DESIGNING A BENEFIT PLAN FOR CHILD AND ADOLESCENT MENTAL HEALTH SERVICES

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ABSTRACT: The rising costs of mental health services for children and adolescents are a growing concern for insurers and employers alike. Several studies have indicated that the costs for children's treatment continue to grow, while others have reported that only a small number of the children diagnosed with mental disorders receive treatment. The authors propose an innovative model benefit plan and briefly provide the rationale for coverage and payment features.

The growing costs of mental health treatment in the United States, paid out as employee benefits, has become the focus of national attention over the past few years. While hospital admissions and lengths of stays for medical conditions have declined over the past decade, utilization of alcohol, drug, and mental health services have increased to the point where it now represents 15% to 20% of the total medical costs for employers. Furthermore, according to a recent A. Foster Higgins and Company study (1990), mental health care costs rose an estimated 27% in 1989 to approximately 5.5 billion dollars, compared with a 17% increase in overall medical expenses. Mental health and substance abuse care now amounts to approximately $244.00 per employee.

Analyzing a claims data base, Frank, Salkever, and Sharfstein (1990) concluded that increases in costs for children's treatment was a disproportionate contributor to cost growth. The Health Data Institute, in a study prepared for the Institute of Medicine, using the experience of one large employer over several years, reported that mental illness and substance abuse treatment
accounted for 14% of all children’s health care costs, and that five of the top ten children’s ICD-9 three-digit discharge diagnosis were for either a mental health or substance abuse category. Considering the aforementioned concern for cost, it remains true that only a fraction of the children diagnosed with the mental disorder obtain treatment (Burns, 1989).

Over 60% of Americans have their healthcare coverage paid through employer-sponsored health insurance programs, making the structure of private health insurance an important matter for social, as well as private policy, as it relates to the payment of children’s mental health and substance abuse services. This paper proposes a benefit plan for coverage for children’s mental health services in private insurance. While it is conceivable that a benefit plan for children could differ from that for adults, it does not appear that it is necessary to do so. Children may be more expensive to treat, but this issue can be accommodated within the plan. However, the model plan described herein is a plan for paying for mental health services for an employed population. Plan features are rooted in basic insurance principles and research on mental health services. (Because of the stronger base of service research in mental health, this paper confines itself to a plan for mental health and not substance abuse treatment services. We believe, however, that the design features proposed here should be considered for substance abuse services as well.) The plan takes advantage of the range of alternatives available for cost control: benefit design, provider payment, and utilization management.

**A MODEL PLAN**

It is presumed that coverage for non-behavioral healthcare includes unlimited hospital care, possibly subject to deductibles and small co-payments, and coverage for office-based physician care, also with small co-payments. Mental health cost sharing is presumed not to count towards a major medical stop loss. Thus, cost sharing for mental healthcare will be enforced independent of other healthcare used by the individual or family. The model benefit plan is summarized in Table 1. The Plan is explained in more detail here, giving some of the rationale for the coverage and payment features. (The arguments in this paper are elaborated in Frank, Goldman, and McGuire, “A Model Mental Health Benefit,” unpublished, 1991.)

What are the incentives to control costs in this most expensive part of the mental health benefit? Patients face substantial cost sharing in the form of a deductible that would range from perhaps $200.00 for some day-only programs, to as much as $600.00 in an expensive full-service hospital. Cost sharing is concentrated around the decision to be admitted. This has the advantage of directing patient cost sharing to a decision where patients and their families have a clear role. By confining the cost sharing to the one-time