

MENTAL HEALTH FINANCING IN THE UNITED STATES

A PRIMER

APRIL 2011



THE KAISER COMMISSION ON
Medicaid and the Uninsured

The Kaiser Commission on Medicaid and the Uninsured provides information and analysis on health care coverage and access for the low-income population, with a special focus on Medicaid's role and coverage of the uninsured. Begun in 1991 and based in the Kaiser Family Foundation's Washington, DC office, the Commission is the largest operating program of the Foundation. The Commission's work is conducted by Foundation staff under the guidance of a bipartisan group of national leaders and experts in health care and public policy.

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Prepared by:

Rachel L. Garfield

Kaiser Commission on Medicaid
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Table of Contents

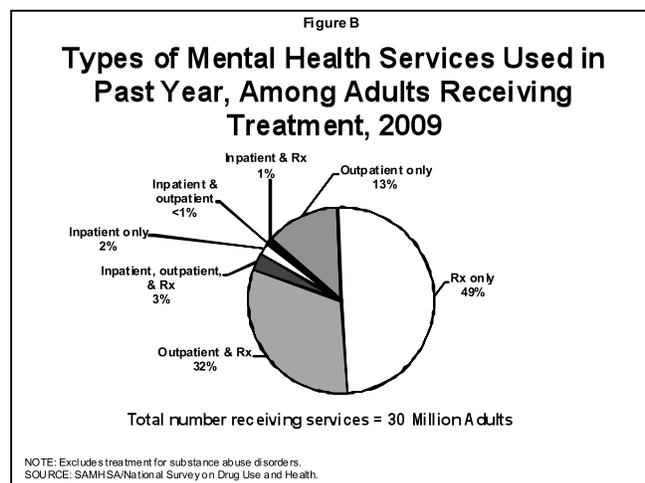
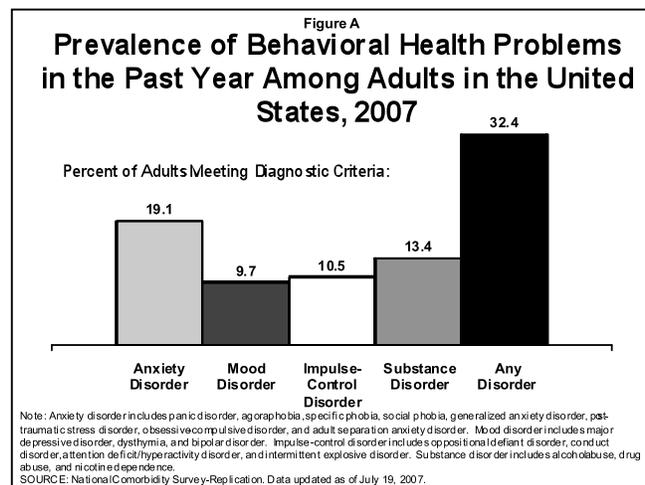
Executive Summary	i
I. Introduction	1
II. Overview of Behavioral Health Care	1
Prevalence of Behavioral Health Problems.....	1
Behavioral Health Services and Utilization.....	2
III. Sources of Financing for Behavioral Health Care	5
Public Sector Financing.....	5
Medicaid.....	6
Medicare.....	9
Other Public Programs.....	10
Private Sector Financing.....	11
Private Insurance Coverage.....	11
Out-of-Pocket Payment.....	13
Other Private Sources.....	14
Interaction between Financing Sources.....	14
Public-Private Interactions.....	14
Public Payer Interactions.....	15
Behavioral Health and Social Services Interactions.....	16
IV. Spending on Behavioral Health Care	17
V. Recent Policy Issues in Financing Behavioral Health Care	19
VI. Conclusion	22
Tables	23
Endnotes	26

Executive Summary

The behavioral health care system to provide mental health and substance abuse services in the United States is financed through multiple sources. These include states and counties, the federal-state Medicaid program, the federal Medicare program, private insurance coverage, patients' out-of-pocket expenditures, and a host of smaller public and private programs. The various funding sources form a complex patchwork of programs, each with particular eligibility rules and benefits packages. The complexity of the system challenges policymakers' ability to undertake reform in mental health policy. This primer provides an overview of behavioral health care, reviews the sources of financing for such care, assesses the interaction between different payers, and highlights recent policy debates in mental health.

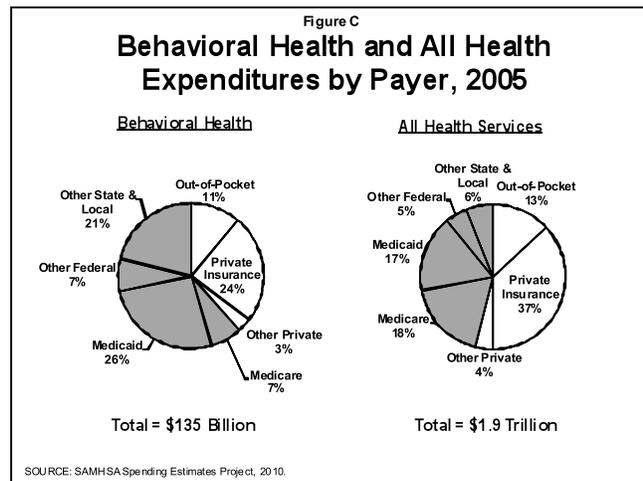
Overview of Behavioral Health Care

- Behavioral health problems encompass a broad range of illnesses, such as anxiety disorder, mood disorder, impulse-control disorder, or substance disorder. Nearly a third of adults and a fifth of children had a behavioral health problem within the past year (see Figure A). These problems range from short term problems to chronic disorders. Smaller shares—about 5 percent of adults and ten percent of children—have a serious mental illness or behavioral health difficulty.
- Treatment for behavioral health problems is most frequently delivered on an outpatient basis. Common treatments for behavioral health problems include psychosocial counseling and pharmacological services, and many individuals receive a combination of both types of therapy (see Figure B). People with serious mental illness often require additional non-medical services, such as income support, vocational training, or housing assistance, to help them manage day-to-day activities. Behavioral health services are delivered by both specialty mental health providers and general medical practitioners.
- Though utilization of behavioral health services has increased over time, a significant share of people who need services do not receive treatment. Over 60 percent of adults with a diagnosable disorder and 70 percent of children in need of treatment do not receive mental health services, and nearly 90 percent of people over age 12 with a substance use or dependence disorder did not receive specialty treatment for their problem.



Sources of Financing for Behavioral Health Care

- The financing system for behavioral health services differs from that for general medical services. Most notably, public sources play a larger role in financing behavioral health care (representing 61 percent of expenditures) than they do in overall health services (representing 46 percent of expenditures) (see Figure C).



- The federal-state Medicaid program is currently the largest source of financing for behavioral health services in the nation, covering over a quarter of all expenditures. Medicaid plays a large role in financing behavioral health services because its eligibility rules reach many individuals with significant need; it covers a broad range of benefits; and its financing structure allows states to expand services with federal financial assistance. Medicaid coverage of behavioral health benefits has been pivotal to deinstitutionalization and adoption of new treatment modalities.
- Medicare's role in financing behavioral health care (covering 7 percent of spending) is much smaller than its overall role in the health system, where it finances nearly a fifth of spending. Many disabled Medicare beneficiaries qualify for coverage on the basis of a mental illness, but other beneficiaries have behavioral health needs as well. Beneficiaries who are dually eligible for Medicare and Medicaid report the highest rates of mental illness (59 and 20 percent of disabled and aged, respectively). Medicare's behavioral health benefits were initially modeled after private coverage and included many coverage limitations. Some limits on Medicare coverage of behavioral health services have been eased over time, but the program's behavioral health benefits still retain some of their historical limits on psychosocial and support services, inpatient psychiatric hospital care, and certain providers.
- A large number of other federal, state, and local public programs finance services to support individuals with behavioral health needs. Many of these programs are not targeted to individuals with behavioral health problems, yet they provide key ancillary support services such as housing, income support, and vocational training. The largest federal program dedicated to financing behavioral health services is the Community Mental Health Services Block Grant (MHBG), which allocates grants to states to support and enhance community mental health systems for individuals with serious mental illness. Stemming from a long history of financing and delivering behavioral health services, other state and local funds finance a range of services and account for nearly a quarter of financing for behavioral health services in the nation.
- Private insurance coverage covers the majority of Americans but finances only about a quarter of spending on behavioral health care. While nearly all (98%) of those with employer-sponsored coverage have mental health benefits included in their health plan, most have limits on these services.
- Though they have a long history of funding mental health in the United States, charitable and philanthropic sources account for a small share (4%) of current financing for behavioral health services. Most of these funds are strategically targeted to pilot innovative programs or provide incentives for systems change.

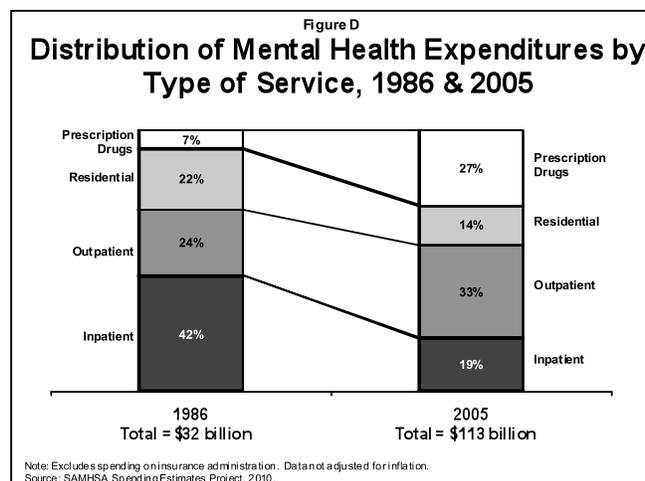
- Out-of-pocket payments for behavioral health (e.g., co-payments for services covered by insurance; payment for services excluded from insurance plans; or direct payment for all services by individuals with no insurance coverage) account for 11 percent of spending in this area. Out-of-pocket payment varies by insurance coverage, with the uninsured and those with private coverage paying a higher amount than those with Medicaid coverage.

Medicaid's Role in Financing Behavioral Health Services

- Though individuals with mental illness are not a specified Medicaid eligibility category, Medicaid's eligibility categories reach many individuals with mental illness. About five percent of current Medicaid beneficiaries qualify because they receive Supplemental Security Income (SSI), a federal cash assistance program for low-income aged, blind, or disabled individuals, due to a mental illness. However, enrollees who qualify for Medicaid through other pathways also have mental health needs. Most Medicaid enrollees who use mental health services (about two-thirds) qualify for the program in ways other than based on a disability.
- State Medicaid programs cover a range of related preventive, acute, and long-term care behavioral health services. Many states use the flexibility under the rehabilitative services optional benefit (or "rehab option") to provide community-based psychosocial services for Medicaid enrollees with mental illness. Medicaid's behavioral health benefits are generally more comprehensive than those offered by other payers, and in some cases, Medicaid is the only insurer that covers a service needed by those with behavioral health problems. It also finances some services outside the traditional medical model, such as family support, transportation assistance, supportive services in the home, respite care, and ongoing case management.
- Medicaid has played an important role in expanding insurance coverage for behavioral health services, financing new treatment modalities, and enabling states to expand mental health services with federal financial assistance for services.

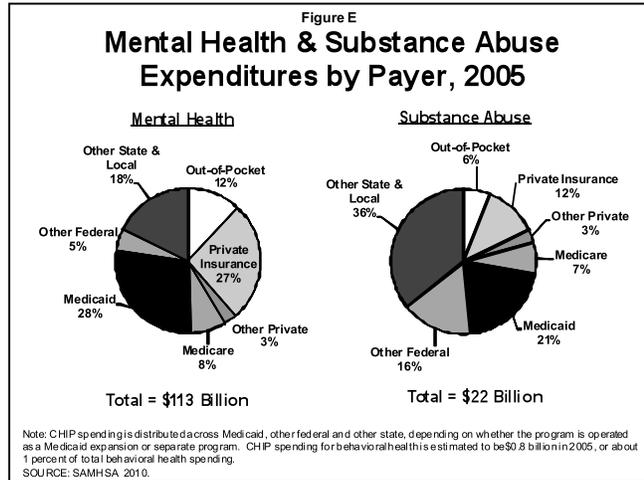
National Spending on Behavioral Health Care

- In 2005, a total of \$135 billion was spent on behavioral health services in the United States. The largest shares of this spending went towards outpatient services and prescription drugs. The distribution of spending by service has shifted over time. For example, for mental health care, increased utilization of prescription drugs and decreased reliance on inpatient services has shifted spending over time (see Figure D).



- Public payers account for the majority of spending for both mental health and substance abuse services, but the distribution of spending across payers differs for mental health and substance abuse (see Figure E). For mental health services, Medicaid is the largest payer, accounting for 28 percent of total expenditures, while private insurance paid for 27 percent and other state and local funds account for 18 percent of these costs in 2005. In contrast, for substance abuse services, other state and local funds are the largest funding source, accounting for 36 percent of total spending.

- While spending on behavioral health services has grown over time, growth in spending for behavioral health care in the United States has been slow relative to growth rates for other health services. From 1986 through 2005, nominal spending for all health services increased at an average annual rate of 7.9 percent, versus 6.9 percent for mental health and just 4.8 percent for substance abuse. The slower growth in behavioral health spending is attributed to the use of budgeting for state and local expenditures, higher cost sharing for behavioral health benefits than for medical care benefits, heavy reliance on managed care, and lower use of technology in behavioral health treatment compared to overall medical care.



Recent Policy Issues in Financing Behavioral Health Care

- The 2010 Affordable Care Act (ACA) has significant implications for financing behavioral health services. Most notably, reform will lead to a substantial expansion of insurance coverage, which could replace out-of-pocket or direct government payment for behavioral health services with insurance coverage to finance costs. Medicaid eligibility will be expanded to everyone with incomes up to 133% of the poverty line, and those with incomes up to 400% of poverty will receive subsidies to purchase coverage through newly-created Health Insurance Exchanges. These expansions will result in new populations accessing behavioral health services through Medicaid and private insurance. Health reform also includes other insurance regulation provisions — such as elimination of pre-existing condition exclusions and minimum benefit requirements for participating health plans — that may impact insurance coverage of mental health services. Several specific provisions directly impact mental health, such as establishment of health homes for individuals with mental illness and new educational training grants for the mental health workforce. While many operational issues remain to be resolved, it is clear that ACA will impact the financing and delivery of care for individuals with behavioral health needs.
- The *Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008* requires parity in insurance coverage of medical/surgical and behavioral health benefits. The intent of the law is to address inequities in coverage of behavioral health services compared to medical services, particularly among private insurance plans. Evidence on the impact of past parity rules indicates that the new parity law is likely to reduce individuals' out-of-pocket expenditures but may not substantially increase private payers' spending on behavioral health services (largely due to a concomitant reliance on intense care management through managed behavioral health organizations).

- An ongoing issue in the financing and delivery of behavioral health services is the separation of physical and behavioral health care systems. The high rate of co-occurrence of mental and physical health problems has led to calls for integration of physical and behavioral health services. Integration could be achieved in many ways, including: co-locating physical and behavioral health services in a single clinic; linking clinical information systems; training providers in interdisciplinary practice; and restructuring financial incentives to include risk-sharing arrangements or cross-care. Efforts to implement these strategies have met varying levels of success, stymied by difficulty navigating information-sharing regulations, cultural norms among providers, and competing priorities.
- An overriding theme in behavioral health services in recent years is the push for “transformation,” or the idea of undertaking fundamental change to the behavioral health system in order to enable individuals with serious mental illness “to live, work, learn, and participate fully in their communities.” While there is broad consensus over the goals of transformation, using existing financing sources to achieve these goals presents several challenges. In a “transformed” system, services are coordinated to provide the full range of evidence-based clinical and support services that an individual needs. However, the financing for this full range of services is fragmented across multiple programs. Further, many of the goals of a transformed system require an infusion of new dollars, but payers are currently struggling to meet their existing commitment to financing behavioral health services and have little capacity to expand their roles.

The numerous sources of financing for behavioral health services in the United States create a patchwork of programs that—sometimes in concert and sometimes in conflict—collectively form the behavioral health system for the nation. This “system” supports a broad range of patients—from those who rely on outpatient services for short-term problems to those with highly-disabling conditions who require intensive medical and social support services—as well as a range of both specialized and general providers. Experts conclude that, in general, the financing system for behavioral health services has led to great improvements in the well-being of individuals with mental health or substance abuse problems. Yet there is still unmet need for care both among those with insurance coverage and those without any source of payment for services. As policymakers debate how to best structure the overall health system to control costs and implement coverage expansions, it is important to bear in mind how proposed changes will impact the complex system that finances services for some of the nation’s most vulnerable individuals.

I. INTRODUCTION

Over time, the United States' behavioral health system has developed into a complex arrangement of payers, providers, and patients. Most notably, financing has shifted from a centralized system of state dollars administered through state mental health agencies to a mix of public and private funding administered through multiple programs in various settings. Mental health and substance abuse services are now financed by states and counties, the federal-state Medicaid program, the federal Medicare program, private insurance coverage, and patients' out-of-pocket expenditures, along with a host of smaller public and private programs. Each program covers a unique set of services and targets a distinct population; operates from a different revenue source; and has a particular mission and goals. In addition, the underlying transformation of mental health services— from a focus on illness and treatment to an emphasis on recovery and wellness—has extended the scope of services financed by behavioral health programs, leading to development and integration of a broader range of services and expanding the set of stakeholders with an interest in mental health policy. The 2010 Affordable Care Act (ACA) will further transform the system, leading to an expansion of health coverage for individuals with behavioral health needs and shifting funding from direct service provision to insurance coverage.

The complexity in the system challenges policymakers' ability to undertake reform in mental health policy. Policymakers face a fragmented system with multiple decision-makers and bureaucracies, mixed control of budgets, and distinct client groups and delivery systems. It may not be clear which financing stream covers which services and populations, how changes to one program impact another, and where and why gaps exist. While there are annual reports that track behavioral health spending, there is no current overview of the system to provide background and context to these figures.

This primer describes how behavioral health care is financed in the United States. It provides an overview of behavioral health care then reviews the sources of financing for such care. For each financing source, we discuss its history, current role in financing for mental health services, and anticipated role after implementation of the 2010 health reform law. We also assess the interaction between different payers. Last, the report highlights recent policy issues in mental health.

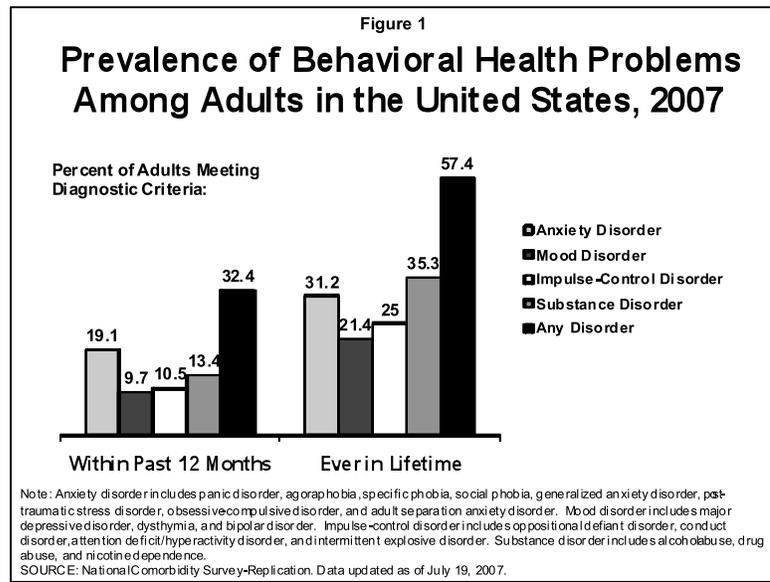
II. OVERVIEW OF BEHAVIORAL HEALTH CARE

Behavioral health care encompasses a broad array of services for people with mental health or substance abuse problems (or both). Behavioral health problems range in severity: at one end of the spectrum, individuals face short-term problems that minimally disrupt their everyday lives, while at the other individuals have chronic, highly-disabling behavioral health disorders.

Prevalence of Behavioral Health Problems

The broad range of problems that fall under “behavioral health” makes it challenging to estimate the number of people impacted by such problems, as the definition of a “mental illness” and best way to capture who is affected by an illness have been debated over time. Today, most define “mental illness” as a diagnosable mental disorder based on the *Diagnostic and Statistical Manual of Mental Disorders (DSM)*, and researchers measure who falls under the definition of a mental illness by assessing symptoms and signs for a particular disorder, measuring mental health-related functional impairment, or asking about use of mental health services.¹

The most-commonly cited estimates of prevalence of behavioral health problems in the United States take the first approach of measuring symptoms and show a high prevalence rate of behavioral health disorders. As shown in Figure 1, data from the National Comorbidity Study-Replication indicate that nearly a third of adults met diagnostic criteria for a behavioral health problem in the past year, and over half meet criteria at some point in their lifetime. The most common type of disorder among adults is anxiety disorder, which includes such diagnoses as phobia, panic disorder, anxiety disorder, and post-traumatic stress disorder (among others). Mood disorders (i.e., major depressive disorder, dysthymia, or bipolar disorder) are the least common behavioral health problem among adults but still affect one in five adults at some point in their life. Comorbidity—or simultaneous diagnosis of more than one illness—is common in behavioral health, affecting about 14 percent of adults within the past 12 months and nearly 28 percent over their lifetime.² Researchers note that these data use a broad measure of mental illness and thus capture a large number of people with mild illness: Fewer people are functionally impaired by their mental illness (about 9 percent), and much smaller shares of the adult population have a serious mental illness (about 5 percent) or a severe and persistent mental illness (less than 3 percent).³



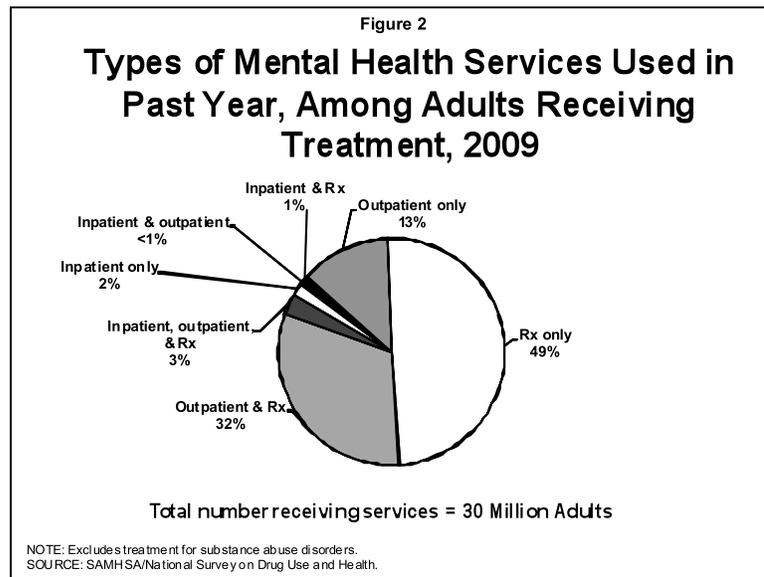
Children also experience behavioral health problems. The most common disorders among youth include mood disorders such as depression, anxiety disorders, oppositional defiant disorder or conduct disorder, eating disorders, attention-deficit/hyperactivity disorder, and substance abuse disorder. In some cases, the behavioral health problems in children persist into adulthood,⁴ but some children with behavioral health disorders do not experience these problems as adults. Studies indicate that behavioral health problems are fairly common among children, with approximately one in five reporting symptoms of mental health problems and one in ten reporting serious behavioral health difficulties.⁵

Among both adults and children, individuals with low incomes are more likely to have a behavioral health problem than those with higher incomes. This relationship has been stable over time and across different measures of mental illness.⁶ Overall rates of mental illness are similar for men and women, but the prevalence of some specific disorders varies by gender: for example, women are more likely than men to experience depression, while substance abuse is found more commonly in men.

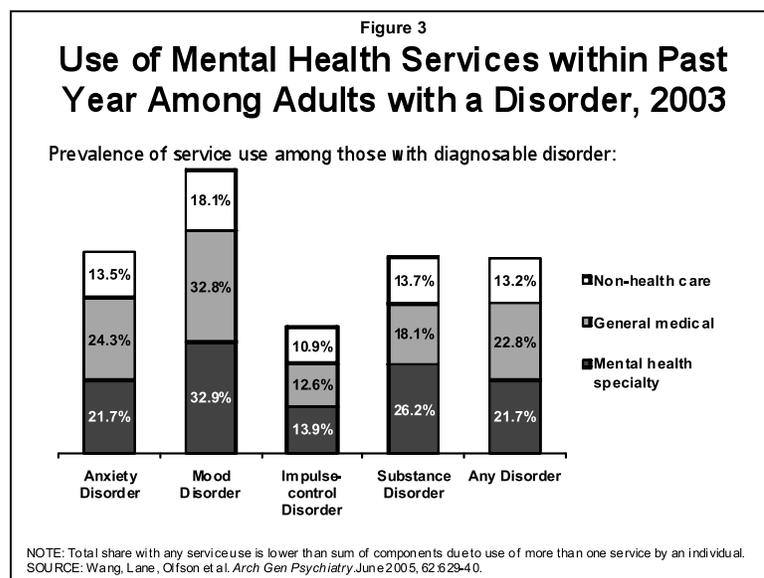
Behavioral Health Services and Utilization

A broad range of services exist to treat behavioral health problems. Most treatments are classified as either psychosocial (i.e., psychotherapy) or pharmacological (i.e., prescription drugs), and many individuals receive a combination of both types of therapy. Behavioral health services vary in intensity, from outpatient counseling to residential treatment to inpatient care, and may be either short-term (for acute problems) or long-term (for chronic problems). Since

the community care and deinstitutionalization movements in the 1960s and 1970s, services have shifted from being largely based in inpatient facilities to being delivered on an outpatient basis. In recent decades, new models of service delivery such as partial hospitalization (also called day treatment), mobile crisis services, and intensive community-based case management or assertive community treatment (or ACT, which entails community-based, comprehensive team psychiatric treatment, rehabilitation, and support) have been developed to support the shift away from hospitalization. As shown in Figure 2, the most commonly-received services today include outpatient therapy, prescription drugs, or a combination of the two. People with serious mental illness often require additional non-medical services, such as income support, vocational training, or housing assistance, to help them manage day-to-day activities.



Behavioral health services are provided in a range of settings by several types of providers (see Figure 3). About a fifth of adults with a behavioral health disorder receive treatment in the specialty mental health sector; providers in this sector include both physicians (i.e., psychiatrists) and non-physician mental health providers such as psychologists, social workers, counselors, and psychiatric nurses. A slightly larger share (22.8%) receives behavioral health care from non-mental health medical providers (e.g. primary care providers). The high proportion of people receiving treatment from non-specialty medical providers has grown significantly over the past decade and reflects the use of primary care gatekeepers, improvements in mental health screening tools in primary care settings, and shift to psychotropic drugs (perhaps without combined psychotherapy).⁷ Over 13 percent of those with behavioral health disorders receive treatment outside the health care system entirely, such as through human services programs or the voluntary support network of self-help groups and organizations. Service use varies across disorders, with those meeting criteria for mood disorders reporting the highest rates of treatment and those with impulse-control disorders reporting the lowest. This variation reflects differences in levels of distress and impairment, patient perception of the need for treatment, and availability of effective treatments across disorders.⁸

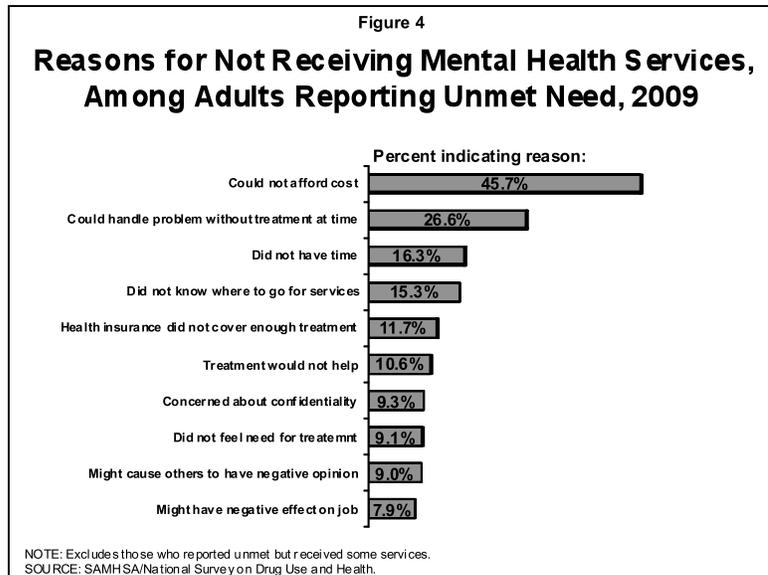


Children also receive behavioral health services in a variety of settings. Children are most likely to receive behavioral health care from specialty mental health providers, with 12.5 percent of those aged 12 to 17 reporting that they used such services in the past year.⁹ As with adults, adolescents are more likely to use outpatient mental health services than inpatient care (11.1 percent compared to 2.5 percent). Unlike adults, adolescents are much less likely to receive behavioral health services from the general medical sector (2.8 percent report such use). Many youth receive mental health services from the educational system (e.g., from a school counselor or special education classes), with 11.5 reporting they used these services.

The utilization rates shown above vary for different populations. For example, utilization of behavioral health services is higher among those with more severe disorders than among those with more mild disorders. Further, higher rates of treatment for behavioral health disorders are found among those over age 60, non-Hispanic whites (compared to other racial/ethnic groups), those with higher incomes, and those in urban areas.¹⁰ Women are more likely than men to receive any mental health treatment, but among those who did receive treatment, men are more likely than women to receive care from mental health specialists. Utilization also varies by insurance coverage: those without insurance were less likely to receive behavioral health treatment from the health sector (as opposed to the human service or complementary service sector). As with other medical services, utilization of behavioral health services is concentrated among a small share of users with high utilization. For example, patients making a visit to a psychiatrist more than 50 times a year account for less than two percent of patients seen by psychiatrists but account for over a fifth of all visits.¹¹

Though utilization of behavioral health services has increased over time, a significant portion of people who need services do not receive treatment for their behavioral health problems.ⁱ Over 60 percent of adults with a diagnosable disorder¹² and 70 percent of children in need of treatment¹³ do not receive mental health services.

Nearly 90 percent of people over age 12 with a substance use or dependence disorder did not receive specialty treatment for their problem.¹⁴ Surveys indicate that cost is a major barrier to receiving care, with perceptions that care was not needed at the time, confusion about where to go for care, and lack of time to seek treatment as the next most frequent explanations (see Figure 4). Some who do receive treatment indicate that they still had an unmet need for care, reflecting either a delay in accessing care or receipt of insufficient care.¹⁵

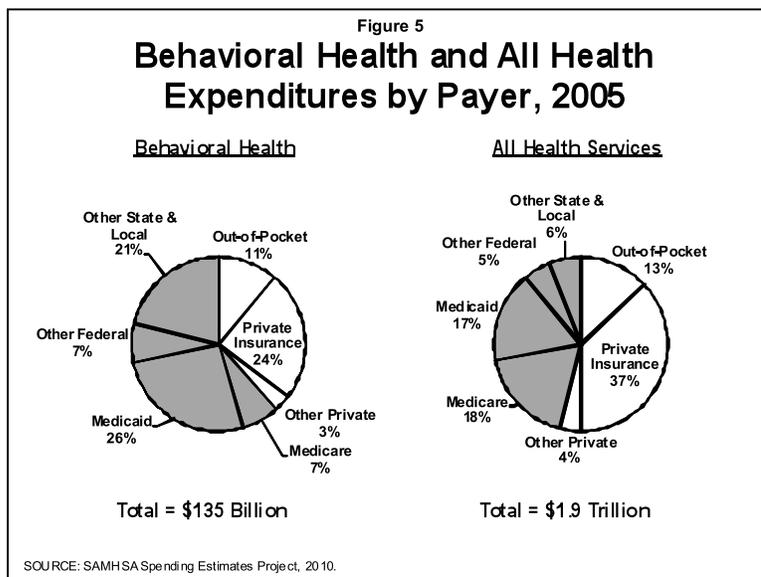


ⁱ Notably, a small share (8%) of individuals who seek treatment for a mental health problem do not have a diagnosable mental illness. (Druss, Wang, Sampon et al.)

III. SOURCES OF FINANCING FOR BEHAVIORAL HEALTH CARE

Traditionally, financing behavioral health services was the responsibility of state and local governments. Over time, this system has developed into more complex network. The enactment of Medicaid and Medicare in 1965, as well as the development of other targeted programs and block grants, expanded the federal role in financing behavioral health. Further, the evolution of treatment—from institutional-based custodial care to medical and social support services delivered in a range of settings—led to a greater number of agencies and funding streams involved in behavioral health financing. For example, housing programs are financed through housing departments, income support through the Social Security Agency, and job training through departments of education and labor. The expansion of private insurance coverage has also included coverage for behavioral health, though its role in financing these services is much smaller than for general medical care. Thus, today, public sources (in particular, state sources) remain the largest source of financing for behavioral health care. As discussed below, the implementation of the ACA will likely shift the distribution of financing sources for behavioral health care, as the expansion of private insurance and Medicaid coverage will lead these sources to account for a larger share of spending.

The current financing system for behavioral health services differs from that for general medical services (see Figure 5). Most notably, public sources play a larger role in financing behavioral health care (representing 61 percent of expenditures) than they do in overall health services (representing 46 percent of expenditures). In addition, while Medicaid and Medicare account for roughly equal shares of general health care financing (17 and 18 percent, respectively), Medicaid's role in financing behavioral health services is more than three times larger than Medicare's (26 and 7 percent, respectively). Last, state and local dollars play a larger role in behavioral health care than overall medical care, reflecting their historical role in financing these services.



Public Sector Financing

The federal-state Medicaid and federal Medicare programs are significant sources of public financing for behavioral health services. Other public programs include those financed by states (usually operated through state mental health agencies, or SMHAs), federal block grants to states, and other federally-operated programs. Publicly-financed programs to provide behavioral health services vary in the populations they target as well as the services they provide (see Table 1).

Medicaid

The federal-state Medicaid program is the largest source of financing for behavioral health services in the nation. Enacted in 1965 to help states cover the medical costs of low-income women and children, elderly, and individuals with disabilities, Medicaid was not explicitly designed to finance behavioral health services. However, over time, the program has served as the basis of significant expansions and shifts in financing for behavioral health care in the United States.

Medicaid Eligibility and Behavioral Health

One reason for Medicaid's large role in financing behavioral health care is its eligibility, which has historically targeted many high-need populations left out of other insurance programs. Traditionally, to be eligible for Medicaid, individuals were required to have low incomes (and limited assets) and fit into one of the categories of covered populations. Individuals with mental illness were not a specified category, and some low-income individuals with mental health needs did not meet eligibility criteria for Medicaid coverage.¹⁶ However, Medicaid's eligibility categories have covered many individuals with mental illness.

Many individuals with serious mental illness receive Medicaid because they qualify for Supplemental Security Income (SSI), a federal cash assistance program for low-income aged, blind, or disabled individuals. Since 1972, most states have been required to provide Medicaid coverage to individuals receiving SSI, and over time, mental disorders have been the fastest growing category of new SSI disability awards.¹⁷ By 2009, 41 percent of SSI recipients under age 65 (and about half of children) qualified for SSI on the basis of a mental illness.¹⁸ Disability criteria for SSI eligibility are similar to that for Social Security Disability Insurance (SSDI, a program linked to Medicare eligibility),ⁱⁱ but SSI eligibility does not require prior work experience as SSDI does. As a result, Medicaid's coverage of the disabled targets a population that may be more severely impaired—that is, was never able to engage in work—than that covered by other payers.¹⁹ Medicaid coverage of the disabled also finances care for many individuals who are in the two-year waiting period between receipt of SSDI and Medicare coverage or who have SSDI and Medicare but also have incomes low enough to qualify for Medicaid.

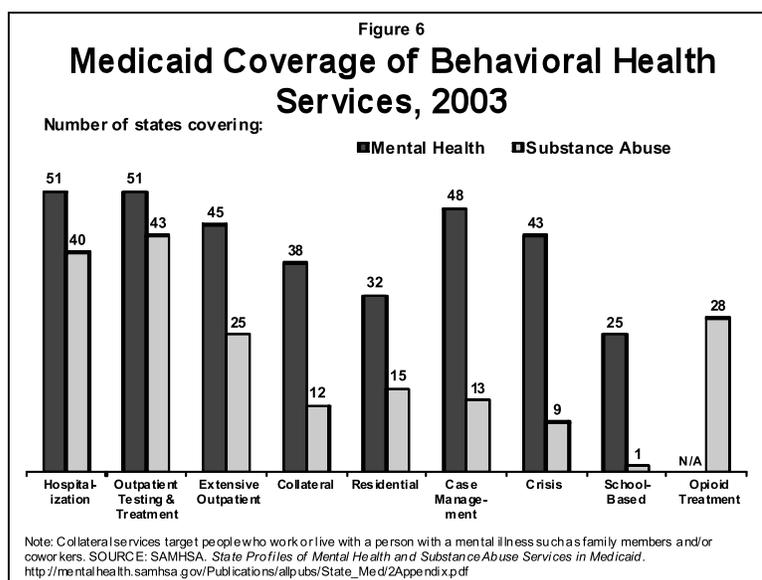
While many Medicaid beneficiaries with disabilities qualify on the basis of a mental illness, most current Medicaid beneficiaries qualify for coverage through categories other than those related to disability (i.e., based on family status and poverty). Thus, among all 59 million enrollees, only about five percent qualify for Medicaid based on a mental illness. However, non-disabled enrollees also have mental health needs. These needs may be significant, given the association between low income and poor mental health. In fact, most Medicaid enrollees who use mental health services (about two-thirds) qualify for the program in ways other than based on a disability.²⁰

With the implementation of ACA, Medicaid will be expanded to include nearly all individuals up to 133% of poverty. Many of these newly-eligible individuals will have mental health needs. According to one analysis, ACA will lead to nearly 2 million new Medicaid enrollees with probable depression or serious psychological distress, and over a million new enrollees without these disorders will also use some mental health services.²¹

ⁱⁱ SSI does not cover individuals for whom substance abuse is a contributing factor to their disability.

Medicaid Benefits and Behavioral Health

A second reason for Medicaid's significant role in financing behavioral health is the breadth of services that the program provides. As with eligibility, behavioral health services are not a specifically-defined category of benefits in Medicaid, but state programs cover a range of related preventive, acute, and long-term care services under several broad categories of benefits (see Table 1 and Figure 6). Some of these services are required by federal law ("mandatory services"), and some, such as prescription drugs, case management, and home- and community-based services, are provided at state option ("optional services"). For all services, beneficiaries are entitled to all "medically necessary" care, and benefits must be available to all beneficiaries and be "sufficient in amount, duration, and scope to reasonably achieve their purpose." States have discretion to limit benefits by choosing to cover or exclude optional categories and through the ability to define what constitutes "medically necessary."ⁱⁱⁱ Medicaid's behavioral health benefits are generally more comprehensive than those offered by other payers, and in some cases, Medicaid is the only insurer that covers a service needed by those with behavioral health problems. It also finances services outside the traditional medical model, such as family support, transportation assistance, supportive services in the home, respite care, and ongoing case management. As shown in Figure 6, existing Medicaid coverage of services for mental health is more comprehensive than that for substance abuse services.



There are some notable limits on behavioral health benefits in Medicaid. Under what is known as the "IMD exclusion," Medicaid does not cover nursing and hospital services in an institution for mental disease (IMD) for those age 22 to 64 years (however, inpatient psychiatric care in a general medical hospital is covered). The IMD exclusion was originally intended to prevent states from shifting responsibility for long-term inpatient care for adult populations from state financing to Medicaid. Many states responded to the IMD exclusion by directing Medicaid disproportionate share hospital (DSH) payments to state psychiatric hospitals.²² [DSH payments are additional Medicaid payments to hospitals serving a large share of low-income or uninsured patients.] The IMD exclusion also created incentives for states to treat Medicaid beneficiaries with mental illness in other types of institutions, such as nursing homes, psychiatric units in general hospitals, or partial hospitalization programs.

States may opt to "carve out" behavioral health services from the delivery of physical care services and provide them through a specialty managed behavioral health organization (MBHO). About 20 states use this approach to deliver behavioral health services.²³ In these cases, beneficiaries remain eligible for the full range of behavioral health services provided by the state, regardless of whether or not these services are included in the carve-out.

ⁱⁱⁱ Under the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) benefit for enrollees under the age of 21, states must provide all necessary services to treat a condition found during a routine screening, regardless of whether or not these services are covered under the state's Medicaid program.

States may also provide services for behavioral health under home- and community-based services (HCBS) waiver programs, which target community-based services to individuals who would otherwise be institutionalized and give states discretion to define services and limit who may receive them. In the past, budget neutrality requirements for establishment of HCBS programs led to their limited use for individuals with mental illness, since the IMD exclusion meant that offsetting the cost of caring for adults in institutions could not be counted in the calculation of cost neutrality.²⁴ Since 2006, states have been able to provide HCBS as a state option rather than under waiver programs, which removes the requirement of budget neutrality. However, use of HCBS for individuals with mental illness is still limited, and only three states (Colorado, Iowa, and Nevada) have taken up the HCBS state option.²⁵ Changes to the HCBS option passed under ACA (and effective as of October 1, 2010) expand financial eligibility for these services, allow states to target such services to specific populations (such as those with serious mental illness) and expand the services states may cover under this option. Many are hopeful that these changes will enable states to improve service delivery for individuals with mental illness.²⁶

Medicaid's behavioral health benefits have played an important role in facilitating changing patterns of care over time. Medicaid coverage of community-based services and prescription drugs (and limits on IMDs) was instrumental in the shift from institutional-based to community-based care.²⁷ Medicaid payment for psychotropic drugs was important in supporting adoption of newer, safer and effective antidepressants and antipsychotic drugs²⁸ as well as evidence-based treatments such as assertive community treatment (ACT).²⁹ One Medicaid service category that has been particularly important to providing behavioral health services is the rehabilitative services optional benefit (or "rehab option"). Under the rehab option, states can provide Medicaid beneficiaries a range of services to reduce mental disability and restore functioning. The flexibility allowed under this service category has enabled states to finance a broad range of psychosocial services in the community, such as skills training and peer specialist counseling.³⁰ The rehab option has also been pivotal to coverage of several emerging evidence-based treatments in behavioral health, such as ACT, family psycho-education, and supported employment.

Under Medicaid expansions enacted under the ACA, states have the option of providing newly-eligible beneficiaries with "benchmark" or "benchmark equivalent" benefits, which are similar to those available through employer-based coverage, rather than full Medicaid benefits. While behavioral health treatment is a required service in benchmark plans, the scope of services available under such plans might be more limited than those traditionally available under Medicaid.³¹ Federal regulations require that some newly-eligible beneficiaries, including those with disabling mental disorders, be offered the option to receive full Medicaid benefits rather than benchmark coverage.³²

Medicaid Financing and Behavioral Health

The third explanation for Medicaid's large role in behavioral health financing lies in the way the program is financed. Medicaid is an open-ended entitlement program jointly financed by the federal government and states. States set program rules within federal guidelines and administer programs, and the federal government reimburses states for 50-77 percent of program costs (depending on the state). There is no cap on how much state Medicaid spending the federal government will match. This structure has enabled states to expand services with fewer state dollars and obtain federal financial assistance for services (e.g., institutional care) that were previously funded with only state dollars.³³ In addition, throughout the 1990s, many states aggressively drew down federal matching funds for DSH payments to IMDs. As a result, federal policymakers have limited states' ability to use DSH payments for IMDs.

Medicare

Enacted in 1965 to finance medical care for the elderly, the federal Medicare program has over time undergone changes to expand its limited role in financing behavioral health care.

Medicare Eligibility and Behavioral Health

The first change was an expansion of eligibility to the under-65 disabled in 1972. To qualify for Medicare on the basis of a disability, individuals are required to receive Social Security Disability Insurance (SSDI) for two years.^{iv} In turn, qualification for SSDI is based on having prior work experience and having a medically determinable mental or physical impairment of sufficient longevity and severity that an applicant had no prospect of returning to substantial gainful employment.³⁴ While SSDI assistance for individuals with mental illness has been restricted at times (e.g., beneficiaries with mental illness disproportionately had their benefits terminated during the period of “continuing disability investigations” in the early 1980s³⁵, and in 1996 eligibility was eliminated for individuals for whom substance abuse is a contributing factor to their impairment³⁶),^v mental disorders are one of the fastest growing categories of disability awards.³⁷ By 2007, nearly 30 percent of individuals who qualified for SSDI did so based on a mental disorder.³⁸

Today, Medicare finances coverage for 38 million elderly and 7 million individuals with disabilities. Many disabled Medicare beneficiaries qualify for coverage on the basis of a mental illness, but other beneficiaries have behavioral health needs as well. Self-reported rates of mental illness among Medicare beneficiaries^{vi} vary by eligibility category, with those who are dually eligible for Medicare and Medicaid reporting the highest rates (59 and 20 percent of disabled and aged, respectively) and those with just Medicare reporting lower rates (46 and 12 percent of disabled and aged, respectively).³⁹

Medicare Benefits and Behavioral Health

Over time, Medicare also has changed its rules regarding coverage of behavioral health benefits. When it was initially designed, Medicare’s behavioral health coverage was modeled after what was available in the private market; thus, the program placed many limitations on coverage of these services. For example, outpatient services for behavioral health were capped at low levels (\$250) and required higher beneficiary cost sharing than physical health services (50 percent versus 20 percent). Inpatient coverage was more generous than the typical private insurance plan. However, care delivered in a psychiatric hospital was limited to 190 days over a beneficiary’s lifetime, while inpatient behavioral health care delivered in a general hospital was not subject to this limit. These limits reflected Medicare’s overall design (to cover acute illness and medical management of chronic illness, not long-term services and support⁴⁰) as well as the belief that long-term financing of mental health care was the responsibility of states and localities.

^{iv} Medicare also covers individuals with end-stage renal disease and amyotrophic lateral sclerosis (ALS, or Lou Gehrig’s disease) upon receipt of SSDI.

^v However, once enrolled in Medicare, beneficiaries can receive coverage of treatment for substance abuse problems.

^{vi} Self-reported mental illness includes beneficiaries who report that they were told by a doctor that they have a mental or psychiatric disorder.

Some limits on Medicare coverage of behavioral health services have been eased over time. In a series of laws in the late 1980s, policymakers raised the \$250 limit to \$1,100, relaxed limits on psychotherapy, added psychologists and social workers as covered providers, lowered cost sharing related to medication management, and created a new partial hospitalization benefit. The addition of Medicare coverage for prescription drugs implemented in 2006 further extended the program's coverage of behavioral health services, given the large role of pharmacotherapy in mental health treatment.⁴¹ In 2008, legislation reduced the 50 percent cost sharing requirement for outpatient mental health services to the same level as physical health (20 percent); this change will be phased in over six years.

Today, Medicare covers a range of behavioral health services (see Table 1), including: inpatient treatment (under Medicare Part A); provider services (under Medicare Part B) such as outpatient therapy, counseling, testing, evaluation, and management; and prescription drugs (under Medicare Part D) for beneficiaries who opt to join a Medicare drug plan.⁴² As mentioned above, Medicare also covers partial hospitalization in some circumstances. Some notable limits still exist in the program, such as psychosocial and support services, the 190-day limit on inpatient psychiatric hospital care, and coverage for certain types of providers (e.g., mental health counselors). Beneficiaries who receive their services under a Medicare Advantage plan may receive additional services but face different cost sharing rules. Other beneficiaries have Medigap wrap-around coverage to fill in some gaps in traditional Medicare.

Other Public Programs

A large number of other federal, state, and local public programs finance services to support individuals with behavioral health needs (see Table 2). Many of these programs are not targeted to individuals with behavioral health problems, yet they provide key ancillary support services such as housing, income support, and vocational training. Each program operates in a unique way, with distinct rules about how funds may be used, how funds are distributed (e.g., to individuals, to localities, or to providers), who may receive services, and how services are reimbursed.

Community Mental Health Services Block Grant

Of the other federal programs detailed in Table 2, the largest dedicated to financing behavioral health services is the Community Mental Health Services Block Grant (MHBG). The MHBG grew out of the 1963 Community Mental Health Centers program, which was combined with other categorical federal mental health programs into the Alcohol, Drug Abuse, and Mental Health Services (ADMS) block grant in 1981 and converted to the MHBG in 1992. Under the MHBG, the federal government allocates grants to states, which have flexibility to use funds to support and enhance community mental health systems for individuals with serious mental illness. MHBG funds are not intended to be a stand-alone funding source, but rather are conceived as support to complement and leverage existing state systems. States use these funds for a variety of programs, such as employment, housing, rehabilitative, and clinical services.⁴³ All states are eligible for funds under the MHBG, and funds are distributed based on a formula. States are required to apply for funding each fiscal year and to meet federal reporting requirements and show compliance with their approved plans.⁴⁴

Financing under the MHBG has coincided with an increase in states' community-based (versus inpatient) behavioral health programs, but much of the shift in services is related to incentives and funding available under other programs. While MHBG funds increased substantially over time, adjustment for inflation shows that real funds actually decreased 46 percent from 1983 through 2005.⁴⁵

State and Local Spending

Other state and local funds are another significant source of financing for behavioral health services. This role grew out of state and localities' historical tradition in financing and delivering behavioral health services, which dates back to the earliest asylums of the 1800s.⁴⁶ Initially, states built and maintained mental hospitals, while localities paid for episodes of care. With the passage of the State Care Acts at the turn of the 20th century, states took on primary responsibility for financing mental health care. As treatments for mental illness developed and shifted from inpatient to community-based, state and local roles in financing services similarly expanded to include services beyond state mental hospitals.⁴⁷ In contrast to other sources of financing, most state and local dollars dedicated to behavioral health services are for direct service provision—i.e., grants and contracts directly to providers—rather than individual insurance coverage.

Today, state and local dollars finance a range of services, including acute or extended inpatient care, case management, outpatient services, partial day and residential care, supported employment, and housing, among others.⁴⁸ States set their own criteria regarding how to deliver these services (e.g., whether to contract with local providers or use state employees to deliver services) and who may receive them (e.g., any individuals with a behavioral health problem or only those with specific illnesses or functional limitations). Typically, state and locally-financed services are targeted to individuals with serious illnesses who lack other sources of coverage for behavioral health services. State funding is also important to mental health care for the prison population, which has a high prevalence rate of serious mental illness and is not eligible for most other sources of payment.⁴⁹ Most often, other state and local dollars for behavioral health services are financed through state general funds, rather than a dedicated revenue source.⁵⁰ This revenue source makes these services particularly sensitive to state's budget conditions.

Private Sector Financing

Private sector financing for behavioral health primarily includes payment from private insurance and individual's out-of-pocket payments. Other private sources of payment—e.g., philanthropy or charity care—play a small role in financing behavioral health care.

Private Insurance Coverage

As private health insurance (in particular employer-sponsored coverage) grew in the second half of the twentieth century, so too did private insurance coverage for behavioral health. By the late 1960s, most (92%) employer-sponsored plans provided some coverage for mental health services.⁵¹ However, coverage for behavioral health services was much more limited than coverage for physical health services. For example, compared to physical health, plans' coverage of mental health typically required higher cost sharing (up to 50 percent for outpatient services), had lower caps (often \$2000/year), and had more limits on the number of visits or inpatient days (commonly 25 visits and 30 days). These limits arose primarily due to cost concerns in covering mental health services. Insurers felt that covering mental health could require them to pay for long-term psychotherapy or extended hospital stays.⁵² They also were concerned that offering generous behavioral health benefits would attract disproportionate enrollment of people with significant needs (and high costs). Last, insurers recognized that mental health services are more price-sensitive than other services and relied on limits to control overuse of highly-subsidized services (i.e., moral hazard). Private insurance limits on behavioral health services persisted for many decades, partially enabled by the existence of a public safety net for those with significant needs and partially tolerated due to stigma attached to mental illness.

Policymakers have taken several steps to address gaps in behavioral health benefits in private insurance coverage.⁵³ Starting in the early 1970s, several states passed insurance mandates requiring minimum levels of behavioral health benefits. Two decades later, many states passed “parity” laws that require that behavioral health benefits not only are offered (as insurance mandates require), but also that they are offered on the same terms as general medical benefits. By 2010, 49 states had passed some requirement for mental health benefits, but these laws vary widely in scope from full parity for both mental health and substance abuse to mandated offering laws requiring only the option of behavioral health coverage.⁵⁴ Further, none apply to self-insured companies exempt from state regulation under the Employment Retirement Income Security Act (ERISA). To address this gap, federal parity legislation was passed in 1996. This legislation addressed only some limitations in private coverage of behavioral health (specifically, it prohibited firms with more than 50 employees, and who offered mental health benefits, from imposing different annual or lifetime limits for those benefits than for general medical benefits).

Parallel with policymakers’ regulation of private insurance for mental health, the health insurance market developed new models of financing and delivering behavioral health benefits. As health insurance plans shifted to managed care models in the 1980s and 1990s, specialty managed behavioral health organizations (MBHOs) developed to provide mental health coverage. MBHOs contract with payers or health plans under “carve out” arrangements, in which responsibility for management of (and sometimes, financial risk for) behavioral health services is separated from general medical insurance. Payers turned to MBHOs in hope of curtailing the cost of financing behavioral health care without limiting insurance coverage for behavioral health—relying on the expertise and managed care techniques of the MCBO, as well as economies of scale and negotiating power of MCBOs, to manage costs.⁵⁵ By 2003, 72 percent of private insurance plans contracted with a MBHO to deliver behavioral health services.⁵⁶

Despite these actions, private coverage of behavioral health benefits remained more limited than that for general medical services. While nearly all (98%) of those with employer-sponsored coverage had mental health benefits included in their health plan in 2008, most had limits on these services.⁵⁷ Most private plans (80%) limited annual outpatient mental health visits to 20 (limits for substance abuse were frequently higher), and the large majority (90%) had a 30-day annual limit on inpatient stays.⁵⁸

In 2008, Congress passed federal parity legislation to expand the 1996 law. The *Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008* (PL 110-343), which went into effect on January 1, 2010, prohibits most group health plans that offer coverage for mental health and substance-use conditions from imposing treatment limitations and financial requirements on those benefits that are stricter than for medical and surgical benefits. As discussed below, the new federal parity requirement could expand the role of private insurance financing for behavioral health services.

The 2010 health reform law will further change private insurance coverage’s role in financing behavioral health services. Under the law, certain private insurance plans (specifically, “qualified health plans” that will cover many newly-insured individuals) must provide an “essential benefits package” that includes behavioral health services. The scope of services is

to be equal to that covered under a typical employer plan, and plans must also adhere to the 2008 parity law. However, some private plans may still exclude coverage of behavioral health services, as many existing plans are “grandfathered” and exempt from requirements for essential benefits.^{vii}

Out-of-Pocket Payment

Another private sector source of financing for behavioral health services are payments made directly by patients. These out-of-pocket payments include co-payments or co-insurance for services covered by insurance; payment for services excluded from insurance plans (e.g., certain prescription drugs); or direct payment for all services by individuals with no insurance coverage.

Out-of-pocket payments for behavioral health care were stable for many years as private coverage incrementally became more generous. From 1998-2002, out-of-pocket spending on mental health accelerated and grew more quickly than such spending on general health.⁵⁹ Much of this spending was related to increased utilization of prescription drugs over this period. In recent years, out-of-pocket payments have moderated, corresponding to a decline in spending for psychotropic drugs.⁶⁰

While out-of-pocket payments account for about the same share of total nationwide financing for behavioral health and total health spending (Figure 5), out-of-pocket payment for behavioral health services have followed a different pattern than out-of-pocket payment for general medical care services. Due to the limitations in private coverage discussed above, patients’ share of costs *increased* as they used more behavioral health services (and hit limits), whereas out-of-pocket costs *decreased* as they used more general medical care services (and met deductibles).⁶¹ The implementation of the 2008 parity law, which requires similar cost sharing rules for behavioral health and general medical care services, may eliminate this difference and lead to similar levels and patterns of cost sharing across service types.

Out-of-pocket payment for behavioral health services varies depending on a person’s coverage. For example, among low-income adults with mental health conditions, average out-of-pocket spending for mental health services was \$261 a year for those with private insurance, versus \$100 for Medicaid beneficiaries and \$519 for those with no insurance.⁶² Because of different levels of utilization between insurance groups, out-of-pocket expenditures account for a different share of total expenditure on mental health services. For example, the privately-insured pay about 25 percent of their total mental health expenditures out-of-pocket. In contrast, individuals with Medicaid pay just 6 percent of their total mental health expenditure out-of-pocket. The uninsured pay 62 percent of their total mental health expenditures out-of-pocket.

^{vii} “Grandfathered” plans include group health plans or insurance in existence on March 23, 2010. These plans are exempt from many provisions of the ACA. To maintain “grandfather” status, plans must meet certain requirements such as maintaining current benefits and not increasing enrollees’ financial burden.

Other Private Sources

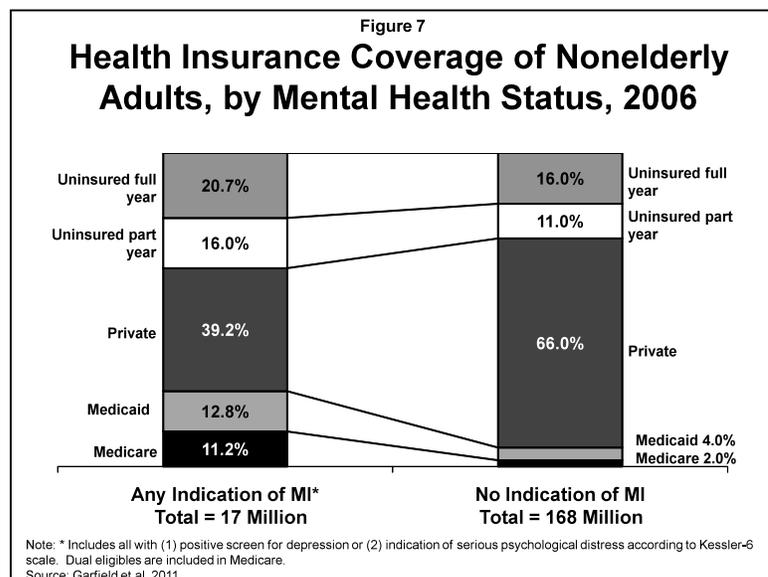
Though they have a long history of funding mental health in the United States,⁶³ charitable and philanthropic sources account for a small share of current financing for behavioral health services. Because charitable and philanthropic resources are modest compared to other financing sources, most of these funds are strategically targeted to pilot innovative programs or provide incentives for systems change.⁶⁴ The share of other private funding for health that is dedicated to behavioral health services has declined in recent years.⁶⁵ This trend reflects the explosion of charitable organizations dedicated to general health, the more general focus of most health-related foundations and charities, and a belief among some that the challenges in financing mental health are beyond the scope of private organizations' impact.⁶⁶

Interaction between Financing Sources

The various funding sources outlined above form a complex patchwork of programs, each with particular eligibility rules and benefits packages. Together, they make up the behavioral health "system," but they were not designed as a coordinated system of care so much as "layered on...as a collection of multiple, well-intentioned programs without overall direction, coordination, or consistency."⁶⁷ These programs do not operate in isolation; rather, they interact closely, sometimes overlapping and sometimes filling in each others' gaps. Policies regarding coverage and services in one program create incentives that shape policy decisions in other programs. The intricate relationships between funding sources have led many to observe that, "The reality is that the mental health system looks more like a maze than a coordinated system of care."⁶⁸

Public-Private Payer Interactions

One key relationship between funders is that between private and public payment sources. As mentioned above, private payers—partially motivated by the fact that their focus is on a relatively healthy, largely employed population and partially motivated by the fact that a public safety net exists to serve those with serious illness—limited their coverage of behavioral health services. Public programs fill in many of the gaps in private coverage, sometimes covering those who are left out of the private system entirely and sometimes covering individuals who have exhausted their private insurance coverage for behavioral health services. Compared to two-thirds of those without a mental illness, only about 40 percent of those with a mental illness receive insurance coverage through a private source (see Figure 7). Rather, individuals with mental illness are more likely than those without to receive insurance coverage through public programs. Notably, publicly-financed insurance does not pick up all of those who do not have private coverage, and uninsured rates among those with mental illnesses are higher than among those without.

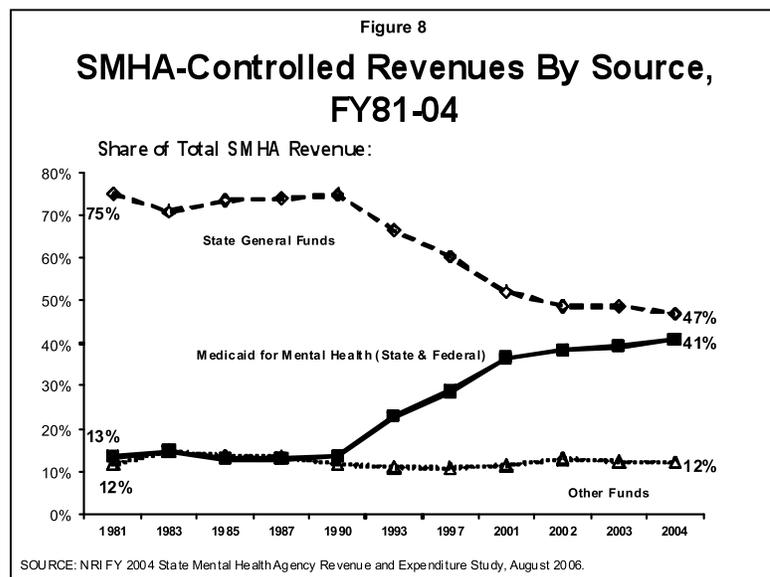


This pattern of insurance coverage is expected to persist after insurance expansions under ACA are implemented. Due to the link between mental illness and poverty, those with mental disorders are more likely than those without to be newly eligible for Medicaid coverage. After reform, simulations predict that, among nonelderly adults with a mental illness, a quarter will be covered by Medicaid and half by private coverage. In contrast, among those without such disorders, 10 percent will be covered by Medicaid and over three quarters by private coverage.⁶⁹

Public Payer Interactions

There are also complex relationships between public payers for behavioral health care. Medicare and Medicaid interact directly through their coverage of dual eligibles—individuals who qualify for both types of coverage simultaneously. For these beneficiaries, Medicaid provides crucial “wrap around” services that fill in the gaps in Medicare coverage of behavioral health services. Until the passage of the Medicare Modernization Act (MMA), Medicaid coverage was particularly essential to dual eligibles’ access to psychotropic drugs; since the implementation of that legislation, duals receive drug coverage under Medicare Part D, but state Medicaid programs are still financing part of this coverage through the so-called “clawback” provision in the MMA. Medicare and Medicaid coverage of behavioral health services also interact in their overlapping coverage of some services—which requires beneficiaries to keep track of each payer’s coverage rules— and their respective focus on acute versus support services. Even though Medicare generally provides acute care and Medicaid primarily non-acute services for dual eligibles with mental illness, utilization of services within the programs is linked, as management of mental illness impacts physical health and vice versa.⁷⁰ Coordination across programs is hampered by use of separate administrative and data systems for the two programs. The 2010 health reform law includes a demonstration program to improve care coordination for dual eligibles, which could improve the interaction between these two funding sources. It also established a new office, the Federal Coordinated Health Care Office, to more effectively integrate Medicare and Medicaid benefits and improve coordination between the federal government and states to improve access to and quality of care and services for dual eligibles.

One of the most notable relationships in publicly-financed behavioral health services is between Medicaid and state funding sources. As mentioned above, the availability of Medicaid as a funding source for state-based behavioral health services has created incentives for states to shift programs traditionally financed with state dollars to services reimbursable with federally-matched Medicaid dollars. This practice, often called “Medicaid maximization,” has increased federal investment in mental health care and thus realigned the roles of states and the federal government in the mental health system.⁷¹ Medicaid is now a crucial component of state mental health systems, and in many states, the two are jointly budgeted, with states attributing their matching funds for Medicaid to the budget of state mental health agencies (SMHAs).⁷² Medicaid is now the source of payment for the majority of consumers served by



SMHAs, and Medicaid funds accounted for 44 percent of payment for SMHA-administered services in 2006 (see Figure 8).^{viii, 73} Medicaid is also the fastest growing component of SMHA spending: from 1981 to 2005, over half of all new funds administered by SMHAs were from Medicaid.⁷⁴

The infusion of Medicaid financing into SMHAs has had several widely-acknowledged beneficial effects on state systems. For example, it increased the amount of funds available for mental health services, led to a shift to community-based treatment over treatment in institutions, provided broader insurance coverage than was previously available to low-income people with mental health needs, and facilitated improved access to care.⁷⁵ It also has posed some challenges. Medicaid and SMHAs have different approaches to service delivery and cannot be wholly incorporated: Medicaid uses an insurance model to delivery services, with an individual entitlement to purchase services, whereas SMHAs traditionally use a community service delivery model, with direct payment to maintain a network of specialty providers.⁷⁶ Further, Medicaid carries federal requirements regarding what and for whom services are reimbursable. Some believe that the focus on drawing down federal funds has distorted state decisions in mental health policy by shifting focus away from those who don't meet Medicaid eligibility rules, in particular the uninsured (often highest risk) individuals and services they need.⁷⁷

The dynamics between state funding and Medicaid are expected to continue with the implementation of the 2010 ACA, as reform will lead Medicaid to play an even larger role in behavioral health than it currently does. The expansion of coverage may lead fewer individuals to rely on state-financed treatment services for behavioral health. It is not clear whether states will expand or contract their coverage of supportive services after reform. On one hand, states may redirect the resources that they currently expend to provide treatment services to expand supportive services. On the other hand, states may use those resources for other expenses, such as their share of the Medicaid match, increased payment to providers, or state expenditures in areas besides behavioral health. In the past, expansions in Medicaid, combined with tight state budgets, led to the latter outcome. That is, states decreased their overall state-only spending on mental health as the availability of matched Medicaid funds increased.

Behavioral Health and Social Services Interactions

A final relationship between funders in behavioral health services is between financing sources targeted to health services and the host of programs that provide social support for individuals with behavioral health needs. Unlike the interaction between Medicaid and state funding, which is often carefully coordinated in order to maximize funds, programs to provide health financing often operate in isolation from programs to provide social services. As a result, programs may have conflicting eligibility rules, service providers, or information systems. Further, social service programs that focus on populations historically excluded from health coverage—such as the homeless or those incarcerated—have limited experience in helping clients navigate eligibility and enrollment systems for health insurance. Lack of coordination leads to fragmentation in service delivery and puts the onus on individuals to manage multiple, complex systems and programs to obtain the full spectrum of services they need. The expansion of coverage under ACA will necessitate new coordination between programs, as many individuals served by social service programs will be newly-eligible for health coverage.

^{viii} This figure only includes Medicaid mental health spending that is administered by SMHAs. The share of Medicaid mental health spending that is controlled by the SMHA varies widely by state.

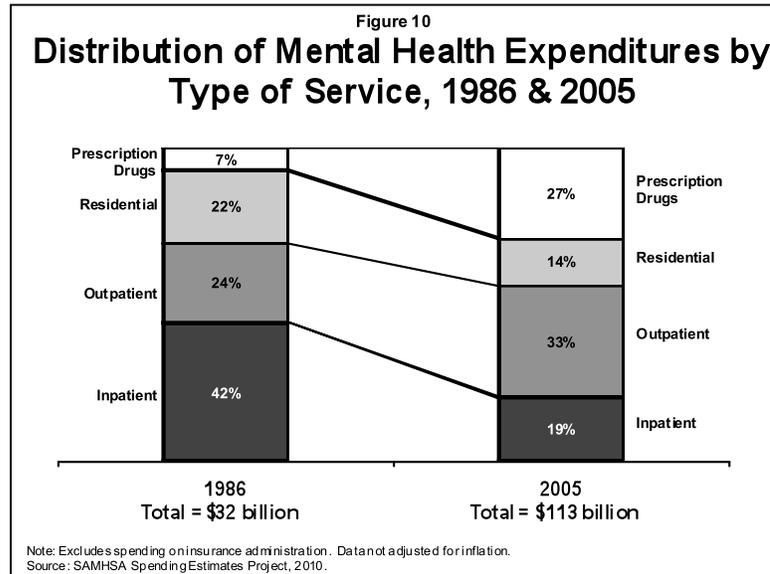
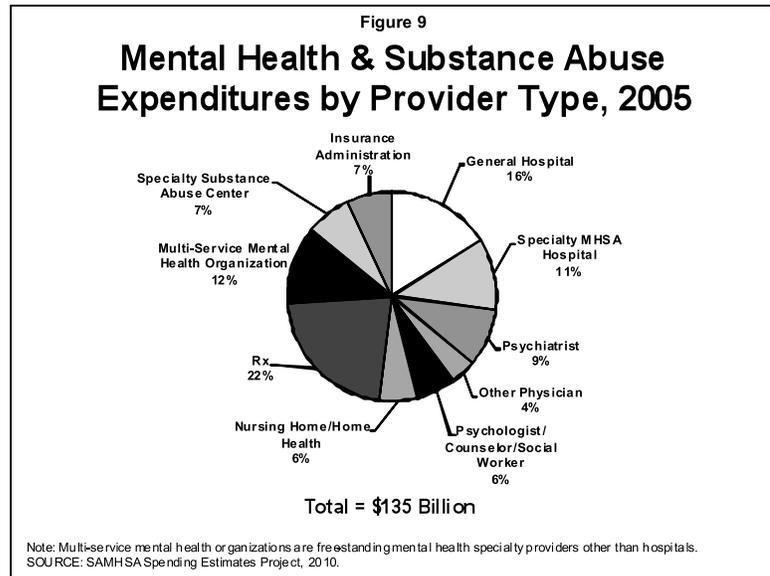
IV. SPENDING ON BEHAVIORAL HEALTH CARE

In 2005 (the most recent year for which data are available), a total of \$135 billion was spent on behavioral health services in the United States. The largest share of this spending (22%) went towards prescription drugs (see Figure 9). The majority of payments to providers went to specialty behavioral health providers such as psychiatric hospitals, psychiatrists, counselors, social workers, or specialty substance abuse providers.

The distribution of spending for behavioral health services has shifted over time, as utilization of prescription drugs has increased and use of inpatient services declined. As seen in Figure 10, for mental health services, inpatient care accounted for 42 percent of total expenditures in 1986 but declined to less than 20 percent by 2005. This decline represents both the availability of new outpatient treatments and the impact of managed care plans limiting inpatient utilization. In contrast, prescription drugs increased from just 7 percent to over a quarter of total spending on mental health over the same

period. The growth in spending on prescription drugs for mental health was particularly high in the late 1990s—growing at over 20% each year from 1996 through 2000—as many new products became available.⁷⁸ Patterns of spending for substance abuse services reflect a similar trend of declining inpatient care and rising outpatient services, though the existence of fewer prescription drugs to treat substance abuse means that spending on this service has consistently remained low over time (data not shown).

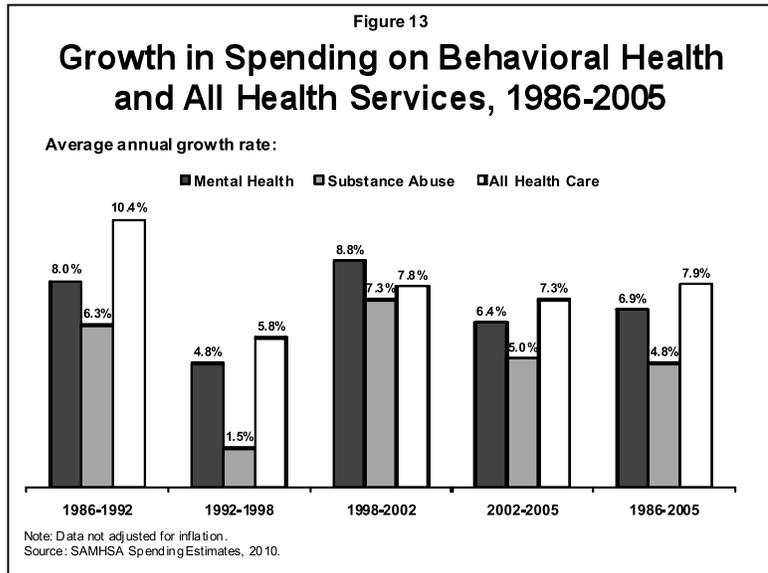
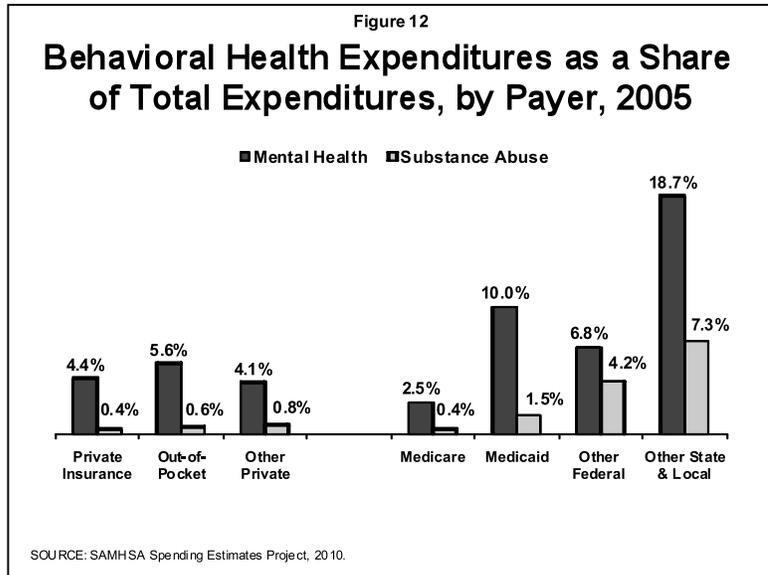
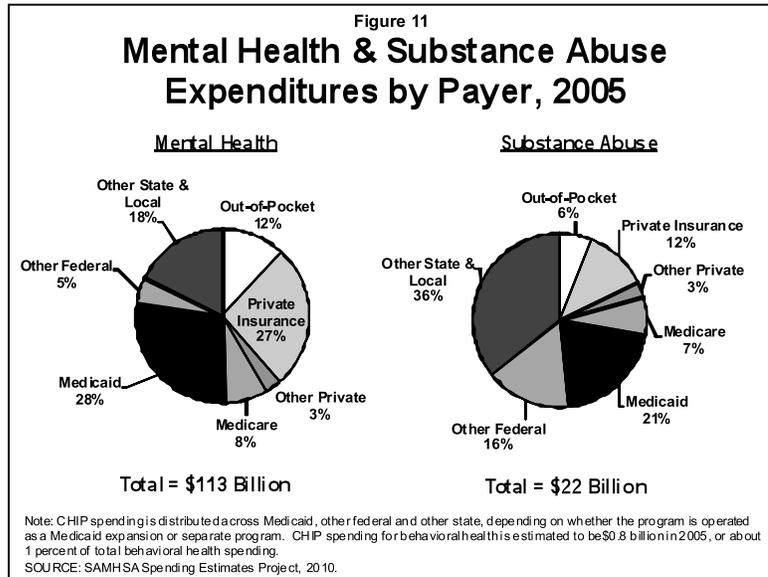
Public payers account for the majority of spending for both mental health and substance abuse services, but the distribution of spending across payers differs for mental health and substance abuse (see Figure 11). For mental health services, Medicaid is the largest payer, accounting for 28 percent of total expenditures, while private insurance paid for 27 percent and other state and



local funds account for 18% of these costs. In contrast, for substance abuse services, other state and local funds cover 36 percent of total spending. A notable portion of this spending is driven by treatment mandated and paid for by correctional institutions, which account for over a third of referrals to specialty substance abuse centers.⁷⁹ While not the largest source, Medicaid is still a major source of payment for spending on substance abuse services, covering 21 percent of expenditures in 2005.

Payers' spending on mental health services accounts for different shares of their total expenditures (see Figure 12). Private payers devote between 4 and 6 percent of expenditures to mental health and less than one percent to substance abuse services. In contrast, 10 percent of Medicaid expenditures and nearly 20 percent of state and local health services expenditures go towards mental health. These differences reflect differences in both funding commitment to behavioral health services and the scope of overall health services financed by each payer.

While spending on behavioral health services has grown over time, growth in spending for behavioral health care in the United States has been slow relative to growth rates for other health services. From 1986 through 2005, nominal spending for all health services increased at an average annual rate of 7.9 percent, versus 6.9 percent for mental health and just 4.8 percent for substance abuse (Figure 13). Higher spending growth for mental health services in some time



periods largely reflects greater use of new prescription drugs that became available in the late 1990s, while periods of low growth are attributed to reliance on managed care techniques to manage inpatient utilization. Using a broader time period, analysis shows that from 1970 through 2003, overall health care costs grew faster than GDP, while expenditures for mental health grew in proportion to GDP.⁸⁰ The slower growth in behavioral health spending is attributed to the use of budgeting for state and local expenditures, higher cost sharing for behavioral health benefits than for medical care benefits, heavy reliance on managed care, and lower use of technology in behavioral health treatment compared to overall medical care.⁸¹ Spending trends also reflect the shift from institutional-based care to community-based care, as funds spent on support services (e.g., housing or cash assistance) do not appear in accounts of spending on behavioral health.⁸²

V. RECENT POLICY ISSUES IN FINANCING BEHAVIORAL HEALTH CARE

ACA Implementation

The passage of health reform has significant implications for financing behavioral health services. Most notably, reform will lead to a substantial expansion of insurance coverage, which could replace out-of-pocket or direct government payment for behavioral health services (e.g., through SMHAs or federal block grants) with insurance coverage to finance costs. Coverage expansions will result in new populations accessing behavioral health services through Medicaid and private insurance.

Health reform also includes other provisions — such as elimination of pre-existing condition exclusions and minimum benefit requirements for participating health plans — that may impact insurance coverage of mental health services. For example, elimination of pre-existing condition exclusions mean that participating plans could not deny coverage to someone based on a history of mental illness or exclude coverage for services related to that illness. Minimum benefit requirements require all plans to offer coverage for mental health and substance abuse services, though the scope of that requirement will depend on how the minimum benefits are defined.

ACA also includes several specific provisions directly related to mental health. For example, the legislation includes beneficiaries with serious and persistent mental illness among the target populations for the new Medicaid health home option and improves states' ability to use the HCBS option to serve individuals with serious mental illness. It also establishes educational training grants for mental and behavioral health providers in its workforce development provisions. Other specific provisions in the law, while not specifically targeted to individuals with mental illnesses, are particularly salient for this population. For example, prevention programs to promote tobacco cessation may reach many individuals with mental illness, given that those with a mental health disorder are twice as likely as those without to smoke.⁸³ Similarly, provisions to address the gap in Medicare prescription drug coverage in the “donut hole” are important to those with mental illness, given the high utilization of prescription drugs to treat these disorders.

Policymakers face several ACA implementation decisions that will influence future financing for behavioral health care. For example, states need to decide whether to offer benchmark or full Medicaid coverage to those with non-disabling mental disorders; structure outreach efforts to reach currently uninsured populations with behavioral health problems; and address provider shortages to ensure that coverage translates to access. While many operational issues remain to be resolved, it is clear that ACA will impact the financing and delivery of care for individuals with behavioral health needs.

Insurance Coverage Parity

In October 2008, the *Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008* was signed into law as part of the *Emergency Economic Stabilization Act of 2008*. This law requires group health insurance plans that cover over 50 employees and provide both medical/surgical and behavioral health benefits to provide those benefits at parity. Specifically, financial requirements (e.g., deductibles, co-payments, or coinsurance) and treatment limitations (e.g., days of coverage, number of visits) cannot be more restrictive for behavioral health benefits than they are for medical/surgical benefits. In addition, if a plan provides out-of-network coverage for medical/surgical benefits, it must provide comparable out-of-network coverage for mental health/substance use disorder benefits. The new law builds on the previous requirement that annual and lifetime dollar limits cannot be more restrictive for behavioral health benefits than for medical benefits.

The new law applies to all group health plans with 50 or more employees, including plans currently regulated by federal ERISA rules and state-regulated plans, as well as qualified health plans established by ACA. However, if a state has a stronger requirement for behavioral health coverage, those requirements remain in place for state-regulated plans. While the law does apply to Medicaid managed care plans as well as coverage under state CHIP programs, it does not apply to Medicare coverage. As discussed above, recent policy changes in Medicare have addressed some of the differences in coverage of behavioral and medical benefits, but substantial differences remain for Medicare beneficiaries.

The requirements for parity in coverage of behavioral health benefits will apply to 113 million people, including 82 million in ERISA plans currently exempt from state parity laws.⁸⁴ To the extent that the law leads to expansion of private coverage for behavioral health services, it could expand these payers' role in financing behavioral health in the United States. However, evidence on parity to date indicates that the law might have only a small effect on overall spending distribution. Studies show that parity requirements do not lead to significant increases in spending for affected plans, largely due to a concomitant reliance on intense care management through managed behavioral health organizations.⁸⁵ Thus, private insurance's commitment to financing behavioral health services is unlikely to significantly expand as a result of parity. Experience also shows that parity requirements do not lead plans to drop behavioral health coverage or employers to drop health coverage;⁸⁶ thus, the potential for it to substantially shrink is also small. Research does show that parity is associated with lower out-of-pocket spending due to improved coverage,⁸⁷ so it is possible that out-of-pocket payment will account for a smaller share of behavioral health financing in the future. Importantly, though, experts predict that the issue of unmet need for care will remain even after implementation of parity, as challenges of lack of insurance, stigma, and insufficient provider networks will remain.⁸⁸

Physical-Behavioral Health Integration

An ongoing issue in the financing and delivery of behavioral health services is the separation of physical and behavioral health care systems. Behavioral health is unique among other health services in that it is the only major disorder for which states and localities operate a distinct, specialty treatment system.⁸⁹ Even for those who receive the majority of their care through the private system, behavioral health is often delivered through carve-out arrangements that separate these services from coverage for medical/surgical benefits. While there are some

advantages to this structure—e.g., specialization and economies of scale—it also creates fragmentation and challenges for meeting the complex needs of the population with mental illness and substance abuse problems.

Researchers have documented a high rate of co-occurrence of mental and physical health problems.⁹⁰ Adults with a serious mental illness are more likely than those without to have chronic medical conditions such as heart disease and diabetes, and children who experience behavioral health problems are more likely to develop general health problems as adults. Similarly, poor physical health has been associated with mental health problems such as depression or anxiety. System fragmentation exacerbates this problem: people with serious mental illness often receive most of their care from the specialty behavioral health sector and have poor access to physical care services (and are less likely to receive evidence-based or high-quality care when they do access services), and physical health specialists are often not attuned to the need for or reimbursed for mental health services.⁹¹

The high rate of co-occurrence has led to calls for integration of physical and behavioral health services. Integration could be achieved in many ways, including: co-locating physical and behavioral health services in a single clinic; linking clinical information systems; training providers in interdisciplinary practice; and restructuring financial incentives to include risk-sharing arrangements or cross-care (i.e., reimbursement for mental health providers who provide general care and vice versa).⁹² Efforts to implement these strategies have met varying levels of success, stymied by difficulty navigating information-sharing regulations, cultural norms among providers, and competing priorities.

Transformation

An overriding theme in behavioral health services in recent years is the push for “transformation,” or the idea of undertaking fundamental change to the behavioral health system in order to enable individuals with serious mental illness “to live, work, learn, and participate fully in their communities.”⁹³ The call for transformation was articulated in the final report of the 2002-2003 *President’s New Freedom Commission on Mental Health*, which identified fundamental shortcomings in the current mental health system and set out comprehensive goals for system improvement. As defined by the *Commission* and ensuing reports, a transformed system is one that addresses stigma and awareness; promotes consumerism and family-driven care; eliminates disparities; facilitates screening, assessment and referral; improves quality; and advances technology.

While there is broad consensus over the goals of transformation, using existing financing sources to achieve these goals presents several challenges. In a “transformed” system, services are coordinated to provide the full range of evidence-based clinical and support services that an individual needs. However, the financing for this full range of services is fragmented across multiple programs. For example, federal vocational rehabilitation funds may reimburse for vocational training in supported employment programs, while Medicaid may finance the individual counseling required to achieve success in such a program. In many cases, an individual does not meet eligibility for services under each distinct program and cannot access the breadth of benefits. Many states have looked to Medicaid for flexibility in financing the range of services needed to achieve transformation. However, the federal government has taken steps to restrict states’ ability to use Medicaid to finance services that can be paid for by other programs. For example, in 2007, it clarified the use of targeted case management services to exclude activities that constitute administration of other programs such as foster care, parole and probation, and special education, among others.⁹⁴ Legislation has been introduced to ease these federal restrictions but was still pending as of November 2010.⁹⁵

A related challenge in financing actions to support system transformation is lack of new funds. Many of the goals of a transformed system require an infusion of new dollars; for example, resources are needed to mount anti-stigma campaigns, develop screening and outreach programs, develop supportive programs such as housing and employment services, and build research capacity. However, in the current economic environment, funders are struggling to meet their existing commitment to financing behavioral health services and have little capacity to expand their roles.

VI. CONCLUSION

The numerous sources of financing for behavioral health services in the United States create a patchwork of programs that—sometimes in concert and sometimes in conflict—collectively form the behavioral health system for the nation. This “system” supports a broad range of patients—from those who rely on outpatient services for short-term problems to those with highly-disabling conditions who require intensive medical and social support services—as well as a range of both specialized and general providers. Experts conclude that, in general, the financing system for behavioral health services has led to great improvements in the well-being of individuals with mental health or substance abuse problems.⁹⁶ Yet there is still unmet need for care both among those with insurance coverage and those without any source of payment for services. As policymakers debate how to best structure the overall health system to control costs and provide coverage to the uninsured, it is important to bear in mind how proposed changes will impact the complex system that finances services for some of the nation’s most vulnerable individuals.

Table 1: Pre-Reform Coverage of Behavioral Health Services, by Payer

Category	Service	Payer				
		BC/BS PPO (1)	Medicare (2)	Medicaid (3)	Other state funding (4)	Other federal funding (5)
Prevention						
	Screening for alcohol misuse	X	^	/	X	
	Screening for depression	X	X	/	X	
	Screening for illicit drug use	X	^	/	X	
	Screening for suicide risk			/	X	
Treatment						
	Diagnostic tests, psychological testing	X	X	X	X	
	Outpatient MH/SA psychotherapy	X	X	X	X	
	Inpatient MH/SA hospitalization	X	X	X*	X	
	Partial MH/SA hospitalization	X	X	X	X	
	Inpatient detoxification	X	X	X	X	
	Outpatient detoxification	X	X	X	X	
	Pharmacological therapies	X	X	X	X	
	Medication management	X	X	X	X	
	Opioid treatment			X	X	
	Short-term MH/SA residential care			X	X	
	Long-term MH/SA residential care			X	X	
	Case management/intensive case management for MH/SA			X	X	
	Crisis intervention for MH/SA			X	X	
Supportive Services						
	Housing assistance				X	X
	Vocational training /support			Limited	X	X
	Income assistance				X	X
	Nonemergency transportation services			X	X	
	Peer support services			X	X	
	Collateral services/family support services			X	X	
	Home-based support services			X	X	
Notes:						
Service list was compiled based on expert reports Mental Health: A Report of the Surgeon General (1999) and President's New Freedom Commission on Mental Health (2002); service benefit plans for various payers; and consultation with behavioral health experts.						
(1) Based on Blue Cross and Blue Shield standard FFS/PPO plan available under the Federal Employees Health Benefit Plan (FEHBP). See: http://www.fepblue.org/						
(2) Column indicates coverage under traditional Medicare (Parts A and B) and Medicare Part D (prescription drug coverage). Beneficiaries enrolled in Medicare supplemental plans (Medigap or Medicare Advantage) may receive additional benefits under those plans. See: http://www.medicare.gov/publications/pubs/pdf/10184.pdf						
(3) Coverage varies by state; column indicates services that are covered by most states. See: http://mentalhealth.samhsa.gov/publications/allpubs/State_Med/						
(4) Coverage varies by state; column indicates services that are covered by most states. See: http://download.ncadi.samhsa.gov/ken/pdf/SMA09-4424.pdf						
(5) Federal block grant dollars supplement state-funded programs detailed in column (4). Column indicates programs funded solely with federal dollars. See: http://www.mentalhealthcommission.gov/reports/Fedprograms_031003.doc						
* Excludes services in an institution for mental diseases (IMD) for those ages 21-64.						
/ Service covered for children under Medicaid's EPSDT benefit; a minority of states covers screening for adults.						
^ Coverage if for alcohol/substance abuse structured assessment and brief intervention services.						
SOURCE: Garfield, RL, Lave JR, and Donohue JM. "Health Reform and the Scope of Benefits for Mental Health and Substance Use Disorder Services." <i>Psychiatric Services</i> . November 2010, 61(11): 1081-6.						

**Table 2:
Government Programs Providing Funding for Behavioral Health Services**

FEDERAL PROGRAMS	
Department/Agency	Programs
Department of Health and Human Services/ Substance Abuse and Mental Health Services Administration (SAMHSA)	<ul style="list-style-type: none"> - Community Mental Health Services Block Grant - Projects for Assistance in Transition from Homelessness (PATH) - Protection and Advocacy for Individuals with Mental Illness (PAIMI) - Disaster Assistance - Comprehensive Child Mental Health Services
Department of Health and Human Services/ Centers for Medicare & Medicaid Services (CMS)	<ul style="list-style-type: none"> - Medicaid - Medicare - Children's Health Insurance Program
Department of Health and Human Services/ Health Resources & Services Administration (HRSA)	<ul style="list-style-type: none"> - Community Health Centers
Department of Health and Human Services/ Administration for Children & Families (ACF)	<ul style="list-style-type: none"> - Title IV-B Subpart I (Child Welfare) - Title IV-B Subpart II (Promoting Safe and Stable Families) - Title IV-E Child Foster Care Services - Head Start/Early Head Start - Temporary Assistance for Needy Families (TANF) - Title XX Social Services Block Grant - Transitional Living for Older Homeless Youth
Department of Health and Human Services/ Indian Health Service (IHS)	<ul style="list-style-type: none"> - Indian Health Service
Department of Health and Human Services/ Administration on Aging (AoA)	<ul style="list-style-type: none"> - Grants to State Agencies on Aging
Department of Agriculture	<ul style="list-style-type: none"> - Food Stamps - Rural Housing Programs
Department of Education	<ul style="list-style-type: none"> - Individuals with Disabilities Education Act (IDEA) - Vocational Rehabilitation - Safe Schools/Healthy Students
Department of Housing and Urban Development	<ul style="list-style-type: none"> - § 8/Housing & Community Voucher Program (HCV) - § 8/Single Room Occupancy Program - Home Investment Partnership Program - Community Development Block Grant (CDBG) - Emergency Shelter Grants - Shelter Plus Care - § 811 Supportive Housing for Individuals with Disabilities - Supportive Housing - § 232 Mortgage Insurance
Department of Justice	<ul style="list-style-type: none"> - Challenge Grants for Juvenile Justice - Community Prevention Grants - State Formula Grants
Department of Labor	<ul style="list-style-type: none"> - Workforce Investment Act
Department of Veterans Affairs	<ul style="list-style-type: none"> - Veteran's Health Benefits
Internal Revenue Service	<ul style="list-style-type: none"> - Low-income Housing Tax Credits
Social Security Administration	<ul style="list-style-type: none"> - Supplemental Security Income (SSI) - Social Security Disability Insurance (SSDI)

Table 2 (Continued): Government Programs Providing Funding for Behavioral Health Services STATE AND LOCAL PROGRAMS*
State Mental Health Agency
Child Welfare
Corrections/Criminal Justice
Early Intervention
Education
Housing
Juvenile Justice
Medicaid & CHIP
Substance Abuse
Temporary Assistance to Needy Families (TANF)
Veterans Affairs
Vocational Rehabilitation
<p>* The specific state and local programs that serve individuals with behavioral health needs vary by state. This table lists state agencies typically involved in financing or administering those programs. Sources:</p> <p>President's New Freedom Commission on Mental Health. <i>Major Federal Programs Supporting and Financing Mental Health Care</i>. January 2003. Available at: http://www.mentalhealthcommission.gov/reports/Fedprograms_031003.doc.</p> <p>National Association of State Mental Health Program Directors. <i>Other State Agency Mental Health Services Project (OSA)</i>. Information available at: http://www.nri-inc.org/projects/OSA/.</p>

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⁹⁴ Centers for Medicare & Medicaid Services. *Medicaid Definition of Covered Care Management Services Clarified, November 30, 2007*. Available at:
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⁹⁵ S.1217 (Stabenow) was introduced and referred to committee on June 9th, 2009.

⁹⁶ Frank and Glied.



THE KAISER COMMISSION ON
Medicaid and the Uninsured

The Henry J. Kaiser Family Foundation

Headquarters
2400 Sand Hill Road
Menlo Park, CA 94025
Phone 650-854-9400 Fax 650-854-4800

Washington Offices and
Barbara Jordan Conference Center
1330 G Street, NW
Washington, DC 20005
Phone 202-347-5270 Fax 202-347-5274

www.kff.org

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