Letters

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Bringing An End To Two-Tier Mental Health Care

To the Editor:

Your recent set of papers on parity in mental health benefits (July/Aug 01) eloquently illustrates the conundrum facing policymakers—that parity begets managed care and that managed care can be used to effectively negate parity. The parity debate raises a second critical policy issue. Thus far, parity has largely focused on the needs of the majority of the insured population who require the type of mental health services offered by private insurance plans—that is, people who can be treated with medication, short-term therapy, or inpatient stays that fall within average utilization rates and lengths-of-stay.

For adults and children with serious mental disorders, parity (even if fully implemented and properly managed) is insufficient. Because of an array of factors, including the impact of serious mental illness on employability, many adults with serious mental illness do not have private insurance coverage. Even those who do tend to turn to the public sector for care once their insurance runs out or when they realize that public-sector services are more appropriate. Problems of private coverage for those with severe disorders include not only inappropriate limits on the duration of their treatment, but the failure of private plans to cover rehabilitative and other intensive community services.

Of great significance are the needs of children with serious mental disorders because, as dependents of working parents, they are covered in significant numbers under private insurance. Unfortunately, children’s needs are even less well met through private insurance due to misunderstanding and skepticism about mental disorders in youngsters or the effectiveness of treatment. Tragically, many families with private insurance relinquish custody to the state child welfare system simply to obtain publicly funded treatment for their children.

Our mental health care system includes a broad web of public-sector services, albeit underresourced and viewed as secondary in quality to the private sector. In part, serious mental illnesses (and addiction disorders) are seen as a public responsibility because of perceptions that they are somehow different—less worthy of attention or less treatable than other disorders are.

Meaningful full parity should not only dissolve the differences between coverage for physical and mental health care but should also help to remedy the aberrations of our nation’s two-tier mental health system. With enactment of full parity, policymakers should address how to more completely integrate health care—for example, bringing to the private sector the expertise of public mental health in treating serious mental disorders and, conversely, bringing to the public sector the private sector’s expertise in managing other mental illnesses. Linking public and private delivery systems and financing could ensure that adults and children with severe disorders, although covered by parity private insurance policies, receive effective, integrated care.

In the meantime, parity is an important step, not least because it improves understanding and accelerates an acceptance (by the public, policymakers, purchasers, insurers, health care administrators, and providers) of mental illness and the necessity of providing good evidence-based care. Such attitude change could help spur a commitment to correct the aberrations of our dual system and, in doing so, dampen arguments for further regu-
lation of managed care (and nostalgia for fee-for-service arrangements). In other words, full parity may indirectly set the stage for appropriate management of mental illness within private plans, and policymakers can then turn their attention to follow-up issues such as partnerships that blend expertise from the public and private sectors.

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Need For Data On Outcomes Of Mental Health Parity

To the Editor:

Three papers in the July/August issue capture the irony and the tone of the debate on parity legislation. Taken together, the papers highlight the principal arguments for and against parity as Congress considers whether to extend parity legislation.

As a result of this legislation, behavioral health services have been more generally carved out by HMOs and insurance companies seeking to contain incremental costs through a de facto definable contribution. While Kevin Hennessy and Howard Goldman believe that full parity represents a “sequential” step toward “the broader goal” of equity for persons needing treatment for mental disorders, Dan Gitterman and colleagues fear that the “growing opposition to specialized care management” (carve-outs) by the American Psychiatric Association and the American Medical Association could lead to a return to limited coverage for the mentally ill. Like the opponents of behavioral health care carve-outs, Hennessy and Goldman argue that “benefit parity is an insufficient mechanism for ensuring equity for those with a mental illness.”

In the arguments for and against parity legislation, there have been surprisingly few data on health outcomes. While psychiatry may complain about managed behavioral health care (MBHC) practices that favor nonphysician caregivers, leaders in the MBHC industry complain about problems finding psychiatrists willing to accept managed care patients. In a number of states that have implemented parity legislation, psychiatrists will only accept patients who self-pay. Academic departments of psychiatry that had established units dedicated to meeting the requirements of MBHC companies in the mid-1990s had closed those units by 2001. Psychiatric hospitals and units in general hospitals have been forced to close or cut back on partial hospital services because of the refusal of some managed care companies to pay for these alternatives to inpatient care.

Acutely ill patients are going directly from rapid stabilization on an inpatient unit to outpatient care of limited intensity. Troubled adolescents are being sent to boot-camp environments that only accept out-of-pocket payments, while professionally directed residential and inpatient child psychiatry programs have been difficult to maintain because of financial pressures. Are any of these trends affecting the quality of health outcomes? With the decline of public-sector programs, many chronically mentally ill patients face lives of Dickensian grimness.

Gitterman and colleagues argue that quality measures of mental health services and managed behavioral health plans are essential to an informed discussion of parity. Unfortunately, it has been virtually impossible to obtain outcomes data in the geographically distributed networks of MBHC firms. No federal agency or corporate purchaser has proposed that the collection of such data is at least as important as collecting data on the incremental costs associated with parity. None has proposed to cover the costs for the collection of these data; with purchasers’ focus on costs, no managed behavioral health plan has the resources to commit to studying health outcomes. Some of the most enlightened leaders in the industry would welcome support for studies of health outcomes as a tool for quality improvement. Without the data, parity is a benign-sounding term with undefined consequences for the people it is meant to serve.

Roger E. Meyer
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Drug Cost Containment In Canada

To the Editor:

Although Devidas Menon has accurately described Canada’s efforts at pharmaceutical cost containment, his recent paper (May/June 01) leads to conclusions that are unwarranted.

He credits the Patented Medicine Prices Review Board (PMPRB) with keeping patented drug prices low, while noting briefly that “currency exchange rates could have some influence.” My research argues that the depreciation of the Canadian dollar from purchasing power parity motivated multinational drug companies to increase the discount offered in Canada versus other developed countries.

This macroeconomic event explains all but 5 percent of the increasing difference in patented drug prices for Canada and the United States between 1987 and 1998. Thus, there is no clear causal relationship between the PMPRB and low Canadian patented drug prices. Recent complaints by the brand-name industry about the PMPRB’s constraints are probably symptomatic of recent political pressure from the United States to have one price in all developed countries.

Provincial drug benefit plans subsidize drug consumption. Therefore, their first effect must be to increase pharmaceutical costs and prices. Policies such as generic substitution and prior authorization, which ration access to the subsidies, may reduce the programs’ budgets, but it is not clear that the net effect reduces society’s total pharmaceutical bill. These measures may not even achieve budget savings for the public programs. For example, the costs of British Columbia’s Pharmacare program have risen faster than those of provincial and territorial drug benefit plans in the rest of Canada since that province implemented reference-based pricing in 1995.

The brand-name industry and the Canadian government have an entente whereby the industry will make local research and development (R&D) investments of at least 10 percent of Canadian sales. Having exceeded the target, the industry credits Canada’s strengthened Patent Act with motivating this investment. The relationship between local R&D to local sales is irrelevant, especially for a global industry. R&D funds should be invested where comparative advantage predicts that they will be most productive, not where government arm twisting demands.

I agree with Menon’s conclusion that device makers should look not only at prices but at demographics, new and innovative drugs, and prescribing practices. Unfortunately, pharmaceutical policy in Canada is a muddle of conflicting political objectives.

John R. Graham
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The author responds:

John Graham raises a number of interesting and relevant points. However, the statements he makes as being based on his own research are not substantiated. I have found nothing in the peer-reviewed literature, authored by Graham or others, that supports the statement that “depreciation of the Canadian dollar from purchasing power parity motivated multinational drug companies to increase the discount offered in Canada versus other countries.” This statement suggests a concerted plan of action by the industry, which I have not seen documented before.

Also, the statement that Graham makes about British Columbia’s Pharmacare program costs ignores the fact that reference-based pricing is only in effect for some classes of drugs and not for all drugs covered by the program. In fact, if one looks at the reference classes alone, the story on expenditures is vastly different.

I would welcome Graham to publish his research in a peer-reviewed journal, thereby making it possible for a meaningful, evidence-based discussion to take place.

Devidas Menon
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HMO Profits And Quality

To the Editor:

Patricia Born and Carol Simon elaborately massaged a virtually useless data set in an effort to defend HMO profit making (Mar/Apr 01). The 1997 National Committee for Quality Assurance (NCQA) data they analyzed are inappropriate for the kind of research they undertook. That year 155 plans (35 percent of all plans submitting data to the NCQA) refused to allow disclosure of their Health Plan Employer Data and Information Set (HEDIS) scores. Moreover, the plans that allowed disclosure (Born and Simon’s data set) represent a biased sample. As the NCQA stressed, poor-quality plans were more likely to refuse release of their scores. Two of the largest for-profit HMO firms that scored poorly in 1996 (CIGNA and Prudential) refused to release scores for any of their seventy-five plans in 1997. It appears that executives at poor-quality HMOs selectively culled their scores from the NCQA’s data. No amount of statistical manipulation can compensate for such market-driven efforts to thwart honest evaluation.

Our earlier analysis demonstrating that for-profit HMOs had strikingly worse quality scores than did nonprofit plans was based on 1996 HEDIS data for 329 HMOs. In that year only 11 percent of the 370 plans submitting data to the NCQA refused to allow public release of their HEDIS scores. The nonreleasing HMOs represented mainly a scattering of small plans; virtually all of the major HMO chains allowed release of their data.

The finding of Bruce Landon and colleagues (Mar/Apr 01) that patients are dissatisfied with for-profit HMOs is also based on far more robust data than those used by Born and Simon. Plans participating in Medicare must participate in the satisfaction survey Landon analyzed, and Medicare releases all scores.

Born and Simon’s use of poor data is compounded by their highly suspect analytic strategy. In univariate analysis, for-profit plans scored lower on quality. Only by throwing a large number of questionable variables into a multivariate model could they reverse this finding. Their multivariate model cut sample size to as few as 140 HMOs (of the 441 that submitted scores to the NCQA).

They apparently forced sixteen or seventeen predictor variables into their multivariate models, whether or not these variables predicted HMO quality scores in univariate analysis. Although they justified this practice by positing that each of their variables is likely to confound the relationship between for-profit ownership and quality, they provided little empirical support for this claim. Forcing large numbers of nonsignificant “predictors” into a model often masks real effects with statistical noise.

Moreover, several of the variables are more properly viewed as path variables than as confounders. For instance, for-profit HMOs may try to cut costs by avoiding contracts with board-certified physicians, which may lower quality. Controlling for board certification ignores this possibility and assumes that board certification and for-profit ownership are unrelated. In fact, this and other predictor variables in the analysis reflect HMO executives’ decisions based on expected profitability and should not be analyzed as if they are independent confounders.

In sum, Born and Simon have tortured a biased subset of data to conclude that the more premium dollars diverted to profits, the better the care. Their conclusions are scientifically indefensible, and silly.

Steffie Woolhandler, David U. Himmelstein, Ida Hellander, and Sidney M. Wolfe
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NOTES
2. Ibid.
The authors respond:

We appreciate the opportunity to respond to Woolhandler and colleagues. We are glad that they have read our work, and we have solid evidence that refutes their speculations.

There is no evidence that omissions drive our results. First, it is important to recognize that our 1997 data are far more complete than those they used. Their 1996 sample covers 56 percent of total HMO enrollment.1 Our 1997 sample covers more than 75 percent. Indeed, there are 120 additional plans in 1997, most of which existed in 1996 but did not report to HEDIS. The plans added in 1997 have scores that are significantly lower than the plans in these authors’ analyses. Any bias runs opposite of the direction suggested. At the same time, many plans that “disappeared” between 1996 and 1997 were acquired by other HMOs in the 1997 data—including many allegedly missing Aetna plans.

Firms that enter or exit a market are often different; HMOs are no exception. In our analyses we carefully compared plans that dropped out with those that entered. Both kinds of plans had somewhat lower quality scores (typically two to four points). However, on net, the expansion of coverage in 1997 pulled down scores by more than the exit of 1996 firms would have raised them. As an extreme test, we simulated what would happen if the CIGNA plans were included in our analysis, but with their 1996 reported scores. None of our findings were altered.2

Regarding specification, a large literature confirms that firm and market characteristics affect performance. We know of no theoretical framework that speaks to regional census designation. Multicollinearity does not bias econometric results, but analyses that omit variables are prone to bias.3

We were intrigued by the remarks on for-profit firms and did some work to look into this. There is no relationship between for-profit status and board certification (correlation is .02). Interestingly, for-profit HMOs have significantly lower turnover in primary care physicians, suggesting perhaps a higher-quality strategy. We appreciate the suggestion for extending our research.

Finally, we are most concerned about the misinterpretation of our results. We find no systematic relationship between for-profit status and HEDIS measures. This is neither an endorsement nor a condemnation of for-profit HMOs. In light of the variation that exists in health care quality, we believe that it is best to focus attention on forces that matter.

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NOTES
2. Authors will gladly provide results upon request.

More Uses For A Tax Credit

To the editor:

Lynn Etheredge’s concept of a “flexible benefits tax credit” that could be used for the purchase of health insurance, retirement savings, and children’s higher education is a big step in the right direction (<www.healthaffairs.org>, March 2001). Etheredge correctly observes that a “flexible benefits tax credit offers American families assistance that can adapt to their differing circumstances.” It recognizes that families know best how to address their own unique needs.

But why stop there? American families have additional pressing financial needs, including housing, transportation, and career training, that only they can appreciate.

A truly flexible tax credit could be created from spending for existing social welfare programs and used to finance an annual tax credit for all Americans. This “National Tax Rebate,” as I call it, would represent a bold new approach where the people determine how to use the money the government currently spends on their own behalf.

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