A report from The Pew Charitable Trusts and the John D. and Catherine T. MacArthur Foundation | June 2015

THE PEW CHARITABLE TRUSTS | MacArthur Foundation

Mental Health and the Role of the States

The State Health Care Spending Project, an initiative of The Pew Charitable Trusts and the John D. and Catherine T. MacArthur Foundation, helps policymakers better understand how much money states spend on health care, how and why that amount has changed over time, and which policies are containing costs while maintaining or improving health outcomes. For additional information, visit pewtrusts.org.

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The report benefited from the insights and expertise of Ted Lutterman, senior director of government and commercial research at the National Association of State Mental Health Program Directors Research Institute (NRI). Although he screened the report for accuracy and provided feedback and guidance at critical stages, neither he nor his organization necessarily endorses the report's findings or conclusions.

Acknowledgments

Thank you to Stephenie Colston, president and CEO of Colston Consulting Group, and Katharine Levit for providing critical guidance during the research process. Thank you to Kavita Choudhry and Kimberly Furdell for their assistance with data collection and analysis. Thank you also to the following Pew colleagues for their contributions to this report: Hassan Burke for his assistance with data checking; Jeremy Ratner, Michelle Blackston, Lauren Dickinson, Bernard Ohanian, Lisa Gonzales, and Demetra Aposporos for their editorial input; and Gaye Williams, Dan Benderly, Sara Flood, Laura Woods, Jerry Tyson, and Liz Visser for their work preparing this report for publication. We also thank Karen Font for her assistance with fact checking.

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Overview

Millions of Americans have one or more forms of mental illness.[1] These conditions have wide-ranging health, economic, and social consequences. For example, mental illness is a major factor in homelessness and incarceration.[2] And serious mental illness—defined as a mental, behavioral, or emotional disorder that causes significant functional impairment that substantially interferes with or limits one or more major life activities—costs the country about $200 billion in lost earnings annually.[3]

Researchers from the State Health Care Spending Project—a collaboration between The Pew Charitable Trusts and the John D. and Catherine T. MacArthur Foundation—sought to better understand the country's mental health challenges and, in particular, the states' role in addressing them. The project found that:

- In 2013, approximately 44 million* adults—18.5 percent of the population 18 and older—were classified as having a mental illness.[4] Of these, 10 million had a serious mental illness. The rate of serious mental illness varied from state to state.[5]
- In 2009, the most recent year for which national mental health data are available, $147 billion was spent on mental health treatment in the United States.[6] (See Figure 2.) A majority of the spending, 60 percent, came from public sources such as Medicaid,† state and local governments, Medicare,‡ and federal grants. Private sources, including health insurance§ and individual out-of-pocket spending, made up the difference.
- Funding from states and localities totaled $22 billion (15 percent) in 2009.[7] This total does not include state and local Medicaid expenditures. Counting those contributions brings total state and local spending up to $35.5 billion (24 percent).[8]

This report is intended to help federal, state, and local policymakers working to address the country's mental health challenges to better understand their prevalence, treatment, and funding trends.

The State Health Care Spending 50-State Report Series

The State Health Care Spending Project, a collaboration between The Pew Charitable Trusts and the John D. and Catherine T. MacArthur Foundation, is examining seven key areas of state health care spending—Medicaid, the Children's Health Insurance Program, substance use disorder treatment, mental health services, prison health care, active state government employee benefits, and retired state government employee benefits. The project provides a comprehensive examination of each of these health programs that states fund. The programs vary by state in many ways, so the research highlights those variations and some of the key factors driving them. The project is concurrently releasing state-by-state data on 20 key health indicators to complement the programmatic spending analysis. For more information, see http://www.pewtrusts.org/en/projects/state-health-care-spending.

* Some of these individuals had a co-occurring substance use disorder.

† Medicaid is a state-administered health insurance program, funded jointly with the federal government, for low-income families and children, pregnant women, the elderly, people with disabilities, and, in some states, other adults.

‡ Medicare is a federal health insurance program for Americans 65 or older and certain younger people with disabilities.

§ Private insurance includes both the employer-sponsored insurance and individual insurance markets.

Prevalence and impact

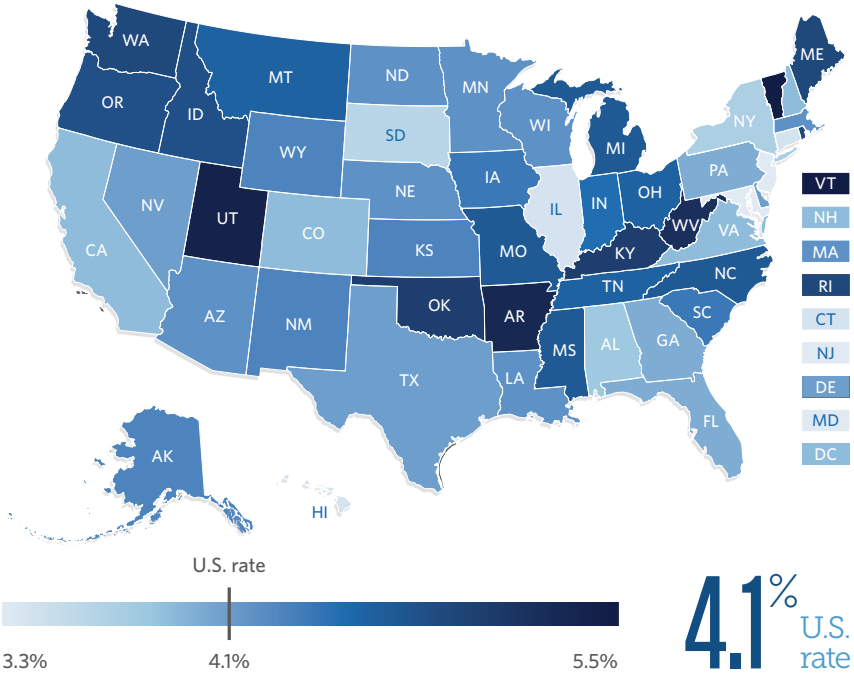
In 2013, an estimated 44 million American adults (18.5 percent of the population 18 and older) had had a mental illness in the past year.[9] Of these, patients with a serious mental illness—defined as any mental, behavioral, or emotional disorder that substantially interfered with or limited one or more life activities—numbered 10 million. Mental illnesses include schizophrenia, depression and anxiety, and bipolar disorder.

During 2012 and 2013, the most recent years for which state-specific data are available, the rate of serious mental illness ranged from 3.3 percent (in Maryland and New Jersey) to 5.5 percent (Vermont).[10] (See Figure 1.)

Figure 1

Rate of Serious Mental Illness

Percentage of respondents with a self-reported mental illness in the past year verified by a clinical interview, 2012–13



Note: Self-reports of a serious mental illness include feeling nervous, hopeless, restless/fidgety, sad/depressed, worthless, or like "everything requires effort."

Source: Substance Abuse and Mental Health Services Administration

The financial implications of mental health issues are significant for states. Because the presence of mental illness is associated with less, and less effective, preventive care and disease management, those with chronic physical health conditions incur higher health care costs than individuals with similar ailments who are not mentally ill.[11] For example, health care expenditures for people with one of the 10 most common chronic physical illnesses* were, on average, 65 percent higher for those who also had a diagnosis of depression, and 77 percent higher for people with anxiety.[12] In addition, nearly 1 in 5 adults with mental illness also had a substance use disorder.[13] The increased disease burden created by these coexisting conditions complicates patient care and adds to its cost. Additionally, people with serious mental illnesses die 25 years earlier, on average, than the rest of the population.[14]

* The 10 conditions studied were arthritis, hypertension, chronic pain, diabetes mellitus, asthma, ischemic heart disease, chronic obstructive pulmonary disorder, malignant cancer, congestive heart failure, and stroke.

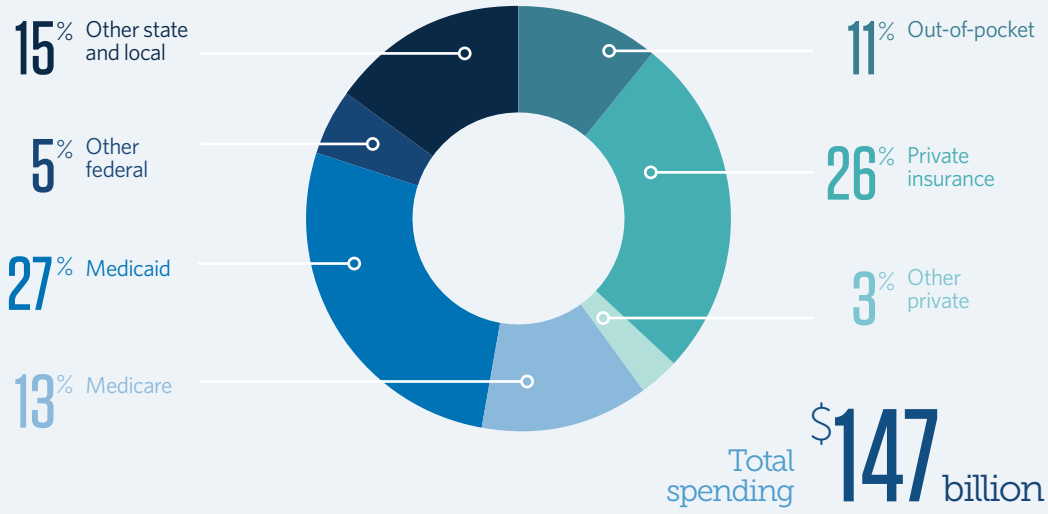
Mental illness is also a major factor in incarceration and the cost of caring for inmates, whose incidence of mental illness exceeds that of the general population. According to one estimate, more than half of all individuals in prison or jail have a mental illness, one factor that contributed to an increase in state correctional spending between 2001 and 2011.[15]

Distribution and growth of spending

In 2009, the most recent year for which data are available, the United States spent $147 billion on mental health treatment.[16] A majority of the spending, 60 percent, came from public sources, such as Medicaid, state and local governments, Medicare, and federal grants. Private sources, including health insurance and individual out-of-pocket spending, made up the rest. (See Figure 2.)

Figure 2

Distribution of Spending on Mental Health Treatment by Payer, 2009



Note: "Other private" includes charity.

Source: Substance Abuse and Mental Health Services Administration

This imbalance between public and private spending on mental health has been consistent over the last 30 years. It differs markedly from overall national health expenditures, where private spending is dominant, due to the historic limitation in private mental health coverage and fragmented nature of the mental health system.[17] Looking forward, public sources—primarily Medicaid and Medicare—are expected to make up a somewhat larger share of spending on mental health as many states expand their Medicaid programs in accordance with the Affordable Care Act and baby boomers become eligible for Medicare.[18]

Medicaid

Medicaid was the largest funding source for mental health treatment in 2009, when it paid $39.1 billion;[19] states funded about 56 percent of Medicaid expenditures on average.[20] The program's role grew substantially from 1986 to 2009, increasing from 17 percent to 27 percent of total mental health treatment spending. (See Figure 3.) Indeed, the program was responsible for nearly a third of the growth in mental health treatment spending over this period.

The Centers for Medicare & Medicaid Services require all state Medicaid programs to provide enrollees with some core mental health services, predominately community-based programs, but states often choose to supplement those services with additional optional evidence-based services and support. These frequently include counseling, case management, medication management, and social work services, sometimes resulting in more comprehensive coverage than that offered under private insurance plans. While coverage varies for adults, states must cover Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services for eligible children younger than 21 in order to receive a federal Medicaid match. EPSDT provides enrolled children with coverage for a wide range (usually greater than for adult enrollees) of mental health services deemed medically necessary by each state. The use of Medicaid options and waivers by states during the 1990s and 2000s contributed to the substantial growth in Medicaid mental health spending during that time period.[21]

State and local governments

In addition to state dollars spent on mental health treatment of Medicaid enrollees, states and localities spent $22 billion on other mental health care in 2009.[22] Besides state mental health agencies, these dollars were directed to child protective services, criminal justice entities, schools, housing authorities, and substance abuse agencies. Adding these contributions to state Medicaid mental health numbers brings the total of state and local spending up to $35.5 billion.[23]

Although total non-Medicaid state and local mental health spending increased from 1986 to 2009, its *share* of total mental health spending fell from 27 to 15 percent and is projected to continue decreasing at least through 2020. (See Figure 3.) This decline is due in part to increased coverage of mental health treatment by other payers, including Medicaid, Medicare, and private insurance.

Medicare

The Medicare program helps pay for a wide range of care, including inpatient hospitalizations; visits with a psychiatrist, clinical psychologist, or clinical social worker; intensive coordinated outpatient care as an alternative to inpatient psychiatric care; and prescription drugs.[24] In 2009, Medicare paid for a smaller share—13 percent, or $19.4 billion—of mental health treatment than Medicaid.[25] However, Medicare's share of mental health treatment more than doubled from 1986, when it was just 6 percent of the total, to 2009. One reason its share of spending increased, in addition to more beneficiaries, is because of a shift in prescription drug costs. The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 transferred the cost of prescription drugs, including those for behavioral health, from Medicaid to Medicare for beneficiaries eligible for both programs.[26]

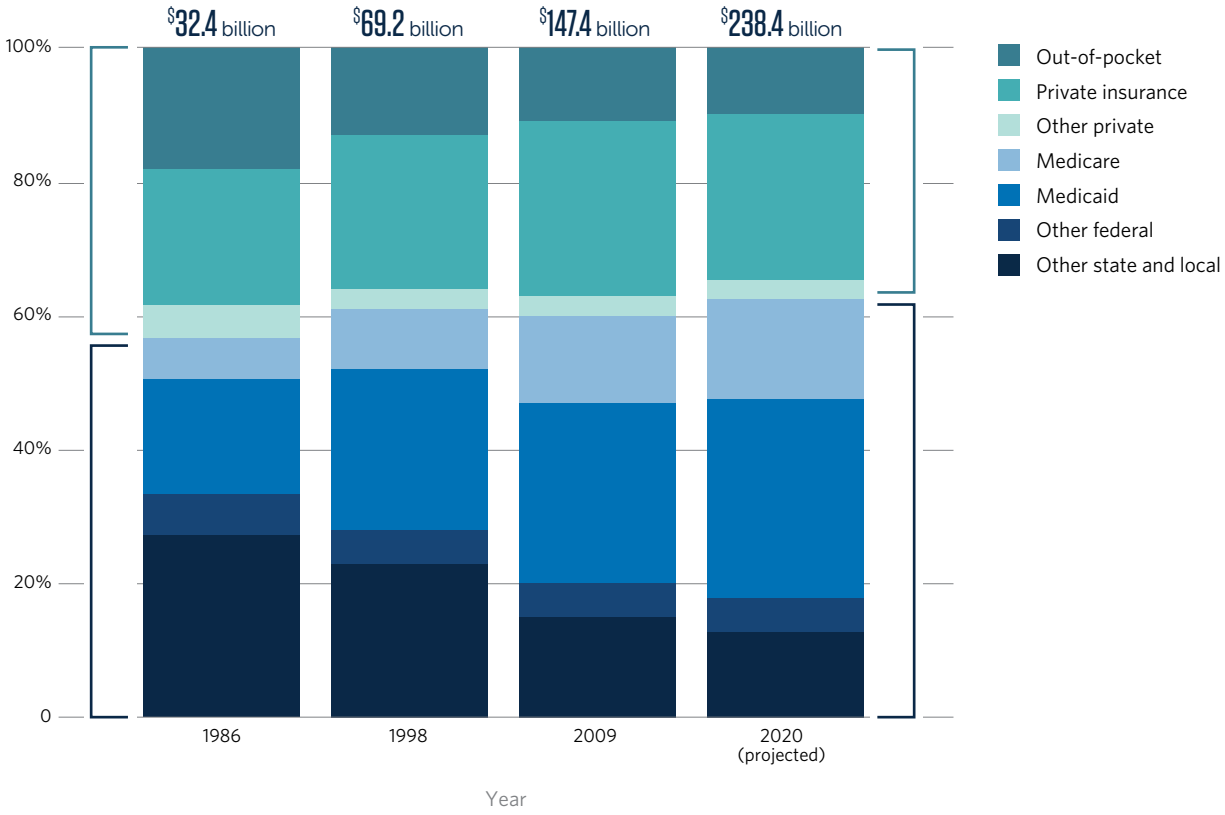
Private insurance

The role of private health insurance in financing mental health treatment has expanded over time, increasing from 20 percent of all spending in 1986 to 26 percent in 2009. Going forward, private insurance will continue to play an important role, in large part because the Affordable Care Act is improving access to private health insurance overall and the Parity Act is increasing mental health coverage specifically.

Figure 3

Mix of Public, Private Spending Relatively Consistent

Spending on mental health, 1986–2020



Note: The designation "other private" refers to funding from private foundations, while "other federal" references spending by government entities such as the Substance Abuse and Mental Health Services Administration and the Department of Veterans Affairs.

Source: Substance Abuse and Mental Health Services Administration and Tami L. Mark et al., "Spending on Mental and Substance Use Disorders Projected to Grow More Slowly Than All Health Spending Through 2020," Health Affairs 33, no. 8 (2014), http://content.healthaffairs.org/content/33/8/1407.abstract

Shifts in treatment

Like all types of health care services, the treatment for mental illness has changed dramatically over time, with treatment dollars following. Since 1986, the share of U.S. spending on inpatient and residential treatment has decreased significantly, while spending on outpatient treatment and prescription drugs has increased dramatically.[27] (See Table 1.) The role prescription drugs play has increased substantially—particularly between 1992 and 2004, when growth in national spending on psychotropic medications* spiked.[28] This hike was due in part to an influx of new and expensive medications with fewer side effects. Most of this spending goes toward antidepressants and antipsychotics.

* Psychotropic drugs are used to affect a person's mood and behavior. Commonly prescribed examples include Prozac, Xanax, and Adderall.

Table 1

Spending on Treatment Shifted From Inpatient to Prescription Drugs

Mental health spending by treatment setting, 1986 and 2009

Treatment setting	Mental health spending, 1986	Mental health spending, 2009
Inpatient: acute care by general hospital, specialty mental health facility, or substance use disorder hospitals	41%	17%
Prescription drugs: psychotherapeutic medications sold through retail outlets and mail-order pharmacies	8%	28%
Outpatient: provided by general or specialty hospitals, emergency departments, and offices or clinics	24%	32%
Residential: 24-hour medical care, including care delivered in specialty facilities and nursing homes	22%	15%

Note: The percentages do not total 100. The remainder of spending was directed toward insurance administration, which covered the cost of running various government health care programs, as well as the administrative costs and profits of private health insurance companies.

Excluded from the prescription drugs total are sales through hospitals, exclusive-to-patient health maintenance organizations, and nursing home pharmacies.

Source: Substance Abuse and Mental Health Services Administration

The changing role of states in mental health

State governments have historically funded and operated psychiatric hospitals, long the primary mode of caring for the mentally ill, as part of their responsibility and authority to care for those who cannot make decisions for themselves. However, in the late 1950s, states began to move patients out of large inpatient mental institutions and into less-restrictive community-based settings—a process commonly known as deinstitutionalization.

Deinstitutionalization had several catalysts. One was increased public awareness of the overcrowding and poor treatment in large state psychiatric hospitals. Another was the development of antipsychotic medications, such as Thorazine in the 1950s, which were thought to make treatment possible outside of an institutional setting. Proponents of deinstitutionalization argued for replacing institutions with a network of community-based treatment centers that could deliver care in a less-restrictive, more patient-centered setting, partly by employing the new antipsychotic drugs and by advances in psychotherapy. Passage of the landmark Community Mental Health Act of 1963 committed the federal government to the goal of establishing community-based mental health services throughout the country. Two years later, the establishment of Medicaid, which prohibited coverage of the care of mentally ill adults in inpatient psychiatric hospital settings,* provided a further incentive for states to reduce their number of psychiatric beds by transitioning care to outpatient settings and thereby transferring some treatment costs to the federal government.

* The federal Medicaid match cannot pay for care in inpatient facilities with more than 16 beds in which the majority of patients are severely mentally ill. This rule is referred to as the IMD (Institutions for Mental Disease) Exclusion.

The deinstitutionalization movement had a profound effect on the way states approached and funded mental health services. Before deinstitutionalization, most mental health patients were treated for extended periods in state psychiatric hospitals. Starting with the movement's peak in 1955, the number of public psychiatric beds decreased 95 percent by the end of the 20th century.[29]

This trend, more recently described as "dehospitalization," has continued, encouraged in part by enactment of the 1980 Civil Rights of Institutionalized Persons Act* and enforcement of the 1999 Olmstead Supreme Court decision requiring states to eliminate the unnecessary segregation of persons with physical or cognitive disabilities and to ensure that persons with disabilities receive services in the most integrated setting appropriate to their needs.[30] Between 2005 and 2010, the number of available state psychiatric beds in all facilities, including general hospitals, declined an estimated 14 percent on top of the already dramatically reduced bed capacity.[31] As a result, most states experienced a large drop in the number of people served in state psychiatric hospitals, leading to a significant reduction in the share of overall mental health spending on inpatient services.[32] (See Table 1.)

In lieu of hospitalization, the number of people served in community-based settings has increased. Alternative models of care have emerged, such as mobile crisis services, intensive community treatment that utilizes case management, medication management, and partial hospitalization.† Nonmedical services have also arisen, including income and housing supports and vocational training. However, while services have become more holistic in nature, funding remains fragmented.

The fiscal implications of dehospitalization are significant because hospital services for mentally ill individuals generally cost substantially more per patient than community-based programs. Meanwhile, the cost of psychiatric drugs has significantly decreased since the patents on several widely used antidepressant and antipsychotic medications expired, leading to the availability of generic versions that on average cost 80 to 85 percent less than the corresponding brand name versions.[33]

Still, critics of dehospitalization argue the movement has gone too far, creating a severe shortage of psychiatric beds and a system of community-based services and social supports that are unable to keep pace with the needs of day-to-day care. They also argue that instead of receiving adequate care, many seriously mentally ill individuals end up homeless or in emergency rooms, the correctional system, and nursing homes that are ill-equipped to provide proper treatment.

State mental health agencies

States have increasingly looked to their mental health agencies (SMHAs) to meet the needs of residents who would not otherwise have access to mental health care. SMHAs served 7.1 million clients nationwide in fiscal 2012 at a cost of $39.7 billion, almost 21 percent of the approximately 34.1 million people nationwide who received some kind of mental health service in 2012.[34] (See Table 2.)

* The Civil Rights of Institutionalized Persons Act guaranteed the right to active treatment and better care for people in a variety of institutional settings, including psychiatric hospitals.

† A partial hospitalization program is a structured program of active outpatient psychiatric services in a doctor or therapist's office that does not require an overnight stay.

Table 2

State Mental Health Agency Revenue Varies Widely

SMHA revenue by source, state fiscal year 2012

State	Total revenue ($)	% from general fund	% from state Medicaid	% from federal Medicaid	% from other sources
United States	39,693,850,457	39.8%	20.2%	28.6%	11.4%
Alabama	366,898,613	44.2%	10.5%	33.5%	11.8%
Alaska	238,174,700	23.0%	32.5%	41.4%	3.1%
Arizona	1,365,600,000	8.6%	28.5%	57.8%	5.1%
Arkansas	132,626,456	56.8%	0.0%	31.6%	11.6%
California	6,427,441,175	41.3%	19.6%	19.7%	19.4%
Colorado	482,867,445	28.1%	34.3%	34.0%	3.6%
Connecticut	788,400,000	93.4%	0.8%	0.8%	5.0%
Delaware	93,590,110	78.0%	8.8%	9.7%	3.4%
District of Columbia	192,258,672	90.9%	2.8%	5.3%	1.0%
Florida	730,056,821	74.4%	5.9%	10.1%	9.6%
Georgia	552,406,718	80.8%	0.0%	0.8%	18.3%
Hawaii	156,045,777	82.9%	5.2%	7.2%	4.7%
Idaho	51,800,000	76.1%	2.9%	6.8%	14.3%
Illinois	961,900,000	51.4%	22.6%	22.3%	3.7%
Indiana	461,207,000	36.3%	19.5%	40.1%	4.2%
Iowa	441,900,000	13.5%	21.9%	43.1%	21.6%
Kansas	398,227,351	25.2%	31.6%	39.3%	3.9%
Kentucky	239,800,000	53.2%	9.4%	26.1%	11.3%
Louisiana	300,116,413	68.0%	8.4%	16.9%	6.7%
Maine	449,185,236	10.5%	32.6%	56.5%	0.5%
Maryland	1,081,300,000	65.4%	2.4%	30.2%	2.0%
Massachusetts	843,300,000	83.9%	0.0%	13.4%	2.7%
Michigan	1,186,499,995	21.2%	23.4%	50.7%	4.6%
Minnesota	904,062,334	26.2%	30.7%	32.3%	10.8%
Mississippi	316,626,000	45.9%	11.8%	34.5%	7.9%
Missouri	739,138,860	46.1%	8.5%	38.8%	6.6%
Montana	198,154,565	25.4%	20.3%	53.1%	1.2%
Nebraska	156,826,196	62.7%	5.3%	7.5%	24.5%

Continued on the next page

State	Total revenue ($)	% from general fund	% from state Medicaid	% from federal Medicaid	% from other sources
Nevada	163,200,000	74.1%	5.9%	7.2%	12.9%
New Hampshire	179,617,352	19.0%	24.9%	39.6%	16.6%
New Jersey	1,864,588,000	50.7%	16.6%	13.5%	19.3%
New Mexico	272,100,000	17.2%	22.9%	58.3%	1.6%
New York	5,013,200,000	28.1%	27.3%	27.6%	17.0%
North Carolina	1,300,014,476	26.8%	24.1%	44.9%	4.2%
North Dakota	58,889,286	50.5%	1.7%	20.3%	27.5%
Ohio	1,275,585,753	37.9%	6.8%	26.6%	28.6%
Oklahoma	213,124,000	79.2%	0.0%	6.0%	14.7%
Oregon	692,800,000	40.0%	21.8%	36.6%	1.7%
Pennsylvania	3,764,500,000	20.3%	37.7%	39.0%	3.0%
Rhode Island	76,622,603	9.1%	27.7%	50.8%	12.4%
South Carolina	267,300,000	42.9%	7.8%	39.9%	9.3%
South Dakota	70,163,611	52.3%	14.1%	22.7%	10.8%
Tennessee	571,600,000	30.9%	21.6%	42.3%	5.2%
Texas	986,500,000	66.7%	5.7%	7.8%	19.7%
Utah	183,600,000	20.2%	20.9%	52.1%	6.9%
Vermont	158,400,000	7.4%	37.6%	51.6%	3.3%
Virginia	747,900,000	60.2%	17.3%	17.3%	5.1%
Washington	787,393,000	23.0%	32.7%	35.9%	8.5%
West Virginia	155,500,000	54.0%	7.7%	34.0%	4.4%
Wisconsin	589,000,394	50.9%	11.9%	18.2%	18.9%
Wyoming	45,841,544	68.6%	11.2%	18.3%	1.8%

Note: Collected data were sent to each state for verification. If a state updated its data, the project used the updated numbers in this report. Because data were rounded, percentages may not equal exactly 100.

Source: National Association of State Mental Health Program Directors Research Institute (NRI)

SMHAs directly operate mental health care programs or fund and oversee other publicly or privately operated programs or hospitals.[35] There are no specific federal requirements mandating the services that SMHAs must provide. However, to qualify for federal Community Mental Health Services Block Grant funds—states' largest source of federal mental health funding after Medicaid—SMHAs are expected to offer "comprehensive community-based mental health systems" that serve adults and children.[36] States are authorized to set eligibility criteria for SMHA services based on various standards, including severity and duration of mental illness, sickness, insurance status, and income.

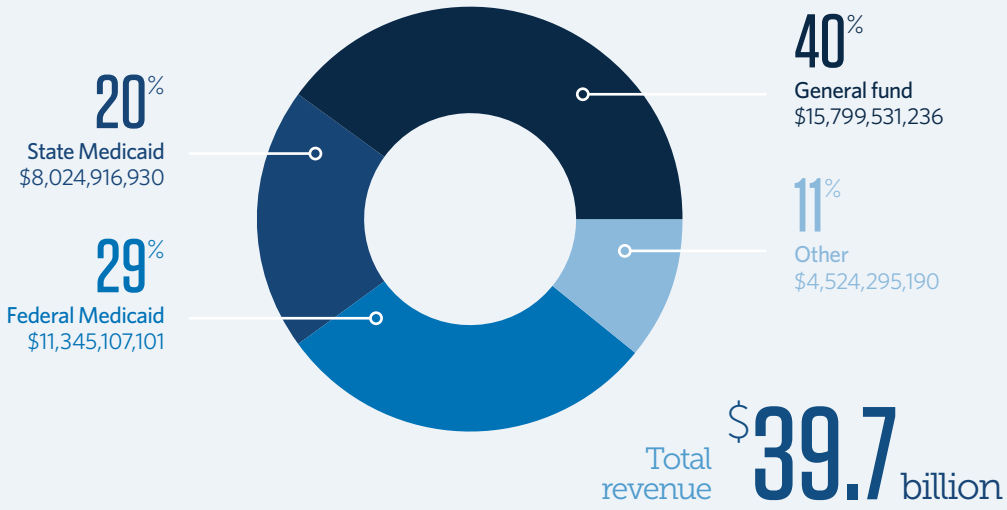
SMHA revenue sources

In 2012, SMHA revenue totaled $39.7 billion nationwide. State general funds and Medicaid (federal and state dollars) provided most—89 percent—of the money.* The remaining 11 percent came from Medicare, federal grants, private insurance, and local funding. (See Figure 4.)

Figure 4

SMHAs Supported Primarily by State General Funds and Medicaid

Agencies' revenue by source, 2012



Notes: Other funds include Medicare, federal grants, private insurance, and local funding.

Total revenue of $39.7 billion reflects fiscal 2012 SMHA funding from all federal, state, local, and private sources. This does not include state revenue spent on mental health through other state agencies, such as child protective services, criminal justice, schools, and state substance abuse agencies.

Source: National Association of State Mental Health Program Directors Research Institute (NRI)

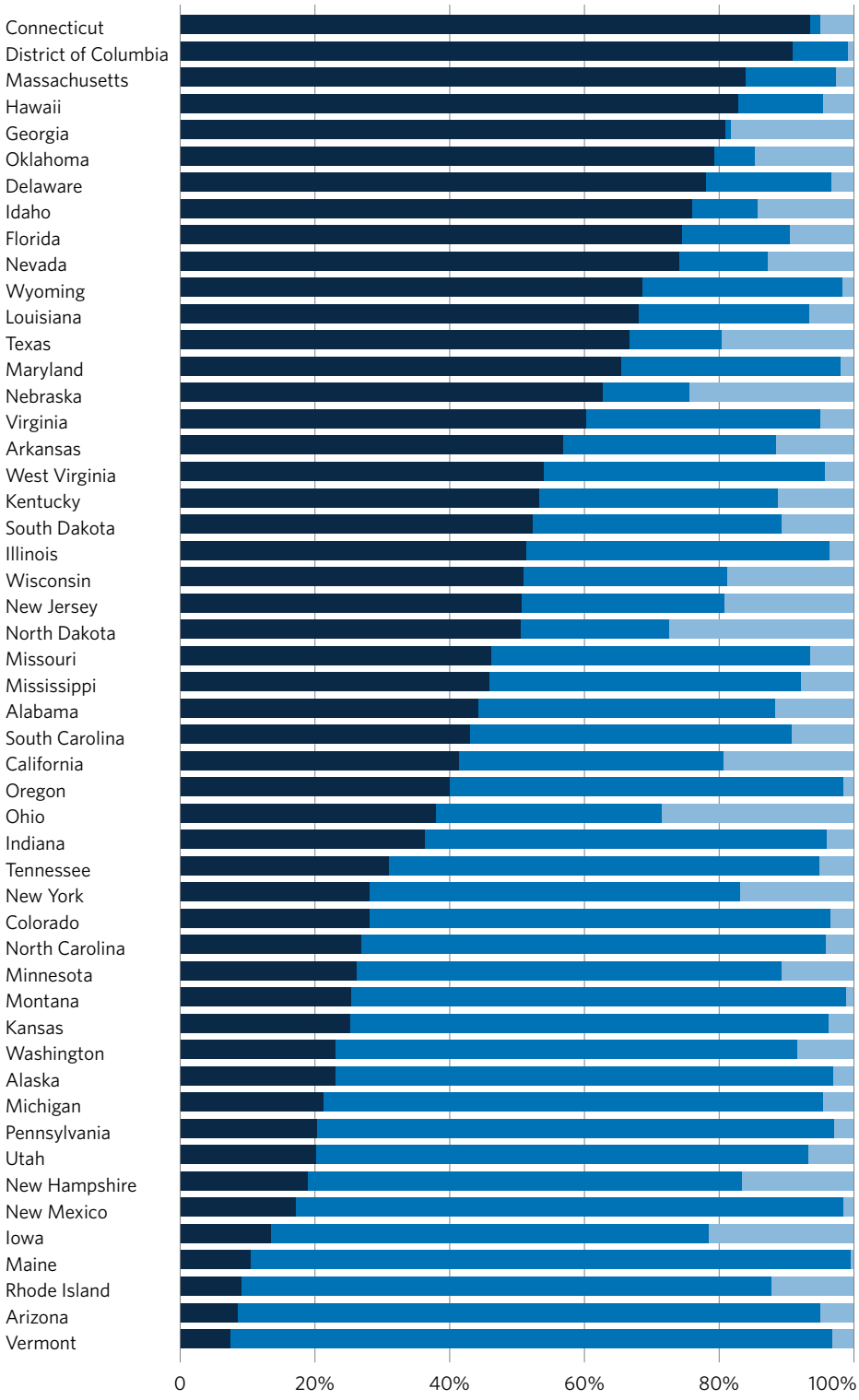
Nationally, Medicaid is a crucial source of SMHA revenue. However, the SMHA portion of revenue from different sources varies widely by state. At one extreme, Medicaid accounted for more than 80 percent of the revenue in four states, while at the other it accounted for less than 15 percent in 10 states. (See Figure 5.) This range reflects several factors, including state eligibility requirements, the need for SMHA services, and whether states route certain federal Medicaid reimbursement funds through their SMHA.

* SMHA funding refers to revenue and not expenditures, due to data limitations.

Figure 5

SMHA Funding Distribution Varies Widely Across States

SMHA revenue by source, 2012



Notes: "Other revenue" includes funds from the Medicare program, federal grants, private insurance, and local funding. For states with missing data, data from a prior or following year were used.

States differ in how they account for revenue. For example, Connecticut deposits federal Medicaid mental health revenue into the state's general fund. The Connecticut mental health agency does not receive the revenue.

Source: National Association of State Mental Health Program Directors Research Institute (NRI)

Medicaid's critical role in SMHA revenue has expanded over time, growing 40 percent from $13.9 billion (42 percent of SMHA revenue) in fiscal 2004 to $19.4 billion (49 percent of SMHA revenue) in fiscal 2012. In fact, the increase in Medicaid funds accounts for almost all of the growth in SMHA revenue from state fiscal years 2004 to 2012. This change was driven in part by an increase in the number of Medicaid enrollees seeking services provided through SMHAs. In fiscal 2012, 63 percent of SMHA clients were at least partially funded by Medicaid, up from 57 percent in 2007.[37]

SMHA funding trends

Total SMHA revenue grew steadily from fiscal 2004 to 2009 ($33.2 billion to $40.2 billion, fiscal 2012 dollars), before plateauing as states grappled with the budget impacts of the Great Recession.[38] Overall, total inflation-adjusted SMHA revenue grew by 20 percent from fiscal 2004 to 2012.

Many states responded to tightening budgets, which coincided with a greater demand for state-funded mental health services,[39] by reducing administrative and staffing costs, closing the state psychiatric inpatient units of general hospitals, reducing the number of people served in the community, and reducing the intensity or duration of services.[40] There are signs, however, that this trend is reversing: 35 states and the District of Columbia increased their budgeted general fund allocations to mental health for fiscal 2014.[41] In fiscal 2015, 29 states and the District increased such funding.[42]

Looking ahead: Expected impacts of federal legislation

Mental health insurance benefits have historically, when offered, been more restrictive than physical health coverage. Federal laws passed in recent years are likely to change that.

The Mental Health Parity and Addiction Equity Act of 2008 (Parity Act) directs health insurance plans that offer mental health and substance use disorder benefits to make them at least equal to physical health benefits. Small employers were exempt from this parity requirement.*

As of 2014, the Affordable Care Act mandated that newly created insurance plans† cover a set of essential benefits that includes mental health care. Moreover, it builds on the Parity Act by requiring all plans to which the essential benefits rule applies to cover mental health and substance use disorder benefits in a manner comparable to general medical and surgical coverage.

With more than half of states and the District of Columbia expanding Medicaid, and millions of individuals enrolling in health insurance marketplaces, insurance access to mental health services has increased significantly. According to 10-year federal estimates, 32 million Americans will gain access to both mental health and substance use disorder coverage through the Affordable Care Act. An additional 30 million Americans who currently have some level of coverage will benefit from federal parity protections.[43] The increase in numbers of insured people—and correlated decrease in people relying on the state as a safety net—will likely reduce the state agencies' share of mental health care costs.

Another provision of the Affordable Care Act is likely to accelerate a movement toward better integration of the treatment of physical and behavioral health conditions.[44] The Medicaid health homes state plan option provides

* The Parity Act became law in 2008, but the final rules—which guide implementation and put the legislation into action—were not released until November 2013.

† The law applies to health insurance plans offered in the individual and small group markets, including those in the new health insurance marketplaces, as well as state Medicaid plans for newly eligible enrollees.

eight quarters of enhanced federal matching funds to support states in establishing health homes for their enrollees. Health homes exist to coordinate care between physical and behavioral health through community and social supports, which can be accomplished, for example, by directly employing behavioral health specialists in a medical practice, or by primary care clinicians closely collaborating with such specialists to coordinate patient care. Early results indicate that health homes can lead to fewer hospitalizations and emergency department visits, as well as lower costs.[45] This movement, driven by SMHAs and state Medicaid agencies, recognizes the interrelatedness of all illness and runs counter to the long-standing division between physical and behavioral health services.

Conclusion

Mental illness is a widespread chronic disease affecting not only 18.5 percent of the U.S. adult population but also the families and communities of these individuals. While the prevalence of such illnesses varies across the states, no community is untouched and each state uses considerable resources to provide treatment through their mental health agencies and Medicaid programs. Mental illness is treated across several types of clinical settings and funded by multiple state agencies, including the courts, prisons, and schools.

New opportunities are opening up to treat more patients under an insurance model and in closer coordination with primary care providers that together, it is hoped, will improve patients' physical as well as mental health. The trend toward bringing mental illness more closely into the mainstream of health care has implications for the funding of treatment and the role of state mental health agencies. As Medicaid enrollment grows in states that have expanded their eligibility, the program's already large role in funding mental health services will increase. Regardless of the insurance status of the mentally ill patient, states must work to meet the needs of patients while using budgeted dollars wisely. This report provides a foundational overview of trends in prevalence, treatment, and spending to support such decision-making.

Methodology

Project researchers analyzed state spending by state mental health agencies (SMHAs) based on SMHA revenue and expenditure data for state fiscal years (SFYs) 2004, 2009, and 2012 collected by the National Association of State Mental Health Program Directors Research Institute (NRI) for the Substance Abuse and Mental Health Services Administration (SAMHSA). These data are collected annually and are reported by each state based on NRI specifications. Officials of mental health agencies in each state reviewed the data. If a state updated its data as a result of this review, the project used the updated data in this report.*

Revenue figures reflected only "SMHA-controlled" revenue, which were all funds received by the SMHA, including funds used directly by the SMHA and those distributed to local providers and governments by the SMHA. SMHA-controlled revenue include Medicaid funds received by community mental health centers and other providers funded by SMHAs, even if the funds went directly from Medicaid to the providers. Revenue dedicated to capital improvements was not included.[46]

Revenue definitions by source[47]

- **State general fund revenue.** This includes state revenue from direct general fund appropriations as well as from interdepartmental funds and special revenue earmarked for a special purpose. Reported by states in three expenditure categories (state hospitals, community programs, and support programs), these data were added together to create total general funds.
- **Medicaid revenue.** This includes revenue from both the state and federal shares of the Medicaid program. Federal Medicaid revenue consists of the portion of the federal share of matching funds that are received by the SMHA. State Medicaid revenue consists of the state and local share of the match funds that are received by the SMHA.
- **Other revenue.** This includes revenue from federal sources other than Medicaid, local jurisdictions, and third-party payers. Each of these totals is reported by states in three expenditure categories (state hospitals, community programs, and support programs). Researchers added these data together to create total other federal funds.
    - **Other federal revenue:** This includes Medicare payments, Community Mental Health Services Block Grants, and other federal funds from SAMHSA and the Department of Health and Human Services.
    - **Local revenue:** This includes funds from local jurisdictions, in large part through state-mandated matching funds.
    - **Other third-party revenue:** This comes from out-of-pocket payments from those receiving services and through private insurance providers or other third-party payers.

State revenue data notes[48]

Medicaid revenue for community programs was not included in SMHA revenue in Alaska, Arkansas, Connecticut, Delaware, Massachusetts, and West Virginia.

Children's mental health care services are not included in SMHA revenue in Connecticut, Delaware, Rhode Island, and West Virginia.

* California, Iowa, Nebraska, Oregon, and Virginia could not verify 2004 data.

Revenue includes funds for mental health services in jails or prisons in California, Maine, Maryland, New Jersey, New York, North Carolina, Texas, Utah, Virginia, and Wisconsin.

Individual state data notes

- In **Connecticut**, Medicaid revenue is included in the general fund.
- In **Kansas**, support services Medicaid revenue data were unavailable for SFY 2012, so 2011 data were used instead and added to the state and U.S. aggregate for 2012.
- In **South Carolina**, certain SMHA revenue was not reported by the state because NRI did not have a category to encompass the state's response.

Endnotes

1 Substance Abuse and Mental Health Services Administration, "Substance Use and Mental Health Estimates From the 2013 National Survey on Drug Use and Health: Overview of Findings," *The NSDUH Report* (Sept. 4, 2014), accessed Sept. 26, 2014, http://store.samhsa.gov/shin/content//NSDUH14-0904/NSDUH14-0904.pdf.

2 National Alliance on Mental Illness, "Mental Illness: Facts and Numbers," accessed April 6, 2015, http://www2.nami.org/factsheets/mentalillness_factsheet.pdf.

3 Ronald C. Kessler et al., "Individual and Societal Effects of Mental Disorders on Earnings in the United States: Results From the National Comorbidity Survey Replication," *American Journal of Psychiatry* 165, no. 6 (2008), http://ajp.psychiatryonline.org/doi/abs/10.1176/appi.ajp.2008.08010126.

4 Substance Abuse and Mental Health Services Administration, "Substance Use and Mental Health Estimates," 5–6.

5 Substance Abuse and Mental Health Services Administration, "National Survey on Drug Use and Health: Comparison of 2011–2012 and 2012–2013 Model-Based Prevalence Estimates (50 States and the District of Columbia)" (2014), Table 23, accessed Sept. 9, 2014, http://www.samhsa.gov/data/sites/default/files/NSDUHStateEst2012-2013-p1/ChangeTabs/NSDUHsaeShortTermCHG2013.htm.

6 Substance Abuse and Mental Health Services Administration, *National Expenditures for Mental Health Services and Substance Abuse Treatment, 1986–2009* (2013), iii, accessed March 24, 2014, http://store.samhsa.gov/shin/content//SMA13-4740/SMA13-4740.pdf.

7 Ibid., 58.

8 Ibid.

9 Substance Abuse and Mental Health Services Administration, "Substance Use and Mental Health Estimates," 5–6.

10 "National Survey on Drug Use and Health: Comparison of 2011-2012 and 2012-2013," Table 23.

11 Benjamin G. Druss and Elizabeth Reisinger Walker, *Mental Disorders and Medical Comorbidity*, Robert Wood Johnson Foundation (2011), accessed June 16, 2014, http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2011/rwjf69438/subassets/rwjf69438_1.

12 Steve Melek and Doug Norris, "Chronic Conditions and Comorbid Psychological Disorders," *Milliman Research Report* (July 2008), accessed July 8, 2014, http://us.milliman.com/insight/research/health/pdfs/Chronic-conditions-and-comorbid-psychological-disorders.

13 Substance Abuse and Mental Health Services Administration, "Substance Use and Mental Health Estimates," 5 and 7.

14 National Association of State Mental Health Program Directors, *Measurement of Health Status for People With Serious Mental Illnesses* (Alexandria, VA: 2008), accessed Jan. 9, 2014, http://www.nasmhpd.org/docs/publications/MDCdocs/NASMHPD%20Medical%20Directors%20Health%20Indicators%20Report%2011-19-08.pdf.

15 The Pew Charitable Trusts, *Managing Prison Health Care Spending* (2013), accessed March 16, 2014, http://www.pewtrusts.org/en/research-and-analysis/reports/2014/05/15/managing-prison-health-care-spending; The Pew Charitable Trusts, *State Prison Health Care Spending: An Examination* (2014), accessed July 28, 2014, http://www.pewtrusts.org/~/media/Assets/2014/07/StatePrisonHealthCareSpendingReport.pdf; and Urban Institute, *The Processing and Treatment of Mentally Ill Persons in the Criminal Justice System: A Scan of Practice and Background Analysis* (2015), accessed April 28, 2015, http://webarchive.urban.org/UploadedPDF/2000173-The-Processing-and-Treatment-of-Mentally-Ill-Persons-in-the-Criminal-Justice-System.pdf.

16 Substance Abuse and Mental Health Services Administration, *National Expenditures*, iv.

17 Richard G. Frank and Sherry Glied, "Changes in Mental Health Financing Since 1971: Implications for Policymakers and Patients," *Health Affairs* 25, no. 3 (2006), accessed Feb. 4, 2015, http://content.healthaffairs.org/content/25/3/601.abstract.

18 Tami L. Mark et al., "Spending on Mental and Substance Use Disorders Projected to Grow More Slowly Than All Health Spending Through 2020," 33, no. 8 (2014), accessed Nov. 5, 2014, http://content.healthaffairs.org/content/33/8/1407.abstract.

19 Substance Abuse and Mental Health Services Administration, National Expenditures, 58.

20 Department of Health and Human Services, "Implementation of Section 5001 of the American Recovery and Reinvestment Act of 2009 for Adjustments to the Third and Fourth Quarters of Fiscal Year 2009 Federal Medical Assistance Percentage Rates for Federal Matching Shares for Medicaid and Title IV-E Foster Care, Adoption Assistance and Guardianship Assistance Programs," *Federal Register* 74, no. 234 (2009), accessed Aug. 9, 2014, http://www.gpo.gov/fdsys/pkg/FR-2009-12-08/pdf/E9-29248.pdf.

21 Ted Lutterman, email communication to The Pew Charitable Trusts, "Re: A Check-In" (unpublished), accessed April 20, 2015.

22 Substance Abuse and Mental Health Services Administration, *National Expenditures*, 58.

23 Ibid.

24 Centers for Medicare & Medicaid Services, *Medicare & Your Mental Health Benefits* (2014), 6, accessed June 18, 2014, http://www.medicare.gov/pubs/pdf/10184.pdf.

25 Substance Abuse and Mental Health Services Administration, *National Expenditures*, 18 and 58.

26 Frank and Glied, "Changes in Mental Health Financing"; and Substance Abuse and Mental Health Services Administration, *National Expenditures*.

27 Substance Abuse and Mental Health Services Administration, *National Expenditures*, 62–63.

28 Ibid., iv.

29 William H. Fisher, Jeffrey L. Geller, and John A. Pandiani, "The Changing Role of the State Psychiatric Hospital," *Health Affairs* 28, no. 3 (2009), accessed July 16, 2014, http://content.healthaffairs.org/content/28/3/676.abstract.

30 U.S. Department of Justice, "Olmstead: Community Integration for Everyone," accessed March 20, 2014, http://www.ada.gov/olmstead/olmstead_about.htm.

31 E. Fuller Torrey et al., *No Room at the Inn: Trends and Consequences of Closing Public Psychiatric Hospitals 2005–2010* (2012), accessed April 18, 2014, http://www.tacreports.org/storage/documents/no_room_at_the_inn-2012.pdf.

32 Substance Abuse and Mental Health Services Administration, National Expenditures, 62.

33 Tami L. Mark et al., "An Analysis of the Slowdown in Growth of Spending for Psychiatric Drugs, 1986–2008," Psychiatric Services 63, no. 1 (2012), accessed May 15, 2014, http://ps.psychiatryonline.org/doi/abs/10.1176/appi.ps.201100564.

34 Substance Abuse and Mental Health Services Administration, *Results From the 2013 National Survey on Drug Use and Health: Mental Health Detailed Tables* (2014), Table 1.22A, accessed April 17, 2015, http://www.samhsa.gov/data/sites/default/files/2013MHDetTabs/NSDUH-MHDetTabs2013.pdf.

35 Substance Abuse and Mental Health Services Administration, *Funding and Characteristics of State Mental Health Agencies, 2010* (2011), xxi, accessed May 16, 2014, http://www.aahd.us/wp-content/uploads/2012/12/FundingStateMentalHealthAgencies2010.pdf.

36 Public Health and Welfare Act, Title 42, http://www.gpo.gov/fdsys/pkg/USCODE-2010-title42/pdf/USCODE-2010-title42-chap6A-subchapXVII-partB.pdf.

37 Substance Abuse and Mental Health Services Administration, "2007 CMHS Uniform Reporting System Output Table: AL Mental Health National Outcome Measures (NOMS)" (2009), 2, accessed March 23, 2015, http://media.samhsa.gov/dataoutcomes/urs/2007/Alabama.pdf; and "Alabama 2012 Mental Health National Outcome Measures (NOMS): CMHS Uniform Reporting System" (2012), 2, accessed March 23, 2015, http://media.samhsa.gov/dataoutcomes/urs/2012/Alabama.pdf.

38 NASMHPD Research Institute, "State Mental Health Agency Controlled Expenditures and Revenues for Mental Health Services, 2004-2012," accessed July 9, 2014, http://www.nri-incdata.org. Collected data were sent to each state for verification. If a state updated its data, the project used the updated numbers in this report. Because data were rounded, percentages may not equal exactly 100.

39 Sarah Burgard, *Health, Mental Health, and the Great Recession,* Russell Sage Foundation and Stanford Center on Poverty and Inequality (2012), accessed March 20, 2014, https://web.stanford.edu/group/recessiontrends/cgi-bin/web/sites/all/themes/barron/pdf/Health_fact_sheet.pdf.

40 Kevin Martone, "The Impact of the State Fiscal Crisis on State Mental Health Systems," National Association of State Mental Health Program Directors (2011), accessed Nov. 1, 2014, http://www.nasmhpd.org/docs/Policy/KevinMartonePPTBriefing2011.pdf.

41 National Alliance on Mental Illness, *State Legislation Report 2013: Trends, Themes & Best Practices in State Mental Health Legislation* (2013), accessed Dec. 12, 2014, http://www2.nami.org/Content/NavigationMenu/State_Advocacy/Tools_for_Leaders/2013StateLegislationReportFinal.pdf.

42 National Alliance on Mental Illness, *State Mental Health Legislation 2014: Trends, Themes & Effective Practices* (2014), accessed Dec. 14, 2014, http://www2.nami.org/Template.cfm?Section=Policy_Reports&Template=/ContentManagement/ContentDisplay.cfm&ContentID=172851.

43 Kirsten Beronio et al., *Affordable Care Act Expands Mental Health and Substance Use Disorder Benefits and Federal Parity Protections for 62 Million Americans* (2013), accessed Nov. 8, 2014, http://aspe.hhs.gov/health/reports/2013/mental/rb_mental.cfm.

44 Michael Stanek, "Promoting Physical and Behavioral Health Integration: Considerations for Aligning Federal and State Policy," National Academy for State Health Policy (2014), accessed Dec. 20, 2014, http://www.nashp.org/promoting-physical-behavioral-health-integration-considerations-aligning-federal-state-policy.

45 Kathy Moses and Brianna Ensslin, "Seizing the Opportunity: Early Medicaid Health Home Lessons," Center for Health Care Strategies Inc., http://www.integration.samhsa.gov/integrated-care-models/Seizing_the_Opportunity-_Early_Medicaid_Health_Home_Lessons_-1-.pdf.

46 Substance Abuse and Mental Health Services Administration, *State Mental Health Agency: Controlled Expenditures and Revenues for Mental Health Services, State Fiscal Year 2009* (Appendix B: FY 2009 SMHA-Controlled Expenditures and Revenues Study: Glossary and Data Reporting Instructions) (2014), accessed Nov. 8, 2014, http://store.samhsa.gov/shin/content//SMA14-4843/SMA14-4843.pdf.

47 Ibid.

48 NASMHPD Research Institute, "State Mental Health Agency Controlled Expenditures and Revenues for Mental Health Services, 2004-2012," accessed July 9, 2014, http://www.nri-incdata.org.

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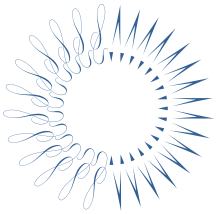

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