

**EFFECTIVE
MENTAL HEALTH SERVICES:
A PRINCIPAL MEANS OF
CONTAINING OVERALL
HEALTH CARE COSTS**

HOW RECENT CHANGES IN THE MENTAL HEALTH
BENEFIT OF THE NEW JERSEY STATE EMPLOYEES
HEALTH PLAN UNDERMINE OVERALL HEALTH
CARE COST CONTAINMENT EFFORTS

AN ANALYSIS PREPARED FOR
**THE NEW JERSEY PSYCHOLOGICAL
ASSOCIATION**

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EXECUTIVE SUMMARY

The New Jersey Psychological Association (NJPA) has conducted an in depth analysis in response to changes in the management of State of New Jersey employee mental health benefits. In a departure from policy that goes back more than fourteen years, the State Health Benefit Plan Commission (SHBP) through the Department of Pensions and Benefits (DPB) decided, on September 1, 2006, to employ managed behavioral health practices for employees who receive "out of network" mental health care. After carefully reviewing and monitoring the consequences that have developed from this change, the NJPA strongly opposes it and questions its value, from both a therapeutic and cost containment perspective.

The change was intended to be part of an overall strategy to contain employee health care costs by channeling enrollees into the New Jersey Plus plan, even though the cost of this plan increased at the fastest rate of any of the State employee plans in the past five years despite having the youngest enrollees. While the DPB's concerns about cost containment are understandable, the targeting of mental health services, the process being used, the basic assumptions, and the economic expectations are all seriously flawed.

Our examination confirms as well as raises several major concerns. Already, this change is having a negative affect on access, confidentiality, and the entire therapeutic process. By applying managed care restrictions to NJ Plus employees, who pay more for this option, without any reduction, the DPB is trying to pressure these enrollees into choosing the "in-network" option which would eliminate their free choice of therapist. Instead of the patient and therapist deciding when treatment should be terminated based on professional judgment and improvement, the insurance company now makes that decision. Continuity of care, so crucial to favorable outcomes, is extremely difficult to achieve when there are major distractions or interruptions in the treatment process. Treatment planning, as well as the cumulative effect of the ongoing care, is undermined. Concerns about confidentiality adversely affect utilization and patients are expressing such concerns. Administrative inefficiencies, which delay the approval to continue care, are also undermining treatment effectiveness.

Contrary to DPB's assertion that this change is limited to only certain, selected cases, this restriction is being applied to all enrollees who receive mental health care "out of network" in the New Jersey Plus plan. In fact, the DPB has advised that they had not established a specific claims threshold in order to trigger such reviews on a discrete basis or criteria by which the review process is carried out.

The major assumptions and expectations underlying the decision to implement this change are seriously flawed. The first is that treatment can be cut back for so-called "mild" conditions primarily by looking at claims data and requiring therapists to submit a Treatment Review Form (TRF). This discourages early identification and provision of care at less restrictive levels and leads to greater expense later. Second, the DPB does not know how much mental health services are really costing the State and could only offer a "ball park" estimate. Yet, it hopes to substantially reduce that cost. By employing managed behavioral health practices, a decreasing percentage of the premium dollar is being spent on direct care and an increasing amount on administration. Experience in other states has shown that contemporary managed care practices can actually increase overall costs to employers while substantially decreasing the amount of care patients receive. Third, in forming the assumption that state plan enrollees

overuse the mental health benefit, there was no comparison of “like enrollees” nor was comparability of health plans established when reviewing the State’s experience against national data. Fourth, the cost of mental health treatment is such a small percentage of the State’s over all health care costs that even if DPB’s “ball park” estimate is true, the entire amount could be eliminated and the savings would be off-set within a few months by the medical cost increases under current practices. Finally, this change attempts to pick what appears to DPB to be the easiest and most vulnerable patients without considering the adverse unintended consequences.

Not only would the cost of the State health plans likely increase due to late diagnoses and treatment, but co-morbid medical conditions, as a result, would cost more to treat than any savings that might be realized. Based upon information provided by the DPB, plus additional New Jersey figures, national data, as well as past experience, our estimate is that this new practice is costing the state of New Jersey many times more than the entire cost of providing mental health services to state employees. Moreover, other major problem areas both within and outside of the state system can be exacerbated. Employee productivity, criminal justice, family violence, and Fetal Alcohol Syndrome are some of the major areas that are adversely affected when treatment for mental and substance use disorders are either insufficient or difficult to access.

The only rational way to contain health care costs is to reduce the demand by assuring that people get the right care the first time, albeit at a reasonable fee for service. There are no quick or easy fixes. A lasting solution requires delving into the complexities of the issue, taking into account the longer as well as shorter term impact, and carefully assessing the potential for unintended adverse consequences. Our conclusion is that this change costs the State of New Jersey more than it could ever save.

INTRODUCTION

The New Jersey Psychological Association (NJPA) has retained J. Wrich & Associates, LLC (JWA) to conduct this investigation in response to changes in the management of New Jersey's State Health Benefits Plan (SHBP). The change initiated on September 1, 2006 by the SHBP, through Horizon, with regard to out-of-network mental health treatment in the NJ Plus Plan, has affected access, confidentiality and the entire therapeutic process in a negative manner. Specifically, the New Jersey Division of Pensions and Benefits (DPB) is now employing managed care practices for employees who receive treatment from "out of network" therapists. After careful review, and observing the consequences that have developed from this change, the NJPA strongly opposes and challenges its value, from both therapeutic and cost containment perspectives.

The change has been discussed with key administrative leadership of DPB. The DPB claims that it has long reserved the right to enact such a review, although it had not previously been applied to out-of-network services. DPB said that only in certain selected cases will psychotherapists be required to submit a Treatment Review Form (TRF) justifying the number of sessions in order to continue to provide treatment to clients who are under their care. If the treatment is not determined to be medically necessary, it will be subject to this review. This is part of an overall strategy by the DPB to contain employee health care costs that has resulted in a migration of enrollees into the New Jersey Plus plan as the Traditional Plan is phased out. The Traditional Plan, which for many years was the principle alternative to HMOs, was not subject to management by a Behavioral Health Organization (MBHO) or the DPB. NJ Plus enrollees have paid extra for the "out-of-network" option, and continue to do so even though it has been materially changed in a manner which is contrary to their vital interests. The NJPA points out that one major reason enrollees are willing to pay more for the option to use such services out-of-network is to specifically avoid the type of restrictions imposed when they receive benefits through the "in-network" system. With the demise of the Traditional Plan, and a new expanded PPO replacing New Jersey Plus expected this spring, the need for a non-managed option is essential.

DPB's concern, as expressed to J. Wrich & Associates, is based in part on a belief that some therapy, especially for "mild depression", is essentially a "feel good" experience and not clinically justified. In addition, DPB claims that State of New Jersey employees and dependents use mental health services at a higher than average rate. In coming to this conclusion, the DPB did not compare like enrollees or plan comparability in the industry data it reviewed. More importantly, it did not consider the serious adverse cost consequences of restricting the service. Moreover, data supports early intervention as the only demonstrable approach to preventing the deterioration of a "mildly depressed" person, and adds significant costs in adjunct co-morbid medical conditions.

That said, the main issue is cost. A key DPB administrator referred to his experience managing the employee health benefit plan for the City of New York, which is roughly the size of the New Jersey State Employees plan. He reported that he sees similarities in the mental health utilization patterns between the two plans. While in New York, he organized a review system similar to what is being enacted for New Jersey state employees that he claims saved the city \$22 million in mental health claims. Once again, there was no analysis of like enrollees to determine the viability of the experiences in New York to New Jersey State employees.

It turns out that the State does not really know how much it spends on mental health much less what portion might constitute "unnecessary care." Only a "ball park" estimate of overall mental health claims costs was offered. Not only are the hopes of saving money through this change largely speculative, but this analysis will show that the opposite will likely occur: costs will increase as a result of various unintended consequences of the change.

The NJPA recognizes the State's legitimate concern with the cost escalation of its health plans. In fact, our review indicates that the cost of the New Jersey Plus plan, into which the DPB is channeling enrollees, increased at a faster rate (51.9%) between 2002 and 2006 than either the Traditional plan (46.6%) or the HMOs (35.5%) even though retirees constitute a much great percentage of the enrollees in the Traditional plan.

The following tables illustrate the change in cost in the New Jersey state employee health plans over a five year period ending June 30, 2006. These tables are based only on employees working directly for the State of New Jersey and their dependents. They do not include teachers and other government or private sector employees and their dependents. Overall, as many as 800,000 New Jersey residents are covered by these plans.

TABLE 1¹

PLAN	2002			2006			Change +(-) %
	EXPENSE (million)	COVERED FAMILIES	MYE	EXPENSE (million)	COVERED FAMILIES	MYE	
TRAD	\$209.8	32,122	\$6532	\$242.2	25,302	\$9573	46.6
NJ PLUS	291.3	66,725	4363	585.8	88,411	6626	51.9
HMO	203.4	36,664	5624	271.0	35,559	7620	35.5
TOTAL	\$704.5	135,011	\$5218	\$1,099.0	149,272	\$7362	41.1

These increases average 7.1% per year, which is significantly lower than either national or statewide increases. However, New Jersey Plus, into which DPB has encouraged enrollment, increased about 23% more than average. At an 8.7% annual increase it is essentially the same as the national and statewide experience. Table 2 shows a lower yet significant increase for prescription drug and dental costs.

Table 2

BENEFIT	2002			2006			Change +(-) %
	EXPENSE (million)	COVERED FAMILIES	MYE	EXPENSE (million)	COVERED FAMILIES	MYE	
Drugs	\$159.2	135,011	\$1179	\$237.0	149,272	\$1587	34.7
Dental	1.7	135,011	13	2.4	149,272	16	33.3
Medical	543.6	135011	4026	859.6	149272	5759	43.0
TOTAL	\$704.5	135,011	\$5218	\$1,099.0	149,272	\$7362	41.1

¹ Source: State of New Jersey Department of the Treasury

The cost escalation problem is real, the challenge is daunting, and the path ahead can be confounded with potential unintended consequences. However, trying to address the problem by starting from a premise that some services are merely “feel good” experiences for the patient is fraught with inaccuracy, bias, and oversimplification. In addition, comparing use patterns of State employees to those in either a national or local study without sorting for “like-enrollees” has dubious validity. Moreover, the basis for selecting cases for review under the new restriction is not defined and is largely left to the insurance carrier, whose primary concern is cost containment.

I. WHAT IS THE PROBLEM?

The professionals who actually provide the care to those with mental and substance use disorders strongly object to DPB's decision. The change has affected access, confidentiality and the entire therapeutic process in a negative fashion. Moreover, this change violated the agreement between state employees and their employer. Experience and our careful analysis indicate that this change will cost New Jersey taxpayers more than it could ever save.

The most basic and most serious flaw in the decision to implement this review process is that it did not adequately consider the potential for unintended adverse economic and clinical consequences, nor were measures installed to guard against them. Therefore, the NJPA, and other major professional organizations, strongly oppose this change based on the overall decision process, the assumptions underlying it, the early experience therapists are having with it, and the high predictability of unintended adverse clinical and cost consequences.

A. Already, this change is having a negative affect on access, confidentiality and the entire therapeutic process. In contrast to the DPB's description of selecting only the high utilizers for review, the NJPA reports that this practice is being implemented with **all** outpatient claims and is not limited only to high "outlier" claims. Based on reports from therapists, patients, and Horizon BlueCross/BlueShield, this practice is being applied to **all** enrollees who receive mental health care "out of network" in the New Jersey Plus plan. In fact, the DPB has advised that they have not established a specific claims threshold to trigger such reviews on a discrete basis.

B. Concerns about confidentiality adversely affect utilization and patients are expressing such concerns. It is noted that the process the DPB described includes identifying patient information. Even with attempts to safeguard sensitive confidential material, the perception by patients, which is supported by repeated news stories of lost or stolen computerized records, discourages use of the benefit. When therapists are required to discuss confidential treatment details with an outside third party whose cost containment agenda is known to everyone, it increases anxiety, distrust, and a sense of vulnerability, adding to the difficulty for which the patient originally sought care.

C. One of the most crucial decisions in the process of recovering from a mental or substance use disorder is deciding when treatment should end. Instead of this decision being made by patients and therapists who discuss and observe the remediation of symptoms while actually evaluating the progress being made, it is rendered under pressure from an insurance company who only looks from afar at the claims history and reviews a form without specific criteria set forth by the State.

D. The patient's choice of therapist is the key to the "out-of-network" option and is often the main element in achieving a favorable outcome. By applying managed care restrictions without a reduction in the enrollees' costs, the DPB is trying to pressure enrollees into choosing the "in-network" option which would eliminate their free choice of provider. For many years, research has shown that the relationship between a patient and a provider of mental health and substance abuse services is paramount to the success of the treatment.²

² Jerome Frank, MD and Julia Frank, MD, Persuasion and Healing (Third Edition), Johns Hopkins University Press 1993.

Education, on-going training, licensing, and experience are essential in assuring technical competency of providers. But, empathy, trust, and the overall quality of the therapeutic relationship is at least as important, particularly in psychotherapy where feelings are a major part of the equation for success.

E. The new review process is a breach of trust. The NJPA points out that this practice has been implemented by DPB even though enrollees pay more for the option to use such services “out-of-network.” Assertions to the contrary notwithstanding, for the State to offer an option unfettered by MBHO restrictions for fourteen years, charge more for it, and then unilaterally withdraw it with no refund to the enrollees, is disingenuous, at best, and possibly illegal.

F. Continuity of care is crucial to favorable outcomes, and involves careful planning, experience, and on-going decision support. This is extremely difficult to achieve when there are major distractions or interruptions in the treatment process. When, as in this situation, the benefit an enrollee chooses and pays for is based on care unfettered by such intrusions, but the actual practice ends up being just the opposite, neither the patient nor the therapist knows what lies in store. Treatment planning as well as the cumulative effect of the ongoing care is undermined.

G. Administrative inefficiencies can be as detrimental to outcomes as the wrong provider. Already the NJPA is receiving a widespread complaint that after a therapist submits the TRF, even if additional sessions are granted the approval process can take so long that the treatment is either threatened or interrupted to the point that its effectiveness is undermined.

H. As important as the review process itself are the assumptions on which the decision was based to implement it. To single out “mild depression” as an example of the type of case that needs review begs the question of how serious such a condition should become before it is treated. For starters, neither the Diagnostic Statistical Manual of Mental Disorders, Rev. IV nor the International Code of Diseases, Rev. 10 has a category referred to as “mild depression.” In essence, there is depression and major depression.

Experience shows that any diagnosis of depression, however serious, can adversely affect one’s work performance and life functioning. But, even if the DPB chooses to refer to some cases as “mild”, such a characterization should not be the determining factor in disallowing treatment to continue. Some fundamental questions are:

- Should treatment of so-called “mild depression” be delayed until the person has trouble getting out of bed in the morning? Would we delay treatment for a small lump in a woman’s breast and wait to see if it gets worse?
- Should an employee with a “mild” depression receive treatment, or should we wait until a problem at work requires either a worker’s compensation or disability claim?
- Should there be family tragedy, with children having trouble because a parent with an untreated “mild” depression is neglectful?
- Should treatment wait until the patient becomes suicidal?
- Should an actual attempt to harm oneself or someone else be the threshold for allowing treatment to continue?
- Should treatment be discontinued even though the therapist sees need for continued care such as a co-morbid alcohol or anxiety disorder?

I. This change will cost the State of NJ more than it could ever save. Claims monitoring can help predict, within reasonable parameters, what the cost consequences may be when someone gets treated. However, it cannot predict the downside of stopping treatment prematurely. No one knows until it's too late what the broader consequences are if someone with even an apparently "mild" condition does not get timely care. Early identification and treatment has long been recognized and accepted as an effective prevention and cost containment method. If the so-called mild cases are not treated properly and early, they can advance to become serious, chronic conditions requiring more expensive care.

While the DPB referred to high outlier claims as a target, it also advised that no claims dollar limit has been set as a trigger for this case review, nor is a differentiation in type or severity of mental disorder taken into account when selecting cases. Moreover, no written procedure has been shared with therapists outlining what the overall review process entails once a case is selected or the criteria on which the final decision rests. This is particularly troublesome when viewed in the overall context of contemporary managed behavioral health care practices, which employ some of the same assumptions that underlie DPB's approach.

The value to the State and its employees of managing mental health care using contemporary MBHO practices is dubious, at best. In Vermont, experience is showing that "unmanaged" mental health services actually cost employers less in claims payments than those managed by MBHOs and the percentage of premium expended on direct care is greater.³ Even in the overall medical/surgical area, managing the care has questionable cost implications. In a separate study of Vermont's State Employee⁴ health plans, a comparison of "like enrollees" showed that the HMO's actually cost the state 3% more than the self-administered indemnity plan and delivered 11% less care as measured in claims paid. While the quality of mental health care is often diminished and MBHO loss ratios are often unacceptably low⁵, such practices usually result in increases in over-all medical costs due to the adverse co-morbid impact of untreated or inappropriately treated mental and substance use disorders. The MBHOs bear no financial consequences for denying care even if such decisions result in medical surgical cost increases that far exceed the mental health savings.

The State of New Jersey, first and foremost, is an employer and the impact of late diagnosis and treatment of these disorders on over-all job performance and attendance will dwarf any potential savings in mental health treatment costs. Second, the impact of untreated mental and substance use disorders in the community at large have a devastating effect costing billions of dollars. Third, the adverse co-morbid impact of untreated mental and substance use disorders on overall health care costs is huge. Finally, the total cost of treating mental and substance use disorders is miniscule as a percentage of overall health care costs making it one of the least promising areas in which to achieve health care cost containment.

³ State of Vermont, "Act 129 Loss Ratio" data.

⁴ J. Wrich & Associates, Inc., "A Comparative Analysis: Choice Plus Versus HMO Costs and Direct Care Expenditures" developed for the State of Vermont, January 19, 2000.

⁵ James T. Wrich, "Brief Summary of Audit Findings" and State of Vermont, "Act 129 Loss Ratio" data.

II. THE PROOF

If the incidence and prevalence of mental and substance use disorders were low, and if the impact at work and in society was insignificant, the stakes would not be so high when it comes to denying treatment. But, that is not the case. In order to truly understand the positive role effective mental health treatment can play, and the adverse impact the DPB change represents, the dimensions of the mental health issue must first be understood. Then, a careful examination of the various tactics to contain health care costs in general, and mental health costs in particular, must be reviewed.

A. New Jersey and the Nation. Research shows that about 30 percent of the U.S. adult population age 15 to 64 has a current (past 12 months) mental or substance use disorder serious enough to be classified in the Diagnostic Statistical Manual of Mental Disorders (DSM IVR). For the New Jersey state employee group, this computes to about 80,000 enrollees at any given time. Approximately 50 percent will encounter such a problem during the course of their lives.⁶ Yet, only 1 in 9 with a mental disorder will receive treatment during their lifetime from a professional with a specialty in their disorder, and for those with a substance use disorder, the ratio falls to 1 in 26. The costs both in money and human suffering are enormous.

When combining Depression, Anxiety, and Substance Use Disorders alone, nationally the social costs may well range from \$200 billion to \$500 billion annually⁷. This includes lost productivity, absenteeism, and accidents at work; increased auto and liability insurance; family violence; child abuse and neglect; and incarceration of those who committed an alcohol or drug related crime. Trauma, especially if experienced in early childhood, can lead to a host of other mental health problems later in life including violence at home and in public, addiction, depression, and anxiety.⁸ A progressive inter-generational cycle of disease and dysfunction can ensue.

Much of the cost is borne by employers, including the State of New Jersey. If the national cost estimate range above is applied to the 149,000 state employees and approximately 225,000 dependents covered under the State of New Jersey employee health plans, the risk computes to \$250 to \$400 million annually. When including all public and private beneficiaries covered by the State health plans, which number is nearly 800,000, the costs soar upwards to a range of \$530 to \$850 million per year. This enrollee group represents more than 9% of New Jersey's population. If this group does not function at an optimal level, both at work and in public, the significant ripple effect will be felt throughout New Jersey's economy and can affect virtually every quality of life area.

6 Ronald Kessler, PhD, et al., National Co-morbidity Survey (NCS), 1996

7 Robert Wood Johnson (2001). Substance abuse: The nation's number one health problem. Princeton, NJ: Robert Wood Johnson Foundation. www.rwjf.org; Substance Abuse and Mental Health Services Administration (2002, October). Report to congress on the prevention and treatment of co-occurring substance abuse disorders and mental disorders (Executive Summary). U.S. Dept. of Health and Human Services. Online: www.samhsa.gov/news/cl_congress2002.html

8 Bessel A. van der Kolk, M.D.: "The Compulsion to Reenact the Trauma", *Psychiatric Clinics of North America*, Vol. 12, Number 2, pp.389-411, June 1989.

A significant percentage of those with mental or substance use disorders suffer from more than one problem. Of those having any of the issues indicated in the Diagnostic Statistical Manual of Mental Disorders (DSM, Rev. IV), more than 70% are afflicted with depression, anxiety, substance abuse, or some combination of the three. Because these conditions are chronic in nature, they will not just go away if they are ignored. Without appropriate care they will usually get worse and will affect virtually every area of private and community life. And, like it or not, employers, particularly large employers such as the State, determine what the fate will be of both those who are afflicted and those who are affected by untreated mental and substance use disorders. The effects of restricting care for these conditions exacerbate the situation.

The nation's prison population in large measure is a reflection of the failure to address mental and substance use disorders. There are now more than 2 million people incarcerated in the United States in federal, state and local correctional facilities. The incidence of mental health problems is rampant in this population and the failure of employer health care plans to adequately cover these diseases is a contributing factor. Among females incarcerated, 75% in local jails, 73% in state prisons, and 61% in federal prisons had a mental health problem. Among males the percentages, while somewhat lower, were still very high: local jails, 63%, state prisons 55%, and federal prisons 44%.⁹ Research indicates that approximately 75% of those incarcerated are in jail or prison as a result of an alcohol or drug related crime or a crime committed while under the influence.¹⁰ The preponderance of these offenders have multiple mental and substance use disorders. There are approximately 27,000 people incarcerated in federal and state prisons in New Jersey, and probably another 12,000 to 14,000 in local jails. Most of them at one time or another were covered by an employee health plan, either from their own employer, or under a parent's or spouse's plan. When adding up the total number of beneficiaries covered by both public and private employers under the State's health plans, it is conservatively estimated that 5% of these offenders may well have been covered at some time under the State's health care plan. At a cost of approximately \$31,000 per year each, this computes to more than \$600 million annually.

Fetal Alcohol Syndrome, which is now more prevalent than Down syndrome and autism, occurs in 40,000 new born babies each year nationally.¹¹ While this may only represent 80 new cases per year covered by the State's health plans, at estimates ranging from \$1.4 to \$5 million per case life time¹², the cumulative annual cost to the State's health plan computes to about \$5 million. We can only speculate as to the cost of FAS that is already incurred by the New Jersey employee health plans. However, based on these national estimates and reducing the incidence ratio by 25%, over the next 10 years FAS could add \$275 million to the cost of New Jersey's employee health plans. Early identification and treatment of a mother's alcoholism could largely reduce this cost and the suffering that goes with it.

⁹ U.S. Department of Justice, Bureau of Justice Statistics.

¹⁰ Robert Wood Johnson Foundation, "Substance Abuse: The Nations Number One Health Problem", 2001.

¹¹ Sources; (1) Mayo Clinic: "Tools for Healthier Lives", May 23, 2007. www.mayoclinic.com/health/fetal-alcohol-syndrome. (2) Center for Disease Control U.S. Department of Health and Human Services, May 31, 2007. www.cdc.gov.ncbddd/fas

¹² Bertis Little, Golder Wilson, et al., The National Organization for Fetal Alcohol Syndrome, and "Fetal Alcohol Syndrome", Dallas Medical Journal, 1995.

Domestic violence, which occurs among roughly 14% of couples,¹³ is largely associated with alcohol abuse, although other mental disorders are also a factor. Among male perpetrators, alcohol was involved in 30% to 40% of the cases, and it was involved with 27% to 34% of female perpetrators. And the cost is huge. In 2000 the national cost of non-fatal injuries due to violence was more than \$70 billion, with \$65 billion due to lost productivity and nearly \$6 billion in medical care. The average cost per case for a non-fatal, self-inflicted injury was \$9726 in lost productivity and \$7234 in medical costs.¹⁴ Applying the national cost ratios to the State of New Jersey's employee population, they compute to approximately \$87 million per year.

That's the bad news. The good news is that effective mental health care can reduce this burden, saving dollars and lives at the same time. Social consequences aside, the State of New Jersey as an employer stands to benefit by assuring that its employees and dependents get good mental health care. Both the overall productivity of its employees and the efforts of the DPB to contain overall health care costs can be served by not placing arbitrary restrictions on access and amount of mental health care that ignore the needs of the specific patient.

B. The State of New Jersey as an Employer. First, let's look at the larger issue of employee productivity. Mental and substance use disorders have been estimated to cost employers huge amounts, not only in added medical costs, but in overall productivity. The cost of alcoholism alone is enormous. One of the best studies, conducted in 1985 by H.J. Harwood, estimated the cost of alcoholism to employers to be \$54 billion annually at that time. That would compute to more than \$100 billion today when adjusting for inflation. When adding the cost of other mental disorders and adjusting for duplication, the total may well exceed \$150 billion.

Many employers, public and private, have discovered how valuable effective mental health treatment can be when they conducted benefit to cost studies of their Employee Assistance Programs. Such analyses conducted by JWA have shown a positive benefit to cost ratio (BCR) ranging from 3 to 1 to 7 to 1 at the five year mark with a payback period as short as 10 months. All costs of treatment, the time off to get it, and the operating cost of the EAP were included in the equation. While there are many benefits to employers that result from effective mental health services, these studies included only one against which the costs were weighed: the improvement in use of sick leave after EAP participation. **Attachment A** summarizes these findings and points to the large potential cost to the state of arbitrarily restricting or denying care.

Such results could not have been possible if the mental and substance abuse treatment had not been effective. Indeed, research shows that "The Effect Size of Therapy" is 80%. This means that 80% of those in therapy are better off than an equivalent untreated population.¹⁵ It is noted that none of the employers in the BCR studies indicated on

¹³ R. Caetano, P. Schafer, C. Cunradi, *Alcohol Research and Health*, Winter 2001.

¹⁴ Centers for Disease Control, Injury Center: "The Cost of Violence in the United States" www.cdc.gov/ncipc/factsheet/CostOfViolence. Sources: Corso, P.S, Mercy, J.A., Simon, T.R., Finkelstein, E.A., and Miller, T.R.: "Medical Cost and Productivity Losses Due Interpersonal Violence and Self Directed Violence". *American Journal of preventive medicine*, 2007: 32 (6):474-482.

¹⁵ Scott Miller, Barry Duncan, and Mark Hubble, "Beyond Integration: The Triumph of Outcome over Process in Clinical Practice", Brattleboro Retreat Workshop, January 6, 2006.

Attachment A enlisted managed behavior health practices, which denied necessary care or constructed barriers to access.

C. The State of New Jersey as an Employee Health Plan Administrator. The primary purpose of the change in managing the out of network mental health benefit is to save the State money. Benefits managers, with limited resources and faced with health cost escalation that is 3 to 5 times greater than inflation, have long been tempted to simply look for quick fixes instead of delving into the systemic complexities that could produce a more permanent solution. For a number of reasons, mental health is often a target when quick cost cuts are sought. However, there are no quick or easy solutions. Short term savings have often meant greater long term expense. Numerous attempts to contain costs that seemed to have promise on the drawing board often backfired once they were implemented. Two major considerations stand out when reviewing the challenges of alleviating the cost escalation problems by cutting mental health services:

1. The impact of untreated or insufficiently treated mental and substance use disorders, and,
2. The cost of mental health treatment as a percentage of total health care costs.

Of all the considerations when attempting to contain employee health care cost escalation one of the most significant is the adverse co-morbid impact on overall medical surgical costs when mental and substance use disorders are either left untreated or are treated inappropriately. Because of its magnitude, the adverse co-morbid impact of untreated or inappropriately treated mental disorders will be discussed first.

D. The Co-morbid Impact of Untreated Mental Health and Substance Use Disorders. Co-morbidity is a health situation in which two or more health problems exist simultaneously and interact with each other to the overall detriment of the patient. The fact that one illness can exacerbate and sometimes even cause another is not news. Studies cited, in early publications on Employee Assistance Programs, about the relationship between alcoholism and medical-surgical conditions go back to the early 1960s.¹⁶ When JWA reviewed the research in depth in the late 1980's, it found that more than 300 studies had been completed on medical-surgical co-morbidity.

Attachment B is a detailed summary estimate of the impact of untreated mental and substance use disorders on a sample of JWA's customers' health care claims across the seventeen ICD-10 categories. The estimates are based on various co-morbidity research studies conducted over the past 40 years. Overall, this estimate is conservative and does not take into account the impact of mental and substance use disorders on congenital anomalies, perinatal diseases and diseases of the blood. As a result, these estimates are lower than those indicated in some studies. Nevertheless, substance use disorders alone were estimated to have affected about one third of the medical surgical claims in Attachment B. Other mental disorders were estimated to have impacted about half the medical surgical claims. If the co-morbid impact of substance use and mental disorders were combined, approximately 59% of the total claims would be affected after deducting for duplication due to mental/substance use

¹⁶ Dr. Per Sunby, "Alcoholism and Mortality" University of Oslo, Norway, The PENJERDEL study by Blue Cross Blue Shield of Pennsylvania, New Jersey and Delaware, 1979, Pell and D'Alonzo "Alcoholism and Absenteeism", Dupont Corporation, 1973.

co-morbidity. For the State of New Jersey, this represents approximately \$700 million of the \$1.1 billion it spent on its own employees in 2006.

Attachment C is based on more recent experience and a broader data base. It shows the co-morbid relationship between depression and four major ICD-10 disorders. Depression has a co-morbid rate of 23% with heart disease, 15% with diabetes, 42% with cancer, and 42% with HIV.¹⁷ While there are variations between the estimates, both represent large amounts of risk. **Attachment D** indicates the five ICD-10 disease categories that are impacted most by alcoholism and represent 40% of the total claims expense in Attachment B.

Not all co-morbid conditions involve a cause and effect relationship, although research indicates that many do. For example, there is a strong cause and effect relationship between alcoholism and injuries; depression and attempted suicides, which often trigger emergency room visits, particularly among women; alcoholism, depression, anxiety, and various traumatic episodes, both among those afflicted and with people in close proximity who are affected. But, cause and effect aside, in virtually all cases the substance or mental disorder can prolong the recovery process of a medical condition, making both the mental and medical issue more difficult and expensive to treat.

E. The Scope of the Problem in Financial Terms. By any measurement, the costs of treating mental and substance use disorders are a very small part of the overall health care cost escalation problem. In 2005 it was estimated that they represented slightly more than 3% of total health spending nationally¹⁸, and in our experience they rarely exceed 5% of our customers' total health expenditures. In plans where the mental health benefit is turned over to a Managed Behavioral Health Organization (MBHO), while the total cost including administration, debt reduction, and profit may reach these levels, the actual percentage spent on direct care is much lower due to loss ratios that are far less than those typically seen in medical HMOs or in plans with unmanaged mental health benefits.¹⁹

Unfortunately, as mentioned earlier, we do not really know how much mental health treatment costs the State's employee health plans. The DBP has not been able to advise us of the actual amount spent because these costs are buried in a labyrinth of contracts and subcontracts with loss ratios that have not been estimated. A ball park estimate, suggested by the DPB administrator, was in the range of \$50 million per year, which would compute to about 4.5% including Medicaid. But, regardless of whether the cost is 3% or 5%, perspective must be maintained in order to assess the contribution mental health can make in helping the DPB to address the overall cost escalation problem.

The bottom line consideration is this: If the total mental health expenditure was wiped-out entirely, the current rate of cost escalation of medical surgical care in the New Jersey Plus plan (51.9% from 2002 and 2006) would off-set such savings within five months, without factoring in the probable increase in medical surgical expense due to increased mental to medical co-morbidity. Again, unaddressed co-morbidity is one of the single most significant factors driving up health care costs in the United States. Even if the DPB change could lead to a savings matching the \$22 million experienced in New York City, which we are not convinced would

¹⁷ National Psychological Association conference on co-occurring disorders, Washington, DC, 2005.

¹⁸ U.S. Government: Substance Abuse and Mental Health Services Administration (SAMHSA).

¹⁹ J. Wrich & Associates, LLC, "Brief Summary of Audit Findings", August, 2006.

occur, it would be off-set within 10 weeks by medical inflation and higher rates of co-morbidity alone. When considering the effect of untreated mental and substance use disorders in areas such as corrections, fetal alcohol syndrome, State employee productivity loss, and family violence, the hypothetical savings coming out of an unknown expenditure seem highly dubious, at best.

To sharpen our perspective further, if the role of mental health professionals is diminished, a greater burden is placed on Primary Care Physicians to diagnose and refer mental health cases for treatment. Consider the untenable position into which both the PCP and the patient are cast. The managed care requirements enlisted by many HMOs have driven PCPs into a practice pattern that puts them in front of a patient for an average of only 7 to 10 minutes. In that brief time, they are expected to select from more than 170 ICD-10 disorders and render an accurate diagnosis. Starting with the presenting symptoms offered by the patients, many PCPs attempt to employ branch logic or a decision tree system to come up with a diagnosis. But, under these conditions, it is extremely difficult to differentiate between presenting and underlying conditions, or primary and secondary issues, much less assess the role of mental-substance use disorders in the overall medical condition. In the latter case, few primary care physicians have adequate training to even render a diagnosis, yet they prescribe more than 70% of anti-psychotic medications. At the same time, patients are rarely referred to a mental health practitioner with a specialty in their specific disorder, as shown earlier. The overall effect on the State of New Jersey's employee health plan is: greater costs for physician care; greater costs for drugs; and worse clinical outcomes.

Even when the focus is limited to the impact of mental and substance use disorders on overall medical costs paid for by the State's employee health plans, the restrictions that are being imposed by the DPB cannot be justified. The amount of money that might be saved hypothetically cannot be justified by the actual amount at risk when one considers the adverse co-morbid impact of untreated mental and substance use disorders on medical surgical costs.

III. CONCLUSION

The State has choices regarding its employee mental health care expenditures. The first is in deciding the amount it should reasonably spend for mental health and substance abuse treatment. Next, and equally important, is the question of *how* it expends these dollars.

Audits conducted by JWA over the past fifteen years consistently found that the loss ratios for managed behavioral health organizations (MBHO) were far lower than for medical HMOs. In many instances, the non-clinical component of the premium exceeded the amount spent on direct care. General and administrative expense, debt reduction brought on by mergers and acquisitions, case management expense, and profit resulted in loss ratios ranging from 38% to 55% in services we have audited versus an average exceeding 80%, typical of HMOs, and more than 90% for Medicare and Medicaid.

Unfortunately, since these costs are often buried in subcontracted service arrangements between primary insurance carriers and MBHOs there is virtually no transparency. Employers and employees are unaware of the relatively small percent of the mental health premium that is actually expended on direct care. As a result, states such as Vermont, Maryland, and most recently New Jersey have enacted loss-ratio legislation that requires disclosure of such information. But even in these States, sub-contract arrangements and ERISA loop holes exempt many MBHOs from the reporting requirements. But, the questions remain: how much should be spent and for what purpose?

In 2000, JWA developed a study based on best practices for the State of Maryland to determine how much should be allocated for mental and substance abuse treatment in their Health Care for All program. Segmented by major DSM IV disorders and Global Assessment of Functioning levels, it indicated that an expenditure level that would compute to approximately 5% of the New Jersey employee health plan expenditures would be adequate when including the medications costs which normally show up in the medical surgical line item. We believe the 3% national average is too low to do the job and the adverse results are seen in a host of problem areas including escalating co-morbid medical costs and incarceration levels that make the U.S. first in the world in both areas.

The following chart, Table 3, illustrates two major scenarios in connection with how mental health allocations can be spent – one with managed behavioral care into which the DPB is channeling enrollees, and one without. Within each scenario are three options regarding the amount spent on mental health. The first scenario assumes an expenditure of 5% of total health care spending; the second uses the \$50 million ball park figure cited by DPB, which computes to about 4.6%; and the third represents the estimated national average of 3%. The managed care administrative costs and loss ratios are based on our experience auditing MBHOs which represent nearly half of the 160 million U.S. citizens covered by such plans. The non-managed administrative cost estimates and loss ratios are based on the State of Vermont's loss ratio data from Act 129. This data shows a loss ratio average of 85% and covers both private and public sector employee plans.

Table 3

	DPB's OBJECTIVE TO MANAGE ALL MENTAL HEALTH SERVICES (000)			VERMONT'S EXPERIENCE WITH UNMANAGED MENTAL HEALTH (000)		
	5% MH Estimate	BallPark Estimate	National Average	5% MH Estimate	BallPark Estimate	National Average
NJ Emp Health Expenses 2007	\$1175930	\$1175930	\$1175930	\$1175930	\$1175930	\$1175930
Tot Estimated MH Exp	58800	50000	37630	58800	50000	37630
Gen&Adm, Debt and Profit	26460	22500	16930	8820	7500	5645
Available for direct care	\$32360	\$27500	\$20700	\$49980	\$42500	\$31985

As the managed care clamp tightens on levels and lengths of care, the associated administrative expense tends to level off, representing an increasingly greater percentage of the total expenditure. Therefore, the chart does not show what the result would be if DPB actually reduced its expenditure from the \$50 million ball park estimate by the \$22 million reportedly saved in New York City down to \$28 million, because contemporary managed care administrative and profit loadings would consume practically the entire remaining amount.

IV. THE SOLUTION.

The State of New Jersey work force is special because, more than any other group of employees, the quality of its work affects every single person in our state. In addition to the 113,000 employees and 36,000 retirees covered by State of New Jersey employee health plans, there are approximately 225,000 dependents – a total approaching 375,000 people. When including teachers, other enrollees from local governments and the private sector, the total number of covered lives may well approach 800,000, more than 9% of the entire state population. Getting the right care the first time at a reasonable cost in the early stages of their mental health problems is a benefit to everyone.

It is in this context that we offer the following recommendations.

A. The state of NJ needs to find out what the actual costs are of providing mental health services. It needs to make an analysis across all employee plans, segmenting these costs from expenses incurred for medical surgical services. This means identifying all the administrative loadings that managed behavioral health organizations pass on to the State under the guise of “managing” the care and differentiating the actual costs incurred for therapy from all administrative loadings in accordance with the Mental Health Loss Ratio legislation enacted by the New Jersey State legislature in 2005.

B. There needs to be a loss ratio analysis comparing the costs of managed care and unmanaged care adjusted for like samples and differentiating between administrative and direct care costs. The purpose of this analysis is to determine what percentage of the premium is expended on direct care between the two types of benefits and the potential co-morbid affect on medical surgical costs.

C. There needs to be an analysis of clinical outcomes of State of New Jersey enrollees. This analysis should compare the recovery rates of those whose care was subjected to managed behavioral care practices and those who were not.

D. The State needs to conduct ongoing and periodic performance reviews for mental health services. The reviews should cover each of the state plans and should be conducted by an independent auditor.

E. The State needs to include NJPA and other licensed mental health professionals in the planning and implementation of the new SHBP. Few issues are more adversarial than health care delivery. Yet, more than most areas, this one requires cooperation, understanding, and advocacy. People tend to support that which they have had a hand in creating.

F. The State of New Jersey needs to return to the system of not managing out-of-network benefits as before. Employees pay extra for the option of securing services without the interference of managed care. They are, therefore, entitled to receive treatment from a qualified therapist who has actually seen them without having the treatment directed, modified, curtailed or terminated by an insurance company.

ATTACHMENT A. SUMMARY OF BENEFIT TO COST ANALYSES (BCR)

Many organizations have have estimated the benefit to cost ratio of their Employee Assistance programs (EAPs). An important factor in such ratios is the cost and effectiveness of treatment for mental health and substance use disorders. If treatment is overpriced or ineffective, the BCR will be adversely affected. Other factors in the formula include the costs of the EAP's operation and of sick leave pre/post program use.

The following table summarizes studies that have been conducted over the past 15 years by J. Wrich & Associates, Inc. and include some of the largest and most prominent employers in both the public and private sectors. Included are both unionized and non-union work environments.

EMPLOYER		PAYBACK PERIOD	BENEFIT TO COST RATIO			OVERALL RATING	
Code	Employees	Months	1st Year	5th Year	10th Year	Score*	Rank
A	900,000	10	1.3 to 1.0	7.2 to 1.0	13.7 to 1.0	12.5	1
B	60,000	14	.8 to 1.0	7.0 to 1.0	15.0 to 1.0	14.5	2.5
C	49,000	18	.4 to 1.0	8.5 to 1.0	15.0 to 1.0	14.5	2.5
D	14,000	23	(2.1) to 1.0	6.8 to 1.0	15.8 to 1.0	17.0	4
E	45,000	11	1.1 to 1.0	6.4 to 1.0	12.3 to 1.0	19.5	5
F	30,000	30	(2.1) to 1.0	5.6 to 1.0	15.3 to 1.0	24.0	6
G	4,500	28	(2.4) to 1.0	6.4 to 1.0	15.2 to 1.0	24.5	7
H	4,800	33	(2.1) to 1.0	4.9 to 1.0	13.6 to 1.0	32.0	9
I	2,500	27	(2.7) to 1.0	5.4 to 1.0	13.8 to 1.0	32.0	9
J	26,000	41	(5.3) to 1.0	5.2 to 1.0	16.7 to 1.0	32.0	9
K	4,200	38	(2.5) to 1.0	3.3 to 1.0	9.0 to 1.0	41.0	11

* Scores are an accumulation of rankings in four categories: Payback Period; 1st year BCR; 5th year BCR; and 10th year BCR. Example: Employer B ranked 4th in Payback Period, 4th in 1st year BCR, 1st in 5th year BCR and tied for 5th in 10th year BCR for a cumulative score of 14.5.

ATTACHMENT B

ESTIMATE OF THE COST OF COMORBIDITY
JWA AGGREGATE CLAIMS SAMPLE

ICD-10 Category	ICD-10 Code	\$\$ Paid	% of Total \$\$ Paid	Comment*	% Est. Comorbidity MH/CD**	\$\$ at Risk Due to C/M (Low)	\$\$ at Risk Due to C/M (High)
Diseases of the Circulatory System	390-459	\$15,734,316	13	Alcoholics have 1.6 to 1.9 times the rate of the gen. pop.	32-49	\$5,041,381	\$7,719,615
Diseases of the Digestive System	520-579	10,873,280	8	Alcoholics have 2.4 times the rate of the gen. pop.	43-65	4,675,510	7,067,362
Diseases of the Genitourinary System	580-629	10,075,692	8	Not significant	N/S	N/S	N/S
Neoplasms	140-239	14,167,826	13	Alcoholics have 2.1 times the rate of the gen. pop.	38-56	5,383,774	7,933,983
Diseases of the Musculoskeletal System and Connective Tissue	710-739	11,979,378	10	Alcoholics have 2.7 times the rate of the gen. pop.	49-73	5,869,895	8,804,843
Complications of Pregnancy, Childbirth and the Puerperium	630-679	4,017,272	3	Alcoholics have 1.6 to 1.9 times the rate of the gen. pop.	32-49	1,285,527	1,868,463
Mental Disorders	290-319	5,496,206	5	Alcoholism has very high comorbidity rates with all high incidence mental disorders, i.e.: Affective Disorders, Anxiety and V-Codes	100	5,496,206	5,496,206
Infections	001-139	1,986,730	2	Most infections do not have a high C/M rate with MH/CD. However, sexually transmitted diseases do: alcoholics have 1.8 times the gen. pop. rate	33-50	655,621	993,365
Endocrine, Nutritional and Metabolic Disease, Immunity Disorders	240-279	3,782,640	4	Alcoholics have 2.7 times the rate of the gen. pop.	49-73	1,853,494	2,780,240
Diseases of the Blood and Blood Forming Organs	280-289	972,836	1	We do not have C/M estimates for this disease category.	Unknown		
Diseases of the nervous System and Sense Organs	320-389	5,171,154	5	Alcoholics have 1.5 times the rate of the gen. pop.	27-41	1,386,212	2,094,317

ATTACHMENT B, continued

ESTIMATE OF THE COST OF COMORBIDITY
JWA AGGREGATE CLAIMS SAMPLE

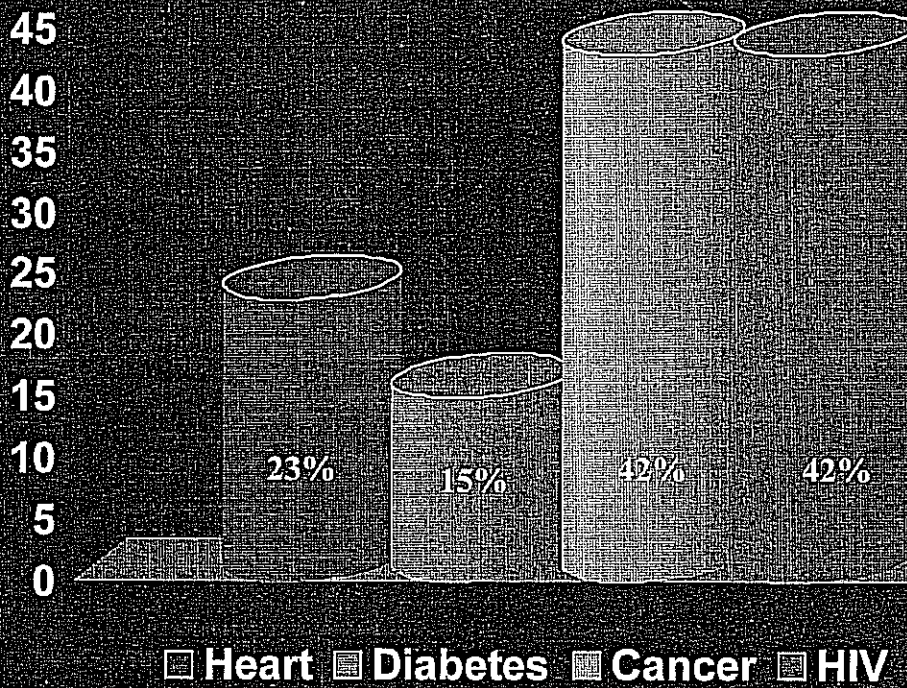
Diseases of the Respiratory System	450-519	\$8,942,748	7	Alcoholics have 1.5 to 2.5 times the rate of the gen. pop.	36-54	\$3,219,389	\$4,829,084
Diseases of the Skin and Subcutaneous Tissue	680-709	1,918,764	2	We do not have C/M estimates for this disease category.	Unknown		
Congenital Anomalies	740-759	1,120,688	1	We do not have C/M estimates for this disease category.	Unknown		
Certain Conditions originating in the Perinatal Period	760-779	5,764,668	3	We do not have C/M estimates for this disease category.	Unknown		
Symptoms, Signs and Ill-defined Conditions	780-799	11,889,054	9	Alcoholics have 1.8 times the rate of the gen. pop.	32-49	3,804,497	5,706,746
Injury and Poisonings	800-999	9,398,226	8	Alcoholics have 2.7 to 3.5 times the rate of the gen. pop.	56-84	5,263,007	7,894,570
F.I. Health Status	N/A		3	N/A			
TOTAL		\$126,529,548				\$43,994,513	\$63,288,734

* Source: Various national research studies.

** The incidence of mental health problems is approximately 50% greater than substance use disorders. Thus, the low end of the range is based on substance use disorders (primarily alcoholism) and the high end is based on mental disorders. If the comorbid impact of mental disorders (MH) and chemical dependency (CD) are combined, the estimated risk would be approximately \$75,000,000 after discounting for duplication due to MH/CD comorbidity of 30%..

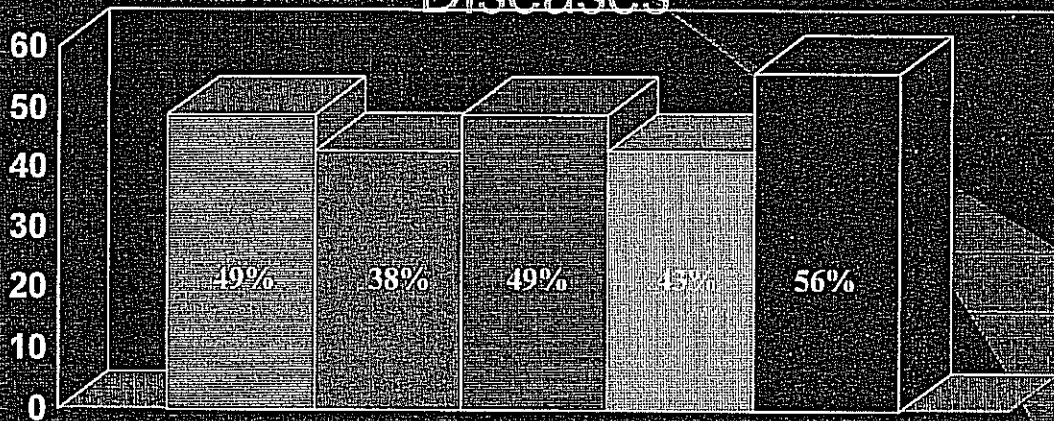
ATTACHMENT C

Comorbidity: Depression and...



ATTACHMENT D

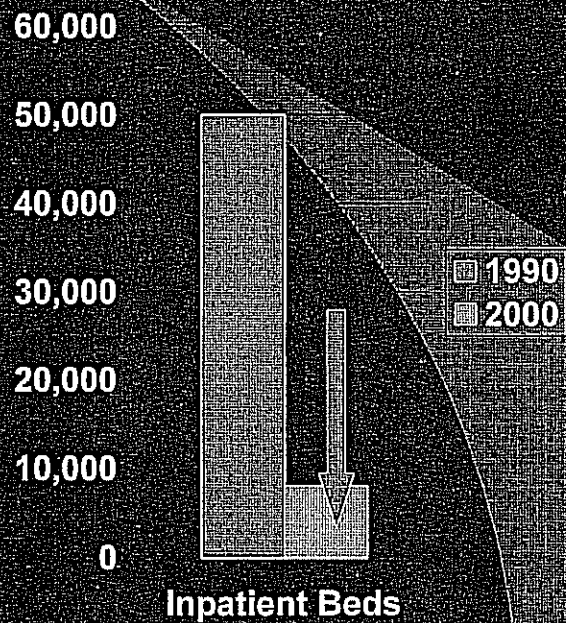
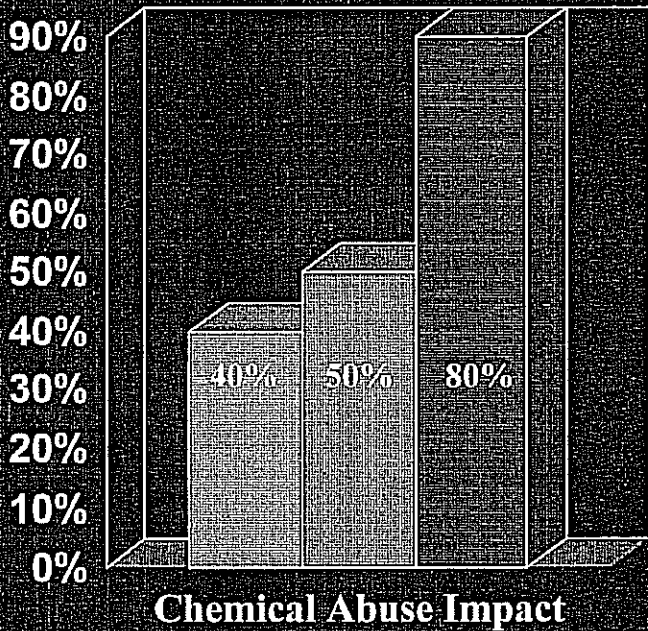
Co-Morbidity: Alcoholism and ICD 10 Diseases



- Endocrine, Nutritional, Metabolic, Immunity
- Neoplasms
- Musculoskeletal, Connective Tissue
- Digestive
- Injury, Poisonings

Attachment E

Impact: Alcohol Problems on Society



■ Health Care ■ Traffic Fatalities ■ Incarcerated