Mental Health Insurance Plans' Constituents: In Sickness and in Health?

During the 1990's, the introduction of managed care in the industry of health insurance meant to reduce the cost of health insurance that had grown significantly. Compared to traditional health insurance known as fee-for-service (FFS), Health maintenance organizations (HMOs) and Preferred provider organisations (PPOs) health insurance plans were introducing restrictions on several dimensions of health insurance. Certain program made pre-approving of treatment mandatory or impose a network of physician to the insured. (Baker, 2003). These major changes in health insurance has raised the interest of researchers in the fields of health.

Many themes have been explored but most often accessibility to health care, quality of care and determinants of accessibility have been the object of analyses. On accessibility, most studies have shown that, HMO type of plans have been reported to be less accessible than other types of plan. (Miller and Luft, 2002). Others have demonstrated that accessibility had multiple factors (Shih and Stevens 2005) or was largely associated with socio-economic status. (Carlson, Blustein, Fiorentino, and Prestianni, 2000). In addition, some studies have shown that access was important, but that quality had to be taken in account. While finding the same access between HMOs and other type of plans, Mark and Muller clearly identify that persons in HMOs report most often unmet health care needs which is a measure of quality of care.(1996).

The studies mentioned before are on general care. Access to mental health care has another story. As the National Mental Health Association acknowledge, the unequal access to mental health insurance coverage is affecting and discriminating millions of Americans who are suffering of mental health problems. The extend of mental health insurance coverage is much more limited then general health care insurance. And it is so, even if several States did adopt State Parity Acts for mental health there was a clear decline in coverage. (Sturn and Wells 2000; Pacula and Sturn, 2000a, 2000b). As Sturn and al. have demonstrated in several studies the parity acts have made no difference on coverage and access to mental health care: "Depite numerous parity bills since 1998, there have been virtually no change."(Sturn and Pacula 2000a, p.1361). Furthermore, the actual components of mental health insurance lead, in some cases, to a lack of appropriate care. For example, Berk et al. have demonstrated "…private coverage is generally better for less intensive or less prolonged treatment, but it may become inadequate in the most serious cases when person need extended care or have recurring problems." (Berk et al, 1995, p.146.). In addition, HMOs have important outpatient and inpatient visit limits which may not give the accessibility to a adequate mental care in terms of length and quality. (1er texte ?)

Most of the studies on general or mental health care are trying to determine whether or not managed care insurance (HMO-PPO) had an impact on accessibility and the quality of care compared to traditional health care insurance (FFS). Our purpose is to go beyond that objective and measure the actual impact of mental health insurance plans on the mental health of individuals. If there has been cuts on mental health coverage and that quality of care varies among plans it is important to measure the outcomes of those factors on the mental health of individuals. We think that being able to determine the impact of this inequality on mental health coverage is central for a society in which mental illness is becoming a central problem. In other words, we want to determine if the constituents of health care leads to recurring sickness or better mental health. In doing so we will be able to evaluate the outcomes of the different mental health insurance plans.