

Can We Learn From History? Mental Health in Health Care Reform, Revisited

Chris Koyanagi

Health reform is again on the national agenda. Serious debate about how mental health might fit into national health policy has not occurred since 1993. The focus of the Clinton reformers was on benefits, integration with the general health system, and a new role for the public sector. A number of issues remain relevant today, such as uncoordinated public and private services, cost-shifting, and poor quality care for people with serious mental illness. This column considers the barriers to full inclusion of mental health in health care reform and proposed solutions that were identified in 1993 and describes how they can inform policy decisions in 2009. (*Psychiatric Services* 60:17–20, 2009)

The nation appears poised, once again, to have a serious discussion about reforming the health care system. Driving this debate is the plight of 46 million uninsured Americans and continued unsustainable cost increases. Questions about the quality of health care, and therefore the value of health spending, are also at issue.

The last serious national debate on health reform was in 1993 when the Clinton Administration proposed a national health plan. It sought access for all low-income families, attempted to contain costs, encouraged coordinated care, and proposed reforms to the insurance market. For mental

health care, the plan proposed a limited benefit for immediate implementation, which shifted to parity in 2001. In its final gasp, the legislation included a provision for immediate adoption of parity coverage of mental health care with medical-surgical care. The provision emerged late in the process in a bipartisan Senate compromise bill and represented the first time federal legislation dealt with parity.

As we face another debate on reform, it is instructive to consider the current relevance of mental health policy issues that confronted the Clinton reformers. Are those issues the same today, and are the solutions proposed in 1993 at all relevant? What has changed, and how should we approach the new debate? How can we ensure that reforms to the overall health system include mental health and advance the field?

Problems identified in 1993

Clinton reformers identified several problems in the system that were critical to address in order to improve mental health service delivery (1). The system was a confusing mix of uncoordinated public and private services that resulted in cost-shifting and private-sector abdication of responsibility for people with severe mental illness. Privately insured individuals had inadequate protection against catastrophic costs, and notwithstanding some excess capacity, many faced access problems. The two-class system (public and private) did not serve people with severe mental illness well, and there was an overemphasis on institutional care. Services were financed through a complex mix of federal, state, local, and private funding.

Most, if not all, of these issues are relevant today.

Actions since 1993

In the years since the Clinton plan there have been many developments in both the health arena and mental health policy. For example, some insurance reforms debated in 1993 were later enacted in the Health Insurance Portability and Accountability Act.

Major reviews of mental health treatment and policy occurred at the federal level during these years. In 1999 the first-ever report on mental health by the Surgeon General was issued, detailing scientific evidence showing that mental illnesses can be accurately diagnosed and effectively treated (2). The report helped to dispel myths that mental health services are not valuable and summarized research showing that mental health treatments had an evidence base as solid as those of many medical-surgical services.

Also in 1999 a White House Conference on Mental Health was convened to develop federal policies, one of which clarified Medicaid coverage of certain evidence-based practices. This policy encouraged states to continue funding community mental health services under Medicaid—today the largest source of funding for public-sector community mental health spending and the single largest payer for behavioral health care (3,4). Such policies have the result of integrating mental health funding, if not services, with general health care.

In 2003 the President's New Freedom Commission Report on Mental Health was released (5). It focused primarily on reforms to make the public mental health system more effective, responsive to consumers, and geared to recovery. The first recommendation of the commission resurrected a basic principle of Clinton's reforms, to integrate mental health and health care,

Ms. Koyanagi is policy director at the Judge David L. Bazelon Center for Mental Health Law, 1101 15th St., N.W., Suite 1212, Washington, DC 20005 (e-mail: thompson@bazelon.org). Steven S. Sharfstein, M.D., Haiden A. Huskamp, Ph.D., and Alison Evans Cuellar, Ph.D., are editors of this column.

viewing mental health as essential to overall health.

Comparing recommendations from the President's Commission with proposals of the Clinton reformers emphasizes both how much and how little has changed. Although there has been significant progress in some areas, important unresolved issues remain. On the positive side is enactment of a federal parity law, significant research to identify evidence-based practices, re-orientation of the public system toward a recovery model, and major reductions in institutional services. In addition, improved data systems have shown the cost-effectiveness of mental health care.

On the other hand, the current system remains a confusing mix of public and private services, with health plans avoiding many of the costs of caring for people with more serious disorders. This two-class system is not serving people with severe mental disorders any better than it did in 1993. During the 1990s federal and state spending for mental health services fell in relation to inflation and all spending on behavioral health fell relative to spending on general health care. As a result, inadequate public systems have become less adequate and access problems remain. Moreover, financing is still "a complex, uncoordinated mix of federal, state, local and private funding" (1).

Objectives for reform

These continuing problems demonstrate that several major objectives outlined by Clinton reformers could be relevant today. [A working paper from the Clinton reform effort outlining concerns, goals, and recommendations for reform is available as an online supplement to this column at ps.psychiatryonline.org.] They include improving access by ensuring parity coverage of mental health care and medical-surgical care, integrating delivery systems and emphasizing coordination and systems of organized care, integrating financing of mental health care and medical-surgical care, increasing the focus on early intervention, and minimizing the two-class, public-private system dysfunctions.

The 2009 debate will provide an opportunity to revisit these concerns in a

new context, recognizing gains made in the past 15 years and addressing new challenges.

Parity benefits

The first issue in reform for mental health advocates is the benefit package. Arbitrary limits on mental health services have been typical. As a result, policy advocates have been consumed with this issue. Although parity is one area where there has been significant progress since 1993, benefit issues may still need some attention.

In 1996 a limited law requiring parity in parts of the mental health benefit was enacted. In 2001 health plans in the Federal Employees Health Benefits Program (FEHBP) were required to offer parity coverage for mental health care. Data from FEHBP (and from large employer plans) have shown parity to be affordable and of considerable benefit to individuals by reducing out-of-pocket costs. These data helped propel Congress to pass a law in 2008 for full parity for coverage of mental and substance use disorders in large group health plans.

Although this law is a strong basis for coverage if health care access is expanded in 2009, it is by no means complete. Plans and purchasers can avoid its requirements by having no coverage for mental health or substance abuse services, and small group and individual plans are not affected at all.

The question therefore arises, are any of the barriers to parity that plagued the Clinton reformers still relevant today? Drafters of the Clinton plan were concerned with the cost of a parity benefit and they wanted to ensure that there were policies to prevent adverse selection (1). The first problem was moral hazard—the tendency of people to use outpatient mental health services more when constraints in the benefit package or high cost-sharing requirements are removed (6). Health plans might try to gain advantage by "cherry-picking" or other underwriting practices that seriously disadvantage individuals with mental illness. Expanding coverage to millions of currently uninsured people in 2009 may also have this result.

To ensure affordability, Clinton reformers looked to managed care to control costs. But in 1993 administra-

tion actuaries and the Congressional Budget Office were reluctant to assume that managed care could, in fact, control costs. There was also concern that the field was not ready to implement managed care effectively and that health plans would manage mental health benefits by simply denying needed care (2). Considerable experience with behavioral health managed care since 1993 has shown that it can be relatively successful in holding down costs while providing appropriate care for acute mental illness. On the other hand, studies show that people with serious mental disorders do not do well in health maintenance organizations and similar plans (7). As a result, both employers and public-sector agencies often rely on carve-outs or fee-for-service arrangements for this population.

Proposals announced by President-Elect Obama and leaders in Congress would expand access to private insurance, retaining the employer-based system, and would create a new public program for those who remain uninsured. The 2008 parity law will mean that these plans will have a parity benefit (unless a plan eliminates behavioral health coverage entirely), although individuals in small group plans or with individual coverage will not. This is likely to continue (or even increase) the tendency of health plans to use managed care to control utilization and cost of mental health services.

It may therefore be just as important in 2009 as in 1993 to guard against adverse selection and denial of necessary care. In 1993 a proposed solution was risk-adjusted premiums along with a mixed capitation approach. In addition, it was felt there should be monitoring to constrain the propensity of health plans to undertreat. With mixed capitation, part of the premium (say 60%) would be paid prospectively. The remainder would be paid retrospectively on the basis of actual cost (1,2).

Comprehensive benefits

The mental health benefit in Clinton's plan included a broad range of services: screening, crisis services, a range of community services, inpatient and residential placements, and case management. There was also a focus on early intervention and prevention. Benefits

were thus more expansive than in the typical private health plan and gave providers greater flexibility in meeting the needs of people with severe mental illness.

Expanding mental health coverage in private plans had a number of advantages and potentially addressed several system problems that had been identified. Both acute care and rehabilitation services could be provided in a coordinated way. There would be flexibility to match patients' needs to treatment, thereby encouraging cost-effective use of alternatives to hospitalization and providing catastrophic protections to all.

Private-sector plans have made few moves since 1993 toward covering the intensive community rehabilitative services that are still generally provided only through the public sector. Business leaders have recognized the need, but their recommendations are quite modest. The National Business Group on Health recommends that employers purchase coverage for evidence-based treatment for people with serious mental illness but limits its suggestions to assertive community treatment, case management, therapeutic nursery services, and therapeutic group homes (8).

In 2009 it will be difficult to include a full range of mental health services in benefit packages designed for the uninsured. However, some steps might be taken. Strategies to facilitate improved identification of mental illnesses and early intervention services are possible. These might include expansion of employee assistance programs, greater emphasis on behavioral health in the public health system, and more support for primary care providers who provide mental health care.

Today's discussions about how to improve treatment and management of chronic illnesses presents opportunities for mental health advocates to insist that such strategies address the needs of people with severe mental illness. For example, proposals for medical homes, patient registries, disease management, and bundled payment rates that give providers flexibility to offer services not defined in the normal benefit package are strategies that could be readily adapted to meet the needs of this population.

Integration of care

According to the Clinton Administration reformers (1), "reform of mental health and substance abuse coverage will remain incomplete until there is full integration of mental health and substance abuse services within general medical care, giving all Americans, regardless of the nature of their illness, insurance coverage for appropriate services." The Clinton reforms included recommendations aimed specifically at greater integration (1). Public-sector providers were to be incorporated into the mainstream health care system and into mainstream funding. Thus, except for forensic patients and those in custodial care, all patients would receive mental health services through the same system as general health care. It would be paid for through insurance and delivered through a single delivery system.

In 2009 it will be important for mental health advocates to press even more vigorously for integration. To begin with, recommendations made in 1993 could be implemented. They include ensuring that parity coverage of mental health services is part of a national plan for the uninsured; incorporating behavioral health screening into general health screens, particularly for pediatric patients; permitting public-sector providers to bill private plans to the greatest extent feasible; and providing support from the federal government for integration policies by underwriting workforce development and providing start-up funds for new services and organized systems of care.

In addition, new policy concepts are on the table for 2009. Medical homes or similar arrangements that create coordinated care and a single point of responsibility for a person's overall health are an opportunity to integrate mental health care more fully with primary care. Co-location of mental health professionals in primary care practices is a well-established effective strategy. Health reform could provide incentives for this approach. Similarly, policies to help general practitioners provide basic mental health care may have validity.

Prevention and wellness are significant issues for 2009. Prevention of mental illness is possible for certain

target populations and might be promoted through health reform and through expansions of the public health system. Addressing the mental health needs of individuals with chronic physical illnesses can improve outcomes and should be discussed as part of the wellness agenda.

Public-sector issues

Under Clinton's plan for covering both acute and rehabilitative services, funding was problematic. Paying for this expanded array of services would require capturing public mental health funds. However, although Clinton reformers considered this essential to fully integrate mental health services, they struggled with how to do it (1).

Such a strategy is not likely to be on the table in 2009. However, several important concepts from 1993 could be relevant in 2009, including shared private-public responsibility for individuals with severe mental disorders and federal funding to facilitate linkages between health plans, public providers, and other social welfare systems.

Mental health in health reform, 2009 version

In 2009 health care reform will likely build on the existing private insurance system and focus on expanding access, controlling costs, and improving the value of health care purchases by improving quality. The changes that have occurred since 1993 will enable mental health reformers to participate more actively than in the past in discussions about these issues. Acceptance of parity by employers and the insurance industry takes one issue off the table. The considerable experience with managed care can be built upon to hold down costs and calm fears of unnecessary utilization, although it will be important to promote strategies that guard against adverse selection and undertreatment. Health reform can also build on a much more solid base of evidence for the effectiveness of mental health interventions.

Mental health advocates can now propose strategies for improving the operation of the overall health system and urge incorporation of mental health care within those broader strategies. They might suggest improv-

ing integration of mental health in primary care and incentives for mental health professionals to be co-located with primary care; including people with severe mental illness in strategies to improve management of chronic illness and ensuring mental health treatment for those with other chronic conditions; incorporating mental health services in medical homes and other organized systems of care; promoting initiatives for prevention and early intervention; including mental health in quality improvement initiatives, such as incentives for adoption of evidence-based practices and outcomes measurement; implementing payment methods that enable flexible benefits, particularly for those with serious mental illness, while protecting against undertreatment by managed care entities; and expanding use of electronic records and ensuring compatibility of mental health and physical health record systems that have appropriate privacy protections for mental health information.

Conclusions

The challenge for individuals interested in moving mental health into the mainstream of health in 2009 will be different from, but in some respects still similar to, the dilemmas that earlier reformers faced. Policy changes since 1993, along with a significant shift in public attitudes toward mental health and mental illness, create a more fertile ground for moving toward a unified and integrated health system that addresses the mind and body as one.

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