STATEMENT OF JAMES E. PURCELL

Chairman Pallone and Members of the Committee…

My name is James E. Purcell. I'm the President and CEO of Blue Cross & Blue Shield of Rhode Island ("BCBSRI"). Prior to joining BCBSRI, I was an attorney by profession.

My comments here today reflect our experience in the area of behavioral and physical health. The two are inextricably intertwined for reasons that I will address later. My statement reflects only the position of BCBSRI and not the BlueCross BlueShield Association, nor any other Blue Cross Blue Shield Plan.

Established in 1939, BCBSRI serves approximately 700,000 members and collects nearly $2 Billion in premiums. We're a small insurer by national standards, but a good size for Rhode Island. We are an independent, local, non-profit insurer, closely regulated by the State of Rhode Island. Our vision is to improve the lives of our members and all Rhode Islanders by improving their health.

On their behalf, and in recognition of the leadership demonstrated by Rhode Island's Senior Congressman Patrick Kennedy, and at the gracious invitation of Chairman Pallone, I am here with a simple message:

I am of the passionate view that without full integration of physical and behavioral healthcare, we cannot fully realize our vision. And unfortunately, without meaningful behavioral health parity, that will not happen on a national level.

I submit this testimony mindful of an insurer's special role: that is, balancing the members' interests in receiving high-quality care with optimal coverage; the providers'

interests in higher reimbursement; and the employers' and subscribers' interests in affordable premiums. That is a contentious and delicate balance, but that's our job.

Like most insurers, BCBSRI is not generally supportive of coverage mandates as they tend to increase premiums. Many are anecdotally driven, and some do not improve the quality of care ultimately given. This is different. Back in 1994, we took a pro-active approach to this issue and worked with the regulator, the behavioral health provider community, and our State legislature to craft a law that accomplished an important milestone in mental health, while protecting our ability to use appropriate medical management techniques to achieve the delicate balance I described earlier.

Given our Company's experience in the implementation of these mandates and modifications, I would strongly encourage the Committee to include in the legislation a provision that allows adequate time, at least a year, for plans to implement these changes. We appreciate the fact that the House bill's intention is not to preclude an insurer's ability to use reasonable medical management tools and network quality oversight. I would urge that the final bill preserve an insurer's ability to do so.

Since the initial passage of Rhode Island's partial mental health parity state mandate in 1994, we have continued to modify our behavioral health coverage to reflect additional changes in state and federal law. But more than that, in a number of instances, we voluntarily went beyond the letter of the law, instituting policies that achieve *de facto* parity.

Some definitions: When I refer to mental health, I mean traditional diagnoses of recognized forms such as depression or schizophrenia. When I refer to behavioral health, I mean mental health plus substance abuse problems and combinations of the two. And

when I refer to parity, there is coverage parity and payment parity (what we pay providers). I am in favor of both.

In 2001, BCBSRI eliminated prior authorization for standard outpatient treatment; at the time a bold step, which has proven successful.

In 2002, the company allowed payments to behavioral health providers for the treatment of the behavioral and emotional components of medical illnesses without a psychiatric diagnosis.

In 2004, we began reimbursing professional behavioral health services at the same level as professional medical services for physical ailments. That achieved *de facto* payment parity.

In 2005, we eliminated prior authorization at admission for higher levels of care at participating providers, including inpatient services – again, at the forefront of the industry.

In 2006, we increased standard outpatient behavioral health service coverage (office visits) from a maximum of 30 per year to 50 for our fully insured members.

Why on earth would we do this when we weren't forced to do it by law? Because it was the right thing to do from the perspective of our members, which this should be all about. It's good care and good business. As a non-profit insurer in Rhode Island, we have the ability and indeed the will not only to look at our bottom line, but also the impact on the community when we make decisions like these. And here, it was definitively in the best interests of our members to do this.

I mentioned integration of behavioral and physical health. This truly is the future, and is so fundamental to complete care. Where is the line separating behavioral health

and physical health for an obese diabetic suffering from depression and eating disorders? Treating just the physical symptoms without treating the behavioral issues is less than adequate care.

Not only is this the right way to care for our members; it also is cost effective. BCBSRI has *de facto* coverage and payment parity. We've seen the results. Yes, it adds some up front costs, but it provides better care to people who desperately need it. And the price tag is not that big.

Typically, the bulk of behavioral services are, for many people and in many places, delivered by medical providers. Behavioral health parity improves access to more appropriate treatment by breaking down the barriers to obtaining the right care.

For BCBSRI commercial business, non-drug behavioral healthcare benefits are 3.6% of premium expense. These costs are distributed about 32% for inpatient care, 12% for facility out-patient care, and 56% for professional services (mostly office visits).

About 1 out of 10 of our members received professional behavioral healthcare services in 2006. Of those members, 71% had 10 or fewer office visits, and 90% had 20 or fewer office visits.

The impact on claims costs of limiting annual coverage to 15 visits rather than 30 would have been about 0.3% of total claims. Our increase from 30 to 50 costs us significantly less, but imagine how that helps our members. The big problem is to get people to see their behavioral health provider. Very few need more than 30 visits a year, but those who do, really, really need them. And with a maximum of 30 visits, they usually run out around the holiday season. And where do they end up? Right; the emergency room, for a much bigger bill. This is more humane care, at a lower cost.

When Congressmen Kennedy and Ramstad held their hearing on this issue in Providence earlier this year, the testimony was overwhelmingly positive on parity. Not surprising. But what might surprise you was the testimony of the human resources director of one of our local banks. She said, and I'm paraphrasing here, that the reason her bank chose BCBSRI to provide health insurance for their employees and their families over the competition was the comprehensive behavioral healthcare coverage offered by our plan. She noted improved worker productivity and lower absenteeism. And in the end, this is all about taking care of people the right way, isn't it?

Your decision comes back to balancing the interests of members, providers, and employers with benefits, costs, and affordability. I would like to close by stating that we have found behavioral health parity strikes the right balance in Rhode Island.