

Policy Challenges in Modern Health Care



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PART IV



*Frameworks
for Fairness
in Health Care*

Integrating People with Mental Illness into Health Insurance and Social Services



RICHARD G. FRANK AND THOMAS G. MCGUIRE

*M*ental disorders are prevalent, impair functioning, and impose a large economic burden on American society and the global community. Careers are cut short, investments in education and training are erased, and families are torn apart. Affected individuals are routinely victimized, and jails and prisons are increasingly filled with people whose conduct is a direct result of their mental illnesses (Harwood et al. 1999).

Medical science has advanced the understanding of mental illnesses and led to improved treatments. *Mental Health: A Report of the Surgeon General*—which summarized much of what is known about mental illness and its treatment—emphasized that mental disorders are a complex mix of biological and psychosocial features, blurring distinctions between mental and physical illness (U.S. DHHS 1999).

Running parallel to the science that, according to the report, “mends the destructive split between ‘mental’ and ‘physical’ health” is an evolving health care delivery system (U.S. DHHS 1999). Public provision, directed by state mental health agencies, dominated mental health care in the 1950s and 1960s. In 1956, for example, the budgets of state and local psychiatric hospitals and specialty mental health clinics accounted for 84 percent of spending on mental health care (Fein 1958). Individual households accounted for the remaining 16 percent, which largely paid for psychotherapy and care in private psychiatric hospitals. Aside from a small sector serving a high-income clientele, governments planned and paid for mental health delivery, markets played a small role in allocating resources, and a small set of specialized providers supplied the care.

Recent analyses of spending on mental health care show how things have changed. Coffey et al. (2000) report that in 1997 government played a significant role in financing mental health care, accounting for about 59 percent of spending, but most of that spending occurred through public insurance programs such as Medicare and Medicaid. Less than 15 percent of total spending went directly from government to state and local public mental hospitals. Now a diverse set of private providers and professionals deliver mental health care, including general

hospitals, nursing homes, primary care physicians, psychologists, and social workers, among others. Private insurance now accounts for over a quarter of all spending.

The advent of insurance as the central form of financing for mental health care has decentralized decision making and given markets a prominent role. Thus, at the start of the twenty-first century, mental health care delivery looks more like general health care delivery than at any time in the last 150 years (Grob 1994). This is largely because the United States has integrated mental health care into the organization, financing, and delivery of medical care.

These broad trends notwithstanding, integrating mentally ill individuals into health insurance and other social programs continues to be a central challenge with a number of dimensions. The first is how clinical care for mental disorders fits into the health care delivery system. Patients with mental illness often initially present their problem to a primary care physician (Morlock 1989). Recent improvements in diagnostic screening and treatment technologies allow primary care providers to identify and treat a high percentage of cases of depression (Wells et al. 1996). However, many primary care physicians and general medical clinics are still reluctant to do so, and depression and other disorders often go unrecognized and untreated (Wells et al. 1996). One set of integration issues thus involves how to manage mental disorders in the context of general medical care.

A second aspect of integration concerns the organization and financing of mental health care. As Medicare, Medicaid, and private insurance have come to dominate financing, coverage and payment have become matters of public policy. The long-standing debate about parity—equality in insurance coverage for mental health care and other treatments—can be cast as an issue of integration. Full parity would make no distinction between mental and physical conditions and treatments (Frank, Goldman, and McGuire 2001). But parity in coverage is only one side of the story: integration also relates to the design of the payment system. For example, when Medicare implemented its prospective payment system in 1983—which was based on diagnosis-related groups, or DRGs—it exempted psychiatric hospitals and specialized psychiatric units of general hospitals. Advocates asked policymakers not to integrate mental health into the new hospital payment system because of evidence that DRGs failed to account for case-mix differences among providers (Lave 2003).

As treatment of people with severe mental disorders has moved from the public mental hospital to community-based settings, care has intersected with social programs aimed at poor and disabled people—a third dimension of integration. (Concerns about equal treatment for people with mental illness also apply to social insurance, job training, housing, education, and criminal justice, although equal treatment may be hard to define in many of these areas.) Integrating people with mental disorders into mainstream social insurance programs such as Temporary Assistance for Needy Families (TANF), Social Security Disability Insurance (SSDI), and Supplemental Security Income (SSI) raises questions regarding whether applying program rules equally to people with mental disorders is fair and efficient. A common theme in these debates is how to design policies that

recognize the special (and disabling) features of mental disorders and would result in fair and efficient treatment of people with mental illness.

Integrated payment systems can create incentives to underserve or otherwise discriminate against persons with mental illness, leading to efficiency problems. Since people with mental disorders are most costly to insure, and payments to plans do not generally recognize such differences, health plans have an incentive to avoid enrolling persons with mental illness. Recent tabulations from the Medical Expenditure Panel Survey show that the per capita health spending of people with mood disorders is more than four times that of individuals without any chronic diseases (Anderson and Knickman 2001; Druss et al. 2001). As we argue, adverse incentives associated with integration pose a serious threat to fair and cost-effective treatment of people with mental illness.

We first encounter this argument in the context of integrated health insurance, but incentives to avoid serving people with mental disorders extend beyond insurance coverage. Social insurance programs generally apply uniform rules to all beneficiaries. Since the early years of the Reagan administration, courts have supported the principle of equal treatment of people with mental illnesses in social insurance programs. Policymakers often make these decisions on simple fairness grounds. In the case of social insurance, however, as with health care financing, fully integrating persons with mental illnesses into social programs can create incentives that will disadvantage those individuals.

Integration in Health Insurance: Parity for Mental Health Services

Parity in insurance coverage for mental health means literal equality in demand-side cost sharing—deductibles, co-payments, and limits—between general health and mental health services. Data on private health insurance from the 1990s show that mental health care is commonly subject to higher demand-side cost sharing, sustaining a discrepancy in benefit coverage that has lasted more than forty years (Buck and Umland 1997).

Governments are passing and implementing parity—or at least partial parity—laws. For example, the federal Mental Health Parity Act required, beginning in 1998, that group health plans provide the same annual and lifetime spending caps for mental and physical illness. Although this legislation delivered a symbolic victory for mental health advocates, it eliminated only differences in annual and lifetime caps, and not the deductible and co-payment features that matter more, thus exerting little impact on equality of coverage. By mid-2000, Gitterman et al. counted thirty-one states with parity laws of their own, ranging from laws that simply matched the federal regulation to those that defined mental illness broadly and applied to virtually all aspects of coverage (2000). In 1999, an executive order established full parity for plans serving federal employees and their families through the Federal Employees Health Benefits Program. Meanwhile, some private employers voluntarily expanded coverage to create parity for mental health while introducing managed care (Goldman, McCulloch, and Sturm 1998; Ma and McGuire

1998a). In fact, the generally favorable experience of the private sector with managed care and parity-like benefits stimulated federal and state regulations (National Advisory Mental Health Council 1998).

Parity, Fairness, and Efficiency

Parity has been the stated objective of mental health advocates since differences in coverage first arose in the early days of private health insurance (Reed, Myers, and Scheideman 1972). These advocates have based their case primarily on the fairness argument: insurance should not discriminate against persons with mental illness. This argument usually focuses on equality of benefit design—that is, on cost sharing and coverage limits. Such parity may or may not result in equity of *use* for persons with mental illness compared with those with physical illness (in relation to measured need).

However, advocates for parity in coverage had to contend with a central question: If parity is such an attractive idea, why were buyers in private health insurance markets not demanding it? Stigma was one answer, but economic analysis supplied another, based on adverse selection. That is, competing health plans may under-provide coverage for some health conditions because of fears that they will attract costly enrollees, even if enrollees value the coverage more than the costs of providing it (McGuire 1981). Thus, competition focuses on avoiding “bad risks”: plans reduce coverage that attracts costly enrollees, such as mental health coverage. Low-cost individuals are drawn to plans offering more limited coverage at a lower premium, leaving the “sickest” enrollees in plans with relatively generous coverage. If premiums do not reflect differences among enrollees, health plans offering more generous coverage will lose money. This distorted competitive dynamic in health insurance is referred to as a death spiral.

Some of the most compelling evidence for adverse selection in mental health comes from the Federal Employees Health Benefits Program, where the dynamics of coverage approached death spiral proportions in the 1980s and 1990s. The proportion of total dollars accounted for by behavioral health claims fell from 7.8 percent in 1980 to 1.9 percent in 1997 (Foote and Jones 1999; Padgett et al. 1993). What was once model coverage for mental health care deteriorated to very limited benefits, as plans cut back on coverage to drive away users of mental health care. Short-circuiting such market failures is the economic rationale for benefit mandates passed by states during the 1970s and 1980s (Frank 1989). While these mandates were popular and effective, they succeeded only in establishing a low floor for coverage, and only for plans within reach of state regulation. Mandates were also often denominated in dollar terms and eroded in purchasing power with medical price inflation.

The equity-in-access argument and adverse selection argument for parity have been articulated for many years, but they have not, until recently, been on the winning side. Against parity policies stood both equity and efficiency objections. Fairness involves issues of vertical equity (fair relative treatment of those better or worse off) as well as horizontal equity (people with mental disorders should be covered the same as those with physical conditions). The most common vertical

equity standard is fairness across income groups. Simply put, vertical equity implies that redistribution favoring higher-income groups is bad, while actions that favor lower-income groups are good. Although the days of insurance-paid long-term psychotherapy are gone, use of outpatient mental health care remains highly correlated with income (Alegria et al. 2000). Thus, adding full coverage for outpatient mental health care to private health insurance serves to redistribute income from lower-income to higher-income groups.

The efficiency argument against parity is well-known in mental health services research (Frank and McGuire 2000). The concern is that offering the same level of insurance coverage for mental health as for general medical care will produce a disproportionate rise in health care spending. And, in fact, studies show that the demand response to changes in coverage is greater for mental than for physical health care (Frank and McGuire 1986, 2000). This is seen as overuse and implies that an insurance-related drop in the price of care would create more inefficiency in mental than in general health care (Frank and McGuire 2000; Newhouse and Insurance Experiment Group 1993). This finding sets up the main efficiency argument against parity: in the interest of consumers, coverage should not be equal for physical and mental conditions.

Parity in the Age of Managed Care

Managed care changes all the arguments—pro and con—bearing on parity. Virtually all private insurance plans include some elements of managed care, including some for behavioral health (Kaiser Family Foundation 1998). Managed care has altered methods of rationing both general health care and mental health care (Glieb 2000).

Managed care weakens or even reverses arguments against parity. For example, under managed care, benefit designs help determine people's use of mental health care. No study since the advent of managed care has considered the aspects of parity concerned with regressive income distribution. However, given that managed care has controlled the use of psychotherapy, and that these treatments are highly correlated with socioeconomic status, it seems likely that managed care would attenuate the regressive effects of parity.

Managed care also undercuts the cost containment argument against parity. Since managed care introduces a number of tools to curtail overuse and control spending, plans no longer have to rely on high levels of cost sharing and service limits. If other mechanisms can better contain costs, benefit design can focus on risk protection. Supply-side payment mechanisms—such as capitation and other forms of prospective payment—enlist providers' financial self-interest in efforts to restrain use and cost. This line of argument implies not only parity in coverage but—with effective managed care—parity at full coverage for all services (Frank, Glazer, and McGuire 2000; Ellis and McGuire 1993; Ma and McGuire 1998b).

However, a key issue is whether health plans will use their cost-containment tools to ration mental health services according to the same standards as for other services. Parity in managing health care implies that health plans would apply the same cost-per-unit-of-quality criteria across all clinical service areas, such as heart

disease, mental health, and cancer care (Frank and McGuire 1998; Burnam and Escarce 1999). Economic analysis implies that full parity in this sense is also efficient. Parity in benefit coverage is thus a necessary but not a sufficient condition for an efficient health plan.

Unfortunately, the very mechanisms that have weakened the traditional cost-control argument against parity imply that competitive insurance markets may continue to supply inefficiently low levels of mental health coverage in the presence of parity laws in the era of managed care. As noted, managed care tactics substitute for demand-side cost sharing. Thus, parity laws regulate just one dimension of cost and access control (benefit design) and leave others (utilization review, network design, physician incentives) open for use by plans to discourage enrollment by persons with mental illness. As Mechanic and McAlpine put it, “Parity in benefit structures means little if ADM [alcohol, drug, and mental illness] care is managed more stringently than other types of health care” (1999, 10).

One could take comfort in observing that parity fixes one problem (benefit design) related to equitable treatment of mental health care. However, this fallback position has problems. If regulators force a plan to make demand-side cost-sharing provisions more generous, the plan will presumably react by managing utilization more tightly. Do we know that the net result is more access, or better access in any sense? Overall, the traditional incentives to avoid enrolling people with high expected costs remain at least as strong as in the past, while the mechanisms available to health plans for affecting selection have expanded with managed care.

Why Integration Fails to Ensure Equal Treatment: Selection Incentives

Adverse selection is an issue for all of health insurance, but may be especially serious in the mental health arena. Deb et al. found that individuals with a family member with mental illness were more likely than similar U.S. residents to choose coverage with more generous mental health provisions (1996). Sturm and colleagues analyzed the treatment of depression across health plans as part of the Medical Outcomes Study, finding that depressed individuals receiving care from specialists were more likely to migrate from prepaid to fee-for-service plans (1994).

Ellis examined the persistence of spending over time and its implications for health plan choice (1985). Individuals with a history of using mental health care had persistently higher levels of spending than otherwise similarly insured individuals. He also found that a history of mental health care utilization had a significant impact on an individual’s choice of health plan. Higher levels of prior-year mental health spending increased the likelihood that an enrollee would choose a low-deductible plan. These studies imply that health insurance plans will anticipate this demand behavior and take steps to prevent it—including offering poor coverage for mental illness to discourage these “risks” from enrolling.

As mentioned, during the 1970s and 1980s, insurers channeled competition in avoiding bad risks into limiting coverage for treating mental and addictive disorders. As health insurance moved away from traditional fee-for-service toward managed care, plans shifted from using co-insurance, deductibles, limits, and exclusions to relying on internal management processes (which are more difficult to

regulate) to ration treatment. The question these changes raise about efficiency is whether incentives to cut back on mental health care in an integrated plan are greater than for other services. Is the threat of underservice for mental health care any worse than for cancer or diabetes care or other medical services?

Empirical research has shown that certain characteristics of services underlie market-driven incentives to ration tightly (Frank, Glazer, and McGuire 2000). If a service is *predictable*, consumers will base decisions on whether to join a plan on their expected future use. If a service is *predictive* of total health care use, a person using this service will tend to use more of all services. Predictable-predictive services are the ones that integrated health plans have the greatest incentive to ration tightly.

The empirical question then becomes, how does mental health compare with other services in incentives to ration tightly under integrated managed care plans, and is there any evidence that integrated plans are acting on this incentive? Frank, Glazer, and McGuire examined these questions in the context of a Medicaid population (2000). They found that plans applied more stringent cost-effectiveness standards to mental health and substance abuse care than to any other service studied, including cancer care, gastrointestinal care, and heart care. This outcome occurred because plans assumed that individuals could predict their service use based on past use, and was primarily driven by the fact that mental health care was much more predictable than the other services.

Some evidence shows that plans act on these incentives. If Medicare rations mental health care more strictly than other services, people using such care may be less likely than other beneficiaries to leave traditional Medicare and join HMOs. Cao compared the health care costs of Medicare enrollees during the year before they switched into HMOs with those who did not switch and found that people who used mental health care were more likely to stay in traditional Medicare than people who used other services (2003). The implication is that people who use mental health services are less willing to subject themselves to health plans that tightly ration services. And the inference is that the plans in the study subjected mental health services to special control.

Cao and McGuire examined another implication of tighter mental health rationing (2003). If mental health users tend to stay in traditional Medicare as HMO market share rises in an area, the average cost of mental health care in regular Medicare should rise with HMO share, compared with other services. Using national data from 1996, the researchers found that average mental health care costs (both Part A and Part B) rise for people who remain in traditional Medicare as HMO market share rises. This contrasts with some other services such as primary care, where the average cost falls in traditional Medicare. These findings are also consistent with tight rationing of mental health compared with loose rationing of primary care.

In sum, empirical evidence shows that health plans' incentives to avoid people likely to use mental health services are stronger than for most other types of services. The evidence is also consistent with the notion that health plans ration mental health services more stringently than other services. This evidence implies that

the main efficiency concern that led to the impulse to use parity laws and benefit mandates to regulate mental health coverage persists in the era of managed care. Unfortunately, parity in benefit coverage fails to solve the problem.

Fixing the System: Separation and Risk Adjustment

Two market-based approaches can counter selection-related incentives to distort the allocation of treatment resources away from mental health care: managed behavioral carve-outs and risk adjustment. Although managed behavioral carve-outs are usually regarded as cost-control devices, they may also moderate selection-related incentives. A carve-out refers to the use of a separate contract—usually with a company specializing in behavioral health care—to provide and manage mental health and substance abuse care.

The economic role of a carve-out program can differ significantly depending on its form. Carve-outs that simply enlist health plan subcontractors may have little impact on adverse selection because consumers continue to choose among integrated health plans where the use of rationing rules across services can affect enrollment patterns. The incentives for an organization to give mental health care special attention in rationing are present with or without a carve-out subcontract.

However, carve-outs that take the form of separate risk contracts from payers (such as employers) remove the risk of mental health service from overall health care, and thus eliminate its management from competition among health plans. Separating mental health care and coverage means that the contract between the payer and the specialty behavioral health company will determine rationing. Of course, carve-out programs have disadvantages that must be considered along with the potential gains in minimizing adverse selection. These disadvantages include high administrative costs (estimated at 8–15 percent), difficulties in coordinating (integrating) care between general medical and mental health providers, and incentives to shift responsibility for care across insurance segments (such as to pharmacy benefits).

Risk adjustment—the other methodology for stemming selection-related incentives in managed care—retains integration in health insurance. The basic idea is that if plans are paid more for care of enrollees likely to be costly, plans will not actively avoid such enrollees. Most risk-adjustment systems rely on demographic factors and clinical information for individuals from past time periods. The clinical information usually consists of diagnoses and procedures arranged in clusters based on judgments about the complexity and intensity of past treatment (Weiner et al. 1996). If individuals choose among plans based partly on predictable medical expenses, then a risk-adjustment scheme capturing this predicted spending variation may be able to address some potential distortions.

Research on risk adjustment shows that careful choice of weights for risk-adjuster variables can improve the incentives to supply care for chronic illness (Glazer and McGuire 2002). However, risk-adjustment methodologies are still evolving and currently explain only 7 percent of general health care spending, and researchers have paid little attention to mental health care (Newhouse 1998). In

1992 and 1993 Ettner et al. examined several commonly used risk adjusters among some 450,000 privately insured employees and their dependents (1998). The investigators showed that no classification system displayed strong predictive ability, and analysis of naturally occurring selection across plans for two large employer groups illuminated the weaknesses of all the classification systems.

So far, risk adjustment in general has failed to make significant progress in stemming the incentives to avoid enrollees who are likely to be costly. Risk adjustment in the mental health and substance abuse area is especially challenging. An important reason is the heterogeneity of conditions that are represented within a diagnostic group. For example, some people with major depression respond quickly to simple pharmacological treatment while others do not, and might require a complex mix of services. Indeed, diagnosis even in the absence of heterogeneity is not tightly tied to a particular course of treatment. One of the characteristics of modern psychiatry is that several evidence-based treatments are available for many mental disorders (U.S. DHHS 1999). The implication is that personal circumstances, patient preferences, and location explain variation in treatment in addition to diagnosis. The result is weak explanatory power of traditional diagnosis-based risk adjusters.

Fully integrating mental health into health insurance, in our view, means applying the same principles to rationing mental health care as to other medical care. Adverse selection incentives stand in the way of this type of integration. Public policy has responded by attempting to regulate benefit design to ensure that it is the same for mental health and general medical care. While we believe this to be a step in the right direction in the context of managed care, it does not meet our standards for full integration. For example, highly effective mental health treatments such as assertive community treatment have no clear parallels in medical care. As a result, health insurance will typically not pay for certain elements of that treatment technology. In that case, simply paying the same amount does not accomplish full integration because the approach fails to apply the same rationing principles to all types of treatment.

Integration in Social Insurance: The Case of Employment Policy

The previous section points to special features of mental illness and mental health care and the resulting selection incentives as key barriers to integrating health insurance. In this section we discuss how selection incentives can compromise the aims of social insurance programs and disadvantage people with mental illness.

Since the 1970s the majority of people with severe mental disorders have spent an increasingly large portion of their time living in communities rather than in institutions. A majority of adults with severe mental disorders receive financial support from Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI). The Temporary Assistance for Needy Families (TANF) program—established under welfare reform—also provides financial support for low-income women and children with mental disorders, among other recipients. Glied and Frank show that these social insurance programs support, at least to some

degree, well over 70 percent of the population estimated to have severe mental disorders (2003).

People diagnosed with mental disorders account for a substantial share of SSI and SSDI enrollees: some 27 percent and 35 percent, respectively, suffer from a mental disorder. People with mental illnesses as their primary cause of disability are the fastest-growing group of beneficiaries in both programs, along with people suffering from musculoskeletal disorders. In the National Survey of American Families, 28 percent of adult TANF recipients had significant mental health problems, as measured by diagnostic questionnaires and symptom counts (Loprest and Zedlewski 1999). Moreover, research has linked improvements in mental health with income support and employment (Alegria, Perez, and Williams 2003).

Social insurance programs have made new efforts to move beneficiaries to employment. Welfare reform is well-known, but the newer Ticket to Work (TTW) program also exerts potential effects on work for persons with a range of disabilities. The TTW program equips SSI and SSDI recipients with vouchers they can use for work-related training from private and some public agencies. Welfare and TTW program rules generally apply to people with mental disorders just as to all other program participants—a form of program integration. The question is, does this form of simple integration, or parity, serve people with mental illness fairly and efficiently?

The Economics of Disability Programs and Challenges to Simple Integration

Social insurance, including disability insurance, spreads risk among members of society, just as health insurance does. The financial support offered by a disability program alters the behavior of individuals and can create moral hazard. Disability insurance provides workers with an income-support payment if they are deemed disabled by a physical or mental condition. If income-support payments were available if—and only if—workers did not recover from disabling conditions, they could receive some protection against the risk of disability at no efficiency cost. Transfer payments cannot be made with such precision, however, and workers typically know more about their own condition than does the social insurance program (e.g., the Social Security Administration). Some workers for whom it would be socially efficient to reenter the workforce will not do so. Low-wage workers and workers less likely to become attached to jobs will be least likely to reenter the labor force.

A range of policy initiatives has tried to address this problem since the creation of social insurance programs. Both welfare reform and TTW rely on employment services to help match workers with jobs. But again moral hazard will prompt too few workers to accept these services. In particular, low-wage workers and workers with lower probabilities of obtaining a match will not seek out employment services. What's more, employment agencies that are paid and evaluated according to their ability to place and maintain beneficiaries in jobs will have incentives not to work with people who have a lower likelihood of success (Frank

and McGuire 2003). These incentives are similar to the health insurance selection incentives discussed earlier. Employment agencies that are paid for performance will potentially lose money if they take on clients that are costly to support and have a low probability of reentering the labor market. Such agencies are more likely to profit from serving clients who have a greater likelihood of obtaining employment.

People with mental illness are among those who may be least likely to either reenter the labor force or seek employment services. People disabled by mental illness are less likely to work than people with most other disabilities. Ettner, Frank, and Kessler used the National Comorbidity Survey to study labor market outcomes and estimated that employment rates are 10–15 percent lower among males and females with diagnosable mental disorders (1997). Mechanic, Bilder, and McAlpine report that about 50 percent of people with a mental disorder work, while just 20 percent of people with serious mental illness hold any type of job (2002). Only 12 percent of people with schizophrenia work full time. Similarly Yellin and Cisternas analyzed the National Health Interview Survey and found that people with mental disabilities have the lowest rates of employment among people reporting disabilities (1996).

Workers with mental disorders earn less than otherwise similar workers, and those with severe mental illnesses are more likely to hold low-wage jobs than similar people without such diseases (Mechanic, Bilder, and McAlpine 2002). Ettner, Frank, and Kessler report that earnings were somewhat lower among workers with mental disorders than among people without such illnesses (1997).

People with mental illnesses are also less likely to keep jobs when they find employment. After examining the Survey of Income and Program Participation, Salkever estimated significantly lower rates of continuing employment for people with mental illnesses (2003). In analyzing the follow-up to the Epidemiologic Catchment Area Survey—the most comprehensive survey of mental disorders ever conducted in the United States—Slade and Albers found that people with recurring symptoms of depression are more likely to exit the labor market than are other similar individuals (2000).

The empirical evidence bolsters the notion that without special accommodation, people with mental disorders enrolled in TANF, SSDI, and SSI will be less likely to participate in voluntary employment services such as those of the TTW program, owing to the disincentives for both workers and employment agencies. People with mental illness will also reenter the labor force less often than people with other disabilities. Welfare-to-work programs that fail to recognize the special difficulties that people with mental illnesses confront in gaining employment will mean that those enrollees will experience sanctions and benefit expirations (Polit, London, and Martinez 2001). This would be an unintended and possibly undesirable program outcome. Thus, the incentives associated with welfare reform and the TTW program will tend to reinforce incentives for people with mental disorders not to return to work, even part time.

Conclusion

To stem the adverse consequences of market failures, some state legislators and policy analysts have proposed to directly regulate managed care contracts and to measure and pay for care based on quality (Gopelrud and Rosenbaum 1998). However, rationing within managed care is a complex, heterogeneous, and poorly understood business. It involves hundreds of decision points within managed care organizations, making direct regulation of these practices costly, complex, and difficult to monitor. Furthermore, given analysts' meager understanding of rationing in managed care, it is unclear whether incomplete regulation will improve or hinder the fair and efficient provision of mental health and substance abuse care.

The science and practice of quality measurement is still developing. Direct measurement of health plan performance is a subject of active research, but efforts to measure the quality of specific services such as mental health care lag behind the overall effort (IOM 1997). Developing quality indicators to regulate rationing thus remains a distant goal. Given the state of these measures, carve-outs and risk adjustments remain ways to address the effects of moral hazard and adverse selection in mental health services.

The integration of people with mental illness into social insurance and social services is widespread and a sign of progress toward full integration of mental and physical illness. At the same time, policies that promote social goals such as employment but do not account for unique features of mental illness appear likely to disadvantage people with mental disorders and compromise progress. The search for ways to improve on the application of all program policies to all populations is a pressing challenge for researchers and policymakers alike.

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Accountability for Reasonable Limits to Care

CAN WE MEET THE CHALLENGES?



NORMAN DANIELS

All health systems, whether public or private or rich or poor, limit access to medical care. Occasionally, this limit setting takes the form of a public melodrama focused on the “heartless” denial by an “evil” insurer or bureaucrat of a “last-chance” treatment for a dying patient. Such drama leaves little room for the limit setter to claim moral authority. For example, when Medicaid denied coverage for a bone marrow transplant to young Coby Howard in Oregon, the script of the public drama barely mentioned the fact that he was not in remission from his leukemia and therefore was not even eligible for a transplant.

The backlash against this case propelled the state to evaluate its Medicaid coverage through a process that attracted international attention. Yet most lightning-rod cases yield no such positive, if unintended, side effects. In *Fox v. Health Net* (Sup. Ct. 219692 [1993]), for example, a California jury decided that a private insurer’s initial denial of an unproven bone marrow transplant contributed to the patient’s death. The resulting \$89 million judgment, combined with lobbying by interest groups, helped make bone marrow transplant the standard of care for advanced breast cancer—delaying discovery that such treatment was ineffective.

Public melodramas generally mislead people about efforts to set limits on health care, for most such efforts do not involve last-chance rescues. Avoiding these dramas—and viewing extreme situations more critically and dispassionately—requires that we learn how to set limits fairly and well in more typical settings.

Consider a case that entailed more established treatments and no life-saving rescue. When Massachusetts Medicaid recently faced cuts owing to steep declines in state revenue, the high cost of psychiatric drugs became a target (Sabin and Daniels 2003a). The agency established a process through which key stakeholders would develop a cost-reducing coverage policy acceptable to psychiatrists and patient advocates. Despite opposition by the American Psychiatric Association (APA) to limits on drug coverage, including requirements that providers obtain prior approval, the decision-making process secured acceptance of the plan among local psychiatrists and patient advocates.

Kaiser Permanente, the giant nonprofit, California-based HMO, also won general acceptance for a generics-first policy for prescribing antidepressants, this time after a careful internal review process (Sabin and Daniels 2003b). In contrast, when the Michigan legislature targeted Medicaid drug coverage for cost savings in 2001, a panel developed a preferred-drug list replete with forty-four categories requiring prior approval. The panel did not consult important stakeholders or conduct follow-up outreach efforts (Bernasek et al. 2003). This limit-setting process provoked considerable resistance and even litigation from patients and providers.

In another case in the mid-1990s, the Centers for Medicare and Medicaid Services (CMS) faced extreme pressure to approve coverage for lung volume reduction surgery for advanced cases of emphysema, even while private providers were making contradictory decisions on whether to cover the procedure. Medicare successfully delayed a decision until the National Emphysema Treatment Trial—a randomized clinical trial—produced clearer evidence on the procedure’s effectiveness. CMS recently decided to cover the procedure only for limited groups of patients in controlled settings.

Why do some attempts to set limits on health care coverage win legitimacy and moral authority, while others convince patients and clinicians that their interests are taking a back seat to cost-cutting efforts? As I recount below, these cases support a model for ensuring accountability and fair decision making in health care coverage while also revealing unresolved policy challenges.

Legitimacy and Fairness Problems

Limit setting creates winners and losers, and thus conflict. These outcomes reflect not only competing interests but also the fact that reasonable people often disagree on how to weigh competing values. Should we refrain from giving a dying child or a woman with cancer a last chance with an unproven therapy because of concern about scarce resources? How much weight should limit setters give to reducing drug costs versus allowing individual patients to escape policies that might force them to accept less-than-optimal drugs? In the Medicare decision regarding lung volume reduction surgery, should decision makers approve only carefully selected patients and providers for an unproven therapy?

Fundamental issues regarding human well-being force decision makers to wear a mantle of moral authority. Under what conditions do those affected by the decisions appropriately grant that moral authority? I refer to this as the legitimacy problem (Daniels and Sabin 1997, 2002).

Legitimacy might be less important if the fairness problem had a straightforward, principled solution that was clear to all. Unfortunately, no such consensus exists. Instead, as the examples suggest, controversy over unproven technologies reflects the competing values of human compassion versus stewardship of scarce resources. There is similar controversy about the fair distribution of burdens and benefits in the drug management cases. Society also lacks consensus on how much priority to give the sickest patients, and on whether modest benefits for large numbers of people should outweigh significant benefits for a few.

In the absence of consensus on such principles, we must develop a decision-making process whose outcomes all who participate in the process and are affected by it will accept as just. The process must eliminate obvious sources of bias and conflict of interest and recognize the values and interests of different stakeholders. This is a classic appeal to procedural justice, wherein a fair process yields a just outcome in the absence of prior agreement on criteria and principles (Rawls 1971).

Some market advocates would claim that my appeal for procedural justice is unnecessary, as consumers can set limits by choosing different health plans. What could better legitimize limits than people's choices? Choice brings consent, and consent brings legitimacy.

Both theoretical and practical problems undercut this appeal to market accountability, however, even if we were to rely entirely on private insurance. Uncertainty about people's needs, the performance of health care plans, and the effectiveness of treatments make the purchase of medical services very different from the purchase of computers or cars. What's more, half of all workers with insurance have no choice of plans, and those who do have choices usually do not understand the limits that affect them until they have medical problems, at which point switching plans is difficult or impossible. Thus, I propose a process—accountability for reasonableness—for resolving disputes over scarce health care resources.

Accountability for Reasonableness

Four general conditions can ensure accountability for reasonableness. If met, they should lead health plan enrollees, patients, and the public to respect the fairness and legitimacy of decisions by managed care organizations and public officials regarding coverage of new technologies and treatments:

Publicity: Decisions and their underlying rationales must be publicly accessible.

Relevance: These rationales must rest on evidence, reasons, and principles that plan managers, clinicians, patients, and consumers agree are pertinent to deciding how to meet diverse needs under resource restraints.

Revisability and appeals: A mechanism must allow challenges to limit-setting decisions, help resolve those challenges, and allow revisions in light of further evidence and arguments.

Enforcement: A voluntary or public regulatory process must ensure that decision makers fulfill the first three conditions.

These four conditions can convert behind-the-scenes deliberations by public agencies and private health plans into a public—and ultimately democratic—deliberation concerning how limited resources might best be used to maintain the health of populations with diverse service needs. A culture of openness would also facilitate learning among clinicians and enrollees about the need for limits on health care coverage. Many people claim that the litigious public will accept no limits;

changing that culture requires a concerted educational effort both outside and inside the institutions that deliver and finance care. Education begins with openness about the reasons for decisions by public and private health providers and insurers. Over time, this process can spur broader deliberation by a public better educated to think about how to share medical resources fairly and its elected officials.

Though some, and perhaps many, health plans proceed carefully and thoughtfully when deciding which procedures to cover, private plans generally fail to make their rationales public. Rationales would make it crystal clear to patients and clinicians alike why the plan's cost and quality controls lead to its criteria for coverage. A public record of a plan's decisions, like case law in legal judgments, provides a basis for judging their coherence and consistency. Such a record enables those affected by those decisions, who often have no real ability to seek alternatives, to understand why they face the restrictions they do. The publicity condition thus satisfies a fundamental requirement of justice.

Participants in a health plan—patients, their clinicians, and plan managers—pursue a common goal: they aim to meet their diverse needs under resource constraints on terms they can justify to each other. Since hard decisions must be made about how to meet those needs fairly, the grounds that decisions are based on must be ones that fair-minded people can agree are relevant. (Being fair-minded means being willing to play by rules of the game they accept and can justify to each other.) The relevance condition imposes constraints on the rationales supporting coverage decisions, thus narrowing the range of disagreement. Involving diverse stakeholders is one way to secure greater agreement.

The relevance condition does not mean that all parties will agree with specific decisions; parties may agree on which reasons are relevant but still weight them differently. As long as fair-minded parties who make the decision and are affected by it can accept that the grounds are relevant, however, even those who do not agree cannot complain that it is unreasonable. Desperate parents and spouses who demand last-chance treatments for loved ones may not behave as fair-minded people interested in mutually justifiable rationales, but a public with experience in limit setting may resist unreasonable demands (Edgar 2000).

Fair-minded people will accept many kinds of evidence and reasons as relevant to decisions regarding health care coverage. These can include scientific evidence on a treatment's effectiveness and safety and even information on its cost-effectiveness, especially when a less-costly approach delivers equal or superior benefits. Controversy occurs when decision makers must sacrifice achievable benefits for some people in favor of greater overall cost-effectiveness. The situation becomes even more controversial when the cost-effectiveness comparison weighs treatments for patients with different conditions. Decision makers must carefully explicate their choices in these cases.

Except for some decisions concerning drug coverage, health plans do not seem to evaluate treatments as competitors within an overall budget for new technologies. If such comparative budget-driven judgments do become common, decision makers will have to pay even more attention to distributive fairness.

Because accountability for reasonableness is intended to apply in various

public and private settings, consumer participation itself is not essential to fairness. Yet such participation, when properly supported, enhances legitimacy. Because such a process does not select consumer participants democratically, they do not make it more democratic, nor do they act as proxy consenters on behalf of other consumers. Rather, consumer participation reassures stakeholders that decision makers are addressing their arguments, broadens stakeholders' perspectives on which rationales are relevant, and ensures transparency.

Coverage decisions often rest on specific evidence about efficacy and cost. Because such evidence can change over time, and because decisions that apply to most patients with a condition may not apply to all, plans must make provision for revising decisions when new evidence emerges or when patients or doctors feel they should be exceptions to coverage rules. Enforcement of the publicity, relevance, and revisability conditions might be achieved by building them into accreditation requirements for health plans, or this may require some legislative mandates, as in the case of state laws regarding independent review of coverage decisions.

Accountability for Reasonableness in Practice

An ideal test of the effectiveness of accountability for reasonableness in solving the legitimacy problem would compare situations that implemented its central tenets and those that did not. Such an evaluation would measure outcomes such as stakeholder perceptions of legitimacy (represented by fewer appeals and complaints), consistency and coherence of decisions, and equitable access to services. This ideal test is not yet feasible, however, as no significant part of the U.S. health care system has explicitly adopted such an approach, and serious obstacles often prevent decision makers from pursuing it. Still, if we examine the narratives cited above in closer detail, we can find explicit use of such principles as well as situations where skilled managers implement those ideas on their own.

Weighing Pharmacy Benefits

In the late 1990s, James Sabin and I worked with executives at Merck-Medco (now Medco Health Solutions), one of the nation's two largest for-profit companies managing pharmacy benefits, to analyze limit setting in a broad range of designs for pharmacy benefits. These executives wanted to make the ethical rationales underlying their decisions available to practitioners, pharmacists, and patients. Consulting with Medco's clients, including large purchasers of pharmacy benefits, clinical managers, pharmacists, and marketing personnel, we developed an "ethical template" for many different pharmacy benefits (Daniels, Teagarden, and Sabin 2003).

This template maps the decisions entailed in designing such benefits onto types of ethical rationales appropriate for each. These decisions include which drug categories a plan will cover, which drugs each category will include, which symptoms each drug can address, and what limitations the plan will impose on the use of a drug. We found that officials based the first two decisions largely on need,

while cost considerations drove decisions on the latter two criteria. The ethical rationale for covering certain drugs, for example, weighs the overall cost advantage of using a cheaper drug against the need to protect patients for whom the cheaper drug does not work.

Our work with one major Medco client, a private health plan, aims to translate the template into a Web site tool that explains the reasons for coverage limits to clinicians, pharmacists, and patients. Many decision makers remain skeptical of using such a template. Health plans often fear that transparency will open them to accusations that they are “the first rationer in town” or to litigation if they are explicit about their decision-making process. Other decision makers are simply not persuaded that such an approach adds value, even if it seems ethically justified (“business is business”).

Two policy challenges are clear. Though strong support for ethically defensible decision making sometimes emerges even in for-profit firms, overcoming skepticism requires showing that transparency yields payoffs, such as fewer patient complaints and lower turnover, or a better market image. And producing such evidence requires research on natural experiments in accountability for reasonableness as they arise. (The Canadian Priority Setting Research Network recently sponsored a workshop to develop a research agenda to measure the value of such an approach.) Overcoming these fears may require regulatory rules that put all players on the same playing field, removing the risks of early experiments. One model for such rules is the independent review processes that forty-two states now mandate.

Return now to the examples of Medicaid drug limits in Michigan and Massachusetts. To avoid the problems encountered in Michigan, Massachusetts decision makers explicitly involved all key stakeholders in the limit-setting process and aimed at transparency. Stakeholders included organized psychiatry (through the Massachusetts Psychiatric Society, MPS) as well as consumer and family groups. These groups nominated psychiatrists to participate in a Psychopharmacology Work Group; consumers chose James Sabin, my collaborator and a psychiatrist, as their representative. He provided information on the accountability-for-reasonableness approach to work group members.

To fulfill two criteria of that approach—transparency and flexibility—the state agency responsible for Medicaid mental health circulated the work group’s proposals for wider review and revised them to address stakeholder criticisms. The result was a set of policies—reinforced through an educational campaign by the MPS—designed to prevent providers from prescribing more than one selective serotonin reuptake inhibitor (SSRI), and five or more psychiatric medications, at a time. This policy curbed expensive and risky co-prescriptions.

Then, as the budget crisis in Massachusetts intensified, the Division of Medical Assistance, which administers the state’s Medicaid program, decided to develop a list of preferred drugs. This approach directly conflicted with the APA’s policy of exempting psychiatric medications from such lists and from requirements that providers obtain prior approval for prescriptions. The Psychopharmacology Work Group carefully evaluated the rationale for the national APA policy and weighed

it against the reality of state budget cuts. Local psychiatrists, many of whom wanted to ensure the widest-possible access to psychiatric drugs given budgetary limits, supported this approach.

In the end, the work group recommended generic fluoxetine as the SSRI for an initial prescription. This decision required careful education of providers throughout the state as to its underlying evidence and rationale. The policy also required reassuring consumer and family groups that people already successfully treated with other antidepressants could easily win exemptions from the policy. Decision makers further added a drug to the list whose slow release diminished the risk of seizures for some patients. Stakeholders initiated some of these consumer protections, while the template spurred the Psychopharmacology Work Group to consider others. Key elements of accountability for reasonableness—transparency, careful deliberation with stakeholder involvement, and revision in light of appeals—may well explain why the Massachusetts approach worked without conflict while Michigan's did not.

This evidence concerning the effectiveness of accountability for reasonableness suggests its potential as best practice. Solidifying and refining this approach requires meeting two policy challenges. The first is to carefully study such natural experiments to determine differences in the value they add. The second is to establish incentives and rewards for individuals and organizations that grab the limit-setting bull by its horns. For example, the state Department of Mental Health's Executive Office of Health and Human Services gave the MPS a Clinical Excellence Distinguished Service Award for its leadership in enlisting local psychiatrists to participate in the Massachusetts decision-making process.

Kaiser Permanente, which serves over 8 million members nationally, including 6 million in California, also instituted a generic fluoxetine-first policy. Its pharmacy policy board based its decision on a controlled study comparing the effectiveness of various SSRIs and on an internal survey of physicians' prescribing patterns that showed that patients switch equally among all SSRIs. Whereas Massachusetts had to secure clinician buy-in to a new policy by soliciting stakeholder involvement, Kaiser had already established such a mechanism: the organization monitors clinicians' prescribing patterns, and clinicians meet to debate the merits of different approaches.

The ethical template requires an easy exception for patients whose conditions do not justify use of a cheaper drug first. In Kaiser's case, all physicians retain the authority—without prior authorization (a sticking point for the APA)—to override drug restrictions whenever they feel that is medically necessary for individual patients. Because of the organization's careful education regarding its rationales for recommended practice, variations in prescribing patterns are not widespread. This kind of peer management embodies central elements of accountability for reasonableness: transparency, deliberation of rationales, and openness to revision. This approach also allows a health plan to emphasize cost-effectiveness while protecting individual patients. These two examples show how a large insurer and a state Medicaid program relied on key elements of accountability for reasonableness to arrive at similar outcomes.

Kaiser's best practice also serves as a policy challenge. Although organizations like Kaiser have a long-standing culture that encourages cost-effective practice, loosely structured physician practice organizations (PPOs) and independent practice organizations (IPOs) lack this culture. Nevertheless, such provider groups can benefit from accountability for reasonableness, at least if they operate on a level playing field.

Moving such highly decentralized health organizations in the right direction will require quantified evidence of success. States that rely on key aspects of accountability for reasonableness to produce cost-effective pharmacy benefits can provide such evidence, especially if they win broad public support for fair limits on coverage. Alternatively, such evidence may encourage regulators to compel the private sector to move toward a more cost-effective approach based on accountability for reasonableness. To propel thinking in that direction, the federal Agency for Healthcare Research and Quality sponsored a conference for senior state policymakers on how to structure cost-effective state pharmacy benefit programs. The conference featured discussions of the ethical template, limit setting for psychiatric drugs, and a case study of the activities of the Massachusetts Medicaid program.

Independent Review: The Underdeveloped Potential of Regulation

Amid growing consumer distrust of managed care organizations, in 1998 California passed the Friedman-Kowles Experimental Therapy Act, which established the first mandatory independent review of decisions by HMOs to deny coverage for care. Some forty-two states have since established such review processes. These reviews overcome the deep conflict of interest entailed when health plans rely on experts who work for them to analyze denial of coverage. The movement toward independent reviews—clearly an idea whose time had come—codifies the appeals-and-revisions condition that underpins accountability for reasonableness.

Michigan has taken the bold step of posting the denial decisions it reverses on a Web site, providing one model of transparency. Advocates overcame resistance to such public posting by arguing that it would provide a body of unofficial case law, even if it lacked legal authority. California also posts brief summaries of its case reviews online.

State-level review of health plan decisions does put all players on a common playing field and reduces barriers to transparency and revisability. Existing legislation falls short, however, of providing incentives for converting the rich body of case evidence into an effective tool for improving health care quality. For example, although Michigan posts its redacted cases, it has no mechanism for encouraging the challenged organizations to change their decision-making policies. Nor does any research mechanism examine the cases and patterns underlying overturned denials and propose the steps insurers might take to modify their practices. Existing regulation of independent review activities could be refined to require health care organizations to systematically analyze the reasons the state reverses their coverage decisions. The resulting information could become the basis for improving quality, offsetting some of the costs of such review and evaluation.

Medicare Coverage Decisions

I noted earlier that the Centers for Medicare and Medicaid Services delayed—courageously, I believe—a decision on whether to cover lung volume reduction surgery until the National Emphysema Treatment Trial (NETT) could provide better evidence on the procedure’s safety and effectiveness. To see why that delay took courage, we must look beyond the intense pressure on Medicare to the private sector, where insurers were also considering whether to cover the procedure. In a case study completed just as NETT began, James Sabin and I found that Northern California Kaiser Permanente decided to cover the procedure at “centers of excellence,” while Health Partners in Minnesota, also a nonprofit plan, decided not to provide coverage. PacifiCare and Aetna, two for-profit plans, also reached opposing decisions on coverage (Daniels and Sabin 2002).

These contrasting conclusions did not reflect differing assessments of the technology or understanding of evidence-based practice. Rather, the decisions reflected member demand for the procedure, the presence of strong internal champions, and local practice patterns and beliefs. The decisions also reflected the degree to which the organizations felt confident of their ability to implement eligibility criteria and coverage limits for the procedure, and the weight they gave to values such as stewardship of scarce resources and rescue of desperate patients.

Such conflicting pressures affect both the private and public sector, so understanding how CMS persuaded stakeholders to wait for better evidence is important. With input from the Agency for Healthcare Research and Quality, CMS established a broad partnership backing NETT, including the National Heart, Lung, and Blood Institute. The authority and prestige of these institutions, and the resulting buy-in from many clinicians, enabled the organization to withstand pressure to provide immediate coverage of the procedure.

Also crucial to managing the social tension was creating public awareness that the decision hinged not only on rising costs but also on the need for better evidence concerning which patients would benefit. In the absence of better evidence, clinicians would be unable to secure proper consent for the procedure’s benefits and risks. Thus, CMS took important steps to create transparency around reasons stakeholders can see as relevant—two key conditions entailed in accountability for reasonableness. Meeting these conditions helped avoid the rush to coverage that occurred with bone marrow transplants for advanced breast cancer.

Moving from the results of a trial like NETT to a coverage decision by both public and private plans still requires accountability for reasonableness. Unfortunately, CMS’s actual coverage decision lacks some elements of that accountability, though the failing may reflect the organization’s legislative charge more than its process.

After public input from its Medicare Coverage Advisory Commission, CMS decided to cover the procedure for several subgroups of patients despite strong warnings that evidence of benefits for those subgroups lacked statistical significance (Ware 2003). By itself, the decision may have been a case where reason-

able people disagreed about how much caution to impose in the face of results showing measurable benefit for some subgroups.

Study results also showed that the procedure was not terribly cost-effective, however (NETT Research Group 2003). Unfortunately, the legislative charge to CMS gave decision makers little room to consider the opportunity costs of covering a potentially very expensive treatment with very modest benefits. No one explicitly asked, if Medicare funds this technology, what other new procedures or services can it not afford, and which are more important? The agency would have to make such tradeoffs explicit if it had to consider novel treatments within a budget for new coverage. And given budget neutrality pressures, still larger questions would loom if adding new benefits meant that services already covered by Medicare would have to be limited further.

The possibility that further delay was not politically feasible, and that attempts to meet urgent needs took precedence over caution concerning treatments not fully proven, suggests that Medicare may find it difficult to hold the line on coverage limits. Pressure from enthusiastic clinicians and desperate patients may lead to coverage “creep.” Such an outcome not only would be costly but might bring harms whose magnitude society is not in a good position to measure. Accountability for reasonableness would require more careful deliberation premised on the convictions that health care resources are limited and that fair and legitimate decisions must evaluate a range of social effects.

Meeting the Accountability-for-Reasonableness Challenge

Efforts to secure accountability for reasonableness in setting limits on health care coverage face three main policy challenges. First, as the discussion of pharmacy benefits shows, resistance to transparency among both public and private health providers and insurers reflects a lack of clear evidence that acting virtuously will yield clear payoffs. Winning support for more transparent decisions will require research on the positive benefits of doing so.

Second, even where regulation has helped improve accountability in decision making, as in the state-level independent review processes, such accountability has not fulfilled its potential for improving quality. Meeting this challenge will require research on reviewed cases and on how incentives and sanctions can encourage health plans to put to good use the information produced by the reviews.

Third, cultural resistance to making hard choices about opportunity costs remains. I see no quick solution to this problem, but public education and broader deliberation can produce change over time. This is a bit of a chicken-and-egg problem: implementing accountability for reasonableness is one mechanism for producing that education, but boosting implementation is difficult without initial education. Perhaps, to switch metaphors, the solution requires “bootstrapping” our way from modest changes in process to modest changes in culture and so on to broader cultural and institutional change.

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