



The Association of the Bar of the City of New York

March 30, 2005

Honorable Joseph L. Bruno
Albany Office
Legislative Office Building, Room 909
Albany, NY 12247

Honorable Sheldon Silver
Assemblyman Sheldon Silver
Legislative Office Building, Room 932
Albany, NY 12248

Dear Sirs:

I. The Committee strongly opposes the Governor's proposal to eliminate coverage of mental illness, alcoholism, and substance abuse treatment services from Family Health Plus

The Committee on Mental Health Law (the "Committee") of the Association of the Bar of the City of New York urges you to restore in the Legislature's version of the state budget the cuts Governor Pataki proposed to the Family Health Plus ("FHP") program with respect to mental health, alcoholism and substance abuse services ("mental health care"). The Committee strongly objects to the proposed exclusion of mental/behavioral health care from coverage under FHP and urges you to take action immediately. The elimination of coverage for mental health care proposed in the Governor's Executive Budget is not a cost-cutting measure but a cost-shifting measure and it is directly contrary to the growing public sentiment in support of parity in coverage of mental health care and physical health care.

The Executive Budget for 2005-2006 (S.992/A.1922) proposes in Article VII, Part C, section 36 to delete from the definition of "health care services" in '369-ee1(e) of the Social Services Law (a) inpatient hospital services provided by a facility operated by the Office of Mental Health and (b) inpatient and outpatient mental health and alcohol and substance abuse services. By excluding these services from coverage in Family Health Plus, the budget would in effect discriminate against low-income New Yorkers who are vulnerable to the economic impact which results when there is not affordable access to these services.

II. The economic benefits which would accrue from achieving parity in coverage weigh against eliminating existing parity under FHP

In the course of expressing its support for enactment of Timothy's Law, S.5329/A.8301, this Committee articulated the concrete economic argument in favor of parity in coverage: the financial cost of not covering mental health care significantly harms employee productivity and drives up the total cost of doing business. The argument in favor of extending coverage to achieve parity in commercial health insurance certainly weighs against reducing coverage to eliminate parity in family health insurance plans, as the Executive Budget would do.

Long-term mental illness is one of the three leading causes of disability.ⁱ Disability caused by mental illness may manifest itself in a number of ways, including increased physical health care costs,ⁱⁱ absenteeism, reduced productivity, alcoholism and substance abuse. Depression, a specific type of mental illness, will affect sixteen percent of Americans sometimes in their lives severely enough to require mental health treatment.ⁱⁱⁱ Depression costs employers \$44 billion a year in lost productive time.^{iv}

There is ample evidence that proper mental health treatment is not only therapeutically effective but cost-effective as well. A number of corporations provide comprehensive mental health benefits because the costs of providing them outweigh the costs of untreated mental illness in the workplace. When a large financial services company increased its mental health benefits, its mental health costs fell over a twelve-year period from 15 percent to 6 percent of total health costs.^v When a large mining company provided mental health counseling for employees, its hospital, medical, and surgical costs decreased 48.9 percent.^{vi} Conversely, after a large Connecticut corporation reduced its mental health coverage by 30 percent, employees who had previously used services available through the corporation's mental health insurance coverage increased their use of physical health benefits by 37 percent and increased their use of sick leave by 22 percent.^{vii}

The foregoing measurements show that mental health care actually reduces the costs to society by stemming mental illness symptoms that will otherwise manifest at a higher cost. Reducing or eliminating mental health care, then, does not reduce or eliminate costs; instead the costs are incurred elsewhere. Reducing or eliminating mental health care coverage does not cut costs: it only shifts costs.

This point argues strongly against reducing mental health care coverage for the approximately 600,000 persons enrolled in FHP.^{viii} It is easily foreseeable that depriving low-income working people of access to mental health care greatly increases the likelihood that FHP enrollees who are treating mental illness or who are at risk for mental illness will be unable to maintain their stability. In 2004, 19,297 FHP enrollees accessed care for “mental disorders,” a major diagnostic category in the American Medical Association’s International Classification of Diseases (ICD-9) Manual, 86,122 times.^{ix} When FHP enrollees lose their functionality and find no means of obtaining help, the absence of support, due to the elimination of mental health care coverage, will lead to more severe consequences on the whole than would result with the current safety net of coverage under FHP still in place.

An intelligent social policy is one that seeks to reduce risks and minimize problems to the extent possible rather than wait to treat a problem at its most severe stage. Both perpetuation of a deficit between coverage of mental health care and coverage of other health care conditions, on the one hand, and elimination of existing parity in coverage, on the other, are both retrograde policy choices that renounce the opportunity to minimize social harm at low costs, and instead externalize the harm at higher costs. We do not believe that death and disability resulting from lower or reduced mental health care coverage are a savings to society. In that regard, we note that both the Senate and the Assembly have expressed their desire to pass a mental health parity law. In any event, if reducing mental health care coverage results in enrollees losing their ability to earn a living and they and their families require public assistance, then New York will not save money.

At the very least, before eliminating mental health coverage from FHP, it is incumbent upon the Governor and anyone else supportive of the proposed exclusion contained in the Executive Budget to commission a study of the social costs likely to result from such an exclusion. Opponents of parity under Timothy’s Law proposed conducting a cost-benefits analysis of mental parity to determine the worthiness of parity as a policy; it would only be appropriate to require such an assessment when the Governor proposes eliminating existing parity.

III. Exclusion of mental health care from coverage for low-income New Yorkers would be a major step backwards from the movement towards parity

Thirty-eight other states have enacted some form of parity law. In New York, a broad public coalition that has been advocating in favor of passage of parity legislation, which advocacy culminated in the introduction of Timothy's Law into the Legislature. From the Committee's perspective, fiscal prudence, the greater welfare of society as a whole, ethical imperatives, and the dominant public sentiment favor enactment of legislation requiring parity in coverage of mental health care and care for other health conditions; they necessarily oppose the Governor's proposed elimination of mental health care coverage as a service covered by Family Health Plus.

Respectfully submitted,

Virginia K. Trunkes, Esq.
Chair, Committee on Mental Health Law

cc: Honorable Peter M. Rivera
Honorable Thomas P. Morahan

The Mental Health Law Committee

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i. See Gabriel P. and Liimatainen M., ILO, *MENTAL HEALTH IN THE WORKPLACE* (2000).

ii. See, e.g., Mark Olsson et al., *Mental Health/Medical Care Cost Offsets; Opportunities for Managed Care*, 18 HEALTH AFF. 79, 82-86 (1999); Mary Jane England, *Perspectives: Capturing Mental Health Cost Offsets*, 18 HEALTH AFF. 91, 91-93 (1999); Brian J. Cuffel, et al., *Does Managing Behavioral Health Care Services Increase the Cost of Providing Medical Care*, 26 J. BEHAV. HEALTH SERVICES & RES. 372.

iii. See Ronald C. Kessler et al., *The Epidemiology of Major Depressive Disorder; Results From the National Co-Morbidity Study Replication, Sponsored by the NIH*, 289 JAMA 3095, 3099 (2003).

iv. See Walter F. Stewart, et al., *Cost of Lost Productive Work Time Among US Workers With Depression*, 289 JAMA 3135 (2003).

v. See United States Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, National Mental Health Information Center: Center for Mental Health. <http://www.mentalhealth.org/publications/allpubs/SMA01-3481ch8.asp>

vi. See GWCMHPC, Inc., *Good Mental Health Coverage Brings Big Returns to the Workplace*, Marland: Greater Washington Coalition of Mental Health Professionals & Consumers, Inc. and the Washington School of Psychiatry.

vii. See Robert A. Rosenheck et al., *Effect of Declining Mental Health Service Use On Employees of a Large Corporation: General Health Costs and Sick Days Went Up when Mental Health Spending Was Cut Back at One Large Self-Insured Company*, 18 HEALTH AFF. 193, 198 (1999); see also David S. Salkever et al., *Disability Management, Employee Health and Fringe Benefits, and Long-Term Disability Claims for Mental Disorders: An Empirical Exploration*, THE MILBANK Q., 78(1), 79-113 (2000).

viii. New York State Department of Health.

ix. *Id.*