
Commentary

What Did The Health Care Reform Debate Mean For Mental Health Policy?

by Chris Koyanagi and Joseph Manes

A new perspective on mental health policy emerged during the debate on national health care reform in 1993-1994. To the surprise of many, the mental health discussions did not revolve around the number of inpatient hospital days and outpatient therapy visits to be available. Instead, it addressed the need to cover comprehensive services, to shift mental health and addiction disorder services into the mainstream of health care, and to integrate the private and public sectors.

Key to the policy shift was an early decision by President Clinton and his advisers not only to include mental health and substance abuse (MH/SA) services in health care reform legislation but also to make them an integral part of his proposal. The decision led to the creation of Tipper Gore's mental health work group within the federal health care reform task force. No other area of benefits design was given such status.

The Mental Health Work Group's Proposals

The mental health work group drew guidance primarily from federal health and mental health policy analysts, but it also received input from national organizations and mental health economists. In late spring 1993 the work group produced its "Tollgate V" paper for review by the health care task force leadership.¹ This paper recommended full participation in a reformed health care system by persons with mental illness or addiction disorders, with services available on the same terms and conditions as those for other care. Motivated by increasing evidence that mental health services are most effective when a full array of service options is available, the paper urged comprehensive treatment and rehabilitation services for acute and chronic conditions, with an emphasis on early intervention and incen-

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tives to encourage the use of nonhospital services. In keeping with the nondiscrimination theme, copayments and deductibles were on a par with those for other services. Based on research showing that organized systems of care have altered the allocation of resources between community services and hospitals and that this has resulted in more cost-effective care and greater consumer satisfaction, the work group proposed to encourage the development of such systems.² Many of these systems also have been able to address the needs of persons with serious and persistent mental illness more successfully than traditional approaches have.³

In making these recommendations, the work group was motivated by increasing evidence that neither the private sector nor the public mental health system has produced a rational and effective system. The private insurance system emphasizes limited coverage to treat short-term acute conditions and relies on the public sector as a safety net for those with more serious needs. The public mental health system, despite sporadic efforts at innovation, relies on outmoded institutional services combined with underfunded community care that produces perverse incentives which result in fragmented, ineffective care, with minimal incentives for cost-efficiency.⁴ As a result of these failings, the welfare, correctional, and other public systems are burdened by persons with mental illness for whom the mental health system has failed.

One of the biggest problems in achieving integration of mental health services with the overall health care system is financing the expensive care of persons with severe mental illness who are now the responsibility of the public system. The work group suggested risk adjustment, through mixed capitation payments, for persons with serious and long-term disorders, to reduce incentives to undertreat or avoid bad risks altogether. For additional financing, the group recommended that the current level of state and local mental health spending be made a part of the new national system, but it could not come up with a feasible way to do this. Integrating the funds now spent by the public sector would have helped to offset the premium costs for individuals and families. Planners of a reformed health care system did not intend to rely upon a separate, substantial public investment in this area, as is the situation under current insurance policies. However, without such additional funds, the work group's proposed benefit would have cost \$275 a year in premiums per person, an estimate that appeared high when contrasted with private insurance costs, and this became a major barrier to the Clinton administration's acceptance of the idea.

There was also a question of whether the administration's cost estimates, developed by the Health Care Financing Administration (HCFA), were accurate. The HCFA actuaries differed significantly in their approach from the health economists in the work group. They made few allowances for the

cost control impact of a managed benefit and the savings that could accrue from greater availability of community and outpatient care. As a result, their exaggerated cost estimates of the benefit in a fee-for-service delivery system forced the White House to rethink the work group's proposal. By the time that the Clinton bill was introduced in November 1993 as the Health Security Act, it contained a set of stringent limits, trade-offs, and high copayments to reduce the cost estimates to a "defensible" level.⁵ Unfortunately, those restrictions also undermined the basic principles of the work group's proposal and would have made the benefits only marginally useful to persons with serious disorders or those with low incomes who could not afford the high copayments.

Despite these problems in the Clinton legislation, however, the momentum behind a more creative approach continued.⁶ Congressional committees took as their blueprint the recommendations of the mental health work group, not the administration bill.

Congressional Legislative Proposals

The first three congressional committees to report legislation—Ways and Means, Education and Labor (both in the House), and Labor and Human Resources (in the Senate)—drafted bills that incorporated mental health benefits into the basic health care plan, and all covered comprehensive services. The bill written by Majority Leader Richard A. Gephardt (D-MO) for House floor action adopted a similar approach. Although these bills were not identical, they had many common elements. Each of the bills included (1) a comprehensive listing of covered services: inpatient hospitals and community residential programs, intensive community services such as rehabilitation and day treatment, and a full array of outpatient interventions including case management, medication visits, psychotherapy, and substance abuse counseling; (2) MH/SA benefits within the general health care benefit, which would be available to all persons through their insurance plans; (3) coverage of the services with few arbitrary restrictions, including no visit limits for outpatient services; (4) copayments that paralleled other copayments in the bills, except for a higher (50 percent) copayment for adult psychotherapy after the first five visits; (5) a mandate for the secretary of health and human services (HHS) to establish rules for managing the benefits to hold down costs; and (6) a requirement that states begin to address the complex issues of how to merge the current public sector (and its financing) into the mainstream of health care.

Later in the process, three Senate bills emerged that contained no defined benefits. Instead, a national board was to write the benefits after legislation was enacted, based on overall actuarial limits and broad legisla-

tive guidelines. These bills—the Senate Finance Committee’s reported bill, Sen. George J. Mitchell’s (D-ME) “leadership” bill, and the bipartisan effort known as the Mainstream Coalition bill—required “parity” for mental health benefits with other health care benefits. These bills, like those reported earlier, relied primarily upon management of the benefit to hold down costs and inappropriate use.

What Happened And Why

The main lesson of the 1993-1994 debate is that political organizing, built on a solid foundation of research and treatment experience, can overcome apathy, fear, and stigma—the three major adversaries of non-discriminatory mental health coverage. The major factors that enabled this change were (1) the explosion of knowledge about the brain and mental disorders over the past decade or so; (2) the findings of service-effectiveness research that support the efficacy of many mental health treatments; (3) the growing use of managed behavioral health care by large corporations and insurance companies to hold down costs; (4) a significant shift in public attitudes about mental health care, especially when compared with attitudes in 1965, when Medicare and Medicaid were enacted; and (5) the growth in advocacy by consumers and families resulting from the reduction in stigma.

Using the new information about mental disorders and the effectiveness of treatment, and promoting management of a comprehensive benefit as a cost-effective approach to coverage, key members of Congress and mental health groups were able to successfully press their case. Unlike during previous efforts, organizations rose above protecting their own turf or special ideology. For example, early in 1993, all major national mental health organizations forwarded a detailed set of recommendations to the work group and Capitol Hill, urging comprehensive coverage of mental health services and integration with mainstream health benefits.⁷ Despite some bumpy moments when old conflicts flared, the mental health community was able to sustain itself as a remarkably unified lobbying force for these recommendations throughout the two years.⁸ Academics, individual advocates, including two former First Ladies—Rosalynn Carter and Betty Ford—and celebrities spoke out, generally articulating the theme of a comprehensive, nondiscriminatory mental health benefit. Yet all of this would have been for naught if the numbers did not add up. It was crucial to the debate that cost data could demonstrate that a full range of service options was manageable.

Based on information showing how managed mental health programs have helped employers overcome their reluctance to provide coverage for

services whose use was considered difficult to control, the congressional committees directly authorized the use of carve-out managed behavioral health care plans or directed the HHS secretary to develop standards for managing the MH/SA benefit.⁹ Also, the Congressional Budget Office (CBO), the official congressional scorekeeper, signaled its willingness to attribute significant cost savings to provisions requiring gatekeepers or other mechanisms to manage use of the benefit.¹⁰ The CBO was aided in this effort by several alternative cost studies and also by consultation with health economists from the mental health work group.¹¹

Potential Impact On Future Federal And State Actions

What was actually gained, since health care reform legislation did not pass? One possible assessment is that nothing was gained. National policy remains unchanged. With the Republican takeover of Congress, federal policy in the 104th Congress likely will focus on retrenchment in current programs, coupled with possible action on insurance reforms to address preexisting condition clauses, portability, and perhaps community rating of premiums. In this scenario it is certainly possible to argue that last year's debate on mental health policy will have no impact on future decisions.

However, the development of public policy is an evolving process, marked by frequent stops and starts. Before reforms of the magnitude discussed in the 1993-1994 debate are adopted, consensus is needed that this is the right approach for the times. That consensus has now emerged on MH/SA policy. Federal legislators, the administration, the public, and national advocacy organizations agree that the present system is neither equitable nor effective. They also agree on the general directions for change. The need to translate principles into legislative language has forced the varied interests to compromise on policy details that too often divide this field and stymie legislative action. As a result, there is a strong case to be made that in the next national debate on health care reform, the debate on insurance coverage for MH/SA problems will begin with the consensus achieved in this one.

The debate over costs led many health economists to review mental health cost estimates and reassess their approach. At the federal level, there is now much greater understanding and information available to key offices responsible for health care assessments, such as the CBO, HCFA, and HHS. Future assumptions on mental health care costs will be far more informed as a result.

Although comprehensive reform may be off the table for the moment, it is clear that changes will continue to occur in the health care delivery system, spurred on by state and private-sector initiatives. The problems that

prompted the 1993-1994 debate are still with us and cannot be ignored: The number of uninsured persons is increasing, health care costs are rising faster than inflation, and many insured Americans continue to fear losing their employment-based health care coverage.

As states move to address these problems, and in particular to expand Medicaid managed care programs to include persons with serious mental illnesses, the impact of the federal debate will be felt. Contracts now being developed between state agencies and managed behavioral health care plans reflect this conclusion. By early 1995 many states were actively putting together plans for Medicaid managed care for this population, and a few (notably Iowa, Massachusetts, and California) were starting to deliver comprehensive services.

Although several factors have influenced the development of state plans, we contend that inclusion of a broad range of mental health services in legislative proposals for national health care reform was an important factor. We believe that had the federal government and Congress developed legislation based on a policy of arbitrary limits and a narrow range of traditional services, state policy would now more closely mirror that approach.

Advocates' roles in state health care reform efforts (as well as in future federal efforts) also have been influenced. Although the gains have not yet been realized in a concrete manner, the recent debate showed the mental health community that nondiscriminatory mental health benefits in an integrated health care system are within reach and that the tactics and strategies used in the national debate can be replicated and built upon in state advocacy or in future federal debates.

NOTES

1. Work Group on Mental Health and Substance Abuse of the White House Task Force on Health Care Reform, *Tollgate V: Mental Health and Substance Abuse*, Revised draft (15 April 1993).
2. R. Frank et al., "Organizational Failure and Transfers in the Public Sector, Evidence from an Experiment in the Financing of Mental Health Care," *Journal of Human Resources* 29, no. 1 (1994): 108-125; and R. Frank et al., "Fiscal Decentralization of Public Mental Health Care and The Robert Wood Johnson Foundation Program on Chronic Mental Illness," *The Milbank Quarterly* 72, no. 1 (1994): 81-104.
3. For instance, a capitated payment system in Rochester, New York, resulted in major improvements in the community's services for persons with serious mental illness and reduced the proportion of care provided in the state hospital. In Utah a public mental health capitated program operating since 1991 provides comprehensive mental health services to Medicaid recipients, with overall improvement in quality of care and cost efficiencies.
4. M. Hoge et al., "Defining Managed Care in Public Sector Psychiatry," *Hospital and Community Psychiatry* 45, no. 11 (November 1994): 1085-1089.
5. Although the Health Security Act included limits, trade-offs, and high copayments in the MH/SA benefit, it also proposed that all of these limitations be removed in 2001 after an appropriate mechanism had been developed to integrate public and private financing and once managed benefits were in place. For more on the process of estimating mental health benefit costs, see R.G. Frank and T.G. McGuire, "Estimating Costs of Mental Health and Substance Abuse Coverage," *Health Affairs* (Fall 1995): 102-115.
6. Once the issue moved to Capitol Hill, the mental health provisions in specific committee bills were developed primarily by a cadre of academics on loan to the key congressional committees. Most members and permanent staff were focused on bigger issues. To the extent that they paid attention to the mental health provisions, they asked only that the cost estimates be reasonable and that the MH/SA communities support the approach. Fortunately, it proved relatively easy to satisfy these conditions. As a result, the mental health provisions were thoughtful, nonpolitical, and farsighted.
7. C. Koyanagi et al., "On Being Very Smart: The Mental Health Community's Response in the Health Care Reform Debate," *Hospital and Community Psychiatry* 44, no. 6 (1993): 537-541.
8. L. Scallet et al., "Reflections on the Mental Health Community's Experience in the Health Care Reform Debate," *Hospital and Community Psychiatry* 45, no. 9 (1994): 888-892.
9. E. Wainstock, "How HMOs Can Effectively Manage Mental Health Services in the 1990s," *Administration and Policy in Mental Health* 21, no. 1 (1993): 15-26; and J. Christianson et al., "Use of Community-Based Mental Health Programs by HMOs: Evidence from a Medicaid Demonstration," *American Journal of Public Health* 82 (1992): 790-796.
10. The final outcome was cost estimates of between 12 percent and 15 percent of the total premium in those bills providing for a comprehensive health care benefit.
11. The most comprehensive of these estimates was issued by the American Managed Behavioral Healthcare Association in January 1994. It concluded that the cost of a comprehensive MH/SA benefit in a managed plan was actually no more than the administration's estimate for the far more restricted Clinton benefit. American Managed Behavioral Healthcare Association, *Managed Behavioral Healthcare Cost Report*, prepared by S.P. Melek (Washington: AMBHA, February 1994).