
Assessing the Need, Use, and Developments in Mental Health/Substance Abuse Care

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This overview presents an introduction to the articles published in this issue of the Health Care Financing Review, entitled "Mental Health Services and Vulnerable Populations." This article discusses the challenges the mental health and substance abuse (MH/SA) care system is confronted with in terms of equity and efficiency and how the system is responding to these challenges. It further addresses research issues in assessing the need and use of mental health services and summarizes recent activities in the research and evaluation of new delivery and payment systems.

INTRODUCTION

In today's cost-conscious health care environment, equity and efficiency are becoming increasingly important considerations in managing and evaluating health care systems, especially as pressure to contain further growth in health care expenditures increases. Equity and efficiency are an integral and essential part of a well functioning health care system. Equitable and efficient health care systems will identify those in need of care, allow timely access to appropriate providers for adequate level of care, and protect service users against the risk of high expenditures. An efficient health care system will also induce proper and cost-effective provider and consumer behaviors through appropriate payment and benefit design.

Among many sectors of health care, the MH/SA care system has been particularly challenged with problems in equity and efficiency. Studies have documented that access in MH/SA remains a serious problem. Not only is MH/SA care manpower concentrated in certain areas, but also the geographic distribution of MH/SA care facilities is very uneven in the United States. In terms of service use, many studies raise concerns over an inefficient and inequitable pattern; underutilization of services among the severely ill and vulnerable population and potential overutilization of care among the less serious may indicate problems in the system (Frank and Lave, 1986, Lave and Frank, 1988).

Faced with many challenges, players in the MH/SA care system have searched, and continue to search, for ways to enhance the system's equity and efficiency. Significant legislative progress toward a more equitable provision of MH/SA care recently took place at the Federal level through the Mental Health Parity Act of 1996 (Public Law 104-204). Taking effect on January 1998, the Act requires that mental benefit provisions be no more restrictive than medical/surgical benefits in group health plans with 50 or more employees. At the State level, 13 States had already enacted a statewide mental illness parity laws, while three additional States enacted a parity law applicable only to State employees (American Managed Behavioral Healthcare Association, 1997a).

Another notable activity in the current MH/SA market is the proliferation of new delivery and payment models, i.e.,

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managed behavioral health care. Nearly absent a couple of decades ago, the managed behavioral health industry is estimated to cover approximately 170 million Americans for their MH/SA care in 1997 (American Managed Behavioral Healthcare Association, 1997b). And growth is expected to continue as more State Medicaid programs adopt a managed behavioral care model. In such a dynamic and evolving market, we need to appraise the impact of new developments on access, use, and financing of MH/SA care. Concomitant with the *Health Care Financing Review's* interest in MH/SA care research, this issue disseminates research findings on access, use, and financing of MH/SA care for vulnerable populations.

MENTAL HEALTH CARE NEEDS

From 1980-85, a comprehensive MH/SA epidemiological survey was conducted by the National Institute of Mental Health (NIMH). Known as the Epidemiological Catchment Area (ECA) study, the survey revealed a surprisingly high prevalence of MH/SA disorders in America. In a given month, about one in six adults are found to have a MH/SA disorder, and approximately one in four adult Americans meet the criteria for MH/SA disorder during a year. The study, however, did not include childhood and adolescent populations. Equally surprising was that, of the population with MH/SA disorders, only one-half of them received MH/SA care at all, and less than one in three receive care within 1 year (Reiger et al., 1993).

Mental disorders encompass a broad range of conditions with different degrees of debilitating effects. As such, prevalence alone does not adequately depict the problems in MH/SA care need in America. Based on the ECA study conducted between 1980 and 1985, the NIMH

estimates some five million adults are suffering from often incapacitating severe mental disorders, such as schizophrenia, manic-depressive illness, major depression, panic disorder, and obsessive-compulsive disorder. It was reported that about 60 percent of the persons with severe MH/SA disorders received care (Goodwin et al., 1993). A recent nationally representative survey, the National Comorbidity Survey reconfirmed this figure (Kessler et al. 1994). Prevalence of severe MH/SA disorders among children are not as well understood. However, according to a recent survey, Mental Disorders in Child and Adolescent Populations (MECA), 3.2 percent of the sample adolescent population had a severe MH/SA disorder (National Institute for Mental Health, 1993).

Accurate assessment of the need for MH/SA care is an essential guide in formulating a policy that allocates resources efficiently and equitably. Especially in today's changing health care market, we have to know what the current need is and to what extent these vulnerable population receive care. Changing population characteristics and family and social structures necessitate continuous tracking of trends in need for mental health care. In an effort to assess the need and treatment in substance abuse care, this issue features an article by Woodward and colleagues. This article presents new estimates of the numbers of persons in this country who need and receive substance abuse treatment. Additionally, a summary of mental health data from the Medicare Current Beneficiary Survey (MCBS) round 13 is featured.

USE OF MENTAL HEALTH SERVICES

As previously discussed, the epidemiological evidence clearly indicates we have serious problems with unmet needs among

vulnerable populations. More than any other factors, the unequal provisions of mental health benefits in health insurance seems to have perpetuated this problem. Rightfully fearing that generous MH/SA benefit would draw unfavorable selection, many private health insurance plans limited their MH/SA care benefits over time (Schuttinga, Falik, and Steinwald, 1985). If the Mental Health Parity Act can restore equity in the provision of MH/SA benefits, it would considerably alleviate the inequity problem.

With the rising concern over the health care expenditure inflation, we need to be more resourceful in planning and allocating resources. Rice et al. (1990) estimated the total expenditure for MH/SA in this country to be as much as \$67 billion in 1990. This amounts to approximately one-tenth of the total national expenditure on health care for the same year. Studies indicate evidence of an inefficient pattern of service utilization in MH/SA care: underutilization of services among the severely ill and potential overutilization of care among the less serious. To enhance equity and efficiency in the system, it is important to monitor patterns of service utilization.

In this issue of the *Review*, there are a number of articles related to MH/SA service utilization in Medicare and Medicaid. Rosenbach and Ammering analyze Medicare's impact of mental health outpatient coverage expansion on utilization and expenditure between 1987 and 1992. Ettner and Hermann examine the pattern of mental health specialist use in Medicare, and report the factors that influence specialist use. An article by Slifkin and colleagues proposes a reimbursement system for the care of the mentally retarded in intermediate care facilities. An article by Cano, Hennessy, Warren, and Lubitz presents information on demographic, diagnostic, utilization, and expenditure

characteristics associated with inpatient psychiatric care among Medicare beneficiaries in 1995.

NEW DEVELOPMENTS IN DELIVERY AND INSURANCE

The most sweeping change in the recent MH/SA system is the proliferation of managed mental health care. Survey data show that the industry nearly doubled in covered lives between 1993 and 1997; the latest estimate puts the enrollment figure at approximately 170 million in 1997 (American Association for Marriage and Family Therapy, 1996, American Managed Behavioral Healthcare Association, 1997b). This means approximately two-thirds (68 percent) of the insured population are enrolled in a managed MH/SA care plan.

This industry's phenomenal expansion was driven, in part, by implementation of Medicaid waivers in many States, a trend which seems certain to persist for the next several years. A total of 28 States and the District of Columbia have implemented some form of managed MH/SA care waiver. Nine States already received approval on their waiver requests, and ten additional States have pending waiver requests with various managed MH/SA care provisions.

The managed MH/SA care contracts typically feature such characteristics as carved-out MH/SA benefits, person-level capitated budgets, risk sharing arrangements, and case management. Compared with the incentives in indemnity insurance, each feature of the managed care contract can differently impact the utilization, financing, and outcome of the MH/SA care. At a time when the managed behavioral health system is emerging as the dominant MH/SA care delivery model, timely evaluation of its performance is imperative.

The third group of articles in this issue address this issue both empirically and theoretically. An article by Stoner and colleagues evaluates a capitation payment demonstration in the Community Mental Health Centers (CMHCs) in the Utah Medicaid program. The authors report how capitation affected utilization and expenditures in three CMHCs. Using AFDC carve-out experience from Massachusetts, Norton, Lindrooth, and Dickey investigate whether the managed MH/SA care vendor shifted costs to the medical care sector. The findings from this relatively mature managed public program will be of great interest to other States that are at an early stage of managed behavioral care contracting. Based on economic theory, Frank and colleagues address the problem of adverse selection in the context of behavioral health care, and offers an explanation of why carve-out and cost sharing—two key features of managed behavioral contracts—offer a solution to this problem.

CONCLUSIONS

The MH/SA care system in America is undergoing a sweeping transformation. While shifting demographics and social and family structure affect the need for MH/SA care, new financing and delivery models are emerging in both the private and public sector. In this highly dynamic and often uncertain era, research must inform the policy makers and guide their decisions. The articles presented in this issue of the *Review* describe, analyze, and evaluate the transformations that are taking place in the MH/SA care system. It is our hope that such research activities ultimately help shape a more equitable and efficient MH/SA care system.

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