

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

June 2008



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ACKNOWLEDGMENTS

The authors of this report are Mary Giliberti, Director of Public Policy and Advocacy at the National Alliance on Mental Illness (NAMI); and Tammy Seltzer, Director of State Policy, Allison Fort, Policy Associate, and Mohini Venkatesh, Policy Associate, at the National Council for Community Behavioral Healthcare (National Council).

NAMI and the National Council would like to express our gratitude to the Robert Wood Johnson Foundation for supporting the development of this report. We particularly want to thank Senior Program Officer Andrew Hyman for his guidance and assistance. We are also grateful for the technical advice and support from the consultants to this project: Victor Capoccia, Director, Closing the Addiction Treatment Gap, Open Society Institute; Ron Manderscheid, Director, Mental Health and Substance Use Programs, Constella Group; Paul Samuels, Director and President, Legal Action Center; and Anita Marton, Vice President, Legal Action Center.

The authors received strong support from their respective organizations and thank Mike Fitzpatrick, Executive Director, NAMI, and Linda Rosenberg, President and CEO, National Council, as well as Ronald Honberg, Director of Policy and Legal Affairs, NAMI and Charles Ingoglia, Vice President, Public Policy, National Council. Angela Kimball, Laudan Aron, Laura Usher, Dana Markey, Katrina Gay, and Darcy Gruttadaro of NAMI also provided research, comments, and support for this project. From the National Council, Alexa Eggleston and Meena Dayak provided invaluable support for this project.

Many NAMI and National Council state affiliates and members provided extensive assistance. We would like to particularly thank the following NAMI state leaders: Sue Abderholden (MN), Kim Arnold (AR), Carol Carothers (ME), Sita Diehl (TN), Gary Mihelish (MT), Grace McAndrews (CA) and Pam McConey (IN). We also thank National Council Association Executives Frank Anselmo (IL), Dick Blackburn (TN), Matthew Brooks (IN), Ronald Brand (MN), Herb Cromwell (MD), George DelGrosso (CO), Elizabeth Earls (RI), and Kenny Whitlock (AR) along with Association staff Terry Carmichael (IL), Lydia Conley (MA), and Stephanie Hirst (MA) and Association consultant George Hovanec (IL).

We also are deeply indebted to Lisa Colpe at the Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services, for assisting us with the combining, tabulating, and understanding of data prepared specifically for this report.

Finally, we extend our heartfelt appreciation to all of the state officials who assisted us with this project. We are also grateful to several individuals from insurance plans who provided information for the report. Any errors or omissions are the responsibility of the authors.

EXECUTIVE SUMMARY

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

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

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

The Scope of the Problem

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

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

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

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

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

History Of Financing For Mental Illness And Substance Use Treatment

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

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

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

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

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

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

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

Analysis of State Benefit Packages

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

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

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

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

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

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

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

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

Major Findings

This analysis leads to 10 major findings, summarized below.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Implications and Recommendations

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

INTRODUCTION

With increasing concern among policymakers and the general public about the number of uninsured Americans and inaction at the federal level, states have aggressively moved forward on healthcare reform. The legislative sessions of 2006 and 2007 brought more activity in this area than ever before—if states were not enacting new policies, governors and legislators were studying and planning new initiatives designed to expand coverage to the uninsured. Although this activity in the states has received considerable attention in the media and in professional journals, no one has studied the impact of the states' initiatives on people with mental illnesses and substance use disorders. Given the prevalence of these conditions in the uninsured population, this issue should be brought to the attention of policymakers who are considering such initiatives.

In this paper, the National Alliance on Mental Illness (NAMI) and the National Council for Community Behavioral Healthcare (National Council) share their analysis of the coverage of mental illnesses and substance use disorders in state plans to cover the uninsured. This analysis focuses primarily on uninsured adults, who have been less well studied than uninsured children.

This paper, which is based on research on 18 state initiatives and proposals, consists of five sections and includes several important findings. The first section details the scope of the problem according to an analysis of combined data from the 2005 and 2006 National Survey on Drug Use and Health that has been tabulated specifically for this report. More than 25 percent of the adult uninsured population has a mental illness, substance use disorder, or co-occurring disorder. Americans with mental illnesses or substance use disorders are also likely to be uninsured; approximately one-third of people with mental illness and/or substance use disorders who are below the Federal Poverty Level (FPL) lack any insurance coverage. The percentage is even higher for those who have co-occurring mental illness and substance use disorders.

The second section provides some historical context for current policy debates; it discusses the evolution of financing of mental illness and substance use treatment, in which Medicaid has played an increasingly important role. At the same time, more than 40 states have addressed the scope of mental health and substance use disorder benefits in private insurance, creating laws that require either a minimum benefit for inpatient and outpatient visits or equal coverage for treatment for mental illness, substance use disorders, or both. Despite those efforts, significant numbers of people with mental illness and substance use disorders are not covered by Medicaid or private insurance and have no access to health, mental illness, or substance use treatment services.

The third section is the primary focus of this paper: the scope of mental health and substance use benefits in state programs or proposals to cover the uninsured. This analysis examines program requirements for outpatient and inpatient benefits for both mental health and substance use treatment, including any limitations on services as well as prescription drug coverage. Benefit packages can be divided into four distinct categories:

- ***Medicaid expansions.*** Provides Medicaid benefit package to an expanded population of low income adults.
- ***Parity and more.*** Provides equal coverage (in amount, duration, cost sharing, and other terms and conditions of the benefit package) for mental illness and/or substance use disorders and other health conditions. Some plans limit parity to a set of conditions; some provide an expansive array of recovery-oriented services.
- ***Limited coverage.*** Imposes narrower limits on the number of visits or the costs for mental illness and substance use disorders than for other health conditions.
- ***Minimal or no benefit.*** Covers few, if any, services for mental illness or substance use disorders. Often limits coverage for physical health benefits as well.

Most state programs or proposals provide benefit packages that can be categorized as parity and more; however, substance use disorders were less likely than mental illness to be covered and more likely to have restrictions on treatment, such as day or dollar amounts per year.

INCLUSION OF MENTAL ILLNESS AND SUBSTANCE USE DISORDERS

The fourth section identifies issues that need further exploration. This section examines a number of issues that require further research, including the experience of consumers who attempt to access covered mental health and substance use treatment and services.

The paper concludes with an analysis of the implications of state coverage decisions with respect to mental health and substance use benefits on future healthcare reform initiatives. Lessons from the states indicate a growing consensus on including parity benefits for mental illnesses in broad healthcare reform initiatives. The unequal coverage of substance use disorders merits further attention in both state and federal initiatives to cover the uninsured.

1. SCOPE OF THE PROBLEM

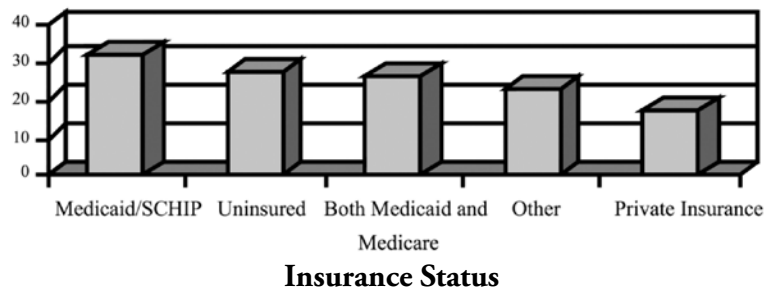
A. Percentage of the Uninsured Who Have a Mental Illness or Substance Use Disorder

Data from the U.S. Census Bureau indicate that 47 million Americans were uninsured in 2006.¹ Families USA used additional data to examine the number of people who lacked health insurance at *any point* in a two-year period and concluded that 90 million, or one in three nonelderly Americans, were uninsured for some or all of 2006–2007.²

Data from a national survey from the Substance Abuse and Mental Health Services Administration (SAMHSA) reveal that more than one in four adult uninsured Americans have a mental illness, substance use disorder, or co-occurring disorder. According to SAMHSA's National Survey on Drug Use and Health (NSDUH), 27 percent of adult uninsured Americans have a mental illness (defined by the survey as “serious psychological distress”), a substance use disorder (defined by the survey as “substance dependence” or “substance abuse”), or both.³ The data from the 2005 and 2006 surveys were combined, tabulated, and analyzed specifically for this report.

The SAMHSA survey highlights that more than 25 percent of the uninsured population has a significant need for mental health or substance use treatment services or both (Figure 1). The percentage of uninsured adults with those needs does not vary by income level. A significant ongoing need exists for mental health and substance use treatment for uninsured adults with incomes above 200 percent of the FPL.

Figure 1. Percentage of nonelderly adults by insurance status who have mental illness, substance use disorders, or both.



Source: National Survey on Drug Use and Health, 2005 and 2006.

B. Percentage of Adults with Mental Illness and Substance Use Disorders Who Are Uninsured

A significant percentage of adults with mental illness, substance use disorders, or co-occurring disorders are uninsured. Approximately 22 percent of adults with mental illness and/or substance use disorders are uninsured—more than one in five. For people with co-occurring mental illness and substance use disorders, the percentages are even higher: About 30 percent lack insurance.

States that have focused on the uninsured have been particularly concerned with their poorest residents, those under the FPL. The percentage of adults with mental illness and/or substance use disorders under 100 percent of the FPL who are uninsured is roughly 32 percent, or one in three. Adults with co-occurring mental illness and substance use disorders are even more likely to be uninsured: 37 percent of them lack health insurance coverage. Although many people assume that low income adults with mental illness and/or substance use disorders are covered by public insurance, such as Medicaid, the NSDUH data show that only 37 percent of people with such a disorder under 100 percent of the FPL are Medicaid recipients.

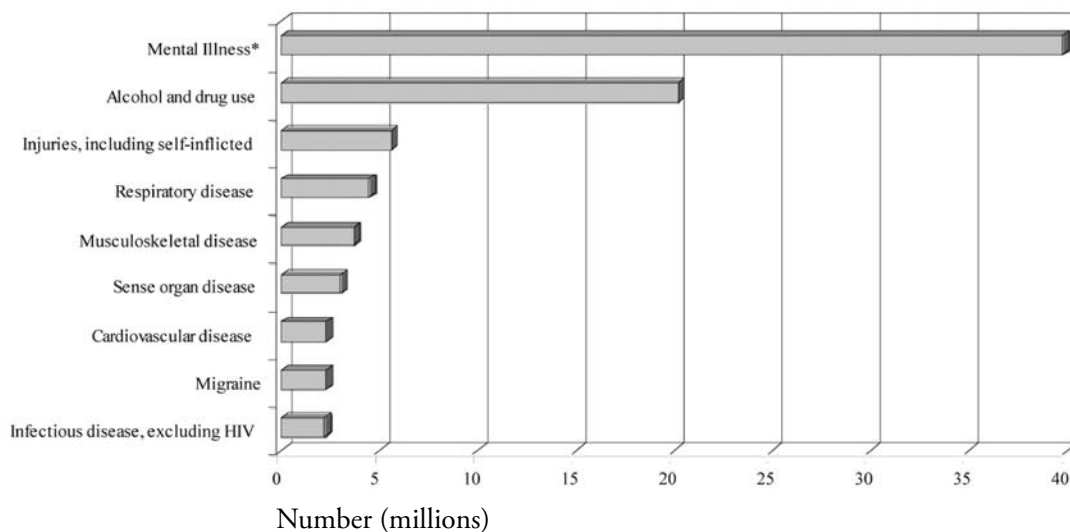
The percentages are similar for adults between 100 and 200 percent of the FPL who have mental illness and/or substance use disorders. About one in three adults in this category lack insurance, public or private.

Lack of insurance is a major barrier to receiving treatment. The NSDUH survey found that 79 percent of uninsured adults with mental illness and/or substance use disorders who needed but did not receive mental health treatment indicated that they could not afford the cost. Underinsurance also continues to be a problem: 34 percent of *insured* adults with unmet mental health treatment needs indicated that cost was also a barrier to receiving mental health treatment. A study comparing adults with different insurance coverage confirmed low access to mental illness and substance use treatment services for people who are uninsured.⁴

C. Economic and Health Consequences of Untreated Mental Illness and Substance Use Disorders

Data from the World Health Organization (WHO) indicate that mental illness is the leading cause of disability in North American adults and that alcohol and drug use are the second leading cause (Figure 2).⁵ Of the noncommunicable diseases, neuropsychiatric disorders, which include mental illness and substance use disorders, contribute the most to disease burden worldwide—more than heart disease and cancer.⁶

Figure 2. Leading causes of disability in North American adults



Source: National Institute of Mental Health. Data from the World Health Organization, World Health Report 2002.

Numerous studies document the effects of mental illness and substance use disorders on workplace productivity and absenteeism.⁷ Researchers at the Milken Institute estimated that in 2003, mental illness and substance use disorders led to \$171 billion in lost productivity (defined as lost workdays and less productivity) and that by 2013, this figure would rise to more than \$300 billion.⁸

For many people, the consequences are more severe. According to the Agency for Healthcare Research and Quality, almost one-fourth of all stays in U.S. community hospitals—7.6 million of nearly 32 million stays—involved depression, bipolar disorder, schizophrenia, and other mental health disorders or substance use disorders.⁹ Two-thirds of the U.S. homeless population are adults with chronic alcoholism, drug addiction, mental illness, or some combination of the three.¹⁰ The U.S. Department of Justice estimates that 16 to 23 percent of jail, state, and federal prison inmates have a serious mental disorder.¹¹ A SAMHSA study determined that adults with serious mental illnesses die 25 years sooner than those who do not have a mental illness.¹²

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

2. FINANCING FOR MENTAL HEALTH AND SUBSTANCE USE TREATMENT

A brief review of the financing of treatment for mental health and substance use disorders is helpful in understanding the current context for discussions about state plans to cover the uninsured. The high percentage of uninsured people with mental health and substance use treatment needs can be traced to some historical trends. The long history of state funding for institutional care, the creation of Medicaid and block grant programs, and the development of private insurance are important precursors to the current policy deliberations regarding the uninsured.

A. Evolution of the Community Mental Health and Substance Use Treatment System

Mental illness and substance use disorders have historically relied on limited public funding. From the 17th through the 19th century, the poor house and then the state “asylum” or “mental hospital” was the primary setting where people with mental illnesses were treated and housed. By the middle of the 20th century, public mental hospitals served a high of 559,000 patients.¹³ Inhumane conditions in those facilities eventually led to a public backlash against institutional care, setting the stage for a movement to support community-based treatment for mental illness and a dramatic decline in state hospital beds.

In the mid-1950s, this movement was accelerated by the advent of psychotropic medications that could treat mental illnesses, and it was furthered by the civil rights and anti-establishment sentiment of the 1960s. During this period, Congress passed the Community Mental Health Centers Act, which established community mental health centers providing treatment for mental healthcare in local communities.¹⁴

State funding for substance use treatment began later than funding for treatment of mental illness. The first specialized treatment institution based on a disease concept of alcoholism opened in 1864 as the New York State Inebriate Asylum.¹⁵ This initial, brief period, during which addiction was recognized as a medical condition, fell out of favor by the end of the 19th century and was replaced by the alcohol and drug prohibition movements in the early 1900s.¹⁶ Specialty institutions closed, and the care of people with substance use disorders shifted to penal institutions and public hospitals.¹⁷

Although the federal government made a small effort to support specialized substance use treatment and research in the 1930s,¹⁸ specific treatment for addictive disorders did not develop until the 1950s. Alcoholics received care in freestanding residential programs staffed primarily by people who were themselves in recovery and who embraced 12-step programs, such as Alcoholics Anonymous. A few facilities offered medical treatment or psychiatric care. No public funding or reimbursement by private insurance for treatment was available. The affluent received treatment in private inpatient facilities, and people who could not afford inpatient treatment used outpatient services.¹⁹ In 1968, Congress amended the Community Mental Health Centers Act to include treatment for substance abuse disorders as society increasingly recognized the need to treat addiction as a medical condition.²⁰

B. Advent of Medicaid and Block Grants as Financing Sources for Mental Health and Substance Use Treatment

The federal government significantly increased its role in financing community-based mental health and substance use treatment services when it created the Medicaid and Medicare programs in 1965. Medicare is solely a federal program, so this analysis focuses on Medicaid, a state–federal partnership in which the federal government assumes 50 to 80 percent of the costs of the healthcare provided, depending on the per capita income of the state.²¹

Medicaid initially provided funding for a range of healthcare services. However, inpatient care in a state mental hospital (defined as an “Institution for Mental Disease”) was specifically excluded from Medicaid coverage for adults.²² Congress wanted to prevent shifting of costs for services that had historically been established as state

responsibilities. This prohibition on paying for care in a mental hospital continues to the present day and reinforces the historical notion that mental health is a fiscal and social responsibility of the states rather than a healthcare issue.

From 1970 to 1990, Medicaid spending on mental health treatment rose rapidly as new community-based treatments were developed.²³ Programs began teaching adults the social and living skills needed to live in the community.²⁴ A new service delivery model was created to serve adults with the most severe illnesses. Known as assertive community treatment (ACT), this program provided integrated care by teams of nurses, doctors, and other professionals in clients' homes and communities rather than in clinics.²⁵ Family psychoeducation programs helped families understand mental illness and provide support in the recovery process.²⁶ An increasing body of research has demonstrated the effectiveness of several of these services, often referred to as "evidence-based services."²⁷ Medicaid continues to fund those services as well as counseling, case management, and other important services for people with mental illnesses.²⁸

Medicaid also can fund a range of inpatient and outpatient substance use treatment services, but states have not used Medicaid for those services to the same extent as they have for mental illnesses. A major factor in this low level of Medicaid funding was the decision in 1994 to eliminate substance use disorder as a basis for disability under the Supplemental Security Income (SSI) program.²⁹ In most states, SSI qualifies a person for coverage under Medicaid. Instead, substance use treatment services have primarily been funded by another federal program. In 1992, when establishing SAMHSA, Congress divided an existing block grant into two new block grant programs for mental health and substance use: the Community Mental Health Services (CMHS) block grant and the Substance Abuse Prevention and Treatment block grant (SAPT).³⁰ Most of the public financing for substance use treatment in the states—from 40 to 60 percent—comes from the SAPT block grant. However, it is worth noting that Medicaid is increasingly being used to pay for substance use treatment; as of 2001, Medicaid made up 25 percent of public substance use disorder expenditures nationally.³¹

Although Medicaid is increasingly used to fund an array of mental health and substance use treatment services, it reaches a limited population as a result of federal and state eligibility criteria. For example, poor adults without children are generally not covered under Medicaid unless they meet strict criteria for disability or the state has sought a federal waiver to include them.³² States can seek special approval from the Centers for Medicare and Medicaid Services (CMS) to cover additional populations through a waiver program, generally known as "Section 1115 waivers."³³

States have flexibility in their Medicaid programs, and the breadth of the benefits varies considerably by state. In addition, Medicaid has historically paid very low reimbursement rates, thereby limiting access to services because many physicians and providers will not accept Medicaid fees. In recent years, states have become increasingly concerned about rising Medicaid budgets, and the federal government has also shown increased concern with the rise in expenditures for rehabilitative services for mental illness.³⁴

C. Role of Private Insurance and the Debate Regarding Parity

The initial development of private health plans in the 1930s and 1940s took place when effective treatment for mental illness and substance use disorders was lacking. Care for these disorders was predominantly provided in institutions that were funded by the states and physically separate from facilities providing other healthcare.³⁵ When the federal government exempted fringe benefits from wage controls during World War II, private insurance became linked to employment at a time when few adults with mental illnesses were employed and scientific understanding of these disorders was limited.³⁶ These factors contributed to the historic inequality between mental illness and substance use and other health treatment in private insurance coverage.

We now know that mental illnesses can be treated effectively. Up to 85 percent of people with depression who are treated with a combination of medication and therapy experience substantially reduced symptoms, enhanced quality of life, and increased productivity.³⁷ Science has also revolutionized our understanding of substance use disorders—treatment has been shown to cut drug use in half, reduce crime by 80 percent, and reduce arrests up to 64

percent.³⁸ Recovery rates for mental illnesses—depression, anxiety, schizophrenia, and bipolar disorder—and substance use disorders are comparable to and even surpass the treatment success rates for many physical disorders, such as heart disease.³⁹

Efforts to secure *parity*—coverage for treatment of mental health and substance use disorders equal to coverage for other health conditions—in employer-based insurance began in the 1960s and continues today.⁴⁰ Congress passed a limited parity law in 1996 that prohibited disparate annual or lifetime dollar limits for mental health care and physical health conditions but failed to address other terms and conditions of insurance, such as cost sharing and benefit limits. It also explicitly excluded coverage for substance use treatment. A Government Accountability Office (GAO) report analyzing implementation of the law found that two-thirds of employer-funded health insurance plans imposed *additional* restrictions following the law’s enactment: The typical employer plan provided 30 days of inpatient coverage for mental health treatment and 20 outpatient visits.⁴¹

In 1999, President Clinton ordered federal employee health plans to provide coverage for mental health and substance use disorders equal to that of other health conditions. A federally funded research evaluation of the policy concluded that costs to the plans did not increase and even declined for some plans, and beneficiaries reduced their out-of-pocket spending when parity was included in the benefit package.⁴²

In addition to the federal government, many states enacted statutes governing mental health and substance use benefits. Beginning in 1971 with Connecticut and continuing to the present day, more than 40 states have a statute either requiring a minimum benefit set for inpatient and outpatient visits or mandating equal coverage for mental health benefits, substance use treatment benefits, or both.⁴³ The statutes apply to all plans in the state except self-insured plans, which are governed by the Employee Retirement Income Security Act (ERISA).⁴⁴

State experiences also demonstrate that parity does not increase costs. Studies have found negligible or no cost increases where managed care was already in place. Costs have decreased if the parity provisions are accompanied by an initial imposition of managed care.⁴⁵

With few exceptions, parity laws do not address issues related to utilization management of mental health and substance use treatment in private insurance plans, despite the prevalence of such techniques. Nearly three in four Americans with health insurance receive treatment for mental illness and substance use disorders that is delivered through a managed care system.⁴⁶ The proliferation of managed care has raised concerns regarding limited access to treatment.⁴⁷

Parity laws focus on equalizing benefits between mental health and substance use treatment and other healthcare, but they often do not require the provision of rehabilitative or other services that are unique to mental health and substance use treatment. Providing such services is becoming more common in employer-sponsored coverage but is far from universal. A study in the late 1990s of large and medium employers found that three-fourths of their health plans covered outpatient detoxification services, approximately 60 percent covered intensive outpatient services for mental health and substance use, and half covered mental health crisis-related services.⁴⁸

As this report goes to press, a comprehensive federal parity law is being considered in Congress. Parity and Medicaid have provided, respectively, the policy framework and funding mechanism for many of the state initiatives covering the uninsured.

D. Precursor to Recent State Efforts to Cover the Uninsured: The State Child Health Insurance Program

Enacted in 1997, the State Child Health Insurance Program (SCHIP) has been a major federal effort to increase access to healthcare, including mental health and substance use treatment, for children and some adults. Because the mental health and substance use benefits in children’s programs have been studied elsewhere, that research is summarized and not replicated here. SCHIP is an important component of recent state efforts to cover all of their residents, and policy changes governing SCHIP will affect financing for future state health care initiatives.

Under the SCHIP program, states have the option of expanding their Medicaid program, creating their own program, or combining the two approaches.⁴⁹ Several reports detail the mental health and substance use treatment services in state Medicaid and non-Medicaid SCHIP plans.⁵⁰ These studies indicate that states provide a wide range of coverage under their programs: Some provide a broad array of services; others impose strict limits; and some include no coverage of substance use treatment benefits.⁵¹ Medicaid programs generally provide a broader array of mental health services, including residential, partial hospitalization, case management, and school mental health services. Non-Medicaid programs impose more day and visit limits on mental health services and higher co-payments than Medicaid.⁵² Substance use services are also very limited in some non-Medicaid programs.⁵³

Recent changes in federal SCHIP policy will have an impact on health coverage initiatives for children and adults. A 2007 CMS directive generally precludes states from expanding health coverage to children with family income above 250 percent of FPL unless the state meets strict conditions and stipulations.⁵⁴ Some states have also used SCHIP funds to cover adults, including parents and childless adults.⁵⁵ This practice has been controversial, and in the Deficit Reduction Act, Congress prohibited the use of SCHIP funds to provide coverage for childless adults in any future federal waivers.⁵⁶ The decline in available funding for children's health coverage and the limits on SCHIP financing for some adults will affect states' ability to expand coverage and achieve universal healthcare for their residents.

3. ANALYSIS OF STATE BENEFIT PACKAGES WITH RESPECT TO MENTAL HEALTH AND SUBSTANCE USE TREATMENT

In this analysis, we explore whether the needs of adults with mental illness and substance use disorders are being considered and met in state healthcare reform initiatives. Drawing on the benefits set forth in legislation, statutes, regulations, handbooks, member guides, proposals, and other official sources of information, including interviews with state officials, this analysis examines the mental health and substance use treatment benefits in 18 states that have made recent, significant efforts to cover the uninsured. We investigated the following issues:

- What is the scope of the benefit package for mental illness and substance abuse in these programs?
- How does that package compare with treatment provided for other health conditions?
- Is there any relationship between the covered populations or the financing methods and the scope of the benefits provided for adults with mental illness and substance use disorders?
- Do state programs address other barriers to treatment, such as cost sharing and utilization management of benefits, for adults with mental illness and substance use disorders?
- Are state initiatives promoting better health outcomes, such as wellness and chronic care management programs, including mental illness and substance use disorders?

States were selected for this study following consultation with experts in state healthcare reform and review of multiple analyses of state healthcare reform efforts.⁵⁷ They were included if their program for the uninsured contained a defined benefit package for mental health and substance use benefits or a clear legal standard governing such services, such as a parity statute. Implemented programs, politically significant proposals that were defeated, and well-defined pending proposals are included. States where the scope of the mental health and substance use benefit is being debated or is unavailable at the time of this writing were not included in the analysis.⁵⁸

The analysis also does not examine state Medicaid and SCHIP packages in each of the profiled states.⁵⁹ It does, however, discuss Medicaid expansions that were a significant component of a state healthcare reform initiative as well as programs funded through Medicaid/SCHIP waivers and state-funded programs. High-risk pool initiatives are also excluded because of their limited effectiveness, which results from exclusions for pre-existing conditions, high premiums, and other restrictive criteria, and because the mental health benefits in those plans have been previously analyzed.⁶⁰

The discussion that follows does not describe every program and proposal in the selected states, but it uses examples to illustrate various patterns and themes across states. The actual experiences of beneficiaries who attempt to obtain care from the programs may differ significantly from the benefits as described by the stated benefit packages and merits further research.

As described earlier, the mental health and substance use disorder benefits in state programs and proposals to cover the uninsured generally fall into four categories: Medicaid expansions, parity and more, mandated minimum benefit coverage, and limited or no benefit (Table 1). The few programs that could not be readily categorized are discussed briefly at the end of this analysis.

Table 1. State Programs by Category and Target Population		
Category	Programs	Populations
Medicaid Expansions Provides Medicaid benefit package to an expanded population of low income adults.	IL: Covered Assist*	Low income
	MA: MassHealth	Low income
	MD: Primary Adult Care program expansion	Low income
	ME: MaineCare	Low income
	VT: Global Commitment to Health Waiver	Low income
Parity and More Provides equal coverage (in amount, duration, cost sharing and other terms and conditions of the benefit package) for mental illness and/or substance use disorders and other health conditions. Some plans limit parity to a set of conditions; some provide an expansive array of recovery-oriented services.	CA: Health Care Security and Cost Reduction Act	All individuals
	CO: Minimum Benefit Plan	All individuals
	IL: Covered Choice	Small employers; all individuals
	IN: Healthy Indiana Plan	Low income
	MA: Commonwealth Choice	All individuals
	ME: DirigoChoice	All individuals; small employer.
	MN: MinnesotaCare	Low income
	MN: General Assistance Medical Care	Low income
	MT: Insure Montana	Small employer
	NM: HealthSOLUTIONS New Mexico	All individuals, small employer
	NM: State Coverage Insurance	low income; small employer
	VT: Catamount Health, Employer-Sponsored Insurance	All residents
	WA: Basic Health	Low income
Limited Coverage Imposes narrower limits on the number of visits or the costs for mental illness and substance use disorders compared with other health conditions.	MD: Comprehensive Standard Health Benefit Plan	Small employer
	NY: Family Health Plus	Low income
	OK: Insure Oklahoma/O-EPIC Individual Plan	Low income; small employer
	PA: Cover All Pennsylvanians	All residents; small employer
	RI: HealthPactRI	Small employer
Minimal or No Benefits Covers few, if any, services for mental illness or substance use disorders. Often limits coverage for physical health benefits as well.	AR: ARHealthNet Program	Small employer
	NY: Healthy New York	Low income; small employer
	PA: adultBasic	Low income
	TN: CoverTN	Small employer
Other Has standards or benefits that do not fit in above categories.	MA: Commonwealth Care	Low income
	MA: Young Adult Plans	All residents
*State-only funding of Medicaid benefit package		

States are categorized according to the benefits for mental illness and substance use, not the degree to which their programs achieve universal coverage of the population. Some states have multiple initiatives, each targeting a different segment of the population, and these initiatives may fall into different categories. A detailed description of each program or proposal for which we could ascertain the benefits is included in the appendix.

A. Medicaid Expansion Programs

Medicaid is a unique program in that it is governed by federal statute and regulations but has flexibility to allow for some state variations regarding scope of benefits and populations covered. As previously noted, states can seek a waiver of the federal rules, and four of the five states in this category have an approved federal waiver to allow expanded eligibility for the program. Medicaid expansions have been an important foundation in states that are attempting to attain universal or near-universal coverage.

Maine and Massachusetts included some of their lowest income residents (childless adults at or below 100 percent of FPL) in their Medicaid programs before implementing their expansions to higher income populations;⁶¹ in their health reform efforts, the states raised enrollment caps for this population. Maine also increased the income eligibility for parents of low income children to 200 percent of FPL.⁶² Building on a prior program, Vermont included several populations in its 2005 “Global Commitment to Health” federal waiver, including parents up to 185 percent of FPL and childless adults up to 150 percent FPL.⁶³ Maryland recently followed these states by expanding the treatment benefits for its poorest residents (at or below 116 percent of the FPL). Illinois proposed a state-funded program to provide a Medicaid equivalent benefit package to individuals up to the poverty limit.

1. Scope of Benefits in States That Have Expanded Their Medicaid Programs to Cover Uninsured Adults

The Maryland initiative substantially improves the benefit package in the Primary Adult Care (PAC) program, a pre-existing state program for low income residents. Parents with family income up to 116 percent of FPL will have access to all Medicaid benefits on July 1, 2008. The additional benefits for childless adults will be phased in, depending on state revenue.⁶⁴

The Maryland initiative will be particularly important for people with substance use disorders because it adds outpatient, methadone maintenance, and inpatient services for those conditions. Outpatient substance use treatment and methadone maintenance are among the first services to be added and are scheduled to begin in 2010. Mental health outpatient hospital services and inpatient services will be added later. The PAC program currently covers an array of outpatient and rehabilitation services for mental illness, including skills training, services for supported housing, mobile treatment, and assertive community treatment.⁶⁵ Some of the other states in this category include similar benefits (see appendix).

When asked about this decision, state officials noted that Maryland had modeled its plan on the other states seeking universal coverage. Those states extended benefits to the poorest residents first before proceeding to cover other classes of uninsured residents. Maryland state officials also noted that very low income adults require a more expansive benefit package to meet their serious healthcare needs.⁶⁶

Although Medicaid can cover a broad array of mental health and substance use services, the scope of the covered services varies considerably by state. For example, MaineCare imposes a 30-week maximum limit on outpatient substance use services and a 12-week limit on intensive outpatient services.⁶⁷

States also vary services depending on the population served. In Vermont, for example, people with a diagnosis of “serious and persistent mental illness” who meet additional criteria of functional impairment and history are eligible for services through the Community Rehabilitation and Treatment program regardless of their income.⁶⁸ Federal waiver funds are a major component of financing for the program. Community mental health centers receive a case rate to provide this array of services, which includes service planning and coordination, community supports (such as assistance with daily living, supportive counseling, support to participate in community activities, and other services), employment services, clinical interventions, crisis services, housing and home supports, transportation, partial hospitalization, and day services.⁶⁹

Some states limit services to certain populations. In Maryland, childless adults will receive expanded services over a phase-in period, depending on revenue. In Maine, rules restrict the mental health benefits for childless adults,

excluding them from some of the more intensive rehabilitative services and imposing a limit of 24 visits per year for outpatient mental health services.⁷⁰

2. Analysis of Medicaid Expansion Plans

Medicaid expansions are consistent with research indicating that lower income adults are more likely to have poor health outcomes and higher incidence of chronic conditions.⁷¹ The Medicaid expansion states decided to build their healthcare reform initiatives on a foundation of healthcare benefits for the poorest residents.

Most of the people covered by the expansions are eligible for a broad package of mental health and substance use treatment services. However, states have flexibility in designing these programs, and the limits they have placed on particular services and populations indicate a need to examine closely any Medicaid expansion to determine the state's unique scope of benefits for particular populations.

Common features of Medicaid expansion programs are as follows:

- States generally provide a broad package of services for treating mental illness and substance use disorders under their Medicaid programs; however, some states have limits for particular services or populations.
- State Medicaid expansions focus on very low income populations—generally, parents with family income up to 200 percent of FPL and childless adults up to 100 percent of FPL.
- Medicaid expansions are often implemented as key components of universal coverage.
- Medicaid co-payments are low and range from \$0 to \$3, depending on income.
- All of the implemented Medicaid expansion programs are partly financed with a federal waiver.
- States often use managed care organizations and administrative service organizations for utilization management.

B. Parity and More

This category includes programs that provide equal coverage for mental illness and/or substance use disorders, and physical health conditions, including programs that offer a variety of recovery-oriented services. Some of the states in this category, however, provide parity for a limited set of conditions, such as serious or “biologically based” mental illnesses, and some do not include parity for substance use disorders.

1. States That Have Recently Expanded the Benefit Package in Their Programs for the Uninsured to Add a Broad Array of Recovery-Oriented Services

Minnesota recently expanded its program to provide one of the most comprehensive outpatient benefits for mental health and substance use. MinnesotaCare covers families, children, and caretakers up to 275 percent of FPL; by 2009, the program will expand to include childless adults up to 215 percent of FPL who do not have access to employer-provided coverage. Minnesota also funds a General Assistance Medical Care (GAMC) program targeted to very low income adults who do not qualify for Medicaid, including those waiting for disability certification, those who are homeless, and those in transition from prison or other settings. GAMC participants must be below 75 percent of FPL.⁷²

In 2007, the legislature passed a statute ensuring that all MinnesotaCare recipients and those who receive GAMC are eligible for targeted case management and a full array of rehabilitative and evidence-based mental health services, which were previously only available to those in the state Medicaid program⁷³ (Box 1). Included in the list are intensive, evidence-based services that have been proven effective for adults with serious mental illnesses.

Outpatient services for substance use treatment are also fully included in these programs. A separate 2007 initiative eliminated limited plans for some MinnesotaCare beneficiaries, thereby removing any restrictions on substance use services. Although the Minnesota benefit package is quite comprehensive for outpatient services, it

Box 1. Mental Health Services Added to MinnesotaCare and GMAC

Adult rehabilitative mental health services (ARMHS) enable the recipient to develop and enhance psychiatric stability, social competencies, personal and emotional adjustment, and independent living and community skills when those abilities are impaired by the symptoms of mental illness.

Assertive community treatment (ACT) is an intensive, nonresidential rehabilitative mental health service that is a federally identified evidence-based practice and is provided according to national fidelity standards. Services are consistent with ARMHS, except ACT services are provided by multidisciplinary staff using a total team approach and directed to adults with a serious mental illness who require intensive services.

Intensive residential treatment (IRT) is a 24-hour-a-day program under the clinical supervision of a mental health professional in a community residential setting other than an acute care hospital or regional treatment center inpatient unit.

Adult mental health crisis response includes several services, such as an immediate face-to-face assessment by a mental health professional. It also includes mobile crisis intervention services, which are short-term intensive mental health services initiated during a mental health crisis or mental health emergency to help the recipient cope with immediate stressors, identify and utilize available resources and strengths, and begin to return to the recipient's baseline level of functioning. Crisis response includes mental health crisis stabilization services, which are provided to a recipient following crisis intervention services and are designed to restore the recipient to the recipient's prior level of functioning.

Source: Adapted from Minnesota Department Human Services, Mental Health Division. (2007, February 14). *PMAP Phase-in for ARMHS, ACT, IRT and Adult MH Crisis Services*.

includes a \$10,000 annual limit on inpatient costs for all health conditions for parents over 175 percent of FPL and for all childless adults.⁷⁴

MinnesotaCare benefits are provided entirely by prepaid health plans under a managed care system, and GAMC is provided under both fee-for-service and managed care systems.

MinnesotaCare is funded by a provider tax, state appropriations, federal waiver funds, and enrollee premiums.⁷⁵ The expansion was also financed by redirecting funding for mental health services and case management from the counties to the MinnesotaCare program.⁷⁶

The package passed by the legislature had two notable features: It included provider rate increases to ensure adequate availability of services, and outpatient mental health services were excluded from co-payment requirements. Outpatient substance use services are also exempt from co-payments pursuant to a prior statute.⁷⁷

Minnesota's comprehensive parity statute for private insurance and its statutory definition of "medically necessary care" for mental health services were important precursors to this expansion.⁷⁸ A broad stakeholder coalition worked to develop and support the initiative to cover the uninsured. For more details of the cost, political environment, and contributing factors to the program, see *Minnesota's Mental Health Initiative: A Case Study*, at www.HealthcareforUninsured.org.

2. States That Are Moving Toward Universal Coverage

The recent initiatives to cover the uninsured that occurred in Maine, Vermont, and Massachusetts are generally viewed as the state reforms closest to achieving universal coverage. Notably, they each provide some form of parity involving commercial plans.⁷⁹ The programs offer or require insurance at all income levels and provide subsidies for people with lower income, generally under 300 percent of FPL. They all use federal waivers to partially finance the expansion for low income populations, and cost sharing varies by income.

Massachusetts is widely credited as making the most legislative progress toward universal coverage. Since reform was enacted in 2006, the state has received much attention from the press and policymakers as the only state to implement a mandate requiring that nearly all of its citizens be insured.⁸⁰ All residents, except those under 150 percent of FPL, are required to have purchased health insurance by December 31, 2007 and to indicate their coverage on their 2007 state income tax returns.⁸¹ Noncompliance with this mandate will result in a loss of the resident's personal income tax exemption, currently worth \$219.⁸² The penalties will increase in 2008.

Although most people refer to the reform in the singular, the state created four different programs tailored to different populations:

1. The MassHealth expansion for low income adults (discussed earlier)
2. Commonwealth Care plans, subsidized by the state, for people up to 300 percent of FPL
3. Commonwealth Choice plans for people above 300 percent of FPL whose employer does not provide coverage or who work for small businesses
4. Young Adult plans for people ages 19 to 27 who do not have employer-sponsored coverage⁸³

Each plan is subject to different requirements governing the scope of benefits. Only the Commonwealth Choice plans apply the standard in the Massachusetts parity law and are included in this category. The other plans are discussed here as part of the comprehensive reform effort, but they are categorized in the last section of this analysis.

The Commonwealth Care plans are similar to Medicaid. Plans must provide all “medically necessary” care. Coverage includes outpatient mental health and substance use treatment services, community support programs, partial hospitalization, psychiatric day treatment, detoxification, and methadone treatment. Inpatient mental health and substance use treatment services are also covered. No day or dollar limits are imposed on any services.

Commonwealth Choice plans are subject to the state's parity statute for private insurance plans passed in 2000. Massachusetts' parity statute requires equal coverage for “biologically based mental illnesses” and other health conditions.⁸⁴ For mental illnesses that are not covered by the statute, plans must provide a minimum of 24 outpatient visits and 60 inpatient days. Substance use disorders are not included in the parity mandate unless they are co-occurring. A separate requirement for treatment of alcoholism mandates minimum coverage of \$500 for outpatient services and 30 days for inpatient care; the insurer may substitute 2 outpatient visits for 1 inpatient day.⁸⁵

Massachusetts law also requires private plans—including those offered as part of the reform effort—to offer intermediate services, which include “level III community-based detoxification, acute residential treatment, partial hospitalization, day treatment and crisis stabilization licensed or approved by the department of public health or the department of mental health.”⁸⁶

The Young Adult plans must provide “reasonably comprehensive coverage” for all health conditions, including mental health and substance use. Because this standard is ambiguous and not further defined by rule, the program is not included in this category. A brief review of a sample of Young Adult plans indicates that they are complying with the same parity mandates as the Commonwealth Choice plans.⁸⁷

Commonwealth Care, Commonwealth Choice, and Young Adult plans are all delivered by managed care organizations. Co-pays for inpatient and outpatient services vary widely both within and among programs.

Commonwealth Care co-payments range from \$0 to \$20 for outpatient services and from \$0 to \$500 for inpatient care, depending on income and the plan chosen. In Commonwealth Choice, outpatient substance use treatment co-payments can range from \$10 to \$50 per visit and inpatient co-pays range from \$0 to \$1,000; for participants with biologically-based mental illnesses, co-pays generally range from \$10 to \$35 for outpatient mental health visits.

3. Additional States with Implemented Parity Programs

After a public advocacy campaign, Indiana's program for the uninsured, the Healthy Indiana Plan (HIP), included parity for mental health and substance use benefits.⁸⁸ See Box 2. HIP beneficiaries have a choice of two managed care plans, and both provide intensive outpatient mental health services and place no limits on substance use treatment or inpatient days.⁸⁹ One plan also includes a variety of recovery-oriented services similar to those available through Indiana's Medicaid program.⁹⁰

Healthy Indiana Plan's cost-sharing requirements, approved in a federal waiver, have come under criticism. HIP requires beneficiaries to pay 2 to 5 percent of their income in monthly installments into a health savings account. Once medical costs exceed \$1,100, the recipient will have access to benefits under the health insurance plans.⁹¹

Critics argue that the program offers fewer healthcare benefits than does Medicaid at higher total cost to the state and consumers. They also argue that the plan requires excessive cost sharing for low income beneficiaries.⁹² State officials in Indiana maintain that this methodology will lead to increased consumer responsibility and an emphasis on preventive care. They also note that the plan has no additional co-payments. The state intends to collect data on the program to help determine participation and retention in the plan.⁹³

Indiana also set provider reimbursement rates for HIP at a higher level than those of the state Medicaid program. The rates for HIP were set at the Medicare rate (or at 130 percent of the Medicaid rate when a Medicare rate is not defined). The state specifically set rates 30 to 40 percent higher than Medicaid "to assure [*sic*] that there is an adequate delivery system to serve the newly insured, as well as an environment that promotes quality through competition among providers."⁹⁴

Although Indiana's program provides parity for mental illness and substance use, many states in this category have parity statutes that only apply to a limited set of mental health conditions and do not include substance use disorders, resulting in less coverage for those conditions. For example, Montana's parity statute, which applies to Insure Montana's benefit package, mandates equal benefits for "severe" mental illnesses only.⁹⁵ The premium assistance part of the program, targeted to employees with incomes under \$75,000, includes unlimited outpatient and inpatient care for people with "severe" mental illnesses. Substance use disorders are not included in Montana's parity statute, and annual dollar limits are imposed for outpatient and inpatient substance use treatment.

New Mexico's State Coverage Insurance program (SCI) also does not provide equal benefits for substance use treatment and other health conditions. Although this program is not subject to state parity laws, it is included here because the benefits closely mirror the intent of the parity law, which only covers mental illnesses. The SCI program provides unlimited outpatient mental health benefits, but it limits outpatient substance use benefits to 42 days (or visits) per year.⁹⁶

Washington enacted parity legislation in 2005, after the Basic Health program was already well established. Basic Health is subject to the parity law, which will phase in mental health parity over several years.⁹⁷ The parity statute does not include substance use disorders.⁹⁸ Basic Health places a \$5,000 total cap on outpatient and inpatient chemical dependency services over a two-year period, with a \$10,000 total lifetime cap.⁹⁹

4. States with Proposed Parity Programs

A number of state proposals to cover the uninsured also include a parity requirement. Those states include the following:

- *California* (proposal was subject to state parity law requiring equal coverage for serious mental illness, but it failed to win passage in January 2008).¹⁰⁰
- *Colorado* (Blue Ribbon Commission's recommendations of January 31, 2008 include parity for mental health—defined in the 2007 parity statute as including serious mental illness and substance use disorders—and physical healthcare in the minimum benefit plan).¹⁰¹
- *Illinois* (Covered Choice proposal included parity for serious mental illnesses only, but the final bill failed to win passage in 2007).¹⁰²
- *New Mexico* (HealthSOLUTIONS NM did not pass during the 2008 regular legislative session. The state parity law for mental illnesses would apply to plans).¹⁰³

Many of these proposals are designed to achieve universal coverage. California, Colorado, and New Mexico have set forth broad health care proposals aimed at all residents in the state.¹⁰⁴ Illinois proposed legislation that included small businesses and adults of any income level who lacked access to health insurance.¹⁰⁵

Although all four proposals provide parity for either mental illness or serious mental illness, only Colorado also mandates equal coverage for substance use disorders.

In Illinois, the governor's staff made a concerted effort to address mental health issues in the reform effort. They prepared a fact sheet summarizing the beneficial provisions for residents with mental illness and used it in outreach to the mental health community and legislature.¹⁰⁶ Among the highlighted provisions is a new definition of "medically necessary" for mental health conditions that relies on the judgment of the treating professional.¹⁰⁷ This definition would apply to all private plans and is intended to give consumers and providers greater protection when challenging an insurer's denial of services. The proposal further specifies an improved and more transparent review process for denied mental health claims.¹⁰⁸

Box 2. Advocacy and Parity

In many of the states with parity, advocacy and provider organizations made a concerted effort to fight for the inclusion of parity in the expansion plans. Most of the organizations had been involved in the earlier battle to achieve parity in private insurance plans.

In Maine, for example, NAMI Maine informed the stakeholder coalition supporting the expansion for the uninsured that it would mount a public campaign against the program in the absence of parity and would fully support it with a grassroots effort if parity were included.

In Indiana, advocates mounted an intense public and legislative campaign for parity in the final days before passage of the Healthy Indiana Plan, the healthcare expansion. Mental Health America of Indiana and NAMI Indiana visited legislators and distributed materials arguing for parity. An op-ed piece in the largest state newspaper by Stephen McCaffrey, President and CEO of Mental Health America of Indiana, set forth several arguments concerning the state's history of parity, economic considerations, and other state experiences with parity:

In the coming days, the Indiana General Assembly will consider whether to provide health insurance for the uninsured. Inherent in this effort is whether to remain on the road previously chosen to eliminate the insurance discrimination that has historically plagued individuals with mental illness and substance abuse. Standing at the junction between mental wellness and competing budget priorities, the legislature must again commit to a policy of mental insurance parity—policy already afforded to state employees and the privately insured in Indiana. . . .

When mental health services are accessible and affordable, the cost of non-mental health care declines. In fact, introducing mental health parity in conjunction with managed care has been found to result in a 30 to 50 percent decrease in total mental health-care costs. For systems that are already using managed care, implementing parity results in a less than 1% increase in health-care costs.

Adequate treatment of mental illness is good fiscal policy due to the large economic burden of under-treated mental illness. It is well documented that people with mental illness have increased use of non-mental health services and increased health-care costs, miss work more often, are more frequently on disability, are more costly in terms of lost productivity, contribute to low morale among co-workers, and contribute to higher turnover rates. . . . Employers in Indiana are increasingly realizing that this is true and many have added mental health benefits to their insurance plans, including Bank One, Eli Lilly & Co., and Motorola. . . .

Overall, providing mental health parity will result in cost savings for the state of Indiana and a healthier population....

Source: McCaffrey, S. (2007, February 7). Sound policy must include mental health parity (Op Ed). *Indianapolis Star*, 11.

5. Analysis of Parity Programs

The states that provide equal or better benefits for mental illness or substance use disorders and other healthcare benefits in their programs for the uninsured generally had enacted parity statutes governing private insurance plans prior to the healthcare reform effort. However, many of those statutes did not include parity for substance use; this exclusion was reflected in the state programs and proposals for the uninsured (see Table 2). Approximately half of the initiatives with parity limited coverage to serious mental illnesses.

States that had implemented or were seeking programs to cover all residents in the state were likely to provide parity for mental illness or serious mental illness. In addition, three of the eight states working toward universal coverage had parity for substance use.

Several of the parity programs include a broad range of services. Massachusetts law requires private plans, including the Commonwealth Choice plans, to offer a range of intermediate services; Indiana's HIP program also includes intensive outpatient services. Those programs reflect a trend whereby intermediate mental health and substance use treatment services are becoming more common in private health insurance plans.¹⁰⁹

Common features of programs that include parity are as follows:

- Equal benefits for mental illness and/or substance use disorders and other healthcare. More states provide parity for serious mental illness or mental illness than for substance use; some plans cover a broad array of community-based services designed to promote recovery from mental illness and substance use disorders.
- Pre-existing parity statutes often applied to or were incorporated into the expansion.
- Relatively high income levels are covered in some states, including plans and proposals covering all state residents.
- The programs generally require significant cost sharing, including co-payments and co-insurance. Minnesota is a notable exception to this trend: The state exempts outpatient mental health and substance use treatment from co-payments.
- Financing for the plans ranges widely and includes federal waivers, state appropriations, and tobacco taxes, among other sources.
- A few states increased rates for providers as part of the initiative.
- Many of these programs deliver services through managed care organizations and preferred provider networks. Illinois's proposal specifically addresses the role of the treating provider in determining medically necessary treatment for mental illness and the review process for mental health claims.

C. State Plans with Limited Coverage for Mental Illness and Substance Use Disorders

A number of state programs offer benefits for mental illness or substance use disorders but impose limits on the number of visits or the costs only on mental health and substance use services. Examples include Pennsylvania's Cover All Pennsylvanians proposal, New York's Family Health Plus, Oklahoma's O-EPIC program, Rhode Island's HealthPactRI, and Maryland's Comprehensive Standard Health Benefit Plan for small employers. Some states have other programs for the uninsured in another category of this analysis.

1. Implemented and Proposed Programs That Impose Day and Dollar Limits on Mental Health and Substance Use Treatment

Pennsylvania's proposal, Cover All Pennsylvanians, which failed to win passage in 2007, is the only program in this category aiming for universal coverage. The proposal would have made insurance plans available to adults under 200 percent of FPL who were uninsured for at least 90 days and to those above 200 percent of FPL who were uninsured for 180 days or more.¹¹⁰ It would have been financed with state resources, tobacco settlement money, funds that Blue Cross plans must invest in nonprofits, federal dollars, and an employer tax.

The statutory proposal for covering the uninsured did not specify the level of mental health and substance use benefits but instead delegated that authority to the Department of Insurance. State officials provided information on the level of benefits that were scored by actuaries as the basis for the premium model (30 visits each for outpatient mental illness and substance use treatment and 30 days for inpatient treatment).¹¹¹ The substance use treatment benefits mirror those in the state's mandate for private insurance, known as Act 106.

Pennsylvania is one of the few states addressing workforce issues in its healthcare reform effort. The Governor proposed and the legislature passed several changes to scope of practice laws.¹¹² In addition, the Governor's broad

health care initiative, Prescription for Pennsylvania, calls for several policy changes to facilitate access to integrated treatment for co-occurring mental illness and substance use disorders. These include joint licensure procedures, preparing statewide standards for treatment, expanding managed care provider networks, and improving training.¹¹³ While these reforms are developing in the Medicaid system, state officials anticipate that some of the same providers would participate in the program for the uninsured.¹¹⁴

Two of the other state programs in this category are similar to Cover All Pennsylvanians, restricting both outpatient and inpatient services. New York's Family Health Plus, which targets low income populations, limits annual outpatient visits for mental illness and substance use treatment combined to 60 days and inpatient to 30 days.¹¹⁵ Rhode Island's HealthPactRI for small employers follows the state's minimum mandate statute for private insurance plans and provides up to 30 visits for mental health treatment, 30 hours of substance use treatment, and 30 days for inpatient residential substance use treatment.¹¹⁶

Maryland's Comprehensive Standard Health Benefit Plan for small employers and Oklahoma's O-EPIC Individual Plan, which targets low income workers, do not limit outpatient services, but they impose annual limits on inpatient services only for mental illness and substance use treatment (see appendix).¹¹⁷

Oklahoma differs from the other programs in this category because it provides access to a variety of rehabilitative outpatient services for mental health, including programs for assertive community treatment and case management services, and unlimited outpatient substance use treatment services.¹¹⁸ These benefits are largely explained by the state's decision to use the same administrative structure as Medicaid, including prior approval for services through the same administrative services organization. It is not a parity plan, however, because the annual limit is set at 24 days for mental health and substance use inpatient services, whereas other inpatient hospital services are covered as medically necessary.¹¹⁹ Oklahoma's program is financed in part by a federal waiver as well as by employee and employer contributions, state funds, and tobacco taxes.

Two of the programs in this category aimed at small employers are seeking to improve wellness. As part of Maryland's health care reform legislation, certain small employers are eligible for a substantial subsidy for the Comprehensive Small Benefit Health Plan if they provide their employees with an additional "wellness" benefit that carriers must offer as a rider to the plan. Proposed rules for this benefit include a requirement for a health risk assessment; no specific details are provided regarding screening for mental illness or substance use.¹²⁰

Rhode Island's HealthPactRI is the only program in any category to include "wellness pledges."¹²¹ HealthPactRI recipients who do not comply with the wellness pledge—by not attending weight management classes, for example—will be moved from the Advantage plan to the Basic plan, where the deductible and maximum out-of-pocket expenses are more than double. Wellness requirements could be a positive incentive for ensuring that people receive integrated physical and mental healthcare, but the requirements can raise concerns for people with mental illness and substance use disorders, who may have difficulty regularly attending classes, may experience weight gain from medications, and often have transportation barriers.

2. Analysis of Limited Coverage Programs

Several of the states with programs in this category do not have state parity laws governing private insurance. For example, Pennsylvania and Rhode Island have minimum mandate statutes, rather than full parity, and New York's parity law, which became effective January 1, 2007, was not in effect when Family Health Plus was implemented.

Financing varies widely. Some states are using federal waivers, and others are relying on tobacco taxes, employer assessments, state general funds, and other sources of financing.

Common features of these benefit packages include the following:

- Programs impose day limits on outpatient and inpatient services, typically in the range of 30 outpatient visits and 30 inpatient days. Substance use treatment services are generally subject to the same limits as mental health conditions.
- Several of the states had statutes that mandated minimums for private insurance plans.
- Most of the programs cover employees of small employers or low income populations.
- Several programs require significant co-payments. New York's program, however, does not impose co-payments.
- Managed care, health maintenance, and administrative services organizations often administer care in these programs.

D. State Programs with Minimal or No Benefits for Mental Illness or Substance Use Disorders

A few programs for the uninsured provide minimal or no benefits for mental illness or substance use disorders. Healthy New York, which targets small employers, and Pennsylvania's adultBasic programs, which serve low income adults, provide the fewest benefits and specifically exclude mental health and substance use treatment from coverage. Arkansas' ARHealthNet and Tennessee's CoverTN, programs targeting businesses that had not offered insurance previously, also include very limited coverage for mental health and substance use treatment.

1. State Programs That Provide Very Limited Benefits for Mental Health and Substance Use *and* Physical Health Conditions

Arkansas' ARHealthNet Program covers only seven inpatient days per year for any health condition, including mental health and substance use disorders, and eight visits per year for other mental health and addiction treatment services. Up to two of the visits can be outpatient services, and up to six can be clinician office visits (which include visits to physicians, licensed social workers, psychologists, or licensed professional counselors).¹²²

ARHealthNet was designed for people who work for mid-size employers (companies under 500 employees) that had not offered insurance in the past 12 months. The program offers subsidies to adults under 200 percent of FPL. ARHealthNet is financed with a federal waiver, employer and employee contributions, tobacco settlement money, and state funds, and it requires co-insurance of 15 percent for inpatient and outpatient services. Only in-network providers may be reimbursed for services.

CoverTN, which is directed at small businesses (50 employees or less), relies on state funding and premium payments and provides very limited coverage for beneficiaries:¹²³

- Outpatient treatment for mental health and substance use treatment combined is limited to 10 visits annually.
- Coverage for physician visits is limited to five or six per year, depending on which plan is chosen.
- Inpatient care is capped at five days per year for mental illness and substance use.
- Only generic drugs are covered.

2. State Programs That Provide No Benefits for Mental Illness or Substance Use Disorders

Pennsylvania's adultBasic program provides unrestricted physician visits and hospital days but completely excludes mental illness and substance use treatment.¹²⁴ The program covers adults under 200 percent of FPL. State officials cite cost as the reason for the mental illness or substance use disorder exclusion and note that the funds for the program are limited to tobacco settlement dollars and an agreement with the Blue Cross/Blue Shield plans.¹²⁵

New York also singles out mental illness and substance use treatment for complete exclusion in its state-funded program, Healthy New York, and cost may also play a role. A study of the program noted that "the standardized benefits package of Healthy New York, with its leaner package of benefits and higher cost-sharing, was designed to keep the premium low."¹²⁶ The program seeks to make coverage more affordable for small businesses and

adults whose income disqualifies them from Medicaid and Family Health Plus.¹²⁷ Employers must contribute at least half of the premium for full-time employees, and the employees must pay the difference. Sole proprietors and individuals pay their own premiums.

Healthy New York includes a state-subsidized reinsurance program that has allowed insurers to cut premiums since the program was launched.¹²⁸ Recognizing the importance that the target population places on premium costs, state officials added a second plan without prescription drug coverage that cuts premiums by 12 percent.¹²⁹ Starting in January 2007, Healthy New York began offering a high-deductible, lower premium health plan option that is designed to be compatible with health savings accounts. The program's history and official actions suggest that cost may be a factor in the decision to exclude mental health and substance use benefits.

Several of the "minimal or no" benefit states offer a more comprehensive benefit package in programs that serve different eligibility groups. As previously mentioned, New York has a Family Health Plus program for parents who are under 150 percent of FPL and for childless adults who are under 100 percent of FPL. The program provides a moderate level of benefits for mental health and substance use disorders. Tennessee has several programs that provide more mental health and substance use treatment than CoverTN, but do not meet the criteria for this analysis.¹³⁰

3. Analysis of Minimal or No Benefit Programs

States that have enacted limited-benefit programs are often trying to encourage reluctant employers to offer coverage by decreasing the cost of insurance.¹³¹ As the governor of Tennessee noted, one of the main goals of the coverage program was affordability for businesses and individuals, and in his view, that required some limits on benefits in the program.¹³² Other states with programs targeting small businesses, however, such as Oklahoma and Montana, have not imposed such strict limits.

Common features of minimal or no benefit programs are as follows:

- Very minimal benefits; people needing treatment for mental health and substance use disorders receive even less than the already pared-down benefit for physical disorders. This element is particularly concerning because people who are nominally covered are exposed to great risk of excessive expenditures or reliance on the safety net for assistance.
- Cost appeared to be a determining factor in developing the scope of the benefits in the plans.
- The programs often target employees of businesses that do not provide insurance.
- Most of these states do not have statutes requiring parity for mental illness and substance disorders in their laws governing private insurers. Instead, they have minimum mandated benefits.
- The programs have significant co-payments.
- Prescription drug coverage is poor. CoverTN covers only generic drugs. Healthy New York offers no drug coverage for mental illness or substance use treatment, and Pennsylvania's adultBasic offers no drug coverage at all.
- HMOs and managed care entities are often used to deliver care in these programs.

E. Other Programs

A few state programs do not fit into the four existing categories because they use standards that are not easily categorized or state parity laws do not apply to them. Those programs include the previously discussed Commonwealth Care and Young Adult plans in Massachusetts.

F. Major Findings

This analysis leads to 10 major findings, summarized below.

1. **People with mental illness, substance use disorders, or both are prevalent among the uninsured. More than 1 in 4 adult Americans who lack insurance coverage have a mental illness, substance use disorder, or co-occurring disorder.**

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

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

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

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

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

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

Only 5 of the 18 states—Colorado, Indiana, Maine, Minnesota, and Vermont—have a parity or more benefit for substance use disorders in at least one of their programs or proposals for the uninsured. For this finding, parity or more is defined as providing at least equal benefits for substance use disorders and other health conditions.

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

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

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

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

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

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

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

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

One state exempts outpatient mental health and substance use services from co-payments to remove a financial barrier to accessing these services. Medicaid plans and a few state programs have very low or no co-payments, but most states are charging more per visit or prescription. Co-payments per outpatient visit are commonly in the \$10 to \$25 range. Prescription drugs are also subject to high cost sharing. A typical benefit package has a \$10 co-pay for generics and a \$15 to \$30 co-pay for preferred brands, with even higher co-pays for non-preferred brand drugs. Some programs have additional deductibles for prescription drugs.

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

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

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

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

Table 2. Examples of Limits on Substance Use Treatment vs. Mental Health Treatment

State Plan	Substance Use Treatment	Mental Health Treatment
Insure Montana	Caps inpatient and outpatient benefits at \$6,000 for any 12-month period.	Imposes no dollar or visit limits on outpatient mental health services.
New Mexico's State Coverage Insurance	Limits outpatient office visits, outpatient detoxification and intensive outpatient care to 42 days or visits per benefit year.	Imposes no dollar or visit limits on outpatient mental health services.
Washington's Basic Health	Limited to \$5,000 every 24 months, with a lifetime maximum of \$10,000.	Parity for mental health treatment by 2010.

Box 3. Wellness Programs

Several states include an emphasis on wellness and preventive care and exempt well visits or annual physicals from deductibles or co-pays. Generally, the state plans specify little regarding well visits or annual physicals. One exception is Indiana, which is developing a checklist for physicians to guide the annual exam. Although the specifics are under development, state officials confirm that alcoholism and/or chemical dependency and mental illness will be included among the screens.¹³³ Indiana also plans to track whether people who are identified through screening receive follow up services.¹³⁴

Other positive aspects of wellness plans that states are adopting in their Medicaid programs, such as free or subsidized gym memberships or exercise classes, are not mentioned in the plans to cover the uninsured.¹³⁵ Exercise has been proven to improve symptoms for people with mild to moderate depression and is also being used to control obesity and diabetes in people with serious mental illnesses.¹³⁶

Box 4. Chronic Care Management Programs

Despite the widespread discussion of disease and chronic care management in health policy, we found little evidence of states using such programs to address mental illness and substance use disorders in their healthcare reform efforts. Two notable exceptions were Vermont and Illinois. In Vermont, the statute creating the state's Blueprint for Health program defined chronic care management broadly to include mental illness and substance use disorders.¹³⁷ The program began implementation with a few physical health conditions, such as diabetes and hypertension, but officials intend to expand the program to include depression.¹³⁸ In addition, the two insurance companies that offer benefits through Catamount Health are required to offer chronic care management programs that, at minimum, cover major depressive disorder. Blue Cross Blue Shield of Vermont has also elected to include anxiety disorder, bipolar disorder, post-traumatic stress disorder, schizophrenia, and substance abuse. Plan participants who work with a "health coach" are exempt from paying co-insurance and are not subject to a 1-year pre-existing condition waiting period.¹³⁹

The Illinois health care expansion proposal includes an initiative creating a statewide system of chronic care and prevention. The examples of chronic conditions listed in the Act include substance use disorders and mental illness.¹⁴⁰ Although this proposal did not pass the legislature, Illinois has moved forward with implementation of chronic care management for people with disabilities and other high risk populations in the state's Medicaid program and has included mental illness and substance use disorders in its efforts.¹⁴¹ Preliminary data indicates a high prevalence of these conditions as a primary diagnosis and as co-morbid conditions.¹⁴² Services are based on a participant's needs and may include assistance in finding a medical home, education and coaching to adhere to a plan of care, help obtaining timely and appropriate treatment, and other services.¹⁴³

4. ISSUES FOR FUTURE EXPLORATION

In addition to the issues discussed earlier, this analysis has revealed a need for further research in several areas, described below.

What is the actuarial cost of providing benefits for mental health and substance use disorders and other health conditions under state plans to cover the uninsured? How does the implementation of parity affect costs?

Several existing studies of the cost of state parity laws for private insurance plans could be replicated for state programs to cover the uninsured.

Are services that appear in the plan documents actually available and received by plan participants?

Low provider rates, lack of providers, strict utilization controls, geographic barriers, and other factors can limit access to what is technically covered under the plans. In addition, some insurance plans may actually provide more than what is listed on plan matrices, particularly with respect to case management, intermediate services, and other services that would decrease reliance on costly inpatient care. Further exploration of the plan services would be helpful in understanding the full scope of benefits provided. Additional research should examine whether consumers receive integrated physical and mental health benefits from their plans.

Are the plans attracting large numbers of uninsured adults, including those who have mental illnesses and substance use disorders? If not, why not? Several of the people interviewed for this report noted that programs did not appear to be attracting expected numbers of the uninsured. Notable barriers included high cost sharing, such as co-pays, deductibles, and premiums (even after subsidies). It is not clear what impact the benefit packages have on participation rates, particularly for adults with mental illness, substance use disorders, and co-occurring disorders. Also, young adults (ages 19 to 24) are one of the fastest growing segments of the uninsured, and mental illness and substance use disorders usually onset during those years. How are states reaching young adults, and will plans specifically targeted to young adults increase enrollment? Will the plans adequately serve young adults with mental illness and substance use disorders?

Which prescription drugs are covered? Preliminary analysis indicates that prescription drug coverage can differ from general access to benefits. Many state programs have preferred drug lists; it would be useful to have a detailed analysis of these lists, particularly when states have multiple plans and allow variation in the formularies. Analyzing classes of medications, such as antipsychotics, antidepressants, and those used to treat substance use disorders, would also be helpful because plans may provide better access in some classes than others. In addition, prior authorization procedures are important in determining the degree of access to prescription drugs.

What is happening to funding for safety net services for uninsured adults? Although we were able to determine some effects on state safety net funds, it was extremely difficult to capture all the changes that were occurring. Several states appropriate funds to serve uninsured adults who have mental illness or substance use disorders, and more research is needed to track any funding changes for those programs. This area is important because people with mental illnesses and substance use disorders, who are disproportionately homeless and underinsured, rely extensively on the safety net for assistance in meeting their treatment needs.

What are the health and mental health outcomes for all beneficiaries of state programs to cover the uninsured, and how do they compare to the outcomes for beneficiaries with mental illness and substance use disorders? Many of the state programs are new, but over time, it will be important to measure the ultimate effects of the programs on health and mental health indicators and to determine whether the 27 percent of the population with mental illness, and substance use disorders, or both are also benefiting from health care reform efforts.

CONCLUSION: IMPLICATIONS AND RECOMMENDATIONS

This analysis highlights a number of issues that need to be addressed to fully meet the needs of adults with mental illness and substance use disorders in healthcare expansion programs (Box 5).

Box 5. Checklist for Including Mental Illness and Substance Use Treatment in State Healthcare Reform Programs

1. What is the scope of benefits for physical and mental illness and substance use treatment services?
 - Will mental health and substance use benefits be equal to physical health benefits?
 - Will the benefits include evidence-based treatments designed to promote recovery from mental illness and substance use disorders?
 - If limits are imposed on benefits, are they equally imposed on all conditions or directed at some?
 - If they are directed at particular benefit categories, is that commensurate with the percentage of the population with those disorders or consistent with the societal burden of those diseases?
 - Will benefits vary by income level?
2. How will the benefits be managed?
 - Will utilization management and prior authorization criteria be implemented, and if so, will they be publicly available?
 - Have any problems arisen with utilization management creating barriers to care, and if so, does the healthcare reform address these barriers to access?
 - Are plans required to apply the same utilization management techniques to mental illness, substance use, and physical health conditions?
5. Is it easy for consumers to understand the scope of the benefits?
 - Is the plan or handbook written in easily understood language?
 - Are the details about the mental health and addiction benefits available and easily found?
 - Is information available in writing and on the web?
6. Is cost sharing imposed on the uninsured population?
 - If so, are there caps on cost sharing?
 - How will the program ensure that people with chronic conditions, such as mental illness and substance use disorders, will not forego needed care?
7. Is a chronic care management program within the healthcare reform effort?
 - If so, are mental illnesses and substance use disorders represented in proportion to their disease burden and representation in the uninsured population?
8. Is a wellness initiative included in the healthcare reform effort?
 - If so, are mental illnesses and substance use disorders included in the effort?
 - Is screening for mental illness and substance use disorders required as part of a check up?
 - Are exercise and nutrition programs included and directed at people with mental illnesses and substance use disorders?
9. Are prescription drugs included in the program?
 - Is access to psychotropic medications and medications to treat addiction disorders decided by doctors and patients or by preferred drug lists?
 - Do beneficiaries have broad access to drugs in the major classes of psychotropic drugs (antidepressants, antipsychotic, mood stabilizers, antianxiety, and others) and those used to treat substance use disorders?
10. Are providers sufficient to ensure access to the listed benefits?
 - Are there particular areas of shortage in mental health and addiction providers?
 - If so, does the proposal address these shortages?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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 - 57 The authors consulted with Enrique Martinez-Vidal, Director, and Isabele Friedenjohn, Deputy Director, of the State Coverage Initiatives, and Donna Folkemer, Director of the Forum for State Health Policy Leadership, National Conference of State Legislatures. The authors also consulted with the program officer and the consultants for this project: Andrew Hyman, Senior Program Officer, Robert Wood Johnson Foundation; Victor Capoccia, Director, Closing the Addiction Treatment Gap, Open Society Institute; Ron Manderschied, Director, Mental Health and Substance Use Programs, Constella Group; Paul Samuels, Director and President, Legal Action Center; and Anita Marton, Vice President, Legal Action Center. Consulted Web sites include State Coverage Initiatives (<http://statecoverage.net/>); National Conference of State Legislatures, Health Reform Bills 2007–2008 (www.ncsl.org/programs/health/universalhealth2007.htm); and Families USA State Expansion Resource Center (www.familiesusa.org/resources/state-information/expansions/).
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illness and substance use disorders and physical health conditions; however a bill to add parity (HB 5617) is pending in the legislature. Washington's Health Insurance Partnership program also lacks sufficient information to be included in this analysis. Beginning in January 2009, Washington state will offer a premium subsidy program for small employers and their employees administered by the Health Insurance Partnership (HIP). The program cannot be classified at this time because the health benefit plans have not been chosen and thus, the scope of the benefit package has not yet been determined. The HIP program for small employers is not subject to the state's parity law or any minimum mandated benefits for mental health or substance use disorders.

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- 130 Tennessee has some programs that are limited to low income people who have been diagnosed with serious mental illnesses and provide no physical health coverage. The State Safety Net program and the State Only program provide treatment for mental illness and co-occurring substance use to low income individuals with serious mental illness. See Tennessee Department of Mental Health and Developmental Disabilities. (n.d.). *Mental Health Safety Net Services*. Retrieved from www.Tennessee.gov/mental/safetynet.html; Tennessee Department of Mental Health and Developmental Disabilities. (2008, April). Manual for Mental Health Coverage for Uninsured Tennesseans. Retrieved from <http://www.state.tn.us/mental/mgdcare/ManualUninsuredTennesseans.pdf>. Tennessee also has a high risk pool program, AccessTN, that has more mental health and substance use benefits. See AccessTN. (n.d.). *Available benefit plans*. Retrieved from www.covertn.gov/web/accesstn_benefitgrid.pdf.
- 131 Friedenzohn, I. (2004, July). Issue brief: Limited benefit policies: Public and private sector experiences. State Coverage Initiatives, p. 1.
- 132 Governor Phil Bredesen. (2006, March 27). *Expanding coverage in Tennessee* [Speech]. Retrieved from www.tennesseeanytime.org/governor/viewArticleContent.do?id=756
- 133 Novotny interview, January 7, 2007.
- 134 Novotny interview, January 7, 2007.
- 135 Connecticut's Medicaid managed care plans pay for medically necessary obesity-related services, nutritional counseling, and exercise programs are an example. See www.ncsl.org/programs/health/shn/2007/sn488c.htm
- 136 See, e.g., Carta, M. G., Hardoy, M. C., Pilu, A., Sorba, M., Floris, A. L., Mannu, F. A., et al. (2008). Improving physical quality of life with group physical activity in the adjunctive treatment of major depressive disorder. *Clinical Practice and Epidemiology in Mental Health*, 4(1), 1; Burbach, F. R. (1997). The efficacy of physical activity interventions within mental health services: Anxiety and depressive disorders. *Journal of Mental Health*, 6, 543–566; Weyerer, S., & Kupfer B. (1994). Physical exercise and psychological health. *Sports Medicine*, 17, 108–116.
- 137 The full definition is: “Health services provided by a health care professional for an established clinical condition that is expected to last a year or more and that requires ongoing clinical management attempting to restore the individual to highest function, minimize the negative effects of the condition, and prevent complications related to chronic conditions. Examples of chronic conditions include diabetes, hypertension, cardiovascular disease, cancer, asthma, pulmonary disease, *substance abuse*, *mental illness*, spinal cord injury, and hyperlipidemia.” Retrieved from www.leg.state.vt.us/docs/legdoc.cfm?URL=/docs/2006/acts/ACT191.HTM (emphasis added).
- 138 E-mail from Nick Nichols, Human Resource Development Chief, Adult Community Mental Health Services, Vermont Department of Mental Health, January 30, 2008. The addition of a mental illness, such as depression, may be delayed due to reorganization of the Department of Mental Health (DMH), which has just been reinstated as a standalone agency. The act that separated DMH from the Department of Health includes specific instructions for DMH to continue to integrate mental health with general health services. See www.leg.state.vt.us/docs/legdoc.cfm?URL=/docs/2008/acts/ACT015.HTM
- 139 Telephone interview and e-mail correspondence with Sarah L. Rugnetta, Assistant General Counsel, Director of Health Rates & Forms, Vermont Department of Banking, Insurance, Securities and Health Care Administration, April 3, 2008 and April 4, 2008.
- 140 Amendment 1 to Senate Bill 5, Section 33-5.
- 141 Illinois Department of Healthcare and Family Services, (2007, November 8). *Your Healthcare Plus: Extra Help for Better Help, Program Overview for Mental Health Council, Powerpoint presentation*. Springfield, IL, attachment to email from Stephanie Hanko, Chief, Bureau of Healthcare Quality Improvement Healthcare and Family Services. November 27, 2007 (providing preliminary data indicating that mental illness and substance use disorders are primary diagnoses for 22% of the population served and co-morbid diagnoses for a significant number of enrollees; by comparison, 26% of enrollees had a primary diagnosis of one of the five major physical disorders – asthma, diabetes, chronic obstructive pulmonary disease, coronary artery disease, and heart failure).
- 142 Illinois Department of Healthcare and Family Services, (2007, November 8).
- 143 Illinois Department of HealthCare and Family Services, (n.d.). *Your HealthCare Plus Factsheet*; retrieved at <http://www.hfs.illinois.gov/dm/fact.html>.

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State	Year ^b	Eligibility	Parity ^a		Benefits				Funding Source
			State	Plan	Outpatient MH Benefits	Outpatient SUD Benefits	Inpatient MH/SUD Treatment	Prescription Drugs (Rx)	
Arkansas AR-HealthNet Program	2006	• Open to businesses with 2 to 500 full-time employees that have not offered a group health plan within past 12 months • At least 1 employee must qualify for subsidized premiums by having an annual household income at or below 200% FPL • Subsidy provided for workers with incomes below 200% FPL.	No Minimum mandated benefit for some plans.	No	• Total of 8 outpatient MH/SUD services per plan year. • 1 MH/SUD visit in outpatient facility or hospital counts as 1 of a maximum of 2 outpatient services annually. • Subject to coinsurance 15% of allowed charge. • MH/SUD treatments are subject to benefit payment maximums in schedule of benefits. • Physician visits are limited to 1 treatment per day up to the plan benefit maximum of 6 professional office visits (which include services from a licensed social worker, licensed professional counselor, or psychologist) per plan year.	• Total of 8 outpatient MH/SUD services per plan year. • 1 MH/SUD visit in outpatient facility or hospital counts as 1 of a maximum of 2 outpatient services annually. • Subject to coinsurance 15% of allowed charge. • MH/SUD treatments are subject to benefit payment maximums in schedule of benefits. • Physician visits are limited to 1 treatment per day up to the plan benefit maximum of 6 professional office visits (which include services from a licensed social worker, licensed professional counselor, or psychologist) per plan year.	• Inpatient MH/SUD hospital covered up to 7 days annually. • Subject to coinsurance 15% of allowed charge.	• Covers only 2 Rx per month • Subject to co-pay but not deductible (\$5 generic, \$15 brand formulary, \$30 brand non-formulary).	• Contributions from employers • Employee premiums • Tobacco settlement funds • Waiver • Existing Medicaid dollars.

Notes

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* See National Alliance on Mental Illness. (2007). *State mental health parity laws 2007*. Retrieved April 7, 2008, from www.nami.org/Template.cfm?Section=Issue_Spotlights&template=/ContentManagement/ContentDisplay.cfm&ContentID=45351

Serious mental illness is also referred to in some states as “biologically based” mental illness. It typically includes schizophrenia and other psychotic disorders, bipolar disorder, major depressive disorder, obsessive-compulsive disorder, and panic disorder. *Mental illness* refers to broad-based mental health disorders. It typically includes schizophrenia and other psychotic disorders, mood disorders, and anxiety disorders as well as eating disorders, personality disorders, pervasive developmental disorders, attention deficit hyperactivity disorder and disruptive behavior disorders, tic disorders, and adjustment disorders.

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State	Year ^b	Eligibility	Parity ^a		Benefits				Prescription Drugs (Rx)	Funding Source
			State	Plan	Outpatient MH Benefits	Outpatient SUD Benefits	Inpatient MH/SUD Treatment			
California Health Care Security and Cost Reduction Act (AB X 1) Proposal	2007	• Residents with incomes up to 250% of the FPL would receive state subsidies for coverage • Residents with incomes up to 400% FPL would be able to fully deduct any healthcare premium costs that exceed 5.5% of their incomes • The plan would extend coverage to children in families with incomes up to 300% FPL, regardless of immigration status.	Yes Parity for serious mental illness; does not include SUD.	Yes Parity for serious mental illness; does not include SUD.	State parity law governs. California's 1999 parity law (AB 88) covers "diagnosis and medically necessary treatment for severe mental illness" in adults and "serious emotional disturbances" for children equivalent to those for medical conditions. Must offer same MH benefits as for physical conditions.	State parity law does not include SUD.	State parity law governs. Must offer same MH inpatient and partial hospitalization benefits as for physical conditions, but parity law does not cover SUD.	If the plan otherwise provides Rx coverage, then must provide same coverage for MH drugs. State parity law does not cover SUD.	• \$14 billion estimate to be paid for by • Payroll tax for employers • Increase in cigarette tax • 4% tax on hospital revenue • About \$5 billion in new federal funding, mostly for Medi-Cal.	
Colorado Minimum Benefit Plan Proposal	2007	• Requires all CO residents to have at least a minimum benefit plan • Requires all CO employers to offer their employees a chance to purchase health insurance with pretax dollars • Provides sliding-scale subsidies for low income uninsured workers at or below 400% FPL who are not offered coverage at work to purchase insurance • For those earning 300% FPL or less, subsidies equal to 80 to 100% of employer's total premium, minus employer contribution • For those up to 400%, subsidy should reduce cost of minimum benefit plan to no more than 9% of annual income.	Yes Parity for serious mental illness	Yes Parity for serious mental illness	TBD; plan specifics not yet available. Blue Ribbon Commission made recommendations to legislature. Minimum benefit plan recommended to include • Parity between physical and MH/SUD benefits • No co-pays for preventive care • Reduced co-pays for chronic care management services as defined by nationally recognized, CO-vetted uniform guidelines, such as those developed by the Colorado Clinical Guidelines Collaborative.	TBD; plan specifics not yet available Blue Ribbon Commission made recommendations to legislature to include parity for "mental disorders," which statutorily include SUD.	TBD; plan specifics not yet available Blue Ribbon Commission made recommendations to legislature. Minimum benefit plan recommended to include parity for "mental disorders," which statutorily include SUD.	TBD; plan specifics not yet available Blue Ribbon Commission made recommendations to legislature. Minimum benefit plan recommended to include Rx coverage.	TBD; plan specifics not yet available Blue Ribbon Commission made recommendations to legislature regarding possible funding. • Contributions from employers • Waiver to expand Medicaid • Tobacco, alcohol, and snack taxes • Increasing personal income tax by 0.8 percentage points.	

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State	Year ^b	Eligibility	Parity ^a		Benefits				Funding Source
			State	Plan	Outpatient MH Benefits	Outpatient SUD Benefits	Inpatient MH/SUD Treatment	Prescription Drugs (Rx)	
Illinois Covered Assist Proposal	2007	Childless adults up to 100% FPL and • Illinois resident • U.S. citizen • Ineligible for Medicaid • Have no access to employer-sponsored insurance.	Yes ^c Parity for serious mental illness; minimum mandated benefit for other mental illness; does not include SUD.	NA	Broad array of outpatient MH services, including crisis intervention, therapy, community support, assertive psychosocial rehabilitation, and others.	Includes outpatient, intensive outpatient/partial hospitalization and detoxification services.	Inpatient MH/SUD is covered.	Rx will be covered. • PDL • \$3 co-pays for brand-name drugs (excluding antipsychotic drugs) • No co-pay on generic drugs.	• State funds
Illinois Covered Choice; Illinois Covered Rebate Proposal	2007	• For Covered Choice program, small employers with no more than 25 employees; employer contributes at least 80% of individual or 65% of family premium. • Individuals are eligible if unemployed or self-employed or employer has not offered insurance in past 18 months. • For Covered Rebate, must be between 19 and 64 years old, IL residents and citizen or legal resident.	Yes ^c Parity for serious mental illness; minimum mandated benefit for other mental illness; does not include SUD.	Yes Parity for serious mental illness; minimum mandate for other mental illness; does not include SUD.	For Covered Choice, outpatient benefits for serious mental illnesses will be the same as physical disorders, and other mental illness would be covered for a minimum of 45 days under the minimum mandate statute.	SUD is not covered under parity requirement.	For Covered Choice, major medical benefits are included. Equal coverage for serious mental illnesses is required by parity law.	Not required by statute.	3% payroll assessment for employers with 10 or more employees that are not spending 4% or more on healthcare. • Premium payments.
Indiana Healthy Indiana Plan	2007	• Adults without disabilities, ages 19 to 64 • Household income between 22% and 200% FPL • Uninsured for at least 6 months and • Ineligible for employer-sponsored insurance.	Yes ^c Parity for mental illness and co-occurring disorders if offered; does not include SUD.	Yes Expands parity and requires equal coverage of mental illness and SUD.	Outpatient MH benefits. Plans differ but both plans provide intensive outpatient treatment, therapy, medication evaluation, and other services. No co-pays.	Outpatient SUD benefits. No co-pays	Inpatient coverage is provided for MH and SUD. \$25 co-pay for emergency room visits can be reimbursed for a visit that meets the "prudent person" standard for emergencies.	Rx are covered. Plans may vary in which drugs they cover. Both plans have a PDL. No co-pays.	• Federal matching funds from waiver • Cigarette tax • Individual contributions (2 to 5% of annual income, depending on income level).

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APPENDIX: Detailed Comparison of Benefits for Mental Illness and Substance Use Disorders in State Initiatives to Cover the Uninsured

State	Year ^b	Eligibility	Parity ^a		Benefits				Funding Source
			State	Plan	Outpatient MH Benefits	Outpatient SUD Benefits	Inpatient MH/SUD Treatment	Prescription Drugs (Rx)	
Maine DirigoChoice	2003	- Any income level may be eligible - Subsidies for those under 300% FPL - Covers small businesses (2 to 50 employees) and individuals	Yes ^c Parity for mental illness and SUD.	Yes Parity for mental illness and SUD.	For mental illnesses included in parity law: - Outpatient care (including evaluation, diagnosis, treatment and crisis intervention) - Outpatient home care - Psychological testing - Day treatment \$25 co-pay for office visits; no deductible - For other services, 20% coinsurance after deductible. For illnesses not covered under the law: 40-day limits \$150 MH deductible 20% coinsurance.	- Outpatient rehabilitation services, including evaluation, diagnosis, treatment and crisis intervention - Outpatient detoxification and medication management - Excludes methadone maintenance. \$25 co-pay for office visits and no deductible. - For other services, 20% coinsurance after deductible.	For mental illnesses included in parity law: - Inpatient care and partial hospitalization - Detoxification is covered. 20% coinsurance For illnesses that are not included: 30-day annual limit with 2 days of day treatment equal to 1 day of hospitalization 20% coinsurance after \$150 MH deductible.	- PDL - Tier 1 drugs (generics): \$10 co-pay - Tier 2 drugs (brands for which no generic): \$30 co-pay - Tier 3 drugs: \$50 co-pay - No deductible.	- Funded with an assessment on insurance carriers and third-party administrators (called "savings offset payments") to reflect cost savings from decrease in charity care and uninsured. - Premium payments.

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State	Year ^b	Eligibility	Parity ^a		Benefits				Funding Source
			State	Plan	Outpatient MH Benefits	Outpatient SUD Benefits	Inpatient MH/SUD Treatment	Prescription Drugs (Rx)	
Maine MaineCare	2003	Increase in eligibility for parents of dependent children from 150% to 200% FPL; previous expansion to cover childless adults up to 100% FPL.	Yes ^c Parity for mental illness and SUD.	NA	• Categorically eligible adults have access to MH benefits (outpatient, crisis, family psychoeducation, medication management and others) • Outpatient services and community support benefits (assertive community treatment, skills development, intensive case management and others) • Noncategorical childless adults have access to MH benefits only and are limited to 24 annual outpatient visits • Emergency, crisis and medication management are not subject to the limits • Co-pays from \$0.50 to \$3 for some beneficiaries.	• Intensive outpatient services maximum: 12 weeks, 5 days per week, 4 hours per day • Outpatient services maximum: 30 weeks, 3 hours per week • Methadone maintenance is covered. • Co-pays of \$0.50 to \$3 for some beneficiaries.	Inpatient treatment is covered. No co-pay.	• PDL • Usual co-pay is \$2.50 with \$25 per month cap.	State and federal waiver funds.

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State	Year ^a	Eligibility	Parity ^a		Benefits				Funding Source
			State	Plan	Outpatient MH Benefits	Outpatient SUD Benefits	Inpatient MH/SUD Treatment	Prescription Drugs (Rx)	
Maryland Comprehensive Standard Health Benefit Plan	2007	• Small employers with 2 to 50 employees • Subsidies available for employers with 2 to 9 employees that meet wage and other guidelines and offer a wellness benefit in the plan.	Yes Parity for mental illness and SUD benefits, with a graduated co-pay structure.	No	• Covers unlimited outpatient benefits • 30% coinsurance in network and 50% out of network paid by the insured.	• Covers unlimited outpatient benefits • 30% coinsurance in network and 50% out of network paid by the insured.	• 60 inpatient days per person per year for MH/SUD combined with partial hospitalization, with 2 days of partial hospitalization substituting for 1 day of inpatient care. • 30% coinsurance in network and 50% out of network paid by the insured.	• PDL • Generic and brand-name drugs \$2500 individual deductible and \$5000 family deductible • Coinsurance: 75% member and 25% plan.	• Surplus from high-risk insurance pool • General fund.
Maryland Primary Adult Care	2007	By July 1, 2008, parents up to 116% FPL will have access to Medicaid package. Later, childless adults up to 116% FPL will be eligible for additional services. Phased-in benefits only apply to childless adults and depend on revenue.	Yes Parity for mental illness and SUD benefits with a graduated co-pay structure.	NA	For MH benefits, the current primary care program includes outpatient and rehabilitation services currently provided under Medicaid. However, it does not include outpatient hospital services, which will be added in FY 2011. No co-pays.	By FY 2010, counseling for SUD and methadone maintenance will be added. By 2011, outpatient hospital services will be added. No co-pays.	In FY 2010, emergency room visits will be covered. In FY 2012, inpatient treatment for MH and SUD will be covered. No co-pays.	• Covers Rx • PDL • Co-pays are \$2.50 for generic and \$7.50 for brand name.	• Surplus from high-risk insurance pool • General fund • Tobacco tax • Federal funds from waiver • Current funds used to cover the uninsured.

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			State	Plan	Outpatient MH Benefits	Outpatient SUD Benefits	Inpatient MH/SUD Treatment	Prescription Drugs (Rx)	
Massachusetts MassHealth	2006	Increased enrollment cap on MassHealth Essential, a preexisting program, to cover nondisabled, childless adults who have been unemployed at least 12 months and have income at or below 100% FPL.	Yes Parity for serious mental illness and co-occurring disorders; minimum mandated benefit for other mental illness and SUD.	NA	• Rehabilitation services, including community support services, crisis, partial hospitalization, day treatment and others. • Outpatient MH services, including diagnostic evaluation, individual, group, and family counseling, community crisis counseling, psychological testing and others. • Diversionary services, including psychiatric day treatment, community support programs, community-based acute treatment, partial hospitalization, and others. • No co-pays.	• Structured outpatient addiction programs • Outpatient visits • Narcotic treatment services (includes methadone maintenance and other services) • Certain substance abuse programs • Narcotic treatment services (including acupuncture and other services) • No co-pays.	Inpatient MH/SUD treatment. No co-pay.	Covers Rx on MassHealth PDL • No co-pay for people under 19 • Co-pays for people over 19 (\$1/covered generics, \$3/covered brand name \$1/covered OTC).	• Redistribution of existing funding, including federal Medicaid payments, employer contributions, and general fund revenues • Federal funds from waiver • New funds from employer contributions and general fund revenues.

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State	Year ^b	Eligibility	Parity ^a		Benefits			Funding Source
			State	Plan	Outpatient MH Benefits	Outpatient SUD Benefits	Inpatient MH/SUD Treatment	
Massachusetts Commonwealth Care	2006	Individuals up to 300% FPL who are • Ineligible for MassHealth and • Whose employer has not provided insurance in the past 6 months that covered at least 20% of the annual premium for a family plan OR 33% of an individual plan Premiums waived for those at or below 150% FPL.	Yes Parity for serious mental illness and co-occurring disorders; minimum mandated benefit for other mental illness and alcoholism.	No Medically necessary services.	Medically necessary care, including outpatient MH care and community-based services, including psychiatric day treatment, community support teams, and others • No co-pay for individuals at or below 100% FPL • \$10 co-pay for alcohol/SUD/MH outpatient or office visit for individuals at or below 200% FPL • \$10/20 co-pay for alcohol/SUD/MH outpatient or office visit for individuals at or below 200% FPL • \$10/20 co-pay for alcohol/SUD/MH outpatient or office visit for individuals at or below 200% FPL, depending on plan.	Medically necessary care, including detoxification and other SUD programs • No co-pay for individuals at or below 100% FPL • \$10 co-pay for alcohol/SUD/MH outpatient or office visit for individuals at or below 200% FPL • \$10/20 co-pay for alcohol/SUD/MH visit for individuals above 100% FPL and at or below 200% FPL • \$50/250 co-pay per inpatient alcohol/SUD/MH visit for individuals above 200% FPL and at or below 200% FPL • \$50/250 co-pay per inpatient alcohol/SUD/MH visit for individuals above 200% FPL and at or below 300% FPL, depending on plan • \$250 co-pay maximum for individuals above 100% FPL and at or below 200% FPL • \$250/500 co-pay maximum for individuals above 200% FPL and at or below 300% FPL, depending on plan.	30-day supply from pharmacy: • For individuals at or below 100% FPL, \$1/generic, \$3/brand name • For individuals above 100% FPL and at or below 200% FPL, \$5/generic, \$10/on PDL, \$30/non-PDL • For individuals above 200% FPL and at or below 300% FPL, \$5/10 generic, \$10/20 on PDL, \$30/40 non-PDL, depending on plan 3-month supply by mail: • \$10/generic • \$20/on PDL • \$90/not on PDL Max total Rx co-pays per year: \$200 for individuals at or below 100% FPL; \$250 for individuals above 100% and at or below 200% of FPL; \$250/500 for individuals above 200% FPL and at or below 300% FPL, depending on plan.	• Redistribution of existing funding, including federal Medicaid payments, employer contributions, and general fund revenues • New funds from employer contributions and general fund revenues.

Notes

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State	Year ^b	Eligibility	Parity ^a		Benefits			Prescription Drugs (Rx)	Funding Source
			State	Plan	Outpatient MH Benefits	Outpatient SUD Benefits	Inpatient MH/SUD Treatment		
Massachusetts Commonwealth Choice	2006	Individuals above 300% FPL who: • Work for companies with more than 50 employees and who do not have access to employer-sponsored insurance • Work for companies with fewer than 50 employees. Employers with fewer than 50 employees.	Yes Parity for serious mental illness and co-occurring disorders; minimum mandated benefit for other mental illness and alcoholism.	Yes Parity for serious mental illness and co-occurring disorders; minimum mandated benefit for SUD and other mental illness.	• No limit on number of services per year for biologically based illness • Minimum of 24 outpatient days per year for treatment for non-biologically based illness • Premiums waived for individuals up to 150% FPL • Those 100% to 150% FPL pay co-pays only, no premiums (co-pay varies by plan). • For participants with biologically-based mental illnesses, co-pays generally range from \$10 to \$35 for outpatient mental health visits.	• Minimum of 24 outpatient days per year for alcoholism treatment • Any SUD that is co-occurring with a MH condition must be treated the same as the MH condition • Other outpatient SUD coverage varies by plan • Co-pay varies by plan, ranging from \$10 to \$50 per office visit	• Covers inpatient services including MH care, SUD detoxification, and SUD rehabilitation • No day limit on treatment for biologically based illness • Minimum of 60 days inpatient care per calendar year for non-biologically based mental illness • Minimum of 30 days inpatient alcoholism treatment • Any SUD that is co-occurring with a MH condition must be treated the same as the MH condition • Other inpatient SUD coverage varies by plan • Co-pay varies by plan for inpatient MH/SUD care, ranging from \$0 to \$1,000.	Co-pay varies by plan and by whether beneficiary is receiving a 30-day supply from a pharmacy or a 3-month supply by mail.	• Redistribution of existing funding, including federal Medicaid payments, employer contributions, and general fund revenues • Federal funds from waiver • New funds from employer contributions and general fund revenues.
	Massachusetts Young Adult Plans (component of Commonwealth Choice)	2006	Individuals ages 19 to 27 whose employers do not offer to contribute 33% to the cost of their coverage or who do not otherwise have employer-sponsored coverage available to them.	Yes Parity for serious mental illness and co-occurring disorders; minimum mandated benefit for other mental illness and alcoholism.	No Required to provide "reasonably comprehensive coverage" of MH services.	• No day limits for biologically based MH conditions • Non-biologically based care generally limited to 24 visits per calendar year • Co-pay varies by plan.	• Outpatient SUD visits generally limited to 24 visits per plan year • Alcoholism treatment generally limited to 8 visits per calendar year • Co-pay varies by plan.	• No day limits for biologically based MH conditions • Non-biologically based MH and SUD care limited to 60 days per calendar year • Inpatient alcoholism treatment admissions limited to 30 days per calendar year • Co-pay varies by plan.	• Co-pay varies by plan and by whether beneficiary is receiving a 30-day supply from a pharmacy or a 3-month supply by mail • Plans without Rx coverage also available.

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		State	Plan	Outpatient MH Benefits	Outpatient SUD Benefits	Inpatient MH/SUD Treatment	Prescription Drugs (Rx)	
Minnesota MinnesotaCare	2007	Yes Parity for mental illness and SUD in state-regulated health plans, including HMOs.	Yes Parity for mental illness and SUD in state-regulated health plans, including HMOs.	For all but the lowest income children and pregnant women, MinnesotaCare previously had limits on outpatient MH services. As of January 1, 2008, limits were removed and rehabilitative services became available. Services are comprehensive and include • Assertive community treatment • Adult rehabilitative services • Crisis response services • Intensive residential services • Other services.	• Outpatient services • Intensive outpatient services • Methadone maintenance and other medication assistance therapies • Outpatient detoxification (as medical treatment) • No co-payments.	• Inpatient MH services • Inpatient SUD services (hospital and non-hospital) • Detoxification services • Residential SUD services • Halfway houses • Extended Care for SUD • For parents over 175% FPL and for all childless adults, a \$10,000 annual limit on inpatient hospital and SUD residential treatment for all medical conditions. • For childless adults, co-pay of 10%, up to \$1,000 annually.	• Rx are covered. • PDL, plans have some flexibility with coverage except for pregnant women and children who are exempt.	• Medicaid and SCHIP federal funding from a waiver for parents and children • Enrollee premiums • State funds generated through a tax on healthcare providers and HMOs • Redirecting funding for MH services and case management from counties.

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State	Year ^b	Parity ^a		Benefits				Funding Source
		State	Plan	Outpatient MH Benefits	Outpatient SUD Benefits	Inpatient MH/SUD Treatment	Prescription Drugs (Rx)	
Minnesota General Assistance Medical Care (GAMC)	2007	• Income at or below 75% FPL • Assets not exceeding \$1,000 per household • MN residency of not less than 30 days, with some exceptions • Citizen or legal status • Must meet one or more of additional criteria, known as GAMC qualifiers, including waiting or appealing disability determination by Social Security Administration, waiting for state medical review team determination of disability, or being homeless or living in shelter, hotel, or other place of public accommodation.	Yes Parity for mental illness and SUD in state-regulated health plans, including HMOs.	Yes Parity for mental illness and SUD in state-regulated health plans, including HMOs. • GAMC previously had limits on outpatient MH services. As of January 1, 2008, limits were removed and rehabilitative services became available. Services include: • Assertive community treatment • Skills training • Crisis services • Intensive residential services • Other services - No co-pays. By January 1, 2009, MH case management will be available.	• Outpatient services • Intensive outpatient services • Methadone maintenance and other medication assistance therapies • Outpatient detoxification (as medical treatment) • No co-payments	• Inpatient MH services • Inpatient SUD services (hospital and non-hospital) • Detoxification services • Residential SUD services • Halfway houses • Extended Care for SUD • No co-payments, except \$25 emergency room visit for non-emergency.	Rx are covered. • PDL, plans have some flexibility with coverage • Co-payment of \$1 generic and \$3 brand name • \$12 limit per month • No co-pay on some MH drugs.	State appropriations.

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			State	Plan	Outpatient MH Benefits	Outpatient SUD Benefits	Inpatient MH/SUD Treatment		
Montana Insure Montana	2007	• Employers must have 2 to 9 employees • No employee can earn more than \$75,000, excluding the owner • The employer cannot have offered insurance in the past 24 months. • Premium assistance varies by family income of employee.	Yes Parity for serious mental illness; minimum mandated benefit for other mental illness and SUD.	Yes Parity for serious mental illness; minimum mandated benefit for other mental illness and SUD.	• Outpatient benefits are the same for all mental and physical disorders • Includes therapy, office visits, counseling, and crisis services • Coinsurance: 25% (premier plan) and 40% (standard plan).	• Outpatient services are covered • Maximum benefit for inpatient and outpatient \$6,000 per 12-month period • Coinsurance: 25% (premier plan) and 40% (standard plan).	• Inpatient treatment for severe mental illness is covered the same as other medical treatment without day limits • Coinsurance: 25% (premier plan) and 40% (standard plan) • For other mental illnesses, 21-day limit with 25% or 40% coinsurance • 2 days of partial hospitalization may be substituted for 1 day of inpatient • Chemical dependency covered with 25% or 40% coinsurance • Maximum benefit for inpatient and outpatient \$6,000 per 12-month period. • Chemical dependency lifetime inpatient limit of \$12,000. After lifetime limit met, \$2,000 combined inpatient and outpatient limit per benefit period. • No annual or lifetime limit on medical detoxification, which is paid like other physical illnesses.	• PDL • \$200 (standard plan) or \$100 (premium plan) deductible per member • For a 34-day supply, co-pay of \$10 (generic) or \$30 (brand name) for formulary Rx; \$75 co-pay for nonformulary brand names • Discounts for co-pays for mail order: a 3-month supply will cost 2 months of co-pay • Ancillary charge for a brand name when a generic is available.	• Tobacco tax (\$1 per pack) • Premiums • State funding.

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State	Year ^b	Parity ^a		Benefits				Funding Source
		State	Plan	Outpatient MH Benefits	Outpatient SUD Benefits	Inpatient MH/SUD Treatment	Prescription Drugs (Rx)	
New Mexico HealthSOLUTIONS New Mexico Proposal	2002	Yes Parity for mental illness; does not include SUD.	Yes Parity for mental illness; does not include SUD.	TBD by governor and legislature based on recommendations of newly created health coverage authority; state parity law would apply.	TBD by governor and legislature based on Authority's recommendations.	TBD by governor and legislature based on Authority's recommendations; state parity law would apply for MH.	TBD by governor and legislature based on Authority's recommendations.	• Federal funds • State funds • Employer contributions to Healthy NM Workforce fund • Individual contributions as determined by newly created Authority, governor, and legislature. • Premium payments
New Mexico State Coverage Insurance	2002	Yes Parity for mental illness; does not include SUD.	State parity law does not apply, but program provides equal benefits for mental illness and other health conditions.	• Office visits for MH evaluation and treatment • Office visit co-pays vary with income: \$0, up to 100% FPL; \$5 for 101% to 150% FPL; and \$7 for 151% up to 200% FPL.	• Substance use services including visits, outpatient detoxification and intensive outpatient care limited to 42 days/visits per benefit year • Office visit co-pays vary based on income: \$0, up to 100% FPL; \$5 for 101% to 150% FPL; and \$7 for 151% up to 200% FPL.	• Mental health services provided in a psychiatric hospital or an acute care general hospital • Substance use detoxification • Inpatient hospitalization is limited to 25 days for MH/SUD combined and 25 days for physical health conditions • Inpatient co-payments vary by income: \$0, up to 100% FPL; \$25, for 101% to 150% FPL; \$30, 151% to 200% FPL per stay.	Rx are covered; PDL. • \$3 per Rx co-pay, up to a maximum \$12 per month • For outpatient services, injectable forms of haloperidol or fluphenazine are included in the office visit co-pay.	• Medicaid 1115 waiver • Premiums.

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			State	Plan	Outpatient MH Benefits	Outpatient SUD Benefits	Inpatient MH/SUD Treatment			
New York Healthy New York	2001	Open to uninsured residents who meet the following criteria: • Self or spouse is working or has been employed in past 12 months • Employer does not provide insurance • Have not had insurance for 12 months prior to Healthy NY application or have lost coverage due to a specific event • Are ineligible for Medicare • Meet monthly household income guidelines based on family size.	Yes ^c Parity for serious mental illness; does not include SUD.	No	None Healthy NY specifically excludes MH services—including treatment and Rx for ADHD, depression, anxiety, and alcohol and substance abuse treatment—from the benefits package.	None Healthy NY specifically excludes MH services—including treatment and Rx for ADHD, depression, anxiety, and alcohol and substance abuse treatment—from the benefits package.	None Healthy NY specifically excludes MH services—including treatment and Rx for ADHD, depression, anxiety, and alcohol and substance abuse treatment—from the benefits package.	None Healthy NY specifically excludes MH services—including treatment and Rx for ADHD, depression, anxiety, and alcohol and substance abuse treatment—from the benefits package.	MH/SUD Rx not covered.	• Individual and employer premiums • State subsidy.
New York Family Health Plus	2000	Open to residents ages 19 to 64 who • Are single adults; couples without children; or parents with limited income who do not have health insurance through a federal, state, county, municipal, or school district benefit plan • Meet monthly household income guidelines based on family size Parent(s) living with a child under age 21 are eligible if the gross family income is up to 150% FPL as of October 1, 2002. Individuals without dependent children in their households qualify with gross incomes up to 100% FPL.	Yes ^c Parity for serious mental illness; does not include SUD.	No	60 days per year of outpatient MH and alcohol and substance abuse services. No co-pays.	60 days per year of outpatient MH and alcohol and SUD services. No co-pays.	30 days per year of inpatient MH and alcohol and SUD treatment. No co-pays.		Co-pay of \$3 (generic) or \$6 (brand name).	Section 1115 Medicaid waiver.

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Oklahoma Insure Oklahoma/O- EPIC Individual Plan	2006	The income guidelines for this program (both employer-sponsored insurance [ESI] and Individual Program [IP]) are set at 200% FPL. All applicants must meet the following criteria: • Between ages 19 and 64 • Oklahoma resident • U.S. citizen or legal alien • Ineligible for Medicaid (Sooner Care), Medicare, or any Medicaid-funded program, such as Family Planning. For the ESI program, the applicant must work for an Oklahoma employer that has 50 or fewer full-time employees, offers one of the qualified health plans, and pays at least 25% of the premium. (The employee will then pay 15% of their premium, and Insure Oklahoma will pay the other 60%) For the IP program, the applicant must be a working adult who does not have access to the ESI program and meets any of the following criteria: • Works for an employer with 50 or fewer full-time employees or is self-employed • Is unemployed and eligible to collect unemployment benefits from the State of Oklahoma • Is a working adult with a disability with a ticket to work..	Yes ^c Parity for serious mental illness; does not include SUD.	No Limits on inpatient benefits for MH/ SUD are included in IP.	For the IP program, outpatient MH services currently include the same services as Medicaid: case management, behavioral health, and assertive community treatment services. Psychiatrist visits are included in the 4 physician services limit per month. • Co-pay is \$10 per visit.	For the IP program, outpatient SUD services are covered. • SUD agencies may provide outpatient therapy and rehabilitation, psychological testing and evaluation, and medication management services. • These agencies may also provide case management services for people who need more intensive services. • Co-pay is \$10 per visit.	For the IP program: • Inpatient care for MH/ SUD combined is limited to 24 days per state fiscal year. • Co-pay is \$50 per admission. • No residential SUD services are provided, except for medical detoxification.	For the IP program: • Rx and insulin are covered; PDL. • \$5 co-pay for generic • \$10 co-pay for brand name • Rx limited to 6 per month, 3 of which may be brand name.	• Tobacco tax • Employee and employer contributions • Federal funds through waiver.

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			State	Plan	Outpatient MH Benefits	Outpatient SUD Benefits	Inpatient MH/SUD Treatment	Prescription Drugs (Rx)	
Pennsylvania Cover All Pennsylvanians Proposal	2007	Individuals who have been a resident of PA for at least 90 days and are not eligible for Medicaid or Medicare. • If household income is below 200% FPL, must have been uninsured for at least 90 days • If above 200% FPL, must have been uninsured for 180 days. • Small businesses that do not currently provide insurance can also purchase subsidized insurance if they have 2 to 50 employees, have not offered health insurance for 180 days, and pay an average annual wage lower than PA's average (\$40,000 in 2007).	No Minimum mandated benefits for mental illness and SUD. ^c	No Minimum mandated benefits for mental illness and SUD.	HB 700 states that the Department of Insurance will determine any limits on services. Governor's staff are estimating premiums based on a limit of 30 outpatient MH visits per year	HB 700 states that the Department of Insurance will determine any limits on services. Governor's staff are estimating premiums based on a limit of 30 outpatient SUD benefits per year.	HB 700 states that the Department of Insurance will determine any limits on services. Governor's staff are estimating premiums based on limits of 30 days per year for psychiatric care and 7 days per year detoxification services.	HB 700 states that the Department of Insurance will determine limits on services, including Rx. Governor's staff indicate that brand, generic, family planning, and OTC drugs will be covered	• State appropriations • Federal funding • Revenue from fair tax on employers • Tobacco settlement funds • Funds that Blue Cross plans must reinvest as nonprofits.
Pennsylvania adultBasic	2007	• Adults ages 19 to 64 • Lack of prior coverage for 90 days, except for loss of job • No other health coverage • Income below 200% FPL • Resident of PA for at least 90 days • U.S. citizen or permanent legal alien status	No Minimum mandated benefits for mental illness and SUD. ^c	No	No outpatient treatment covered for mental illness	No outpatient treatment covered for SUD.	No inpatient benefit for mental illness or SUD only.	No Rx coverage except for Rx related to diabetes and transplants.	• Tobacco settlement funds • Funds from agreement with Blue Cross/Blue Shield plans

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^a See National Alliance on Mental Illness. (2007). *State mental health parity laws 2007*. Retrieved April 7, 2008, from www.nami.org/Template.cfm?Section=Issue_Spotlights&template=/ContentManagement/ContentDisplay.cfm&ContentID=45351

Serious mental illness is also referred to in some states as “biologically based” mental illness. It typically includes schizophrenia and other psychotic disorders, bipolar disorder, major depressive disorder, obsessive-compulsive disorder, and panic disorder. *Mental illness* refers to broad-based mental health disorders. It typically includes schizophrenia and other psychotic disorders, mood disorders, and anxiety disorders as well as eating disorders, personality disorders, pervasive developmental disorders, attention deficit hyperactivity disorder and disruptive behavior disorders, tic disorders, and adjustment disorders.

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APPENDIX: Detailed Comparison of Benefits for Mental Illness and Substance Use Disorders in State Initiatives to Cover the Uninsured

State	Year ^b	Eligibility	Parity ^a		Benefits				Prescription Drugs (Rx)	Funding Source
			State	Plan	Outpatient MH Benefits	Outpatient SUD Benefits	Inpatient MH/SUD Treatment			
Rhode Island HealthPactRI Basic	2006	Open to all employees of small (50 employees or less) businesses..	No Minimum mandated benefits for mental illness and SUD.	No Minimum mandated benefits for mental illness and SUD. ^d	30 visits per year for MH services. • Co-pays of \$30/60 for physician office visits (primary care or specialist) • 20% coinsurance for most outpatient services.	30 hours per year for SUD services. • Co-pays of \$30/60 for physician office visits (primary care or specialist) • 20% coinsurance for most outpatient services. • Methadone maintenance not covered.	Covers inpatient MH. 30 days per year for inpatient community residential care services for SUD treatment • For SUD detoxification services, 5 occurrences or 30 days per year, whichever comes first • 20% coinsurance.	Co-pays range from \$10 to \$75, depending on the preferred status of the drug.	• Contributions from employers • Employee premiums.	
Rhode Island HealthPactRI Advantage		Open to employees of small (50 employees or less) businesses In Year 1 of enrollment, employees and dependents 18 and older must • Select a primary care doctor • Complete a wellness pledge and a health risk assessment to qualify for advantage coverage In Year 2, employees and dependents must have • Visited doctor by the 6th month of the 1st year • Submitted annual participation checklist • Participated in disease or case management if medically applicable	No Minimum mandated benefits for mental illness and SUD.	No Minimum mandated benefits for mental illness and SUD. ^d	30 visits per year for MH services. • Co-pays of \$10/50 for physician office visits (PCP/specialists) • 10% coinsurance for most outpatient services.	30 hours per year for SUD services. • Eight 30-minute tobacco cessation counseling sessions per year. • 10% coinsurance for most outpatient services.	Covers inpatient MH. 30 days per year for inpatient community residential care services for SUD treatment • For SUD detoxification services, 5 occurrences or 30 days per year, whichever comes first • 10% coinsurance for most inpatient services.	Co-pays range from \$10 to \$75, depending on the preferred status of the drug.	• Contributions from employers • Employee premiums.	

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		State	Plan	Outpatient MH Benefits	Outpatient SUD Benefits	Inpatient MH/SUD Treatment			
Tennessee Cover TN	2006	No Minimum mandated benefit for mental illness; mandated offering for SUD. ^c	No Statute specifies that plans do not have to comply with mandates.	• Outpatient behavioral health services limited to 10 visits per year • Outpatient facility charges have \$25 co-pay • Outpatient practitioner charges related to MH services have no co-pay.	• Outpatient behavioral health services limited to 10 visits per year • Outpatient facility charges have \$25 co-pay • Outpatient practitioner charges related to SUD services have no co-pay • Excludes methadone maintenance therapy and buprenorphine maintenance therapy.	• Inpatient behavioral health services limited to 5 days per year. • \$100 co-pay per admission • Subject to \$10,000 or \$15,000 annual limit, depending on plan, for inpatient medical, MH and SUD services combined. • Plan may substitute 2 partial hospitalization days for 1 inpatient day or 3 intensive outpatient program days for 1 inpatient day.		• Formulary for generic drugs • Only brand drugs are insulin and diabetic supplies • Depending on the plan, \$8 or \$10 co-pay for 30-day supply • Quarterly payment limits of \$250 or \$75.	• State funded • Employer and employee premiums.

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State	Year ^b	Parity ^a		Benefits				Funding Source
		State	Plan	Outpatient MH Benefits	Outpatient SUD Benefits	Inpatient MH/SUD Treatment	Prescription Drugs (Rx)	
Vermont Catamount Health	2006	Yes Parity for mental illness and SUD.	Yes Parity for mental illness and SUD.	• \$10 co-pay per visit. • 1-year pre-existing condition waiting period unless in chronic care management program.	• \$10 co-pay per visit. • 1-year pre-existing condition waiting period unless in chronic care management program.	• Covers 80% after deductible of \$250 for an individual or \$500 for a family.	- Co-pays for Rx as follows: • \$10 generic • \$30 brand name on PDL • \$50 brand name not on PDL • Catamount Blue plan offers 90-day mail order supply for price of 60 days.	• Section 1115 waiver • Tobacco taxes • Employers' premium contribution • State general fund appropriations.
Vermont Global Commitment Waiver	2005	Yes Parity for mental illness and SUD.	NA	Outpatient services may include evaluation, counseling, and medication prescription and monitoring. Individuals in the CRT program also may receive service planning and coordination, community supports (including assistance with daily living, supportive counseling, support to participate in community activities, and other services), employment services, clinical interventions, crisis services, housing and home supports, transportation, partial hospitalization, and day services. No co-pays.	Outpatient SUD benefits include a buprenorphine hub, detoxification, halfway houses, outpatient programs, intensive outpatient programs, methadone programs, residential programs and others. No co-pays.	Inpatient MH/SUD treatment. VHAP participants pay a \$25 co-pay for an emergency room visit.	Rx are covered. Vermont has a PDL. No co-pays.	Vermont consolidated all programs for Medicaid, SCHIP, and VHAP into one public managed care organization under a federal waiver. Funded with state and federal dollars.

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			State	Plan	Outpatient MH Benefits	Outpatient SUD Benefits	Inpatient MH/SUD Treatment	Prescription Drugs (Rx)	
Washington Basic Health	2007	Open to low-income residents (at or below 200% FPL) who are • Ineligible for Medicare • Not institutionalized during enrollment and • Not attending school full-time on student visa.	Yes ^c Parity for mental illness; minimum mandated benefit for SUD. Law requires parity for co-pays, co-insurance, out-of-pocket limits and Rx. As of July 1, 2010, will include parity for deductibles and treatment limitations (e.g., outpatient visits).	Yes Parity for mental illness; minimum mandated benefit for SUD. Law requires parity for co-pays, co-insurance, out-of-pocket limits and Rx. As of July 1, 2010, law requires parity for deductibles and treatment limitations (e.g., outpatient visits).	• \$15 co-pay • 12 visits per year • \$150 annual deductible and then beneficiary pays 20%. • Maximum annual out-of-pocket is \$1500. • Office visits for medication management do not count toward total visits per year. • As of July 1, 2010, MH deductibles and treatment limits must be the same as for physical health.	• "Chemical dependency" (inpatient and outpatient) limited to \$5,000 every 24 months • \$10,000 lifetime maximum (includes inpatient and outpatient) • \$15 co-pay per visit.	MH: • \$150 annual deductible and then beneficiary pays 20%. • Limited to 10 inpatient days per year. • May incur up to \$300 in "facility charges" per visit • As of July 1, 2010, MH deductibles and treatment limits must be the same as for physical health SUD: • \$150/person annual deductible, then beneficiary pays 20%. • Limited to \$5000 every 24-months, \$10,000 lifetime maximum (includes inpatient and outpatient) • May incur up to \$300 in "facility charges" per visit.	30-day supply: • \$10 for generics in PDL • 50% of Rx costs for brand-name drugs in PDL • Annual deductible, out-of-pocket maximum, and coinsurance do not apply	• State funds • Tobacco tax.

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About NAMI

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

www.nami.org

About the National Council

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

www.TheNationalCouncil.org

The development of this report was supported by the Robert Wood Johnson Foundation.

www.HealthcareforUninsured.org

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