Financing of Behavioral Health Services: Insurance, Managed Care, and Reimbursement

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Introduction

Behavioral health has evolved over time to largely insurance-based and insurance-financed systems of care, becoming much more like the rest of the health-care system. Up until the 1950s, most behavioral health services were provided in state and local long-term psychiatric hospitals and financed primarily through state and local general revenues. The Community Mental Health Centers Act of 1963 added federal funding for more community-based services through grants to the states. But it was the passage of the Medicare and Medicaid health insurance programs in the 1960s that fundamentally altered the way behavioral health services were financed in this country. Medicaid, in particular, created powerful incentives to provide services outside of state psychiatric facilities because only half the costs of treatment provided in the community were paid for by the states. In contrast, states were responsible for all of the costs of inpatient treatment in psychiatric and other long-term facilities under the Medicaid Institutions for Mental Disease (IMD) rule. The federal Social Security Disability Income (SSDI) program, passed in 1956, and later the Supplemental Security Income (SSI) program in the 1970s provided further impetus for community-based services by giving income support to those individuals disabled by mental disorders.

Private health insurance systems have also become central to the financing of behavioral health services. Most Americans under the age of 65 obtain health insurance coverage through employers and unions rather than through public insurance

The views expressed in this chapter are those of the author, and no official endorsement by the Agency for Healthcare Research and Quality, or the Department of Health and Human Services is intended or should be inferred.

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B. L. Levin, A. Hanson (eds.), *Foundations of Behavioral Health*,
https://doi.org/10.1007/978-3-030-18435-3_4

programs. The introduction of new classes of antidepressant in the 1980s and 1990s led millions more Americans into treatment, the majority with private health insurance coverage (Kessler et al., 2005; Zuvekas, 2001). Similarly, greater recognition and acceptance of medication-based treatment of ADHD, anxiety, and other behavioral disorders have led still more Americans into treatment. The availability of both public and private health insurance to finance medication-based and other treatments has considerably broadened the behavioral health systems beyond those with the most severe and persistent mental illnesses such as bipolar disorders and schizophrenia.

The movement to insurance-based behavioral health treatment systems also means tighter integration with the larger and constantly evolving health and social insurance systems. Thus, changes in the Medicaid and Medicare public insurance programs and private health plans largely drive how behavioral health services are organized, delivered, and financed. In particular, the expansions in insurance coverage under the 2010 Affordable Care Act (ACA) led to some 20 million Americans gaining insurance and, with coverage, a means of financing their behavioral health treatment (Uberoi, Finegold, & Gee, 2016). The ACA also extended the 2008 Mental Health Parity and Addiction Equity Act (MHPAEA) requiring equivalent coverage (or parity) between behavioral health and other health-care services and contained other important protections for behavioral health treatment (Barry, Goldman, & Huskamp, 2016; Beronio, Glied, & Frank, 2014).

The principal goals of this chapter are to (1) understand how insurance-based models of financing operate in theory and in practice and (2) understand the implications of increasing strains on private and public insurance systems, including the ACA insurance expansions and parity, for the future of behavioral health services.

Review of the Literature

Paying for Behavioral Health Treatment

Funding for behavioral health treatment comes from a complex array of public and private sources (SAMHSA, 2016), predominantly insurance-based. An estimated $220 billion was spent on behavioral health in 2014, accounting for 7.5% of all health-care spending in the United States (see Table 1). Public and private health plans together paid 64% of behavioral health care in 2014, up from 45% in 1986. In comparison, insurance financed 74% of all non-behavioral health spending in 2014 (Mark et al., 2016; SAMHSA, 2016). Private insurance coverage (26%) and Medicaid (24%) each accounted for about a quarter of all behavioral health spending in 2014, followed by Medicare (14%). Medicaid is a more important source of financing for behavioral health services compared to other health-care services, while Medicare and private insurance plans are less important.

Table 1 Distribution of spending by payment source, 1986, 2004, and 2014

	Behavioral health care						All health care	
	1986		2004		2014		2014	
	Billions ($)	Percent	Billions ($)	Percent	Billions ($)	Percent	Billions ($)	Percent
Private—total	18.5	44	50.8	39	86.3	39	1492.6	51
Out-of-pocket	6.9	17	14.6	11	22.3	10	343.8	12
Private insurance	9.5	23	32.4	25	58.1	26	1020.3	35
Other private	2.1	5	3.7	3	6.0	3	128.6	4
Public—total	23.1	56	79.4	61	133.6	61	1422.7	49
Medicare	2.4	6	8.5	7	30.3	14	616.8	21
Medicaid[a,b]	6.4	16	36.3	28	53.0	24	507.0	17
Other federal[b,c]	3.0	7	8.3	6	14.4	7	136.4	5
Other state and local[b]	11.2	27	26.3	20	35.9	16	162.5	6
Total	41.5	100	130.2	100	220.0	100	2915.3	100

Source: Adapted from Table A7, SAMHSA (2016)

[a]Includes state and local share of Medicaid

[b]State Children's Health Insurance Program (CHIP) spending is distributed across Medicaid, other federal, and other state and local categories, depending on whether the CHIP program was run through Medicaid or as a separate state CHIP program.

[c]SAMHSA block grants to "state and local" agencies are part of "other federal" government spending

It is important to note that the trend toward insurance-based financing of treatment over the last couple of decades extends mainly to mental health treatment services and not substance use disorders (Mark et al., 2016). The majority of funding for substance use disorders still comes from public sources other than Medicare and Medicaid and is unchanged over the last couple of decades (Mark et al., 2016; SAMHSA, 2016). Other sources of funding are still important for mental health treatment as well. State and local authorities still accounted for 16% of all behavioral health spending in 2014 apart from Medicaid (Table 1). Other federal sources, including Veterans Affairs, military health care, the Indian Health Services, and the $2.3 billion in SAMHSA block grants (SAMHSA, 2015) to state and local agencies, accounted for 7% of all behavioral health spending. Patients and their families financed 10% of all behavioral health care themselves out-of-pocket, while other private sources accounted for 3%.

Where Do Treatment Dollars Go?

Behavioral health treatment today is largely community-based. Only about one in four behavioral health treatment dollars was spent in specialty psychiatric and general hospitals in 2014, down from 43% in 1986 (Table 2). Because these aggregate

Table 2 Behavioral health services spending by type of service, 1986, 2004, and 2014

	1986		2004		2014	
	Billions ($)	Percent	Billions ($)	Percent	Billions ($)	Percent
Specialty sector	*27.2*	*65*	*67.3*	*52*	*108.9*	*50*
General hospitals. Specialty units[a]	5.6	14	13.8	11	25.3	12
Specialty hospitals	9.7	23	14.1	11	19.6	9
Psychiatrists	2.6	6	7.8	6	10.5	5
Other professionals[b]	2.2	5	7.4	6	14.5	7
Specialty mental health centers[c]	4.8	11	17.1	13	28.4	13
Specialty SUD centers[d]	2.3	6	7.2	6	10.5	5
General sector providers	*9.8*	*23*	*20.4*	*16*	*39.5*	*18*
General hospitals. Non-specialty units[a]	2.5	6	6.6	5	15.4	7
Nonpsychiatric physicians	2.0	5	6.0	6	11.3	5
Free-standing nursing homes	5.1	12	6.6	5	9.4	4
Free-standing home health	0.1	0	1.2	1	3.4	2
Retail prescription medications	*2.6*	*6*	*32.0*	*25*	*52.9*	*24*
Insurance administration	*2.0*	*5*	*10.5*	*8*	*18.7*	*9*
Total	*41.5*	*100*	*130.2*	*100*	*220.0*	*100*

Source: Adapted from Table A.4. (SAMHSA, 2016)

[a]All spending for psychiatric services in Department of Veterans Affairs hospitals is included in general hospital specialty unit providers.

[b]Includes psychologists, counselors, and social workers

[c]Includes residential treatment centers for children

[d]Includes other facilities for treating SUDs

figures for hospitals also include outpatient and partial day treatment, the amount spent on inpatient treatment is even less. Spending in psychiatric specialty hospitals now accounts for less than 1 of every 10 behavioral health-care dollars, down from 23% in 1986. Much of the drop was due to the rapid growth of specialty managed behavioral health-care organizations (MBHOs) during the 1980s and 1990s. MBHOs achieved cost savings primarily by promoting outpatient care in place of more expensive inpatient treatment (Ma & McGuire, 1998; National Advisory Mental Health Council, 2000; Sturm, 1997). However, administrative costs of insurance have increased as a by-product of increased management of behavioral health services. That is, over time proportionately fewer dollars are going to direct patient care.

Spending on psychiatrists has grown less rapidly than spending on other behavioral health professionals (Table 2). The nonpsychiatric physician share of total spending remains only about 5%. However, these aggregate estimates may understate the true amount spent on primary care physicians because behavioral health services and diagnoses are often not coded as such in the insurance claims data that form the basis for these estimates. In fact, the majority of people receiving behavioral health services get their care from nonspecialist providers, although they tend

to have many fewer visits on average than people who receive services from specialists (Wang et al., 2005).

Prescription medications account for about a quarter of all behavioral health spending (Table 2). Spending on medications grew rapidly from the 1980s through the turn of the century with the introduction of expensive new classes of antidepressants, antipsychotics, and other behavioral health-related medications. These newer medications were many times more costly than older medications. Equally, if not more important, many more people were prescribed psychotropic medications. Spending on behavioral health medications has moderated over the last decade as generic versions of most of these medications became available and the growth in the number of Americans taking them flattened out.

Principles of Insurance

The main function of insurance is to protect people from financial risk when catastrophe strikes. In this sense, health insurance is much like automobile, homeowners, or life insurance. Instead of paying a fixed amount to your family if you die under a life insurance policy or paying to rebuild your house, health insurance helps pay medical bills when you are sick. When private health insurance plans first began in the 1940s and 1950s, they principally covered inpatient hospital stays. As other services grew in importance and expense, coverage expanded to include physician and other provider expenses and, more recently, prescription drugs. As late as the 1970s, many private plans did not offer prescription drug coverage—now it is almost universal. Likewise, Medicare did not offer the Part D prescription drug benefit until 2006—now approximately 86% of Medicare beneficiaries have drug coverage (Kaiser Family Foundation, 2018a). Health insurance, however, differs in crucial ways from other common types of insurance (Arrow, 1963).

Principles of Insurance: Moral Hazard

Health insurance contracts tend to be more open-ended than other types of insurance contracts because it is difficult to predict beforehand which of the many different types of illnesses you might get and how much health care you might need. That is, health insurance contracts are rarely written in such a way that if I get, say, leukemia, I will be paid a fixed $200,000, or if I get pneumonia, I will be paid $10,000. The open-ended nature of health insurance coverage leads to a situation that economists call *moral hazard*, where people overconsume health care. With health insurance coverage, out-of-pocket costs are generally less than the true cost of providing health care. At some point, the benefits of additional health-care services (e.g., extra tests) in terms of improving health are not worth their full costs, but because the insured only pay a fraction of the costs, they still want to use the services to get better.

Consumer cost-sharing evolved in response to this fundamental problem of moral hazard. By shifting at least some of the costs of health care to consumers, they become more sensitive to the true costs of health care. Current health-care reform discussions often refer to this idea as consumers having "skin in the game." Traditionally, health insurance plans imposed a *deductible*, where the health insurance plan only paid for services after consumers had paid a certain amount out of their own pockets (typically, $250 or $500). More recently, high-deductible health plans (HDHP), where health-care services, except for a limited set of preventive care services, are only covered after a deductible of $1350 or higher in 2018 is met (most often considerably higher), have become popular with employers (AHRQ, 2017; Claxton, Rae, Long, Damico, Foster, Whitmore, 2017).

Health plans also traditionally imposed cost-sharing in the form of *coinsurance*, where the consumer paid, typically, 20% of the cost of services (after the deductible had been met) and the plan 80%. As health insurance plans evolved, fixed *co-payments* for particular services, for example, $25 for an office visit or $35 for a brand-name prescription drug, have become common. While consumer cost-sharing can reduce excess use of health-care services, it can also reduce appropriate use of health-care services (Goldman, Dirani, Fastenau, & Conrad, 2014; Rice & Matsuoka, 2004). Thus, there is always a trade-off between the benefits of more generous insurance coverage and moral hazard. The goal with cost-sharing is to strike a balance in this trade-off (Besley, 1988; Zeckhauser, 1970).

The best-known evidence regarding moral hazard in health insurance coverage comes from the RAND Health Insurance Experiment (HIE), a large-scale, randomized control trial conducted from 1977 to 1982. This landmark study found that consumers' use of mental health services was twice as responsive to their out-of-pocket price as other medical services (Keeler, Manning, & Wells, 1988). The RAND HIE results became the main justification for providing less generous coverage for mental health services on economic efficiency grounds: moral hazard is greater where consumers are more sensitive to the price of services. However, several lines of evidence suggest that consumers are no longer as sensitive to the price of outpatient mental health services as they were four decades ago when treatment options were more limited (Goldman et al., 2006; Meyerhoefer & Zuvekas, 2010).

Principles of Insurance: Adverse and Favorable Risk Selection

Economists refer to moral hazard as a type of market failure because it leads to less than 100% insurance coverage. *Risk selection* can lead to even more serious market failure. Consumers with greater anticipated health needs are naturally more motivated to seek insurance coverage to cover the costs of services, and the more generous the coverage the better. This will drive up costs in plans that attract sicker-than-average patients (*adverse selection*). Insurers can respond by raising premiums, restricting coverage so as not to attract higher-risk consumers, and/or using other means to discourage higher-risk consumers. If insurers raise premiums,

this can lead to a situation where the healthier consumers drop coverage (because it is no longer as good a deal). This causes premiums to go still higher, in turn, causing the next-healthiest consumers to drop coverage and so on (Rothschild & Stiglitz, 1976). In the extreme, this can lead to an insurance "death spiral," where the insurance market ceases to exist altogether, something that has been observed in the real world (Cutler & Reber, 1998; Cutler & Zeckhauser, 1998).

Adverse selection is thought to be especially acute in behavioral health (Frank, Glazer, & McGuire, 2000; Frank & McGuire, 2000; McGuire, 2016; Montz et al., 2016). Consumers with behavioral health disorders have much higher medical costs on average than other consumers and are thus unattractive risks from a health plan's perspective. For example, depression frequently co-occurs with diabetes and heart disease. The Federal Employees Health Benefits (FEHB) program during the 1960s and 1970s provides the classic illustration of adverse selection (Frank et al., 2000; Padgett, Patrick, Burns, Schlesinger, & Cohen, 1993). Federal employees have long had the choice of a number of health plans through the FEHBP. Several of the plans in the FEHBP began offering generous mental health coverage, others did not. Not surprisingly, consumers with behavioral health disorders migrated to the more generous plans, which raised costs. In response, the generous plans cut their behavioral health-care coverage so that coverage was low in all the plans by the late 1970s. Behavioral health coverage remained low in the federal health plans until 2001, when an executive order mandating parity coverage in all plans went into effect (Goldman et al., 2006).

Regulatory actions, such as parity mandates, are one potential solution to adverse selection. *Risk adjustment*, where payments vary according to the risk the plan faces in their population, is another standard approach to mitigating adverse selection. Risk adjustment is used, for example, in the payments made to Medicare and Medicaid managed care plans and in the ACA private insurance marketplaces. Much work has gone into devising better risk-adjustment methodologies over the last few decades, but they remain imperfect: predicting future medical expenditures is inherently difficult. With imperfect adjustments for risks, insurance plans have strong incentives to seek out better risks (favorable selection, often referred to as "cream skimming" or "cherry picking") and avoid sicker patients.

Mechanisms to induce pooling of consumers are another potential means for mitigating adverse selection. The dominance of employment-related health insurance arose partly by accident as employers used health insurance coverage as a means to attract and retain high-quality workers, much like retirement benefits. But public policy has also deliberately encouraged this development. Employer groups are seen as a convenient way to pool consumers independent of their health status. The value of health insurance benefits is not taxed, creating incentives for employers to provide, and employees to receive, compensation in the form of health insurance benefits, rather than higher wages, which are taxable. Some argue that this tax subsidy encourages too much insurance and overconsumption of medical care due to moral hazard. The ACA, for example, contains provisions to tax "Cadillac" plans above a certain threshold, although its implementation has been continually delayed. Other reform proposals would eliminate the tax subsidy altogether. Others argue

that it is the glue that keeps the employment-related insurance system together and that the system might fall apart altogether due to adverse selection as the healthier workers opt out without the subsidy (Bernard & Selden, 2002; Monheit & Selden, 2000).

Principles of Insurance: Social Insurance

The Medicare and Medicaid programs that finance much of behavioral health services and the SSDI and SSI programs that provide many with severe and persistent mental illness with income support are examples of social insurance programs. Social insurance programs serve two primary purposes: (1) they are a means of overcoming market failure in private markets; and (2) they serve a redistributive function in providing safety net resources to vulnerable populations.

The Medicare program, enacted in 1965, serves both functions. Medicare Part A, which covers hospital services, was made compulsory explicitly to overcome adverse selection problems and is funded primarily out of payroll taxes. Nearly all people 65 and older are covered by Part A. Medicare, after a 2-year waiting period, also covers those under the age of 65 who have qualified for the SSDI program (those with a disability who paid into the Social Security System for 40 or more quarters).

The Medicare Part B program, which covers office-based and other services, while not compulsory, is funded 25% out of Medicare beneficiaries' own pockets and 75% out of general revenues.

The premiums for the optional Medicare Part D drug benefit are similarly heavily subsidized, encouraging high rates of participation, as well. Substantial penalties for late enrollment in Medicare Part B and Part D further encourage participation. The large subsidies combined with late enrollment penalties have also been effective in overcoming adverse selection: 86% of Medicare beneficiaries eligible for Part D prescription drug coverage have some form of drug coverage (Kaiser Family Foundation, 2018a).

The Medicaid program, unlike Medicare, was not designed to provide broad-based coverage for the population but as an insurer of last resort for vulnerable populations. It has long provided coverage to low-income children and their parents (many with Temporary Assistance to Needy Families), low-income pregnant women, low-income elderly, and people with disabilities. Eligibility varies widely by state. The 2010 ACA significantly expanded Medicaid coverage to childless adults and other low-income adult populations in states that chose to expand coverage.

Medicaid is an especially important source of coverage for people with mental disorders who qualify for SSI income support (many of whom do not have the 40 quarters of work needed to qualify for SSDI and, thus, Medicare). It also plays an important role in filling in gaps for Medicare, which requires significant cost-sharing and does not cover many behavioral health services.

Concerns regarding the potential loss of Medicaid and Medicare coverage create strong disincentives for people with disabilities to seek work and incentives to stay on social insurance programs and have led to a number of initiatives, such as the Ticket to Work program (Office of Disability Employment Policy, 2007).

Principles of Insurance: Managed Care

Managed care is ubiquitous in health care, no more so than in behavioral health treatment. But it also takes many different forms and is hard to categorize, especially with the extensive hybridization of models in recent years. Managed care evolved as another way to control the use of health-care services and restrain cost increases, which continued to rise rapidly in spite of the widespread use of consumer cost-sharing in health insurance plans.

Traditional staff/group model Health Maintenance Organizations (HMOs), such as Kaiser Permanente of Northern California and Group Health of Puget Sound, pioneered many of the basic managed care techniques. These staff/group model HMOs offered substantially reduced consumer cost-sharing compared to traditional fee-for-service (FFS) plans in return for (1) restrictive provider networks, with providers either salaried directly by the HMO or members of large groups contracted principally with the HMO; (2) physician gatekeeping, that is, requiring a referral from the patient's primary care provider to see specialists; (3) extensive utilization controls, such as prior authorization for services such as inpatient hospitals stays, physical therapy, and behavioral health services; and (4) drug formularies, where HMOs frequently offered market exclusivity to manufacturers in return for price breaks on specific drugs.

Traditional indemnity insurance has all but disappeared in private health insurance markets, supplanted by HMO plans, preferred provider organization (PPO) plans, and hybrid plans. PPOs consist of networks of providers, who provide services to plan members at a discounted price negotiated with the PPO. Consumer cost-sharing is much lower for network ("preferred") providers, but consumers have a choice of whether to use in-network providers or pay more for out-of-network providers. In contrast, in a closed HMO, consumers must use HMO providers or face denial of benefits (the HMO may either hire the provider directly as in a staff/group model HMO or contract with individual and groups of providers). PPOs also differ from closed HMOs in that they generally do not require referrals to access physician specialists. Some insurers offer both HMO and PPO products using the exact same network of providers, differing mainly in the use of physician gatekeeping and the ability to use of out-of-network providers.

Point-of-service (POS) plans contain elements of both HMO and PPO plans. For example, an "open-ended" HMO plan might allow consumers to see out-of-network providers (with higher cost-sharing) but still require referrals for specialists (gatekeeping).

HMOs enjoyed rapid growth into the late 1990s, doubling from 39.0 million enrollees in 1992 to a peak of 80.5 million in 1999 (Interstudy, 2002, 2003). A managed care "backlash" subsequently led to a decline in HMO enrollment to 71 million in 2006 (Interstudy, 2007). However, HMO enrollment has since risen to 92 million enrollees as of 2016 primarily due to increases among Medicare and Medicaid populations (Kaiser Family Foundation, 2018b). PPOs grew rapidly in the 1990s and 2000s and remain the most popular type of plan in the employer-sponsored insurance markets.

In contrast to private health insurance, Medicare remains largely a traditional fee-for-service program. Managed care plans were first introduced in the Medicare program in 1990. Enrollment in what are now called Medicare Advantage (Medicare Part C) plans has grown unevenly over time. However, it has accelerated recently with the introduction of new options reaching 34% of the Medicare population in 2018 (Centers for Medicare and Medicaid Services, 2018b).

State Medicaid programs continue to shift Medicaid recipients into managed care plans. In 1997, almost half (48%) of Medicaid recipients were enrolled in managed care plans, mostly in HMOs. By 2013, this had grown to 80% of all Medicaid recipients (Centers for Medicare and Medicaid Services, 2016).

Outside of the fee-for-service Medicare program, the majority of specialty behavioral health services for insured populations are organized and delivered through managed behavioral health organizations (MBHOs). Medicaid programs and private insurers alike contract with these specialty MBHOs, in what are termed behavioral health *carve-outs*. MBHOs generally develop their own networks of behavioral health specialists, usually reimbursed on a fee-for-service basis, along with extensive prior authorization and utilization review systems. Products marketed to both employers (direct carve-out) and health plans (indirect carve-out) range from employee assistance plans (EAP) to stand-alone utilization management products to comprehensive packages providing all specialty behavioral health services (network plus utilization management).

MBHOs spread rapidly during the 1980s and 1990s by successfully adapting many of the techniques originally pioneered by HMOs to the management of specialty behavioral health services. Industry sources show total enrollment in MBHO products increasing from 86 million in 1992 to an astounding 227 million in 2002 (Open Minds, 2002). MBHOs achieved impressive cost savings early on due primarily to dramatically reduced lengths of stays for inpatient hospitalizations (Ma & McGuire, 1998; National Advisory Mental Health Council, 1998, 2000; Sturm, 1997). This success led more and more plans and employers to contract with MBHOs. MBHOs also achieved cost savings partly through negotiated discounts from network providers and partly through what are termed "network" effects: the fear that a provider will be discontinued from the network if they provide too many services to patients (Ma & McGuire, 2004). Their growth, however, naturally reached a plateau as they came to dominate the market for specialty behavioral health services provided through insurance in the last couple of decades.

MBHOs' effects on access and quality of behavioral health services remain ambiguous. On balance, reducing lengthy inpatient stays and shifting resources to

outpatient settings has likely been beneficial to patients. There is also evidence that MBHOs accelerated the diffusion of evidence-based practices (Ling Davina, Berndt, & Frank, 2007). But there are also concerns that MBHOs restrict access to specialty services, so that patients must seek treatment in primary care settings. MBHOs are also rarely at risk for the costs of psychotropic medications (management of prescription medications are generally contracted to yet another third party, see below). This creates incentives for psychotropic medication interventions, at the possible expense of evidence-based behavioral therapies (the cost for which they would be responsible). Evidence of cost shifting either to primary care settings or to prescription drugs, however, is mixed (Dickey, Normand, Norton, Rupp, & Azeni, 2001; Norton, Lindrooth, & Dickey, 1997; Zuvekas, Rupp, & Norquist, 2007).

Once a somewhat peripheral concern, prescription drug financing is now central to behavioral health treatment. Similar to specialty behavioral health services, management of prescription drugs in the private plans, including plans that serve Medicare and Medicaid populations, is now largely contracted out to third-party administrators called pharmacy benefit managers (PBMs). Also similar to MBHOs, PBMs contract directly with employers who have carved out their prescription benefits from the rest of their health coverage.

PBMs apply many of the basic tools of managed care to prescription medications. They develop and maintain networks of pharmacies with which they negotiate prices. They negotiate discounts and rebates from pharmaceutical manufacturers and wholesalers. Much like MBHOs, the PBM industry is highly concentrated, so PBMs are able to leverage their volume purchasing power with both pharmacies and manufacturers. Leverage with manufacturers is further increased through the use of drug formularies, essentially lists of approved drugs.

Multi-tiered formularies are the norm and, in private plans, are closely tied to consumer cost-sharing. In a standard three-tier plan, the first tier includes inexpensive generic medications with zero or low co-payment levels to encourage their use. The second tier includes a preferred medication(s) in a therapeutic class, with somewhat higher cost-sharing. The third tier includes non-preferred medications in a therapeutic class, with the highest cost-sharing.

Not all medications in a therapeutic class will necessarily appear in a formulary; formularies vary widely in their restrictiveness. Some particularly expensive medications, such as cancer drugs and atypical antipsychotics, may be listed but require prior authorization before use. PBMs, managed care plans that manage their own pharmacy benefits and Medicaid programs, use the leverage of tiers or preferred status of drugs, in return for discounts and rebates from manufacturers.

The treatment of psychotropic medications in drug formularies is an area of great controversy. Patients respond differently to the range of medications within therapeutic classes such as antidepressants and atypical antipsychotics. A restrictive formulary can thus create barriers to treatment for patients who do not respond to preferred drugs.

Consumer cost-sharing can also create barriers to treatment. Higher cost-sharing can lead to reduced use of medications (Goldman et al., 2004; Hodgkin, Parks Thomas, Simoni-Wastila, Ritter, & Lee, 2008; Huskamp et al., 2005; Landsman, Yu,

Liu, Teutsch, & Berger, 2005; Wang et al., 2008). In recognition of this potential problem, some employers and health plans have experimented with lower cost-sharing or eliminating it altogether for maintenance medications used to treat chronic conditions. For additional information on the topic of psychopharmacology, see chapter "Pharmacy Services in Behavioral Health" in this volume.

Principles of Reimbursement

Private health plans, public insurance programs, and state and local mental health authorities face difficult decisions in choosing how to organize and pay for health-care services provided to clients. A wide variety of reimbursement mechanisms has evolved over time. Each creates its own set of incentives, good and bad.

Closed systems, such as the Department of Veterans Affairs (VA), state and local psychiatric institutions, and the original staff/group HMOs typically own their own hospitals and clinics. That is, these closed systems combine insurance functions and health-care provision functions. They also typically hire providers directly, paying them a salary, or use other similar contractual methods to provide care. In principal, monitoring of provider behavior and patient outcomes is easier in a closed system, and providers can be made to more closely follow the dictates of the organization if their salary depends on it (either explicitly or implicitly). Success depends upon the strength of internal monitoring systems and organizational dynamics. In the public sector, political considerations also play a large role. Closed systems have other problems. The large investments needed to build, maintain, and staff closed systems, even in the private sector, reduce flexibility to shift resources as circumstances change. Many consumers also dislike the restricted choice of providers in closed systems.

The many variants of cost-based and fee-for-service reimbursement are administratively simpler alternatives to directly hiring providers. Cost-based reimbursement, where providers submit their actual costs, was once common for hospital services but is now the exception. Medicare, for example, paid hospitals on a strictly retrospective cost basis until 1982 (Hodgkin & McGuire, 1994). Under a fee-for-service system, providers receive a fixed amount for each service performed. This fee is administratively set in the traditional Medicare and Medicaid programs (although providers can indirectly influence fee setting through the political process). In private plans, the fees are usually set in negotiation with providers.

However, a significant percentage of behavioral health providers, especially in large metropolitan areas, have opted out of all insurance-based reimbursement, focusing on clients who pay up front out of their own pockets (with some patients filing claims with health plans and some declining to do so) at rates set by the providers (Bishop, Press, Keyhani, & Pincus, 2014; Cummings, 2015; Mitchell, 1991; O'Malley & Reschovsky, 2006; Wilk, West, Narrow, Rae, & Regier, 2005). Other providers opt out of specific plans, most commonly Medicaid plans, because of low reimbursement rates set by many states (Cunningham & Hadley, 2008; Mitchell,

1991; Zuckerman, McFeeters, Cunningham, & Nichols, 2004). The declining number of providers willing to treat patients with Medicaid raises concerns that access to care for individuals with low incomes and disabilities has diminished (Atherly & Mortensen, 2014; Cohen & Cunningham, 1995; Cunningham & Hadley, 2008; Decker, 2012; Sharma et al., 2018).

Cost-based and fee-for-service reimbursement also create incentives to overprovide services, as providers earn more revenue the more services they perform as long as the actual reimbursement amount covers their costs. For example, there is substantial evidence that paying hospitals fixed per diem rates creates incentives for longer lengths of stay (Berenson, Upadhyay, Delbanco, & Murray, 2016, April; Hodgkin & McGuire, 1994). Actual costs tend to be front-loaded, so patients become increasingly profitable the longer they stay. Perversely, cost-based and fee-for-service reimbursement can even create incentives for poor quality care, since there are often no real consequences for bad outcomes and providers can earn still more revenue correcting their mistakes.

Fee-for-service systems have the additional disadvantage of distorting treatment decisions, as some types of services are more profitable than others. For example, primary care providers are rarely separately reimbursed for screening for depression, addiction, and other behavioral health disorders, while they are routinely reimbursed for laboratory tests, a significant barrier to wide-scale behavioral health screening.

Capitation and other prospective payment systems were developed in response to the poor incentives created under fee-for-service or cost-based reimbursement systems. The basic idea is to shift some or all of the financial risk of additional services to providers, creating incentives to be as efficient as possible in providing services. Capitation to health plans and capitation to providers are commonly confused. Under provider capitation, providers receive a fixed amount per month for each patient in that provider's panel (or at least those covered by the plan), regardless of the amount of services they use or whether a particular patient uses services at all. Under plan capitation, the health plan receives a fixed amount for each patient to cover all the health-care services for all the providers in the plan, essentially an insurance premium. Plan capitation is far more common than provider capitation. Even in capitated managed care plans, including carve-outs to MBHOs, the predominant form of reimbursement to providers is fee-for-service or salary (Strunk & Reschovsky, 2002; Zuvekas & Cohen, 2016). This is primarily due to the administrative complexity of determining capitation formulas and unwillingness of providers, especially in small or solo practices, to assume risk (Berenson & Rich, 2010; Frakt & Mayes, 2012; Goldsmith, 2010; Mechanic & Altman, 2009).

Medicare's Prospective Payment System, where hospitals receive a fixed payment for all patients within a Diagnosis Related Group (DRGs) regardless of the services they use (with provisions for outliers), works in similar fashion to capitation. Lengths of inpatient hospital stays fell dramatically after Medicare switched to this system in 1983. Many state Medicaid programs and even private health insurance plans have adopted similar prospective payment systems.

While there is some evidence that capitation and prospective payment increase efficiency of care, they also create incentives to under-provide care (in contrast to the over-provision of care in fee-for service systems). This is especially true where outcomes are difficult to monitor. Capitation and prospective payment reimbursement also create strong incentives for the same types of risk selection behavior (cream skimming or cherry picking) evident in health insurance markets. Healthier patients will obviously be more profitable than sicker patients. As a result, the same types of risk-adjustment methods are also commonly applied to capitated and prospective payments systems, again imperfectly.

There is increasing recognition that both fee-for-service and capitation are imperfect reimbursement methods if they are not linked explicitly to outcomes and/or quality. The term "pay for performance" has become ubiquitous in recent years to describe various attempts to create better incentives in payment systems. The Centers for Medicare and Medicaid Services (CMS) prefers the terms "alternative payment models." Results to date are mixed, but the CMS and private payers continue to experiment with wide variety of payment models (Hussey, Ridgely, & Rosenthal, 2011; Rosenthal, Landon, Narmond, et al., 2007; Rosenthal, Frank, Li, & Epstein, 2005; Rosenthal, Landon, Howitt, Song, & Epstein, 2007; Rosenthal, Landrum, Robbins, & Schneider, 2016; Sinaiko et al., 2017). Among the models being tested are various forms of bundled payment linked to clinical outcomes for episodes of treatment (e.g., knee replacement) encompassing most or all components of treatment (hospital, physician, laboratory, rehab) rather than paying individual providers separately.

Closely related are Accountable Care Organizations (ACOs), which combine hospitals, physicians, and other providers to accept bundled payments or to participate in other alternative payment models, as well as patient-centered medical homes (PCMHs) (Centers for Medicare and Medicaid Services, 2018a). These new payment models may have accelerated a growing trend of consolidation and integration of health-care providers (e.g., hospitals buying up physician practices). Adoption of these new payment models has been much slower in behavioral health, partly because of concerns about adverse selection and partly because of concerns about measuring behavioral health outcomes.

Presentation of Critical Issues

As we have seen, the financing of behavioral health services is closely and increasingly tied to the health insurance coverage Americans hold (Mark et al., 2016). Loss of health insurance reduces use of behavioral health services, while extending health insurance coverage tends to improves access (Beronio et al., 2014; Frank & McGuire, 1986; Garfield, Zuvekas, Lave, & Donohue, 2011; Zuvekas, 1999). Thus, changes in the health insurance system have immediate consequences for behavioral health services. We consider here the impact of long-run structural changes in the health insurance system along with two major health reform initiatives of the

last decade or so: the 2010 Affordable Care Act (ACA) and the 2008 Mental Health Parity and Addiction Equity Act (MHPAEA).

Long-Run Trends in Health Insurance Coverage

The mixed public and private nature of US health-care systems extends to health insurance coverage. Only those aged 65 and above have near universal coverage through the federally funded Medicare health insurance program. In contrast, working-age Americans and their children still depend primarily on private insurance obtained through employers or unions to pay for their health care. However, not all Americans have access to employment-related insurance. Some employers do not offer health insurance coverage or offer coverage only to certain types of employees (e.g., full-time but not part-time workers). Some employees decline their employer's offer of insurance either because they are covered by other insurance or cannot or do not wish to pay the employee out-of-pocket share of the insurance premium.

Prior to the ACA, the percentage of non-elderly Americans who were uninsured remained stable for decades. Approximately 17% of the non-elderly US population was uninsured in both 1997 and 2013 with little variation in between (Fig. 1). This stability masks enormous changes. In 1997, 71% of the non-elderly population was covered by private health insurance. By 2013, this had declined a full 10 percentage

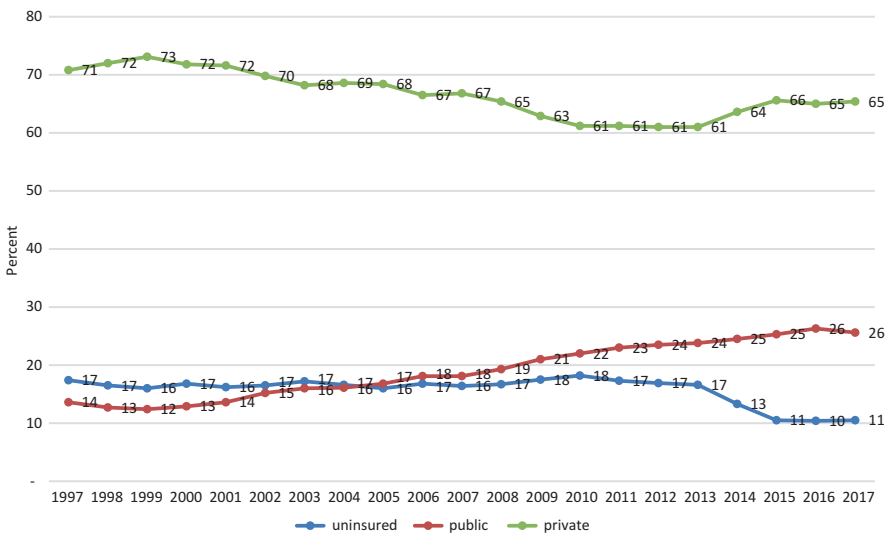

Fig. 1 Trends In insurance coverage, under 65, 1997–2017. Note: Percentages add to more than 100 because a small percentage of people report both public and private coverage. Source: Adapted from Tables 1.1b, 1.2a, 1.2b. Clarke, Schiller, and Norris (2017)

points to 61%. Rising insurance premiums are thought to be a major factor in the decline. For example, the average total cost of an employer-sponsored family plan rose from $4954 in 1996 to $16,029 in 2013 and to $17,710 in 2016 (Fig. 2). Economists generally believe that employees absorb most of these increased insurance costs in the form of lower wage increases. For example, unions have been willing to make wage concessions in return for continuing guarantees of health insurance coverage in collective bargaining agreements.

However, as total premiums continue to rise, so too do the amounts employees are required to pay out of pocket for their coverage by employers. The average out-of-pocket share for a single plan was $1325 and $4956 for a family plan in 2016 (Agency for Healthcare Research and Quality, 2017, September). This is a likely reason why Americans are increasingly declining employer offers of insurance coverage (Agency for Healthcare Research and Quality, 2017, September; Cooper & Schone, 1997; Cooper & Vistnes, 2003). It is this declining "take-up rate" that is largely responsible for the decline in private health insurance coverage prior to the ACA.

Several successive federal and state expansions of Medicaid coverage beginning in the 1990s and the State Children's Health Insurance Program (SCHIP), enacted in 1996 for lower-income uninsured children, have compensated for the loss of private health insurance. The percentage of non-elderly Americans covered by public programs rose substantially from 14% in 1997 to 24% in 2013, fully offsetting the 10-percentage point decline in private insurance coverage over that same period (Fig. 1).

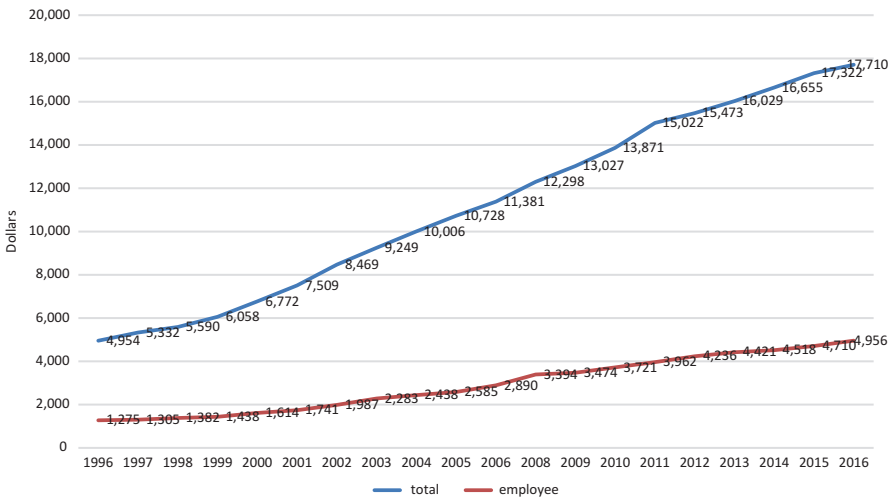

Fig. 2 Total family premium per enrolled employee, private sector establishments, 1996–2016. Source: AHRQ (2017)

Recent Trends Under the Affordable Care Act

The 2010 Affordable Care Act (ACA) legislated substantial changes in the structure of health insurance coverage in the United States and led to a decline in the number of uninsured Americans. The most widely known of the ACA's many provisions were three expansions of insurance coverage: (1) dependent coverage to age 25 in private plans, (2) ACA marketplace coverage, and (3) Medicaid expansions.

The first expansion implemented allowed parents to cover any of their children through the age of 25 through their employer's family plan beginning in 2010. This popular provision is especially important for young adults with behavioral health needs. The vast majority of uninsured young adults are healthy. Yet they are also vulnerable as they transition from their parents' homes to school (for some) and into the workforce (for others). The onset of many mental disorders, such as schizophrenia and bipolar disorder, tends to occur at precisely this time. Previously, only students up to the age of 22 (or less commonly, age 25) were generally covered, and if the student was forced to drop out of school because of behavioral health issues, they might lose that coverage. The expansion significantly increased coverage in young adults by 5–8 percentage points (Barbaresco, Courtemanche, & Qi, 2015; McClellan, 2017).

Correspondingly, use of mental health but not substance use disorder treatment increased (McClellan, 2017; Saloner & Le Cook, 2014), and out-of-pocket treatment costs decreased (Ali, Chen, Mutter, Novak, & Mortensen, 2016). However, it is important to note that many young adults do not have access to this type of coverage because their parents do not have private employer-sponsored coverage themselves.

A second expansion under the ACA established state-based private insurance marketplaces (operated by states alone or in partnership with the federal government) providing new options for individually purchased and small employer plans beginning in 2014. Premiums paid by eligible individuals and families in the marketplace are subsidized for those with family incomes between 100 and 400% of the federal poverty line, with larger subsidies for those with lower incomes. These subsidies are tied to a cap on the percentage of income that a person has to pay for the second lowest cost "silver" (benchmark) plan offered in the area.

Silver plans are required to cover a minimum of 70%, on average, of medical costs (bronze plans (60%), gold (80%), platinum (90%)) with the rest paid out-of-pocket by individuals. Individuals and families under 250% of poverty are also eligible for "cost-sharing reduction" silver plans, where in addition to premium subsidies they also have more generous coverage with fewer out-of-pocket costs. These subsidies were coupled with a mandate that individuals must be covered by insurance or face a "shared responsibility" tax penalty.

This "carrot and stick approach" of combining subsidies on the one hand with mandates and tax penalties on the other hand was intended to minimize the amount of adverse selection faced by insurers and reduce premium increases. The ACA also contained a number of other provisions to both encourage private insurers and

consumers alike to participate in the marketplaces and to limit adverse selection. Particularly relevant for behavioral health, the ACA mandates that all plans offered in the marketplaces (as well as non-grandfathered individual and small group market plans offered outside of marketplaces) must contain coverage for ten essential health benefits (EHBs). Included among these EHBs are mental health and substance use disorder services.

The third expansion under the ACA gave states generous subsidies to provide Medicaid coverage to individuals with family income up to 138% of the federal poverty level beginning in 2014. Initially, the federal government covered 100% of the cost of newly eligible enrollees falling to 95% in 2017 and 90% in 2020 and beyond (Kaiser Family Foundation, 2018c, January 16). The Supreme Court ruled in 2012 that this Medicaid expansion was effectively optional for states, rather than mandatory for continued participation in the overall Medicaid program as originally enacted in the ACA. Subsequently, not all states adopted this expansion (18 in all as of January 2018) including large states such as Texas and Florida.

The ACA led an estimated 20 million previously uninsured Americans to gain coverage (Uberoi et al., 2016). This reduced the share of the uninsured to 11% of the non-elderly population in 2017, down from approximately 17% before the ACA was enacted (Fig. 1). Notably, after declining for many years, the share of Americans covered by private insurance coverage stabilized and then increased from 61% in 2010 to 65% of the non-elderly in 2017 (Fig. 1). This represents the combined effect of the dependent coverage expansions, individual mandates and Marketplace coverage, along with other new mandates and subsidies to employers to provide coverage. Public coverage too continued to increase in importance through the ACA Medicaid expansions (Fig. 2).

Parity

For decades, coverage for behavioral health services in private health insurance plans lagged behind other services with much higher co-pays and coinsurance (e.g., 50% vs 20%) and strict limits on the number of days, visits, or dollars covered in most plans (Barry et al., 2016; Beronio et al., 2014). The main argument advanced in favor of this discriminatory coverage was on economic efficiency grounds, because of the potential for moral hazard the RAND HIE study found. More likely, adverse selection was the driving force with insurers seeking to deter more expensive consumers with behavioral health problems from enrolling in their plans (Barry et al., 2016).

Proponents of parity in coverage advanced two main arguments. First, it is discriminatory to provide less generous coverage to those with behavioral health disorders, regardless of economic efficiency arguments. Second, parity was affordable in the context of managed care, as a number of studies strongly supported (Barry et al., 2016; Goldman et al., 2006; National Advisory Mental Health Council, 1998, 2000).

Mental health advocates successfully pushed almost every state to enact at least some legislation designed to strengthen mental health coverage in private health plans. However, most of these state mandates fell well short of parity. Even in states with fairly strong parity laws, parity failed to cover most people (Buchmueller, Cooper, Jacobson, & Zuvekas, 2007). Under the provisions of the 1974 Employment Retirement and Income Security Act (ERISA), firms that self-insure are exempt from state health insurance regulations including parity mandates. Consequently, strong parity laws covered only 20% of working Americans with health coverage (Buchmueller et al., 2007). In addition, most of these strong laws covered only severe or "biologically based" disorders and typically did not apply to drug and alcohol services.

The federal 2008 Mental Health Parity and Addiction Equity Act (MHPAEA) went far beyond these state parity mandates and the earlier 1996 federal law in at least four important ways. First, the MHPAEA eliminated differential co-payments and coinsurance, deductibles, and limits on number of visits and days of treatment for firms that offer behavioral health coverage beginning in 2010–2011.

Second, unlike the state mandates, it applies to all employers with 50 or more employees that offer behavioral health coverage. The subsequent 2010 ACA legislation further extended parity to all non-grandfathered small group and individual market plans by requiring both that behavioral health services be covered as an EHB and requiring these plans to also meet MHPAEA requirements.

Third, the MHPAEA is applied not only to services related to mental health conditions but also drug and alcohol disorders. Fourth, the federal administrative regulations implementing MHPAEA interpreted parity to apply not only to quantitative plan features like deductibles and out-of-pocket maximums but also to "non-quantitative treatment limits" (NQTLs) such as medical necessity requirements and prior authorization. For example, if a plan had no prior authorization requirements for office-based visits for a physical condition, the plan could not impose prior authorization requirements for behavioral health visits.

Congress also extended parity to the Medicare program. HR 6331 gradually reduced cost-sharing for mental health services from 50% to 20% between 2010 and 2014.

Parity does not seem to cost insurers much (Barry et al., 2016; Goldman et al., 2006), but what does it mean for consumers? The available evidence suggests that parity does indeed reduce the out-of-pocket burden of behavioral health services, albeit modestly (Barry et al., 2016; Ettner et al., 2016; Goldman et al., 2006). Parity's effects on access to behavioral health services are less certain with modest improvements at best (Barry & Busch, 2008; Barry et al., 2016; Busch et al., 2006; Ettner et al., 2016; Goldman et al., 2006; Pacula & Sturm, 2000). The majority of Americans receiving behavioral health services (especially for mental disorders such as depression, anxiety, and ADHD) get the bulk of them through their primary care doctors and/or pharmacies. For all intents and purposes, these services were already largely covered at parity before the MHPAEA and state parity mandates.

However, in theory all else being equal, parity should have increased access to those needing more intensive, specialty-based behavioral health services. But all

else is not equal. Parity creates incentives to tighten other aspects of the management of behavioral health services to offset cost increases in several ways (Barry et al., 2016; National Advisory Mental Health Council, 1998, 2000; Ridgely, Burnam, Barry, Goldman, & Hennessy, 2006).

First, NQTLs are by their nature more difficult to monitor and enforce than quantitative limits such as deductible, co-pays, and other cost-sharing features that are written down in policy booklets. Second, plans might use restrictive provider networks to limit access to behavioral health providers. Third, plans can use low reimbursement rates to providers to discourage participation in their plans.

Significance for Behavioral Health

Closer integration with the constantly changing and evolving insurance-based and insurance-financed systems of health care in the United States has profound implications for the way behavioral health-care services are financed, organized, and delivered. The costs of providing health care continue to rise increasing pressure for further reforms in health-care systems. The direction these reforms take will have significant impacts on Americans with behavioral health-care needs.

Less than a decade old, the ACA faces an uncertain future. Providing insurance coverage for millions of American, it significantly reduced the ranks of the uninsured, many with behavioral health needs (Garfield et al., 2011; Mark, Wier, Malone, Penne, & Cowell, 2015). Adults with behavioral health conditions tend to have lower incomes on average and less access to employer-sponsored coverage than other Americans (Garfield et al., 2011). Thus, the ACA Medicaid expansions and substantial premium and cost-sharing reduction subsidies in the marketplaces for lower-income Americans are especially important for them. However, many of the specific provisions of the ACA are unpopular (although some also enjoy fairly widespread support, such as the dependent coverage expansion) leading to calls for either further reform to ACA provisions at the federal level or outright appeal.

Short of full repeal, the future of the ACA Medicaid expansions is dependent mainly on the decisions of individual states. As of January 2018, 33 states (including the District of Columbia) have opted to expand Medicaid, with several adopting after the initial 2014 start year (Kaiser Family Foundation, 2018, January 16).

Debate continues in many of the remaining 18 states so more may opt to eventually expand. However, there have also been discussions in states that have already expanded about whether to drop the program. Some, like Kentucky, have also sought waivers from the federal government to reduce the scope of the expansion programs offered either in terms of populations served or services offered, including behavioral health services. The Centers for Medicare and Medicaid Services has signaled to states that they are interested in giving states more flexibility in the program.

Changes in how the ACA marketplaces operate may also have disproportionate effects on Americans with behavioral health needs. For example, the 2017 Tax

Reform eliminated the unpopular individual mandate for insurance coverage and shared responsibility tax penalties after 2019. It remains to be seen whether this actually leads to adverse selection, the main conceptual argument for why the mandate is necessary, and significantly higher premiums in the marketplaces. It is possible that, in practice, this "stick" side of the equation is less important than subsidies to consumers and insurers in maintaining a stable marketplace.

Other proposed changes to the marketplaces, besides outright repeal, include eliminating the EHB requirements altogether and thus allowing insurers to sell plans without coverage for behavioral health or other EHB services. These reduced coverage plans would likely be unattractive to consumers with behavioral needs but might be attractive to healthier individuals, potentially leading to adverse selection and higher costs in plans that meet behavioral health needs.

The Centers for Medicare and Medicaid Services (2018c) is already giving states more flexibility in selecting essential health benefit benchmark plans beginning in 2020. This might reduce behavioral health coverage and increase the potential for adverse selection if states select less generous plans as their benchmarks for coverage.

Even without further legislative action, concerns remain that provider networks are more limited and NQTLs greater for behavioral health services in marketplace plans compared to other private coverage (Stewart et al., 2018). In addition, there is concern that the flexibility given to states has led to uneven implementation of parity requirements in the marketplaces and considerable variation in the scope of mental health and especially addiction treatment services covered (Berry, Huskamp, Goldman, & Barry, 2015; Tran Smith et al., 2017).

Proposed reforms to public insurance and other health programs extend well beyond further ACA reform or outright repeal. As health-care costs continue to rise and the population ages, the Medicare program share of the federal budget continues to grow. Many argue this growth is unsustainable in the long run. The ACA itself contained a number of provisions to limit the growth of spending in Medicare, but many of these are unpopular especially with providers and insurers.

Market-based proposals include turning Medicare into a voucher system. Instead of providing a defined set of benefits universally to all Medicare beneficiaries, individuals would receive a fixed dollar amount to purchase private plans. Plans would compete against each other to most efficiently provide coverage to consumers (in many respects, like the ACA marketplace). Instead of an open-ended commitment on the government's part, federal contributions under many of these proposals would be limited to an inflation-indexed voucher value, regardless of how much health-care costs rise. If competition between plans drives substantial innovation leading to better coverage, greater health outcomes, and reduced costs, then consumers clearly gain. If not, Medicare beneficiaries may see their premiums increase and/or the value of their insurance coverage erode over time. Moreover, there are concerns about how higher-risk consumers, including those with behavioral health needs, would fare in markets where insurers might find them unattractive risks.

The share of the federal budget devoted to Medicaid also continues to rise. Reform proposals range from giving states more flexibility within the current

program (e.g., changing eligibility requirements, cutting benefits, and/or increasing enrollee cost-sharing) to converting Medicaid to a block grant program. Currently, Medicaid is jointly financed by the federal government and individual states with the federal government matching state outlays a minimum of 50% but often higher for traditional Medicaid programs and 95% for the Medicaid expansion populations (falling to 90% by 2020).

Under some block grant proposals, states would receive a fixed per capita allocation with constrained growth over time and allowed flexibility to run the Medicaid program as they wish. A per capita allocation would significantly shift resources away from higher spending states, many of whom provide extensive recovery and support services (sometimes termed "wrap around services") to those with behavioral health needs in addition to paying for health-care treatment. These potential reforms in turn are likely to place increasing pressure on public mental health systems at a time when those systems are already experiencing financial pressures.

Calls for reform extend as well to the Veterans Health Administration (VHA) health-care system, a significant provider of behavioral health treatment for millions of veterans (Tsai & Rosenheck, 2016). Proposals range from giving veterans more treatment options outside VA owned and operated facilities to converting the program from a wholly government owned and operated closed system to entirely a private insurance-based system, such as the TRICARE program for spouses and dependents of active duty military personnel.

Rising health-care costs and premiums continue to threaten the employment-based private health insurance system that provides health insurance coverage to most Americans under the age 65. In spite of its recent stabilization, many predict the employer-based insurance system will continue to slowly erode, increasing the pressure on the ACA marketplaces, state Medicaid budgets, and public mental health and addiction systems.

Market-based reform efforts to shore up the private health insurance system also have implications for the coverage of behavioral health services. The 2003 Medicare Modernization Act contained provisions to encourage the creation of *Health Savings Accounts (HSAs)*. HSAs allow individuals to pay for health-care services and save for future health expenses tax-free. However, these accounts can only be used by consumers who purchase high-deductible health plans (for individuals, a deductible of at least $1350 and families $2700 in 2018). This requirement means that individuals and families pay more for health care including behavioral health services directly out of their own pockets. Legislation has also encouraged employers to offer similar types of savings accounts in combination with high-deductible health plan coverage.

Not all of these high-deductible plans provide behavioral health benefits (Wildsmith, 2009, October). High-deductible plans grew slowly at first but have accelerated in recent years. In 2016, 85% of all employer provided coverage contained a deductible with an average individual deductible of $1696 and an average family deductible of $3069 (Agency for Healthcare Research and Quality, 2017, September).

Other proposed market-based reforms would supplant the employment-based system altogether with vouchers or tax credits for the purchase of individual health insurance plans. Lacking the pooling mechanism of a large employer, there are concerns that adverse selection would lead to problems accessing affordable and adequate insurance coverage for those with behavioral health needs if these individual markets are not well-designed.

Implications for Behavioral Health

The share of the nation's resources devoted to behavioral services, as measured by gross domestic product (GDP), has remained largely level since the 1970s (Frank & Glied, 2006; Substance Abuse and Mental Health Services Administration, 2016). This stands in marked contrast with the health-care system as a whole, which has grown from 7% to 18% of GDP since 1970 (Centers for Medicare and Medicaid Services, 2018, January 8). In one sense, this represents a phenomenal success (Druss, 2006; Frank & Glied, 2006). The continued movement away from hospitals to community settings has allowed millions more Americans to be drawn into behavioral health treatment, without increasing the share of the country's resources needed to finance these services.

However, the shift to insurance-financed treatment systems has also led to a relative shift in resources away from individuals with severe and persistent mental illness and addiction toward those with other mental disorders such as anxiety, depression, and attention-deficit/hyperactivity disorder (ADHD). Treatment has undoubtedly improved for most people with serious and persistent mental illness (SPMI), but the still fragmentary nature of financing creates substantial gaps, especially for addiction treatment (Druss, 2006; Frank & Glied, 2006; Mechanic, 2007). Plugging these gaps within ever changing and increasingly costly insurance-based systems of financing remains a challenge.

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