MENTAL HEALTH AND
SUBSTANCE ABUSE
COVERAGE UNDER
HEALTH REFORM


Prologue: Over time, the delivery and financing of mental health and substance abuse care have evolved into a complex patchwork of services. The result has been gaping holes in the public delivery system for the poor and private insurance that runs out too quickly for many who could benefit from care. To remedy this situation, the reform of mental health and substance abuse care received a high profile on the President’s Task Force on Health Care Reform, due in large part to the advocacy of the vice-president’s wife, Tipper Gore. She served as co-chair of the task force’s Working Group on Mental Health along with Bernard Arons, acting director of the Center for Mental Health Services, Department of Health and Human Services (HHS), and lead author of this paper. Indeed, all of the authors here were deeply involved with the working group and the vision of moving the nation’s mental health system toward full integration with its acute health care system by 2001 under the president’s health reform plan. Richard Frank, an economist, served on the mental health working group and is a professor in the Department of Health Policy and Management, The Johns Hopkins School of Hygiene and Public Health. Howard Goldman also served on the working group and is professor of psychiatry and director of mental health policy studies at the University of Maryland. He holds degrees in medicine and public health and a doctorate in social welfare research. Economist Thomas McGuire is a professor at Boston University and served as a consultant to the working group and to the National Institute of Mental Health. Sharman Stephens is a health policy analyst in the Office of the HHS Assistant Secretary for Planning and Evaluation. She holds degrees in nursing and public health and was also a member of the mental health working group.
Abstract: President Clinton’s health care reform proposal articulates a complete vision for the mental health and substance abuse care system that includes a place for those traditionally served by both the public and the private sectors. Mental health and substance abuse services are to be fully integrated into health alliances under the president’s proposal. If this is to occur, we must come to grips with both the history and the insurance-related problems of financing mental health/substance abuse care: (1) the ability of health plans to manage the benefit so as to alter patterns of use; (2) a payment system for health plans that addresses biased selection; and (3) preservation of the existing public investment while accommodating in a fair manner differences in funding across the fifty states.

For the first time in modern U.S. history, a federal administration has articulated a complete vision for the mental health and substance abuse care system. President Bill Clinton proposes to move forward in two steps. The first step, to be taken in conjunction with other parts of his health reform proposal, is to provide basic coverage for mental health/substance abuse care for all Americans. The second step, scheduled for the year 2001, is to fully integrate mental health/substance abuse services into the mainstream of health care by covering such care at parity with other health services and by eliminating the need for a separate acute care (noncustodial) public system to serve the indigent.

The organization and financing of mental health and substance abuse care need reform. We pay too much for care that in many cases is poorly matched to patients’ needs. At the same time, the complexity of the mental health/substance abuse system makes it difficult to change the system quickly. The president’s proposal for a basic mental health benefit will require far more adjustment by the mental health system than by the general health care system. Although reform is essential, the unfortunate fact is that comprehensive reform now could lead to chaos. The proposed basic benefit is not the ideal, but by pulling all Americans into the same financing system for at least basic mental health/substance abuse care for the first time, some improvements in coverage can be made immediately, and the mental health/substance abuse care system can be put on the path to comprehensive reform envisioned in seven years.

Americans spent roughly $225 per person on mental health and substance abuse treatment in 1990, approximately 10 percent of all personal health expenditures. This average encompasses great differences among population groups in spending per person and in sources of funding. The typical person covered through employer-based health insurance incurred $100–$120 of mental health expenses in 1990, whereas the typical uninsured individual (a significant fraction of whom suffer from severe mental illness) incurred expenses of approximately $400 over the same period. Those who are privately insured pay for care through insurance and through out-of-pocket expenditures. The uninsured receive support from a patchwork of federal and state programs. In aggregate, private insurance and
out-of-pocket payments account for less than 40 percent of all expenditures in this sector. The federal government, through Medicare, Medicaid, the Department of Veterans Affairs (VA) health system, and block grants to states, accounts for about 22 percent of expenditures. Spending by state and local governments accounts for the remaining 38 percent. The confusing constellation of private insurance coverage, public spending programs, and public facilities distorts incentives in the mental health/substance abuse treatment system. For thirty years major payers have been consumed with designing policies that meet their core responsibilities while shifting as many costs onto other payers as possible. Students of mental health/substance abuse policy agree almost unanimously that the unclear and often patently irrational division of responsibilities among the many actors in the system leads to excess capacity, uncoordinated service use, access problems, and excess costs.

The most common failures of the treatment system are an overemphasis on expensive institutional care (60 to 65 percent of all expenditures are for inpatient care); inadequate protection against catastrophic consequences of illness (typical private insurance coverage limits inpatient coverage to thirty days per year); and the existence of a two-class system of care in which the severely ill and the economically disadvantaged are treated in public hospitals and dispensaries, while those with private insurance are treated in clinicians’ offices and private inpatient facilities. At the same time, employers are disturbed by the costs of mental health and substance abuse benefits under private insurance, and states are hard pressed to meet existing budgetary commitments.

The president’s proposal articulates a vision for the year 2001 in which mental health/substance abuse care is integrated with the proposed health alliances. In this paper we describe the basis for the fully integrated plan and discuss some major factors that must be considered in moving toward the 2001 proposal. We also offer some thoughts on how to assess whether the plan is proceeding on the right track during the transition.

**The Case For Full Integration**

The mental health/substance abuse treatment system involves a complex, uncoordinated mix of federal, state, local, and private funds to purchase services from general hospitals, specialty institutions (public and private), clinics, and office-based clinicians. Research suggests that mental health/substance abuse treatment technologies and delivery systems are effective and have a solid scientific base. The literature also shows that treatment works best when delivered in a coordinated way. Design of a financing system should complement, not interfere with, clinical science.
Public and private insurance for mental health/substance abuse care generally have proceeded along separate tracks. Fragmentation in the supply of services reflects fragmentation in financing. Recommendations for transforming the public mental health/substance abuse treatment system have emphasized integration of services and financing. While these proposals stress integration, they take for granted that the public and private mental health/substance abuse treatment systems will remain separate.

The fundamental flaw of most private insurance coverage for mental health/substance abuse care is that it fails to protect individuals and their families against catastrophic costs of serious illness. Insurance coverage for mental health/substance abuse services typically is structured so that it offers the most comprehensive coverage for relatively low levels of financial risk (twenty psychotherapy visits and thirty inpatient days per year), whereas the services needed to treat the most severe illnesses (extended hospital stays, day treatment, residential and rehabilitative services) usually are not covered. Once an individual or a family exceeds the limits, the family must pay for care out of its own funds or must rely on the public system. The proposed initial benefit does not fully resolve these problems. A public mental health/substance abuse care sector has made it possible and acceptable for private health insurance to avoid the role of providing catastrophic insurance coverage for these disorders. To fully succeed, reform of private insurance must remove limits and expand the scope of services covered at a reasonable cost. Creative use of utilization management and reimbursement systems (prospective payment, capitation, prospective budgets, and performance contracts) opens up opportunities for eventually providing deeper coverage.

In the president’s year 2001 proposal a fully integrated insurance plan under a budget would provide for acute and most rehabilitative care; allow flexibility to improve matches of patients to treatments; encourage cost-effective alternatives to hospitalization; and provide catastrophic protection. Moreover, the creative energies of administrators would go toward organizing effective and efficient systems of care, not clever cost shifting.

The president’s proposal recognizes that the mental health/substance abuse treatment field raises a unique set of challenges for cost containment. Clearly, it is not feasible to provide full coverage of all such treatment for all persons without substantial changes in the organization and financing of care.

Complexity Of Implementation

If the case for full integration of mental health/substance abuse treatment into overall health reform is so compelling, what steps need to be taken to
implement an integrated plan? As indicated above, it is now infeasible to provide parity coverage for mental health/substance abuse services under existing organizational and financial arrangements. Parity calls for dramatic expansion of private insurance coverage accompanied by equally dramatic changes in the methods by which we control costs and pay for care. The ability to implement full integration under managed competition with a budget rests on three building blocks: (1) the ability to make use of public funding currently devoted to mental health/substance abuse care; (2) the broad-scale implementation of good management of the costs and quality of mental health/substance abuse services; and (3) the ability to address issues of biased selection in health plans.12

Public financing. Fully integrating mental health/substance abuse treatment into health plans means that states must shift control and responsibility for billions of dollars in services to “private” organizations. In 1990 state and local governments spent $20.1 billion (or 38 percent of all expenditures) on mental health/substance abuse care.13 Enormous diversity exists among states and localities, however. Based on 1990 data from the National Association of State Mental Health Program Directors, for example, New York State potentially would have $118 per person to contribute toward the health plan premium, whereas Iowa would have only $17 per person to contribute to the same premium.14 Now assume that the 1990 premium for the fully integrated plan was $330 per covered person. This means that the difference between the state contribution and $330 would have to be paid by a combination of private contributions, federal subsidies, and new state and local revenues. The impact on citizens and state government in New York and Iowa would be quite different for the same reform.

Diversity raises major issues of fairness for businesses and taxpayers and challenges the historical role of the federal government in mental health/substance abuse treatment. Note that the federal government (excluding Medicare) spent $5.3 billion on matching funds for Medicaid plus an additional $4.2 billion on the VA system, federal block grants to states, and miscellaneous other programs. Thus, there is relatively little in the way of existing federal support to equalize differences in the burden for states that result from, say, the ability of their populations to generate tax revenues. The policy problem is to find a mechanism for fairly distributing the costs of the fully integrated system when the usual method of doing so, federal subsidies, is of only limited use.

Application of managed care. Integrating a comprehensive mental health/substance abuse benefit into health reform is predicated on the successful management of use and costs of such care. Over the past ten years there has emerged a body of evidence showing that payment methods and managed care techniques can control use at least as effectively as do more
traditional methods such as copayments and coverage limits. The advantage of management and payment approaches to cost control is that they do not depend on limitation of coverage.\textsuperscript{15}

The literature on payment systems in mental health/substance abuse care is quite extensive and shows clearly that per case prospective payment, prospectively set budgets, and capitation payments all lead to substantial reductions in use and costs of mental health/substance abuse treatment.\textsuperscript{16} It is important to note that the impact has been especially strong for inpatient psychiatric care, the sector with a high proportion of existing expenditures. Substantial reductions in these expenses open up the possibility of expanding coverage without major increases in total outlays.

While the literature on managed care in mental health/substance abuse treatment is considerably more limited, experience in the public and private sectors holds out hope for successful management of this type of care. Evaluations of the experiences of the Aetna Life Insurance Company’s Focused Psychiatric Review Program and of the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) with establishing a network of mental health providers illustrate the potential of managed mental health care.\textsuperscript{17} The Aetna program uses preadmission certification, concurrent review, case management, and retrospective review. Evaluators estimated net savings from the program (including administrative costs) to be $35 per enrollee. CHAMPUS experimented with a contracting and managed care system in the Norfolk, Virginia, metropolitan area during the mid-1980s. The contract established a network of providers, implemented a case management system, and negotiated rates with providers. This is quite consistent with the way in which we envision administration of the mental health/substance abuse treatment program within fee-for-service health plans. The evaluation of this demonstration found that the contracting approach reduced spending by about 30 percent.

Even though managed mental health/substance abuse care appears to have much potential based on demonstrations and initial experience, little of this has been done on a large scale or studied in formal research programs. Thus there is uncertainty regarding how rapidly such systems could be put into place nationwide. Because the ability to manage mental health/substance abuse services is central to full integration, the president’s plan calls for time to phase in management capabilities. If market behavior can be taken as a guide, it is encouraging to point out the rapid expansion of national managed mental health/substance abuse treatment firms.

**Risk selection and monitoring.** Managed competition under a budget creates strong incentives for favorable risk selection of enrollees in a health plan. The president’s plan calls for several measures to counter these incentives. They include (1) risk adjustment to premiums paid to health plans,
monitoring of utilization and enrollment patterns, and (3) encouraging use of treatment standards. The potential hazards associated with risk selection are especially onerous for individuals with mental health/substance abuse problems.\textsuperscript{18}

There are a number of features of mental health/substance abuse care that make favorable selection an attractive strategy for health plans to pursue. Some mental health/substance abuse problems are chronic and persistent and are therefore more predictable than other medical conditions, both to the individual and to the potential health plan.\textsuperscript{19} Severe mental illnesses and substance abuse disorders are very costly to treat. Also, use of general medical services is higher among persons with mental health/substance abuse problems.

A fundamental premise of managed competition is that consumer choice over plans that are paid a fair premium will enforce acceptable quality levels. But the ability of managed competition to maintain quality of care for persons with severe mental health/substance abuse problems is called sharply into question when (1) the mental health/substance abuse risk group can be identified by health plans (usually after enrollment) and by providers; (2) there is a potential financial payoff to health plans that do not enroll (or maintain) persons at risk of mental health/substance abuse problems; and (3) the mentally ill and many substance abusers function poorly in the “consumer role” of fully understanding the benefits available and aggressively pursuing entitlements.

One solution to the biased selection problem is to develop a sophisticated risk adjustment system. A second is to partially relate revenues to costs through the premium payment system. The specific details of each approach are critically important. A poor ability to risk-adjust can undermine the entire intent of establishing a risk adjustment system to be administered by the health alliances. The mental health/substance abuse content of all existing risk adjustment systems is minimal. Moreover, there are no well-developed patient classification systems available for risk rating mental health/substance abuse care plans. Much work needs to be done in this area before a workable system can be proposed for implementation.

A health plan can be eligible for extra payments from a purchasing alliance over and above the premium for certain categories of costs, such as costs of mental health/substance abuse treatment exceeding a certain threshold. This would represent a form of risk sharing between the purchasing alliance and the health plan.\textsuperscript{20} The advantage of risk sharing is that one need not rely primarily on a classification system to adjust premium payments. Nevertheless, there has been very little experience with such arrangements. Managed mental health/substance abuse care vendors generally have risk-sharing contracts with the employers and insurers who retain
their services. Because there are major uncertainties related to biased selection and a very vulnerable set of clients (those with severe mental health/substance abuse problems), a great deal of work is needed to develop a policy for constraining the consequences related to biased selection, in addition to prohibitions on enrollment practices related to health status. The phase-in period allows for time to test such policies.

Proposed Benefit And Transition

Exhibit 1 contains a summary of the entire mental health/substance abuse benefit prior to full integration in 2001. The plan improves existing insurance for many people in some important ways. There are no lifetime limits and no exclusions due to preexisting conditions. A wide range of treatment modalities are covered for mental health/substance abuse care. Lower-cost-sharing plans (such as closed-panel health maintenance organizations [HMOs] and other plans with careful management and limited provider choice) impose very little demand-side cost sharing up to the benefit limits. In plans with less strict management and more choice of providers, copayments are used to restrain demand for psychotherapy and to discourage some residential and intensive nonresidential care.

Under this benefit it will be necessary for the public sector to retain some of its acute care capacity along with its traditional extended long-term care services. The public-sector safety net will need to continue to provide protection to individuals and families at risk of catastrophic expenditures.

As we argued above, it is not feasible for an insurance system to subsume immediately all of the historical state functions in caring for the most seriously ill. This leaves the challenge of starting with a limited benefit and putting in place an implementation strategy that leads to a nondiscriminatory approach to mental health/substance abuse coverage.

A number of issues need consideration in this strategy. For example, what needs to be done to assure incentives to health plans to move toward focusing on managing care rather than simply relying on the proposed benefit’s care limitations and demand-side cost sharing? How can health plans be encouraged to work collaboratively with the state mental health and substance abuse systems to use the structuring of the inpatient and residential benefit with thirty annual days and the flexibility for thirty additional days under some conditions to meet most acute care needs? What needs to be done to avoid plans using this flexibility to impose a de facto thirty-day benefit as a means to discourage enrollment by persons at risk for mental health/substance abuse problems? What can states in their role do to assure the former outcome rather than the latter?

A second set of issues involves the likely response of the insurance
<table>
<thead>
<tr>
<th>Service</th>
<th>Coverage</th>
<th>Copayment in lower-cost-sharing plan or in-network combination plan</th>
<th>Cost sharing in higher-cost-sharing plan or out-of-network combination plan</th>
</tr>
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<tbody>
<tr>
<td>Inpatient hospital and residential services</td>
<td>Prior to 1 January 2001, treatment is subject to an aggregate annual limit of 30 days. A maximum of 30 additional days shall be covered for a person if a health professional designated by the health plan determines in advance that (1) the person poses a threat to his or her own life or the life of another person; or (2) the person's medical condition requires inpatient treatment in a hospital or psychiatric hospital in order to initiate, change, or adjust pharmacological or somatic therapy</td>
<td>No copayment</td>
<td>1-day deductible, 20% coinsurance, payments count toward out-of-pocket limit</td>
</tr>
<tr>
<td>Intensive nonresidential treatment</td>
<td>Prior to 1 January 2001, covered days are through a trade for inpatient days at the rate of two intensive nonresidential days for one inpatient day, until the 30-day inpatient limit is reached</td>
<td>No copayment</td>
<td>1-day deductible, 20% coinsurance; for mental illness, payment on first 60 days done as trade counts toward out-of-pocket limit For additional 60 days, 50% coinsurance, not counted toward out-of-pocket limit</td>
</tr>
<tr>
<td>Prescription drugs</td>
<td>Medical necessity</td>
<td>$5 per prescription, payments count toward out-of-pocket limit</td>
<td>$250 deductible, 20% coinsurance, payments count toward out-of-pocket limit</td>
</tr>
<tr>
<td>Screening and assessment, diagnosis, medical management, crisis services, somatic treatments</td>
<td>Medical necessity</td>
<td>$10 per visit, not counted toward out-of-pocket limit</td>
<td>20% coinsurance, not counted toward out-of-pocket limit</td>
</tr>
<tr>
<td>Psychotherapy and collateral services</td>
<td>Prior to 1 January 2001, 30 visits per year, additional visits may be covered at the discretion of the plan to prevent hospitalization or facilitate earlier discharge Inpatient benefits are reduced 1 day for each 4 additional visits</td>
<td>$25 per visit, not counted toward out-of-pocket limit</td>
<td>50% coinsurance, not counted toward out-of-pocket limit</td>
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### Exhibit 1
Mental Health and Substance Abuse Benefit Plan in Health Security Act (cont.)

<table>
<thead>
<tr>
<th>Service</th>
<th>Coverage</th>
<th>Copayment in lower-cost-sharing plan or in-network combination plan</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Outpatient substance abuse counseling and relapse prevention</td>
<td>Substance abuse counseling and relapse prevention will be covered based on an exchange of 1 inpatient day for 4 visits Prior to 1 January 2001, after a person receives residential or intensive nonresidential treatment, 30 visits in group therapy</td>
<td>$10 per visit, not counted toward out-of-pocket limit</td>
<td>20% coinsurance, not counted toward out-of-pocket limit</td>
</tr>
<tr>
<td>Case management</td>
<td>Defined as assisting persons “in gaining access to needed medical, social, educational, and other services” Available if a health professional designated by the health plan determines that the person should receive such services</td>
<td>No copayment</td>
<td>No insurance</td>
</tr>
</tbody>
</table>

Source: Health Security Act.

*Includes general and psychiatric hospitals, residential treatment centers, residential detoxification centers, crisis residential programs, mental health residential treatment programs, therapeutic family or group treatment homes, community residential treatment, and recovery centers for substance abuse.

*Includes partial hospitalization, day treatment, psychiatric rehabilitation, home-based services, ambulatory detoxification, and behavioral aide services.

Market’s provision of supplemental coverage for mental health and substance abuse care beyond the guaranteed benefit package. Almost half of Americans now have private insurance coverage for more than thirty days. What is the likely response of cost-conscious employers and insurers to providing supplemental coverage? How will the marketplace interpret the proposed benefit?

Furthermore, the guaranteed benefit is sure to have an impact on the public sector. The number of people who would be forced to shift to the public sector may change in unpredictable ways. Based on data from the Center for Mental Health Services, we estimate that 54 percent of persons treated in state hospitals use fewer than thirty days during a year. Unless the type of care they received changed when marketed in a private plan (which is likely but hard to foresee), these persons would not be treated in public facilities. On the other hand, as discussed above, there is the potential that after reform some plans could limit their coverage to thirty days. Data from MEDSTAT Systems for 1989 indicate that roughly 0.3 percent of a population with relatively generous mental health/substance abuse coverage
used more than thirty days of inpatient mental health/substance abuse care in a year. Figured on the large base of millions of privately insured persons in 1990, care for these persons may now move to state facilities. Depending upon the response of a supplemental insurance market during the transition, states may be put in a relatively new role. Instead of providing all care for the uninsured poor, states would be asked to provide care beyond the guaranteed coverage for the poor and the middle class.

The need to address these transition issues should not obscure the fact that the president’s proposal represents a clear step away from the status quo in mental health/substance abuse coverage and a step toward the year 2001 vision. The benefit proposed by the Clinton administration is significant for three reasons. First, because coverage is expanded to all citizens, much acute mental health/substance abuse care that traditionally has rested in the public sector now will be integrated into private health plans. Moreover, because the range of services covered is expanded beyond the existing level, the benefit offers greater catastrophic coverage than does today’s typical health plan. Second, services specifically designed to serve persons with severe mental health/substance abuse problems outside of institutions are central elements of the coverage. Specifically, medical management, partial hospital care, psychiatric rehabilitation, residential care, home-based care, and case management are all covered. These services typically have been available only through some Medicaid plans and via specialized public mental health treatment programs. Inclusion of these services provides alternatives to expensive inpatient care and represents a major effort to integrate health and mental health services in the context of health plans.

Finally, the dollars to be allocated to health plans for mental health/substance abuse care are significant. Yet the coverage is not so broad as to allow states to responsibly remove the safety net of the public mental health/substance abuse system. In fact, over the short run national expenditures for mental health/substance abuse care are likely to be higher than they will be under the year 2001 plan. This is because of the substantial amount of duplication that will be present in the public: and private treatment systems. This appears to be an inevitable cost of transition.

How Will We Know We Are On The Right Path?

Reform of mental health and substance abuse coverage will remain incomplete until there is a full integration of mental health/substance abuse services with general medical care, giving all Americans, regardless of the nature of their illness, insurance coverage for appropriate services. Our state-run system of care for persons with serious mental illness is partly a
continuation of historical patterns and partly a reflection of the failure of private insurance markets to cover chronic illness whose treatment is sensitive to financial incentives. Vast differences in public funding across the fifty states must be accommodated fairly. A payment system for health plans that addresses biased selection must be developed. Finally, the ability of health plans to manage the benefit so as to alter traditional use patterns of mental health/substance abuse services needs to be demonstrated.

Recognizing that states have vastly different systems for paying for and providing mental health/substance abuse services to their populations, a fair and economical way must be found to transfer responsibility for financing these services to the private sector. The goals of fairness across states and minimizing federal budget costs are likely to conflict here. Policy research must begin immediately to identify alternatives for putting already enlisted state mental health/substance abuse treatment resources within the fiscal framework of health reform.

Setting a capitation payment for all, including persons with serious mental illness, and making these payments to health plans does not eliminate the problems of including coverage for mental illness and substance abuse in insurance plans. Biased selection will be a serious problem. A methodology for setting fair premiums for persons with mental illness/substance abuse disorders needs to be developed. Consideration needs to be given to a separate carve-out premium. Some risk sharing between the health alliance and health plans likely will be necessary to include coverage of high-cost treatments for mental health/substance abuse disorders.

Cost and the responsiveness of the mental health/substance abuse treatment system to financial incentives also will remain a problem. The maturation of managed care will help, but how much remains unclear. Intelligent design of payment systems and integration of management with service delivery must also be explored. How successfully these concerns are addressed should be measurable through observed reductions in inpatient use. The combination of the availability of community-based services and the development of high-quality case management systems should result in reduced inpatient use.

Experience with the administration of the proposed mental health/substance abuse benefit in the president’s plan will be telling in terms of how well new private organizations are able to manage the cost/quality trade-off in mental health and substance abuse treatment. Some failures are inevitable. Keeping a state-funded safety net in place will reduce the social costs of these failures and will give us time to make necessary adjustments prior to full integration. We believe that none of these problems constitutes an insurmountable obstacle. Work should begin now on achieving full integration in the very few years before 2001.
The views expressed in this page are those of the authors and do not represent the positions of any of their organizations.


2. Revenues from charitable contributions and foundations have been omitted, which is why the private spending total is less than 40 percent. The 38 percent figure for state and local government spending includes state and local contributions to Medicaid. Data for these estimates are from the Federal Employees Health Benefits Program (FEHBP) Blue Cross plan and MEDSTAT Systems.


9. Medicaid represents an important boundary problem, with recipients drawing on both an insurance-like entitlement and direct public services for mental health/substance abuse care. Traditionally, under Medicaid the federal government has set rules, which state governments have seen as opportunities to shift costs of care to the federal budget, often disturbing the treatment process.


14. Iowa uses local government contributions to raise its per capita spending. Still, the interstate differences are very large. Moreover, state/local financial arrangements further complicate the picture.

15. Frank et al., “A Model Mental Health Benefit in Private Health Insurance.”


20. One form of risk sharing between purchasing alliances and health plans was recently proposed by Schlesinger and Mechanic, “Challenges for Managed Competition from Chronic Illness.”


23. Health Security Act, Title 1, Subtitle B, 47-51.