kaiser commission on KEY FACTS
medicaid and the uninsured
THE HENRY J. KAISER FAMILY FOUNDATION

November 2012

The Role of Medicaid for People with Behavioral Health Conditions

Introduction

Behavioral health conditions encompass a broad range of illnesses, such as anxiety disorders, mood disorders, impulse-control disorders, and substance use disorders (SUD), and affect a substantial share of the United States population. Nearly a third of adults met diagnostic criteria for a behavioral health problem in the past year, and over half meet criteria at some point in their lifetime.[1] Smaller shares are functionally impaired by their mental illness (about 9 percent) or have a serious (about 5 percent) or a severe and persistent mental illness (less than 3 percent).[2] Common treatments for behavioral health problems include psychosocial counseling and pharmacological services, and many individuals receive a combination of both types of therapy. People with serious mental illness often require additional non-medical services, such as income support, vocational training, or housing assistance, to help them manage day-to-day activities. However, many people who need behavioral health services do not receive any treatment: Over 60 percent of adults with a diagnosable disorder[3] do not receive mental health services, and nearly 90 percent of people with SUD do not receive specialty treatment for their problem.[4] Individuals with low incomes are more likely to have a behavioral health problem than those with higher incomes,[5] and surveys indicate that cost is a major barrier to receiving care.[6]

In 2005 (the most recent year for which estimates are available), a total of $135 billion was spent on behavioral health services in the United States.[7] The federal-state Medicaid program is the largest source of financing these services, covering over a quarter of all expenditures. Medicaid plays a large role in financing behavioral health care because its eligibility rules reach many individuals with significant need; it covers a broad range of benefits; and its financing structure allows states to expand services with federal financial assistance. Medicaid's behavioral health benefits are generally more comprehensive than those offered by other payers, and in some cases, Medicaid is the only insurer that covers a service needed by those with behavioral health problems. It also finances some services outside the traditional medical model, such as family support, transportation assistance, supportive services in the home, respite care, and ongoing case management.

Beginning in 2014, the Affordable Care Act (ACA) enables states to expand Medicaid eligibility to cover all individuals up to 138% of poverty, including adults without children, a group that has historically been ineligible for the program. Many newly eligible Medicaid enrollees were previously uninsured and may enter the program with undiagnosed or untreated behavioral health problems. This brief examines Medicaid's role in providing care for adults with mental illness and substance use disorder and the program's potential to expand access for these new beneficiaries. It compares low-income adults with Medicaid coverage to low-income adults who are uninsured with respect to prevalence of chronic mental illness/substance use disorder and, within the population with such illnesses, compares their health care spending, access to care, and utilization of services. [A more detailed description of the data and methods for the analysis in this brief is included in the Appendix at the end of the report.]

Findings

Prevalence and Health Status

Among low-income, nonelderly adults, Medicaid beneficiaries were much more likely than the uninsured to have a mental illness, with 35 percent and 13 percent of these groups, respectively, having a chronic mental illness (Table 1). The higher prevalence rate among Medicaid enrollees is likely a reflection of Medicaid eligibility rules that extend coverage to people in poor health, such as medically needy individuals and people with disabilities. Though lower, the prevalence rate among uninsured low-income adults indicates that a sizable share is living with chronic mental illness. The actual rate of disease among the uninsured may be even higher than these estimates, as uninsured adults are more likely than those with coverage to have undiagnosed chronic illness.[8]

Table 1: The Health Status of Medicaid and Uninsured Nonelderly Adults ≤138% FPL

	Medicaid		Uninsured	
Prevalence of Mental Illness	35%[a]		13%	
	With Mental Illness	**Without Mental Illness**	**With Mental Illness**	**Without Mental Illness**
Had Other Chronic Physical Condition	61%[ab]	33%[a]	39%	15%
Fair or Poor Health Status	56%[b]	26%[a]	48%	14%

[a] Statistically significant difference from Uninsured population, $p < .05$
[b] Statistically different from Medicaid population without mental health conditions, $p < .05$
SOURCE: KCMU analysis of 2009 Medicaid Expenditure Panel Survey data.

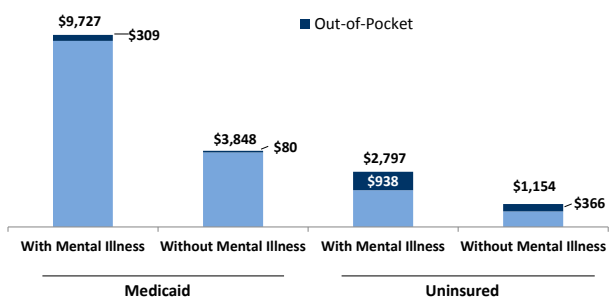
Comorbid chronic physical conditions among those with mental illness were also considerably more prevalent among Medicaid beneficiaries (61%) than among the uninsured (39%), an indication of the often complex health care needs of these Medicaid beneficiaries. Medicaid adults without mental illness were also more likely to have a chronic physical condition than the corresponding group of the uninsured (33% versus 15%). The shares of the two groups with mental health conditions rating their health as fair or poor were not significantly different, with around half of each group having this view of their health. However, among adults without mental health conditions, Medicaid beneficiaries were more likely (26%) than the uninsured (14%) to rate their health as fair or poor.

Spending

Among low-income adults with mental illness, average total annual per capita spending on all services was higher among Medicaid enrollees ($9,727) than among uninsured individuals ($2,797) (Figure 1). These figures include spending on all services and thus reflect both more intensive use of mental health services and higher need for other medical care. Average annual spending per capita was also significantly greater for Medicaid adults without mental illness ($3,848) than for uninsured adults who did not have a mental illness ($1,154).

Figure 1

Total Annual Per Capita Health Expenditures Among Low-Income Adults Ages 18-64, by Insurance and Mental Health Status, 2009



Notes: Differences within Medicaid population significant at the 0.01 level, two-tailed test.
Differences between Medicaid and uninsured significant at the 0.01 level, two-tailed test.
Source: KCMU analysis of the 2009 Medical Expenditure Panel Survey.

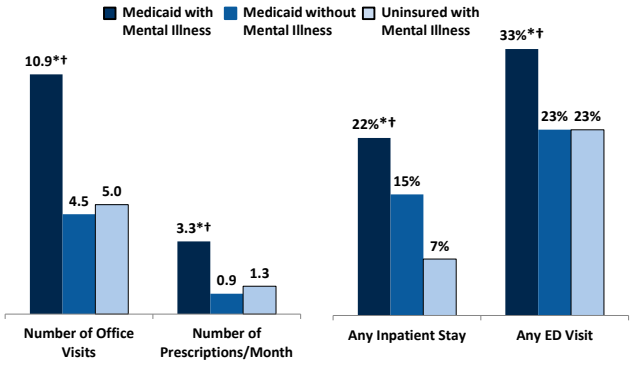
Despite overall higher spending, average out-of-pocket spending among low-income adults with mental illness was more than three times greater among uninsured adults ($938) than among Medicaid enrollees ($309) (Figure 1). This difference is a result of Medicaid rules that limit beneficiary cost-sharing to nominal amounts and is seen even among those without mental illness, where Medicaid beneficiaries still spent less than one-fourth the amount that the uninsured did ($80 on average versus $366). While uninsured individuals face high out-of-pocket costs for their care, charity care and uncompensated care funds, which make up the remainder of their spending, also account for a substantial share of their spending.

Utilization

The spending patterns above reflect differences in utilization by insurance coverage and health status. Among low-income adults with mental illness, Medicaid beneficiaries had significantly more provider visits (10.9 versus 5.0) and filled more prescriptions (3.3 per month versus 1.3 per month) than uninsured adults (Figure 2). Moreover, 22% of Medicaid beneficiaries had an inpatient stay in the previous year— roughly three times the share of the uninsured (7%). Adults covered by Medicaid were also more likely to visit the emergency department during the previous year, with 33% of Medicaid beneficiaries and 23% of the uninsured having had a visit. As with spending, utilization rates were higher among Medicaid beneficiaries with mental illness than beneficiaries without, reflecting the high needs of those with mental illnesses and comorbid conditions.

Figure 2

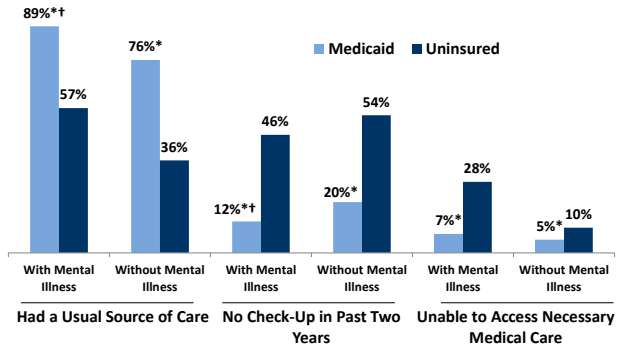
Service Utilization Among Medicaid and Uninsured Nonelderly Adults at or below 138% FPL, 2009



*Statistically different from Uninsured (p<0.05). †Statistically different from without mental illness (p<0.05)
SOURCE: Kaiser Family Foundation analysis of 2009 Medical Expenditure Panel Survey data.

Figure 3

Access to Care Among Medicaid and Uninsured Nonelderly Adults at or below 138% FPL, 2009



*Statistically different from Uninsured (p<0.05). †Statistically different from without mental illness (p<0.05)
SOURCE: Kaiser Family Foundation analysis of 2009 Medical Expenditure Panel Survey data.

Access

Despite their more complex health needs, Medicaid enrollees reported better access to care than their uninsured counterparts. Approximately nine in ten Medicaid beneficiaries with a mental illness reported that they had a usual source of care, versus six in ten uninsured low-income adults. A high share of uninsured adults (46% of those with mental illness and 54% of those without) reported that they had not had a check-up in the past two years, versus just 12 and 20 percent of Medicaid enrollees with and without a mental illness, respectively. Given the rates of comorbidity and recommended treatments for people with mental illness, the high shares of uninsured adults without a check-up may indicate large unmet need. When asked directly whether they were unable to get needed services, uninsured adults with mental illness were four times as likely as those in Medicaid (28% versus 7%) to report facing such a barrier.

Policy Implications

There is a high prevalence of mental illness among low-income adults covered by Medicaid, and most also have at least one additional chronic physical health condition. This prevalence is in part a result of Medicaid eligibility rules that explicitly extend coverage to people with substantial health needs. Reflecting these needs, Medicaid adults with mental illness have higher spending and utilization rates than enrollees without these illnesses. Despite their substantial need and complex health status, Medicaid enrollees with mental illness are not more likely to report a problem getting needed medical care than those without.

Medicaid adults with mental illness were more likely than low-income uninsured adults with these illnesses to have access to and utilize services; they also had lower out-of-pocket costs despite higher overall spending for their care. These findings indicate the important role Medicaid plays in supporting the health and well-being of these individuals by providing access to critical health care services with minimal financial burden.

Though low-income uninsured adults have a lower prevalence of mental illness and comorbidity than their Medicaid counterparts, there is still a substantial share of uninsured adults who live with these illnesses. Many of these individuals may become eligible for Medicaid in 2014 and are likely to present with substantial health needs. The analysis in this brief suggests that these individuals may see improved access to health care services and prescription drugs that may help them manage their illnesses, as well as reduced out-of-pocket costs.

The ACA also offers opportunities for states to improve the care that Medicaid beneficiaries receive. The relatively high number of ED visits and hospital stays, as well as provider office visits and prescriptions filled, among Medicaid adults with mental illness in this analysis indicates that there may be opportunities to better coordinate care or provide it more efficiently for beneficiaries with complex care needs. In addition, the high rate of physical health comorbidity among adults with mental illness presents opportunities for improved coordination of physical and mental health services. The Medicaid health homes option in the ACA presents an opportunity for states to coordinate care across providers to prevent duplicative or inappropriate care, especially for patients with multiple conditions and complex health needs. This option extends a 90% federal matching rate for state spending on health home services for eight quarters. Qualifying health home services include care coordination and management, referral to community and social supports, and transitional and follow-up care.

While the ACA provides a number of opportunities to improve care for more many uninsured adults with chronic illness, it will be critical for states to ensure adequate provider capacity in their Medicaid programs so that these new enrollees have adequate access to the primary, preventive, and specialized care necessary to adequately treat their conditions. If states can meet these challenges, the results of this analysis suggest that enrollment in Medicaid may provide timely access to important services that would enable newly eligible adults with mental illness to better manage their conditions.

Appendix

This analysis draws on data from the 2009 Medical Expenditure Panel Survey (MEPS) household component. The publicly-available MEPS-HC dataset is a nationally-representative survey of healthcare access, utilization, and expenditure among the United States civilian, non-institutionalized population. We restrict our analysis to low-income nonelderly adults who are either uninsured or covered by Medicaid for twelve consecutive months. We exclude those with coverage changes throughout the year to match the timing of insurance and access measures, which ask about all access and use over the past year. We define "low-income" as having family income at or below 138% of the federal poverty level. Medicaid beneficiaries with Medicare ("dual-eligibles") are excluded.

For this analysis, "mental illness" includes adjustment disorders, anxiety disorders, impulse-control disorders, mood disorders, personality disorders, psychotic disorders, substance use disorders, and other disorders. It excludes brain disorders including dementia and other cognitive disorders as well as developmental disorders. To identify individuals with mental illness and comorbidities, we use the MEPS Medical Conditions file, which is based on self-reports of whether a person had been told by a health care provider that he or she had any "priority" mental health condition,[9] self-reports of individuals taking a day or more of disability during the year for a condition and of a condition "bothering" a respondent, and ICD-9 codes, classified using Clinical Classification Codes, from the event files. We also use the HCUP Chronic Condition Indicator (CCI) to specify whether a condition was chronic; only chronic conditions are included in this analysis. Spending data include expenditures from all payers and on all health care services. All spending values are calculated as annual, per capita expenditures.

---

[1] Kessler RC and Wang PS. "The Descriptive Epidemiology of Commonly Occurring Mental Disorders in the United States." *Annual Review of Public Health.* 2008, 29:115-29.

[2] U.S. Department of Health and Human Services. *Mental Health: A Report of the Surgeon General—Executive Summary*. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health, 1999.

[3] Druss BG, Wang PS, Sampson NA, et al. "Understanding Mental Health Treatment in Persons without Mental Diagnoses." *Arch Gen Psychiatry.* 2007, 64(10):1196-1203.

[4] Levit, K.R. et al. "Future Funding for Mental Health and Substance Abuse: Increasing Burdens for the Public Sector." *Health Affairs.* Web Exclusive, 7 October 2008, w513-22.

[5] Frank RG and Glied SA. *Better But Not Well: Mental Health Policy in the United States Since 1950.* (Baltimore: Johns Hopkins University Press), 2006; Sareen J et al. 2011. Relationship between household income and mental disorders. Archives of General Psychiatry 68(4): 419-427.

[6] Substance Abuse and Mental Health Services Administration. (2008). *Results from the 2007 National Survey on Drug Use and Health: National Findings* (Office of Applied Studies, NSDUH Series H-34, DHHS Publication No. SMA 08-4343). Rockville, MD.

[7] Substance Abuse and Mental Health Services Administration. *National Expenditures for Mental Health Services and Substance Abuse Treatment, 1986-2005.* DHHS Publication No. (SMA) 10-4612. Rockville,MD: Center for Mental Health Services and Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration, 2010.

[8] Wilper AP, Woolhandler S, Lasser K, et al. A national study of chronic disease prevalence and access to care in uninsured U.S. adults. *Ann Intern Med.* 2008 August, 149(3):170-6.
[9] See MEPS documentation available at http://meps.ahrq.gov/mepsweb/data_stats/download_data/pufs/h128/h128doc.shtml#Appendix4 for a list of priority conditions.

This publication (#8383_BHC) is available on the Kaiser Family Foundation's website at www.kff.org.