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ALL HEALTH INSURANCE PLANS MUST COVER MENTAL ILLNESS

STATEMENT AT PUBLIC HEARING

NEW YORK STATE JOINT LEGISLATIVE COMMITTEE ON HEALTH INSURANCE PLANS

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by

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Senator Metcalf and members of the committee:

I feel it a particular privilege to testify before this very important committee this morning, because I know of no greater problem in the field of mental illness than the inability of most people afflicted by emotional disturbances to pay for the psychiatric care which they so desperately need.

Sigmund Freud, the father of modern psychiatry, was deeply aware of the economic barrier which prevented the great masses of people from gaining access to psychiatric treatment. Toward the close of a life dedicated to the relief of suffering humanity, Freud wrote that "at present we can do nothing for the crowded ranks of people who suffer exceedingly from neuroses."

Looking a bit into the future, Freud expressed his hope for the dissemination of psychiatric care to the great masses of people in the following words written in 1919:

"Now let us assume that by some kind of organization we were able to increase our numbers to an extent sufficient for treating large masses of people. Then on the other hand, one may reasonably expect that at some time or other the conscience of the community will awake and admonish it that the poor man has just as much right to help for his mind as he now has to the surgeon's means of saving his life; and that the neuroses menace the health of a people no less than tuberculosis, and can be left as little as the latter to the feeble handling of individuals."

In 1958, some forty years after the aforementioned statement by Freud, there appeared a remarkable book "Social Class and Mental Illness" by Dr. Frederick C. Redlich and Dr. August B. Hollingshead of Yale University. In essence, this book is a meticulously detailed study of the economic factors involved in the availability of psychiatric care to the American people. It includes a study of the psychiatric care available to, and the economic costs borne by, close to 2,000 patients and their families.

The patients studied in the survey were divided up into five classes according to their residence, occupation and formal education. These criteria basically reflected their economic status. They ran the scale from the wealthy group in Class I to the low-income group in Class V.

At the outset of the eight-year study, the authors posed this fundamental question: "Are expenditures on psychiatric care linked to the class status of the patients?"

They have produced 400 pages of documentation in answering the question affirmatively. Since this committee is most

interested in the care of psychiatric patients in general hospitals or in private mental hospitals, I will restrict most of the data to that area. The Class V patients--the low income group--rarely use any general or private psychiatric facilities. In the other four classes, the length of hospital stay is directly related to the pocketbook. For example, the average length of stay for the Class I group is 138 days as against 27 days for the low-income Group IV patients. Furthermore, the authors document the very interesting point that the wealthy patients even get much better discount rates based upon their class position.

"Clearly, a patient's class status is linked to the length of time he remains in a private mental hospital. . . . Private mental hospitals are oriented primarily toward the aristocratic tradition," the authors report.

They also explode the sacred myth of charity care for indigents in the following incisive comment:

"The folklore of medical practice fosters the belief that a considerable portion of patients are carried free by practitioners. This belief may be true in the general practice of medicine, but it needs to be modified before it fits the facts of private psychiatric practice. Only nine patients were carried free by private practitioners, and no psychiatrist carried more than one free patient. . . . Not a single psychoanalyst and analytically-oriented private practitioner is treating a patient free, although a few patients are treated at slightly reduced fees."

I was most shocked by the amount of caste distinction prevalent in public psychiatric clinics. I was under the impression that

these clinics treated all people equally, regardless of social status. The Redlich and Hollingshead study flatly refutes this. Leaving aside Class I patients, who rarely use a public clinic, the survey documents the fact that Class II patients receive the most therapy and Class V patients the least, leading the authors to conclude that "the subtleties of status enter into the practice of psychiatry in clinics as well as in private hospitals and in private practice."

The economic discrepancies are really appalling in this so-called democracy of ours. For example, the average cost of caring for the Class I and II well-heeled psychotics in private facilities is approximately $3,400; the cost for the low-income Class V psychotic is $13. Some of the bills for the care and cultivation of wealthy psychotics are really staggering. One family studied in the survey paid $160,000 over nine years for analytic therapy and treatment for a family member in four private hospitals, and they received heavy discounts from each hospital.

All of this data, and much more which limitations of space prevent me from introducing, led the authors to this somewhat bitter summation:

"Social inequalities in treatment are seen most clearly among schizophrenic patients. The Class IV or V schizophrenic, once cast off by his family and community, may receive one or two series of organic treatments in a public hospital. If these treatments do not succeed, the patient drifts to the back wards where, in stultifying isolation, he regresses even more into a world of his

own. Rarely, however, do we see in the Class I or II schizophrenic patients in private hospitals, who may get the benefit of psychotherapy and environmental treatment, deterioration comparable to what we see regularly in the chronic wards of the state hospitals. Indeed, in wealthy families who can afford to provide show farms and boat yards as occupational therapy for their schizophrenic scions, we have observed over a period of years unmistakable schizophrenic symptomatology, but little deterioration. . . . These differences add up to deep social fissures in psychiatric treatment, such as we do not encounter in the rest of medicine with the possible exception of peacetime cosmetic surgery."

The Redlich-Hollingshead data is but one of a number of impressive studies of the economic problems involved in getting psychiatric care. At the 1957 convention of the American Psychiatric Association, Mrs. Edith Alt, of the Health Insurance Plan of Greater New York, presented some interesting figures on income levels in relation to obtaining private psychiatric care. A study of the subscribers to HIP revealed that only about 10 per cent of the group is in a financial position to buy even minimal private psychiatric care. She pointed out that a family of four with an income of $10,000 would not have much more than $20 a week for payment of psychiatric fees. At the present level of private psychiatric fees in New York, this would buy from 30 to 45 minutes a week of psychotherapy. On the basis of a great deal of data collected by her organization, Mrs. Alt concluded:

"It is probably no exaggeration to acknowledge that this challenge of providing psychiatric care, particularly on an

ambulatory basis, for low and middle income groups may well head the list of unresolved health service problems facing our country."

The solution to this critical problem seems to me rather simple. The non-profit and commercial insurance companies must cease and desist from any further discrimination against mental illness in their basic policies. The present insurance coverage of mental illness is sporadic and really an actuarial joke. Let me cite you a few examples taken from the 1955 official Blue Cross Guide published by the Blue Cross Commission.

If you live in the Commonwealth of Pennsylvania, the insurability of acute mental illness depends upon the city in which you reside. If you live in Harrisburg, you are entitled to only ten days of hospital coverage during your entire lifetime. In Philadelphia, with the same illness, you can get 20 days of hospitalization a year, and in Allentown you can get 30 days a year. If you live in Pittsburgh, you can stay in the hospital until your malady is diagnosed as mental illness. At that awful moment you are no longer covered, and you have to either pay out of your own pocketbook or get out of the hospital.

As you members of the committee know, the situation in New York is even worse. In the city of Buffalo, where we are presently assembled, you are covered until diagnosed. The same holds true for the capital city of Albany. If you live in Syracuse, Utica, Watertown, or Jamestown, you better not get mentally ill--you can't get one single solitary day of coverage in your entire lifetime. If you live in the great city of New York, you get only ten days

a year if they use the shock machine on you. If they do anything else, such as psychotherapy, you are not covered. However, you can get 21 days of surgical coverage from the day of operation, although I don't know what this covers outside of the possible removal of the patient's head.

If you live in other parts of the country, you are much more fortunate. In Cleveland and Cincinnati, you can get from 70 to 120 days a year of hospital coverage for mental illness. If you live in the empire of Texas, where everybody is supposed to be normal, you can get 70 days of hospital coverage for each confinement. If you live in California, for once it is better to live in Los Angeles. You can get 70 days of coverage in Los Angeles, but if you live in Oakland, for example, you get none.

The whole thing is actuarially absurd. For example, Cleveland Blue Cross can cover mental illness for 120 days in a year, but Columbus Blue Cross can't cover it at all. It is the same kind of illness, it has pretty much the same kind of diagnosis, and yet geographic location pretty much determines the length of coverage.

Why these differences in coverage? They really reflect two important factors--the varying prejudices of individual insurance companies and the general apathy of the public.

Take the example of one of the most enlightened insurance companies in the country, Cleveland Blue Cross. In 1934, when it was founded, it provided 21 days of hospital care for physical illness, but it specifically excluded "nervous and mental conditions." In 1939, the 21 days of coverage was extended to mental

conditions. Between 1945 and 1953, the days of coverage were extended from 21 days per year for physical and mental illness to 120 days per year.

How did Cleveland do this? As John R. Mannix, executive vice president of the Cleveland plan, explained to the American Psychiatric Association last year, it came about "only as a result of public demand and could come only as fast as the public was willing to meet the necessary cost of such care on a prepayment basis." What does it cost the average family in Cleveland? It costs $12.40 a month for a comprehensive 120 day semi-private contract and a broad medical-surgical contract covering both physical and mental illness. It is important to note also that Cleveland Blue Shield provides the same physicians' benefits in psychiatric cases as in other medical cases. Like the hospital plan, these benefits cover physicians' services in hospitalized cases for a period of 120 days.

Some actuaries say that the addition of psychiatric care to insurance coverage will bankrupt the companies. What are the facts? Cleveland Blue Cross has been covering mental illness for approximately 20 years. The cost of such care has been running somewhat <u>less than one per cent</u> of total hospital claims of all types.

Then there is the old bromide about the length of hospital stay of psychiatric patients. In other words, people love schizophrenia so much that they will do anything to prolong its miserable course. What are the facts? While the Cleveland Blue Cross plan provides 120 days of hospital care for mental illness, the average length of stay of psychiatric patients is only about 30 days.

Furthermore, insurance actuaries argue that as you increase the insurance coverage of mental illness, you will prolong the hospital stay of psychiatric patients. The Cleveland experience is exactly the reverse of this. Although the days of coverage were extended from 21 to 120 days between 1945 and 1953, the average length of stay of the psychiatric patient decreased from 37 days in 1947 to 29 days in 1956. This latter figure is undoubtedly due in great part to improved treatment procedures now available to psychiatric patients.

The Cleveland Blue Cross experience is not atypical; it is really quite representative of the experience of most insurance plans which cover mental illness without discrimination. Take the cost of hospital coverage. Dr. Louis Reed, formerly a health economist with the United States Public Health Service and one of the nation's top authorities on health insurance, made a comprehensive study of the costs of coverage of mental illness which he reported to the American Psychiatric Association.

"As regards costs, at present about two per cent of all patient days in short-term general hospitals are provided to patients in the psychiatric units of these hospitals. This should indicate that on the basis of prevailing practices, full coverage of psychiatric cases in the general hospitals should not increase a plan's cost by more than two per cent," Dr. Reed told the association. . . . "One Blue Cross plan, which covers mental cases for up to 120 days in general hospitals and 30 days in other hospitals, reports that its payments for mental, psychoneurotic, and personality

disorder cases amount to 3.2% of its total in-patient payments. An insurance company estimates that under its basic hospitalization plan, three to five per cent of its hospital expense is for psychoneurotic disorders."

The National Association of Private Psychiatric Hospitals recently issued a study which confirms both the findings of Dr. Reed and of the Cleveland Blue Cross plan. For example, it reports the actuarial experience of the Dallas Blue Cross plan, which since 1941 has covered mental and emotional illnesses, alcoholism, and drug addiction without discrimination. In a cost study of more than 12,000 consecutive patients, mental and emotional disorders accounted for only 2.7% of the total claims of the Dallas plan. Compared to this, tumor cases accounted for about five per cent of the claims, and heart diseases between five and six per cent of the claims.

The persistent myth about the excessive length of hospitalization for psychiatric illness is also exploded by much additional data across the country which corroborates the Cleveland Blue Cross experience. For example, Blue Cross of Southern California reports that mental and emotional cases have an average hospital stay of 15.8 days as against 45.8 days for tuberculosis and 13.9 for virus diseases.

At the Syracuse hearing of this committee, you received evidence from the managing director of the Rochester Blue Cross plan that the average stay in a psychiatric facility is about 21 days, from which he concluded that a 30-day hospital benefit is sufficient

for the vast majority of patients. At that same hearing you received impressive data from Strong Memorial Hospital, which has one of the finest psychiatric wings in the nation. Over a ten year period, Strong Memorial has given an average of 11,000 in-patient days of care a year to about 700 patients. The average hospital stay in the psychiatric wing has been about 16 days. Over 90 per cent of the patients treated at Strong Memorial have been discharged back to the community, their jobs, and normal productive lives.

All of the aforementioned data, and much more which time prevents me from including, offer incontrovertible evidence that emotional illness can, and should be, covered for a minimum of 30 days a year by every health insurance plan. Furthermore, I want to make it crystal clear that this should be included in the basic coverage of the plan. I am against an extra rider for mental illness which asks the family to pay an extra charge for this coverage. This is actuarial nonsense. If the Insurance companies of America cannot cover the most prevalent illness in the nation in in their basic policies, they really forfeit the right to the patronage of the people.

I know that there are serious and controversial problems involved in the rising costs of Blue Cross premiums due to increased professional salaries, a rise in the cost of equipment, and increased demands for a higher level of hospital care. Rate adjustments have had to be made, here in New York and elsewhere.

However, I do not think that Blue Cross and Blue Shield rates should be as high as they are. At public hearings of the President's Commission on the Health Needs of the Nation, of which I was staff Director, we received an enormous amount of data indicating excessive over-hospitalization of patients by doctors. One reason for this over-hospitalization lies in the narrow limitation of many insurance contracts. For example, in thousands of cases patients are hospitalized for diagnostic procedures which are not covered if given outside of the hospital. I think these procedures should be covered on an out-patient basis; health insurance must reach the point where it covers physicians' care in the office or the clinic.

Doctors have additional reasons for hospitalization of patients. It is convenient for them to have the patients in one place so that they can make quick morning rounds and then get on to the 50 patients in the waiting room at their office. Furthermore, in this way the doctors are assured that their bills will be paid, and this is no minor incentive in the over-hospitalization of patients.

Many of the thoughtful leaders of the insurance industry have pleaded with the medical profession to stop killing the golden goose which feeds them. Many leaders of Blue Shield, the doctors' own plan for coverage of surgical expenses, have warned their colleagues against excessive surgical procedures which are threatening the solvency of a number of Blue Shield plans. They remember, with some bitterness, the Blue Shield scandals in California a few years

back when more than a million dollars in excessive and false billings by the doctors themselves threatened the very future of that plan.

Organized labor is pretty well fed up with some of these practices. For a number of years, the United Mine Workers tried to cover their workers in a contractual plan with the doctors. It failed. Dr. Warren Draper, the former Deputy Surgeon General of the United States Public Health Service and now Executive Medical Officer of the United Mine Workers, has presented evidence to the American Medical Association on a number of occasions of the false and excessive billings his organization was saddled with by doctors in Pennsylvania, West Virginia, and elsewhere. On the basis of this unfortunate experience, the United Mine Workers has set up its own hospital and medical care plan. Within the past year the United Auto Workers have begun to move in the same direction, and just two weeks ago the newspapers reported that the United Steel Workers of America are planning a similar hospital and medical care system of their own. I mention these developments because they directly concern this hearing today. I strongly favor the continuance of voluntary health insurance in America. But I say, categorically, that its days are numbered if it continues to jack up its premiums because of over-hospitalization and excessive billings by the medical profession.

Mr. Chairman, there is no doubt in my mind that every health policyholder in the state of New York can be covered for a minimum of 30 days per year for psychiatric illness. I am delighted that

the Rochester Blue Cross has pioneered in this coverage, and I hope that its example will persuade other Blue Cross and insurance companies in the state to cover mental illness for the same length of time.

If persuasion does not work, there are several alternatives. These plans are licensed by the state of New York, and their rates are subject to approval by the State Insurance Commissioner. I think no health insurance plan in the state should continue to receive a license if it refuses to cover psychiatric illness for at least 30 days per year. If the State Insurance Commissioner needs some persuasion on this matter, then it might be necessary for this distinguished committee to prepare legislation making it mandatory for all health insurance plans licensed in the state of New York to cover psychiatric illness.

Mr. Chairman, we are on the move in this state and in the nation in the provision of an increased number of beds in general hospitals for the care of psychiatric illness. However, too many of these beds are out of the economic reach of the average citizen. The only solution is complete and non-discriminatory coverage of psychiatric illness so that these beds and these facilities can achieve their full treatment potential.