Mental Health Parity: Where It has Been and Where It's Going

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One in four Americans will experience a mental health condition each year, and about half of Americans will develop a mental health disorder in their lifetime. An additional 27 percent of the population will develop an addiction.

For some people, those conditions overlap. For others, mental health conditions coexist with physical health problems such as heart disease or diabetes. For those with physical health conditions, mental disorders such as depression can make them three times less likely to follow treatment plans.

People with behavioral health issues—that is, addiction or mental health disorders, or both—visit the emergency room more and are more likely to be admitted and readmitted to the hospital. And it's not all people who present with primary mental health disorders.

As many as 80 percent of medical patients who frequently use hospitals have comorbidities of psychiatric disorders. Those disorders can make it difficult for those patients to adhere to medical treatment plans for diabetes, high blood pressure or heart disease, all of which means worse outcomes and potential penalties for the provider.

Until recently, such patients were seen as an inevitable but difficult-to-treat part of the health care system. A 2012 opinion piece in the *New England Journal of Medicine*, critical of the Center of Medicare and Medicaid Services, (CMS) new readmission rules, listed mental health disorders with poverty and poor social support as circumstances that are "deeply engrained" but nonetheless "difficult for hospitals to change."

But it is changing. Under the Affordable Care Act, behavioral health care is one of 10 essential health benefits, meaning insurers must cover them in equal proportion to physical health services. With millions more Americans gaining access to such coverage under the state and federal insurance marketplaces and the expansion of Medicaid, physicians will be expected to coordinate care with behavioral health specialists to treat physical and mental health issues concurrently.

Although the change may be a challenge in the coming years, there's evidence that integrating such care could save money and improve outcomes.

From institutionalization to the ER

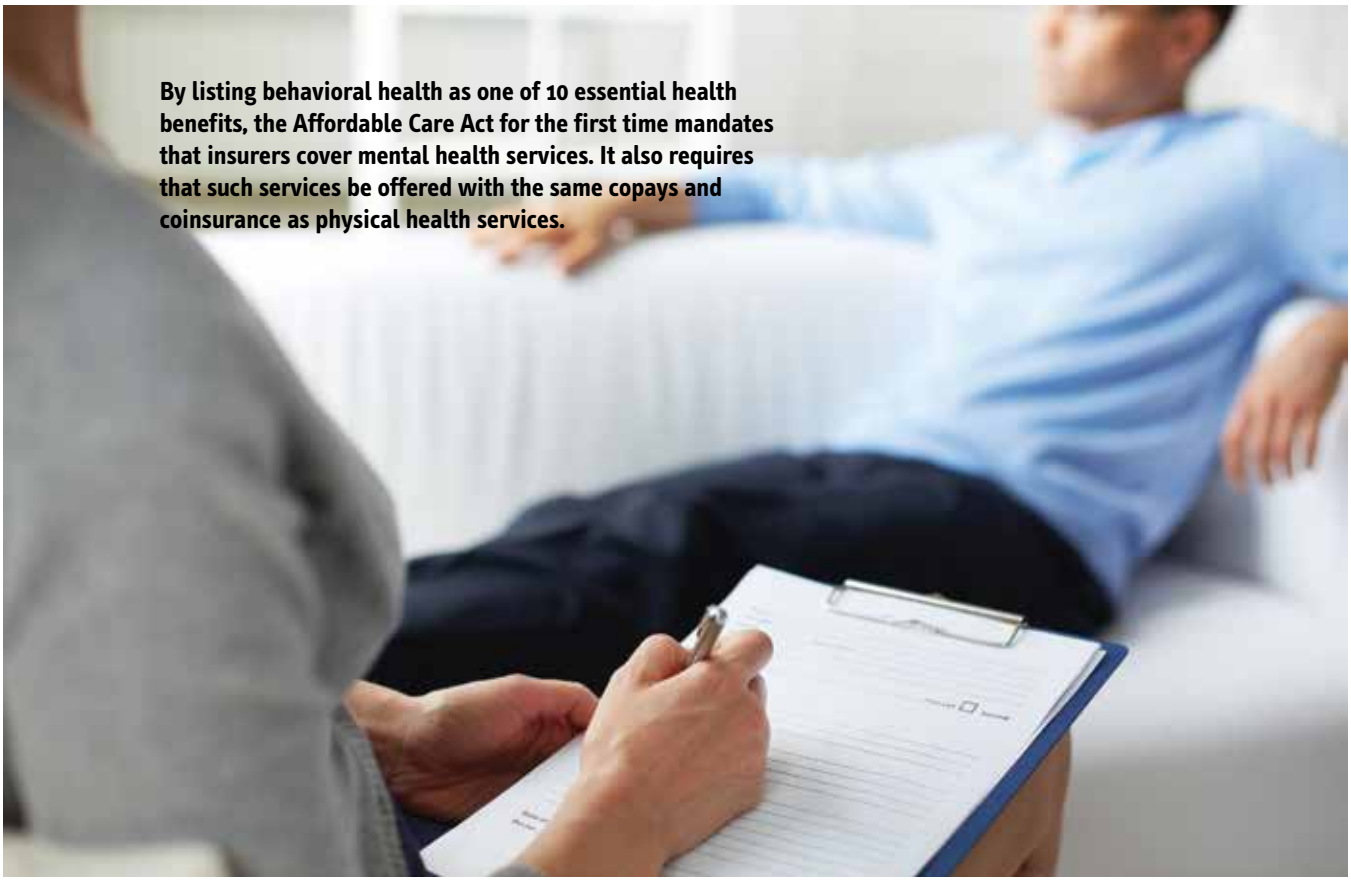
Before the 1960s, most patients with behavioral health issues were treated at inpatient psychiatric hospitals. Then the deinstitutionalization movement arrived, closing many psychiatric hospitals and bringing those patients to community mental health clinics and acute care hospitals in large numbers for the first time.

Many of these patients couldn't get coverage, and those who had it often faced severely limited benefits that affected what physicians could offer their patients.

Then came 1996 and the Mental Health Parity Act. The law, which expired in 2001, required insurers who offered mental health coverage to offer comparable annual and lifetime coverage caps. The law did not require employers to provide mental health coverage, and it didn't cover addiction care. It also didn't apply to small group or individual plans.

The 2008 Mental Health Parity and Addiction Equity Act expanded on this beginning. The law didn't mandate coverage for mental health and addiction services, but it did require large group and self-insured plans that provided behavioral health care to cover it in equal measure to physical health services. That meant comparable copays and coinsurance.

The law was only spottily enacted. A 2013 report from the U.S. Department of Health and Human Services followed up on the law's impact and found that, although insurers typically covered inpatient behavioral health care at commensurate levels with physical health care, a third of plans offered by midsize companies in 2010 still charged higher copays and



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required more cost sharing for outpatient behavioral health services than their physical health counterparts. By 2011, a fifth of plans still didn't comply with the law.

The results don't surprise Adam Rubinstein, MD, an internist and president of the board of advisers for Chicago's Advocate Condell Medical Center PHO: "My own experience is that, for my patients, that 2008 act has had almost no impact that I could name on their ability to get [behavioral health] care."

Meanwhile, patients with mental health disorders were more and more turning to emergency rooms (ERs) for care. Between 2006 and 2009, the number of people seeking ER care for a primary behavioral health problem rose from 4.2 million to 5 million. And those who visited the ER for physical health symptoms often left without a behavioral health comorbidity being diagnosed or treated.

This can be a major problem if the mental health condition—whether the primary diagnosis or a comorbid condition—interferes with a patient's ability to follow treatment plans or follow up with doctor visits.

Essential care

Then came the 2010 Patient Protection and Affordable Care Act (ACA). In it, behavioral health is considered one of 10 essential health benefits, right up there with prescription coverage and inpatient care.

As Rebecca Chickey, director of member relations in the psychiatric and substance abuse services section of the American Hospital Association, put it, "Behavioral health was at the table."

The ACA addresses behavioral health needs in several ways:

- Starting in 2010, the law allowed parents to keep children on their health plans until age 26. This is important, said Chickey, because many severe mental illnesses, such as bipolar disorder and schizophrenia, first manifest in one's early 20s. Previously, children aged out of their parents plans at age 19-22 if they were students.
- Today, insurers can no longer use pre-existing conditions, including mental health or addiction problems, to deny coverage. Before the law, an analysis by the Kaiser Family Foundation found that about 36 percent of people with such conditions were uninsured. Some simulations expect that rate to fall to 15 percent under the ACA.
- By listing behavioral health as one of 10 essential health benefits, the ACA for the first time mandates that insurers cover mental health services. It also requires that such services be offered with the same copays and coinsurance as physical health services.

- With their emphasis on care coordination and integration, Accountable Care Organizations (ACOs) and patient-centered medical homes (PCMHs) are expected to treat mental health conditions concurrently with chronic physical conditions to improve outcomes and lower costs.

Rewards for good behavior

Montefiore Medical Center in Bronx, NY, is one of 32 institutions selected by the Centers for Medicare and Medicaid Services to participate in the Pioneer ACO program under the ACA.

The program brings 23,000 patients under the ACO model and charges Montefiore with reducing readmissions, improving outcomes and coordinating care, or else face a penalty. The organization did so well coordinating care that it qualified for $14 million in shared savings after its first year.

Bruce Schwartz, MD, head of psychiatry at Montefiore Medical Center says care integraton has taken root at the medical center, with psychiatrists, social workers and therapists being colocated with physicians at many medical group sites, telepsychiatry being offered to patients who don't respond to mental health treatment guidelines enacted by primary care doctors and other pilot approaches.

It's showing results already: Patients with primary high blood pressure have seen their blood pressure go down when their psychiatric needs are also addressed; the same is true for those with diabetes.

"How much of the $14 million in savings is a result of this is hard to know," Schwartz said. "The potential quality improvements alone justify the approach."

In Chicago, Rubinstein is helping to implement a few similar programs. (Advocate is also a Pioneer ACO.) He and a psychiatrist created a one-hour continuing education program to train primary care doctors in diagnosing, evaluating and treating depression.

Advocate is already implementing a 24-hour psychiatric telemedicine program for its ERs. And, in one medical building under construction, floors are designed to colocate behavioral health specialists down the hall from primary care physicians. That way, patients who show up for a routine screening can have behavioral health issues addressed right away.

Even non-ACOs have benefited from integrating some behavioral health care into medical services. One 2004 study of an early collaborative care model found that ER visits dropped by 42 percent when primary care services were offered in a behavioral health clinic.

Likewise, a screening for addiction among inpatients at a large hospital reduced ER visits by half in the next three years. Better coordination of outpatient and inpatient psychiatric care has also reduced readmissions from 17 percent to 10 percent in one Florida program.

Addressing challenges

Rubinstein admits that it's somewhat easier for Advocate to enact these changes—after all, their reimbursement is based on how well they integrate care. For physicians operating under no such agreement, the task may be more daunting.

For one thing, there just aren't enough behavioral health specialists to go around. In 2011, a National Alliance on Mental Illness report stated that more than half of all U.S. counties lack even one psychiatrist, psychologist or social worker.

It's an issue the industry at large is grappling with, but it will be true for both behavioral health and primary care, said Rachel Garfield, a senior researcher at the Kaiser Family Foundation and specialist in the area of the uninsured, Medicaid and public financing for behavioral health services.

"Patients will have coverage for things like outpatient mental health services or short-term detox," she said. "Is there going to be a bed available to get them into?"

And then there's the question of how these services will be reimbursed. Traditionally, many insurers have farmed out behavioral health coverage to specialist groups, and employers have contracted independently with separate companies for their behavioral and physical health care coverage. This approach could be potentially disastrous for fledgling attempts to integrate care, Schwartz said.

"These mental health insurers tend to use providers who are usually remote from primary care providers," he said. "They're not at all integrated in the system."

Add in the challenge of integrating separate electronic medical records for physical and behavioral health care, and you have a process that Garfield expects to take several years to shake out.

First, we got a law that covered behavioral health, she said.

"The second [goal] is to coordinate and integrate things," she said. "Now that that's there, how do we set up a payment system and service delivery system that can deliver care effectively? That's the next great challenge in this field."