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The Bottom Line on Behavioral Health Care Costs

by Steve Melek

What are the real costs of behavioral health care today? To answer this question most payers look at their behavioral health carve-out spending and claim that costs have remained level over the past decade or perhaps even decreased. This is a result of the excellent job that managed behavioral health care companies have done in managing specialty behavioral health care over this period. However, by only examining carve-out spending, payers are overlooking significant mental health expenditures from treatment by Primary Care Physicians (PCPs). Under our current health care system, PCP involvement in behavioral health care delivery may lead to less efficient and effective treatment and is an increasing cost that many plans haven't yet begun to address.

If one only considers the carve-out piece when analyzing mental health care spending, costs have indeed remained fairly level. However, this approach disregards the portion of mental health care that comes from primary care physicians. PCPs are the sole deliverers of about 50 percent of mental health care, and also prescribe two-thirds or more of all psychopharmacological drugs. These costs are not included in mental health carve-out expenditures. Considering these facts, it becomes obvious that mental health costs are increasing. The distribution of private insurance mental health expenditures over the last decade shows a steady decrease in facility and professional costs and an increase in prescription drug costs. Together these result in a net increase of approximately 7 percent annually. These costs exclude the additional costs of treatment by PCPs for physical symptoms associated with mental health conditions.

The high contribution of PCP costs to total mental health expenditures reflects a lack of public understanding about behavioral health care and is a serious obstacle to delivering it effectively. In many cases, failure to recognize a mental condition leads individuals to seek treatment from their PCP. This is in large part due to most people's inability to differentiate between the symptoms of a mental health condition and a physical illness. Mental illness often manifests itself through physical conditions such as headache, backache, nausea, fatigue, or even chest pain. In fact, there is a positive correlation between the number of physical symptoms and the prevalence of mood and anxiety disorders. As the number of physical symptoms increases, the more likely a mood or anxiety disorder exists.

In fact, only a small percentage of the population with mental disorders or emotional distress will ever see a mental health professional and many will remain untreated. Because a patient generally spends only 12 to 16 minutes with their PCP, little time is available to adequately assess multiple and/or vague symptoms, make a diagnosis, and develop a treatment plan. Physicians may be able to treat symptoms in such an environment. However, the underlying mental condition often remains undiagnosed. In these cases the individual may experience temporary symptomatic relief, but

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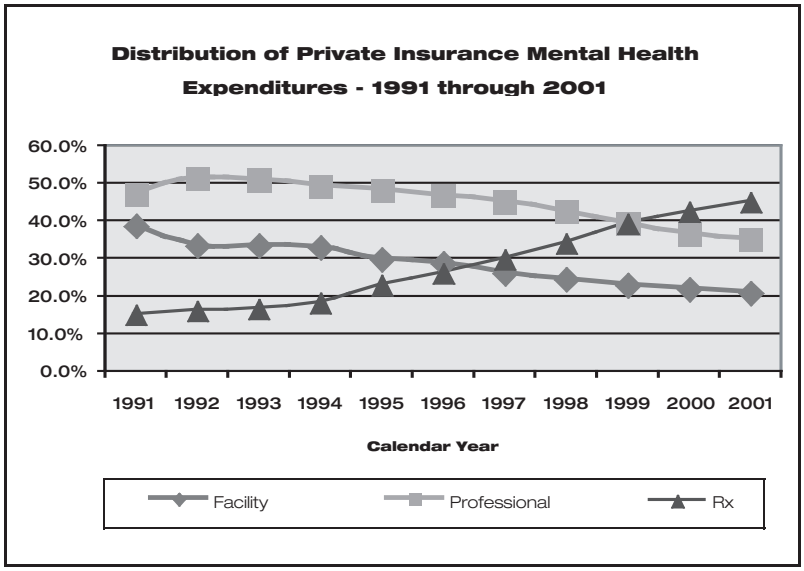
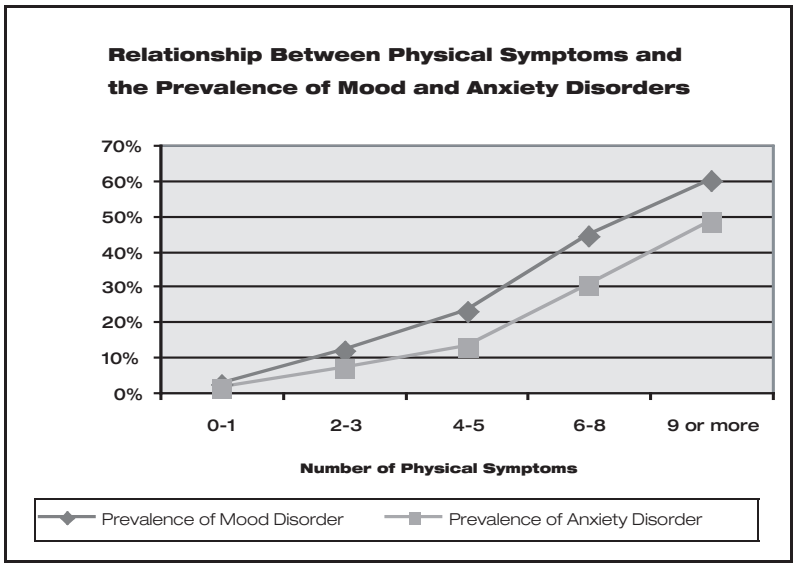


Source: National Estimates for Mental Health and Substance Abuse Treatment, 1991-2001, USDHHS, SAMHSA, March 2004



Source: Kronke et.al. Physical Symptoms in Primary Care; Predictors of Psychiatric Disorders and Functional Impairment, Archives of Family Medicine. 1994, 774-779.

will often return with different or more persistent problems. When referrals to behavioral health care specialists are made, 50-90 percent of patients are noncompliant and never see the specialist. Ultimately, PCP utilization becomes higher than necessary and the patient is inadequately treated.

When the PCP does diagnose a mental condition, they may prescribe a psychopharmacologic agent. Sometimes patients will even request such medication on their own. However, these medications require close monitoring and supervision to determine proper dosage and reduce side effects. PCPs see over 30 patients a day and lack the necessary time to educate and counsel patients about these drugs. Thus, the agents are often used improperly and are less effective in addressing the patient's condition.

I believe that a substantial opportunity for savings in health care exists from more effective and timely treatment of mental health disorders. After auditing total mental health care spending to identify areas of wasted spending, there are generally three areas of focus to improve quality and value from mental health care: benefit design, PCP support and patient education.

For example, changes in benefit design to improve quality may include removal of barriers, such as higher copays to visit behavioral health specialists, which discourage patients from seeking proper care for their conditions. The use of pharmacy benefit managers to help monitor drug utilization and patient compliance is an example of PCP support that may help improve mental health care provided in the primary care office. Finally, disease management programs that monitor patients and provide 24-hour call-in lines may aid in providing patient education about their mental disorder and treatment plan. This is particularly important for mental illnesses where medications take much longer to become noticeably active and have the challenge of more immediate side effects.

The bottom line is that, like other areas of health care, mental health care costs, when considered in their entirety, are also increasing rapidly. We need to be continually exploring new methods to reduce and manage them. By focusing on systems that get patients the right mental health care at the right time, improving patient adherence to drug treatment regimens, and aligning incentives in physical and behavioral health care benefit plans and delivery systems, not only can health care be greatly improved, but the bottom line can be as well.