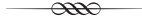


# *Integrating People with Mental Illness into Health Insurance and Social Services*



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*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 (Glied 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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