New Parity, Same Old Attitude Towards Psychotherapy?

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Full parity of health insurance benefits for treatment of mental illness, including substance use disorders, is a major achievement. However, the newly-published regulations implementing the legislation strongly endorse aggressive managed care as a way of containing costs for the new equality of coverage. Reductions in "very long episodes of out-patient care," hospitalization, and provider fees, along with increased utilization, are singled out as achievements of managed care. Medical appropriateness as defined by expert medical panels is to be the basis of authorizing care, though clinicians are familiar with a history of insurance companies' application of "medical necessity" to their own advantage. The regulations do not single out psychotherapy for attention, but long-term psychotherapy geared to the needs of each patient appears to be at risk. The author recommends that the mental health professions strongly advocate for the growing evidence base for psychotherapy including long-term therapy for complex mental disorders; respect for the structure and process of psychotherapy individualized to patients' needs; awareness of the costs of aggressive managed care in terms of money, time, administrative burden, and interference with the therapy; and recognition of the extensive training and experience required to provide psychotherapy as well as the stresses and demands of the work. Parity in out-of-network benefits could lead to aggressive management of care given by non-network practitioners. Since a large percentage of psychiatrists and other mental health professionals stay out of networks, implementation of parity for out-of-network providers will have to be done in a way that respects the conditions under which they would be willing and able to provide services, especially psychotherapy, to insured patients. The shortage of psychiatrists makes this an important access issue for the insured population in need of care. (*Journal of Psychiatric Practice* **2009;16:115–119**)

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Parity at Last

Achieving parity in private health insurance for treatment of mental illness and substance use disorders has been a tremendous accomplishment. Long overdue, it is the culmination of decades of work by professional and consumer groups dedicated to eliminating stigma and obtaining fair and equitable insurance coverage for those conditions. The "Paul Wellstone and Pete Domenici Mental Parity and Addiction Equity Act of 2008" was the vehicle for this victory. This Act applies to private insurance plans sponsored by employers of over 50 employees. Comparable legislation had already been passed to gradually phase in parity (the standard 80% coverage for other outpatient services) in Medicare coverage of outpatient psychiatric services by 2014, beginning in 2010 by slightly lowering the reprehensible "Psychiatric Reduction" so that this year Medicare will pay 55% instead of 50% of the allowed fee.

In January, the Departments of Health and Human Services, Treasury, and Labor published the interim final rules for implementing the 2008 Wellstone and Domenici Act.[1,*] Detailed analysis of this lengthy document will occupy experts in numerous concerned organizations for months, so I certainly cannot presume to offer an authoritative reading here. An initial perusal suggests a concerted effort to assure that the intent of the parity act not be subverted in the process of applying the act to myriad forms of insurance coverage. When trying to reconcile benefits and

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cost-sharing for mental and addictive disorders with those for other medical disorders, ambiguities appear to be consistently resolved into more stringent requirements or direct integration of the two. For example, equivalent but separate deductibles are rejected in favor of a single deductible for both.

Parts of the regulations offer data to support expectations that parity will increase access to care and in turn benefit patients and employers by reducing the loss of productivity attributable to mental illness, including addictive disorders; lessening morbidity from concurrent medical illnesses; reducing the need for costly inpatient psychiatric treatment; and shifting the preponderance of treatment of psychiatric disorders from primary care physicians to specialists who can provide psychotherapy as well as prescribing medications as needed. That the evidence for all of these expectations is now well established in the minds of the government officials, employers, and insurance companies who control the health care economy is a tribute to the hard work of health systems researchers as well as the persistent advocacy efforts of mental health consumer and professional organizations.

But the price of parity is aggressive managed care

In the preamble to the Interim Final Rules for implementing the 2008 Wellstone and Domenici Act, the following statement makes unequivocally clear that the framers rely heavily on managed care to reduce the added cost of parity to a negligible level (elsewhere they predict it will be well below 1%):[1]

> Since the early 1990s, many health insurers and employers have made use of specialized vendors, known as behavioral health carve-outs to manage their mental health and substance abuse benefits. These vendors have specialized expertise in the treatment of mental and addictive disorders and organized specialty networks of providers. These vendors are known as behavioral health carve-outs. They use information technology, clinical algorithms and selective contracts to control spending on mental health and substance abuse treatment. There is an extensive literature that has examined the cost savings and impacts on quality of these organizations. Researchers[2,3] have reviewed this literature and estimated reductions in private insurance spending of 20 percent to 48 percent compared to fee-for-service indemnity arrangements. Also, it appears that the rate of utilization of mental health care rises under behavioral health carve out arrangements. The number of people receiving inpatient psychiatric care typically declines as does the average number of outpatient visits per episode.
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> The OPM [Office of Personnel Management] encouraged its insurers to consider carve-out arrangements when implementing the parity directive in 2000 for the FEHBP [Federal Employees Health Benefit Program]. This is because of the ability of behavioral health carve-outs to use utilization management tools to control utilization and spending in the face of reductions in cost-sharing and elimination of limits. Thus, parity in a world dominated by behavioral carve-outs has meant increased utilization rates, reduced provider fees, reduced rates of hospitalization and fewer very long episodes of outpatient care. Intensive treatment was more closely aligned with higher levels of severity. (p. 5422)

Outpatient-visit and hospital-day limits coupled with aggressive management in the FEHBP "had already reduced the percentage of total health benefits paid for mental health services from 7.8 percent in 1980 to 1.9 percent in 1997," when President Clinton instituted parity for in-network services in the FEHBP.[4,5] Nothing is said about the human cost of a 76% reduction in outlays for the treatment of mental disorders.

That the regulations rely heavily on the concepts of "medical necessity" or "medically appropriate" treatments is evident in the following example of what would be considered acceptable under parity:[1]

> *Example 3*. (i) *Facts*. A plan generally covers medically appropriate treatments. For both medical/surgical benefits and mental health and substance use disorder benefits, evidentiary standards used in determining whether a treatment is medically appropriate (such as the number of visits or days of coverage) are based on recommendations made by panels of experts with appropriate training and experience in the fields of medicine involved. The evidentiary standards are applied in a manner that may dif-

fer based on clinically appropriate standards of care for a condition.

(ii) *Conclusion*. In this *Example 3*, the plan complies with the rules of this paragraph (c)(4) because the nonquantitative* treatment limitation—medical appropriateness—is the same for both medical/surgical benefits and mental health and substance use disorder benefits, and the processes for developing the evidentiary standards and the application of them to mental health and substance use disorder benefits are comparable to and are applied no more stringently than for medical/surgical benefits. This is the result even if, based on clinically appropriate standards of care, the application of the evidentiary standards does not result in similar numbers of visits, days of coverage, or other benefits utilized for mental health conditions or substance use disorders as it does for any particular medical/surgical condition. (p. 5436)

Apart from broad references to a panel of medical experts, the regulations do not address two critical factors: 1) who decides what is "medically appropriate" and 2) on what do they base that arbitrary decision that may profoundly affect the welfare of a suffering person. Overall, the regulations display a naïve acceptance of managed "behavioral" health care with little regard for its demonstrated negative impact on the mental health care system.

Same old attitude towards psychotherapy?

The regulators uncritically and unreservedly endorse managed care and strictures on fee-for-service practice. While this wariness about runaway costs also applies to inpatient services, it explicitly targets "very long episodes of outpatient care." At the same time, the regulations implicitly endorse reduced provider fees and redistribution of mental health services under managed care so that more people can obtain services. Thus they expect that under parity the percentage of health care costs attributable to mental disorders will rise very little from the greatly reduced levels that were achieved by managed care over the past 20 years.

To psychotherapists, however, the reference to "very long episodes of outpatient care" looks like discrimination against patients who need sufficient psychotherapy to meet their individual needs, achieved by arbitrary determinations of medical necessity or appropriateness of care rather than treatment that is clinically individualized to each patient. Thus, the new "parity" as implemented under the regulations risks looking just like the frustrating system we have endured over the last two decades. Managed care has cut costs by denying services or driving otherwise well insured patients into obtaining necessary mental health care through self-payment and/or discriminatorily limited out-of-network benefits.

Furthermore, the term "medical necessity" has been widely abused by insurance companies to deny psychotherapeutic treatment or force its premature termination. This directly parallels managed care abuses that limit hospital care and force psychiatrists and hospitals to make the excruciating choice between discharging a risky, not fully stabilized patient, on the one hand, and running up uncollectible hospital and doctor bills, on the other. The criteria for "medical necessity" are usually treated as proprietary secrets that insurance companies divulge very reluctantly. If determinations of medical appropriateness of care in the new world of parity are to have any validity, the criteria for psychotherapy must be set independently by experienced psychotherapists, including those whose patients need long-term therapy, rather than by insurance company executives, in-house mental health professionals, or academics who rarely conduct psychotherapy themselves in the real world of practice.

Insurance companies are fond of referring to "moral hazard"—people in need of a particular treatment flocking to isolated insurance plans that offer exceptional benefits for that treatment. This happened several decades ago in a few plans that supported long-term psychotherapy and psychoanalysis; the reaction to this was used to justify the discriminatory attitudes of the insurance companies. But with parity now a condition of most private insurance, the need for long-term therapy will be spread across the system rather than concentrated in one plan—as is the case with other catastrophic medical illnesses whose costs dwarf the cost of long-term psychotherapy. In Medicare's universal coverage of senior and disabled citizens, the cost of long-term therapy, including psychoanalysis, is a relatively minor item.

*The term "nonquantitative" treatment limitation refers to utilization management or other limits not based on concrete, quantifiable variables such as dollar or visit limits.

True, the regulations target "very long episodes of outpatient care" without defining it as psychotherapy. Most serious mental illness is chronic and requires very long episodes of outpatient care. Some patients will inevitably need care most of their lives, referred to as "maintenance" in the regulations. Such care helps to prevent relapses and reduces disability or the need for hospital care. Effective maintenance commonly includes a very important element of supportive psychotherapy in a sustaining relationship with a mental health professional, at a frequency that could range from intervals of a few weeks or months over long periods, but might need to be every day or two in a crisis. The forced interruption of such a treatment relationship commonly leads to a crisis.

These scattered thoughts lead me to the conclusion that the regulations don't overtly demean psychotherapy, but they pose a serious challenge to psychiatrists and other psychotherapists to be aggressive in presenting a strong case for true equity in support for psychotherapy services, including intensive or long-term psychotherapy. True equity means that management must be in tune with clinical reality, not an arbitrary system that doles out just enough penicillin so that everyone can have a little without having to spend money to reach the effective dosage range.

How should the professions respond?

We must vigorously make the case for true equity in coverage for psychotherapy services to health care planners, employers, government agencies, and insurers, using education and consultation. In advocating for appropriate psychotherapy coverage, it will be helpful to keep the following points in mind.

The evidence base for psychotherapy, including long-term therapy, is strong and growing.[6,7] There is now abundant evidence that psychotherapy works, that it augments the benefits of medication when the two are combined, that long-term psychodynamic psychotherapy (LTPP) is especially effective with complex mental conditions[8] (defined as "multiple or chronic mental disorders or personality disorders"), and that the benefits of LTPP continue to accrue even after termination. The benefits of LTPP can't be keyed to one specific disorder because most patients have multiple comorbid conditions that often include a personality disorder. Personality disorders have significant detrimental effects on personal well-being, effectiveness at work, and important relationships. They warrant serious treatment which generally lasts over a period of several years. There is now evidence for the efficacy of structured forms of psychoanalytic therapy as well as dialectic behavioral therapy for borderline personality disorder. Psychoanalytic treatment also seems to be the only effective way to ameliorate the devastating effects of narcissistic disorders. Effective psychotherapy probably uses the innate plasticity of the brain to effect lasting functional changes. The restructuring of thought patterns, better regulation of affects, changes in behavioral responses—however they are accomplished—take time and repetition because they involve retraining of neural networks.

Psychotherapy is a process with a structure that should be supported through completion. Like a surgical procedure that is not over until the incision is closed and post-surgical care has taken place, psychotherapy should not be vulnerable to interruption through arbitrary, thoughtless decisions by care managers. This is as true for a course of cognitive-behavioral or interpersonal psychotherapy as it is for LTPP that seeks fundamental change. Long-term supportive psychotherapy for maintenance treatment needs to be covered for an indefinite duration at widely variable intervals. Sometimes years of "just-enough" maintenance therapy can be averted by doing it right the first time by providing appropriate intensive psychotherapy for long enough to do the job.

Managed care is itself costly in money, time, and impact on therapy. Managed care requires a significant outlay of personnel and time by both the managers and the treating clinician, adding substantial overhead costs and administrative burden for both. Money is diverted from patient care to utilization management. Even though strong advocacy efforts have reduced to the "minimum necessary" the amount and sensitivity of information that must be routinely provided in managed care, the invasion of privacy and patients' loss of confidence about continuity of care interferes with the process of psychotherapy. In cases of more in-depth review, the greater loss of confidentiality can imperil the treatment, and the administrative burden adds greatly to the costs.

Providing psychotherapy is stressful and demanding work that requires extensive and

costly training and accumulated experience to do well. Since psychotherapy generally requires the structure of specific time periods, it cannot be compressed for greater efficiency. It is not compensated at a level comparable to what can be earned by seeing multiple medication management patients in the same time period. Many psychiatrists have regretfully given up doing much psychotherapy for financial reasons. Sadly this means that more recently trained psychiatrists are often inexperienced at providing the full spectrum of biopsychosocial psychiatric care. The fault for this lies with both insurance companies and public plans like Medicare and Medicaid.

Out-of-network services are essential to genuine access to mental health care

The regulations imply that out-of-network benefits, no longer subject to arbitrary caps, should also be subjected to aggressive utilization management. Current managed care network practices exclude many practitioners and seriously limit access to care. In my office, it's at least a weekly occurrence to hear from a distressed new patient who is unable to find a network clinician who is accepting patients. Significant changes of network recruiting and management and/or acceptable arrangements for out-of-network practitioners will be required to enlist sufficient manpower to meet mental health needs. The present disparity will be even more severe if health care reform legislation expands the insured population that has access to care. Psychiatrists are in short supply, and the majority of them are not on insurance panels, largely by choice. Experienced, skilled psychotherapists are especially likely to stay out of networks.

Psychiatrists' low participation in managed care panels is strikingly illustrated by the findings of a recent study of parity and the use of out-of-network mental health benefits in the FEHBP.[4] The study was conducted in the greater metropolitan area of Washington, DC, which is well supplied with mental health clinicians. Only around a third of psychiatrists, psychologists, and social workers participate in FEHBP networks, and only 44% of FEHBP patients receiving mental health care receive that care from network clinicians. The study found that the major reasons network providers do not accept new patients and other clinicians stay out of networks are low compensation, the heavy administrative burden of utilization management, and serious concerns that the intrusion of managed care is detrimental to the essential process of psychotherapy. Network and out-of-network arrangements under insurance will have to take these serious concerns into account. If insurers impose aggressive management of out-of-network care benefits in a manner that compromises the integrity of the psychotherapy, psychotherapists will limit themselves to self-paying patients and the intent of parity will be defeated.

Mental health professional organizations and insurance companies (and the employers who select those companies) have the choice of taking on the transition to full parity as either partners or adversaries. I suggest that the results will be better for all concerned if the task is approached in a spirit of partnership with the interests of patients at the heart of the task. Regrettably, my personal experience with psychiatrists who tried to initiate such a partnership with an employer purchasing coalition was that they were greeted with overt hostility. As a result of this experience and many of the issues I have presented, I am doubtful about the prospects for parity to bring change for the better.

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