

June 2006

TO: MENTAL HEALTH TASK FORCE

SUBJECT: FINDINGS FROM THE NATIONAL BUSINESS GROUP ON HEALTH

Objective: To review the findings from another study groups and see if there are any that the Mental Health Task Force wishes to include in its report

Background:

Within the past year, the National Business Group on Health has completed a report, An Employer's Guide to Behavioral Health Services, with three goals:

1. To review major trends in the epidemiology, treatment and cost of behavioral health services in the United States,
2. To summarize the state of employer-sponsored behavioral health services in the United States, and
3. To make recommendation to improve the design, delivery and purchase of employer-sponsored behavioral healthcare services.

Attachment A reproduces the twelve key findings from the report.

Action:

The Mental Health Task Force is requested to review the findings from the National Business Group on Health and determine if any of their findings should be included in the task force's report.

National Business Group on Health, An Employer's Guide to Behavioral Health Services.

The *Committee's* review resulted in twelve key findings. They are summarized as follows:

1. Mental illness and substance abuse disorders are serious, common, and expensive health problems.

In 2001, mental health and substance abuse treatment costs totaled \$104 billion and represented 7.6% of total healthcare spending in the United States (\$1.4 trillion).¹ Unlike other medical conditions such as heart disease or diabetes, the indirect costs associated with mental illness and substance abuse disorders commonly meet or exceed the direct treatment costs.

2. Research has conclusively shown that depression and other mental illness and substance abuse disorders are a major cause of lost productivity and absenteeism.^{2,3,4}

Mental illness causes more days of work loss and work impairment than many other chronic conditions such as diabetes, asthma, and arthritis.³ Approximately 217 million days of work are lost annually due to productivity decline related to mental illness and substance abuse disorders, costing United States employers \$17 billion each year.⁴ In total, estimates of the indirect costs associated with mental illness and substance abuse disorders range from a low of \$79 billion per year to a high of \$105 billion per year (both figures based on 1990 dollars).^{5,6}

3. Disability costs related to psychiatric disorders are high and continue to rise.

Mental illness and substance abuse disorders represent the top 5 causes of disability among people age 15-44 in the United States and Canada (not including disability caused by communicable diseases) [Note: includes employed and unemployed populations].⁷ Further, mental illness and substance abuse disorders, combined as a group, are the fifth leading cause of short-term disability and the third leading cause of long-term disability for employers in the United States.

4. The efficacy of treatment for mental illness and substance abuse disorders is well documented and has improved dramatically over the past 50 years.⁹

For most mental illnesses there is a range of well-tolerated and effective treatments. Current research suggests that the most effective method of treatment is multimodal and combines pharmacological management with psychosocial interventions such as psychotherapy.⁹

5. A significant proportion of individuals with behavioral health problems are treated exclusively in the general medical setting, which has become the "de-facto mental healthcare system."¹⁰

Among patients diagnosed with a mental illness, 42% of those with clinical depression and 47% of those with generalized anxiety disorder (GAD) were first diagnosed by a primary care physician.¹¹ Approximately 22.8% of individuals treated for a mental illness or substance abuse disorder¹², and half (51.6%) of patients treated for depression, are treated by a general medical provider such as a primary care physician.¹³ Further, it is estimated that 11%-36% of patients presenting at primary care have a mental illness.¹¹ Numerous studies over the past two decades have found that the adequacy and quality of mental healthcare delivered in the general medical setting is sub-optimal.¹² In fact, the *National Co-morbidity Survey Replication* (NCS-R) found that only 12.7% of individuals treated in the general medical sector received minimally adequate care compared to 43.87% of patients treated in the specialty mental health sector.¹²

6. Primary care physicians (PCPs) and other general medical providers are — and will continue to be — an integral part of behavioral healthcare in the United States.

However, significant quality problems have been found with general medical providers' screening, treatment, and monitoring practices. Many of the recommendations presented in this *Guide* suggest programs, benefits, and practices that will support general medical providers in the provision of high-quality behavioral healthcare services.

7. Psychotropic drugs have become the major treatment modality in behavioral healthcare whether prescribed by general medical physicians (e.g., primary care physicians) or by behavioral health specialists (i.e. psychiatrists).

The availability of prescription medications as a method of treatment has improved the lives of many individuals with mental illness and substance abuse disorders. However, a number of quality problems have been identified with current psychotropic medication prescribing practices (e.g., pharmacological management is frequently the sole treatment modality). Further, the escalating cost of psychotropic drugs is of concern to employers. In 1987, psychotropic medications were responsible for 7.7% of all mental healthcare spending in the United States (including expenditures from private insurance, Medicare, Medicaid, etc); by 2001, psychotropic drug spending was responsible for 21.0% of total mental health spending.¹⁴ In 2001, private employers spent approximately 17% of their total behavioral health expenditures on prescription medications.¹

8. While employers have focused their attention on the management of high cost chronic medical conditions (e.g., heart disease and type 2 diabetes), such management efforts have not fully addressed the significant additional burden of co-morbid mental illness. Access to specialty behavioral healthcare services is critical to delivering effective disease management services for chronic medical problems. Therefore, limitations on behavioral healthcare benefits may limit the efficacy of disease management programs for individuals with co-morbid medical and behavioral health conditions. Disease management programs will not realize their full potential without fostering better coordination between the general medical healthcare system and the specialty behavioral healthcare system.

Research has shown that individuals with chronic medical conditions and untreated comorbid mental illness or substance abuse disorders are the most complicated and costly cases. For example:

- Healthcare use and healthcare costs are up to twice as high among diabetes and heart disease patients with co-morbid depression, compared to those without depression, even when accounting for other factors such as age, gender, and other illnesses.^{15,16}
- Patients with mental illness and substance abuse disorders are often less responsive to treatment. For example, depressed patients are three times as likely as non-depressed patients to be non-compliant with their medical treatment regimen.¹⁷
- The presence of type 2 diabetes nearly doubles an individual's risk of depression and an estimated 28.5% of diabetic patients in the United States meet criteria for clinical depression.¹⁶
- Approximately one in six patients treated for a heart attack experiences major depression soon after their heart attack and at least one in three patients have significant symptoms of depression.¹⁷

9. Access to specialty mental healthcare services is constrained due to benefit design with higher co-pays, visit limits, and management of utilization. These additional financial limitations are not applied to psychotropic drug benefits or to many behavioral health interventions delivered in the general healthcare setting.

This has created a perverse incentive for patients to a.) access mental healthcare from general healthcare providers (where there are no visit limitations and co-pays are significantly lower) and to b.) rely on psychotropic medication as an exclusive method of treatment.

10. Limiting behavioral healthcare services can increase employers' non-behavioral direct and indirect healthcare costs.

One study found that limiting employer-sponsored specialty behavioral health services increased the direct medical costs of beneficiaries who used behavioral healthcare services by as much as 37%.¹⁸ Further, the specialty behavioral health service limitation substantially increased the number of sick days taken by employees with behavioral health problems. The study concluded that savings attributed to limiting behavioral health benefits were fully offset by increased use of other medical services and lost workdays.¹

11. Employers have tightly managed behavioral health benefits delivered by the specialty mental healthcare system, but have not as yet implemented comprehensive and integrated management programs to address quality and costs for psychotropic drugs and behavioral health services delivered by general medical providers.

Specialty mental health services have been managed tightly by managed care systems over the past two decades. Utilization review techniques and other methods have reduced the

percent of total healthcare dollars employers spend on mental healthcare benefits. In fact, private employers experienced a 50% decline in their mental healthcare premiums (not including the cost of psychotropic drugs) during the 1990s: the average cost of private employers' behavioral healthcare premiums dropped from 6.1% of total claims costs in 1988

to 3.2% in 1998.¹⁹ Yet, employers have not adequately managed the cost or quality of behavioral healthcare services delivered in the general medical setting despite the high proportion of patients treated for behavioral disorders in the general medical setting. Further, employers are not receiving good value for their investment in psychotropic drugs.

12. The lack of coordination and integration among managed care vendors of employers (MCOs, MHBOs, EAPs, PBMs, and others) has created significant quality and accountability problems.

Employers can address these problems by improving the design of their health insurance benefit structures, and by requiring their behavioral health vendors and managers to coordinate

with one another. Figure 1.0 lists and explains the vendors and employers currently use to manage their health, behavioral health, disability, and employee assistance