Mental Health Benefit Design: Striving to Achieve Parity in Washington State

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In 1993 Washington became the first state in the nation to pass comprehensive health care reform legislation mandating universal coverage, a standard minimum benefit package, and managed competition (1). A Washington State health services commission was established to oversee implementation of the legislation. During March 1994 the commission created a mental health benefit issue investigation group whose charge was to develop consensus recommendations for the mental health component of the benefit plan.

People in the Northwest have historically had minimal mental health coverage. In Washington State more than 75 percent of persons who have private health insurance have a plan that provides coverage for fewer than 12 inpatient days and 20 outpatient visits per year. Consequently, legislators are concerned that expanding benefits might increase the cost of mental health coverage.

This column describes features of the law as well as recommendations of the group established to develop consensus about the mental health component of the plan. Results of these reform efforts are also briefly described.

Washington's health care reform law

The Washington Health Services Act of 1993 has several important features. The legislation mandates formation of certified health plans that must provide a full array of health care services, referred to as the uniform benefit plan. These health plans bid on contracts to provide the benefit plan based on a community rating. Under the law, each subscriber has a choice among at least three health plans. Employers are required to pay 50 percent of the premium but may pay up to 100 percent of the premium of the least expensive health plan.

Individuals are required to pay the remainder of the premium as well as copayments and deductibles. People whose incomes are below 250 percent of the federal poverty line may be exempted from the premium, deductible, and copayments. The health plans contract with clinicians and other health care organizations to provide services. The legislation provides for fee-for-service care only when health plans choose to contract with clinicians in this manner. The legislation calls for universal coverage to be achieved by 1999. A long-term-care plan will be added in 1999.

The legislation requires that the benefit plan include "case managed mental health . . . services, to the extent that such services reduce inappropriate utilization of more intensive or less efficacious medical services." This provision has been interpreted by the commission to call for comprehensive mental health coverage with utilization review based on medical necessity. Utilization review decisions are to be made by the health plans or their representatives.

The benefit issue investigation group

Members of the health services commission were concerned by the lack of agreement among stakeholders about the mental health component of the uniform benefit plan. They were also concerned that commission members lacked expertise in the area of mental health. Consequently, the first author was asked by members of the health services commission to form and chair a mental health benefit issue investigation group.

The goal of the group was to develop consensus recommendations acceptable to the broadest possible range of stakeholders. Twenty-one individuals representing psychiatry, child psychiatry, psychology, social work, nursing, consumers, health services research, rural issues, state government, community support networks, employers, insurance companies, a health maintenance organization, and a national managed behavioral health care firm were invited to participate in the group.

Although the diversity of the group helped ensure that major stakeholders participated, it made achieving consensus difficult. The group met for four two-hour discussions that were guided to move from broad principles to more specific proposals. Background information on

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mental health benefits was provided through a review of literature and presentations by experts in mental health benefit design. An actuarial analysis of the proposed plan was subsequently prepared for a commercially insured population under the supervision of the commission.

Group recommendations. The investigation group agreed that certain broad principles should apply to the mental health benefit design. For example, recognizing that all of the services in the benefit plan would be subject to utilization review, group members reached a consensus that the plan should include as many components of parity between mental health and medical services as possible. This approach meant that the plan deductible should apply to mental health services as well as to medical and surgical services, that mental health copayments should be equivalent to those for medical services, and that psychotropic and medical pharmacy coverage should be equivalent. In addition, the group agreed that mental health services reflecting a continuum of intensity should be available and that services should be culturally and developmentally appropriate.

In an attempt to operationalize these principles, and given important concerns about the cost of the benefit, two specific benefit options were developed. In the full parity plan, service utilization is case managed and limited only by medical necessity. Mental health is included in the annual $1,200 deductible for the plan as a whole. A second option, the partial parity plan, is similar, except that the inpatient benefit is capped at 30 days and the outpatient benefit is capped at 30 visits.

Many group members wanted to design a benefit that would target the needs of persons with severe and chronic mental illness. Under both options, outpatient medication management visits are broadly defined and limited only by medical necessity. They include brief individual patient contacts and medication groups. Medication management visits are allowed for starting medication, medication maintenance, fostering medication compliance, and providing care to persons who for reasons such as pregnancy or adverse drug reactions require interruption of pharmacological treatments.

In the partial parity plan, the group recognized that limiting specific types of services creates an incentive to substitute other services, which may be more costly and less effective. Although any benefit structure that uses fixed amounts of defined services has shortcomings, the group could not agree on an alternative. However, the following mechanism for interchanging services was adopted by the commission to provide maximum flexibility in the partial parity benefit. Inpatient hospital days may be converted to brief residential days or partial hospital days at a ratio of 1:2 based on medical necessity. Inpatient days may also be converted to intensive outpatient program days, defined as a step down from partial hospital program days, at a ratio of 1:3. These ratios are intended to approximate current national costs. It is anticipated that these ratios will be updated regularly to reflect changing costs and to include new cost-effective intensive mental health services.

The role of public mental health services. The group felt that to prevent cost shifting between the public and private mental health sectors, the interface of these sectors should be clearly defined and seamless. The organization bearing responsibility for the care of each patient must be clear to the patient and to his or her provider at all times. In the full parity plan, care is provided on an unlimited basis as long as medical necessity criteria are met and the care is not deemed to be custodial. In the partial parity plan, a patient does not become the responsibility of the public sector until inpatient and outpatient mental health benefits are exhausted. The public sector may choose to collaborate with health plans by offering services not usually provided by the health plans such as long-term supervised apartment placement or group home placement with the goal of providing comprehensive care.

Options considered but not recommended. The group considered and rejected the use of dollar limits to define the size of the inpatient or outpatient benefit. Although it was recognized that dollar limits would promote flexibility, dollar limits would also lead to erosion of the benefit over time due to inflation.

Other options considered by the group and rejected included the conversion of inpatient days to outpatient visits. Several group members felt this approach would lead to an increase in accounting costs and to patients' dissatisfaction because they might view this conversion as an entitlement. In addition, health plans are at liberty to provide for patients who need outpatient psychotherapy services beyond the outpatient service caps in order to decrease their inpatient costs. A benefit using a different copayment structure was considered, but the group strongly supported adoption of a mental health benefit that has as many elements in common with medical coverage as possible.

Shortcomings of the proposals. Although it represents an improvement over most existing private insurance plans in Washington State, the partial parity plan has many shortcomings not present in the full parity plan. Most important, it allows inequity to persist in mental health coverage. Between 4 and 7 percent of persons who are currently commercially insured and who require psychiatric inpatient hospitalization will exceed their mental health inpatient benefit cap with medically necessary services each year. On average, these people will pay $10,000 to $15,000 in addition to their out-of-pocket maximum of $1,200.

Individuals who are not eligible for Medicaid will in some instances be forced to impoverish themselves to pay psychiatric hospital bills even if their treatment meets strict criteria for medical necessity. For many people with severe mental illness, care may become fragmented as more patients are turned over to the public sector.

Utilization review and quality assurance. Because utilization decisions are made by the health plans or their representatives, attempts will be made to ensure that qualified persons participate in this process. In

addition, it may be possible to require that health plans make their utilization review algorithms publicly available.

One of the next tasks in Washington State will be the development of a rigorous quality assurance system to ensure that medically necessary services are not denied. To be effective, this system must be simple, and it must rely on both process and outcome indicators of quality. It must also be overseen by a group that has the authority to modify health plan behavior.

Political considerations. Although the mental health benefit represented a small portion of the total uniform benefit plan premium (3 percent to 6 percent), it was a high-profile item. Facing the possibility of mandated employer participation, employers lobbied for low health care premiums and narrow benefits. They repeatedly pointed to mental health services as an area where cutbacks could be made. Several commission members believed that if the full parity plan was approved, it would have improved the efficiency of the mental health care delivery system. However, they were concerned that it might take one to two years before utilization review would enable mental health care costs to be managed and reduced to projected levels. They were also concerned that a comparatively rich mental health benefit could cause the legislature to reject the uniform benefit plan as a whole.

Implementation of reform

The report of the benefit issue investigation group was completed and presented to the health services commission in August 1994. The commission included the partial parity plan in the benefit plan on a preliminary basis. After a series of public hearings, the commission reviewed the merits of the options during October 1994.

In January 1995 the commission submitted a final uniform benefit plan with the partial parity mental health benefit to the state legislature. Later that month, as a result of a change in political will and the failure of Washington State to win a waiver of the Employee Retirement Income Security Act (ERISA) from the federal government, the legislature voted to postpone implementation of the Health Services Act of 1993. ERISA effectively prevents states from requiring that all employers provide a standard minimum benefit package for their employees. In May 1995 large sections of the act were repealed. The uniform benefit plan was replaced by the basic health plan. The basic structure of the partial parity plan was incorporated into this new basic health plan, which is expected to provide mental health coverage to more than 200,000 people who were previously without such coverage.

Conclusions

Despite the failure of Washington State to implement fully the Health Services Act of 1993, the proposed partial parity mental health benefit elicited strong support from both policy makers and legislators in the major debates over the uniform benefit plan. The consensus-building process and the conclusions of the mental health benefit group may serve as a model for health care reformers in other states. The authors believe that future health care reform will continue to demonstrate that comprehensive and universal mental health coverage can be affordable.

Reference

1. Crittenden RA: Managed competition and premium caps in Washington State. Health Affairs 12(2):82–88, 1993

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for patients in the chemical dependency group and from $9,150 to $5,898 for patients in the panic disorder group, for a total savings of $6,231.

Conclusions

The reaction to the integrated care model among the physicians in our medical group has been positive. Physicians in the family practice and internal medicine departments have shown greater ability in detecting cases of chemical dependency and panic disorder and in intervening appropriately. Some physicians have remained more reserved in their acceptance of the new philosophy, although this resistance has been minimal.

The results of our naturalistic study provide examples of the possible outcomes of integrated care. We plan a study of a larger sample of patients to allow more definitive conclusions about the effects of this model of care.

Our medical group now operates on the basis of a philosophy of managed care that includes "carving in" mind-body medicine. This philosophy has been translated into practice through a flexible, inclusive, and integrated organizational structure. From the top of the organization, where policy is developed, to the front line, where medical and mental health services are delivered, there is a common understanding of the organization's goals and approach for achieving them.

We have come to believe in the value of competence and accuracy in assessing mental health problems in the primary care arena and to view this practice as a prerequisite for ongoing coordination and collaboration among care providers. In summary, we believe that by addressing the full range of our patients' health and mental health care needs, we will increase both their overall well-being and their satisfaction with care, enhance providers' sense of effectiveness, and possibly reduce the cost of health care delivery.

References

1. Benson H, Stuart EM: The Wellness Book. New York, Simon & Schuster, 1993
2. Glazer W: Evaluating psychiatric disorders in primary care settings: anxiety, depression, and somatoform disorders. Medical Interface, Jan 1993, p 81
3. Budd M: Heidegger and wholeness: new possibilities for the practice of medicine. Presented at a meeting of the National Association of Managed Care Physicians, Phoenix, Sept 29, 1994