The Business Case for Mental Health Equity

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KEYWORDS

• Mental health • Substance use disorder • Opioids • Disparities • Business case

KEY POINTS

- Racial and ethnic disparities persist in mental health and substance use disorders, as minorities face greater challenges accessing mental health and substance use disorder services and receive a lower quality of care.
- Mental health expenditure exceeds that of other medical conditions, increases the costs of addressing physical health, and is exacerbated by health disparities.
- Real-world evidence trials account for strategic and operational concerns along with the disparate financial incentives of multiple stakeholders.
- Real-world evidence trials offer great promise to solidify the business case for equity, reduce disparities, and combat the major challenge of mental health and substance use disorders.

INTRODUCTION

Mental health has garnered increased attention in recent years as more than 47 million Americans experience mental illness each year, and 9.2 million Americans suffer from mental health and substance use disorders (SUD).[1] The need for services to address this growing epidemic has become a public health and policy priority; more than 60% of adults with mental illness and 81% of those with SUD do not receive treatment.[1,2] Nevertheless, health system investment in mental health and SUD services remains challenging for multiple reasons, including low reimbursement and low return on investment as compared with more profitable health system services. At the same

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Abbreviations	
MAT	Medications for addiction treatment
OUD	Opioid use disorder
SUD	Substance use disorders

time, payors historically have carved out mental health and SUD from physical health and reimbursed less for these services, and regulators have not appropriately monitored or enforced policies such as the Mental Health Parity and Addiction Equity Act. As the monetary and human costs from our nation's mental health and SUD burden escalate, however, strong business and ethical cases arise to better address this crisis in a meaningful and sustainable manner. This need is further magnified as our nation pushes toward value-based care and population health management, where improving outcomes and performance in physical health requires concomitant treatment of mental illness and SUD. This article describes the root causes and cost of disparities in mental health and SUD and offers an innovative perspective on aligning stakeholders to make the business case for equity in mental health and SUD treatment and outcomes.

A deeper exploration of the mental health and SUD crisis demonstrates that racial and ethnic disparities persist. For instance, minority populations tend to have limited access to health care, and receive lower quality care, than their white counterparts. Although research shows that minorities have a lower or equivalent prevalence of mental illnesses as whites, mental health services are more likely to be used by those that are white, high income, and living in urban areas.[3,4] Black and Latinx populations are less likely to receive mental health services and receive adequate quality care.[5–8] For example, between 2008 and 2012, whites had the highest average use of mental health services at 16.6%, followed by American Indian/Alaskan Natives (15.6%), African Americans (8.6%), Latinos (7.3%), and Asians (4.9%).[9] Further, the mental health needs of patients with limited English proficiency are dramatically unmet, with research revealing that only 8% of patients with limited English proficiency who express a need for services receive them.[10] Given that these minority and populations with limited English proficiency also disproportionately suffer from and receive lower quality care for chronic conditions such as heart disease, asthma, and diabetes, and because physical health outcomes worsen and costs increase by inadequate treatment of mental illness, an even stronger business case is evolving for mental health equity.

BACKGROUND ON MENTAL HEALTH AND SUBSTANCE USE DISORDERS

Disparities in Mental Health

Mental health disparities describe the unequal access to mental health services, lower quality of care, and decreased probability of favorable risk-adjusted health outcomes that minority groups experience.[11] Although mental health services use has generally increased in the United States over time, minority populations have faced greater challenges accessing them, for both historical and structural reasons. Mental health disparities are impacted by social and physical stressors that impact minority populations at greater rates.[12] These include racial discrimination and social exclusion; adverse early life experiences; poor education; unemployment, underemployment, and job insecurity; poverty, income inequality, and neighborhood deprivation; poor access to sufficient healthy food; poor housing quality and housing instability; adverse features of the built environment; and poor access to health care.[13] Generally,

the greater the social inequality, the higher the risk of developing a mental health disorder.

Barriers to receiving mental health care are extensive. Research demonstrates that high cost and limited insurance coverage are the highest reported barriers to using mental health services among all racial and ethnic minority groups. Other barriers include stigma, negative experiences with providers, perceived ineffectiveness of treatment, and structural barriers such as limited appointment availability and lack of transportation.[14] For example, research has shown that black, Latinx, and Asian populations are more likely to report prejudice, discrimination, and a lack of confidence that the services would help as reasons for not seeking treatment.[9] The burden of mental health disparities is further exacerbated by the political climate. For example, 1 study showed that lesbian, gay, and bisexual populations living in states with bans on same-sex marriage had higher rates of psychological distress as compared with lesbian, gay, and bisexual populations living in states without these bans.[15] In another study that compared rigid immigration policies and mental health in the Latinx community, Latinx people residing in states with stringent immigration policies experienced a greater number of poorer mental health days.[16] In summary, mental health disparities are longstanding, widely prevalent, and deeply problematic.

Disparities in Substance Use Disorders

Addiction to drugs or alcohol comprises a mental illness known as SUD. SUD is defined as a problematic pattern of substance use that causes significant impairment or distress.[17] SUD are shaped by genetic, environmental, and developmental factors, leading to an array of mental, physical, and behavioral symptoms.[18] A subset of SUD is opioid use disorder (OUD). The term opioid is used to describe a class of drugs that includes prescription pain relievers, synthetic opioids, and heroin.[19] OUD carries a great possibility of developing a physical dependence in a short timeframe, sometimes as little as 4 weeks—and abruptly stopping opioid use can lead to severe withdrawal symptoms.[20] Because mental health and SUD are closely tied together, similar disparities exist among minority populations. African Americans and Latinx populations are less likely to complete treatment for SUD, because psychosocial stressors and the severity of drug use are cited as influences on the completion of treatment.[21] Compared with whites, Latinx populations have a 92% likelihood of completing treatment for substance abuse and African Americans have a 69% likelihood.[8] African Americans are also less likely to complete treatment across several substances, including alcohol, cocaine, marijuana, heroin, and methamphetamine compared with whites.[8]

Not only do minority groups have lower rates of treatment completion, but they are also less likely to receive treatment at all. OUD is now considered a public health emergency as more than 130 Americans die daily as a result of this crisis.[22] One of the most beneficial evidence-based treatments for OUD involves medications for addiction treatment (MAT). MAT is the use of medications in combination with counseling and behavioral therapies; it is proven to be effective in the treatment of opioid use and in helping to sustain recovery.[23] Buprenorphine, methadone, and naltrexone are the 3 drugs that have been approved by the US Food and Drug Administration to fight opioid dependence.[23] Typically, these treatments have been most effective when combined with counseling and psychosocial support.[23] From 2004 to 2015, buprenorphine was more likely to be provided to patients that were white, had private insurance, and/or could self-pay.[4] Research shows that, between 2012 and 2015, there were a total of 13.4 million patient visits that resulted in a buprenorphine prescription; white patients accounted for 95% of those visits and minority patients accounted for

only about 3%.[24] Further, for every 35 white patients who received a buprenorphine prescription, 1 minority patient did, with an overall 77% lower odds of having an office visit that included a buprenorphine prescription.[24] Race and class are inextricably linked, making race, ethnicity, and income defining aspects of access. Between 2012 and 2015, approximately 40% of outpatient visits involving buprenorphine prescriptions were paid for by the patient outside of insurance, with private insurance covering only 34% of these costs, and only 19% were paid for by either Medicare or Medicaid.[24] Although 69% of counties in the United States have at least 1 SUD facility, about 40% do not have at least 1 outpatient SUD facility that accepts Medicaid.[25] Counties in the South and Midwest, as well as those with higher proportions of African American and/or Latinx residents, were less likely to have SUD outpatient facilities that accept Medicaid.[25]

Amid the OUD epidemic, several barriers hinder treatment for co-occurring disorders, including personal beliefs (ie, perceived stigma, cultural attitudes) and structural barriers (ie, insurance coverage, service availability and location, disorder identification, and lack of provider training to identify the disorders).[26] There is a lack of specialized services for treatment for substance abuse and mental health, particularly in rural areas.[26] Further, research suggests that negative stereotypes may contribute to the underdiagnoses and misdiagnoses of racial, ethnic, gender, and sexual minorities.[26] As the number of Americans with SUD grows, there is a pressing need to increase access to treatment for black, Latinx, and low-income populations to ensure all who could benefit from this treatment are provided appropriate access.

THE COST OF MENTAL HEALTH AND SUBSTANCE USE DISORDERS

Mental health care costs the United States about $300 billion annually, including $100 billion in health care expenditures.[27,28] Mental disorders are considered some of the highest cost medical conditions, with spending having increased by 5.6% between 1996 and 2013.[28] When substance use is taken into account, mental health and SUD services combined account for 7% of overall health care spending in 2014.[29] Medicare and Medicaid covered more than one-half of all spending on mental health care and SUD services, totaling $110 billion and $22 billion, respectively.[29] Early recognition and treatment of mental illness can lead to a decreased number of medical visits, ultimately decreasing costs. Further, mental illness increases the likelihood of morbidity for several chronic diseases, including cardiovascular diseases, obesity, diabetes, and cancer.[27] This finding suggests that providing accessible and high-quality treatments has the potential to improve outcomes for chronic diseases, further decreasing health care expenditures.[27] Eliminating mental health disparities by providing additional care can lead to the United States saving up to $38 million in emergency room expenditures and $833 million in inpatient expenditures for black and Latinx populations.[30] These significant cost decreases indicate an urgency to promote mental health and SUD equity. The World Health Organization states that investing in mental health is key to the advancement of and well-being of populations and improves economic efficiency.[31] The World Health Organization lists 4 ways to begin this investment:

1. Increase awareness and education about mental health and illness.
2. Provide better quality health and social care services for underserved populations with unmet needs.
3. Provide better social and financial protection for persons with mental disorders, particularly those in socially disadvantaged groups.

4. Provide better legislative protection and social support for persons, families, and communities adversely affected by mental disorders.[31]

These investment areas highlight the need for interventions that address equity not only at the individual and community level, but the structural level as well.

MENTAL HEALTH PARITY AND SUBSTANCE USE DISORDER EQUITY

The Mental Health Parity and Addiction Equity Act, which was enacted in 2008, requires that, when mental health or SUD benefits are covered, they are covered equally with physical health services.[32] SUD treatment is an essential health benefit for individual and small group coverage under the Affordable Care Act.[33] Although the passing of this landmark law helped to ameliorate the bifurcation of mental health and physical health, mental health and SUD parity compliance remains a work in progress across public and commercial payers, despite having been the law for more than a decade.

Meaningful oversight and enforcement of mental health and SUD parity are critical to reversing the current opioid epidemic, yet legislation alone is not the solution. In addition to enforcement, the removal of barriers such as prior authorization for MAT services, ensuring that MAT is affordable, and that health insurance companies have an adequate network of addiction medicine and mental health physicians are also crucial to addressing disparities in treatment. The business case has to be made at the intersection of regulators, payers, and providers who need appropriate incentives for investment. Both payers and health systems have become adept at adhering to the letter of the law, balancing regulatory requirements with financial restraints in deciding how to respond to shifts in regulations. Consequently, an ecosystem approach that accounts for the multiple and varied incentives of key stakeholders to address mental health and SUD is required and tangible; meaningful data must be acquired and disseminated.

MAKING THE BUSINESS CASE: REAL-WORLD EVIDENCE TRIALS

Traditional clinical trials, although of great value, are costly and time consuming, often spanning multiple years in development and navigating the complex approval process. Moreover, clinical trials are often conducted with specific populations, controlled in certain environments that do not reflect clinical or community realities.[34] Historically, clinical trials have struggled to have diverse participants and have, at times, increased disparities by focusing their studies on discrete populations.[34] Real-world evidence trials have the potential to compensate for the limitations of traditional clinical trials, improving the ability to generalize findings to be more inclusive of diverse populations.[34] This allows researchers to answer questions that better pertain to these populations, gaining a deeper understanding of how clinical settings, providers, and health systems affect treatments and outcomes. Real-world evidence trials involve information gathered beyond typical clinical research settings (ie, electronic health records, claims and billing data, disease registries, data from health informatics, personal devices, and health applications).[34] Thus, although efficacy trials aim to understand whether an intervention leads to a certain result under ideal conditions, effectiveness trials seek to assess the degree of effect under real-world clinical settings that are often impacted by factors such as patient preference, organization culture, administrative decisions, and organizational structure of the entities involved.[35] Real-world evidence trials, which embrace a health ecosystem approach and account for multiple entities and diverse incentives, could uncover financial,

operational, and strategic factors required to enhance the business case for meaningful investment in mental health and SUD.

Enhancing the business case using real-world evidence trials in mental health and SUD would best be served by incorporating a health ecosystem approach and collaborating with appropriate payers, health systems, and related parties in the recovery ecosystem, including those involved in outpatient care, inpatient care, housing, and social support services. Collecting and analyzing patient outcomes and financial outcomes could offer a data-driven and strategic opportunity to compel investment in mental health and SUD. For example, regarding OUD, strategic questions to answer would include the following: Does reducing the barriers to access, such as prior authorization of MAT, lead to fewer overdose deaths? Does reducing barriers save payers and health systems money when compared with the cost of overdose in the emergency room and other high-cost settings? Does the costlier injectable extended-release version of buprenorphine lead to fewer hospitalizations and emergency room admissions than the less expensive oral buprenorphine, and ultimately save more despite the higher upfront costs of injectable medications? Providing the answers to such trenchant questions in a real-world setting with a lens toward operational, financial, and patient outcomes could form a cogent argument for investing in OUD, and mental health and SUD more broadly, in minority communities.

MAKING THE BUSINESS CASE: MEDICAID AND REAL-WORLD EVIDENCE

Medicaid is both a federal and state program that provides health insurance for low-income individuals, and is one of the largest purchasers of health care services in the United States, providing coverage for more than 70 million people at an annual cost of more than $460 billion.[36] Medicaid is also the largest payer for mental health services in the United States and generally the first or second largest item in every state budget.[37] Given that Medicaid is a program for the poor and largely serves Latinx and black populations, Medicaid could act as the epicenter for rapidly addressing disparities in mental health and SUD access and treatment. Medicaid's size, scope, and centrality in the health insurance market make it a viable opportunity. Historically, for Medicaid, cost containment has meant imposing arbitrary across-the-board rate cuts or cutting eligibility, but the time is ripe for state Medicaid agencies to leverage real-world evidence trials.

Unlike Medicare, which is managed across the country under central administration, each state Medicaid office has latitude regarding how they administer the program. This latitude presents both a challenge and an opportunity. Coverage policy, in its broadest sense, is intended to promote value in medical care by using reimbursement to favor the use of effective care and avoid payment for ineffective care.[38]

Ways in which Medicaid can address disparities become apparent when exploring mental health and OUD treatment. For example, all state Medicaid offices are required to pay for mental health inpatient stays, but optional benefit categories include effective evidence-based nonclinical services such as peer support and community residential services and vary greatly by state.[37] On a more granular level, although all state Medicaid offices offer coverage for buprenorphine, which is used in MAT, 40 states require prior authorization for its use.[39] In a similar vein, Medicaid coverage for extended-release injectable buprenorphine is covered by 33 state Medicaid offices but only 7 do not require prior authorization.[40] Prior authorization is an effective tactic to prevent overuse and manage costs, but it has also been proven to be a barrier to care particularly for minority communities.[4] Real-world evidence trials could be a powerful tool to study financial and patient data, connecting the decrease of prior

authorization requirements to the decrease in overdose deaths and expensive emergency room visits associated with overdose. Similarly, real-world evidence trials could determine the impact of oral buprenorphine and the extended-release injectable buprenorphine and analyze cost differentials and overdose rates based on geography, health system characteristics, and race and ethnicity. Data-driven decision making based on patient and financial data in real-world settings could positively impact the opioid crisis, decrease costs, and meaningfully address disparities in mental health and SUD.

PRIVATE SECTOR INVESTMENT

There are instances of local communities across the country taking this leap; communities in Kansas and Colorado have now passed local taxes to build their capacity to address mental health and SUD.[41,42] In private industry, the Google affiliate, Verily, in Dayton, Ohio—considered the epicenter of the OUD crisis—established a nonprofit organization called OneFifteen to highlight and address the 115 people who die daily from OUD.[43] Additionally, private foundations in different states, including the Colorado Health Foundation, are now offering zero interest loans to inspire investment in mental health as well as in mental health innovation and technologies.[44,45] Although community investment in mental health and OUD is promising, more remains to be done at the payor, provider, state, and federal levels to address the OUD epidemic and decrease disparities in access and treatment to mental health and SUD services more broadly.

SUMMARY

The cost of our nation's mental health and SUD burden continues to escalate and is further exacerbated by health disparities that impact minority and low-income populations. Acknowledging the business case for addressing our mental health and SUD crisis is of vital importance. Although there are no easy answers, it is incumbent upon health systems, policymakers, and payers to address the human and financial cost of this crisis. A health ecosystem approach that aligns disparate incentives and accounts for financial, operational, and strategic concerns of payers and health systems is needed to inspire investment in mental health and SUD in underserved communities across the country. Although the human cost of the mental health and SUD epidemic is clear, navigating the "whose pockets" issue of cost decreases associated with these investments remains a challenge. Real-world evidence trials, which account for strategic and operational concerns along with the disparate financial incentives of multiple stakeholders, offer great promise to reduce disparities and combat this major challenge of our generation.

DISCLOSURE

The authors have nothing to disclose.

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