

Mission Unfulfilled: Potholes On The Road To Mental Health Parity

The quest for parity should be driven by the desire to provide the best care, not by indiscriminate cutting of costs and services.

by David Mechanic and Donna D. McAlpine

PROLOGUE: The rapid emergence of managed behavioral health care has transformed the treatment of the mentally ill in many ways that have been documented. But there are other dimensions that have been less well explored. In this lead paper prepared by David Mechanic and Donna McAlpine of Rutgers University, the most important (and disturbing) conclusion they reach is that as managed behavioral health care has grown to dominate treatment of the mentally ill, an increased democratization of that care has occurred. That is, individuals, however ill, have tended to receive a similar level of treatment. This approach obviously places at greater risk those patients suffering from the most serious forms of mental illness.

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ABSTRACT: Managed care holds the promise of facilitating parity between general medical care and alcohol, drug, and mental health care by reducing expenditures, even while expanding benefits. Limitations in our knowledge of variations in needs and treatment standards for substance use and psychiatric illnesses make such disorders an easy target for management. Costs for behavioral health care services have been reduced at a faster pace than has been the case for general medical care costs. The most severely ill face the potential burdens of managed care as access and intensity of care become more uniform across patient populations.

IT IS COMMONLY ASSERTED THAT the organizational approaches and strategies of managed behavioral health care (involving capitated payment and utilization management) will allow wiser and more efficient use of resources, thereby facilitating parity with general medical care.¹ Such optimism derives from the large reductions in costs that managed behavioral health care has achieved for public and private employers. In addition, studies of particular employer health plans under behavioral health care carve-outs suggest that parity can be achieved with small additional yearly premiums if the structures and strategies for management are in place. The passage of the Mental Health Parity Act in 1996 can be attributed in part to research evidence showing that management strategies could contain costs, even while benefits were expanded.

This paper addresses a number of issues that are fundamental to parity but that have not typically been central to discussions of managed care's impact on spending. First, we examine national trends in behavioral health care spending as a proportion of all health spending. We ask whether there are attributes of mental health practice that have made it an easier target for cost reduction than are other areas of health care. Second, because reductions in costs do not necessarily imply poor care, we make some effort to look into the "black box" of managed care and inquire whether the results of care management strategies appear to be rational. The data are inadequate for answering such questions definitively, but they provide cautionary guides for future monitoring efforts. Third, we focus on the clients with the most serious illnesses and greatest disabilities, and we consider the consequences of managed care for achieving parity for these groups. We examine evidence that managed care strategies "democratize" the provision of services and thus reduce the intensity of care for the sickest patients.

We argue that the concept of parity, as typically applied, remains limited. As ordinarily used, *parity* refers to maintaining the same annual and lifetime benefits, coinsurance arrangements, and limits on hospital days and visits that apply to general medical conditions. Even this ambitious goal is narrow because it fails to account for the

critical importance of benefit design and for the fact that usual concepts of medical necessity may exclude vital services needed by persons with mental health and substance abuse problems, particularly clients with the most serious and persistent conditions. Moreover, the implementation of parity depends on being able to ensure access to appropriate care of high quality. Management strategies may enable or inhibit such implementation.

Managed Behavioral Health Care And Spending

A recent study comparing national spending for alcohol, drug, and mental health (ADM) treatment between 1986 and 1996 reported that average annual growth of such expenditures was 7.2 percent, compared with 8.3 percent for overall personal health care.² Findings from studies of health spending by employers are consistent with this national trend. The Hay Group estimated that behavioral health benefits, as a proportion of total employer health care costs, fell from 6.1 percent in 1988 to 3.1 percent in 1997.³ These figures should be interpreted cautiously, because we know very little about the representativeness of this convenience sample. Jeffrey Buck and Beth Umland, using a convenience-panel survey of large employers collected by Foster Higgins, similarly report that ADM costs fell from 9 percent of all health costs in 1989 to approximately 4 percent in 1995.⁴ They also report that ADM spending among employers with 500 or more employees declined from about 6 percent of health benefit costs in 1993 to 4 percent in 1995.

These studies have limitations, but they plausibly suggest that spending for behavioral health care is falling behind other areas. Given the consistent body of research that documents large untreated ADM conditions in the general population, clinical studies that repeatedly document minimal and inadequate treatment, and the pattern of discrimination against and stigmatization of persons with ADM problems, behavioral health spending's failure to keep pace with health spending overall requires continuing scrutiny.⁵

A case can be made that the slower growth of behavioral health care spending is a correction of a pattern of indiscriminate growth in the early 1980s. Saul Feldman, chief executive officer of a behavioral health care company, reports that by the mid-1980s the proportion of total health care costs attributable to behavioral health care in large companies climbed to 15–18 percent or even more but has now stabilized at below 10 percent.⁶ He reports that the introduction of managed care strategies achieved savings of 30–40 percent or more in the first few years; this is generally consistent with the literature.⁷ However, many large companies that became clients of behavioral health care companies were motivated to do so by very high, and

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often increasing, behavioral health care costs. In part, these increases were catching up with unmet need, improved treatment, and reduced stigma associated with seeking such care. But they also reflected the opportunistic behavior of specialty providers that could offer services to the level of enriched insurance coverage. Thus, in the early period of managed care it appeared relatively easy to bring costs down without doing harm.

Managed care may function very differently, when expenditures are initially moderate or low, relative to the success stories reported by companies such as IBM and Xerox that have so often been reported in the literature.⁸ Given similar levels of overall health spending, the consequences of reducing behavioral health spending from 15 percent to 10 percent of expenditures are different from reductions from 10 percent to 5 percent and even to 3 percent, as some report. Experience also is likely to depend on the total constellation of strategies for dealing with employee problems, including employee assistance programs (EAPs). In many of the instances noted in the literature, significant savings were made by attacking “low-hanging fruit,” such as routine inpatient alcohol and other substance abuse treatment, long hospital stays for children and adolescents, and other excesses of cost-based reimbursement. By curtailing inpatient days and bargaining aggressively with providers and facilities, managed care companies initially have not faced much difficulty in reducing costs. Forecasts that parity could be achieved because of the substantial saving possibilities inherent in managing care may be based, therefore, on evidence that cannot be reliably generalized.

A case also can be made that the reductions in growth of ADM spending, compared with overall personal health care spending, reflected a widening gap between the benefit packages employers offered for mental and physical health care. There is much evidence of a growing deficit in benefits for ADM services over the past decade. Limits in coverage for mental health care have become more common, and cost sharing has increased more substantially for mental health care than for general medical care.⁹ This situation was inadequately addressed by the Mental Health Parity Act.

Health care spending commonly follows new knowledge and technology, new treatment opportunities, changing patterns of illness, opportunities created by new reimbursement rules, and the supply of professionals and facilities. Medications and patient man-

agement strategies in mental health care have improved greatly, but it would be difficult to argue that these advances are greater than, or even comparable to, advances in other areas of medicine. There is no inherent logic in maintaining that ADM spending needs to grow at the same pace as other spending. But in light of the trends, it does seem prudent to inquire whether ADM care is being targeted more than physical health care and, if so, what the consequences are for those who require the most intensive services. Parity in benefit structures means little if ADM care is managed more stringently than other types of health care. We now turn to this issue.

Targeting And The 'Black Box' Of Managed Care

ADM services have been an easy target for managed care because they traditionally have been based in institutions, with longer lengths of inpatient stay than was the case for most other medical care. While lengths-of-stay also have been falling for medical and surgical conditions for several years, ADM inpatient care has had a longer way to fall.¹⁰ The greatest reduction in patient days continues to be in mental hospitals, where the aggregate number of such days has fallen markedly over time.¹¹ Even in general hospitals, length-of-stay among persons with primary psychiatric disorders has fallen sharply over the past decade. For example, average length-of-stay among persons with a primary psychiatric diagnosis in private, non-profit general hospitals—the primary place for acute inpatient care—fell from 12.6 days in 1988 to 8.6 days in 1995, despite a more severely ill patient population.¹²

Individual studies suggest that managed care may be targeting ADM services more than other types of medical care. Thomas Wickizer and Daniel Lessler performed a retrospective analysis of the effects of utilization management on hospital use among almost 50,000 patients between 1989 and 1993.¹³ Requested admissions were rarely denied, but concurrent review of length-of-stay caused hospital days to plummet. Patients with mental illness were most affected by these utilization review strategies: While they only constituted 5.7 percent of inpatient cases that were reviewed, they accounted for 55 percent of the gap between the total number of days requested and the number of days approved. Requests for bed days for patients with psychoses were allowed at no higher a rate (54.6 percent) than were those for all mental health admissions (54 percent). In contrast, approved bed days for obstetrics, medical admissions, and surgical admissions were 93 percent, 86 percent, and 83 percent, respectively. Average length-of-stay (adjusted for sex, age, and region) fell significantly for all types of admissions but especially for mental health from 1990 to 1993. The average number of

medical days approved fell from 6.8 days to 5.2 days (-23.5 percent), but the average number of mental health days approved fell from 20.7 days to 10.9 days (-47.3 percent).

The observation by Wickizer and Lessler that denials did not vary by the seriousness of the mental health diagnosis suggests that managed care may reduce care indiscriminately. Full understanding of how managed care works, however, requires knowledge of the epidemiology of need in each population, the utilization levels that predate the managed care carve-out, the structure of the managed care contract, and the degree of local competition among mental health facilities and providers. Such information is almost never available, so we have to make inferences from ambiguous data.

Case studies of large employment groups and state employees' programs indicate that managed care carve-outs do achieve substantial savings per enrollee. However, the data suggest various explanations for the savings. For example, Ching-to Ma and Thomas McGuire, in a study of a carve-out for Massachusetts state employees, found a 10 percent increase in mental health inpatient admissions and only a slight reduction (5 percent) in length-of-stay but a very large drop (70 percent) in price per day (from \$1,257 to \$384).¹⁴ The decline in costs for inpatient substance abuse care was similar, except that admissions decreased by 5 percent and length-of-stay increased slightly. In contrast, William Goldman and colleagues, in a study of a large West Coast employer, reported a 24 percent reduction in inpatient admissions and a 43 percent reduction in length-of-stay.¹⁵ Roland Sturm and colleagues, examining the implementation of a managed care parity benefit among Ohio state employees, reported a reduction of more than 75 percent in inpatient days.¹⁶

If managed care strategies are functioning properly, we anticipate that large reductions in inpatient care should be accompanied by sizable increases in alternative services that can reasonably substitute. We observe this pattern in some studies. Goldman and colleagues reported substantial increases in claims paid for outpatient treatment, and more modest increases in claims paid for residential and day treatment, during the years following implementation of a carve-out when inpatient claims were declining.¹⁷

In other instances, however, we see no significant substitution, suggesting that the motivation is more to manage costs than to manage care. Ma and McGuire, for example, found reductions in outpatient costs per enrollee for both mental health and substance abuse outpatient care (-47.9 percent and -50.8 percent, respectively).¹⁸ This cost reduction reflected declines in number of users and number of visits per year. Similarly, in comparing the periods before and after the carve-out, Sturm and colleagues observed sub-

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stantial declines in outpatient visits among enrollees in an indemnity medical plan, although they also reported slight increases in the use of intermediate services for the years following the carve-out.¹⁹

We know little about the internal strategies and rationales adopted by managed care providers that may explain these different patterns. One notable exception is Ma and McGuire’s invaluable case study of the Options contract in Massachusetts.²⁰ They evaluated the performance of the managed care organization relative to what might have been expected from the formal economic incentives built into the contract. They found, in this instance, that the contractor continued to reduce utilization and costs well beyond the target and the financial gains that would accrue. They speculate that the contractor was going beyond the contract to build its market reputation and to position itself for future competition.

There are indications that reductions in the intensity of care may go too far. Wickizer and Lessler examined whether reduced length-of-stay resulting from utilization management made it more likely that patients would be readmitted to the hospital within sixty days.²¹ For every day of reduced stay, the odds of readmission within sixty days increased by 3.1 percent. This is not a large increase, since the risk of readmission within sixty days is small. However, for those with large reductions (ten or more days), the risk of readmission within sixty days was 37 percent higher than for patients whose days of care were not reduced. This is one of the few studies than begins to enter the “black box” and alert us to possible problems in utilization review strategies.

It is disconcerting when investigators observe that reductions in intensity of care are comparable across diagnostic groups with different needs. Haiden Huskamp, analyzing data from the carve-out for Massachusetts state employees, found that decline in costs of facility-only and outpatient episodes was much greater for patients with unipolar depression than for patients with less serious disorders; reductions in cost were no smaller for persons with schizophrenia and bipolar disorders than for persons with less severe disorders.²² In this instance, managed care appeared to reduce intensity of care for the patients who we would anticipate to have the greatest need. Some very disabled high users may require a high intensity of care, and the “democratization” in the distribution of services that may occur under managed care may not serve them well.

To understand how this happens, one needs to examine the political dynamics of implementing managed care and the decision processes of managers and clinicians who function in varying managed care frameworks. The chaotic introduction of Medicaid managed care by TennCare Partners in Tennessee, while not necessarily representative of any other state, provides useful cautionary tales on how not to proceed and how easy it is to do harm. A valuable case study by Cyril Chang and colleagues suggested that the process of implementation not only reduced services overall but also shifted “resources away from severely mentally ill individuals, for they now must compete for scarce resources with enrollees who have milder mental health needs.”²³

The evaluators of the Utah managed care program found a reduction in utilization among patients with schizophrenia who had the most intensive service use prior to managed care. These seriously ill patients had worse outcomes with managed care.²⁴ It is plausible that within a context of many needs and constrained resources there is an inclination toward increased democratization of care. We need to understand much better how judgments on intensity of care are made and the extent to which managed care is substituting forms of care. Reductions across the board should be carefully audited, particularly with highly vulnerable clients and in situations where the overall pattern of service use is not unduly high.

Medicaid Managed Care And Vulnerable Populations

The Health Care Financing Administration (HCFA) estimates that half of Medicaid beneficiaries will soon be under managed care arrangements.²⁵ Initially cautious about enrolling disabled populations in such arrangements, some states have begun to move them into some type of managed care. The structure of managed behavioral health care varies widely from one state to another, but careful studies of individual cases are beginning to appear. These indicate that managed care can reduce Medicaid costs with little evidence of impaired overall quality.²⁶

Concepts of parity, however, require a different perspective when applied to Medicaid and to persons with greater disabilities. Medicaid has had a more comprehensive benefit structure that better responds to long-term care problems than most private insurance and has often been effectively coordinated with other public services. Thus, usual concepts of parity appear overly narrow when applied to the population of persons with the most severe psychiatric illnesses. A study examining spending for persons with severe and persistent mental illness in Wisconsin found that more than half

were for nontraditional services, and many such services are unlikely to be included under usual definitions of medical necessity.²⁷

Carve-out arrangements involving persons with psychiatric disabilities require careful contractual language about the availability of specific services such as psychosocial rehabilitation and housing assistance and about the intensity of such services. The boundaries defining the responsibilities of the managed care vendor, other public programs, and the general medical system need to be specifically addressed, and accountability needs to be well defined. Criteria for evaluating performance should be explicit, with appropriate arrangements made to ensure that the data required to monitor performance will be available and appropriately formatted. Excellent legal work has been done to assist states in understanding their contractual roles in arrangements with vendors that are typically more expert in contracting than the states are.²⁸

The Vacuum In Evaluating Quality

The history of mental health services has taught us that it is quite easy to reduce utilization and cost simply by administrative fiat.²⁹ Many localities emptied their mental hospitals but failed to provide the necessary substitutive services in the community. They served the mentally ill population badly and did a great deal of harm. This is not to suggest that managed care practices will necessarily repeat this experience. But it should make clear that reducing admissions, length-of-stay, hospital days, or other services, and their associated expenditures, is the easy part of the process. Doing so in a manner that provides high-quality care and good outcomes is the more difficult and more important task.

The importance of developing indicators of quality has been well articulated, and there is a consensus that measuring quality is important.³⁰ Moreover, we have seen substantial efforts by proprietary companies, government agencies, and other stakeholders to develop standardized quality measures for behavioral health care.³¹ These efforts are relatively young, which makes it difficult to judge their eventual utility. Early experiences, however, do provide some reason for circumspection. Within the propriety sector, for example, the American Managed Behavioral Healthcare Association (AMBHA) devised a set of measures (Performance Measures for Managed Behavioral Healthcare Programs, or PERMS) to be used by behavioral health care companies to assess quality; indicators range from measures of access to measures of satisfaction. Results among thirteen managed care companies using these indicators ranged widely, so it is nearly impossible to judge whether the observed variations were the result of quality differences or methodological problems.³²

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Within the public sector, the Mental Health Statistics Improvement Program (MHSIP) developed a set of indicators that also incorporate access and utilization measures as well as consumer satisfaction and prevention.³³ It is too early, however, to judge the usefulness of these indicators as they are collected in practice. Others have strongly argued for the need to collect outcome indicators, in addition to indicators of processes of care, yet it may prove difficult to include such measures in large databases.³⁴ Despite these considerable efforts, we continue to be nearly flying blind. Complaints and anecdotes do exist, and these may be indicative of real trouble spots.³⁵ However, anecdotes are not evidence.

The few good outcome studies we have give us grounds for caution. The RAND Medical Outcomes Study found that depressed patients were less likely to be recognized by primary care physicians in health maintenance organizations (HMOs) and, when identified, were less likely to receive the medication continuity that fee-for-service patients received and had poorer outcomes.³⁶ Evaluations of managed care for the Medicaid populations in Minnesota and Utah, which had longer follow-up periods than most other such studies, suggest that clients with the most serious illnesses, and who were the most intensive users of services, were more likely to show worsened outcomes.³⁷ In one of the more comprehensive investigations of changes after implementation of a prepaid plan for Medicaid enrollees with schizophrenia in Utah, Michael Popkin and colleagues report that the prepaid plans were associated with poorer outcomes in terms of patients’ terminating treatment, overreliance on crisis intervention, poor medication management, and reduced use of psychotherapy.³⁸

Some of these studies are now out of date, and each refers to different managed care arrangements. Thus, we should be careful not to generalize their findings too widely or to make too much of them. Managed care is a work in progress, and management strategies are presumably being improved with experience. The studies themselves all have limitations. Nevertheless, they provide the cautionary guideposts that are greatly needed as we continue down the managed behavioral health care road. They raise some important questions: Do some managed care practices shift costs, increase risks of suicide and violence, reduce work productivity, or limit functioning and quality of life?

Parity requires an understanding of the components of a good mental health service and of what is required to treat clients with variations in need and severity of illness. The uncertainties that persist within any kind of evidence-based framework make it relatively easy to reduce services in a shotgun fashion. The call for parity by advocates came within the context of indemnity insurance, but few believed that this could be achieved without managing services. Behavioral health care management thus offers advantages in expanding the range of insured services and giving more patients access to a mental health service. The challenge for the coming decade is to develop clear standards based on the best evidence and clinical judgment so that parity has substance in implementation as well as in concept. Parity is not simply some match in service limits to what a medical or surgical patient experiences. It should be a configuration of management strategies fitted to careful assessment of patients' needs and a response that is consistent with our best scientific knowledge.³⁹

A Concluding Note For The Policymaker

There is much rhetoric about managed behavioral health care, but policymakers must appreciate the uncertainties. Most state policymakers have been wise in moving slowly and cautiously in extending such practices to their disabled populations. Most disabled persons enroll voluntarily in managed care, and only a few states have required participation of severely and persistently mentally ill persons.

Managed behavioral health care has gained much valuable experience with employed populations and in moderating some of the excesses of traditional patterns of fee-for-service and cost reimbursement in mental health care. But until we have (and use) more-sophisticated quality measurement, the temptation will remain to manage costs and not care. Awareness of the mental health parity issues has increased in recent years, and there is growing support for policies that remove discrimination against the mentally ill. A well-managed parity benefit need not be expensive, as some analyses have suggested. But it is equally important to understand that any parity policy must be implemented through access that extends beyond traditional concepts of medical necessity, particularly in relation to public clients.

Managed behavioral health care is new to the arena of disabled clients and their multiple needs. It is still unclear whether such clients will be attractive to managed care providers, given their complex needs and the financial constraints likely to be imposed by public purchasers. But to the extent that such clients are attractive, public purchasers take on new and important roles. First, they must

be sophisticated buyers and understand that they share responsibility for poor outcomes when they simply seek to pay the lowest capitation rate. They need to become expert in contracting, understanding not only the elements of appropriate benefit design but also the boundaries between contracted responsibilities and what remains of the public safety net. They also need to give attention to preserving the safety net, because experience indicates that it will still be needed. Behavioral health care is an area in which it is relatively easy to shift costs and responsibilities to other sectors, so boundaries have to be clear and transparent to monitoring efforts. However inadequate the existing outcome studies are, they make it clear that aggregate outcomes for populations often fail to reveal the consequences for small subpopulations who have the greatest needs and who are often the most disadvantaged and vulnerable.

Quality measurement in behavioral health care is still relatively primitive. In the long run, the accountability of managed care will depend on our ability to develop a reasonable consensus on practice standards and quality indicators. Work is proceeding on such development, but the field is not advanced enough to provide the needed assurance. As a start, policymakers and purchasers in both the public and private sectors must ensure, through their contracting, that the necessary data are available to monitor access and performance and that such data are not simply proprietary products.

We are now entering a period in which the challenge of managing care and reducing expenditures will become more difficult without doing harm. Several elements contribute to this. First, most of the easy reductions have already been made, and the cost/quality trade-offs are tougher. Second, purchasers, having had a taste of the possible cost reductions, have learned to bargain more aggressively with behavioral health care organizations. This puts greater pressure on these organizations to keep utilization low. Third, consumers and their advocates have become more knowledgeable and aggressive and will increasingly act as a countervailing force. Fourth, the availability of new, more expensive drugs, and coalitions between pharmaceutical companies and consumers to make drugs more available, will contribute to increased costs. Fifth, increasing government regulation of managed care practices in general, and behavioral health care in particular, in response to many complaints by consumers and advocates, will make cost reductions more challenging.

IT IS TOO EASY TO BLAME MANAGED CARE for all of the deficiencies of mental health practice. Policymakers, purchasers, providers, and consumers all have a vital role and responsibility and need to cooperate in supporting patterns of practice that pro-

vide value for money but also are sensitive to the special needs and vulnerabilities of persons with widely varying conditions and disabilities. Purchasers need to understand that going with the lowest bidder will mean that clients are much less likely to benefit from new technologies. Advocates must understand that while in an ideal world they would like unlimited access, they too must establish priorities and not demand a pattern of service that is unsustainable. Providers must accustom themselves to a more scientifically based pattern of practice. Parity is a fine concept, but if it is to be fully meaningful it must be designed to meet access and quality challenges and diversity of need.

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NOTES

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