HEALTH POLICY REPORT

Mental Health and Substance-Use Reforms — Milestones Reached, Challenges Ahead

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Mental and substance-use disorders, hereafter referred to as mental disorders, are major contributors to the burden of disease around the world.[1] More than half of all Americans will have symptoms of a mental disorder at some point in their lives.[2] Yet, persons with these conditions have historically faced limits on health insurance coverage that have restricted their access to treatment, along with shortages of mental health specialists (particularly those who accept insurance) and a treatment system plagued by fragmentation in care delivery. Such fragmentation stems from the historical separation of mental health providers from the rest of the health care system.

The Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008 — the federal law requiring parity in mental health and medical benefits — and the Affordable Care Act (ACA) of 2010, which extended the parity requirements of the MHPAEA and expanded coverage options, dramatically improved financial access to treatment for millions of Americans. Nevertheless, problems remain, and the quality of care is still often poor.[3]

In this report, we will cover issues that surround treatment for mental disorders, including the prevalence of mental disorders, spending trends, the shortage of practicing mental health specialists, efforts to break down the separation between mental health providers and the rest of the health care system, the impact of the MHPAEA and ACA, and the status of proposed federal legislation that seeks to address the shortcomings of the current mental health system.

MENTAL HEALTH TREATMENT AND SPENDING

Millions of Americans have symptoms associated with mental disorders each year, yet only a minority of such persons receive treatment for those conditions. On the basis of the latest survey by the Substance Abuse and Mental Health Services Administration (SAMHSA), an estimated 45% of some 43.6 million adults with any mental illness in 2014 received mental health services during the previous year, with only 69% of the approximately 9.8 million adults with a serious mental illness receiving services.[4] Treatment rates for substance-use disorders (related to the use of alcohol, illicit drugs, or both) were even lower. Only 4.1 million Americans who were 12 years of age or older received treatment in 2014, whereas an estimated 22.5 million Americans in this age group had a substance-use disorder.[5]

Spending on mental health treatment from all public and private sources is expected to total $280.5 billion in 2020, an increase from $171.7 billion in 2009.[6] Medicaid, which is financed jointly by federal and state governments, is the largest payer, and the Medicaid share of spending is projected to grow now that the ACA has passed (Fig. 1).[6,7] The Medicaid and CHIP (Children's Health Insurance Program) Payment and Access Commission, a nonpartisan legislative-branch agency that provides policy and data analysis on issues affecting Medicaid and the state CHIP, reported that in 2011 (the year of the most recent commission analysis) one in five Medicaid beneficiaries had received a diagnosis of a mental disorder, and total health care spending for these beneficiaries accounted for almost half of Medicaid spending in that year, with average outlays that were four times as high as those for beneficiaries without a diagnosed mental disorder ($13,303 vs. $3,564).[7]

KEY BARRIERS TO TREATMENT

A long-standing barrier to the receipt of mental health treatment is limited insurance coverage for these services. Before the passage of federal

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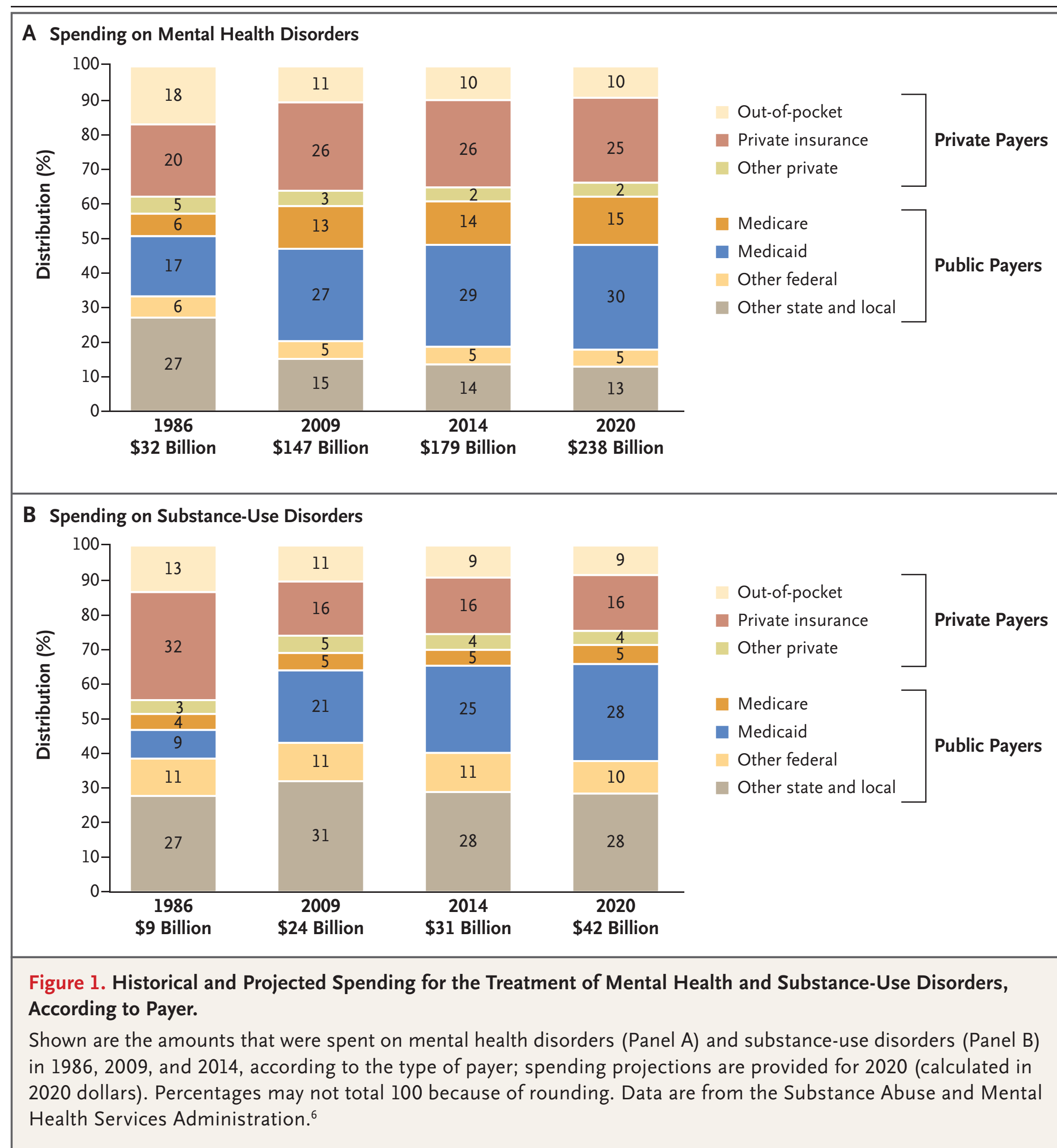

Figure 1. Historical and Projected Spending for the Treatment of Mental Health and Substance-Use Disorders, According to Payer.

Shown are the amounts that were spent on mental health disorders (Panel A) and substance-use disorders (Panel B) in 1986, 2009, and 2014, according to the type of payer; spending projections are provided for 2020 (calculated in 2020 dollars). Percentages may not total 100 because of rounding. Data are from the Substance Abuse and Mental Health Services Administration.[6]

parity legislation, coverage of mental health services was generally more restrictive than coverage of other types of care, with private insurance plans imposing higher cost-sharing requirements (e.g., 50% coinsurance for mental health outpatient visits vs. 20% for medical or surgical outpatient visits) and special benefit limits on the number of covered mental health outpatient visits or inpatient days.[8] Persons with severe mental disorders, who quickly hit annual limits and incurred large out-of-pocket expenses, were disproportionately disadvantaged by the coverage restrictions.

A shortage of mental health workers represents another long-standing barrier. One 2009 study estimated that 77% of U.S. counties had a severe shortage of either psychiatrists or other mental health specialists.[9] In 2007, SAMHSA reported that 55% of U.S. counties that were surveyed had no practicing psychiatrists, psychologists, or social workers.[10] From 2003 through 2013, the median number of practicing psychiatrists per 100,000 residents in hospital referral regions dropped by 10.2%, while the number of neurologists and primary care physicians (PCPs) grew.[11] Shortages of mental health specialists are compounded by the fact that many such practitioners (including nearly half of psychiatrists,

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according to one recent study[12]) do not accept insurance as a form of payment. This situation leaves patients to make out-of-pocket payments or to face the seemingly inevitable hassle of seeking some reimbursement from an insurance carrier after treatment if they have out-of-network coverage. Low provider-participation rates owing to poor reimbursement are a particular concern for the Medicaid program,[13] although questions have also been raised about the difficulty of finding network providers who are taking new patients in plans offered through the federal insurance exchanges.[14,15]

An additional barrier to the receipt of high-quality care for persons with mental disorders is the fragmentation in service delivery that has resulted from the historical separation of mental health specialists from the rest of the health care system, a separation that was reinforced through the widespread use of behavioral health carve-outs, in which an employer or a plan contracts separately with a managed behavioral health organization that specializes in the management of services delivered by mental health specialists.[16] As a result of fragmentation, mental disorders often go undetected or untreated in primary care settings, and the physical health needs of persons with these conditions are often not properly addressed in the specialty mental health sector.[17,18] Some 68% of persons with a mental disorder have at least one chronic health condition, such as high blood pressure, obesity, or asthma, and they are less likely to receive appropriate care for these health conditions than those without a mental disorder.[18-20]

In addition to problems with coverage, workforce shortages, and fragmentation, there is growing evidence that the mental health system may not be meeting the needs of some of the most disadvantaged persons in our society. For example, according to SAMHSA, more than a quarter of homeless persons (26.2%) on a given night have a severe mental illness, and more than a third (34.7%) have chronic substance-use issues.[21] Rates of serious mental illness in the criminal justice system are much higher than in the general population, with one study reporting the diagnosis of a serious mental illness in 14.5% of male jail inmates and 31.0% of female jail inmates among those incarcerated.[22] Jails and prisons currently house more persons with mental illness than psychiatric hospitals.[22,23]

ACA AND MHPAEA EXPANSIONS

Despite all the controversy that has beset the ACA, the law, in combination with the MHPAEA, represents a crucial milestone for persons with mental disorders. As stated by David Mechanic, the founding director of the Institute for Health, Health Care Policy, and Aging Research at Rutgers University, "For the first time, behavioral health . . . has been given centrality in discussions of health reform."[24] With enactment of the MHPAEA in 2008, large commercial plans that offer mental health benefits, as well as Medicaid managed-care plans, are required to provide benefits for mental health services that are at least as generous as those for general medical care. The MHPAEA and its regulations require parity in cost-sharing requirements, benefit limits, and the application of managed-care techniques used to influence service use and spending, including utilization-review processes, criteria for determinations of medical necessity, and provider network management. The ACA and reauthorization legislation for CHIP extended parity requirements to small-group plans and individual-market plans through the insurance exchanges, Medicaid alternative-benefit plans (which enroll the ACA Medicaid expansion population), and CHIP. The Medicare Improvement for Patients and Providers Act, enacted in 2008, had already begun phasing out the higher coinsurance rate for outpatient mental health visits (50%) than for other outpatient visits (20%) for Medicare beneficiaries. However, parity requirements do not apply to approximately 3 million disabled adults — about one third of whom have a severe mental illness — in the Medicaid fee-for-service program.[25] Several states currently impose annual limits on mental health visits but not on general medical visits for fee-for-service beneficiaries.[26,27]

In addition to parity, several provisions of the ACA have provided new coverage options to millions of persons with mental disorders. These provisions include the ACA's Medicaid expansions, subsidies to help low-income persons purchase plans on the exchanges, reforms of the individual and small-group insurance markets (e.g., the prohibition of exclusions based on preexisting medical conditions), and the requirement that commercial plans allow dependents to remain on their parents' insurance until the age

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of 26 years. The ACA also mandates coverage of mental health services as 1 of 10 categories of "essential health benefits" that must be covered by all plans in the individual and small-group insurance markets and to those who are newly eligible for Medicaid under the ACA. Together, the MHPAEA and ACA have dramatically expanded financial access to mental health treatment, particularly for services related to substance-use disorders, for which public and private coverage have typically been even more restrictive than that for overall mental health coverage.

Given that final MHPAEA regulations were implemented only last year, it is too soon to know what effects these changes will have on mental health treatment and expenditures. Reports on the early post-MHPAEA experience documented that although most plans initially complied with parity requirements, a sizable minority had not fully implemented parity.[28] Advocates are especially concerned about the enforcement of parity in applying criteria for the determination of medical necessity, for utilization-review protocols, and for provider network management, given that the use of these techniques is much harder for regulators to observe than are benefit features such as copayments and visit limits.[15] Several studies that have evaluated earlier parity policies have shown that parity results in improvements in financial protection for users of mental health services with little or no increase in total spending (i.e., by both the plan and the enrollee) for this care.[29] A recent study of the use of mental health services before and 1 year after the implementation of the ACA's coverage expansions showed increased rates of mental health treatment among patients with serious psychological distress but no increases in the use of services for substance-use disorders among those with past-year substance-use disorders.[30] Also, research has documented increases in the use of mental health treatments among young adults between the ages of 18 and 25 years (a common age group for the first onset of many mental disorders) after implementation of the ACA's dependent-coverage requirement in 2010.[31]

PURSUIT OF INTEGRATION

The American Academy of Family Physicians, the American Board of Family Medicine, the American Academy of Pediatrics, the American College of Physicians, and the American Medical Association have all released statements calling for improved integration of mental health care and general medical care,[32-35] and much innovation is happening across the country. However, recognition of the fragmentation in care for persons with mental disorders and efforts to improve integration are not new. A number of models that were designed to improve the integration of mental health care within primary care settings have been successfully implemented and have resulted in improved outcomes for patients. The Collaborative Care Model, developed more than two decades ago, has the strongest evidence base.[36,37] Under this model, care is provided by a collaborative team that includes a PCP, a care management staff member (e.g., a nurse or clinical social worker who is trained to provide care coordination, deliver brief behavioral interventions, and support treatments initiated by the PCP), and a psychiatric consultant to advise the team on complex cases. Although this type of model is effective, the sustainability of such models over time has been problematic, owing in part to financing barriers — in particular, a lack of reimbursement in fee-for-service payment systems for key elements of the models (e.g., care manager services and consultations with mental health specialists).[16,38]

Alternative approaches that may be well suited to improving the integration of care for persons with severe mental illnesses involve colocation of PCPs in settings with mental health specialists[39] and the creation of integrated practice units that combine clinical and nonclinical personnel and providers of both mental health and other health services into an integrated team located in a mental health clinic.[40] However, there is a lack of evidence with respect to the effectiveness of these approaches as compared with that of the collaborative care models thus far.[41,42]

A financing approach that may promote increased integration and that is increasingly common among both public (Medicare and Medicaid) and commercial insurers is the use of risk-based payment models. Under these models, large provider organizations assume financial risk for the cost and quality of all health care services used by the patients they care for. Under the Alternative Quality Contract (AQC) that Blue Cross Blue Shield of Massachusetts implemented in 2009, provider organizations receive a risk-adjusted

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prospective payment that covers all care received by its enrollees to create incentives for efficiency and integration in care delivery, coupled with bonuses that are based on meeting specified quality metrics designed to prevent stinting and to ensure the quality of care. A similar model authorized under the ACA is the Medicare Accountable Care Organization (ACO) demonstration program, through which provider organizations can share with the government financial risk for spending for a defined population of Medicare beneficiaries rather than accept full risk through a global budget like the AQC. Early results from both programs have suggested that there were no drastic cuts in the use of mental health services, as some observers had feared from the strong incentives to control costs inherent in risk-based payment; they also have suggested little initial progress on improving integration as hoped, although many provider organizations have reported that they now are engaged in various efforts to improve integration.[43,44] One barrier to early efforts to improve mental health integration and quality was the lack of metrics for evaluating the quality of mental health services that were viewed as meaningful and achievable with a reasonable level of effort. This lack of metrics in general has been a shortfall in the mental health field, which has lagged behind other clinical areas in the development of appropriate measurements of performance.

The ACA included other provisions aimed at encouraging integration besides the Medicare ACO program, such as funding for colocation grants to allow the integration of PCPs within community mental health centers. In addition, the ACA added new authority for states to experiment with a "health home" model to improve coordination of care for Medicaid beneficiaries with two or more chronic conditions, one chronic condition and an increase in the risk of a second condition, or a serious mental illness. The concept calls for Medicaid programs to develop improved care management and coordination across a variety of providers and agencies, with the federal government footing 90% of the bill for the first 2 years. Thus far, 20 states have won approval to test the model by focusing on different at-risk populations. For example, 3 states (Maryland, Rhode Island, and Vermont) are targeting persons with opioid-use disorders in their health-home programs. The Veterans Administration (VA) has developed its own variant of a health home by creating "patient-aligned care teams," in which mental health professionals are embedded within primary care teams. At some 300 VA medical centers and other venues, the number of mental health visits rose from 10.5 million in 2005 to 19.6 million in 2014 — a relative increase of 87%.[45]

Some observers have questioned whether carve-outs should still have a place in a care system that values close integration of the delivery of mental health services and general medical care.[46] In the mid-2000s, there was some movement away from carve-outs, with some of the largest insurers (e.g., UnitedHealthcare, Cigna, and Aetna) creating their own units to manage care provided by mental health specialists. However, member organizations of the Association for Behavioral Health and Wellness, the largest trade association for providers of managed behavioral health care, still manage benefits for almost 150 million Americans.[47] Some organizations are focusing on partnering with health plans to better integrate mental health care with general medical care.[40] Although carve-outs may complicate integration efforts, large integrated health systems have their own challenges with efforts to improve integration internally, given differing cultures for mental health specialists and other clinicians, provider shortages, restrictions on sharing patient-level information on the treatment of mental disorders, and limitations of their electronic health records.

PROPOSED LEGISLATIVE REMEDIES

One subject that has raised great concern among the public and sharpened political disagreements over mental health policy is the recent epidemic of mass shootings, in which some observers have suggested that mental illness may have led the perpetrators to commit these acts of violence. Although epidemiologic studies have shown that the risk of committing violent acts appears to be slightly higher for persons with a severe mental illness than for those in the general population, estimates suggest that approximately 4% of interpersonal violent acts can be attributed to severe mental illness.[48] Moreover, persons with such conditions are much more likely to be victims of violence or suicide than to commit violent acts toward others.[48] Nevertheless, the

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shootings have led some policymakers to reassess the current mental health system. After the 2012 shootings at the Sandy Hook Elementary School in Newtown, Connecticut, which took the lives of 20 children and 6 adults, Representative Timothy F. Murphy (R-PA), a child psychologist and chair of the House Energy and Commerce Subcommittee on Oversight and Investigations, conducted a review of federal mental health programs. In an opinion piece, Murphy wrote, "The investigation revealed that the approach by the federal government is a chaotic patchwork of antiquated programs and ineffective policies across a number of agencies."[49]

After the panel's review, Murphy introduced the Helping Families in Mental Health Crisis Act, which attracted 207 sponsors (including 60 Democrats) and the verbal support of House Speaker Paul Ryan (R-WI), who stated, "One common denominator in these tragedies is mental illness . . . That's why we need to look at fixing our nation's mental illness health system."[50] Murphy's bill would authorize grant programs to fund specialized training for law enforcement personnel and first responders on how to respond to mental health crises as well as treatment programs for individuals with severe mental illness (e.g., Assertive Community Treatment), require federal agencies to collaborate to improve MHPAEA compliance, and codify the recently released rule from the Centers for Medicare and Medicaid Services (CMS) that relaxes long-standing restrictions (known as the Institutions for Mental Disease exclusion) on payments by Medicaid managed care plans for short-term stays in psychiatric hospitals for adult Medicaid beneficiaries, among other provisions. On July 6, 2016, the House of Representatives passed a version of the bill by a vote of 422 to 2. In the Senate, Bill Cassidy (R-LA) and Chris Murphy (D-CT) have introduced the Mental Health Reform Act, which includes some of the features of the House bill but differs on a few key dimensions. However, time is rapidly running out on the 114th Congress, given its frequent breaks and early departure for 2016 election campaigning. Nevertheless, there is interest in the Senate to pass a mental health bill despite the obstacles that may lay in its path, thus giving President Obama an opportunity to sign a measure into law before he departs office.[50]

The dramatic increase in mortality and morbidity associated with addiction to opioids, including both heroin and prescription painkillers, has also captured the attention of policymakers. Between 2000 and 2014, the number of persons who died from a drug overdose involving an opioid analgesic quadrupled.[51] Heroin-related overdose deaths have more than tripled since 2010.[52] Several state governments have recently passed or have bills pending that address this crisis.[53] This issue also surfaced among both Republican and Democratic presidential hopefuls, with Jeb Bush, Hillary Clinton, Ted Cruz, and Carly Fiorina disclosing how the use of illicit drugs had touched them personally because a family member, friend, or professional colleague had succumbed to their use. New Jersey Governor Chris Christie told a small group of New Hampshire voters, "We need to start treating people . . . not jailing them."[54] On July 22, 2016, President Obama signed into law the Comprehensive Addiction and Recovery Act, a measure designed to address the opioid epidemic, although in a statement he expressed disappointment with Republicans for blocking efforts by Democrats to include $920 million in treatment funding. He added, "Every day, 78 Americans die from opioid overdoses," and more treatment facilities are needed.

CONCLUSIONS

Until recently, care for persons with mental disorders has been characterized by exceptionalism,[55] with separate coverage rules, separate financing streams, and separate delivery systems. The implementation of provisions in the MHPAEA and ACA has spurred tremendous progress toward addressing separate coverage rules and ensuring financial protection for persons with mental disorders, particularly those with severe conditions — patients who were a primary focus of policymakers and advocates who worked for decades to secure equal coverage. The ACA has also contributed to the growing momentum to bridge the historical separation of financing and delivery for mental health and other care. The integration of financing and delivery of mental health care and medical care brings its own set of risks, including increased concern about the possibility of stinting on mental health treatment. However, the coming together of payers, providers, and consumers in support of integra-

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tion has the potential to spur system-level change that could help to better meet all health care needs of persons with mental disorders.

As important as the MHPAEA and ACA have been to the mental health system, there is more work to be done, although making additional progress could be challenging in the current politically charged environment. The opioid crisis and recent episodes of gun violence have focused attention of both policymakers and the public on the mental health system and its shortcomings. No matter how the November election turns out, when the newly elected president takes office and the 115th Congress convenes in January 2017, leaders of both parties will have to decide whether they want to pursue compromises that allow continued progress on policies intended to improve the treatment of persons with these conditions.

Disclosure forms provided by the authors are available with the full text of this article at NEJM.org.

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