

Mental Health Parity and Beyond:

Aligning the Public and Private Systems of Care for People with Mental Illness

by Kitty Purington



Maine is one of the first states to mandate comprehensive mental health coverage for its citizens under private insurance plans. Mental health advocates nationwide long have lobbied for such parity. In this article, Kitty Purington first provides an overview of the federal and state legislation leading up to the present law. She then compares current parity provisions under private plans with those of MaineCare. She concludes that coverage under MaineCare for individuals with serious mental illness still exceeds that which is mandated under private plans. She discusses several bridging models to close the gap between public and private healthcare spheres. 



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Millions of Americans with mental illness do not have equal access to health insurance. Many health plans limit coverage for mental health and substance abuse care by having lower annual and lifetime spending caps, imposing lower day and visit limits, and having higher co-payments and deductibles than they do for physical (somatic) conditions.

Maine has made notable strides in its efforts to provide coverage for people with mental illness in group insurance plans. With the enactment of legislation mandating additional parity requirements by the 121st Legislature, Maine has positioned itself as one of the leading states in mandating comprehensive coverage of mental health services.

This article provides an overview of parity: its background as a national movement, its statutory history in Maine, and a description of the covered benefits. The article also addresses what might lie beyond parity: a review of the trends and current thinking in mental health and general health care practice that may begin to broaden mental health coverage for people in private insurance plans.

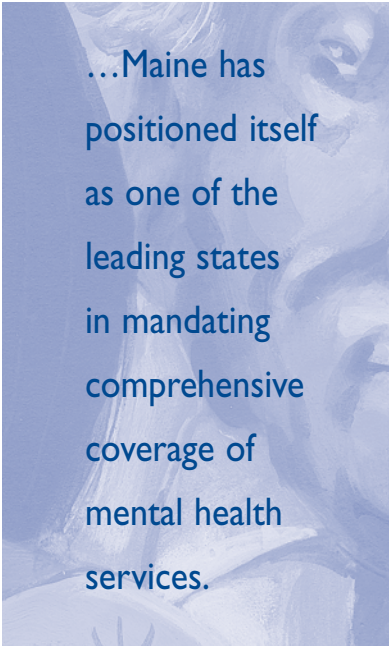
PARITY

Mental health parity—defined as providing a level of benefits for mental health services under private insurance plans comparable to benefits provided for somatic conditions—has been a rallying cry of advocates for decades. Beginning in the early 1990s, policymakers at both the state and federal levels began to heed the cry, leading to passage of a variety of legislation. The research to do so was compelling. In any given year, 5–7% of people will experience an episode of serious mental illness, and about a quarter of the workforce, or about 28 million workers, will experience a mental health or substance abuse episode. The costs incurred annually by business as a result of absenteeism and loss of productivity from these two illnesses is estimated at between \$17–24 billion (Hertz and Baker 2002). The President's New Freedom Commission, citing a 1999 report from the Department of Health and Human Services, puts the figure for loss of productivity from mental illnesses at \$63 billion. In addition, depression often complicates and exacerbates

other existing conditions, making these other conditions more costly and difficult to treat (President's New Freedom Commission on Mental Health 2003).

The 1999 surgeon general's report on mental illness states that "(t)he burden of mental illness has long been profoundly underestimated." Citing the Global Burden of Disease study conducted by the World Health Organization (WHO) in 1996, the surgeon general's report notes that mental illness, including suicide, ranks second in the burden of disease scale in established market economies. This puts mental illness as a cause of death in most industrialized nations ahead of all cancers, respiratory illness, infectious diseases, and alcoholism—second only to all cardiovascular illness (U.S. Department of Health and Human Services 1999). Moreover, according to the same WHO study, mental illness ranks first in terms of causing disability in the United States, Canada, and Western Europe (President's New Freedom Commission on Mental Health 2003). Indeed, the WHO study found that major mental illnesses account for 25% of all disability across large industrialized nations.

However, combined with these statistics is encouraging research that reveals mental illness as one of the most treatable of illnesses. Studies have shown that 80% of people with depression who complete treatment respond to either antidepressants or psychotherapeutic interventions (National Institute of Mental Health, D/ART Campaign 1995). Case management also has been shown to help people increase their ability to manage daily life, improve independence, and reduce hospitalization (Ziguras and Stuart 2000). Case management involves locating resources, coordinating services and resources to respond to assessed needs, and monitoring service delivery (Baldwin and Woods 1994).



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Moreover, policymakers, providers, and advocates here in Maine and throughout the country increasingly are focusing their efforts on “evidence-based practices” in order to better standardize and implement successful strategies in local settings. Evidence-based practices are interventions for which there is consistent scientific evidence showing that they improve client outcomes. These proven interventions include medication, illness self-management, assertive community treatment (ACT), family psycho-education, supported employment, and integrated treatment for people with both mental illness and substance abuse (Drake et al. 2001). In fact, the surgeon general’s report stated that finding *effective* treatments for serious mental illnesses is not the problem. *Access* to those effective treatments is.

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Given such findings, it is little wonder that the availability of mental health services in private health insurance plans has become an increasingly important objective for mental health advocates. Consumer and family groups who had experienced the success of treatment firsthand also had intimate knowledge of the double standards found in private health insurance. In a study done in 1997 by Mercer/Foster Higgins, a survey of employer-sponsored health plans revealed that 75% of these plans restricted mental health care coverage to a greater degree than they did general health care benefits (Buck et al. 1997). As treatments for mental disorders, bolstered by research, became more acceptable, the restrictions on these services started to look more and more like simple discrimination. Organizations such as the National Alliance for the Mentally Ill (NAMI) were critical in making the

case for parity by arguing that mental illness is a biologically based, “blameless” disease, deserving of all *medically* necessary treatment (NAMI 2000).

FEDERAL PARITY LEGISLATION

Federal legislation mandating a limited version of mental health parity was signed into law by President Clinton on September 26, 1997. The law took effect on January 1, 1998, and was written with a sunset provision for September 30, 2001.

The federal government’s first foray into parity legislation was, relative to state efforts at the time, fairly meager. The Mental Health Parity Act mandated aggregate lifetime limits and benefits for mental health services that were the same as those for physical illnesses. However, the federal legislation did not mandate any minimum level of coverage or benefit. The law did not provide for a mandated floor of benefits. It did not protect consumers from higher co-pays or deductibles for mental health services. A plan could avoid the requirements of the law by *not* offering any mental health benefits. If a plan did include mental health coverage, then the parity requirements would kick in. Businesses of less than 50 employees were exempt from the legislation. The act also provided an exemption for those employers who could show a 1% cost increase as a result of their having to provide insurance coverage that included mental health benefits. The law did cover so-called “ERISA” plans—self-insured private plans that are generally exempt from state insurance laws. The law did nothing to address inequities in the federal government’s own health plan, Medicare.

Since 1997, federal legislators have made various attempts to expand the protections provided by the initial parity law. These efforts have not been successful, and have resulted in little more than the continued reauthorization of the initial legislation. Although President Bush has signaled, through his New Freedom Commission on Mental Health, that he sees mental health parity as an important component in a system of effective healthcare, these efforts have not yet led to additional mental health parity protections on the federal level.

MAINE'S HISTORY IN MENTAL HEALTH PARITY

Maine was one of the first states in the nation to pass legislation providing for some kind of mental health parity in private insurance plans (American Academy of Child and Family Psychiatry 2003). Maine began in 1995 with passage of what was, at the time, a relatively comprehensive statute mandating coverage of specific mental illnesses. The statute required that mental health services necessary to treat specific diagnoses be included in health plans covering more than 20 individuals. Plans with fewer than 20 individuals needed to provide this coverage as an option to customers. The specific diagnoses that were covered under the 1995 law were schizophrenia, bipolar disorder, pervasive developmental disorder or autism, paranoia, panic disorder, obsessive-compulsive disorder, and major depressive disorder. Coverage also was required to include the services of psychologists, social workers and psychiatric nurses. Optional access to licensed clinical professional counselors and other licensed counselors also was required.

Maine revisited its mental health parity legislation again in 2003, which led to the passage of LD 566, An Act to Ensure Equality in Mental Health Coverage. This legislation broadened the scope of the previous parity legislation in several important ways. Certainly the major improvement in LD 566 was the expansion of the covered conditions to include all diagnoses listed in the *Diagnostic and Statistical Manual*, Fourth Edition. The DSM-IV, as it is known, is the diagnostic manual used by the medical profession in diagnosing a wide variety of mental health disorders. The revisions broadened the scope of the statute to include the more expansive categories of illnesses, as they are organized in the DSM-IV. The only remaining diagnostic limitations in the statute were the so-called "V-codes," which include issues such as academic, situational, or family problems, which are still excluded from coverage.

The statute further states that insurance policies must provide for medically necessary health care for a person suffering from mental illness. This coverage is then described to include, but not be limited to, such specific services as inpatient care, outpatient services,

day treatment, and home health services, when provided by a licensed professional.

Maine's mental health parity statute was vastly improved by changes made in the 121st Legislature. In comparison with other state statutes, Maine has done a good job of ensuring parity protections (National Mental Health Association 2004). Where other states have limited the covered diagnoses, Maine has broadened its coverage. Other states have stopped short of including substance abuse treatment or covering children; Maine has done both. Maine's parity statute does not allow plans to opt out of parity provisions due to cost increases, a strategy some other states have chosen.

One remaining roadblock for some people covered under private health insurance in Maine is that parity applies only to plans covering more than 20 people. For a state such as Maine, where many people are employed in small businesses, this represents a significant gap. Other states have chosen to cover this market; Maine should take this step as well and close this gap in coverage.

Passage of Maine's mental health parity law came about, in part, due to the perception that savings could be achieved in the state budget by shifting costs from the state Medicaid program (MaineCare) to the private sector. This shift would be realized through those recipients of MaineCare who also had private insurance and who could now access these benefits to pay for services such as medication management and outpatient therapy. However, for a variety of reasons, expected savings as a result of parity have not come to fruition. MaineCare operates under a fairly rigorous rubric of federal regulation. One of the primary tenets of the MaineCare program is that MaineCare, with very few exceptions, is the payer of last resort. Both federal and state regulation, therefore, have long mandated that any private payer must be billed before MaineCare. The services most likely to be covered under a private policy are medication management (typically, a regular visit with a psychiatrist) and outpatient therapy services. Because of existing regulation, Maine's mental health providers had already routinely been billing for these services prior to the most recent expansion of the mental health parity law; these savings, therefore, were already being realized.

In addition, providers of mental health services have for some time understood that the payer landscape is changing. Billing departments in non-profit agencies have consequently become much more knowledgeable about third-party reimbursement. Virtually all of the larger mental health agencies in the state have active relationships with the major insurance carriers. Changes in Maine's parity law have been coupled with efforts by third-party payers to increase provider education and facilitate billing; whether any additional savings to the state will be realized under the expanded parity law through these and other efforts is something that remains to be seen.

PARITY AND MAINECARE

Another very clear reality has emerged in the months since passage of Maine's comprehensive parity law: parity was never intended to provide a similar level of coverage in private plans as that provided in the state's MaineCare plan. Even good parity coverage probably never will be able to take the place of the system of services available under MaineCare for some people with serious mental illness. Although parity offers a bridge between the two systems for the more medically recognized treatments, other critical components of Maine's public mental health system are still not covered under private plans, and may never be appropriately shifted to the private sector.

The private and public systems of care historically have been created using distinct sets of assumptions about the recipients of their services. The private sector assumes a level of functioning that includes work and some degree of self-sufficiency. The public system traditionally has assumed a level of chronicity and dependence on federal income benefits such as Social Security or Supplemental Security Income. Within the private system, the focus typically has been on a more traditional medical model that includes licensed practitioners delivering office-based, per-visit treatments. A patient sees his or her doctor—and manages his or her illness—with medication and time-limited therapy. The public system, on the contrary, operates as part of an overall state obligation to provide care for people with disabilities. The state mental health system, now overwhelmingly funded

by MaineCare (Medicaid), includes a far broader conception of services for people with mental illness. This system, without any ability to cost shift, must have this safety net, or else face higher costs in inpatient treatment and incarceration. This has led to a perhaps more expansive, more flexible definition of mental health services and treatments in the public system than in private care. In particular, MaineCare services rely on the widespread use of non-licensed staff in the delivery of its medically necessary, supportive services.

SELECTED MAINECARE/PARITY COMPARISONS

Community Integration

The public system of care has, as its cornerstone, the concept of “case management.” Currently described as “Community Integration Services,” the service is considered fundamental to serving people with serious mental illness in the community. A community integration worker, typically a non-licensed professional with a bachelor's degree, is engaged in “the identification, assessment, planning, linking, monitoring, and evaluation of services and supports needed” (MaineCare Benefits Manual, Chapter 101, Section 17). This service provides the critical link for people with mental illness to all other services and supports in the complex constellation of available options. The community support worker helps procure other treatments and coordinates welfare, housing, and vocational services, as well as serving as a basic human connection in what can sometimes be a very isolated existence.

Community integration is not specifically identified as a covered service under Maine's parity law, and typically is not offered by health insurance companies in Maine as a covered benefit.

Assertive Community Treatment

Assertive Community Treatment (ACT) is another service offered under MaineCare that is not found in Maine's parity statute—this despite significant research backing its efficacy as a mental health treatment. Under ACT, an interdisciplinary team (at minimum including a psychiatrist, registered nurse, certified rehabilitation specialist or employment specialist and substance abuse

counselor) provides comprehensive, around-the-clock access to services and supports for a small caseload of clients. The service involves adherence to national standards, and given the expense of providing the service, is provided typically when other resources fail to produce good results.

In-Home Supports for Children and Adults

This service is offered under MaineCare, primarily to children and adults who are at risk of hospitalization or, in the case of children, at risk of entering state custody. The term covers a fairly wide range of services offered under MaineCare. Some services, such as Multi Family Systemic Therapy (MST), have proven outcomes for treating children and families and preventing placement in higher levels of care. Others services, such as Daily Living Supports, defined as providing “personal supervision and therapeutic support to assist [clients] to develop and maintain the skills of daily living,” grew out of specific identified needs in Maine.

Although the breadth of these services is clearly not envisioned under the parity statute, the law does mandate “home health services,” which presumes some access to home-based supports for people with mental illness. Again, using a more medical model, the statute defines home health as “those services rendered by a licensed provider of mental health services to provide medically necessary health care to a person suffering from a mental illness in the person’s place of residence...prescribed in writing by a licensed allopathic or osteopathic physician or a licensed psychologist who is trained and has received a doctorate in psychology specializing in the evaluation and treatment of mental illness” (24 MRSA 2325-A(3)A-2). It remains to be seen how this service will be used, and whether people with serious mental illness will avail themselves of this benefit. The statute does require that a person seeking the service must first prove that “hospitalization or confinement in a residential treatment facility would otherwise have been required if home health care services were not provided” (24 MRSA 2325-A(3)A-2(1)).

Private Non-Medical Institutions (PNMI)

These kinds of services and facilities are another critical component of Maine’s mental health system that

typically are not paid for under private insurance. Residential treatment is not covered specifically under Maine’s new parity statute. This MaineCare-funded service provides the backbone in providing residential supports for adults and children with serious mental illness. Everything from therapeutic foster care for children with emotional disturbance to transitional housing for adults is funded through PNMI. Private insurance pays for very little residential care, and it is under no specific mandate to do so.

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BRIDGING THE GAP: TRENDS IN THE PUBLIC AND PRIVATE SYSTEMS

As the previous section outlines, Maine’s parity statute does not mean that everyone with health coverage in Maine will be receiving “parity” in their mental health treatment. Stark contrasts remain, much of it due to the reality of having private and public spheres of healthcare that care for two purportedly distinct populations. Parity legislation was never intended to create parity between the public and private sectors. Parity was designed to create some equitable minimum standards between somatic health care and mental health care. Still, as people with mental illness recover, as stigma is reduced, and as providers of mental health services are required to straddle these two systems of care, the question of parity takes on a broader meaning: how do we, as a state, provide care for people with mental illness, so that neither the public sector nor the private sector shoulders a disproportionate share of the burden? How do we support people with serious mental illness in recovery to move

Example: Integrated Primary and Behavioral Health Services

The Common Ties Mental Health Coalition and the Sisters of Charity Health System are collaborating to provide integrated primary care and behavioral health services to their clients at the B Street Health Center in Lewiston. In this model (funded in large part by a grant from the Maine Health Access Foundation), a primary care physician heads up a team that includes a psychiatric nurse practitioner, a mental health nurse case manager, a medical technician, and the medical receptionist. The services provided in this integrated practice, including behavioral health services, are covered largely by private insurance, Medicare, and/or MaineCare. The goals of the practice, now in its second year, are to provide earlier and more effective behavioral health interventions for people who may not access or follow up on these treatments on their own, and also to improve and better coordinate healthcare for people with serious mental illness.

more seamlessly into employment, while ensuring continued access to the supports they need? An in-depth discussion of these ethical and practical questions is beyond the scope of this article. However, some encouraging trends in healthcare, some of them embraced by policymakers and the private sector in Maine, point to what are perhaps some of the next steps in “parity” for mental health services.

Integration of Somatic/ Psychiatric Treatment

Over 50% of mental health treatment is delivered in primary care settings. Research indicates that people accessing this type of care may not be getting the best treatment, and that disorders are under-diagnosed (Mauer 2002). Conversely, many people with serious mental disorders do not receive treatment for other, physical disorders. At issue in both of these scenarios is the historical disconnect between “mental” and “physical” health. A new trend in healthcare posits the belief that all people are at risk for mental health disorders, and so should have routine access to screening, assessment and treatment of these disorders.

Integration may mean a variety of practices, depending on the treatment setting and the needs of a particular individual. For people with serious mental illness, one model for integration may be that a mental health

professional acts as the primary care practitioner, but effectively coordinates the care of physical needs. For people with serious physical conditions, another specialist from that field may need to take the lead in coordinating links to mental health treatment. For people who fall somewhere in the middle, integration may mean that a physician practice has on staff a behavioral health specialist, able to provide onsite screening, assessment as indicated, and follow-up care as needed. In all of these scenarios, mental health treatment is normalized, provided seamlessly, and recognized as a critical component in overall healthcare. Research supports better outcomes for both serious mental illness and other chronic conditions when all treatment needs are addressed.

Maine has been actively participating in this discussion as well. Through partnerships with the Maine Center for Public Health, the Maine Health Access Foundation, and the active participation of the former Behavioral and Developmental Services (BDS) (which is now part of the new Department of Health and Human Services), partnerships and pilots are being supported across the state that will provide research and models for future consideration in both the public and private sectors. The Maine Center for Public Health reports that there are now over 20 integrated projects underway around the state that involve local mental health providers working closely in physical health care settings (see sidebar).

Old paradigms about what is mental health and what is physical health tend to drop away in these models. “Behavioral health service” can mean a variety of things, from treatment for depression, to supportive behavioral interventions so that a person better complies with diabetes treatment. The implications for the mental health field are potentially of great consequence: recognition of the importance of mental health services, not only for people with specific serious disorders, but for the population as a whole.

Chronic Care/Disease Management

Related to integrated care, chronic care or disease management may be a vehicle for extending access to mental health services, using practice models rather than statutory mandates. Disease management programs, for

instance, generally provide guidance to patients and physicians using well-established, best-practice guidelines and procedures. These programs identify patients with chronic conditions, such as diabetes, asthma, or depression, and target these patients for specific outreach and educational services. The educational efforts are geared toward providing patient and physician support in following established disease management protocols. This may involve phone calls to patients from specialist nurses, informational mailings, reminders about medications, and other assistance.

Care or case management is another increasingly popular tool for use in the management of chronic illness. Long used in community mental health as a key component in managing serious mental illness, this practice has lately been receiving some attention by private insurers in an effort to reduce the cost of caring for people with other kinds of chronic illness. The industry is seeing an increased use of case management techniques for serious and complex disorders, such as those involving multiple medication regimes and multiple specialists.

Case management for people with mental illness typically has been limited to the public sector under MaineCare. However, recent reports show that sizable numbers of insurance companies are exploring ways to use disease management and care coordination as cost control strategies (Short et al. 2003).

This suggests another model that could serve as a bridge to more comprehensive, routine mental health services. Case management services, as discussed previously, are not a specifically covered service under Maine's parity statute. However, "care management" frequently is cited as an effective tool in the treatment of major mental illness in the private sector, most notably in treating serious depression.

If research supports this trend (and the jury is still out on this), we may see the expansion of case management in the private sector—not due to mandates, but due to good practice and effective treatment.

DIRIGO/STATE HEALTH PLAN

Governor Baldacci clearly has made Dirigo Health the centerpiece of his efforts in providing access

to healthcare for all Mainers. Dirigo is an insurance product that will provide affordable coverage, including a sliding fee scale, to Mainers working for smaller employers. The state has recently signed a contract with Anthem to provide the insurance product to the Maine market. Until this agreement was reached, it was unclear what level of mental health benefit would be provided under the Dirigo plan. Dirigo was created with the under-50 participants market in mind. Maine's parity statute kicks in as a mandate for employers of 20 or more, leaving a gap in coverage under Dirigo for people in the under-20 participants market. It has now been addressed in the plan that all Dirigo products will include the full parity coverage, in effect extending the force of Maine's mental health parity statute to the under-20 market for consumers who choose the Dirigo product.

Dirigo also will overlap with MaineCare for low-income beneficiaries, providing a bridge in coverage for people with serious mental illness as they reenter the workforce. The extension of MaineCare, combined with the benefits of Dirigo, may allow more people to recover to real employment and self-sufficiency.

Dirigo draws together other themes, such as disease management, in its high-risk pool feature. Dirigo's design requires disease management protocols for certain types of diseases, including psychotic disorders. By January 2006, Dirigo is required to report back to the legislature on its efforts in designing disease management protocols, and its claims history experience for these high-risk recipients.

STRENGTHENING PARTNERSHIPS BETWEEN COMMUNITY MENTAL HEALTH AND THIRD-PARTY PAYERS

A final trend has to do with an overall change in the culture of doing business between local community mental health providers and third-party payers. In part, this change in relationship has been brought on through changes in Maine's parity statute. Over the past decade, since Maine's initial parity law, providers have become increasingly sophisticated regarding third-party reimbursement. How this gets worked out in practice, however, is on a case-by-case determination

of medical necessity and utilization review. Parity may be the mandate, but third-party payers may in some cases be willing to go beyond specific, enumerated services to pay for what works because they can better serve the beneficiary and save in health costs overall. Services beyond those explicitly enumerated in statute (e.g., residential treatment, Assertive Community Treatment, case management) should be, and are sometimes, reimbursed because they are deemed medically necessary. The ongoing challenge for providers of community mental health services will be in marketing their services to the private sector in a way that they have not had to do in the public sector for some time—essentially expanding the currently accepted limits of “medical necessity.” Evidence-based practices, better data collection on outcomes, and a more active role in negotiating contracts and rates all will play an important part in these evolving relationships.

SUMMARY

As this article is being written, third-party payers are still in the process of renewing policies within the structure of the new parity law. The impact of parity healthcare on costs and access to services for Mainers still remains to be seen. More analysis on the impact of parity on claims and premiums can be accomplished with the first wave of data in 2005. However, in addition to parity as a statutory mandate, other forces are at work to bring the public and private sectors of mental health services together. These trends allow us to see what may be the next frontier in the effort to bring quality mental health services to all, regardless of payer source. Private insurers may be moving further into what traditionally have been public sector services, through primary care integration and chronic care and disease management. In turn, the public sector may start to look more at how the private sector does business in order to become more adept at billing and contracting with third-party payers and to become more sophisticated about selling its evidence-based practices to the private sector. At the same time, Maine’s own innovations in healthcare—such as Dirigo

Health—provide an ample arena for playing out new ideas in cost containment and best practice.

Maine’s parity mental health statute is in many ways state-of-the-art legislation, and an example for other states to follow. But the real action in the future may not be in mandating specific benefits, but in the cross-pollination of ideas between the public and private sectors. Some services may always be the purview of state government. Even with improvements to treatment, some individuals may still struggle to achieve the long-lasting recovery that takes them out of a disability-based public healthcare system. But the hope is that many more will see the increase in benefits, access, and innovation in public and private insurance coverage as important stepping stones on their road to recovery. 

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