U.S. Spending on Mental Illness Soars as Number of Treatment Seekers Nearly Doubles

Between 1996 and 2006 spending on the diagnosis and treatment of mental illnesses grew at a faster pace than spending on other health conditions, according to a statistical brief issued by the Agency for Healthcare Research and Quality. During the same period, the number of Americans who sought treatment for depression, bipolar disorder, and other mental disorders almost doubled, outpacing increases among patients seeking treatment for other conditions.

In 1996 and 2006 the same five conditions ranked highest in terms of direct medical costs: heart conditions, cancer, trauma-related disorders (injuries and burns), mental disorders, and asthma. As shown in Figure 1, spending for all five conditions increased over the ten-year period ($p \leq .05$ for all). For mental disorders, spending rose from $35 billion (in 2006 dollars) to almost $58 billion. Figure 1 also shows the number of people with expenditures associated with the five conditions. For mental disorders the number rose from 19 million people in 1996 to more than 36 million in 2006.

In both years mean per-patient costs were highest for cancer, $5,067 in 1996 and $5,176 in 2006, and for heart conditions, $4,333 and $3,964, respectively. Similar to the trend for heart disease, per-patient costs fell for mental disorders, from $1,825 in 1996 to $1,591 in 2006. Trauma-related per-patient costs showed the greatest dollar increase, from $1,220 to $1,953. Asthma had the lowest mean expenditures per person in both 1996 and 2006—$883 and $1,059, respectively.

Out-of-pocket expenses in both years were highest for mental disorders (23% of total spending on mental disorders in 1996 and 25% in 2006), followed by asthma care (15% and 17%, respectively). In 1996 the out-of-pocket share was lowest for cancer treatment, at 3.8%. In 2006 heart disease replaced cancer as the condition with the lowest out-of-pocket costs, at 8.2%.

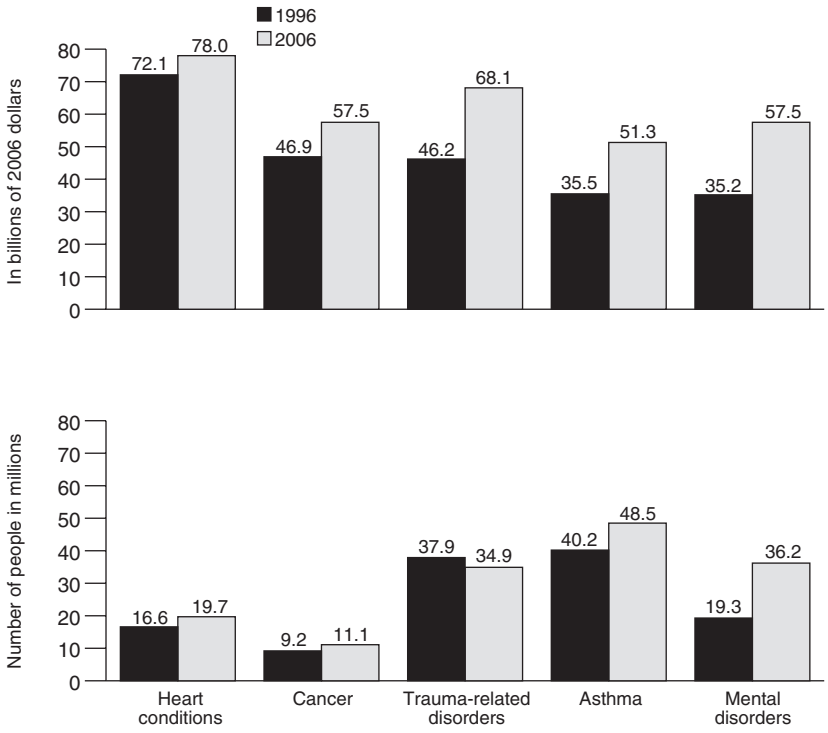
Data for the statistical brief are from the Medical Expenditure Panel Survey (MEPS). *The Five Most Costly Conditions, 1996 and 2006: Estimates for the U.S. Civilian Noninstitutionalized Population* is available at meps.ahrq.gov/mepsweb/data_files/publications/st248/stat248.pdf.

NEWS BRIEFS

Improving policy for "dual eligibles": Health care reform presents an opportunity to realign federal and state policy for nine million people who are covered by both Medicare and Medicaid, about a third of whom have serious mental illness. The dually eligible population accounts for nearly half of all Medicaid spending, which limits the ability of states to fund other priorities. Navigating two programs with different rules and financing incentives is complex for beneficiaries and providers, impedes coordination, and results in cost shifting between programs that does not promote better outcomes. Realigning federal and state responsibilities for this population could provide improved coordination and management of services, better accountability, and more stable financing. An eight-page brief from the Kaiser Family Foundation examines federal and state roles and lays out health policy options, focusing on opportunities to improve coverage, delivery and payment, and financing. Options include developing systems that provide integrated acute and

Figure 1

Expenditures for the five most costly health conditions and number of people with such expenditures, 1996 and 2006[a]



[a] Source: Medical Expenditure Panel Survey, Agency for Healthcare Research and Quality

long-term services and supports, increasing the availability of home- and community-based care, and providing more stable financing. *Health Reform Opportunities: Improving Policy for Dual Eligibles* is available on the Kaiser Web site at www.kff.org/medicaid.

NIMH RAISE project announced: The National Institute of Mental Health (NIMH) has announced awards to two research groups for a large-scale project exploring whether early and aggressive treatment that is individually targeted and that systematically integrates a variety of therapeutic approaches will reduce the symptoms and prevent the gradual deterioration of functioning that is characteristic of chronic schizophrenia. Treatment will be delivered in up to 30 clinical sites across the United States. Recovery After an Initial Schizophrenia Episode (RAISE) will rely on active involvement of government agencies, providers, and consumers and family members to help ensure that if the evidence-based approach is successful it can be disseminated and adopted rapidly. Two research groups will work in parallel to develop and test potential approaches. One group is led by John M. Kane, M.D., of the Zucker Hillside Hospital, Feinstein Institute for Medical Research, Manhasset, New York. The second group is led by Jeffrey Lieberman, M.D., of the Research Foundation for Mental Hygiene, Inc., New York City. American Recovery and Reinvestment Act funds will underwrite the initial two phases, during which the investigators will refine the interventions with input from stakeholders and then conduct a feasibility study to demonstrate that interventions can be fielded in real-world settings and can be evaluated in a randomized clinical trial. With long-term NIMH funds committed to these phases plus the clinical trial, funding for the study is $40 million. More information about RAISE is available on the NIMH Web site at www.nimh.nih.gov.

SCHIP expands in states after reauthorization: At least 13 states have increased income eligibility levels for their State Children's Health Insurance Program (SCHIP) since the program's reauthorization in February 2009, which has added 250,000 children to SCHIP rolls, according to a *New York Times* report in July. The reauthorization gives states the option of raising eligibility to 300% of the poverty level (or $66,150 for a family of four) from a ceiling of 250% set by a Bush Administration directive. States receive about 70% of SCHIP funds from the federal government, but they can receive a larger share by committing more state funds. In addition, three states are dropping rules that legal immigrants must wait five years before becoming eligible, which the new legislation permits. Other states have extended coverage to pregnant women or streamlined enrollment and eligibility procedures. SCHIP served about 7.4 million people in 2008. Of the 8.2 million children who remain uninsured, about two-thirds are eligible for either SCHIP or Medicaid but have not been enrolled, according to the Kaiser Family Foundation. The reauthorization includes $100 million in grants to help states sign up eligible children. The report on SCHIP, which is accompanied by an interactive state map, appeared in the July 19 *New York Times.*

Improving women's mental health: Recent decades have brought advances in understanding of the role of gender in the risks, course, and treatment of mental illnesses and the effectiveness of new treatment options. The Office of Women's Health of the U.S. Department of Health and Human Services, in collaboration with several other federal agencies, has developed a series of recommendations for policy planners, health care providers, researchers, and others to promote improved mental health for U.S. girls and women. The 56-page document reviews and summarizes research on the burden of mental illness for women and gender differences in rates of and risk factors for mental illness. Twelve action steps and the rationale for each are then presented. For example, one step calls for recognition of the prevalence of trauma, abuse, and violence in the lives of girls and women and for increased prevention efforts and support of promising new approaches that enhance recovery. A 30-page appendix includes an extensive list of resources and a bibliography. *Action Steps for Improving Women's Mental Health* is available on the Web site of the National Mental Health Information Center at mentalhealth.samhsa.gov.