
RISK CONTRACTS IN MANAGED MENTAL HEALTH CARE

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Prologue: *The term risk contracting has become a familiar part of the vocabulary and the landscape of managed care. Risk contracting refers to an arrangement whereby the cost or claims risk for an insured population is borne by the entity that is designated to bear risk: a prepaid plan or, as is increasingly the case for mental health care, a specialty managed behavioral health care plan. Such plans have gained an enormous foothold in the United States over the past five years; one estimate is that virtually half of all Americans with insurance (including public plans) are enrolled in some type of “carve-out” managed behavioral health care plan. In addition to bearing claims risks, these plans are responsible for providing and managing mental health care services. In this paper economists Richard Frank, Tom McGuire, and Joe Newhouse make the case for risk contracting in behavioral health care, describing the economics of risk contracting and its implications for the quality and cost-effectiveness of a large fraction of the mental health care delivered in today’s system. Frank is a professor in the Department of Health Care Policy at Harvard University and is a research associate with the National Bureau of Economic Research. He holds a doctorate in economics from Boston University.*

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Abstract: Private employers and state Medicaid programs are increasingly writing risk contracts with managed behavioral health care companies to manage mental health and substance abuse benefits. This paper analyzes the case for a carve-out program and makes recommendations about the form of the payer-managed behavioral health care contract. Payers should consider using a “soft” capitation contract in which only some of the claims’ risk is transferred to the managed behavioral health care company. To avoid incentives to underserve seriously ill persons, we recommend that payers not allow choice by enrollees among risk contractors.

The most striking development in the financing and organization of mental health services in the past five years is the extremely rapid growth of specialty managed care organizations, referred to here as the managed behavioral health care industry. According to Monica Oss, 102 million Americans—virtually half of all persons with health insurance (including Medicare and Medicaid)—were enrolled in some form of managed behavioral health care program as of January 1994.¹ The managed behavioral health care industry is new, unconcentrated, and rapidly evolving; enrollment has grown 15 percent per year in the past two years. Of the companies that Oss surveyed (forty-three of which responded), the largest in terms of enrollment in 1994 (Value Behavioral Health) accounted for 16 percent of the total enrollment, and nineteen companies enrolled more than one million persons each. The ranking of largest firm in the industry has changed in each of the past three years.

The most common role for a managed behavioral health care company is to conduct utilization review and case management on behalf of a payer (37.0 million enrollees, or 37 percent of the total, are in this category). Managed behavioral health care companies also operate employee assistance programs (EAPs) and set up provider networks. The most rapidly growing activity of the industry, however, accounting in Oss’s survey for twenty to twenty-five million enrollees and more than half of the industry’s revenues, is “risk-based contracting.” In a risk contract, the managed behavioral health care company assumes some of the claims risk for a population and is responsible for providing and managing the services. In effect, the employer or insurer “contracts out” to a private vendor for mental health and substance abuse (MH/SA) benefits.

Risk contracts in MH/SA care are of interest for two main reasons. First, as a new and growing institutional feature in the MH/SA treatment area, risk contracts have a measurable impact on costs of, access to, and effectiveness of services. Second, risk contracting addresses two of the three stumbling blocks as identified by Bernard Arons and colleagues in their proposal to include a comprehensive MH/SA benefit in a national health insurance policy: (1) controlling its cost, and (2) setting a per person or capitation payment to a risk-bearing organization that does not create adverse incentives.² The “solutions” to these problems embodied in contracts that are

emerging between employer/payers and managed behavioral health care vendors deserve public policy attention. This paper is part of an initial effort to describe and analyze these contracts, and to draw implications for public policy in mental health and substance abuse.

Experience With Risk Contracting

Risk contracting and managed mental health care predate the specialty industry of managed behavioral health care. Prepaid group practices and health maintenance organizations (HMOs) have accepted risk contracts for MH/SA services, along with other health care, for some time. In general, these contracts are capitation contracts in which all of the cost or claims risk is borne by the prepaid group. As part of the Health Insurance Experiment conducted at RAND in the mid-1970s, Willard Manning and colleagues compared the cost and use of care by families assigned to a prepaid group practice, the Group Health Cooperative of Puget Sound, with that of families assigned to receive free care in the fee-for-service sector.³ Although enrollees with the two types of insurance sought care at the same rate, the fee-for-service population had mental health expenditure levels almost three times greater than those of the prepaid health plan enrollees (\$69.70 versus \$24.60 in 1977 dollars).⁴ Paula Diehr and colleagues compared the use of outpatient mental health care in a fee-for-service unmanaged benefit plan, a staff-model HMO, and an individual practice association (IPA) prepaid plan for Washington State employees, with results that were consistent with Manning's.⁵ However, because the Washington employees chose their plan and were not assigned to an insurance condition as in the Health Insurance Experiment, the Diehr findings may at least partly reflect differences in each study group's needs and not just an effect of the plan.

Prepaid groups can exert direct managerial authority over the supply of mental health services. Indeed, by controlling the number of therapist hours available, they can almost directly ration the volume of care provided. Managed behavioral health care companies, however, may have weaker incentives to reduce costs than prepaid groups do, and they typically have much less direct control over their contracted providers. Thus, the cost reductions from managed behavioral health care should be expected to be more modest than those from prepaid groups.⁶

The Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) experimented with an at-risk preferred provider organization (PPO) during the late 1980s in the Virginia Tidewater area. This region was known for its high mental health care costs. The demonstration showed significant savings (about 31 percent below expected costs) stemming largely from reduced inpatient care. In spite of the reported savings,

however, there clearly were areas of considerable waste in expenditures and difficulties in running the program effectively.⁷

The managed behavioral health care industry, particularly its risk contracting portion, is very new, and the research literature contains little study of the impact of risk contracting. Dominic Hodgkin's review noted the drawbacks of relying on "before-and-after" company reports in the trade press and identified only a single methodologically sound study, which showed cost savings in the range of 10–15 percent.⁸ Lags in research notwithstanding, the clear impression in both the employer and financial communities is that the potential savings associated with managed care in the MH/SA area are considerably larger than in overall health care.⁹ Major corporations such as DuPont, Dow, Federal Express, and Xerox have reported cost reductions of 30–50 percent over one or two years and have increased the flexibility of their mental health benefits by eliminating certain coverage limits.

The Massachusetts Medicaid program created a carve-out plan for 375,000 enrollees in January 1992 for MH/SA services (with the exception of state hospital care). In the first year of the program, Medicaid costs were 22 percent below projections based on past experience (taking into account the higher administrative costs of the managed benefit).¹⁰ The managed care vendor achieved savings by diverting hospital admissions to outpatient care (particularly for substance abuse care) and by negotiating substantial price reductions with hospitals. Access, as measured by users per enrollee, actually grew slightly in the program's first year.

In another example from Massachusetts, the Group Insurance Commission (GIC), which is responsible for providing health insurance for state employees and their dependents, contracted with a managed behavioral health care firm to provide a carve-out plan for employees in its indemnity and PPO options beginning 1 July 1993. Prior to the carve-out, the benefit was "managed" by the GIC's indemnity carrier, which applied a utilization review protocol to MH/SA benefits. The GIC has released information about costs in the year prior to and in the first year of the carve-out.¹¹ Total benefits paid per employee fell by 50 percent in the one-year period. The effect of the carve-out deserves careful study because of the simultaneous benefit change, institution of benefits both in and out of the network, and PPO and management features of the carve-out itself.

Both Massachusetts contracts featured risk sharing between the payer (Medicaid or the GIC) and the vendor, which we refer to here as a "soft" capitation contract. We discuss this feature of managed behavioral health care contracting below.

Case studies such as these must be viewed with suspicion. In a version of the "file-drawer" problem in research, only "good" experience tends to see

the light of day.¹² Furthermore, companies that hire a managed behavioral health care firm are likely to be those with the highest costs and most inefficiency in their existing plan and hence most likely to regress toward the mean in any event. We are attempting to gather more systematic information about the impact of risk contracts, to avoid these methodological pitfalls. In the meantime, as more experience accumulates, the success of the managed behavioral health care industry in capturing market share clearly indicates that it has a satisfied customer base. It is reasonable to conclude that cost savings result from risk contracting and managed behavioral health care, but the magnitude of those savings is highly uncertain, as are the determinants of those savings.

Some Economics Of Risk Contracting

Risk contracts for MH/SA services in the private sector commonly share three main features: (1) care management and financing organized as a “specialty carve-out;” (2) contracts relying typically on “soft” capitation payment systems with little use made of classification systems for the purpose of “risk-adjusting” premiums; and (3) competition for contracts, not competition for enrollees. In combination, these contract features are used to attract managed behavioral health care firms or “vendors” to bid on contracts, limit administrative costs of management, create cost containment incentives, limit incentives to undertreat, and curtail opportunities for risk selection. The discussion that follows examines how these contract features emerge from the economics of contracting for behavioral health care.

Carve-out programs. Managed care contracts introduce a fourth player into the relationship among the traditional three parties in health care. The payer delegates to the vendor responsibility for managing and often paying for mental health (and usually substance abuse) care. Interposition of the vendor between the payer and the patients and providers creates new relationships on both sides of the vendor. The vendor establishes and manages its relationships with the enrollees and the providers. This is essentially the work the vendor is paid for in the contract it has with the payer (which may be an employer, or a public or private insurer).

Of the three sets of tools for cost and quality management—insurance benefit design, provider payment policy, and utilization management—managed behavioral health care vendors rely primarily on the second and third, the basic insurance benefit usually being predetermined by the payer. Given the benefit to be managed, the vendor may have wide scope. It may decide on the providers eligible to provide services under the benefit (this could involve a network of providers with preferential coverage), the pay-

ment contract with providers, and utilization review and management consisting of prior authorization, ongoing review, and high-cost case management.¹³ Beyond this, the vendor may have the authority to develop sources of supply of special services (such as innovative residential or day services), extend benefit coverage (for example, by removing visit limits on outpatient care), or even, as Michael Freeman and Tom Trabin put it, “manage the health” of covered persons by educational and health promotional activities.¹⁴ Laura Altman and William Price describe Alcan Aluminum’s “full-service” carve-out featuring a set of preferred providers, utilization review standards, and health promotion activities coordinated through the company’s EAP.¹⁵ These broad sets of activities, not all of which appear in each case, reflect the diverse historical roots of managed behavioral health care in insurance, HMO, and EAP activities.¹⁶

Two main arguments can be made in support of the carve-out concept. The first asserts that a specialty organization is helpful in managing costs and the quality and appropriateness of mental health care.¹⁷ Carve-outs can be thought of as a distinct health plan for a specialty area such as mental health and substance abuse.¹⁸ Such programs typically have separate budgets, provider networks, and incentive arrangements that are distinct from the larger plan. The argument about specialization is reminiscent of, but distinct from, the position that mental illness is better treated by specialists.¹⁹ Specialization in treatment services does not, of course, imply a specialization in financing through a carve-out; an insurer or prepaid group practice could seek to channel patients to specialty providers without the carve-out mechanism. Indeed, there are many specialized services, such as neonatal intensive care units, within general health insurance. An integrated HMO such as the Harvard Community Health Plan uses specialized services through a mental health department but without a separate financing/organizational structure.

What seems to distinguish MH/SA services are important organizational problems in coordinating the activities of a specialty MH/SA program within a general health plan. A few industry attempts to accomplish such integration, outside of a limited group- or staff-model HMO, have met with both financial and operational difficulties.²⁰ A managed behavioral health care vendor may already have a provider network in place or may be experienced in selecting providers and negotiating provider contracts. The vendor may have experience in administering utilization review protocols and contending with disputes raised by clients and providers. In principle, an insurer or other payer could set up and manage an MH/SA component of a larger benefit plan, and of course many do. In a large number of cases at present, however, payers appear to have decided that it is easier to “buy” rather than “make” a managed network for MH/SA care, economies of

scale and scope giving the edge to specialized managed behavioral health care firms.²¹

Some existing cost advantages come from discounts given by suppliers, as in the Massachusetts Medicaid example. Whether these discounts will or can be extended as the industry expands is difficult to say. One would suspect that they cannot be if marginal cost is low relative to average cost, just as the airlines could not survive if they gave all payers the same discounts they give the federal government.

The second argument advanced in favor of a carve-out is that it “protects” or “sets aside” a designated level of funding for MH/SA services. Integrated health plans (responsible for all services including MH/SA services) may tend to compete for “good risks” in an insurance pool by making their plan unattractive to persons with expensive chronic illnesses, such as mental illness. In a managed care environment, funding for MH/SA services may be very heavily managed in part to deter persons who may use these services from joining the plan. The severely mentally ill, because of the high costs of their care and other undesirable qualities, are persons that health plans have attempted to avoid enrolling.²²

We refer here to the issue of adverse selection as it occurs in a managed care environment. Historically, a health plan (insurer) might compete for good risks by not offering coverage or offering only poor coverage for a chronic illness, such as a mental disorder. The traditional remedy is a mandated benefit that forces all competing insurers to provide at least a minimum level of coverage.²³ With managed care, however, mandating a plan to offer insurance coverage may not be sufficient to achieve the goals of access and utilization. Managed health plans can control access to services, which effectively reduces coverage.²⁴ This is especially the case for services aimed at treating persistent and severe forms of mental illness and substance abuse. Such services include extended hospital care, case management, and day hospital programs.

A specialty mental health carve-out program addresses the problem of underservice caused by selection bias, by allowing the payer to directly stipulate the incentives and financing of MH/SA services. Thus, a sub-budget is created that identifies a specific level of funding for MH/SA care. Although the payer may not be able to guarantee that the budgeted funds are spent on MH/SA services, it can include contract provisions (some of which are discussed below) that limit the vendor’s incentives to underspend on MH/SA services. We view specification of an MH/SA sub-budget as analogous to a benefit mandate in the indemnity insurance world. The carve-out contract sets a level of expenditure for mental health services that may constrain tendencies to undertreat persons with mental illness because of selection pressures in insurance markets.

Shared risk and reliance on prior utilization to set rates. The second feature of managed behavioral health care contracting noted above is the use of a soft capitation contract and the absence of risk adjusters in setting payment rates. The word *capitation* implies that a vendor accepts a payment per person per year in exchange for the responsibility of providing MH/SA services. In a pure capitation contract, all financial risk rests with the vendor. The vendor may be unwilling to make a low bid to an employer if it must bear all of the risk. Once a vendor has gained a contract, it has strong incentives to limit use and, if employee enrollment is an issue, has strong incentives not to enroll (or induce to reenroll) persons expected to be costly. Although we have not assembled a systematic set of data to describe the contracts in the managed behavioral health care industry, a soft capitation contract is a prevalent form. (Both the Massachusetts Medicaid and GIC contracts are examples of soft capitation contracts.)

A soft capitation contract is one in which the employer or payer shares the risk with the vendor. Suppose T represents the estimated (or target) claims cost per person per year in a carve-out contract. A pure capitation contract would pay the vendor T and leave all of the risk with the vendor. A soft capitation contract pays the vendor more if costs go above T and less if costs go below T , according to an agreed-upon formula. For example, a simple and representative soft capitation contract would constrain both profits and losses to the vendor in the following way: If claims costs fall below T , vendor profits may increase at a rate of 50 percent of the cost shortfall, up to a limit of 5 percent of the target amount. Similarly, if actual costs go above T , net payments to the vendor will fall at a rate of 50 percent of the cost overrun, up to a limit of 5 percent of the target. (This in effect would come out of the vendor's administrative fee.) The corridor over which a vendor can increase profits or experience losses is quite limited, and, in fact, in such an arrangement, most of the risk rests with the employer/payer.²⁵

How is the target amount T determined? One approach to establishing a fair rate is to use risk-adjusted premiums based on methods of classifying persons accurately according to their expected future costs. A good deal of research in the general health services field is being devoted to this topic, although little of the ongoing research focuses on mental health care. Moreover, although the existing systems of risk-adjusting premiums based in part on past use have been shown to improve prediction of expenditures over what is possible using only demographic indicators, their success has been quite limited.²⁶ It is notable that in our experience with private managed behavioral health care contracts, we know of no example in which a classification system is used to set T .

The pattern in the managed behavioral health care industry is to use

average past utilization for the population in question as a basis for setting *T*. A payer typically provides potential vendors with information on its past utilization under its existing benefit. Vendors then use actuarial methods and their own experience to forecast what they believe the MH/SA cost of the population (perhaps with a new benefit in terms of coverage and network provisions) will be under their management. Although demographic information is sometimes supplied in requests for proposals (RFPs), the crucial information is the prior utilization of the population, often supplied for two years, and broken down by inpatient and outpatient and by mental health and substance abuse.

To understand why such arrangements might emerge, it is necessary to consider the motives of the key players involved. Different payers will have different goals when entering into a contract for a carve-out MH/SA benefit. Although in general all payers can be assumed to value effective, accessible care and to welcome low costs, payers will differ in their relative emphasis on the benefits and costs of MH/SA spending. A private employer, for example, may view MH/SA spending as part of a compensation package used to attract workers. Other payers may view such spending as a necessary evil. Administrators of a Medicaid program may regard their real clientele as taxpayers and may seek only to provide an acceptable level of services at the lowest cost in state general funds. The political process of federal health reform debate led Uwe Reinhardt to conclude that the American public, if not agreeing on a specific direction of reform, at last settled on the answer—"yes"—as to whether we are comfortable with a two-tier (or three-tier) medical system.²⁷ Reinhardt predicts that while the upper classes (in the first tier) enjoy a high-quality, "open-ended, free-choice" medical system, and the employed middle class enrolls in prospectively budgeted plans (the second tier), the poor (in the bottom or third tier) will face "severe limits" on physical capacity and technology. For our purposes, we note that the payers who run these systems will manifest different values in the cost/benefit trade-off. A private employer with a white-collar professional workforce, for example, will see the role of an MH/SA carve-out differently than will a state mental health authority contracting for MH/SA services for an indigent population.

Take the perspective of the employer as a point of departure, and make the assumption that the employer regards itself to be responsible for a fixed population of workers and their dependents and is interested in providing a compensation package that maximizes the value to workers for a given level of cost to the employer. (Tax incentives may distort the package toward spending on fringe benefits, but given a level of fringe spending, the employer will want to use these funds to maximize the value to its workers.) An implication is that the employer would like to achieve a given level of

benefits to workers paying as little in “profit” to a vendor over and above the benefit cost as possible. The vendor can be assumed to have relatively simple, business-oriented motives, such as profit and growth, with no special interest in the welfare of the covered population or in their mental health per se.

In comparison to a pure capitation contract, in which all of the risk rests with the vendor, a soft capitation contract presents the employer/payer with several advantages. First, if the vendor is risk-averse, inducing a vendor to accept a pure capitation contract may require in effect a large “risk premium” in the form of a high target amount. The natural year-to-year variance in MH/SA costs alone imposes significant risk on a vendor if the vendor is small, or if year-to-year variance is correlated across contracts. By keeping most of the risk, the employer may elicit more aggressive bids on the target by vendors.

Second, limiting vendor profits means that any savings from reduced utilization benefit the employer/payer. Certain employers subject to public scrutiny (such as the Massachusetts GIC) may find this provision especially attractive because it minimizes the risk of an embarrassing disclosure of high profits paid out to a private-sector firm to accept a state contract. A limit on profit potential typically will come at the cost of some incentive to the vendor to minimize cost, but as the next reason states, this may not be a problem, at least for some range of incentives.

Third, the employer must delegate decisions to the vendor and accept the fact that, in the course of managing the benefit, the managed behavioral health care company may not make the same set of decisions the payer would have made in the same circumstances. For example, a managed behavioral health care vendor regularly decides which services are worth paying for. Once a vendor has won a contract, the employer cedes decision-making authority about the administration of the benefit to the vendor. Monitoring the activities of vendors is difficult and done only with a substantial time lag. Information about the claims cost in the first year of the contract is usually unavailable until approximately midway through the second contract year. Thus, in practice, a vendor will typically be managing a benefit for nearly two years before an employer has systematic information about one of the basic elements of a vendor’s performance, including use and cost. Increasingly, vendor contracts have explicit stipulations about “performance” indicators such as phone answering and referral practices, but these indicators, while perhaps quite important to enrollees, only constitute part of what an employer expects of a vendor in terms of performance. By using soft capitation, the employer can attempt to align the vendor’s incentives to its own trade-offs between costs and benefits to workers and their families.

Competition for the contract, not for enrollees. The typical MH/SA carve-out contractor is selected by means of a competitive procurement process. During such a process, potential contractors are identified and invited to bid. Detailed proposals are sought from qualified vendors. Proposals are reviewed and are commonly supplemented by information obtained from site visits to vendors. Limiting the use of market mechanisms to competition for contracts means that potential vendors must make price and quality proposals based on managing the MH/SA care for an entire insured population. Hence, the proposals will be less likely to reflect the ability to select risks.

Introduction of market forces is often proposed as a means of encouraging efficiency by health plans. Competition among health plans can take two forms: competition for a contract and competition for enrollees. In managed behavioral health care the most prevalent form of competition is competition for a contract. An employer would seek a single vendor to assume responsibility for the MH/SA benefit. This can be contrasted with competition for enrollees, whereby an employer might have contracts with several prepaid health plans (the employer does not need to select just one in a competitive process), and the health plans then compete to attract enrollees. Both forms of competition were part of the Clinton administration's recent health care reform plan, but the central economic incentive to maintain quality of care in a "managed competition" environment is competition among plans for enrollees.

The experience in managed MH/SA care is quite different. Payers such as large employers and state governments often adopt measures that actually reduce competition for enrollees while at the same time increasing competition for contracts. This design feature undercuts the incentives for competing health plans to use their MH/SA provisions to obtain a favorable risk selection of enrollees. A primary concern related to contract design is associated with the incentives for health plans to avoid mentally ill persons by limiting access to services that are of value to persons with severe MH/SA problems. We have argued that such concerns serve, in large part, to justify a number of the features that are unique to MH/SA risk contracts. The use of carve-out vendors, and competition for contracts instead of enrollees in particular, is aimed at limiting incentives to under-treat and to select "good" risks. Capitated payments to general health plans strengthen the traditional incentives to minimize services for treatment of severe mental disorders. A small fraction of enrollees require very expensive mental health care. Capitated health plans have an incentive to limit use of all services. They have an especially strong incentive to avoid persons who are expensive to treat.

Addressing the selection problem in a competition-for-enrollee environ-

ment entails aligning expected premium revenues and treatment costs for various types of persons. If revenues and the costs of treating different groups of persons can be closely aligned by a classification system, for example, there is no economic incentive to avoid a group of potential enrollees. However, as we noted above, there is little immediate prospect that a classification system is ready to meet this challenge.

Furthermore, costs themselves are only one side of a benevolent employer's objective of maximizing value in relation to cost. The value that employees receive from management of their care is by nature difficult to monitor. Increasing efforts are being made to obtain information on quality of care and patients' satisfaction with services. Rewards and penalties in these areas are now found in MH/SA carve-out contracts.

Conclusions

The failure of private markets to offer insurance coverage for MH/SA care that provides broad financial protection, controls costs, and results in high-quality care in the context of a market-oriented health care system has been a persistent problem. At the heart of the issue are the traditional reasons for failure of insurance markets: moral hazard and biased selection. These factors have created particular difficulties for insurance coverage of MH/SA services. Managed behavioral health care is clearly changing the terms of the debate over the design of insurance coverage for MH/SA care. Major corporate health plans and a growing number of state Medicaid programs have adopted managed behavioral health care carve-out programs. The use of such arrangements represents an application of a new combination of insurance design tools to address the problems of moral hazard and biased selection. Moral hazard issues are addressed via the use of "at-risk" contracts and the development of tightly controlled provider networks in conjunction with application of aggressive utilization review techniques.

Biased selection represents a more difficult challenge for health plan design in the context of market-oriented health insurance. Managed behavioral health care arrangements make use of a set of strategies for constraining risk selection and the accompanying incentives to undertreat persons with severe MH/SA problems. These include (1) the carve-out mode of organizing managed care for MH/SA problems; (2) the use of soft capitation payment arrangements; and (3) focusing the use of market forces on competition for contracts. This set of mechanisms represents major innovations in the design of insurance coverage for MH/SA care. Our analysis of these mechanisms suggests that they have considerable potential for improving market outcomes in the area of coverage for MH/SA care.

Our observations on existing arrangements point to the complex and sometimes restrictive set of arrangements that must be put into place to attenuate the moral hazard and biased selection threats to coverage for MH/SA care. It is particularly notable that to successfully harness market forces for efficient production of managed care services, it may be necessary to limit managed behavioral health care plan choices for consumers.

The economics of the managed behavioral health care industry involves more detail than we are able to include in this paper. One key issue is the appropriate power of the incentive to contain costs, or how soft the capitation rate should be. Of course, reducing incentives to undertreat as in a soft capitation plan also reduces incentives to contain costs. Therefore, it is critical to find a payment system that mixes the prospective and retrospective components in such a manner as to create incentives to economize while limiting profits stemming from undertreatment. This is a fundamental strategic decision for both public and private policymakers, and is analogous to the right mix of cost sharing for consumers.

Performance standards are becoming more prevalent in the managed behavioral health care industry, and vendors are sometimes asked to put a portion of their fee “at risk” if standards—in terms of phone answering, consumer satisfaction, network development, data accuracy, claims payment, and others—are not met. Contract renewal features also should be considered in a complete study of the incentives in managed behavioral health care. Target amounts may be adjusted in subsequent years based on early experience, moderating incentives to vendors to contain costs.

Dozens of variations of the general forms of plan designs discussed above continue to be available in the marketplace. It now remains to be seen what specific combinations of plan features will prove to be most beneficial to payers and to the greater polity. Systematic assessment of the impacts of managed behavioral health care plan features will provide government, private payers, and the industry with a means of learning and refining the next generation of managed behavioral health care products.

The authors gratefully acknowledge financial support from The Robert Wood Johnson Foundation (Grant no. 23498), the Department of Veterans Affairs, and the National Institute of Mental Health (Grant no. K05-MH01263).

NOTES

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13. A.R. Rodriguez, "Directions in Contracting for Psychiatric Services Managed Care Firms," *The Psychiatric Hospital* 21, no. 4 (1990): 165–170.
 14. M.A. Freeman and T. Trabin, "Managed Behavioral Healthcare: History, Models, Key Issues, and Future Course" (Unpublished paper, prepared for the Center for Mental Health Services, 5 October 1994).
 15. L. Altman and W. Price, "Alcan Aluminum: Development of a Mental Health 'Carve-Out,'" in *Managed Mental Health Care*, ed. W. Goldman and S. Feldman, New Directions for Mental Health Services Monograph 59 (San Francisco: Jossey Bass, Fall 1993), 55–65.
 16. Freeman and Trabin, "Managed Behavioral Healthcare."
 17. In terms of the history of mental health policy, this argument is about the "moral hazard" problem—that MH/SA services tend to be "overused" when a population has comprehensive insurance coverage. Managed care carve-outs have been asserted to be an efficient way to manage costs and quality without imposing financial risk on beneficiaries through copayments, deductibles, and other limits. See R.G. Frank, H.H. Goldman, and T.G. McGuire, "A Model Mental Health Benefit in Private Health Insurance," *Health Affairs* (Fall 1992): 98–117.
 18. Other services, such as disability determination and long-term care, can be dealt with similarly.
 19. See, for example, K.B. Wells et al., "Detection of Depressive Disorder for Patients Receiving Prepaid or Fee-for-Service Care: Results from the Medical Outcomes Study," *Journal of the American Medical Association* 262, no. 23 (1989): 3298–3302.
 20. This point has been made in several interviews with persons within the managed behavioral health care industry.
 21. A payer may find it useful to hire a vendor even if the vendor has no special skills because the vendor can do things the payer cannot do in another sense. A state Medicaid program, for example, may be unable for political reasons to exclude certain hospitals from a provider network. A private managed behavioral health care vendor may be better insulated from the pressures that provider groups can bring to bear. A government payer also may find it difficult to secure adequate funds for the administrative costs associated with starting and maintaining a mental health PPO with utilization review and provider contracts. Contracts with managed behavioral health care vendors include relatively high administrative costs.
 22. M. Schlesinger and D. Mechanic, "Challenges for Managed Competition from Chronic Illness," *Health Affairs* (Supplement 1993): 123–137.
 23. T.G. McGuire, *Financing Psychotherapy* (Cambridge, Mass.: Ballinger, 1981).
 24. Schlesinger and Mechanic, "Challenges for Managed Competition from Chronic Illness."
 25. This contract bears a striking resemblance to the way psychiatric facilities are paid under Medicare's Tax Equity and Fiscal Responsibility Act (TEFRA) system. See J. Cromwell et al., "A Modified TEFRA System for Medicare Discharges from Psychiatric Hospitals," in *Economics and Mental Health*, ed. R.G. Frank and W.G. Manning (Baltimore, Md.: The Johns Hopkins University Press, 1992). Joseph Newhouse calls "soft" capitation "partial" capitation. J.P. Newhouse, "Patients at Risk: Health Reform and Risk Adjustment," *Health Affairs* (Spring I 1994): 132–146.
 26. Newhouse, "Patients at Risk: Reform and Risk Adjustment."
 27. U.E. Reinhardt, "Post-Mortem on Health Care," *Princeton Alumni Weekly* (22 February 1995): 55–56; and U.E. Reinhardt, "Turning Our Gaze from Bread and Circus Games," *Health Affairs* (Spring 1995): 33–36.

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