

Policy Intervention

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This paper addresses market failure due to externalities, as well as information asymmetries and public policy problems that need to be solved to ensure high quality care for affective disorders. We delineate the problems in parity legislation, managed care, as well as Medicare and Medicaid that need to be addressed to reduce the burden of illness affective disorders. A research agenda is developed for formulating and implementing public policy.

KEY WORDS: affective disorder; market failure; public policy.

BACKGROUND

This paper, the third in our series on intervention research for affective disorders, considers priorities for research on policy interventions. One of the main themes in our working group's review of barriers to reducing the burden of affective disorders is that current practices, policy priorities, and incentives do not promote appropriate care for affective disorders. One way to cast this problem is as a mismatch between who benefits from treatment and who bears the costs of treatment. When one decision maker (perhaps a patient or a clinician) is in a position to accurately weigh the full costs and benefits of a treatment decision, an appropriate (efficient) decision is likely to be made. When this comprehensive perspective is not taken by a key decision maker, public policy intervention may be justified to correct any resulting misallocations.

In the policy literature, the term "externality" is used to characterize situations in which a decision-maker does not bear all the consequences of a decision. It is generally expected that if someone sees the

benefits but not the costs, for example, they may be too likely to proceed with an action. This is the source of one of the major efficiency problems in health care: insured patients see the benefits of treatments but do not directly bear the costs. One way to view this incentive problem is as an "externality" flowing from a patient/clinician pair to the members of the insurance pool. Conversely, when an individual sees the costs but not the benefits, they may be too unlikely to take an action. Immunization decisions are the classic illustration of this from public health. The benefits from one person's decision to be immunized fall predominantly on the full population.

In the case of affective disorders, benefits and costs of treatment decisions are widely dispersed, but research has not yet defined the full extent of these externalities. The lack of precise information limits appropriate policy formulation. For example, consumers with affective disorders and their families account for most pain and suffering due to affective disorders but most healthcare costs in the short run fall on payers and providers. Primary care providers have a direct concern about the costs they face, but less concern about costs by other parts of the health care system. When specialized treatment for mental health care is "carved out" of the general medical benefit, primary care providers may be affected by the incentive to "externalize" the cost of treatment and refer patients too readily to the specialty organization. Health plans and providers may fail to adopt measures to reduce the burden of affective disorders if they believe the

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potential benefits of intervention (including prevention) will accrue in the too-distant future (e.g., as a result of a stronger focus on short-term profitability or survival in the market); and they may calculate cost effectiveness of treatment from an organizational rather than a societal perspective (Gold et al., 1996). Thus, health plans may value interventions that reduce drug costs or inpatient care costs but ignore interventions that reduce burden on educational, employment, and other “nonhealth” domains. These issues become further aggravated when health plans face high turnover in membership, thereby diminishing interest in long-term investments in health that would primarily benefit others in the future.

Sometimes, the cause of poor decisions is simply that pertinent information is not available to the people who need it. The public and even patients often have a poor understanding of the illness and treatments (for example, because of fear or stigma) and have little information on the quality of care provided by particular providers. Providers and practices may have more information on quality of care provided. Without good information on who provides what quality of care, patients cannot select among providers on these characteristics, and so good quality may be under-rewarded in a market. Thus there is an important role for public policy in correcting the incentive structure and information exchange to achieve the changes in preventive behaviors and access to and use of societal treatments, to achieve societal reduction in burden for affective disorder.

These examples of incentive and information problems are certainly not exhaustive of the kind of issues that come up in organizing treatment for depression; they are illustrative of the nature of the two major types of policy problems. Policy research analyzes the incentive structure, such as level and type of externalities or informational problems, and evaluates potential policy initiatives in terms of their ability to achieve the target goals and taking into account the possibility of unanticipated consequences. Effective public policy shapes behavior of different stakeholders (purchasing and supply decisions), to result in the (socially) desired goal, with minimal unexpected (adverse) consequences.

WHAT IS KNOWN

The U.S. healthcare market is complex, with different policy issues and policy initiatives directed at

different stakeholders. Some current major policy research themes are discussed below.

Employment-Based Health Insurance

The most distinctive feature of the U.S. health care system is its reliance on private employers to set the terms of health insurance coverage for approximately 60% of the population. Although there are many regulations affecting employer health insurance choices, employers can choose to offer no insurance at all, can choose generous or tightly managed plans, can choose to offer one or many plans, and so on. Employers have an interest in a productive and satisfied workforce (imposed on them by market forces), but at the same time, employers' interests are not the same as a social or public interest in costs and benefits of treatment of illness. One can conceptualize employers' decisions about health plans as potentially imposing “externalities” on consumers, families, and other stakeholders. The following issues have been important in economic and policy research within the employer-sponsored private health care market.

Affective Disorders and Labor Outcomes

Labor economic studies suggest that acute illness may temporarily prevent people from working or may reduce productivity, but these transient effects can lead to reduced raises and promotion opportunities (Miller & Kelman, 1992). Long-term morbidity may induce people to change jobs, find ways to accommodate on the current job, or leave the workforce (Bound et al., 1999; Chirikos, 1993; Currie & Madrihan, 1998). Disability associated with depression could also affect the employment of other family members (Mitchell & Anderson, 1989; Ruhm, 1992). Some studies suggest that mental illness, including depression, reduces labor force participation and/or productivity (Dooley, Prause, & Ham-Rowbottom, 2000; Mitchell & Anderson, 1989; Kessler & Frank, 1997; Ruhm, 1992). Marcotte, Wilcox-Gok, and Redmon (2000) found depression to be associated with lower employment rates among women but not among men; but Ettner, Frank, and Kessler (1997) found that psychiatric disorders reduced employment rates among both women and men. Few studies have explored effects of treatment or service delivery interventions on employment or other labor participation outcomes. Mintz et al. (1992) found effects of depression treatments on work-related interpersonal functioning, using meta-analysis of clinical trials. Smaller

individual studies found positive, negative, or no significant effects of depression treatments on employment (Agosti, Stewart, & Quitkin, 1991; Berndt et al., 1998; Giller et al., 1988; Heiligenstein et al., 1995). Nevertheless, one recent randomized trial of dissemination of quality improvement intervention for depression in primary care found positive effects on employment status for patients in intervention practices compared to usual care (Wells et al., 2000).

An implication of this set of studies is that successful treatment of affective disorders will benefit a worker's current employer, but some of the benefits will also go beyond the short-term labor contract. An employer can be reasonably expected to take account of the benefits it is likely to receive from improved treatment for affective disorders, but cannot be relied upon to respond to the full range of labor market and other social benefits.

Parity Legislation and Mandates

Concerns regarding the potential for misuse/overuse of mental health services, stigma, adverse selection, and price responsiveness have contributed to limitations for coverage of mental health services. Parity laws at state and federal levels as well as a recent Federal Employees Health Benefit Plan (FEHBP) Presidential mandate have addressed coverage differences between mental and physical health. However, most laws have been weak and without regulation or accountability. When health plans can "manage" care, parity of defined benefits may be relatively meaningless (Burnam & Escarce, 1999). Studies of implementation of mandates or parity laws have been limited, but generally suggest weak implementation and little or no effect on services utilization (Gitterman et al., 2001; Gitterman, Strum, & Scheffler, 2001; Scheffler & Gitterman, 2000; Scheffler et al., 2000; Scheffler, 1999; Scheffler & Ivey, 1998; Pacula & Sturm, 2000; Sturm, 1997; Sturm, Goldman, & McCulloch, 1998; Sturm & Sherbourne, 2001); an evaluation of parity for FEHP is in the field. Some recent parity laws have tougher mandates, such as California's legislation requiring parity of coverage for mental health and substance abuse services, including for most childhood psychiatric disorders. Limitations of state parity laws include exclusion of larger self-insured employers and typically do not mandate inclusion of at least some mental health coverage; so employers concerned about costs can simply drop mental health care coverage.

A research and policy agenda concerning parity from the 1970s does not fit the current state of affairs. It is clear that parity in demand-side benefits has become less expensive with managed care, and that demand response to increased coverage is no longer a major stumbling block when resource use is constrained more effectively in health plans by other means (McGuire, 2000). As Frank and McGuire (1998) have put it, parity in cost sharing for consumers is necessary but not sufficient to ensure equal access to mental and physical health care. Furthermore, parity applies to medical treatment costs and misses many of the services necessary to care effectively for persons with severe affective disorders (Frank, Goldman, & McGuire, 2002). Identifying and studying the other rationing devices affecting care in managed care is a critical research topic.

Cost Containment Strategies

There are complex management systems in health care (often referred to under the general heading of managed care) using techniques such as capitation, utilization review, precertification, limited provider panels, physician profiling, etc. These are poorly understood and have been difficult to characterize in a changing environment. Much of the information is on generosity of fee-for-service plans not under management or on Health Maintenance Organizations compared to fee-for-service care (Frank & McGuire, 1986; Keeler, Manning, & Wells, 1988; Manning et al., 1984; Wells et al., 1989); these studies predate the recent rapid rise and diversification of managed care strategies, even within fee-for-service plans. Early studies of prepaid care suggested that it was associated in some practices with lower rates of detection of depression, higher rates of use of inappropriate minor tranquilizers for long-term medication management, and in psychiatric practices, worse functioning outcomes, relative to fee-for-service care (Rogers et al., 1993; Wells et al., 1996). In addition, a staff-model Health Maintenance Organizations lead to similar or higher rates of access to mental health care, but lower intensity of services and lower costs, relative to comparable fee-for-service coverage (Manning et al., 1987). Similar findings about effects of prepaid relative to fee-for-service care apply to patients with unipolar depression (Sturm et al., 1994).

Recent studies suggest that practice management policies such as existence of closed panels and salary construction may affect care. For example, Meredith et al. (2001) found that clinician performance-based

salary bonuses affect continuity of the doctor–patient relationship for patients with depression. One recent national study suggests that more intensively managed general health insurance plans have lower rates of unmet need and higher rates of active treatment compared to unmanaged or partially managed private plans (Wells et al., 2001).

Currently, over 80% of private mental health care is delivered under carve-out, managed specialty mental health care. The limited literature on carve-outs suggests, relative to prior integrated coverage, they may raise access to mental health care but lower costs (Goldman, McCulloch, & Sturm, 1998; Ma & McGuire, 1996). Impact on quality indicators for affective disorder is largely unstudied. In one paper, Merrick (1998) found that rates of outpatient treatment following discharge from a hospital for treatment of depression improved after a carve-out.

One recent study found that geographic penetration of Health Maintenance Organizations (HMOs), one market indicator of greater regional management of services, was associated with higher rates of use of general medical providers, and through this mechanism, indirectly with higher rates of access to specialty mental health care. This effect was independent of individual insurance coverage. However, literature on the influence of insurance market characteristics on access to mental health are limited.

Social Programs and Financial Externalities

Expanded Coverage for the Uninsured

Rates of uninsurance are increasing among persons with psychiatric disorders, including affective disorders (Sturm & Wells, 2000). The uninsured with psychiatric disorder may have higher rates of unmet need relative to privately insured or Medicaid populations (Norquist & Wells, 1991; Wells et al., 2001). Further, among persons with need for mental health or substance abuse care, the uninsured have lower rates of active treatment compared to insured populations (Wells et al., 2001). Yet among persons with affective disorder, type of insurance coverage per se, that is, uninsured versus public or private insurance, may not be related to access to guideline-concordant care (Young et al., 2001). Lack of insurance coverage is strongly related in children to higher levels of unmet need for mental health care (Kataoka, Zhang, & Wells, in review). Policies to provide coverage to uninsured persons vary greatly across the states but have

tended to target children and families; states have considered expanding coverage to parents of uninsured children. While S-CHIP and related programs represent a significant step in offering coverage to uninsured children, coverage and implementation is highly variable across states (Szilagyi et al., 2000; U.S. Department of Health and Human Services, 2000).

Medicaid and Public Services

In the public sector, basic access to some mental health services may be equivalent to or better on average than in the private sector (Sturm & Wells, 2000). However, the need for care is much higher in the public sector and the adequacy of services—especially for more severely ill (bipolar disorder)—is unknown (Mechanic, 1998; Mechanic & McAlpine, 1999). Strong concerns have been raised about the impact of heavily managed care and capitated plans for public insurance of the severely mentally ill, which may include some persons with affective disorder (Mechanic, 1998). Empirical studies primarily suggest similar outcomes and variable cost differences for capitated and fee-for-service Medicaid coverage, and some evidence of worse outcomes for the sickest patients with schizophrenia (Lurie et al., 1998; Manning et al., 1999). The impact of managed care programs within Medicaid may vary by state and by region within state.

Medicaid represents the largest group of persons for which a capitation formula is used to pay health plans. Medicare is the next largest group—private employers negotiate, eschewing formal risk adjustment mechanisms (Keenan et al., in press). Medicaid is thus the policy area where the incentives from capitation are most important in promoting access and quality of care in managed care plans. Using Medicaid data from one state, Frank, Glazer, and McGuire (2000) found that incentives to “undersupply” care for mental illness were larger than for other areas of care, a result later confirmed by Gomes (2001) using hospital data from Medicaid in another state. Our present knowledge is based on data from a handful of states, however.

Medicare

Medicare coverage for prescription medications and the enrollment of seniors in managed care plans are topics of current political debate. Substantial issues for research include the impact on health and functional status of elderly with affective disorders in

the absence of coverage for prescription medications. Studies need to assess the impact of the exit of managed care providers from the Medicare marketplace and the resulting impact on access as well as the quality of services available, especially in the outpatient sector. Cao and McGuire (2002) find evidence that mental health services are among the most tightly rationed in Medicare managed care organizations.

SSA Disability

Affective disorders are one of the main reasons for being on SSA disability rolls. Despite this, most persons with disabilities do not receive adequate health/mental health treatment (Johnson & McFarland, 1996; Unützer et al., 2000; Wells et al., 1993, 1996; Wells, Schoenbaum, Unützer, Lagomasino, & Rubenstein, Young et al., 2001). Little research has been conducted on this population.

Health Insurance Market Limitations

Contract Limitations

Health insurance in private markets has a fundamental limitation imposed by the nature of short-term contracts. Any insurer, either an insurer offering comprehensive care or one bearing risk for only part of the spectrum of illnesses, has a strong incentive to shift costs outside of its responsibility either by (a) postponing costs or (b) moving costs outside its boundary or (c) taking actions to discourage membership by high cost individuals. Major payers, such as HCFA, have attempted to implement monitoring of either quality distortion to cause selection (e.g., barriers to access or lower satisfaction with care); it has been more difficult to monitor cost shifting to public safety net providers.

Consolidation of Carve-Out Behavioral Health Management

Mental health care in the private sector is predominantly provided through a handful of consolidated, national specialty management companies, or so-called mental health “carve-outs.” For affective disorders, understanding the impact of carve-out care is especially important because the majority of persons with bipolar disorder in the private sector are probably managed through such companies. In addition, carve-outs may pose challenges for mental health care delivered in primary care. When mental health

benefits are carved out, primary care providers may feel few incentives to provide mental health services. This is especially problematic in primary care, where most people with depression are treated and only about 25% of depressed people receive appropriate treatment. Despite the proliferation of carve-out services, almost no scientifically rigorous research has been conducted to assess the quality or continuity of care, or the impacts on costs and access. What, if any, impact does the lack of integration have on the societal burden of affective disorders? Existing studies suggest that implementation of carve-outs may increase access and lower costs, relative to prior fee-for-service contracts (Goldman et al., 1998; Ma & McGuire, 1996) but impacts on quality of care are unknown.

Integration of Mental Health and Substance Abuse Services and Benefits

Despite the common co-occurrence of affective disorders and substance abuse, service delivery and insurance coverage are often separated or unrealistically disconnected; this also applies to separation in the target of state and federal parity laws, and particularly substance abuse benefits are commonly not included in such laws. However, implications of coupling or uncoupling of mental health and substance benefits for persons with affective disorder are not known.

Policies that Promote Fairness

There is a long tradition in public finance/public choice to consider equity along with efficiency criteria in social welfare policy. Most of the approaches are heavy on the formalisms, and not so useful with respect to particular policy questions. Medicaid, Medicare, and S-CHIP represent federal and state/federal partnership policies to at least partially address equity for vulnerable populations. However, little research has been conducted on how the various types of policies discussed above affect the distribution of either treatment opportunities or burden of affective disorders across income, gender, or racial ethnic groups.

Concern for disparities in treatment among members of racial/ethnic groups spans all of health care services. The mechanisms generating disparities, and the policies likely to fix them, are not well understood. Given the range of findings in the research literature, it seems likely that causes are multiple and diverse, and are further likely to differ according

to the importance of certain disease and treatment characteristics (Institute of Medicine, 2002). Personal information and communication are probably much more important, for example, in the diagnosis and treatment of depression than for many other illnesses (Balsa et al., 2002). The manifestation of disparities in depression treatment is therefore worthy of special study. The policies that may be effective in the case of an illness like depression may be different than for many other health problems. The concept of fairness may be particularly difficult to address for comparisons of coverage relying on managed care strategies, where the basis for allocation decisions may not be explicit.

GAPS IN KNOWLEDGE

- There has not been an active research agenda on evaluating how policy initiatives (such as programs to provide insurance to the uninsured) impact burden of affective disorders. This is a major gap in the field. For example, we have little knowledge of how even major federal programs such as Medicaid or Medicare affect care for affective disorders. Evaluations of effects of changes in Medicare policies on quality of care for depressed elderly have been conducted (Wells et al., 1993) but are dated and limited to inpatient care. Similar, evaluations of impact of prepaid versus fee-for-service care are dated (Wells et al., 1996). Recent evaluations of carve-outs have not had the data to evaluate quality or outcomes of care for affective disorder. One promising approach for estimating outcomes or quality more broadly under alternative financing strategies is the approach of Frank (Frank et al., 1999) to apply expert ratings of likely effectiveness to patterns of care as identified in claims data.
- Little is known about how services delivery interventions for affective disorder affect productivity or other labor force outcomes, and the value of these outcomes to consumers, families, and employers or purchasers.
- We do not know how to formulate policy to promote equitable distribution of either process or outcomes of care to vulnerable populations with affective disorders.
- Evaluation of emerging new policy initiatives is limited by the short time lag to policy implementation, given long time lags for research funding, as well as limited options for control groups and collecting adequate baseline data.
- Data sources available for policy analyses, such as claims data, often have severe limitations for research purposes, such as missing data, poorly validated measures, or changes in format across different periods of data collection.
- Advancing research on the impact of policy initiatives on burden of affective disorders will require integrated research with policy researchers and clinicians; but clinicians particularly often have limited formal training in policy and policy research.
- We know little about the impact of programs to cover uninsured children and families on care and outcomes for persons with affective disorder.
- We know little about whether improving treatment for affective disorders can reduce SSA disability enrollment or reduce maintenance of disability.
- We know little about how information from monitoring of quality or outcomes of care for affective disorders at the level of health care systems can affect consumer knowledge and demand for high quality services.

RESEARCH RECOMMENDATIONS

Research is needed to guide policymakers in formulating and implementing public policies to reduce the burden of affective disorders. Such research includes understanding the market for care for affective disorders from the perspective of diverse stakeholders, understanding the impacts of ongoing public policy on multiple outcomes for persons with affective disorders, and using information on the distribution of burden of illness across stakeholders, and on the marginal effects of interventions on that distribution, to propose and then evaluate new public policy.

Next steps include identifying the determinants of consumer demand and purchaser decisions about insurance coverage for affective disorders; identifying sources of market failure for such insurance and options for correcting such failures. Research is also needed to determine how variation in benefit design and cost-containment or management strategies affect access, quality of care, and the burden of illness for affective disorders, within the public and private sectors.

Research is needed on how parity legislation, mental health mandates, and programs for the

uninsured, such as Healthy Families and S-CHIP, affect individual and societal burden of affective disorders. Research is needed on how variation in state funding of Medicaid and other public programs, and coordination of mental health and substance abuse benefits, affect the burden of affective disorders—especially for persons with more severe disorders, including bipolar disorder. Such research will require new funding mechanisms that permit timely, substantive, and rigorous evaluation of public policies.

Research should also be conducted to formulate, pilot test, and evaluate innovative public policies that fill major gaps in coverage for or increase consumer demand for effective interventions for affective disorders. Examples include providing coverage for care management or prescription medications to the elderly, or increasing the generosity of reimbursement for use of evidence-based psychotherapies for affective disorders.

Research is needed on whether either current public policies such as S-CHIP or alternative public policies affect equity or distribution of the burden of affective disorders across diverse populations.

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