

# Coverage for All: Inclusion of Mental Illness and Substance Use Disorders in State Healthcare Reform Initiatives

EXECUTIVE SUMMARY

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## EXECUTIVE SUMMARY

Frustrated by inaction at the federal level to address the growing number of uninsured Americans, states are increasingly moving forward on healthcare reform. Although state initiatives have been the subject of front page news, no one has examined the impact of their programs on people with mental illnesses and substance use disorders.

This analysis by the National Alliance on Mental Illness (NAMI) and the National Council for Community Behavioral Healthcare (National Council) examines benefits for mental illness and substance use disorders for adults in state plans that cover the uninsured. The paper, which is based on research on 18 states' initiatives and proposals, includes important findings on the following topics:

- The scope of the problem
- The history of financing for mental health and substance use treatment
- Analysis of state benefit packages
- Issues for future exploration
- Implications for the future

### The Scope of the Problem

People with mental illness and substance use disorders are prevalent in the uninsured population. Data from the 2005 and 2006 National Survey on Drug Use and Health (NSDUH) that were tabulated specifically for this report indicate that more than one in four adults who are uninsured have a mental illness, substance use disorder, or co-occurring disorder. Approximately one-third of people with mental illness, substance use disorders, or both who are under the federal poverty level (FPL) are uninsured.

Not having insurance is a significant roadblock for people with mental illness and/or substance disorders. Almost 80 percent of people with these disorders who needed mental health treatment but did not receive it cited cost as the reason. Underinsurance is also a problem: 34 percent of *insured* people who had unmet mental health needs indicated that cost was a barrier to seeking treatment.

Data from the World Health Organization show that mental illness is the leading cause of disability in North American adults; substance use is the second leading cause. Neuropsychiatric disorders, which include mental illness and substance use disorders, are more significant contributors to disease burden worldwide than are other noncommunicable diseases, such as heart disease and cancer.

The consequences of untreated or under-treated mental illness, substance use disorders, and co-occurring disorders can be quite severe. Almost one-fourth of all stays in U.S. community hospitals—7.6 million of nearly 32 million stays—involved depression, bipolar disorder, schizophrenia, and other mental health disorders or substance use disorders. Two-thirds of the U.S. homeless population are adults with chronic alcoholism, drug addiction, mental illness, or some combination of the three. Approximately 16 to 23 percent of jail, state, and federal prison inmates have a serious mental disorder, and adults with serious mental illnesses die 25 years sooner than those who do not have a mental illness.

Given the health and economic consequences of untreated mental illness and substance use disorders, along with the high prevalence of those conditions in people who are uninsured, states that do not include benefits for their residents will fail to address significant treatment needs of a considerable percentage of the uninsured, leaving them to suffer poor health and economic distress.

### History Of Financing For Mental Illness And Substance Use Treatment

The high percentage of uninsured people with mental health and substance use treatment needs can be traced to

certain historical trends, such as state funding for institutional services, the increasing role of the federal government through the creation of Medicaid and the block grant programs, and the evolution of private insurance.

People with mental illness and substance use disorders have historically relied on limited public funding. For centuries, people with mental illness were sent to poorhouses and state “asylums” or “mental hospitals.” Inhumane conditions in those facilities, coupled with scientific discoveries of antipsychotic medications, eventually led to a movement to treat mental illness in community-based programs.

The federal government increased its role in financing community-based mental health and substance use services when it created the Medicaid and Medicare programs in 1965. Although it covered a full range of healthcare services, Medicaid excluded payment for inpatient care in state mental hospitals for adults. This exclusion continues today and reinforces the historical notion that mental health is the social and fiscal responsibility of the states rather than a national healthcare issue. Medicaid provides less funding for substance use treatment services than for other kinds of care. The Substance Abuse Prevention and Treatment block grant, created in 1992 when Congress established the Substance Abuse and Mental Health Services Administration (SAMHSA), provides 40 to 60 percent of the funding for state substance use treatment services.

Private insurance programs developed in the 1930s and 1940s, when scientific understanding of mental illness and substance use was lacking and people were served in institutions that were physically separate from other healthcare settings. This structure contributed to the historical inequality between insurance coverage for mental illness and substance use and other health disorders.

Congress passed a limited parity law in 1996 to eliminate disparate annual and lifetime limits for mental healthcare and physical health conditions. The law specifically excluded substance use treatment and failed to address other conditions of insurance, such as cost sharing and benefit limits. In 1999, President Clinton ordered the federal employee health plans to provide equal coverage for mental health and substance use disorders. Research has confirmed that costs did not increase and even declined for some plans, and out-of-pocket expenses for consumers were reduced.

Since the 1970s, many states have enacted statutes governing mental health and substance use treatment benefits. More than 40 states now require either a minimum benefit set for inpatient and outpatient visits or mandate equal coverage for mental illness, substance use disorders, or both. State experiences also indicate that parity has had negligible or no impact on cost when managed care is in place.

## Analysis of State Benefit Packages

Coverage for mental illnesses and substance use disorders in state plans and proposals to cover the uninsured generally falls into four categories:

1. Medicaid expansions
2. Parity and more
3. Limited coverage
4. Minimal or no benefits

Several states in the Medicaid expansions category are moving toward universal coverage and working to ensure that their lowest income residents have access to a full array of services funded under their traditional Medicaid program. For example, Maine, Massachusetts, Vermont, and Maryland expanded coverage to low income populations, such as childless adults and parents of poor children, and Illinois proposed a similar expansion. Medicaid expansion programs often provide a broad array of recovery-oriented services. However, states have flexibility in their Medicaid programs to impose some limits on certain services and populations.

A sizeable number of states have included parity in coverage between mental illness and/or substance use disorders and physical health conditions in their benefit package to cover the uninsured. Parity is defined as equal coverage of

mental illness and/or substance use disorders and other health conditions. Many states in this category, however, only provide parity for a limited set of mental health conditions, such as “serious” or “biologically based” mental illnesses, and exclude substance use disorders. Serious mental illnesses in these statutes typically include schizophrenia and other psychotic disorders, bipolar disorder, major depressive disorder, obsessive-compulsive disorder, and panic disorder. Most of the implemented programs and state proposals seeking to cover all residents include a parity requirement, but many do not include treatment for substance use.

An advantage of parity plans is the breadth of services offered compared with more limited plans. Some states with parity provisions clearly specify services that must be provided by the plans to cover people who are uninsured. Minnesota, for example has one of the most expansive outpatient benefit packages; it includes a range of proven, effective treatments, such as rehabilitative services, crisis response, intensive residential treatment, assertive community treatment, and targeted case management.

State programs in the limited coverage category impose limits on the number of visits or covered costs for mental illness and substance use treatment that are not imposed on other health conditions. States with limited coverage include Pennsylvania, New York, Rhode Island, Oklahoma, and Maryland.

The last category applies to states that provide minimal or no benefits for mental illness or substance use disorders. Healthy New York and Pennsylvania’s adultBasic program provide the least benefits; they specifically exclude mental illness and substance use treatment from coverage. State programs in this category often target small employers, and cost is a primary factor in coverage decisions.

## Major Findings

This analysis leads to 10 major findings, summarized below.

- 1. People with mental illness, substance use disorders, or both are prevalent among the uninsured. More than one in four adult Americans who lack insurance coverage have a mental illness, substance use disorder, or co-occurring disorder.**

People with mental illness and/or substance use disorders are also likely to be uninsured. Approximately one-third of adults with mental illness, substance use disorders, or both who are below the FPL are uninsured.

- 2. The scope of the benefit package for mental illness and substance use treatment varies greatly. Some state programs provide a variety of services designed to promote recovery from these disorders. Two state programs provide no coverage for either mental illness or substance use disorders.**

The Medicaid expansion programs generally provide a broad array of services, but some states impose limits on particular services or populations. Of the non-Medicaid plans, Minnesota’s MinnesotaCare and General Assistance Medical Care programs have the most comprehensive outpatient benefit. Healthy New York and Pennsylvania’s adultBasic program completely exclude treatment for mental illness and substance use disorders.

- 3. Approximately 60 percent of the states evaluated had at least equal coverage for serious mental illness or mental illness compared with other health conditions in at least one of their programs for the uninsured.**

Eleven of the 18 states have a parity or more benefit for mental illness or serious mental illness in at least one of their programs or proposals. For this finding, parity or more is defined as providing at least equal benefits for mental illness and other health conditions. Most of these states had pre-existing parity statutes governing private insurance plans.

- 4. Substance use disorders fare worse than mental illness in many state programs. Roughly 28 percent of the states evaluated have an equal benefit for substance use and other health conditions in at least one of their programs.**

Only five of the 18 states—Colorado, Indiana, Maine, Minnesota, and Vermont—have a parity or more benefit for substance use disorders in at least one of their programs or proposals for the uninsured. For this finding, parity or more is defined as providing at least equal benefits for substance use disorders and other health conditions.

States that provide less than a parity benefit for substance use disorders impose a variety of service limits, including caps on outpatient treatment visits, limitations on inpatient stays, and maximum dollar limits.

- 5. The states that are generally viewed as closest to achieving universal coverage provide mental health parity as a component of their healthcare reform effort. Of the eight states that proposed or implemented programs for residents of all incomes, approximately 90 percent require mental health parity for serious mental illness or mental illness. Roughly 40 percent provide parity for substance use disorders.**

Maine and Vermont include equal benefits for mental illness and substance use disorders and other health conditions in their programs. Massachusetts provides equal coverage for serious mental illness, co-occurring disorders, and physical health conditions, whereas treatment for alcoholism is subject to mandatory minimums. Of the proposals for universal healthcare expansions, only one, Colorado, had equal coverage for substance use and other health conditions.

- 6. Approximately 80 percent of the programs with more limited benefits target employees or employers with small to mid-size businesses.**

Of the nine programs categorized as providing limited or minimal benefits, seven are aimed at employees or employers of small-to-mid-size businesses.

- 7. Federal waivers have been a component of reform in approximately 75% of the states with implemented programs, highlighting the critical importance of federal policy in future state healthcare reform efforts.**

States with varied levels of mental health and substance use benefits use federal waivers, but many of the programs with the broadest array of services and those closest to universal coverage receive federal waiver funds. The widespread use of federal waivers underscores the reliance on federal funds and the influence of the Center for Medicare and Medicaid Services' policy in furthering healthcare reform. Legislative restrictions on federal waiver financing will also have an important impact on states' ability to move toward universal coverage.

- 8. Increased cost sharing, a trend in healthcare, is reflected in state plans to cover the uninsured. With few exceptions, the programs often have significant co-payments, including those targeting low income and small-employer populations.**

One state exempts outpatient mental health and substance use services from co-payments to remove a financial barrier to accessing these services. Medicaid plans and a few other state programs have very low or no co-payments, but most states are charging more per visit or prescription.

- 9. The use of utilization management cuts across categories of benefits and is widely implemented regardless of the scope of the benefit. States generally do not limit utilization management of mental health and substance use treatment in their programs.**

States use many different tools to manage mental illness and substance use treatment benefits, including prior authorization and in-network providers. Many state programs rely on managed care, administrative service, and health maintenance organizations. With few exceptions, state statutes creating programs for the uninsured generally do not limit utilization management.

**10. Despite the importance of these healthcare policy issues, state plans for the uninsured direct little attention to workforce shortages in mental health and substance use, chronic care management of those conditions, and wellness benefits for these conditions.**

Some states have engaged in innovative practices to address these issues, but efforts have not been prevalent across states.

## Implications and Recommendations

For policymakers and stakeholders who are considering new healthcare reform expansions or improvements to their current programs, the following recommendations emerge:

*Parity for mental illness and substance use disorders is an important component of healthcare reform efforts seeking to meet the needs of people who are uninsured.*

The inclusion of parity for serious mental illness or mental illness in almost all of the state initiatives that strive for universal coverage indicates a growing consensus to include these disorders as part of healthcare reform efforts. The continuing inequalities between substance use treatment and other physical health conditions point to the need to address this disparity in future federal initiatives to cover the uninsured and for states to reexamine their policies. This need is particularly urgent in light of the high percentage of adults with substance use and co-occurring disorders who are uninsured.

*Parity, by itself, does not ensure access to a broad array of services necessary to treat mental illness and substance use disorders; some states have also addressed the scope of benefits, utilization management, cost sharing, and provider availability in their healthcare reform initiatives.*

*Scope of benefits:* Medicaid expansion programs often provide a variety of recovery-oriented services in those states that do not impose limits on particular services or populations. Minnesota developed a model benefit set for its program through broad stakeholder input and political leadership. Massachusetts had a pre-existing statute specifying that plans would cover specific mental health and substance use services.

*Utilization management:* Illinois's proposal included a definition of medical necessity specifically for mental health treatment and an improved review process for denied mental health claims. Minnesota passed legislation defining medical necessity for utilization management of mental health services as a precursor to expanding the scope of its benefits. These measures apply to all private plans, including those participating in the program for the uninsured.

*Cost Sharing:* Minnesota exempts outpatient mental health and substance use services from co-payments to remove financial barriers to receiving treatment for these chronic conditions. Medicaid expansion programs and a few other state programs impose low or no co-payments on services.

*Provider availability:* Indiana and Minnesota raise provider rates as part of their efforts to ensure that beneficiaries have access to the services in their plans. Pennsylvania's health care reform proposal increases access to integrated treatment for co-occurring mental illness and substance use disorders.

*To improve health outcomes, several states have included mental illness and substance use disorders in chronic care management and wellness initiatives.*

Indiana is including mental illness and substance use disorders in its wellness program. Vermont's program for the uninsured and Illinois's healthcare reform proposal and the state Medicaid program include mental illness and substance use disorders in their chronic care management programs.

*States would benefit from access to information regarding efforts to address mental illness and substance use disorders in state programs to cover the uninsured.*

With the exception of parity, the practices highlighted here have been implemented in select states, but are not common across state healthcare expansion programs. Efforts to educate policymakers and to provide them with opportunities for sharing innovations would be helpful in developing consensus regarding best practices.

*To facilitate stakeholder input and informed decision-making, healthcare expansion initiatives should clearly define the scope of benefits for mental illness and substance use disorders and specify whether people with these disorders are included in all parts of the reform effort.*

Throughout the research for this report, publicly available websites and plan documents frequently lacked clarity or information regarding the scope of benefits and other aspects of the program. Interviews with state officials and insurance plan administrators were needed to understand the extent of the coverage for mental illness and substance use treatment and whether adults with these disorders were included in state programs. This information should be readily available to facilitate stakeholder participation and ensure informed choices about health insurance coverage.

Over the past 40 years, the evolution in the scientific understanding of the biology of mental illnesses and substance use disorders and the effectiveness of treatments has been dramatic. Policy—aided by recent research showing the high cost of untreated mental illness and substance use disorders and the low to negligible cost of including equal benefits for those disorders and physical health conditions—has begun to reflect those trends. Yet, stigma and concerns about cost persist.

As the nation moves to cover more of the uninsured, the debate on the scope of benefits for mental illness and substance use disorders will continue. Policymakers will also seek better healthcare outcomes and lower costs for all conditions, including mental illness and substance use disorders. Lessons from the states indicate the need for further innovation as well as sharing of current practices to fully address mental healthcare and substance use treatment in state plans to cover uninsured populations.

## About NAMI

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The National Alliance on Mental Illness (NAMI) is the largest grassroots mental health organization dedicated to improving the lives of individuals and families affected by mental illness. NAMI has over 1,100 affiliates in communities across the country who engage in advocacy, research, support, and education. Members of NAMI are families, friends, and people living with mental illnesses such as major depression, schizophrenia, bipolar disorder, obsessive-compulsive disorder (OCD), panic disorder, post-traumatic stress disorder (PTSD), and borderline personality disorder.

[www.nami.org](http://www.nami.org)

## About the National Council

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Every day, more than 1,400 member organizations of the National Council for Community Behavioral Healthcare (National Council) reach out to nearly 6 million adults, children, and families with mental illnesses and addiction disorders to give them a chance to lead productive lives, while treating each and every one with dignity, respect, and cultural sensitivity. As a not-for-profit 501(c)(3) association, the National Council offers a critical safety net to our nation's poorest and most vulnerable citizens. We support our members' work by advocating for policies that help the people they serve receive accessible, high-quality care. We envision a nation where everyone has access to effective mental health and addictions treatment and the supports essential to live, work, learn, and participate fully in their communities.

[www.TheNationalCouncil.org](http://www.TheNationalCouncil.org)

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[www.HealthcareforUninsured.org](http://www.HealthcareforUninsured.org)

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