treatments, with limits of inpatient stay being reduced to less than 14 days. The DRG limits were criticized by psychiatrists nationwide as being too short, as they were based on the average length-of-stay at a hospital that provided crisis services rather than treatment. At that time, however, the criteria that were acceptable to justify an inpatient psychiatric hospitalization filled two pages, and

included not only danger to self and danger to others but also a situation where a person was “out of control”, or unable to care for him/herself due to over a dozen different symptom pictures.⁹⁵ By the mid 1980's, competitors to Blue Cross/Blue Shield were clearly emerging. Physicians Health Plan and Share were formed, and mental health and substance abuse care was carved out to a newly-formed company, the Metropolitan Clinics of Counseling (MCC). They hired some of the finest clinicians from various treatment programs in the Twin Cities metropolitan area, and patient loads per clinician were increased. “Talk therapy” was assigned to non-M.D. providers and the psychiatrists in the program were primarily responsible for medication management and consultation with staff. Yearly quotas on inpatient days were created, and the staff at MCC were apprised when their “quota” for the year was up. In 1987, this inpatient quota was exhausted by the first half of November, and we as review staff were told to discourage psychiatric admissions from that point until the end of the year. Similar criteria were applied to substance abuse treatments. Inpatient days spent on preparing for discharge were disallowed, as were extensions of stay to complete individual, family, or group psychotherapy. Over the next decade, admission criteria had been reduced to acutely dangerous situations primarily, and discharges are expected as soon as the imminent danger has been resolved. Today, the average length of stay for psychiatric admissions is less than 10 days in most hospital settings.

Approximately three dozen Minnesota psychiatrists participated in the creation and implementation of these review strategies, myself included. To my knowledge, none of the insurers conducted any prospective research demonstrating that a reduction of hospital treatment was an effective strategy for long-term outcome of the patients involved. In 1987 Blue Cross/Blue Shield hired a psychiatrist-led company to manage inpatient hospitalizations for psychiatry. This group was offered financial incentives for reducing the number of inpatient days per 1000 policyholders. The physicians involved have since admitted that it was probably unethical to engage in such a contract, and have reassured the psychiatric society that such incentives are no longer involved in their continuing work with Blue Cross/Blue Shield. It appears that such strategies have evolved to the point where tragedies involving the seriously mentally ill are increasing in Minnesota, and there is evidence for similar mortality increases due to similar inappropriate denial of services in other states.^{65, 178} The Minnesota Psychiatric Society recommended in 1987 that a number of permanently funded, forensically specialized, involuntary psychiatric emergency beds be maintained in the state; a recommendation that if followed may have prevented the many recent deaths in our state due to mismanaged mental illness.¹⁰¹

➤ **Limiting Outpatient Utilization**

Management of **outpatient** mental health procedures also developed in the mid 1980's. Some insurance companies required prior authorization for any psychiatric care, and primary care physicians were designated as “gatekeepers” to the referrals for specialty treatment. Approval for psychiatrist-ordered laboratory testing by the gatekeeper was usually required. Some insurers required prior authorization even for psychological testing, the more specific “lab tests” of the psychiatrist. The extra time taken in creating the different authorization forms and trying to reach insurers by telephone created such a sheer number and variety of road blocks for service providers that one must conclude that there has been a consistent pattern that suppresses the use of psychiatric services.¹¹⁶ Currently, most insurers will allow 10 “visits” per year to a

psychiatrist without prior authorization, a concession that assuaged many psychiatric activists of the 1980's. These 10 "visits" include not only doctor-patient sessions but also meetings with patients' families, consultation with other professionals, and psychological tests. The best research of outpatient psychotherapy, however, suggests that 16 to 30 psychotherapy sessions alone are necessary for reasonable results ¹⁶¹.

➤ **Use of Formularies**

Another strategy is to offer less expensive medications to policyholders and not more expensive ones. Not infrequently, physicians are forced to prescribe second- or third- choice medications, usually having more side effects and risks to the patient, because the best are not covered by a certain insurance policy and most patients cannot afford the more expensive medications.⁵⁹ This leads patients to go off their medicine prematurely, resulting in relapse and more inpatient treatment days.

➤ **Use of Carve-outs**

The use of mental health/substance abuse carve-outs in Minnesota is the rule. The several carve-out companies here subcontract with insurers to provide mental health and substance abuse services to their policyholders. By the year 1983, only 10% of 300 private sector health insurance plans surveyed nationally provided outpatient psychiatric benefits on the same basis as other medical services ¹⁰¹. Approximately half of the states, including Minnesota, use carve-out programs.¹²⁰ However, even those states that use "carve-in" programs still evidence discrimination in the administration of health care benefits for mental health and substance abuse. Although the use of carve-out programs will frequently increase use of behavioral health care services, and clearly reduce the long-term costs,^{49, 52} it appears that the use of substance abuse services decreases.¹⁶⁵ There is also growing evidence that the "split treatment" by a psychotherapist and a psychiatrist has become the rule nationally,²⁸ without scientific evidence that this is a more effective or efficient treatment model.

The collegial relationship between psychiatrists and other physicians is frequently harmed by the carveout practice. Splitting off psychiatrists from other physicians limits evolution of effective treatments available to all physicians, since the skills and treatments that are used by primary care physicians were developed and refined by the specialists and then passed on for wider use.¹ In a survey of nearly 1000 Minnesota physicians, almost 20% said that they were denied permission to refer certain patients for mental health services in 1996. That same year, two large Minnesota HMO's said that most of their mental health patients received only one to three sessions of outpatient psychotherapy and rarely more than ten sessions. It appears as if the number of patients served is higher in carve-out plans, but the utilization of sufficient treatments to do a good job is decreased.¹⁴⁶

One common strategy insurers use to enforce carveouts is to deny payment of psychiatric procedures to primary care physicians, and to deny payment of general medical procedures to psychiatrists. This leads to frustrating delays in collections and mislabeling of the procedures performed with a patient. Psychiatrists are licensed to practice medicine and surgery, and should be able to do this in Minnesota without being forced to commit billing fraud in order to get paid.

A good example can be found in the diagnosis and treatment of Alzheimer's disease, which can be done skillfully by psychiatrists, neurologists, internists, and family practitioners. Insurance plans usually reimburse these services at different rates and with different procedure codes for psychiatrists.

➤ **Putting a Cap on Benefits**

Many insurers in the 1980's began to limit the annual benefits for psychiatric and substance abuse treatments. The Minnesota Care insurance system placed an arbitrary and discriminatory \$10,000 limit on psychiatric benefits per year. A 1999 survey by 577 employer-sponsored plans nationally showed that approximately 35% still imposed a lifetime limit on outpatient MH/DA expenditures.¹⁴⁶ In 1985, the Medicare limit on outpatient psychotherapy was only \$250 per year. Although today there is no such limit, reimbursement for mental health and substance abuse services under Medicare is only 50% of the usual and customary charges **of 1989**, whereas it remains 80% for the rest of medicine. Certainly many people at the mild end of the illness spectrum do not require professional help, and it does make sense to have limits for the milder conditions. However, insurance strategies seldom, if ever, offer different limits to patients with more severe disorders¹⁴⁹.

➤ **Use of Capitation**

Capitation has recently become a more popular payment method for provider contracts. It is advertised by the health care industry as "aligning incentives among physicians, protecting individual physicians from their colleague's less efficient practice patterns, and allowing physicians to share in the rewards of their own clinical effectiveness."³⁸ This method provides an up-front, regular income for ailing independent physician associations, physician-hospital organizations, health plans, and other risk-bearing entities. It appears as if this change in contracting can produce a 25% reduction in mental health visits per episode.¹⁴² In Minnesota, we have heard of capitation agreements that will reimburse for about four sessions per patient referral. Under capitated agreements, physicians are noted to use more medications, and clinicians at risk will generally tap into collateral services that are less costly such as self-help programs, community mental health centers, and charities.⁶⁹ There are concerns that such a system discriminates against persons with schizophrenia, dementia, and other chronic disorders.^{69, 185, 191} There is evidence of a devastating impact of these cost-shifting practices on state, county, and local mental health systems.⁹⁷

➤ **Summary**

The use of such labor-intensive utilization review procedures for mental health and substance abuse is expensive. It is estimated that administrative costs in the United States are 60% higher than those in Canada and 97% higher than in Britain.¹⁸⁹ Federal agencies have expressed a need to curb the administrative costs for managed care organizations.¹⁶² In Minnesota, it is estimated that between 2% and 3% of our health care dollars are spent providing MH/SA services to patients, and that 1.2% of our health care dollars are spent in managing the administration of this money.¹⁰⁰ In other words, **over 40% of private insurance dollars dedicated to MH/SA in Minnesota are spent on administration rather than services.** This appreciable amount of

administrative money is enough to attract physicians into the management and utilization review processes. This creates conflicts of interest by its very nature, and certainly leaves scientific evidence behind as a valuable tool in designing mental health and substance abuse health care delivery systems.^{82, 98}

Protection of physicians who accept responsibility for utilization review has been offered by the recent Supreme Court decision, *Pegram v. Herdich*.¹¹⁹ However, the American Psychiatric Association has established a policy that encourages medical liability for treatment decisions made by an insurer and its physician consultants,³ recognizing that patient care can be abusively constrained by these decisions. There is a growing movement among physicians towards improving the quality of care by making utilization review a formal medical practice, susceptible to research, ethical standards, and malpractice processes.¹⁷⁴ There are over 76 licensed utilization review companies in Minnesota.⁸ The secrecy of their involvement in the delivery of MH/SA care in Minnesota has always been high, with evidence of a dramatic reluctance to disclose utilization review criteria and techniques.¹⁸⁸

Mental Health And Substance Abuse Expenditures Are Declining

The strategies outlined above have been quite successful in reducing the relative cost of diagnosing and treating mental illnesses and substance abuse disorders in the United States, particularly in Minnesota. This health care reform has had a profound effect on the way psychiatric treatment occurs. Decreasing inpatient lengths of stay, increasing acuity, and reduced staff levels are making traditional approaches to mental health care infeasible.^{18, 19, 90} Substance abuse treatment programs in both urban and rural areas are under unprecedented pressure to adapt to reduced governmental funding, diminished entitlement program resources, and managed care reforms. Some say the most difficult task of a professional in these areas is to accept the continuing unmet need for services.¹³² What has not been researched is whether patients with MH/SA disorders are doing as well today as they were 20 years ago, before this reform.

Between 1980 and 1984, the value of coverage for nervous and mental illness began to decline, by as much as 60%.⁶³ In 1987, the Minnesota Psychiatric Society concluded that the percentage of health care dollars devoted to the treatment of these disorders in Minnesota ranged between 7% and 10% in the early 1980's, and that by 1987 that percentage had been reduced to 3% of total healthcare allocations "despite the fact that 20% of the population needs such treatment every year."¹⁰¹

Private insurance claims were analyzed from a national study group of 3.9 million privately insured individuals from 1993 to 1995 in a large study conducted by the Veteran's Administration, Mental Illness Research, Education, and Clinical Center in West Haven, Connecticut. Inpatient mental health costs fell 30.4% over that period, driven primarily by decreases in hospital days per patient year. Outpatient mental health costs also declined over that period, falling 13.6% for patients also using inpatient services and 14.6% for patients receiving only outpatient care. Those persons whose primary diagnosis was mild to moderate depression saw the largest decreases in inpatient cost per patient (42.8%); those diagnosed with schizophrenia experienced the smallest decrease (23.5%). For patients using outpatient services only, those diagnosed with substance abuse experienced the largest decrease in costs (23.5%); those diagnosed with schizophrenia experienced the smallest decrease (8.6%). **Declines in inpatient service use were not accompanied by increases in outpatient service use, even for severely ill patients requiring hospitalization.** The authors conclude that, "Managed care has not caused a shift in the pattern of care but an overall reduction in care."⁷⁸

On a national basis, it appears as if the cutbacks in mental health and substance abuse coverage have been less dramatic than in Minnesota. Between 1986 and 1996, a major study found that expenditures for mental health and substance abuse treatment declined from 9% of total health care spending to 8.1%. In 1996, the amount spent nationally on health care was \$943 billion. A total of \$79.3 billion was spent on mental health and substance abuse: \$66.7 billion for treatment of mental illness, \$5 billion for treatment of alcohol dependence, and \$7.6 billion for treatment of other substance use disorders. In Minnesota, by contrast, the Minnesota Council On Health Plans found that in 1996 only 2.1% of health care expenditures by the three major insurers in Minnesota was spent on mental health and substance abuse disorders. Indeed, 2.4% was spent

on dental care, and an estimated 38.4% on total administration costs!^{99, 100} The 2.1% figure is also small compared to the 9% spent on mental health by large employers in 1989.^{15, 100} More recently, the National Association Of Psychiatric Health Systems - Hay Group found that from 1988 to 1997 the total value of health care benefits for over 1,000 large U.S. employers had declined by 10%; general health care benefits declined by 7%, but **behavioral health benefits declined by 54%**. As a proportion of total health benefit costs, behavioral health benefits decreased from 6% to 3% during that period.¹²⁸ This same study found that between 1993 and 1996, the use of outpatient behavioral health services dropped 25%, but use of outpatient general health services increased 27%. Inpatient psychiatric admissions between 1991 and 1996 declined by 36%, compared with a 13% decline for general health admissions during that same period. Mental Health Economics reported in September of 1999, "Despite the robust economy of the past five years, and the growing awareness of disparity between mental health care benefits and general health care coverage, the value of employer-provided mental health care benefits has declined by over 50% since 1988."⁹⁴

In July of 2000, the results of an ongoing study to track spending on mental health and substance abuse treatment nationwide were published. Data has been gathered from the years 1987 through 1997. During this time, spending on mental health and substance abuse grew on the average of 6.8% per year while national health expenditures as a whole grew by 8.2%. These figures represent total expenditures, from both public and private sources. **The percentage of mental health and substance abuse treatment provided by public funds has increased substantially whereas the percentage provided by private insurers has decreased substantially.**¹⁸ The results of this study led Bernard Arons, M.D., Director of the Federal Center for Mental Health Services, to comment, "This study provides us with the documentation to show that disparities exist in health care spending. This is indefensible because mental health services have been shown to be as effective as other types of health care available to American citizens," Psychiatric News, August 18, 2000. Dr. Arons points out that the public sector spent more on mental health and substance abuse treatment than did the private sector in 1997. The reverse is true for other types of health care treatment. Numerically, 82 billion dollars was spent on mental health and substance abuse versus over 1 trillion dollars for total health care expenditures. These findings led Dr. Mady Chalk, Director of the Office of Managed Care in the Center for Substance Abuse Treatment to state, "If these trends continue, the market share for mental health and substance abuse treatment will continue to decline. These are the most limited and restricted benefits in the private sector," Reuters Health, July 19, 2000. This same source suggested that the efforts of managed care to decrease the amount of spending in the area of mental health and substance abuse has led to a 3.4% decline per year in the cost of health insurance premiums in and of itself. However, the increase of expenditures for general health care when mental health and substance abuse treatment is neglected is, as we shall see, substantially more.

Important Mental Health/Substance Abuse Services Have Been Cut Back In Minnesota

Despite the efforts of the Minnesota Psychiatric Society in 1987,¹⁰¹ funding for both inpatient and outpatient psychiatric treatment from private insurance markedly decreased during the 1990's. Some of these cutbacks were necessary in cases where the cost effectiveness of hospitalization was low. The denial of patient care on the basis of "medical necessity" emerged as the cornerstone of utilization review by most Minnesota insurers.^{9, 46} Treatments that could be provided outside of the hospital, or in a day hospital format, were denied for inpatient coverage. Many psychiatric hospitals and general hospital psychiatric units closed, most of them in the metropolitan area and the state hospital system (as the state of Minnesota has appeared eager to reduce its large psychiatric hospital expenses). The only new psychiatric units built recently have been in the state prison system and also the Anoka Metro Regional Treatment Center, although at AMRTC they did close more beds in the 1990's than they built. Although exact figures are unknown, it is likely that funding for psychiatric hospitalization was at least cut in half over the last 15 years.⁴⁵ Lengths of stay have been cut 66%, and the number of discharges has increased. Specialty inpatient psychiatric and substance abuse treatments have been lost: behavior therapy units, eating disorder units, sexual disorder treatment units, family disorder treatment units, and numerous adolescent and child inpatient programs. Even the Wilson Center for children and adolescents in Faribault will close at the end of February, 2001.

Certainly the dollars spent previously on inpatient treatments have not moved over to outpatient psychiatric care. Although exact figures are not available readily, declines in outpatient funding of about 15% over the past five years are likely in Minnesota⁴⁵. The number of outpatient psychotherapy sessions covered by Minnesota insurers has declined from unlimited prior to the 1980's to 50 sessions, and now down to 30 sessions. The 30 session minimum limits have been mandated for HMO's by the state of Minnesota. Since patients who are discharged after short hospitalizations are more symptomatic,⁶ the reduction in outpatient funding magnifies the stress on outpatient teams and practitioners.

Income generated by academic psychiatrists and their residents has been affected by insurance protocols as well. Medicare requires that the professor sit in on each therapy session with the resident, rather than allow billing to be paid for work provided by the residents independently, as had been the case before. There is no evidence that this level of mandated supervision improves patient care or the training the resident receives. In fact, the director of residency training in the Department of Psychiatry at the University of Minnesota says that the independence and confidence of the resident is stunted by this practice. A resident psychiatrist is a fully licensed physician, with a strong interest in psychiatry, and with ongoing education and supervision by professors of the medical school involved. The requirement of this time-intensive supervision has led residency programs to reduce the care they provide not only to Medicare recipients but also to most other outpatients. It has reduced the time available to those professors for teaching and research. Private managed care companies provide little funding for psychiatric education and research.³⁵ Also, insurers have refused to refer patients to the faculty of the University of Minnesota as a whole, instead limiting referrals to those doctors who have short average hospital

stays. This limits the number of inpatients and professors from which a psychiatric resident can learn.

The growth of managed care and the possibility of biased enrollment and dis-enrollment rates have raised concerns about cost shifting. A large study by the RAND Corporation last year analyzed more than 250,000 policyholders working for 11 large employers. When an employee is judged on job performance for continuing medical coverage, the dis-enrollment rate increases. Patients with substance abuse problems or severe psychiatric disorders are significantly more likely to dis-enroll than patients with less severe problems.⁵³ We have seen a number of cases in Minnesota where behaviorally difficult adolescents have been referred by insurers to the correctional system, religious and other charity support services, or self-help groups. Often these referrals occur by default when a patient rapidly exhausts the limits of their insurance contract.

The rate of civil commitment in the Twin Cities metropolitan area has skyrocketed during the decade of the 90's, with the total number of commitments doubling from 1987 to 1994 (see Figure 3).¹⁴ In the face of closure of many psychiatric and substance abuse inpatient beds, most probate courts in the metropolitan area have stopped committing persons who are unable to care for themselves because of mental illness. An imminent dangerousness criterion has been adopted by most of these courts. Dangerousness frequently has been associated with homicidality and suicidality only, to the exclusion of persons whose health, welfare, and destiny are clearly damaged by untreated mental illness and/or substance abuse. This can frequently lead to loss of employment and more dependence upon public maintenance and treatment systems. We have seen increases in the public efforts to expand commitment criteria to involve early intervention and outpatient commitment as a strategy to help those Minnesotans who are actively ill and who do not realize this, so they may receive care and ideally forestall the huge losses in occupational, family, and personal life that can occur with untreated mental illness. "There has been, during the last couple of decades, a kind of unwitting conspiracy between civil libertarians and conservative politicians concerned about the budgets of their states. What has happened is that laws raise the threshold for involuntary hospitalization so that mental health crisis teams have their hands tied," says Dr. Robert Lieberman of the UCLA Medical School and Director of the UCLA Center For Research on Treatment and Rehabilitation of Psychosis.⁵⁴ He goes on to describe a "wilting of state responsibility" to "pony up the money for services or oversight" of mental health or substance abuse systems. Dr. Richard Lamb, Professor of Psychiatry at the University of Southern California, notes, "**A place to take the mentally ill would be nice, but it would also be nice if they had a place that would keep them for a while... Jails are now the mental health care facilities of last resort**".⁵⁴

There are few psychiatrists in my experience who would argue that there was never any need to manage the care of psychiatric patients. Some of the limitations imposed by the managed care process have been favorable to our overall health economy, and even to certain groups of patients who develop dependency on psychiatric hospitals or outpatient delivery systems. However, there are even fewer psychiatrists who would currently argue that all of these cutbacks have been justifiable. **We have not been presented with scientific evidence that the reduction in care provided has been safe and effective for our patients. I think that all psychiatrists would argue that any further cutbacks would constitute abandonment of those Minnesotans who are mentally ill or substance-dependent.**

Growing Evidence of Deteriorating Care Is Gathering

Although managed care strategies have taken a foothold over the past 20 years, their impact is being realized more and more over the past three years. The Nobel Peace Laureate, Bernard Lown, M.D., notes, in 1999, “Never before have I encountered such a breakdown in the system of medical care, such a dismissiveness of human values, such a disdain for ethical principles. We cannot permit bankers and insurance executives, who know nothing of medicine, to determine the future of health care. I aim to enlighten and mobilize our colleagues, our patients, and the large public in order to stop this corrupt tide and bring back sanity, accountability, and human values to health care”.⁸¹ A number of authors and editors have reached similar conclusions.^{12, 16, 41, 91, 129, 164} Increases in mortality rate,¹⁵⁴ less thorough care of cardiovascular disease (Reuters, November 15, 2000), and less careful obstetrical standards¹⁷⁵ have been reported. A University of Connecticut survey of 700 physicians in that state revealed nearly nine out of ten doctors feel that medical care in the United States is worse under managed care than the fee-for-service system. 26% of these physicians said that they were personally aware of a patient who died after an HMO refused to authorize treatment that a doctor recommended (Associated Press, October 23, 2000). In 1993, a survey done by the Kaiser Foundation in California and reported by the Harvard School of Public Health in Boston revealed that 48% of nurses conclude that a managed care denial had harmed one of their patients. An equal number of medical doctors report this as well. This study involved over 1,000 physicians and 750 nurses.

About half of those professionals surveyed said that they have exaggerated the severity of a patient’s condition in order to get coverage. “This level of conflict and administrative haggling between doctors and plans can’t be good for our health care system or for patients who are caught in the middle,” says Drew Altman, Ph.D., President of the Kaiser Family Foundation. In this survey, doctors specifically reported that denials of mental health services were harming the patients.⁶⁸ In 1999, a study surveying how social workers, psychologists, and psychiatrists document their treatment revealed that a sizeable proportion of those practitioners also believe that it is necessary to report treatment needs in ways to assure certification rather in ways that accurately depict patients’ clinical profiles.⁷¹ Therefore, the medical records of a large number of patients may not accurately portray the diagnosis, with the resultant clinical inefficiencies inherent in that type of practice.

As troubling as the data surrounding general medical care is, the **majority of evidence in the literature reflects deficiencies in the delivery of mental health and substance abuse treatment.** In 1999 the American Psychiatric Association documented that fewer privately insured, Medicaid, and Medicare Managed Care enrollees received care from a psychiatrist than did “non-managed” enrollees.¹⁹⁰ A Massachusetts survey reported also that there were lower levels of quality, access, utilization, and length of stay since the onset of managed care in the Massachusetts Behavioral Health Program. They conclude that, “Intractable problems continue, and full participation of stake holders in a managed care setting seems difficult to achieve.”¹⁰ In a study of their employees by McDonnell Corporation, it was found that employees who sought mental health care through their managed care organizations were four to five times likely to quit

or be fired within four years than those employees who used the company's employee assistance program.⁸⁹ Co-payments for outpatient drug and alcohol treatment were found to discourage ongoing treatment in a study of seven years of claims data from a large behavioral health care carve-out plan.¹⁶⁶ Several studies have concluded that persons with schizophrenia receive inadequate treatment under behavioral health carve-out plans and that the outcomes were worse than with fee-for-service treatment programs.^{30, 77, 84} Authors who focus on the treatment of depression have found exactly the same situation: outcomes are better for fee-for-service patients than for managed care patients,¹³⁷ medication treatment is less intense and of less-than-adequate duration under managed care,¹⁸¹ and diagnostic accuracy is highly variable.¹⁸⁶

Indeed, other authors have documented a sobering picture of inadequate treatment for psychiatric illness. The Patient Outcomes Research Team (PORT) reported in 1998 that less than 10% of persons with schizophrenia received family education and support. Only 23% received vocational rehabilitation, and only 10% received the best psychological treatment for schizophrenia: Assertive Community Treatment. "The results are nothing short of an outrage," says coordinator A. F. Lehman, M.D.⁷⁶ A careful study of the impact of managed care on the outcome of schizophrenia in Utah was reported last year by Drs. Manning and Minnesota's Mike Popkin. They conclude that there is less improvement in mental health status under the carve-out arrangement than what would have happened under traditional Medicaid.⁸⁴ According to data from the Mid-Life Development In The United States study of 3,000 persons, **half** of the 18% of Americans that reported mental illness problems in the past year received some type of mental health care. **Only 14% received care that was based on scientific evidence.** Even among those persons who suffered with severe illness, the rate of evidence-based care was only 25%.¹⁰⁸ One of the potentially valuable contributions in psychiatric treatment and management offered by managed care plans is the assignment of case managers. A case manager can find resources for patients, coordinate the care of various mental health professionals, and assist in many activities of daily living. However, in one study from Tennessee exploring the value of court-mandated case management under a managed care contract, 47% of those seriously ill patients refused this service. We know that many persons with schizophrenia do not believe that they are ill and therefore would refuse such help. It is unlikely that Assertive Community Treatment would ever be popular with that carve-out company manager. His budget is dealt with apart from the rest of the healthcare conglomerate, and thus the interaction of MH/SA care delivery upon emergency rooms, primary care expenses, and other diseases takes longer to discover. These findings demonstrate that health care providers must offer sufficient information so that patients will use the managed care system more effectively, or use Assertive Community Treatment methods to ensure that a greater proportion of these vulnerable individuals receives modern services.¹¹³ Dr. David Thatcher, America's Surgeon General, writes in his 1999 report on mental health that **"The lack of access to mental health care has driven far too many vulnerable people into homelessness and our jails and prisons."**¹⁵¹

Unplanned hospital readmission within 30 days of discharge is generally considered evidence of poor quality. General hospital readmissions in the elderly are over three times more likely for those patients with a history of depression. They appear to be over twice as likely with patients who are discharged without documented patient or family education.⁸⁶ The odds of having a preventable hospital readmission within 90 days of an index admission were three and a half times as high for Medicare HMO enrollees compared to Medicare fee-for-service participants.⁸⁴

Another study found that readmissions increased when hospital days decreased, and that **denials of care in the mental health area did not vary by the seriousness of the diagnosis.**¹⁸⁷

The situation in American psychiatry and addictionology has not escaped the notice of our country's medical students. The appeal of psychiatry is not what it used to be. Researchers report that, for American medical school graduates, the rate of recruitment into psychiatry residency programs is currently between 2% and 3%, far below that in the 1950's, when the recruitment rate was closer to 12%.¹⁰³ Residency programs in the United States have admitted more and more doctors that are foreign medical graduates to fill their psychiatric residency positions.¹²³ The proud practice of psychoanalysis has become marginalized in modern American psychiatry. Even though it is the treatment of choice for numerous personality disorders and neurotic disorders,⁵⁶ it is no longer practical due to limited coverage. A contemporary psychiatrist can expect to be paid more by prescribing medications to a patient than for doing psychotherapy. Most closed-panel insurance plans offer psychotherapy only by less expensive providers. This type of practice is less satisfying for some psychiatrists and is also evidently less effective and more expensive for many patients.⁴⁸

The standard of care in providing psychotherapy appears to have lowered amidst the reform of MH/SA funding. There is evidence that psychotherapy was becoming more commonly the subject of malpractice suits over the last 25 years. Juries returned verdicts in a large number of cases awarding damages totaling millions of dollars. More recently, however, there have been fewer. One side effect of managed care is to reduce the standard of care as well as the choice of treatment, and this has likely protected some less thorough psychotherapy practitioners from lawsuits that in earlier days would have been brought successfully.¹⁶⁰ It appears as if we as a society could lose protection from poor psychotherapists if the checks and balances of the malpractice process are lost.

Finally, whereas in the past voluntary hospitals were thrilled to provide unprofitable services and unreimbursed care for the poor, such charitable activities now threaten the economic survival of these institutions.¹³¹ Low reimbursement to physicians who treat the poor under Medicaid and Medicare insurance have led to a movement away from these patients by private practitioners.⁴⁷ The practice of Minnesota psychiatry is thus far less gratifying to the practitioner than in the days when reimbursement was more generous.

Money Spent On Mental/Substance Abuse Treatment Decreases Overall Health Care Expenditures

Since the brain is connected to every other organ, it is logical to conclude that disorders of the brain will produce illness in many different ways depending on the constitution of each individual. We know that stress almost doubles the vulnerability to cold viruses,¹²⁴ and that persons who suffer from dementia incur 1.5 times the annual medical costs compared with control subjects without dementia.⁵⁷ **There is extensive and irrefutable evidence that concurrent depression, anxiety, and substance use disorders prolong hospital stays in the medically ill.**^{25, 33, 62, 70, 79, 183} Average general medical inpatient stays have been found to be 40% longer, 10 days longer, and up to 90% more expensive. Moreover, more aggressive mental health treatment has been shown to decrease hospital stays by as much as 24% and 31.8 days.

Over the last 15 years, there have been many other reports in the literature describing studies, both small and large, that show that money spent on mental health care and substance abuse care decreases the overall utilization of general medical services in many different populations.^{51, 58, 61, 105, 109, 141, 155} Dozens of studies, not only in the United States but also around the world, have shown strongly that there is a significant cost offset when psychotherapy is utilized. General medical problems are almost invariably less expensive to manage when psychiatric and substance abuse problems are well-financed.⁶² In a review of 58 cost-offset studies, 85% reported a decrease in medical utilization following psychotherapy. Although patients receiving outpatient mental health care had higher initial overall health care costs than a control group, their charges leveled off and became lower in every subsequent year. Those over age 55 showed the most dramatic decline in medical expenses.¹⁰⁴ In Germany, such research led to relaxation of MH/SA cost control strategies there and more liberal and less expensive health care overall.³¹ In a recently published review of the literature by a prominent American psychiatrist, 18 controlled studies on the cost-effectiveness of psychotherapy were summarized. 80% of these studies concluded that psychotherapy reduced overall healthcare costs, with particular findings that the cost-effectiveness of family therapy for patients with schizophrenia was particularly impressive.⁴³

There are a number of studies that demonstrate dramatic reductions in overall health care expenditures in certain populations. For general medical patients who suffer from somatization disorders, long-term psychotherapy (average of 33.9 sessions) reduced inpatient medical stays by over 60%, and this decrease began within the first year of psychotherapy and remained steady over many years.²⁴ This study lasted for 20 years, and the savings over that period of time were astronomical. A recent study found that **primary care physicians who diagnosed the highest number of psychiatric disorders in their patients accounted for 9% lower overall health care expenditures than those physicians who diagnosed the smallest number of such disorders.** Inpatient expenditures were even lower: 20% less for the physicians who were more likely to recognize the mental health disorders.¹¹⁷ Another study of more than 11,000 patients showed that when treatment for depression is referred to specialists rather than treated in primary care clinics, there is a net mean annual savings of \$877 per patient.¹⁹² For corporate employees, it has been found that there is a four-dollar cost saving for every one dollar spent on employee assistance programs. Other studies show an average 3-to-1 rate of return on these dollars spent,

with up to a 13-to-1 return when employees have been referred because of poor job performance.¹⁹² There is also evidence that placing higher co-payments for mental health care than for general medical care results in an increase per year of \$850 in the medical expenses per person in a corporation with 21,000 employees.¹⁴⁰

A review of 12 studies of alcoholism treatment programs showed that treatment cut general medical costs 26% to 69% and reduced the number of sick days 38% to 42%.¹²⁵ Dramatic reductions in the costs of general medical care have been demonstrated in large studies.^{29, 36, 87} In fact, one study found that, for every \$10,000 invested in chemical dependency treatments there is a savings of \$56,263 dollars!³⁶

After reviewing the extensive evidence about the overall cost effectiveness of psychotherapy, other psychiatric treatments, and substance abuse care, **why is it that the reimbursement for these services continues to be restricted by almost all third party payers?** One reason must certainly be that these are one of the most prevalent of all medical disorders, affecting 20% of Minnesotans. Moreover, the brain is the most complicated substance ever discovered by man, and 3% of Americans are born with visible brain malformations alone. Earlier cost-cutting methods frequently blamed health providers for fraudulent over-utilization (This appears to be a myth, however, based on more recent research¹¹). The prevalence of non-medical providers in administering care for mental illness and substance abuse disorders is another reason MH/SA treatment has been viewed less favorably than other types of medical treatment.¹¹ It has been asserted that the ability to predict expenditures for psychotherapy and substance abuse care is low due to the nature of the illnesses and the overlap with the personality disorders or adjustment disorders to our complex modern life. However, research has repeatedly shown that, far from being unpredictable and unstable over time, the demand for and costs of psychotherapy can be projected with an accuracy similar to those for general medical care.¹⁵³

Insurers may feel that offering higher outpatient mental health coverage will lead to “adverse selection” of their plans by the mentally ill. This occurs despite evidence of the constancy of the percentage of total benefits (about 7%) paid over the years for mental health services through a variety of plans offering a wide range of restrictions on mental health benefits.⁶² There is evidence that increasing benefits in several plans did not result in an increased utilization of psychiatric benefits over any previous limits. Less inpatient treatment and more outpatient psychotherapy usually was accompanied by much less than average amounts of other medical expenses.⁷⁴ A study of federal employees’ mental health coverage that was reduced showed significantly more inpatient hospitalization use and the net result of no overall cost savings despite a 20-visit outpatient psychotherapy limit.⁷³ A review of over 84,000 health plans covering over 8 million Americans which included mandated mental health, alcohol, and drug abuse benefits showed that there were no significant premium increases due to these mandated benefits.¹⁸ One study even showed that mandating mental health benefits for various employers’ insurance coverage reduced that state’s direct expenditures for such care by 11%.³⁹ A more subtle form of benefit discrimination occurs when higher standards of proof of efficacy are required for treatments of mental illness than for physical illness. Only 10% to 20% of currently accepted “and insurable” non-psychiatric medical techniques have been “proven” by clinical trials.⁶² For example, coronary bypasses and Caesarean sections are still being done at huge costs, and paid for by insurers, despite growing evidence for the efficacy of much less costly

medical treatments. The grim prognosis for carcinoma of the pancreas, for example, has not substantially changed with treatment, and yet insurers reimburse for treatment. We invest because we hope. The stigma surrounding psychiatric illnesses is such that, even when care is possible, it is disputed; and when management, not cure is available, it is often denied to the patient. Insurers would not think of denying payment for outpatient health care for such chronic physical disorders as diabetes, but many refuse to provide outpatient treatment for chronic sufferers of mental illness despite the fact that such treatment and management is just as effective as that for diabetes in preventing complications and long-term morbidity.

There is evidence that employers do not understand the important role that brain disease plays in increasing overall medical costs. Only 15% of a group of Midwestern employers in 1988 thought that mental health problems had a “large” impact on medical/surgical and worker’s compensation costs. Over twice as many respondents (32%) thought that the impact was relatively small.²² Mental health advocates still need to continue educating employers about cost-offsets, since they play a major role in determining mental health benefits levels nationwide.

As one can conclude by this review, the most widely studied outcome variables have been health care costs and health care utilization. We need to study also work productivity, job satisfaction, the ability to achieve maximum education, ability to care for family, marital satisfaction, as well as the effects of private insurance decisions on public psychiatric and substance abuse utilization. Functional outcomes need to be taken into consideration, not just the clinical outcomes and financial outlays for treatment.⁷⁵

Options For Improving Minnesota Mental Health And Substance Abuse Treatment At This Point In Time

Bioethicists have recently concluded that health care is not a commodity and that treating it as such is deleterious to the ethics of patient care. They have published that **health is a human good** that a good society has an obligation to protect from the market ethos.¹¹⁴ Such lofty ideals for a “good society” are not practical in the face of a fiscal situation where the needs of our growing and aging population can never be met by the limited resources available now. Cost containment pressures have led most psychiatrists to the discomfiting position that whatever is affordable, i.e., reimbursable, is best. Some are able to accept that incremental improvement in a patient’s situation is better than no help at all. Short-term and crisis intervention therapies have been substituted in most systems for longer-term, dynamic types of therapy which may well be more cost effective in the long run.⁶² Such compromises may have been reasonable on a trial basis 15 years ago, when still 5% of the health care dollar was spent for these patients. They are more difficult to defend in the present, as cutbacks have continued to the point where **more and more Minnesota clinicians are concluding that effective reform of these systems is crucial.** Long-term increases in overall healthcare expenditures have now become fairly obvious, as evidenced by this year’s jump in insurance premiums.

The reductionists in this group of would-be reformers speak of mandating that all Minnesota insurers devote 6%, or some similar proportion of their premiums, to mental health and substance abuse treatment in Minnesota. Outcome studies across diagnoses could expose which disorders are not being adequately treated under the present treatment limitations, and the extra monies generated by such a requirement could be devoted to revamping treatments using the scientific method. Most experts believe that such a bill is unlikely to become law in the near future, for political reasons.

The abolitionists propose ending carve-outs of MH/SA benefits if an insurer is to do business in Minnesota. Although there is an increasing number of insurers that have removed utilization review for general medical care, none have done so with MH/SA benefits to date. The rationale behind these changes is that the standard of care itself has been changed, and that doctors will continue cost-effectiveness principles without the expenses of utilization review. We believe that MH/SA providers would behave similarly, yet still we are discriminately overmanaged. The money saved in reduced management would be more than enough to restore a reasonable amount of quality to MH/SA care. The Minnesota Medical Association, the American Medical Association, and the American Psychiatric Association have officially joined the Minnesota Psychiatric Society in its opposition to MH/SA carve-outs. A bill may be advanced if legislative sponsorship can be found.

Some reformers believe that expanded parity laws are the solution. The federal Mental Health Parity Act of 1996 amended the Employee Retirement Income Security Act of 1974 (ERISA) and the Public Health Service Act to require employer-sponsored health plans to have annual and lifetime dollar limits for mental health coverage that are no more restrictive than those for all medical and surgical coverage. However, the impact of this law has been minimal in helping current treatment scenarios. The law does not apply to plans sponsored by an employer with 50

or fewer employees. Group plans that experience an increase in plan claims costs of at least 1% because of compliance are also exempted. Policies sold to individuals are also exempt. Furthermore, the law does not **require** any plan to offer mental health coverage. It excludes treatment of substance abuse disorders, and it does not prevent a plan from imposing more restrictive service limits (e.g., hospital days or annual outpatient visits). This law does not prevent plans from requiring higher co-payments for mental health and substance abuse services than on medical and surgical coverage. The law only applies to health plans for plan year beginning on or after January 1, 1998. According to testimony given by Kathryn Allen, Associate Director at the Health, Education, and Human Services Division of the United States General Accounting Office (GAO) in May of 2000, fully 86% of employers in the United States have complied already with this federal parity requirement, up from 55% in 1995. However, only 3% of the 863 plans surveyed reported that claims costs rose as a result of this Act. Insurance payments for MH/SA care rose only 6 cents per member in plans with a \$10,000 annual limit and only \$3.40 for those plans with a \$1,000 annual limit.¹⁷³ As several authors have recently noted, “Benefit parity is not sufficient to ensure equity for those with mental disorders in this era of managed care.”^{2,19} As Drs. Mechanic and McAlpine of Rutgers University have recently noted, “Managed care holds the promise of facilitating parity between general medical care and alcohol, drug, and mental health care by reducing expenditures, even while expanding benefits.”⁹²

Other researchers surveyed tens of thousands of employers in 1999. About 60% of the responding employers did not know whether compliance with the Mental Health Parity Act increased their plan’s claims costs, and about 37% reported that compliance had not raised their claims costs. Only about 3% of the respondents reported that claims costs rose as a result of the law. Research suggests that overall health care costs are at most very slightly increased when these requirements have been relaxed.^{73,121} Those employers who were in compliance with the law noted that compliance was associated with a greater number of other restrictive provisions, such as limits on the number of office visits or days spent in the hospital.

Twenty-nine states, including Minnesota, have passed laws on parity that are more comprehensive than the federal parity law. These laws generally require parity not only in dollar limits but also in service limits or deductibles. 16 of these states require that mental health coverage be included in all group plans sold in their states. Laws in six states are essentially parallel to federal law requiring parity only for annual and lifetime dollar limits. Laws in eight states and the District of Columbia are more limited and insufficient to conform to federal law, and seven states have no laws that address mental health benefits. A broader policy perspective is required to address concerns about fairness under managed care.¹⁹

Some reformers believe that defining utilization review as the practice of medicine, with all of its ethical and legal connotations, would help this situation. Congress originally intended ERISA to secure the contractual benefits negotiated between employers and employees. In 1974, when the statute quickly moved through Congress, no one realized what its eventual significance for health care would be. Certainly, no one expected that ERISA would allow managed care health plans to reduce professional standards of care while being protected from liability. The Department of Labor believes that it was never the intention of Congress to preempt ordinary damage claims from malpractice against insurance companies.¹⁶⁹ According to Alan Stone of Harvard

University Law School, “Perhaps ERISA will make the profession recognize that malpractice liability can serve a useful purpose.” Experts recommend that significant statutory reform is the proper remedy for consumers and practicing physicians who are now confronted with objectionable managed care organization behavior and practices.¹¹⁵ The Minnesota Psychiatric Society concluded that, “The reviewers must be accountable for their part in the review process. Insurers must not force psychiatrists to release them from professional or financial responsibility for treatment decisions which insurers influence or in which insurers participate.”¹⁰¹ In a recent article in the *New England Journal of Medicine*,¹⁷¹ an opponent of this type of legislation stated that, “Even though there is every reason to believe that awards of punitive damages will affect the behavior of insurers, two outcomes would be certain: millions of dollars will go towards attorney’s fees, and these costs will need to be paid, at least in part, out of health insurance premiums”. This attorney suggests that a “more sophisticated approach” is necessary: namely, “carefully crafted regulatory oversight that is responsive to the need to reconcile the protection of patients and quality assurance, on the one hand, with the cost containment that consumers demand from managed care, on the other.” This attorney offers no specifics as to the mechanics of such a “sophisticated approach.” The Minnesota Psychiatric Society and the Minnesota Patient-Physician Alliance, in 2000, supported a utilization reform bill which would, among other things, define the practice of utilization review as the practice of medicine. The Minnesota Board of Medical Examiners supported such legislation, but it died in a House committee. Similar legislation is now before the 2001 Minnesota legislature. Many pray that it can become a Minnesota law.

Another option for Minnesota is again suggested by the Minnesota Psychiatric Society: “In order to make treatment for mental illness affordable to all Minnesotans under all insurance plans, legislation to increase outpatient benefits is needed...”¹⁰¹ The MPS suggests state legislation mandating not only inpatient coverage but also outpatient treatment which would provide up to 60 visits per year. In addition, a commitment “to the development of tertiary-care multi-disciplinary psychiatric evaluation units for evaluation and treatment of complex patient problems of both the public and private sector” was recommended. They add that, “Training and research into mental illness should be the key components of such units.” It is possible that such a law would provide rapid restoration of a vital part of quality psychiatric treatment.⁷²

New techniques for diagnosing psychiatric disorders have been developed over the last 15 years. Several of these have been proven to be effective but are not commonly used now in Minnesota because of insurance restrictions. Such tests as single photon emission computerized tomography (SPECT) and qEEG (quantitative computerized electroencephalography) can contribute to more accurate diagnosing of Alzheimer’s disease, attention deficit disorders, organic disorders of the brain, and probably mood disorders and schizophrenia. More effective psychotherapies such as Assertive Community Treatment and network therapy have also been proven to be more effective than current psychotherapies, but they are not funded adequately by any insurer in Minnesota at this time. Legislative or judicial pressures on insurers to finance such therapies is another option to consider.¹⁵⁶

An additional option in improving the outcomes for Minnesotans who are psychotic and who are unable to recognize this in themselves is to revise the state commitment law to mandate good treatment for them. The Minnesota Psychiatric Society has noted that, “The present Minnesota

Commitment Act adversely impacts access of care for psychotic individuals who do not meet commitment criteria for dangerousness.”¹⁰¹ The recent fatal tragedies involving psychotic Minnesotans are evidence that a generation of commitment reforms has made it more difficult to treat these individuals. Recent efforts by legislators Mindy Greiling and Don Betzold are addressing most of this need, but future passage of effective legislation is uncertain. Most Minnesota legislators over the past two decades have acceded to the powerful anti-commitment lobbying groups, who are not aware of the major issues of involuntary treatment and its successes. Continuous antipsychotic treatment for a lifetime is by far and away the best treatment for schizophrenia and other related psychotic disorders. We know that interrupted treatment or no treatment results in permanent brain damage for a sizeable percentage of these individuals, and that substantial improvements in quality of life can be obtained for most of these Minnesotans.³⁴ The number of Minnesotans who would be treated against their will under this proposal is small, because this severity of mental illness is rare. However, the cost savings in law enforcement, brief and ineffective crisis hospitalizations, and social support systems would be substantial.

A further option for reform is a class action lawsuit, brought on behalf of mentally ill Minnesotans who are receiving inadequate care. Such an approach successfully reversed major gaps in care in Maricopa County, Arizona, in the mid 1990's. Although this lawsuit affected only public mental health care delivery to severely ill individuals, there is reason to believe that similar action could also be applied to Minnesota insurers who, under scrutiny, have participated in the ill-advised cutbacks previously described. At the present time, the major mental health care advocacy groups do not appear to be seriously considering such an approach, but instead have focused on an omnibus bill including reforms distilled from the wishes of many key state organizations devoted to improving mental health and substance abuse care. The MPS is in support of this effort. It will be introduced in the 2001 Legislature.

“Unionizing” in many different forms is occurring and being discussed. It is a last resort in the minds of most Minnesota psychiatrists, but is on the minds of many. There are huge legal problems as well as ethical arguments that limit the prompt development of these strategies. One idea is to create a “universal Minnesota psychiatric contract” that incorporates minimum fiscal, ethical, and utilization review standards. It could be recommended by the Minnesota Psychiatric Society to its members as an ethical prerequisite of a contracting psychiatrist. Another idea is to create an “umbrella” professional corporation of psychiatrists to take care of contracting and credentialing hassles. It could require similar minimum standards. Either strategy could have a restorative impact if enough psychiatrists join and stay the course, and would avoid antitrust scrutiny if well designed.

A final option that I will mention is to reform Minnesota (and perhaps federal) health care provision into a single payer system run by the government. R. Paul Olson, M. Div., Ph.D., a professor at the Minnesota School of Professional Psychology in Bloomington, in 1999 created an impressive thesis recommending such action. Other medical leaders in our state also feel that it is hopeless to work with competitive insurance and that scrapping the entire marketplace healthcare venture in favor of socialized medical care is the best option. Major reductions in administrative costs would be immediate, and funds saved could be directed towards providing

more health care to Minnesotans without increasing the total number of dollars spent. A bill for such a reform failed recently in the Minnesota legislature.

How will Minnesota proceed? This question promises to occupy the minds of a growing number of important Minnesotans in upcoming years. This author and the Minnesota Psychiatric Society hope that knowledge, ingenuity, and compassion will guide the efforts of all involved in the creation of tomorrow's health care in Minnesota.

Figure 1

PERCENTAGE OF COMMERCIAL HMO ENROLLMENT HELD BY THE THREE LARGEST PLANS

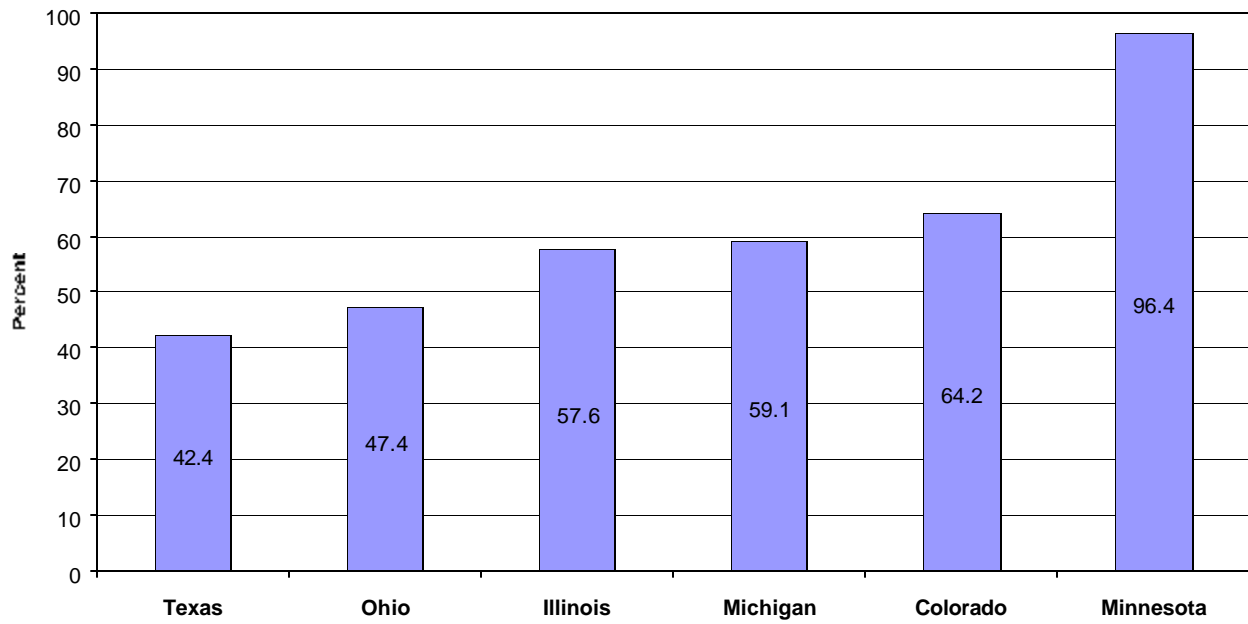


Figure 2

COMMERCIAL HMO PREMIUM REVENUE BY STATE

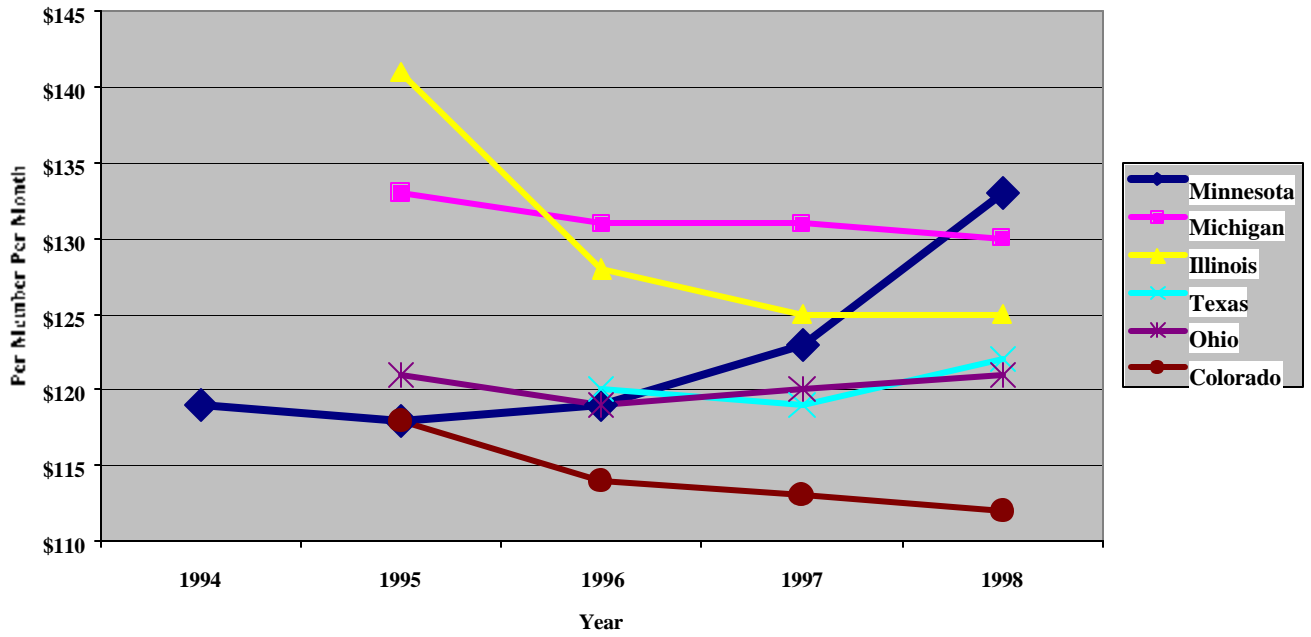
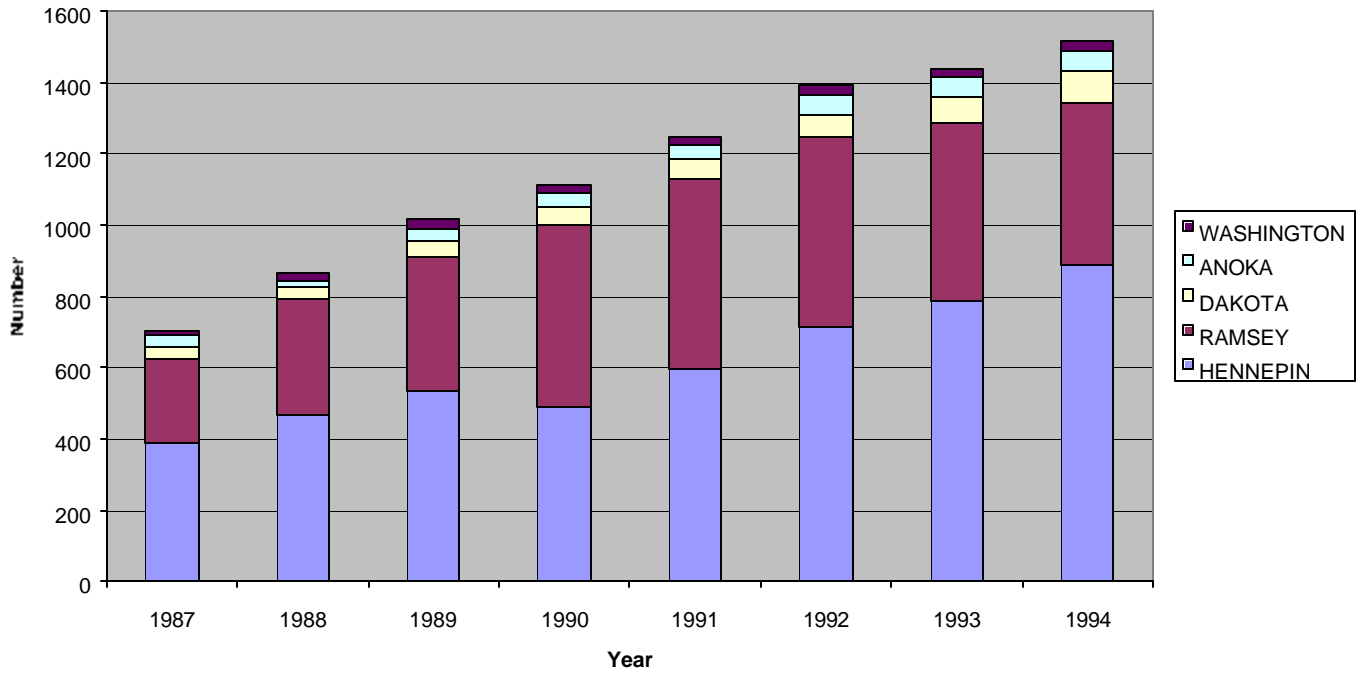


Figure 3

COURT COMMITMENTS AS MI and MI/CD in the TWIN CITIES AREA



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