Cite this article as:
R M Scheffler, S E Foreman, B J Cuffel and C Mackley
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Health Affairs 13, no.2 (1994):201-210
doi: 10.1377/hlthaff.13.2.201

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Commentary

Mental Health Benefits In The Clinton Plan

by Richard M. Scheffler, Stephen Earl Foreman, Brian J. Cuffel, and Carter Mackley

During the past thirty years few components of the health care delivery system have developed as rapidly as mental health and substance abuse treatment. Historically characterized by stigma, a paucity of funding, and genuine doubt as to its efficacy, mental health and substance abuse treatment is now sought by some twenty-three million Americans each year.1 Moreover, the fabric of mental health and substance abuse treatment has undergone drastic transformation. Thirty years ago the bulk of mental health and substance abuse care was provided by state mental hospitals and general practitioners.2 Now treatment takes many forms: short- and long term inpatient care, partial inpatient care, outpatient care, medication management, group counseling, family counseling, and a full range of therapies. Mental health and substance abuse treatment is a growing field characterized by rapid evolution of knowledge and application of such knowledge in new forms of treatment.

The Clinton plan. Given current development and growth in mental health and substance abuse treatment, the import and timing of the Clinton administration’s health reform proposal is of particular concern.3 The Clinton proposal makes maintenance of the status quo unlikely. Mental health and substance abuse treatment either will continue to evolve or will regress. Given the need for these services by millions of Americans, many of whom have no access to them now, we believe that the administration has little choice but to provide incentives for continued development of this vital sector of the health care system.

The Clinton plan strives to achieve universal access, comprehensive benefits, equity of care, and a fair distribution of the cost of providing

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health care to all Americans. Under the current version of the plan, however, mental health care is not initially accorded equity or fair distribution of costs. Equity and fair distribution are contemplated for 2001. In 2001 limits on mental health and substance abuse coverage will be replaced by benefit management. The Clinton plan proposes coverage under three scenarios: low cost sharing, high cost sharing, and mixed cost sharing. The 2001 plan covers inpatient and residential treatment, intensive nonresidential mental health treatment (for example, partial hospital services), and professional and outpatient services including psychotherapy. The 2001 plan substantially eliminates discrimination between general medical care and mental health/substance abuse treatment.

Setting Principles For Mental Health Reform

In this Commentary we evaluate the mental health portions of the Clinton administration’s plan to reform the U.S. health care system, using a principles-based approach. As part of our evaluation we reviewed the principles of two groups of researchers who have used them to recommend reform of mental health and substance abuse financing. These principles, by and large, were used to design insurance benefit packages. Our proposal is built on “first principles,” that is, universal and fundamental tenets that provide the basis for sound public health policy.

Richard Frank, Howard Goldman, and Thomas McGuire have formulated a reform proposal for private mental health insurance based on principles that set a standard for sound policy development. These principles provide that (1) the most important risk to insure is catastrophic loss; (2) services with more responsive demand should carry higher cost sharing; (3) supply-side limits should be used in place of demand-side limits where possible; (4) the payment system should encourage the substitution of low-cost for high-cost providers; and (5) the payment system should be consistent with effective managed care.

Portions of Frank and colleagues’ plan look very much like the Clinton plan, and their principles are sound and appropriate standards for benefit design. Our concerns regarding these principles deal with the way they interrelate, the context of their application, and whether they are broad enough to apply to a universal system of coverage for a diverse population.

Steven Sharfstein, Anne Stoline, and Howard Goldman recently advanced a set of principles intended to produce an “optimal benefit design” for mental health and substance abuse treatment. These principles include (1) nondiscriminatory coverage; (2) payment on the basis of service rather than diagnosis; (3) identical application of cost containment principles; (4) retention of the public sector as a backup for high-cost, long-term cases; (5)
encouragement of a continuum of care and lowercost alternatives to hospitals; and (6) recognition of the distinction between psychotherapy and medication management.

We propose here our own fundamental tenets that should undergird sound health policy making. We review the mental health and substance abuse provisions of President Clinton’s health reform proposal in the context of these six “first principles.”

**Principle one: Optimal coverage for mental health and substance abuse treatment will take a societal view of costs and benefits.** We start with the premise that health reform should address the primary goal of maximizing the well-being of each citizen. To obtain this outcome, any reform plan must consider mental health status as an integral part of overall health status. Health security must encompass both general medical care and mental health care.

Effective national health system reform requires adoption of a social cost and social benefit standard that recognizes mental health as an essential element of the social fabric. Historically, health care financing policy has proceeded from a narrow perspective on the cost of treatment. Health benefit design focuses coverage on access and the means to control costs. However, mental health problems have far-reaching effects, often unforeseen by those involved in health care financing and delivery. For example, mental health issues strain the criminal justice system, affect worker productivity, impair education, and impede the functions of the family. Some experts claim that the indirect costs of mental health problems reach $100 billion annually. In addition, the mentally ill are more likely to die younger and to use more medical care resources. Further, mentally ill persons who cannot gain access to mental health care often seek less efficient treatment in the general medical care sector. Given these costs, reform efforts should give priority to allocating funds for mental health and substance abuse treatment to those groups who most need this type of care: children and the severely mentally ill.

The Clinton plan offers a wide range of mental health and rehabilitative benefits in a structure that attempts to assure universal access. However, truly visionary reform would consider the role of behavioral disorders in America’s social problems. We urge the administration and Congress to take a societal view of the impact of mental and behavioral health problems by broadening benefits and by ensuring access to care for a wider range of problems. We suggest that they convene a group representing criminal justice, management and labor, education, and family services advocates. This group should study the impact (economic and otherwise) of mental illness and behavioral disorders and make recommendations regarding coordination of efforts between and among various public sectors, including
health care. Such an effort might produce even greater incentives to improve mental health and substance abuse benefits. The social benefits produced by such a program could easily outweigh its costs.

**Principle two: Health care reform should promote a “seamless fabric” of mental health and general health services.** Mental health and substance abuse treatment is an essential part of the health care system, increased use of which can lead to reductions in the use of general health services. Mental health care, like general medical care, is potentially a seamless fabric of short- and long-term inpatient care, partial hospitalization, special outpatient services, provider office visits for medical treatment and psychotherapy, group counseling sessions, family counseling, and other treatment modalities. With greater understanding of medication and the importance of diet and exercise, the distinction between mental health care and general health care will continue to diminish.

The health system’s failure to understand and deal with the linkages between general medical care and mental health care will guarantee continuation of inappropriate treatment. For example, substance abusers commonly receive treatment only for the symptoms of substance abuse rather than for the problem underlying the abuse. General practice physicians prescribe psychotropic drugs for such patients, knowing that mental health care would be preferable but that the patient will be unable to obtain it.

A strong health care reform package should recognize and encourage appropriate use of the entire system. The goal of the Clinton plan is to foster the provision of a comprehensive array of services, along with the flexibility for providers to offer services based on individual need. By 2001 a comprehensive, integrated benefit structure with appropriate management will replace detailed limits on individual services. Accordingly, the Clinton plan squarely addresses principle two.

The Clinton plan constitutes a major advance in that it provides treatment parity, a concept advocated by David Mechanic and other scholars. However, we believe that the Clinton reform proposal can do more. We believe that the health system should get those in need of health services to the right treatment modality at the right time. Two mechanisms advance this goal: structure and payment. The structural aspects of the Clinton plan promise to be powerful in advancing this principle.

Institutional economics suggests that organizations and contractual relationships address transaction cost issues that provide difficulty for traditional economics. Referrals within the health care system constitute a transaction cost. To get patients to the right place at the right time, the system must be structurally conducive to patient referrals and must contain mechanisms that encourage referrals. Full-service health maintenance organizations (HMOs) offer such a mechanism. For this reason we advocate
development of specialized HMOs to treat persons with severe mental illness. Our conclusion extends to mental health care in general. A full-service HMO, with appropriate incentives, may best provide a seamless fabric of general medical and behavioral health services. The Clinton plan addresses this principle, in that it provides strong incentives for regional health alliances to contract with HMO-type health plans. While alliances may limit the number of fee-for-service plans, they must contract with an HMO unless the HMO fails to meet certain standards.

Principle three: Health reform efforts should identify treatment that produces optimal outcomes and funding incentives that help generate such outcomes. Heretofore, payment policy has emphasized diagnosis and treatment, while ignoring outcomes. However, Congress has charged the Agency for Health Care Policy and Research (AHCPR) with developing practice guidelines and outcome measures for a range of medical conditions including depression and schizophrenia. Our knowledge of treatments and their relation to outcomes is growing.

Incentives play a major role in health care. This is as true for mental health services as it is for general medical care. Payment systems that focus on the reduction of costs will reduce costs, if they are effective. However, the ultimate cost reduction would eliminate all services. Accordingly, an appropriate payment system considers both cost and benefit.

As the results of outcome studies become available, funding mechanisms can provide incentives for patients and providers to produce optimal outcomes. Such incentives can encourage providers to refer patients to appropriate treatment modalities. The funding system would identify treatments that are clinically efficacious, determine optimal outcomes for these treatments, and provide for payment mechanisms that reward such outcomes. Payment mechanisms ideally would take into account differing sociodemographic demand responses as well as varying consumer deductibles and copayments. Paul Ellwood emphasizes that outcomes management is patient welfare. As such, an incentive system that produces optimal mental health outcomes is welfare-maximizing and should be an essential part of any health care reform package.

The Clinton plan provides a treatment-based payment approach to mental health and substance abuse. Payments will be based on inpatient days and visits. Given the infancy of outcomes measurement for mental health and substance abuse, it would be inappropriate to expect the reform plan to apply payment techniques based on outcome measures. The Clinton proposal is based on state-of-the-art theory as advanced by Frank and Sharfstein and contemplates a significant advance in 2001: the elimination of discrimination between mental health/substance abuse care and general medical treatment. Adoption of this goal alone promises major
advances that will improve treatment outcomes. Accordingly, we believe that the Clinton plan addresses the spirit of our third principle. Yet the Clinton proposal could do more. Our third principle could be advanced if the AHCPR were specifically charged to redouble efforts to develop mental health and substance abuse practice guidelines and outcome measures.

The Clinton plan seems to assume that providers will be able to fend for themselves under the new contracting system. However, the contracting system will create winners and losers. If mental health providers become losers, public health goals will not be advanced. The plan should provide mechanisms that recognize the need for providers to receive revenue at a level that encourages short-run and long-run financial health for those providers that deliver efficient and effective mental health care. The funding system must be set at a level that encourages appropriate entry into the profession. Any system that imposes arbitrary limits on overall resources without adequate attention to the appropriate level of demand and the supply of services to meet this demand will not produce effective access. The Clinton plan could encompass provisions that charge the National Health Board with ongoing responsibility to review each sector of the health care industry, with particular attention to mental health, and to devise responses that ensure coordination of services.

Principle four: Health care reform should consider the broad impact of cost controls. Freedom of choice can be an efficient allocator of resources. However, persons who do not have adequate resources are often unable to exercise choice. Accordingly, mental health funding principles should consider patients’ ability to pay. A plan that is limited to supply-and-demand cost sharing can create access problems for patients and their families. By making mental health services less available, such a plan may actually increase global costs. As emphasized by Frank and colleagues, moral hazard is reduced by demand-side cost controls. However, demand constraints negatively affect those least able to bear the brunt of them: poor persons and entry-level employees. A well-considered plan should temper the negative impact of utilization controls, perhaps by using an income-based sliding scale for copayments and deductibles, or by imposing low deductibles and copayments for initial treatments or visits, followed by increased cost sharing over time.²³

The traditional approach to deductibles and copayments fails to consider the relative appropriateness or desirability of particular services. While the American Psychiatric Association, Mechanic, and other scholars advocate “nondiscrimination,” simple equality may not be enough.²⁴ For example, there are instances in which mental health and substance abuse treatment are preferable to general medical care. Here financial incentives should favor the use of mental health care as opposed to general medical care.
Cost controls also affect supply. For example, bans on balance billing reduce providers’ willingness to offer treatment. Payment incentives can distort treatment decisions. Payment in full for medication management of mental health cases coupled with partial payment for psychotherapy encourages use of medication at the expense of psychotherapy.

The Clinton plan provides coverage for inpatient hospitalization, partial hospitalization, case management, medication management, crisis management, home-based care, and behavioral aide services. However, copayments associated with some of these services will have a dramatic impact on the populations that need them. Also, the Clinton plan, particularly during the phase-in period, provides no explicit encouragement of health care services in what may be their most cost-effective forms, such as assertive community treatment teams. Accordingly, we suggest that the Clinton administration take a closer look at the impact of mental health and substance abuse cost controls on the efficacy and efficiency of care delivery.

Further, the Clinton plan proposes supply-side limits. Global budgets applied to health plans through alliances will limit the supply of health services. Bans on balance billing will make it impossible for some consumers to receive the care they desire, even if they are willing to pay for it. HMOs will regulate the way health care is provided within the health plan. The specific reach of supply-side cost controls in the Clinton reform proposal is unknown at this time.

We would give the National Health Board and the alliances the task of reviewing specific impacts of cost controls on mental health and substance abuse care. Where supply-side limits cause access problems, particularly for mental health and substance abuse treatment, the board and the alliances should be directed to relax global budgets and to provide for resource reallocation in a manner that fosters appropriate provision of care.

Principle five: Health care reform should remove the artificial distinction between public and private systems of mental health care in a way that protects health security. In the past, basic benefits for mental health and substance abuse treatment have been privately supplied: funded by insurance coverage (employment-based or Medicare) or paid for by the patient. The public system has acted as a safety net for catastrophic illness. This dichotomy has led to a breakdown in the provision of mental health care. For patients to gain access to the public system, their mental illness or substance abuse had to advance to an acute level, often leading to depletion of private resources and an advanced stage of disease. Moreover, the public mental health system has eroded as a safety net over the past twenty years.

This poses a dilemma. A reformed system that maintains separate private and public care offers the opportunity for continuation of treatment patterns that permit patients to “fall through the cracks.” Failure to deal with
the erosion of the public system will limit security for persons who have limited funds. This problem could be solved by merging the public into the private system. However, elimination of the public system would threaten the traditional safety net relied upon by many, particularly the severely mentally ill. If the resulting benefits require private delivery (as contemplated by the Clinton plan), we may be relying on a system that traditionally has been unable to address the special needs of the severely mentally ill. While the Clinton plan would bring market forces to bear, some mental health services may not belong in the market.\textsuperscript{28} As advocated by Sharfstein, continuation of the public system may be warranted. An adequate health care reform package will eliminate distinctions between public and private delivery that cause gaps in treatment while maintaining access to services traditionally viewed as public, particularly intensive mental health services.

\textbf{Principle six: Health reform should foster creativity, innovation, and change in the delivery of mental health and substance abuse treatment.} There is the danger that any regulated system will freeze in place an existing system and stifle innovation and creativity. The Clinton plan’s contracting system will favor larger organizations that are not necessarily innovative. Moreover, in a cost-cutting environment, providers that improve quality of service without cutting costs will find their creativity blocked by actuaries and efficiency experts. In a treatment-oriented payment environment, providers that generate better outcomes using less treatment will be penalized.

A well-considered reform package should recognize the need for continuing advances in the delivery of mental health and substance abuse services and will provide a mechanism to foster such advances. In addition, the Clinton reforms should encourage the development of new clinical services, particularly for behavioral medicine, and should give new entrants (providers and health plans) an even chance for success. We believe that with as much government involvement as is intended for the reformed health system and without a number of bold steps, creativity, flexibility, and innovation will be lost. This will seriously impair the spirit of the Clinton reform effort. Bold steps might encompass a range of incentives from funding set-asides for demonstration programs to financial incentives and rewards for entities that find ways to reduce cost and improve quality. We suggest that the National Institute of Mental Health (NIMH) develop and the Clinton administration and private foundations fund a joint public/private program specifically devoted to innovation in mental health and substance abuse treatment and delivery.
Conclusion

Public mental health care in the United States has grown from its origins in state mental hospitals through the chaos of deinstitutionalization to an embryonic fascination with reform. The promise for implementation of mental health reforms in 2001 is symbolic. We warn, however, that neither the health alliances nor the private sector are inherently invested with a vision of the nation’s health care priorities. Our nation’s health must be driven by a broad public health view of the health care system that provides health security for medical and mental health services for all Americans. Our task is to keep health reform on the right course.

NOTES

4. The phase-in of the Clinton plan’s mental health and substance abuse benefits provides for limits on inpatient treatment (thirty days per episode and sixty days annually), partial hospitalization (120 days with offsets against inpatient treatment), outpatient services (a 20 percent copayment), and psychotherapy (a thirty-visit limit annually with a 50 percent copayment). White House Domestic Policy Council, The President's Health Security Plan (New York: Times Books, 1993), 29-35.
5. Ibid., 30-34.
9. Sharfstein et al., “Psychiatric Care and Health Insurance Reform.”
12. M. Sabshin, Statement of the American Psychiatric Association on Coverage of Treatment for Mental Illness in Health care Reform, Senate Committee on Labor and Human Resources, 8 November 1993.
13. Ibid.
14. C. Horgan and D. Salkever, “Demand for Outpatient Mental Health Care from Nonspecialty Providers,” in Advances in Health Economics and Health Services Research,
19. This can be done directly by the HMO or under contract between the HMO and entities that have specific expertise dealing with behavioral health issues (and that can generate economies of scale).
27. Sharfstein et al., “Psychiatric Care and Health Insurance Reform.”