



## Shuffling toward Parity — Bringing Mental Health Care under the Umbrella

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For half a century, advocates and reformers have sought to ensure that mental illnesses are addressed in the same way as all other illnesses. Considerable progress has been made, and today

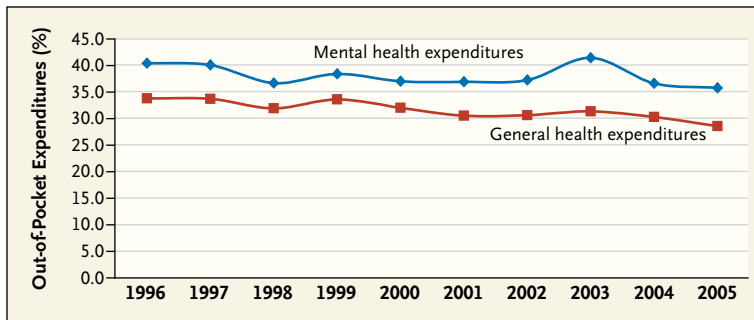
treatment of mental disorders is increasingly part of the medical mainstream. But some glaring exceptions remain. One of the most visible and troubling manifestations of continuing unequal treatment of mental health conditions can be found in the structure of health insurance contracts. For a mental illness, most private health insurance contracts impose special limits on the amount of treatment they will pay for. The federal Medicare program and many private insurers impose much higher cost sharing for mental health treatment than for physical health treatment. Continued calls for parity — equal insurance coverage of mental and other medical conditions — seek to redress this inequity.

This Congressional session marks the first time that both houses of Congress have passed legislation requiring parity. Last fall, the Senate unanimously adopted the Mental Health Parity Act (S. 558), and in March the House followed suit by passing the Paul Wellstone Mental Health and Addiction Equity Act (H.R. 1424). But differences in the language of the two bills have left the legislation stalled, and final passage of legislation remains uncertain.

The difference between the Senate and House bills that is causing the current impasse involves the defining of mental illness. The Senate bill is silent on the matter, which means that insurers would be able to define the set of covered conditions them-

selves. The House bill explicitly defines the conditions covered under the law as all the mental or substance-related disorders that appear in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM).

To put this distinction into context, it is useful to consider how health plans define the set of non-mental health conditions they cover. Most health insurance plans follow the Senate's strategy — they do not formally define the medical conditions whose care they cover. Rather, the scope of coverage is generally governed by the rule that services be "medically necessary." This term, which is not always defined, generally refers to care that is "accepted medical practice or community standards of care; not for the convenience of the patient or provider; not experimental or investigational; and appropriate and effective."<sup>1</sup> Insurers do not always require that a set of symptoms meet the criteria delineated by an official categorization of



**Proportion of Mental Health and General Health Expenditures Paid Out of Pocket by Privately Insured Adults Who Used Health Services.**

Data are from the Medical Expenditure Panel Survey ([www.meps.ahrq.gov/mepsweb](http://www.meps.ahrq.gov/mepsweb)).

medical conditions — such as the *International Classification of Diseases* (ICD) — if they are to pay for a benefit under the medical-necessity standard. Conversely, plans are not obligated to — nor do they — pay for the treatment of all conditions included in the ICD. They may deny coverage because of a judgment that a condition would not improve with treatment or because the treatment being contemplated is not appropriate or effective or is experimental.

Like the ICD, the DSM aims to classify illnesses and patterns of symptoms — in this case, mental health illnesses and symptoms — so that they can be measured and studied in a common language. Both classification systems contain many conditions — more than 100,000 in the ICD and about 300 in the DSM — and both contain “many disorders [that] are mild, nondisabling, and self-limited and need no professional intervention.”<sup>2</sup>

The disagreement between the House and the Senate about whether to define what constitutes mental health care, though apparently arcane, reflects an underlying difference that has dogged every debate about parity<sup>3</sup>: Do insurers design mental health benefits to balance cost control and access to valuable care? Or do they design their plans to discourage enroll-

ment among people with serious and chronic mental health conditions?

Under traditional fee-for-service indemnity insurance, the use of mental health treatment was found to be significantly more responsive to cost sharing than was the use of other medical treatment. That is one reason that insurers have kept cost sharing high for mental health services (see graph). Opponents of the House legislation are concerned that requiring insurers to cover all the conditions in the DSM will prevent plans from managing “parity” mental health benefits in a way that trades off costs and access, which will lead to excessive costs from a torrent of claims for treatment of trivial conditions such as jet lag and caffeine intoxication.

But recent studies have shown that parity need not lead to unnecessary care under modern managed-care arrangements. The parity requirement in the Federal Employees Health Benefit (FEHB) Program, for example, led to equality in coverage but not to an explosion in the costs of care.<sup>4</sup> The medical-necessity limits that are always included in health plans have been enough to protect insurers from having to pay for the care of frivolous mental health problems, just as these limits —

and not limits based on diagnostic criteria — protect insurers from paying for the treatment of equally trivial physical health problems. Payments made for mental health services by health insurance plans that already operate under parity rules are primarily for the treatment of well-recognized illnesses that cause impairment, reduced functioning, and disability and that are known to benefit from appropriate intervention. The overwhelming share of spending for mental health services under the parity coverage program of the FEHB Program in 2002, for example, went for the treatment of anxiety, attention deficit-hyperactivity disorder, depression, bipolar disorder, and schizophrenia. An analysis of claims under that program found no claims for jet lag or caffeine intoxication.

If medical-necessity rules will trump the DSM criteria anyway, does it make any sense for the House to include these criteria in the legislation? Including the DSM criteria may address the possibility that insurers design their mental health benefits so as to avoid attracting high-cost enrollees. Mental health conditions are often exceptionally persistent and costly. Insurers who offer relatively generous coverage for mental health care will disproportionately attract people with mental disorders — people who have been shown to incur higher costs for health care and mental health care than most other enrollees. Being the best mental health plan in a competitive health insurance market is a losing financial proposition, so insurers may compete to narrow their benefits and avoid enrolling people with mental illness. A parity law that requires all plans to offer mental health benefits as generous as their general

health benefits ought to reduce the ability of plans to engage in this race for the bottom. But if plans can specify which conditions “count” as mental health and therefore qualify for the parity benefit, they may persist in competing to drive away high-cost enrollees.

The evidence from the existing parity plans suggests a possible compromise between the House and Senate positions. Insurers should not be permitted to exclude entire categories of conditions from coverage. On the other hand, they should be permitted, and even encouraged, to use the existing criterion of “medical necessity” to ensure that covered services are

directed to the types of mental disorders that are most impairing and disruptive and that can be treated effectively with medical care. Parity in mental health should not mean mental health services for all problems, for everyone, at any time — that’s not how good insurance works for any condition. But the promise of parity is that treatment for people with mental illnesses that cause impairment, disability, and suffering will not be excluded from insurance coverage, and effective legislation needs to make sure that happens.

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## The (Slowly) Vanishing Prescription Pad

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The prescription pad, as familiar a medical emblem as the stethoscope or the white coat, is on its way to becoming a historical curiosity. Electronic prescribing — narrowly speaking, the electronic transmission of prescriptions from physician to pharmacy, but generally considered to encompass a broader range of information exchange and connections — is spreading rapidly, propelled by improved technology, expectations of improved care and decreased costs, strong pushes from a variety of advocates (the pharmacy industry, some medical societies, insurers, and the companies that manage pharmacy benefits), and the threat of mandates. As of March 2008, about 7% of the 560,400 office-based physicians in the United States were actively writing e-prescriptions, and about 73% of the 57,500

retail pharmacies were actively receiving them (see Figure 1).

The paper prescription, however, is unlikely to be extinct anytime soon. In 2007, 3.5 billion prescriptions were filled in the United States, according to the National Association of Chain Drug Stores; 1.8 billion were new prescriptions or renewals, and the rest were refills. But only 2% of the prescriptions that could be transmitted electronically were so routed, and e-prescribing accounted for less than 5% of total prescriptions in all but three states (see Figure 2).<sup>1</sup> Many physicians and pharmacies have the requisite computer equipment and software but have not set it up. Prescriptions that are created electronically and then printed, signed, and handed to the patient or faxed to the pharmacy are not e-prescriptions. Moreover, e-prescribing, like other com-

puter applications used in medical offices, may not be as straightforward, efficient, and interoperable as it should be.<sup>2</sup> All states and the District of Columbia permit e-prescribing — Alaska became the last to legalize the practice in 2007. But the Drug Enforcement Administration (DEA) still prohibits the e-prescribing of controlled substances, which, in 2007, accounted for 12.8% of filled prescriptions.

E-prescribing should eventually be less expensive than the paper-based method; however, the start-up costs and required workflow changes may be substantial. Doctors won’t necessarily save money, since most of the direct savings will go to insurers and some to patients. Some insurers, however, provide higher payments to physicians who use e-prescriptions.

Although patient safety should