To: Vicki Veltri
CT Healthcare Advocate

From: Eric Arzubi, MD
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Take-home points:

1. Private insurance companies have strong financial incentives to deny coverage or reimbursement for mental health services when possible.
2. Poor coverage of mental health services leads to unnecessary and avoidable deaths.
3. Please use all necessary means to keep market forces from hurting our citizens at the most vulnerable time of their lives.

- I am one of two Co-Chairs of the Keep the Promise Coalition, and I am a child and adolescent psychiatry trainee at the Yale Child Study Center. Also, I am a member of the Executive Committee of the CT Council of Child and Adolescent Psychiatry.
- I do not claim to speak for everyone from each of these organizations; however, my connection to them does indeed inform my testimony.
- Before I started medical school in 2003, I had the good fortune to work on Wall Street for nearly a decade. First as a financial news reporter for Bloomberg Business News, then as a trader for a hedge fund and for Morgan Stanley. The biggest lesson I took away from those wonderful experiences is that money makes the world go round. I am not against big business and corporate America - I just happen to understand the business world pretty well.
- Therefore, I am not naive when it comes to analyzing the issue of mental health parity. The top health insurance companies are publicly traded companies with leadership that answers to shareholders. Insurance companies generate revenue by collecting premiums. They aim to keep costs to a minimum in an effort to maximize profit. The delivery of mental health services represents a cost to insurance companies that they are seeking to contain. Insurance companies are doing a great job for shareholders:

Company	FY'11 Operating Income	YTD FY'12 Operating Income
UnitedHealth Group (United Behavioral Health)	$8.5 billion	$4.5 billion
Cigna	$2 billion	$1.3 billion
Aetna	$3.3 billion	$1.4 billion
WellPoint (Anthem/Blue Cross Blue Shield)	$4 billion	$2.3 billion
TOTAL	$18.4 billion	$9.5 billion

I only picked a few big, publicly traded companies. It's a little harder to get the information for Connecticare as it is a privately held company.

Here are some other numbers as a way to offer perspective:

- DMHAS annual budget is around $800 million.
- Dept of Developmental Services annual budget is about $1 billion.
- DCF annual budget is about $900 million.

Why are these numbers relevant? Every year the executive and legislative branches go at it, nickel and diming each other over the budget, fighting shrinking tax revenues. Wonder where the money is going? See above!

How does this happen? Insurance companies engage in corporate strategies designed to make recovering mental health care costs onerous and difficult. How do I know? During my psychiatry training, I've worked at 6 different hospitals, each of which has faced the same problems obtaining reimbursement from private insurers. It is not uncommon for private insurers to deny coverage for inpatient hospitalization or a partial hospital program, even for a patient who is at risk for committing suicide. By denying first and asking questions later, insurance companies often hurt patients and their families in what are often the most difficult times of their lives. I have spent countless hours speaking with insurance companies in an effort to fight denials of coverage - I only appeal these denials when they are in fact "medically necessary" in the true sense of the phrase.

Many private insurers are violating the letter and spirit of the mental health parity law in a quest to satisfy shareholders and to meet quarterly profit forecasts published by Wall Street. I've been on both sides of the business.

Another popular strategy employed by insurance companies is "cost-shifting". Publicly traded insurance companies know that many patients have secondary or tertiary insurance coverage. In other words, if the primary insurer denies coverage, a secondary or tertiary insurance policy is likely to cover services. I've seen this dozens of times in child mental health: a publicly traded insurance company denies coverage for inpatient hospitalization in the case of a suicidal child. That insurer knows that the family has secondary coverage through the BHP, the mental health arm of HUSKY or Medicaid. BHP often does the right thing and pays for the services, shifting the costs to taxpayers.

Another important example of cost shifting is the use of CT's unique EMPS. Did you know that 33% of children referred to EMPS have private health insurance? EMPS is a DCF-funded service that is NOT reimbursed by private insurers. Taxpayers are fully funding this.

According to the WHO, depression is the #1 global cause of years of health lost to disease in both men and women. Mental illness is a very real medical problem that costs lives and damages quality of life. Antipsychotic medications are the top-selling class of prescription drugs in the country at more than $14 billion in annual sales...and we're still fighting for "mental health parity"?

I'm not against big business or corporate America. People who work at publicly traded insurance companies are NOT bad. The trouble is that in their world, shareholders come first, and patients come second. I NOW live in a world where patients come first. I am here to ask that you use the legal tools at your disposal to make sure that the market forces do not lead to unnecessary and avoidable deaths.

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