

The Mind/Body Continuum

Cost Considerations for Whole Person Health

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Discussion points

- Historical trend to consider mental health disorders in the US as separate and distinct from physical health
- Historical management of mental health disorders
- Recognition of the mind/body continuum. That mental health and physical health are two components of whole person health
- The advent of mental health parity laws
- Economic perils of managing physical health while ignoring mental health



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Early management of mental health disorders

Ancient Times



Treatment – exorcisms, prayers, herbal remedies and rituals

Early management of mental health disorders

From 1500 to 1800, there was renewed interest in the problem and potential medical explanations, but treatments remained crude.

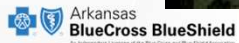
- Restraints
- Bloodletting
- Purging
- Institutionalization

Early management of mental health disorders

Bedlam - a scene of uproar and confusion (Oxford dictionary)



Bedlam Royal Hospital, London



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Early 20th Century management shift toward a biological understanding

- Freudian psychoanalysis
- Electroconvulsive therapy (ETC)
- Lobotomies– surgical removal of the frontal brain (1930s-1950s)
- Institutionalization was still dominant



Modern understanding and management of mental health disorders

- Understanding of the brain biology and pharmacodynamics has advanced
- Management is multi-faceted (talk therapy, medications), evidence-based and increasingly patient centered
- Diagnostic classifications are far more developed
- Pharmacological treatments are much more refined and targeted to the biochemical disorders promoting disease
- The interaction between psychiatric disorders and substance use disorders is better understood
- Treatment has shifted from inpatient to outpatient

Modern understanding

- Despite all the advancements, there is a tendency to divorce mental health from physical health by society in general
- Until recently, the healthcare industry and the health insurance industry harbored the same segregation
- Recent understanding now appreciates the necessity of viewing health, overall, as having components inclusive of mental and physical

Modern understanding



Mental
Health



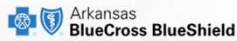
Physical
Health



Reality

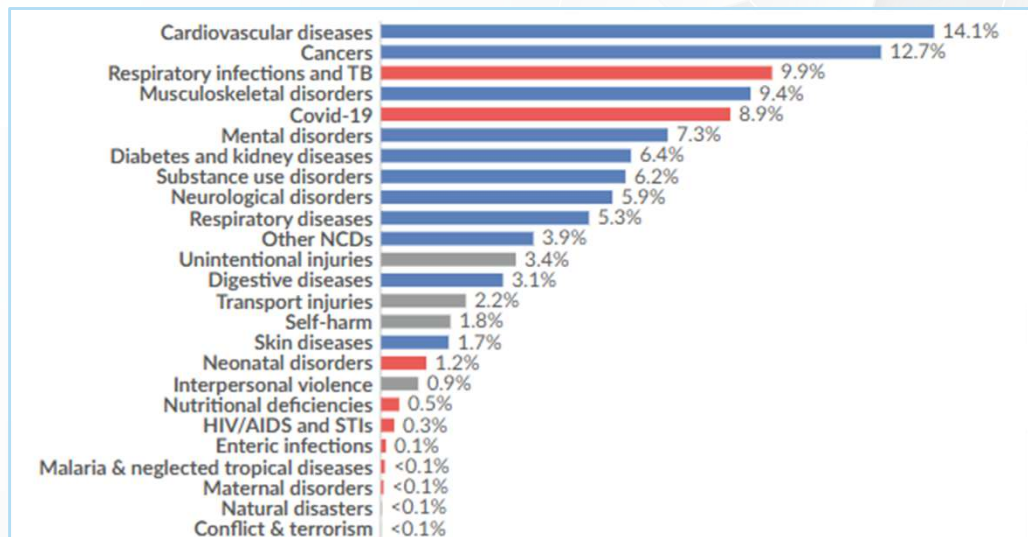
Patricia Gibson, MD

- Mental and substance use disorder rates nationally and in Arkansas, and the increased cost for employers, employees and payers.
- Legal requirements for health plan benefit designs to meet federal requirements for mental health parity
- Current mental health treatment and addressing the lack of access by integrating behavioral health into primary care to improve clinical and financial outcomes.



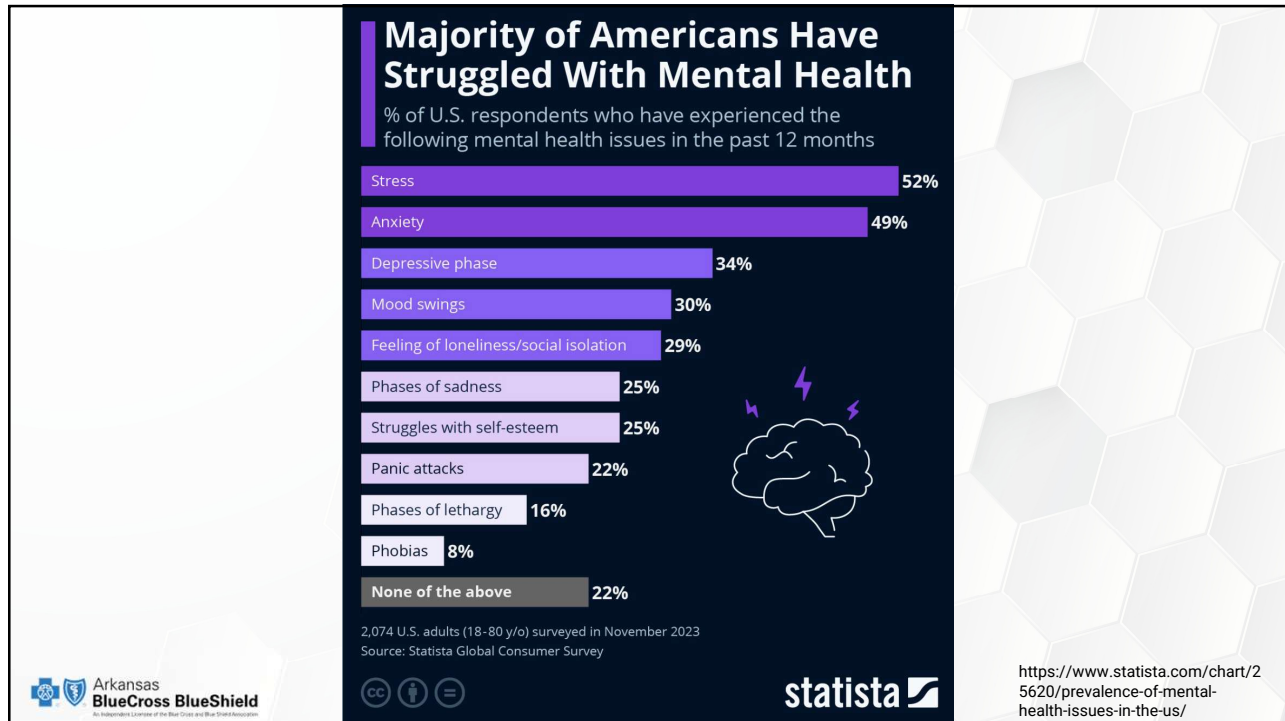
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Share of total disease burden by cause, United States, 2021



<https://ourworldindata.org/burden-of-disease>

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Mental Health in Arkansas

An inadequate mental health system affects individuals, families and communities.

- High school students** with depression are more than **2x more likely to drop out** than their peers.
65.7% of Arkansans age 12–17 who have depression **did not receive any care** in the last year.
- 2,366 people** in Arkansas are homeless and **1 in 8 live with a serious mental illness.**
- On average, 1 person in the U.S. **dies by suicide every 11 minutes.**
In Arkansas, **554 lives were lost to suicide** and 106,000 adults had thoughts of suicide in the last year.
- 1 in 4 people with a serious mental illness has been arrested** by the police at some point in their lifetime – leading to over **2 million jail bookings** of people with serious mental illness each year.
- About **2 in 5 adults** in jail or prison have a history of mental illness.
- 7 in 10 youth** in the juvenile justice system have a mental health condition.

nami National Alliance on Mental Illness
NAMI Arkansas is part of NAMI, National Alliance on Mental Illness, the nation's largest grassroots mental health organization dedicated to building better lives for the millions of Americans affected by mental illness.
This fact sheet was compiled based on data available in February 2021. For full citations, visit: nami.org/imhpolicystats.

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Suicide Data: Arkansas

Suicide is a public health problem and leading cause of death in the United States. Suicide can also be prevented – more investment in suicide prevention, education, and research will prevent the untimely deaths of thousands of Americans each year. Unless otherwise noted, this fact sheet reports 2023 data from the CDC, the most current verified data available at time of publication (May 2025).

10th leading cause of death in Arkansas

3rd leading
cause of death for ages 15-24

2nd leading
cause of death for ages 25-34

4th leading
cause of death for ages 35-44

7th leading
cause of death for ages 45-54

9th leading
cause of death for ages 55-64

17th leading
cause of death for ages 65 and older

66% of communities did not have enough mental health providers to serve residents in 2023, according to federal guidelines.

Over **three times** as many people died by suicide than in alcohol related motor vehicle accidents.

The total deaths to suicide reflected a total of **12,443 years** of potential life lost (YPLL) before age 65.

59% of firearm deaths were suicides.
63% of all suicides were by firearms.

Suicide Death Rates

	Number of Deaths by Suicide	Rate per 100,000 Population	State Rank
Arkansas	626	20.21	11
Nationally	49,316	14.12	

See full list of citations at afsp.org/statistics.

afsp.org/statistics

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Distribution of Population & Total Healthcare Costs

From 2020 Milliman Research Report

FIGURE 4: DISTRIBUTION OF THE POPULATION AND TOTAL HEALTHCARE COSTS AMONG COST AND BEHAVIORAL HEALTH GROUPS, 2017

Group	% of Population	% of Total Healthcare Costs
High-cost Group - with BH (Top 10%)	5.7%	43.8%
High-cost Group - without BH (Top 10%)	4.3%	26.4%
Non-high-cost Group - with BH (Bottom 90%)	21.6%	12.7%
Non-high-cost Group - without BH (Bottom 90%)	68.4%	17.2%

<https://www.milliman.com/en/insight/How-do-individuals-with-behavioral-health-conditions-contribute-to-physical>

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Impact of MH/SUDs on Total Healthcare Costs: Higher Medical Costs for Patients with MH/SUDs

FIGURE 9 EXCERPTS FROM MILLIMAN: AVERAGE ANNUAL HEALTHCARE TREATMENT COSTS (SERVICES AND PRESCRIPTION DRUGS) PER INDIVIDUAL BY BEHAVIORAL HEALTH CATEGORY, 2017 TOTAL POPULATION

BH CATEGORY	INDIVIDUALS		AVERAGE ANNUAL HEALTHCARE COSTS		% OF COSTS FOR BEHAVIORAL HEALTH	COSTS RELATIVE TO "NO BH" MEDICAL/ SURGICAL
	NUMBER	%	BEHAVIORAL HEALTH	MEDICAL/ SURGICAL		
No BH	15,275,323	73%	\$0	\$3,552	0.0%	1.0x
Any MH	5,317,964	25%	\$1,017	\$11,204	8.3%	3.2x
Any SUD	908,499	4%	\$1,989	\$17,807	10.0%	5.0x
Both MH and SUD	492,465	2%	\$3,413	\$22,189	13.3%	6.2x
Total Population	21,009,321	100%	\$263	\$5,669	4.4%	1.6x

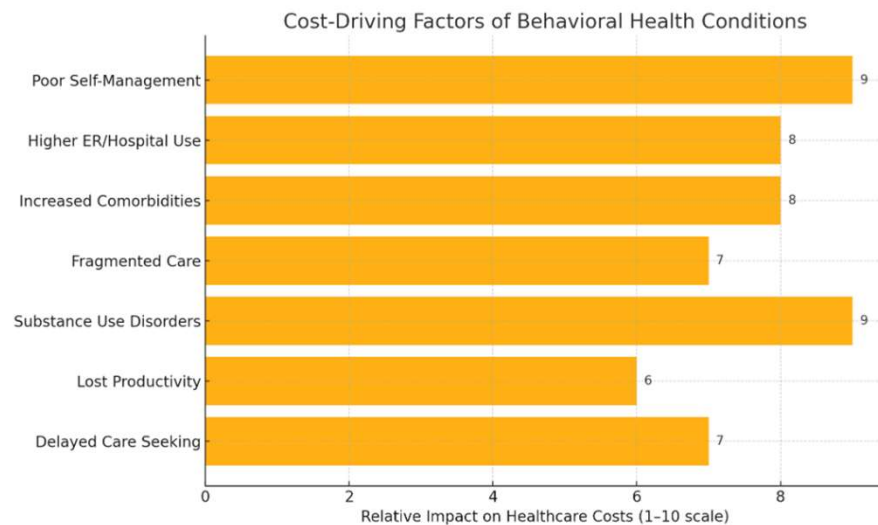
BH = Behavioral Health condition MH = Mental Health condition SUD = Substance Use Disorder

Source: Davenport S, Gray M, Melek S. "How do individuals with behavioral health conditions contribute to physical and total healthcare spending?" Milliman. Published August 13, 2020. <https://www.milliman.com/-/media/milliman/pdfs/articles/millimanhigh-cost-patient-study-2020.ashx>

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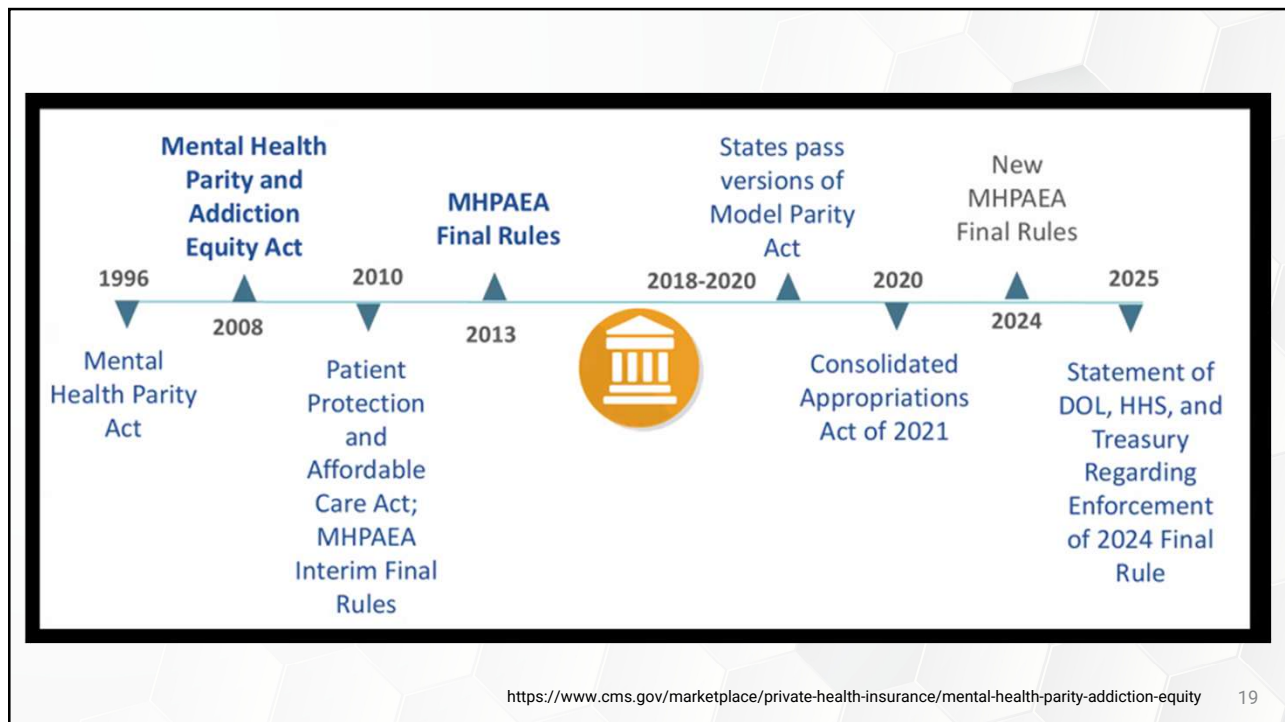
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Cost-Driving Factors Of Behavioral Health Conditions




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ACTION REQUIRED: Mental Health Parity Compliance for Employers/Healthcare Purchasers
Information and tools to ensure compliance, reduced costs, and a healthier workforce

 **National Alliance of Healthcare Purchaser Coalitions**
 Driving Health, Equity and Value

Employers/healthcare purchasers have a fiduciary responsibility to participants in their employee benefits plans to require their vendor partners to comply with the [Mental Health Parity and Addiction Equity Act](#) (MHPAEA), which requires that Mental Health/Substance Use Disorder (MH/SUD) benefits are not more restrictive than Medical/Surgical (M/S) benefits.

Key Areas of Focus for Employers/Healthcare Purchasers

- 1 Employers/Healthcare Purchasers Need to Take Action NOW**
 - Employer/healthcare purchaser fiduciary responsibility
 - Department of Labor (DOL)/Centers for Medicare and Medicaid Services (CMS) is escalating enforcement
 - DOL/CMS report that most employers/healthcare purchasers are noncompliant in the area of Non-Quantitative Treatment Limits (NQTLs)
 - Do you know how to comply?
- 2 Mental Health Parity Requirements**
 - Three main areas:
 -  **Financial Requirements (FRs)** – e.g., copayments, deductibles...
 -  **Quantitative Treatment Limits (QTLs)** – e.g., # days or visits...
 -  **NQTLs** – e.g., prior authorization, network adequacy, reimbursement rates, exclusions...
 - NQTLs are the most complex to analyze and compare. The Employer/Healthcare Purchaser Toolkit contains tools for documenting comparative analyses for the most common NQTLs.**
- 3 Employer/Healthcare Purchaser Action Checklist**
 - Require your TPAs/service providers to complete the [NQTL Multi-Step Comparative Analysis Tools](#) (and embedded MDRF templates) specific to your plan information.
 - Document communications with TPAs/service providers when requiring them to perform comparative analyses.
 - Talk to your broker, consultant, and/or legal counsel about their ability to review the responses you receive from TPAs/service providers.
 - Require TPAs/service providers to correct insufficient responses, noncompliant areas, and disparities in outcomes data.
 - Require TPAs/service providers to update and have available these comparative analyses annually, especially if new or different NQTLs or programs are implemented (e.g., value-based purchasing, narrow networks...)

<https://www.nationalalliancehealth.org/wp-content/uploads/Mental-Health-Parity-Toolkit-FINAL-3.pdf>

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Coverage alone does not guarantee care

EBRI EXECUTIVE Summary

September 15, 2025

2025 EBRI Employee Mental Health Survey

The most common challenges:

- Lack of awareness (47%)
- Stigma (43%)
- Confidentiality concern (40%)
- Cultural barriers (33%)
- Limited budgets (33%)

Hire. Keep. Benefit.

Attracting and retaining employees is a top priority, and benefits are key.



Nearly all employers say **attracting and retaining talent is a top priority (99%)**, and nearly as many view **health and wellbeing benefits as essential to that effort (96%)**. Most feel this strongly—68% strongly agree on the priority and 53% strongly agree on the role of benefits.

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Key findings

EBRI EXECUTIVE Summary

September 15, 2025

2025 EBRI Employee Mental Health Survey

1. Mental health needs are widespread

- 27% of employees reported having a MH condition (or a family member)
- most commonly in ages 25-54, married, with children
- most common conditions anxiety (17%), depression (11%) ADHD (8%)

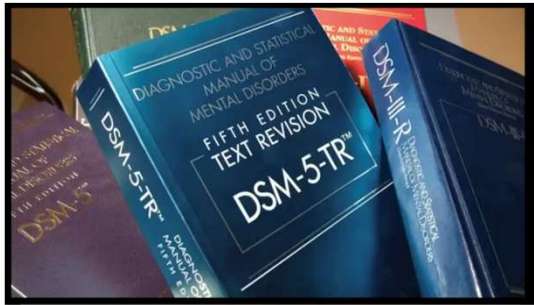
2. Having coverage is not enough

- these employees – 2x as likely to report being unable to get medical care they thought was necessary
- 33% struggled to get MH services & 32% could not get prescriptions
- 2x as likely to report doctors not taking insurance as reason for not accessing care
- Lack of time off & childcare were also factors

3. High reliance on emergency departments

- 62% reported visiting an ER in the past 6 months
- 50% more likely than their peers to use ER
- 4x more likely to visit ER four or more times in that period

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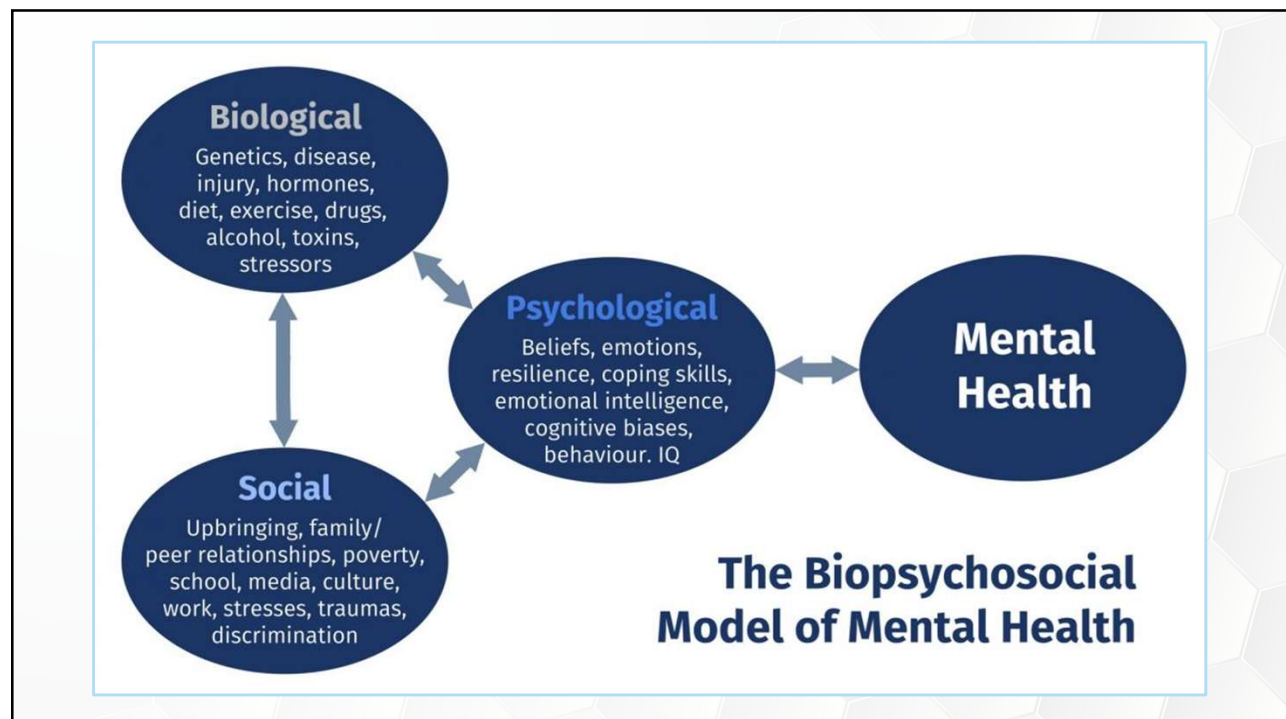


DSM-5-TR

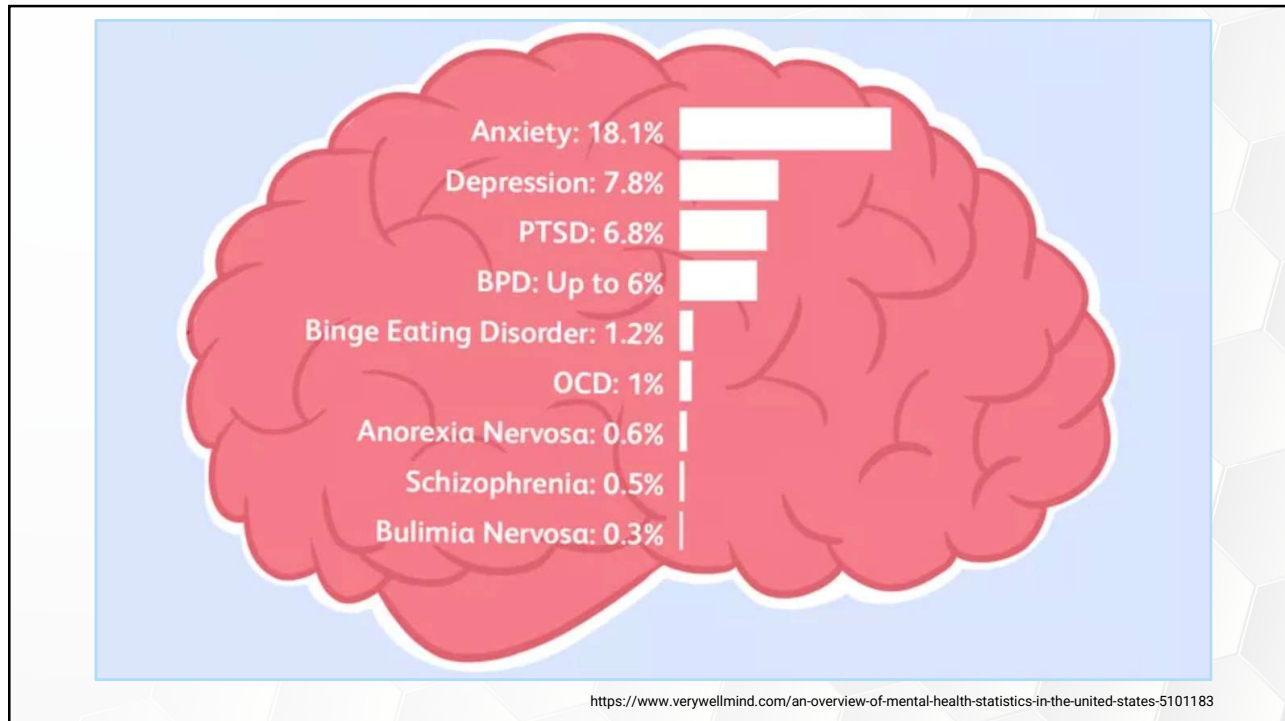
- 297 mental disorders
- 8 editions since #1 in 1952

Neurodevelopmental Disorders
 Schizophrenia Spectrum and Other Psychotic Disorders
 Bipolar and Related Disorders
 Depressive Disorders
 Anxiety Disorders
 Obsessive-Compulsive and Related Disorders
 Trauma- and Stressor-Related Disorders
 Dissociative Disorders
 Somatic Symptom and Related Disorders
 Feeding and Eating Disorders
 Elimination Disorders
 Sleep-Wake Disorders
 Sexual Dysfunctions
 Gender Dysphoria
 Disruptive, Impulse-Control, and Conduct Disorders
 Substance-Related and Addictive Disorders
 Neurocognitive Disorders
 Personality Disorders
 Paraphilic Disorders
 Other Mental Disorders and Additional Codes
 Medication-Induced Movement Disorders and Other Adverse Effects of Medication
 Other Conditions That May Be a Focus of Clinical Attention

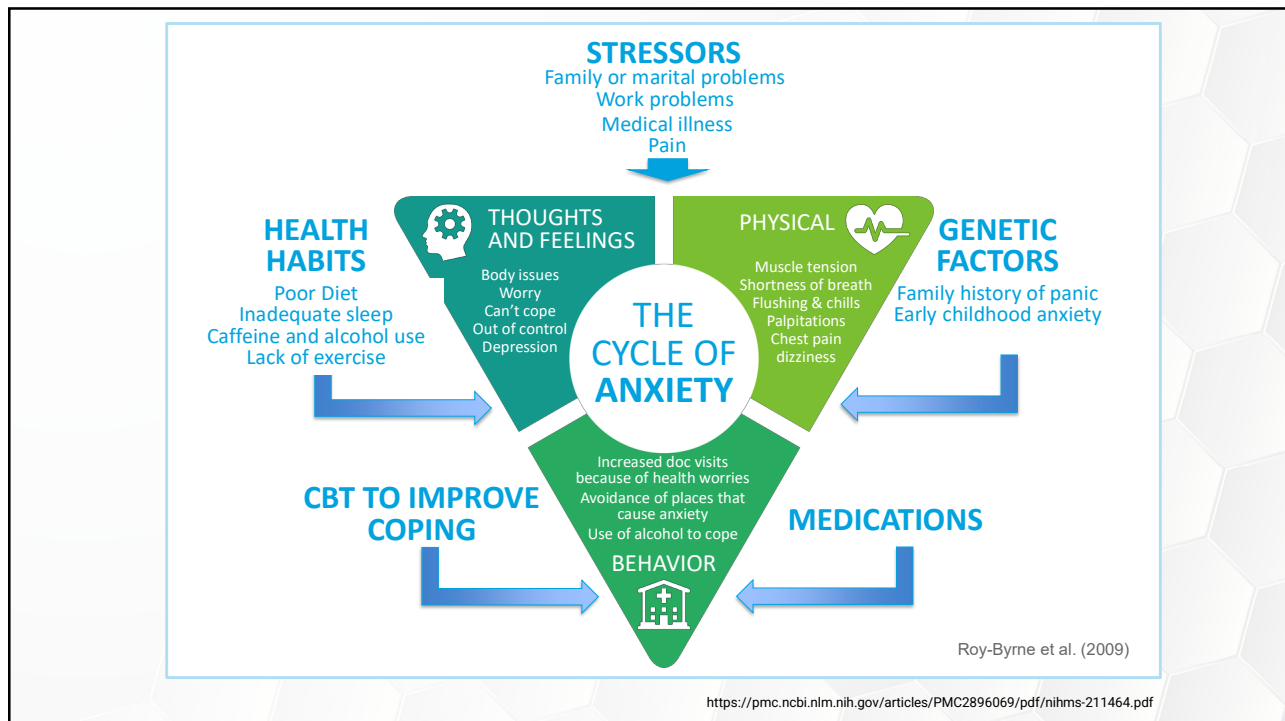
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Primary Care is the de facto mental health system

60-80%

of psychiatric medications are prescribed in primary care

No Treatment

Primary Care Provider

Mental Health Provider

Wang et al 2005 ©2013 University of Washington

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Why Not Just Refer?

Patient Factors

- Half of those referred do not follow through
- Mean # of visits = 2

Provider Factors

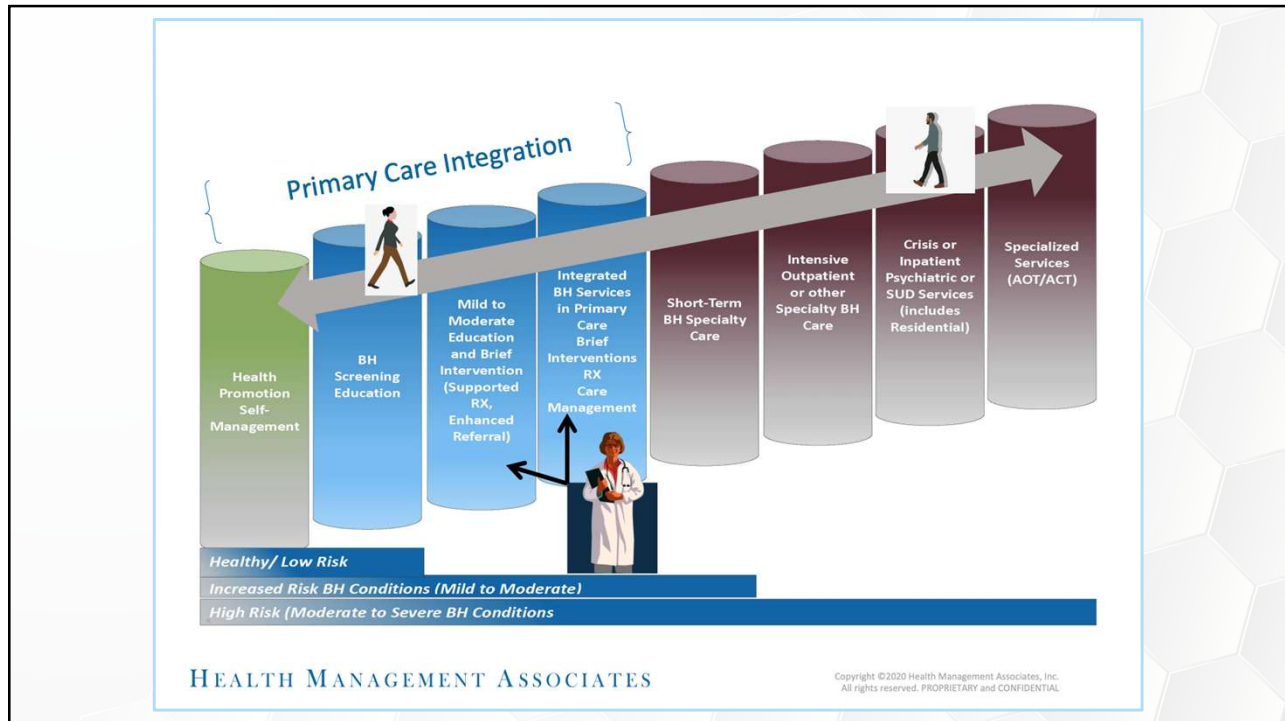
- 46.1% of counties at least one psychiatrist
- Majority of counties had no psychiatrists

Grembowski, Martin et al., 2002
Simon, Ding et al., 2012

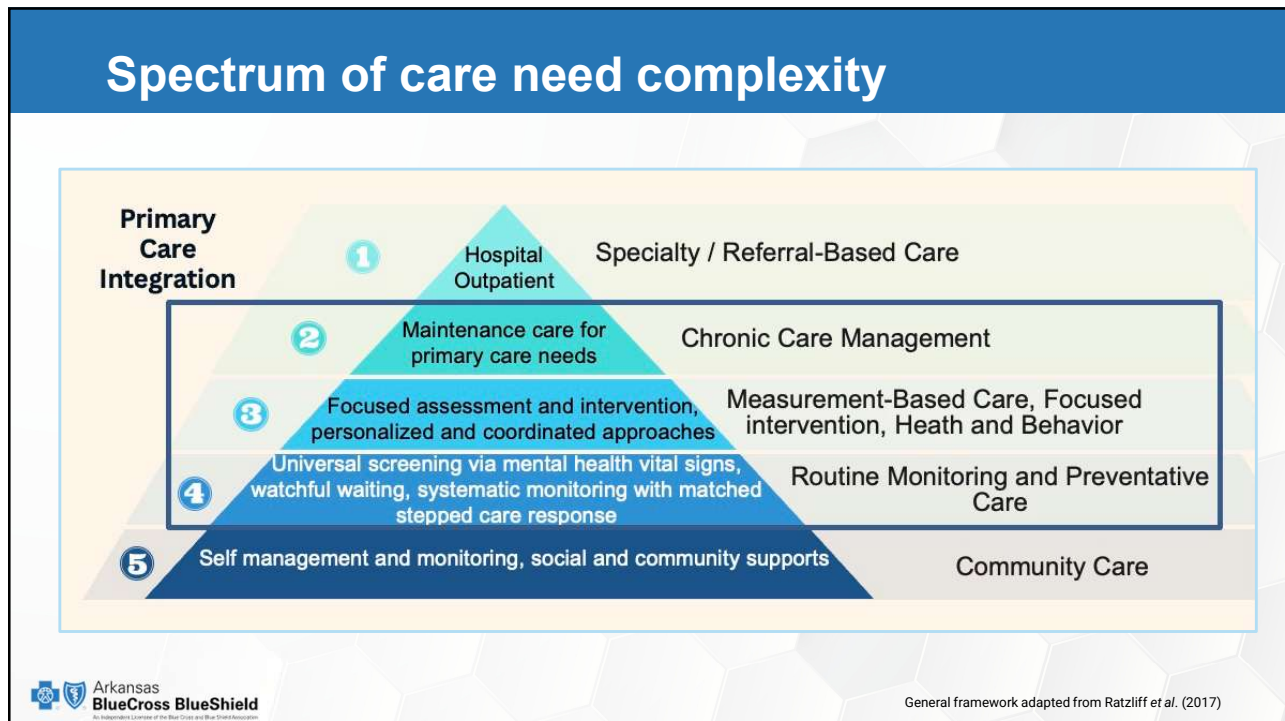
<https://www.healthworkforceta.org/research-alerts/mapping-supply-of-the-us-psychiatric-workforce/> 2018

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Moving to integrated care: Levels of collaboration/integration

Behavioral health integration **fortifies primary care** by bringing together primary care and behavioral providers, working with patients and families.

- ↑
 - Patient outcomes
 - Patient/family engagement
 - Provider care/team satisfaction
- ↓
 - Cost/utilization
 - Administrative coordination
 - Provider care/team burnout

Coordinated		Co-Located		Integrated	
Level 1 Minimal Collaboration	Level 2 Basic Collaboration at a Distance	Level 3 Basic Collaboration Onsite	Level 4 Close Collaboration Onsite with Some System Integration	Level 5 Close Collaboration Approaching an Integrated Practice	Level 6 Full Collaboration in a Transformed/ Merged Integration Practice

Source: SAMHSA, [Six Levels of Collaboration/Integration](#)

California Quality Collaborative



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Impact on clinics & patients



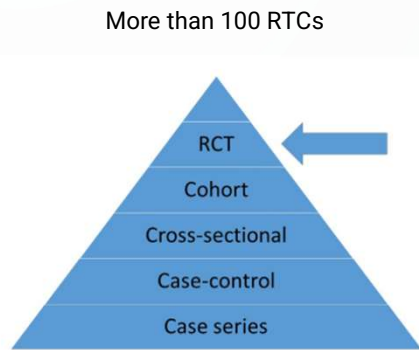
- Better continuity of care
- Reduced provider burnout
- Stronger patient engagement
- Improved population health
- Using a team saves time – more efficient & effective
- Decreased stigma
- Improved equity in care



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Evidence for integration



Improves patient outcomes (chronic disease management, depression, anxiety)

Reduces ER visits & hospitalizations

Increases provider satisfaction

Demonstrates cost savings across systems

Improves access to BH care

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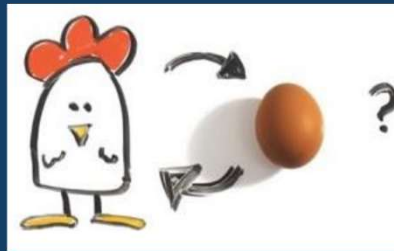
Aaron Novotny, PhD

- Research: the financial impact of a mental health disorder on the overall cost of care for an individual
- The financial consequences to the system of being unaware of the existence of a mental health disorder in a member
- The positive fiscal impact of recognizing mental health disorders in individuals in an insured population and moving them to effective management as soon as possible

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Mental Health & Physical Health

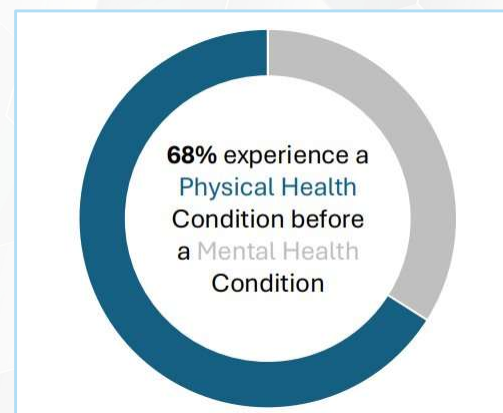
Costs and utilization: A Chicken and an Egg



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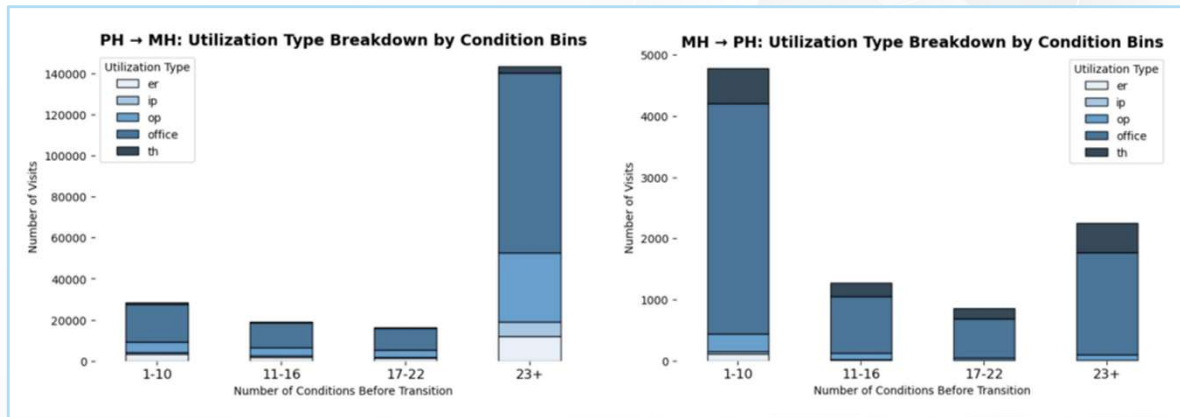
Who do we see first?

- Most members present with a physical health condition *before* they present with a mental health condition
- Of members that present with both:
 - people with a diagnosed physical condition usually are diagnosed with a mental health conditions **11 months later**
 - People that have a mental health condition diagnosed first tend to have a physical health condition diagnosed **3 months later**



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How many diagnoses need to occur before people get co-diagnosed?



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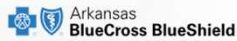
Looking at the Arkansas population over 5 years...

- Behavioral health conditions present for 46.1% of the population at some point in timeframe, ranging from:
 - Anxiety, Stress, PTSD
 - Substance Use Disorder
 - Depression
- Most frequent physical health condition is hypertension, with a presentation rate of 28.1% followed by:
 - Obesity – 25.9%
 - Diabetes – 10.4%

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What are the most frequent co-diagnosed conditions (within 1 month)?

- For Behavioral Health
 - Abnormal test results (that can indicate advanced disease)
 - MSK problems
 - Endocrine and nutritional problems
 - Respiratory problems
- For Hypertension
 - Endocrine and nutritional problems
 - Abnormal test results (that can indicate advanced disease)
 - MSK problems
 - Mental Health problems



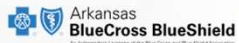
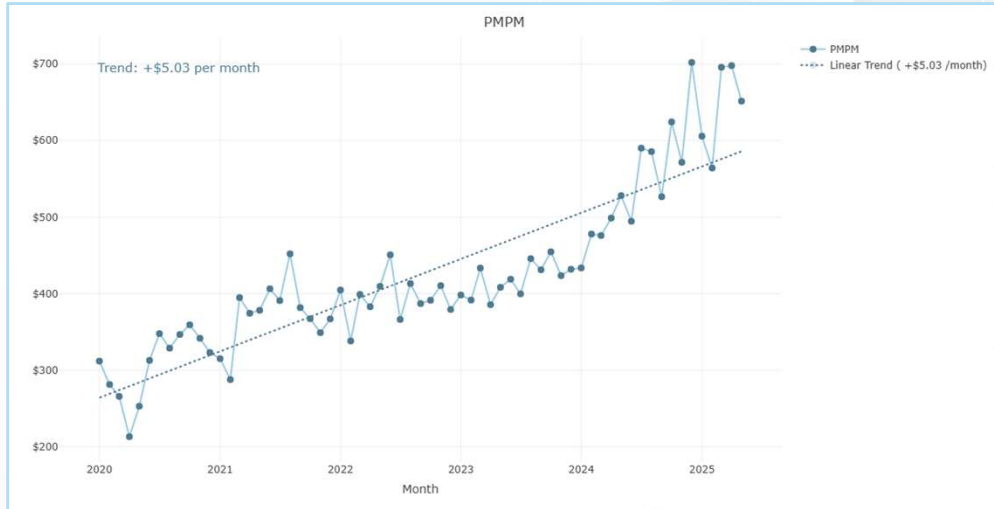
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**BH and MH conditions combine
to create costs ...**



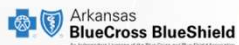
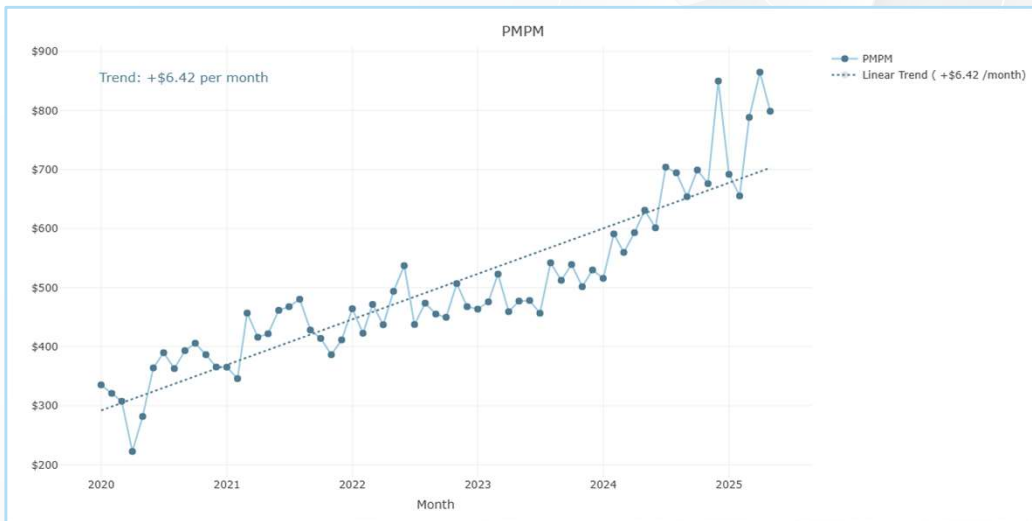
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BH trend

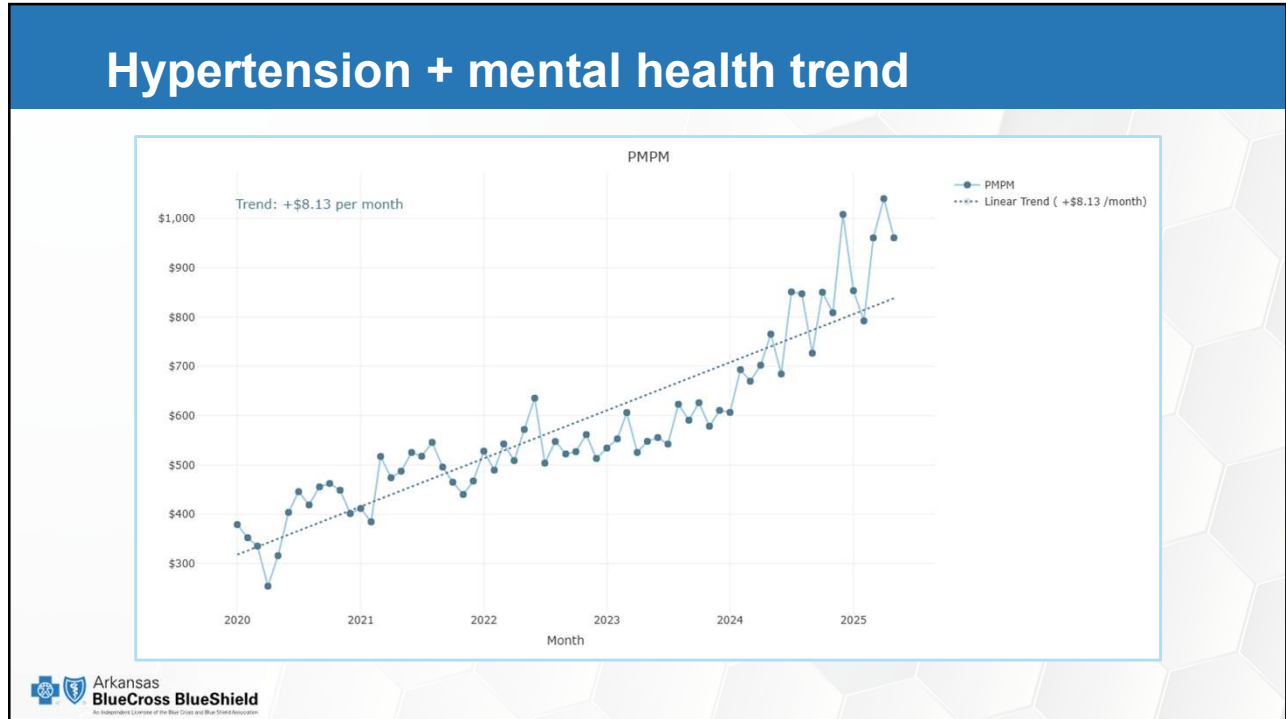


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Hypertension trend



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How does this happen? Disease escalation

51.3%

of liver disease patients have diagnosis of hypertension AND mental health

62.1%

of paralysis patients have both diagnoses of hypertension and mental health

61.9%

of renal patients have both diagnoses of hypertension and mental health

Arkansas BlueCross BlueShield
An Independent Company of the Blue Cross and Blue Shield Association

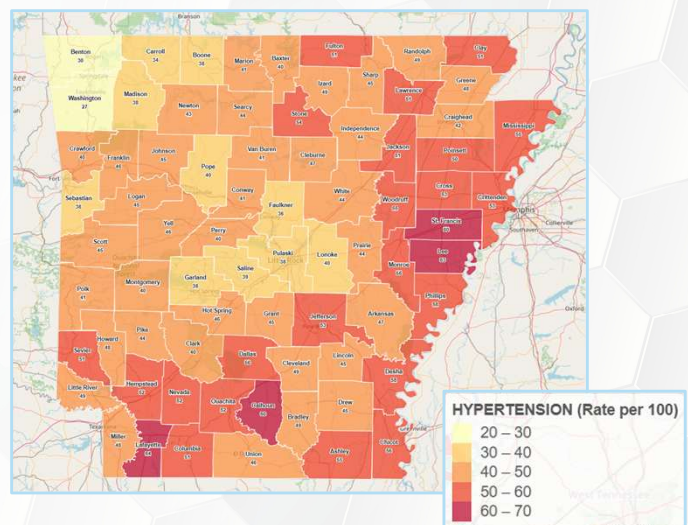
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Addressing the problem isn't so simple ...

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Where do we see high prevalence of BH AND hypertension?

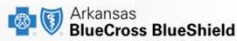
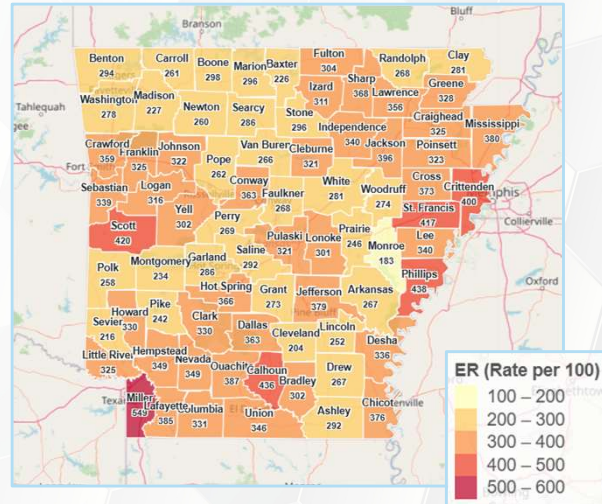
- Less populated areas have higher rates of co-diagnosis creating difficulty reaching these populations to help
- Moreover, these members suffer from barriers to access such as
 - Transportation difficulties (56.1%)
 - Rural locations (42.1%)
 - Socioeconomic struggle (57%)



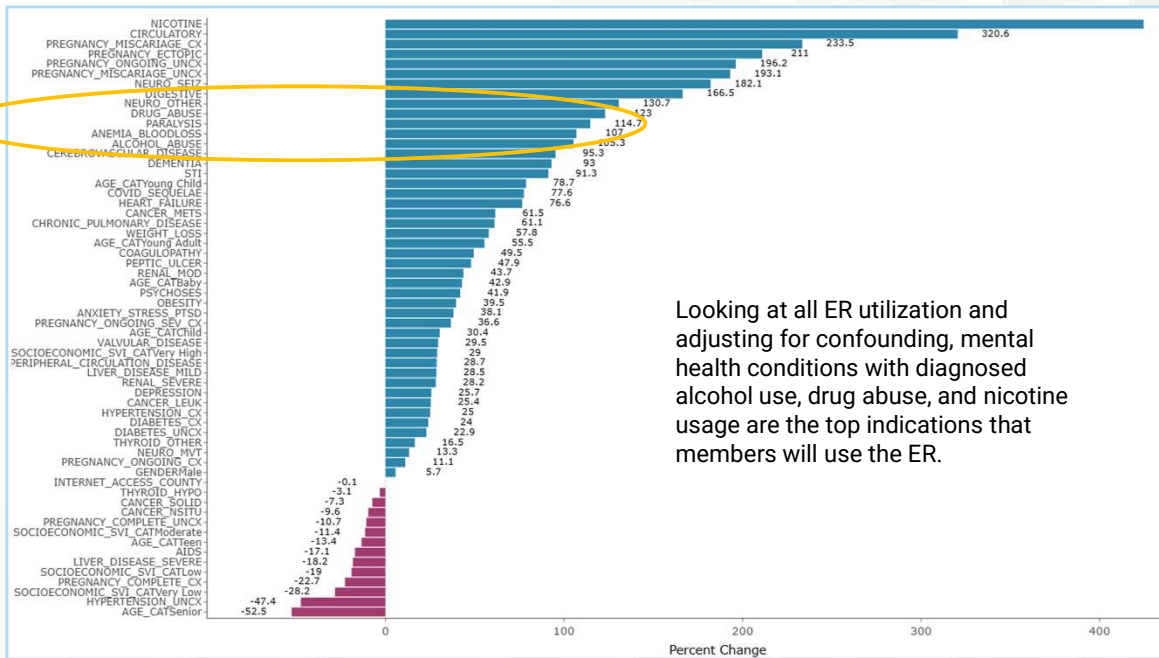
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Low access and multiple conditions ...

Emergency room rates are elevated in these areas, highlighting how low access, BH and PH conditions can impact utilization.



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Looking at all ER utilization and adjusting for confounding, mental health conditions with diagnosed alcohol use, drug abuse, and nicotine usage are the top indications that members will use the ER.

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Treating mental health separately from physical health ...

- It's a no-win situation
- Members may present PH or MH first, but they (ultimately) arrive at the same place over time
- PH and MH influence each other, and this is not a bad thing

Questions/Comments