Mental Health Financing in the United States: Assessing “the System”

Daniel Eisenberg and Richard Scheffler

I. Introduction

“Although no one would argue that the current U.S. behavioral health system is perfect, it is in many ways an improvement over what came before.”

-Jonathan Book, 2002 chair of the American Managed Behavioral Healthcare Association

“I am generally cautious in my use of the word ‘crisis,’ but as best I can tell, the current situation in the mental health system qualifies for that label.”

-Paul Appelbaum, 2001-2003 President of the American Psychiatric Association

Mental health care in the U.S. is no different from health care in general: reasonable, intelligent people disagree about whether “the system” is making steady progress or going to hell in a hand basket. In part the disagreement stems from the vast and nebulous nature of the system. Optimists and pessimists may be focusing on different aspects of the constellation of patients, providers, hospitals, treatments, insurance companies, public agencies, and other players.

In this article we attempt to bring the mental health system in the U.S. into focus by describing it from an economic perspective. This perspective is clearly not the only way to understand the system, but it is an important one. How much money is involved? Where does the money come from? How does it get spent?

One statement that everyone would agree upon is that the economic landscape of mental health has changed dramatically over the past 15 to 20 years. To characterize this evolution we describe ten specific trends. Two of the most prominent movements have been towards managed care and insurance benefit “parity,” both of which we discuss in detail. Our emphasis is on mental health, but note that substance use is also included whenever the term “behavioral health” is used. Mental health and substance use are combined under this single term at various points in our discussion because the two are frequently connected epidemiologically and because much of the relevant data combine the two.

II. How Much Money?

The most recent reliable estimate of total spending on mental health is $73.4 billion for the year 1997 (Mark et al, 2001). To put this number in perspective, consider that it is about seven percent of the one trillion dollars plus health care total in 1997 or just under
0.1 percent of the eight trillion dollars or so GDP. Comparisons to other countries are inevitably imprecise, but there is some evidence that the U.S. spends a smaller proportion of the health care budget on mental health than other western countries such as Britain, Canada, and Australia (Triplett 1998). On the other hand, the U.S. spends more money per capita in absolute terms on mental health than these countries, as its overall health spending per capita is so much higher.

**Trend #1: Behavioral health spending has grown faster than GDP, slower than overall health care**

Like overall health care spending, behavioral health spending has far exceeded the average growth rate of the economy, which is about 2%. Most evidence suggests, however, that behavioral health spending has not quite kept pace with overall health care. For example, one research group estimates that behavioral health spending rose 6.8% per year from 1987 to 1997, whereas overall health spending rose 8.2%. This divergence contrasts with the 1960s, 1970s, and 1980s, during which behavioral health spending growth tracked overall health spending growth closely (Triplett 1998).

Why has behavioral health spending grown briskly, and why has it not kept pace with overall health? The answer to the first part of the question undoubtedly involves factors common to all health care. Insurance coverage has expanded and technology has progressed rapidly, particularly for prescription medications. A number of effective new treatments are available. Also, as our society has become richer, increasing health expenditures has become more attractive for the average person than increasing expenditures on basic necessities (e.g. housing, clothes, and food) and other material goods. Another catalyst for growth that applies particularly to behavioral health is an increasing acceptance of mental and substance use disorders as real, treatable illnesses. For better and worse, behavioral health has gained legitimacy through a movement to frame the disorders in diagnostic and biological terms.

Perhaps the main reason that behavioral health spending growth has not kept pace with overall health spending growth is managed care. Managed care has reduced spending for all types of health, but it appears to have been especially effective in reducing behavioral health costs. We will elaborate on this point later. Another explanation for slower behavioral health spending growth relates to technology. Some observers have speculated that technological progress has not affected behavioral health care as much as health care in general because a lot of the best mental health and substance use treatments are still “low-tech” interventions such as behavioral therapy.

**III. Where Does the Money Come From?**

In characterizing sources of funding for behavioral health care, we can examine two dichotomies: public versus private funds, and out-of-pocket versus other funds. The first dichotomy distinguishes between funds provided by the government (public) and those that are not (private). The second dichotomy distinguishes between funds provided by
the consumer herself (in addition to insurance premiums) and funds provided by someone else (e.g. insurers, government, or charity care).

**Trend #2: Government’s role in mental health has been large and growing**

Public funding has accounted for a large and increasing source of mental health care. For example, from 1987 to 1997 the proportion of funds for mental health care from public sources increased from 53 to 56 percent (Mark et al, 2001). In contrast public funds’ contribution to overall health care has remained well under 50 percent. Some would argue that the relatively large public presence in mental health funding is a historical oddity that perpetuates itself: public funds are provided because private funding is poor, and private funding is poor because public funding is ample. At the state level and local levels in particular, public providers (e.g. in state or community psychiatric hospitals) constitute a safety net for the mentally ill more so than public providers do for people with other illnesses.

Although the state and local levels organize and administer much of the publicly funded mental health care, the original source of funding has increasingly been federal programs, including Medicare, Medicaid, Social Security Disability (SSD) and Social Security Income (SSI). Predictably, Medicare’s contribution has grown with the aging of the population. Medicaid is growing even faster. According to a study by Jeffrey Buck of the Substance Abuse and Mental Health Services Administration (SAMHSA), Medicaid accounted for one third of state and local public mental health spending in 1987, one half in 1997, and may grow to two thirds by 2017. Medicaid’s share has risen largely due to expansion of eligibility terms for recipients, as well as efforts by states to maximize federal revenue by shifting state funded items to Medicaid funded items. Medicaid is set up as a “matching grant” in which the federal government matches the state’s contribution at a rate determined by the state’s per capita income (poorer states receive more favorable rates).

Finally, the social security programs SSD and SSI do not provide medical care directly, but rather provide income for disabled people, who include many with mental disorders. SSI and SSDI now represent the largest public budget items for mental health. In 2000, the federal government paid $20 billion in disability benefits to people with mental disorders, more than Medicaid, Medicare, or state mental health systems spent on mental health services. Michael Hogan, Director of Ohio’s Department of Mental Health and Chair of President Bush’s New Freedom Commission on Mental Health, questions whether it makes sense to spend so much on disability benefits while many people go untreated or under-treated. “We are spending too much on mental health in all the wrong places,” he writes in a 2002 *Psychiatric Services* article.

**Trend #3: State mental health systems have decentralized**

Although the public sector plays a large role in providing mental health services, many would argue that its funding is still woefully inadequate. In the tight fiscal times of the past couple years, many state mental health budgets have been hit hard. Hogan suggests
that state mental health funding has been eroding even in good economic times, largely because many state mental health systems decentralized during the 1990s. During this period state governments devolved administration and responsibilities for mental health services to the county and community levels. As a result, mental health funding frequently lost its foothold as a fixed state budget item tied to inflation. By 1999, decentralization had reached the point where three quarters of the nation’s population lived in states where mental health service responsibilities were held by county-based organizations.

Many people hold additional concerns about how the government finances mental health services provided at the state and local level. Like the private insurance market, state mental health systems, including Medicaid programs, have largely shifted towards managed care. More than half of Medicaid enrollees participated in managed care in 1999, a sevenfold increase from 1991, according to Center for Medicare and Medicaid Services (CMS) statistics. The evidence clearly suggests that managed behavioral health care has reduced state costs dramatically, as in the private market, but in some cases people have been concerned about the extent and ways in which services were reduced. In the past few years some observers have also become worried about the increasing influence of Medicaid on state and local mental health services. Jeffrey Buck from SAMHSA describes a shift from a “community model” to a “health plan model,” as Medicaid accounts for an ever-growing share of the mental health budget. Under the “community model” local agencies have great flexibility regarding how to organize and deliver services whereas under the “health plan” model this flexibility is limited by insurance plan (Medicaid) eligibility terms and other rules prescribed from the federal and state levels.

**Trend #4: Out-of-pocket payment rate has fallen**

One trend that has been heartening to mental health advocates is a decline in the out-of-pocket payment rate by consumers. The out-of-pocket rate, also known as the cost sharing rate, refers to the proportion of health costs that consumers must pay for services, on top of whatever insurance plan premiums they have already paid at the start of the year. For example, suppose a man has 10 therapy visits at $100 each, and his insurance plan requires a $500 deductible plus a 20% coinsurance. He would pay the $500 deductible plus 20% of the additional $500 in costs, or $600 total. The out-of-pocket rate would be $600 divided by $1,000, or 60 percent.

In the U.S. between 1987 and 1996, the out-of-pocket rate for mental health and substance use care fell from 26 percent to 23 percent, according to figures by Sam Zuvekas at the Agency for Healthcare Research and Quality (AHRQ). For child mental health care, the rate has fallen more steeply, from 47 percent in 1987 to 33.5 percent in 1998, according to research by Sherry Glied and Alison Evans Cuellar at Columbia University. They attribute the decreased rate to a number of factors: expanding insurance coverage through Medicaid and the state children’s health insurance program (SCHIP), increased services through primary care (not subject to the stricter mental health limits), increased coverage of prescription drugs, and a shift from demand-side cost controls (e.g.
high co-payments and deductibles) to supply-side controls (e.g. limited provider networks, utilization review).

IV. How Does the Money Get Spent?

In examining how mental health funds are spent, it is useful again to consider various dichotomies: inpatient versus outpatient care, therapy versus medication, and primary care versus specialty care. Note that there are additional ways of categorizing mental health spending that we do not discuss, due to lack of reliable data and space constraints. For example, we could examine different types of providers (e.g. psychiatrists, psychologists, marriage and family therapists (MFTs), and social workers) or more settings than simply inpatient versus outpatient (e.g. general hospitals, psychiatric hospitals, clinics, schools, and the criminal justice system).

Trend #5: Inpatient care has declined relative to outpatient care

Behavioral health spending data unambiguously show that inpatient care has dwindled in proportion to outpatient care. The relative decline has been greater than for health care in general. Hospital spending fell from 42.5 percent of behavioral health spending in 1987 to 31 percent in 1997 according to researchers at MedStat (Mark et al, 2001). Most studies find that inpatient treatment costs have fallen or risen only slightly, while outpatient treatment costs have risen steeply. Much of the reduction in inpatient costs is due to shortened lengths of stay. For example, Judy Lave from the University of Pittsburgh finds that the average length of stay for Medicare psychiatric inpatients dropped from 25.6 days in 1990 to 10 days in 2000. Undoubtedly, the rise of managed care has been largely responsible for the shift from inpatient to outpatient treatment.

Trend #6: Medication has been on the rise relative to therapy

Prescription medications and therapy are not the only two sources of mental health costs, but they constitute a much-discussed dichotomy. Spending on medications has been soaring in comparison to spending on therapy (or any other category of mental health costs, for that matter). The proportion of mental health costs spent on medications has approximately doubled in ten years or less. Between 1987 and 1997 the proportion for mental health spending jumped from 7.5 percent to 12.3 percent. The change has been even more dramatic for employer-based samples: from 22 percent of mental health and substance use spending in 1992 to 48 percent in 1999. Depression treatment is a prime example of this trend. For outpatient treatment of depression, the medication rate doubled from 37 to 74 percent between 1987 and 1997, while the psychotherapy rate declined from 71 percent to 60 percent (Olfson et al, 2002). As anyone aware of the ADHD phenomenon knows, the rapid rise of medications has occurred for children as well as adults.

Why are meds outpacing therapy? An obvious answer is that, despite the many concerns about the pharmaceutical industry, it is producing innovations at a spectacular rate. Drugs such as Prozac are highly effective for certain people, and with modest side effect
profiles. While the benefits for mental health of recent drug innovations are undeniable, some observers point with concern to other factors promoting the relative growth of medication costs. Financial incentives within the mental health system are sometimes heavily biased towards prescribing medications. For example, psychiatrists can typically receive much higher reimbursements by seeing multiple patients for short medication management visits as opposed to one patient for a therapy visit, as Joyce West and colleagues from the APA discuss (West et al, 2003). Also, pharmacy costs are frequently “off-budget” for behavioral health or primacy care providers; their profits are not diminished when they prescribe medications, whereas they bear the costs of providing therapy.

**Trend #7: Primary care’s contribution to MH care has been relatively flat**

Due to the increasing relevance of medication, many people are under the impression that primary care providers are providing an increasing proportion of behavioral health care. The numbers, however, suggest this is not the case. Specialty care actually grew as a fraction of total behavioral health care between 1987 and 1997 (Mark et al, 2001). Looking at depression specifically, Frank, Huskamp, and Haiden from Harvard find that out of office visits in which medications were prescribed, the proportion in primary care remained around 50 percent during the 1990s. Opposing forces probably account for the relatively stable role of primary care. On one hand, primary care physicians have become increasingly knowledgeable about and capable of administering mental health treatments such as antidepressant prescriptions, and some managed care systems may encourage them to provide the care rather than refer to a specialist. On the other hand, managed behavioral healthcare “carve-outs,” which we discuss more below, have encouraged treatment by behavioral health specialists.

**V. Impact of Managed Care**

Everyone who talks about health care financing in the U.S. says the words “managed care” at least once every two sentences, or so it seems. Yet the term is nearly as nebulous as “mental health system.” In the context of behavioral health, managed care is an especially confusing concept, because behavioral health carve-outs have entered the lexicon as a related but distinct entity.

Managed care typically refers to any of a collection of supply-side devices used to ration health care. Prime examples of these devices include provider networks, gatekeepers, utilization review, and capitation. The most common forms of managed care organizations are health maintenance organizations (HMOs), preferred provider organizations (PPOs), and point of service organizations (POS’s). Managed care in one form or another has come to dominate the provision of both behavioral health care and health care overall in the U.S.

The term behavioral health carve-out refers to an organization that solely concerns itself with behavioral health care. In some cases the organization only provides administrative functions (such as managing care) and in other cases the organization provides actual
delivery of care as well as administrative functions. Almost every behavioral health carve-out operates under at least some key principles of managed care; therefore, most carve-outs are known as managed behavioral health organizations (MBHOs).

**Trend #8: Managed behavioral health organizations have taken over**

Behavioral health care in the U.S. has become both more managed and more likely to be carved-out. Enrollment in managed behavioral health rose from 70 million in 1993 to 169 million in 2000. Furthermore, the majority of behavioral health care is now delivered using carve-outs, even though carve-outs had virtually no presence before the late 1980s.

**Trend #9: MBHOs have cut costs dramatically**

MBHOs have cut costs, often in remarkable fashion. Multiple studies have calculated reductions on the order of 30 or 40 percent (Ma and McGuire, 1998; Goldman et al, 1998; Zuvekas et al, 2002). Cost savings have been achieved largely through reduced inpatient utilization and negotiating lower prices for services and medications. Managed care has been effective in reducing behavioral health costs in part because unmanaged behavioral health care is especially susceptible to “wasteful” spending. The results of the famous RAND Health Insurance Experiment suggest that people are likely to consume a lot of behavioral health care that they do not value much, if they are faced with very low out-of-pocket rates and their care is not managed. It is important to emphasize, however, that while behavioral health care has been shown to be provided at inefficienctly high levels in some contexts, there is also plenty of evidence that it is provided at inefficienctly low levels in other contexts (in fact, most people with severe mental disorders are not treated at all in a given year).

Critics of mental health financing debate the vices and virtues of MBHOs fiercely. To summarize an ample discussion, we present the following abbreviated list of points on each side. Vices: lower quality of care; concentrated market power; disconnection between general health care and behavioral health care; reduced autonomy of providers; excessive administrative burden. Virtues: greater efficiency; more accountability (measurement of outcomes and value); less cost sharing by patients; increased capacity to uniformly implement evidence-based practice; greater consolidation of mental health plans (which reduces adverse selection, the phenomenon in which competing insurers all offer poor benefits to avoid attracting the sickest patients). Most observers would agree that MBHOs have brought significant improvements as well as new problems. Without a doubt they have helped eliminate some inefficiency. A crucial question still up for debate is whether they provide lower quality care. In any case, the key policy question is not all-or-nothing (whether to discard MBHOs entirely), but rather which of their aspects should be encouraged and which should be discouraged.
VI. Mental Health Parity

Partly in response to diminished revenues and autonomy under managed care, mental health providers have joined forces with mental health advocacy groups to promote the concept of “mental health parity.” The goal of the movement is to obtain insurance coverage for mental health at parity with coverage for physical health. Insurance benefits for mental health have traditionally been much more restricted than those for physical health conditions. For instance, Gail Jensen and colleagues find that in the early and mid 1990s only 18 percent of employers offered inpatient mental health coverage equal to inpatient physical health coverage and only 2 percent offered comparable outpatient coverage. Inferior benefits for mental health have typically taken the form of higher cost sharing, lower visit and day limits, and caps on annual or lifetime spending.

Trend #10: The parity movement has boosted MH benefits but its impact has been largely symbolic

A federal Mental Health Parity Act was enacted in 1998 and continues to be in effect. A more comprehensive bill is currently being considered (the Paul Wellstone Mental Health Parity Act). Additionally most states have passed parity laws that exceed the federal act in some ways. The mandates have helped bring mental health benefit terms closer to those for physical health. For example, in 2002 only 22 percent of employers required higher cost sharing for mental health, according to researchers at Health Research and Education Trust (HRET) and Harvard (Barry et al, 2003).

At the same time, true parity remains elusive. With a few exceptions at the state level, the mandates contain loopholes by which mental health can be covered at inferior levels. For example, the federal act enacted in 1998 requires equal dollar amount limits but does not require equal limits on number of visits or inpatient days. The state laws are typically closer to true parity but do not apply to the approximately fifty percent of workers who are covered by employers who self-insure. Furthermore, academic researchers have pointed out that complete parity in benefit design does not necessarily imply equal coverage, because managed care techniques can still be used more vigorously on the supply end (e.g. stricter utilization review).

One can make compelling arguments both for and against parity. On the pro side, it can help combat adverse selection (described earlier) problems in the insurance market and help reduce the stigma surrounding mental illness. Also, an admittedly paternalistic argument may be important. To the extent that people undervalue mental health care relative to physical health care, parity can help correct an inefficiently low demand for mental health care. Considering that a large percentage of people suffering from mental illnesses do not seek treatment, it is logical to assume that many people undervalue the treatment.

On the con side, mental health services are more susceptible to wasteful over-utilization, as discussed earlier. Also, one could regard the parity movement cynically as a move by mental health providers to recapture lost income and authority.
Parity as it is now defined appeals with its simplicity: mental health coverage should be exactly the same as physical health. No more, no less. Noted mental health economists Richard Frank and Tom McGuire, however, have proposed an alternative definition of parity that is more complicated but makes more sense. Essentially their proposal is that mental health services should be provided to the point where they have the same marginal cost effectiveness as other health services. A dollar spent on mental health care should bring the same value as a dollar spent on other care. The value of care, as experienced by the patient, can be difficult to measure, particularly for mental health care, but techniques are improving. For political practicality’s sake, a simple definition of parity may be preferable, but advocates on both sides and decision-makers should keep in mind the more nuanced and appropriate definition based on cost-effectiveness.

VII. Challenge for the future: integration (the eternal dilemma of American health care)

How can we improve our system of financing mental health services? In one word: integration. As many people have observed, most of the problems in the system result from the lack of appropriate connections between the various components. For example, drug prescriptions, primary care services, and specialty care may be drawn from three separate budgets, without a sound mechanism for finding the appropriate mix. Financial incentives may unduly favor prescriptions over therapy. Behavioral health care may be separated from other health care in a way that does not account for their interdependence. The incentives of the public system are constructed in ways that may make it difficult for someone to return to employment and private insurance.

To some, integration is a code word for a single payer system of universal health coverage. In theory, such a single payer system could solve many of the problems in mental health financing, not to mention health financing in general. But that is a whole other debate. Even with the basic structure of our current decentralized system, we can integrate the parts in more productive ways. A Robert Wood Johnson program, Depression in Primary Care: Linking Clinical and System Strategies, is an example of a step in the right direction. The program is funding demonstration projects that attempt to align primary care and behavioral health carve-out incentives with practice that is collectively cost effective and evidence based. Another promising trend is improvement in quality and outcome measurements. These can be tied more closely with financial incentives. These are just a couple examples that foreshadow a promising future for mental health financing in the U.S. No matter what type of model we try to construct, the key will be to make sure the pieces fit together properly.
Selected References:


