ASPE ISSUE BRIEF

Benefits of Medicaid Expansion for Behavioral Health

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March 28, 2016

EXECUTIVE SUMMARY

Across the country, state and local officials are increasingly focused on improving health outcomes for people living with mental illness or substance use disorders. This brief analyzes national data on behavioral health and reviews published research focused on how Medicaid expansion under the Affordable Care Act advances the goal of improving treatment for people with behavioral health needs. The key findings are the following:

- Many of those who could benefit from Medicaid expansion have behavioral health needs. In 2014, an estimated 1.9 million low-income uninsured people with a substance use disorder or a mental illness lived in states that have not yet expanded Medicaid under the Affordable Care Act.[1] In addition, people with behavioral health needs make up a substantial share of all low-income uninsured individuals in these states: 28%. While some of these individuals had access to some source of health insurance in 2014, many will gain access to coverage only if their states expand Medicaid, and others would gain access to more affordable coverage.

- In states that have not yet expanded, Medicaid expansion would provide considerable benefits for individuals with behavioral health needs and their communities. Among low-income adults, Medicaid expansion is associated with a reduction in unmet need for mental health and substance use disorder treatment. For example, one study estimates

[1] Michigan, New Hampshire, Pennsylvania, Indiana, Alaska, and Montana expanded Medicaid during or after 2014; these states are not included in totals in this report. Louisiana has made the decision to expand but plans to implement expansion beginning July 1, 2016; it is included in these totals.

that low-income adults with serious mental illness are 30% more likely to receive treatment if they have Medicaid coverage. This will be especially important to states as they work to address opioid use disorder and serious mental illness.

- Access to appropriate treatment results in better health outcomes. For example, projections based on experimental research on the effects of Medicaid coverage expansions suggest that if the remaining states expanded Medicaid, there would be 371,000 fewer people experiencing symptoms of depression.

- States that choose to expand Medicaid may achieve significant improvement in their behavioral health programs without incurring new costs. State funds that currently directly support behavioral health care treatment for people who are uninsured but would gain coverage under expansion may become available for other behavioral health investments.

- Medicaid expansion also reduces costs that are incurred by state and local governments and state economies as a consequence of behavioral health problems. In addition to improving quality of life for individuals, treating behavioral health conditions has been shown to reduce rates of disability, increase employment productivity, and decrease criminal justice costs.

INTRODUCTION

There is a large literature on the benefits of Medicaid expansion under the Affordable Care Act for individuals and states. Drawing upon this literature, a June 2015 Council of Economic Advisers (CEA) report outlines a range of benefits from Medicaid expansion, including improved access to care and increased regular preventive care and screenings, resulting in better self-reported health and fewer deaths. Beyond the health benefits, those gaining coverage experience greater financial security, and state economies benefit from higher standards of living through the infusion of federal funds,[2] greater macroeconomic resilience, and healthier, more productive workers (Council of Economic Advisers, 2015).

This brief focuses on several major benefits of Medicaid expansion related to behavioral health. First, we examine how expansion improves states' ability to address unmet behavioral health needs, and the resulting benefits of expanded access to treatment for behavioral health conditions. Second, we also examine effects on state and local government budgets. Public expenditures for uninsured individuals with behavioral health conditions are significant because states have historically funded and operated public mental health and substance use disorder treatment systems and because the incidence of behavioral health conditions is generally higher in the uninsured population than in the general population. Medicaid expansion can free up state funds that currently directly support behavioral health treatment for people who are uninsured to meet a range of other behavioral health needs like prevention and early intervention programs.

[2] The Federal Financial Medical Assistance Percentage (FMAP) for the ACA Medicaid expansion is 100% in calendar years 2014-2016, 95% in 2017, 94% in 2018, 93% in 2019, and 90% in 2020 and beyond.

Finally, we survey evidence demonstrating that the social consequences of untreated behavioral health conditions frequently extend far beyond the affected individual to include the family, employer, and larger community, making the issue of behavioral health treatment and access a top priority for many states.

Behavioral Health Needs and Unmet Needs

In 2010-2014, among adults 18-64 living in the U.S., 37.6 million (19.5%) had a mental illness, and 19.2 million (9.9%) had a substance use disorder in the past year, according to analysis of data from the National Survey of Drug Use and Health for 2010 through 2014 by the Substance Abuse and Mental Health Administration (SAMHSA). This analysis pooled multiple survey years to provide a sample size large enough to permit state-level estimates.

Table 1 uses these data to estimate the prevalence of mental illnesses and substance use disorders among adults ages 18-64 during the 2010-2014 period. Among states that have not yet expanded Medicaid, 24.9% had either or both of these conditions. (This total is smaller than the sum of the shares of individuals with only one of these conditions, due to the high prevalence of co-occurring mental illness and substance use disorders (Mericle, Ta Park, Holck, & Arria, 2012; Nait, Fusar-Poli, & Brambilla, 2011)).

Table 1 also shows that non-elderly individuals without health insurance in Medicaid non-expansion states were somewhat more likely to have either a mental illness or substance use disorder, with about 28% of this group having such a disorder during the 2010-2014 period. Likewise, individuals with a mental or substance use disorder constitute 28% of all uninsured individuals age 18-64 with incomes below 138% of the Federal Poverty Level (FPL), the income limit for Medicaid coverage under expansion.[3]

As noted above, the estimates reported in Table 1 are based on data spanning the years 2010 through 2014 in order to ensure a sufficient sample size to support state-level estimates. Thus, most of the data underlying Table 1 are from before the Affordable Care Act's major coverage provisions took effect in 2014. While these states have not expanded Medicaid, individuals in these states with family income between 100 and 400% of the FPL are eligible for financial assistance to purchase coverage through the Health Insurance Marketplaces. Nevertheless, the data underlying Table 1 provide the best available guide to the characteristics of the uninsured population in these states. If anything, the percentages of people with a mental or substance use disorder reported in the last two columns of Table 1 are likely to be somewhat higher in updated data since the lowest-income individuals saw smaller coverage gains in these states and the data indicate that the prevalence of mental illness and substance use disorders is somewhat higher in lower-income uninsured populations.

In order to provide an accurate picture of the current number of uninsured individuals in these states with a substance use disorder or mental illness, we utilize the 2014 American Community Survey (ACS) that has more recent estimates of individuals that are uninsured by income

[3] Note that not all individuals who are eligible to enroll actually do so, and some of those that meet the income requirements may not be eligible to enroll, for example, due to immigration status.

category. We combine the data in Table 1 from the 2010-2014 pooled NSDUH data which provides us with the percentage of the population with a mental or substance use disorder in the income and insurance category with data from the 2014 American Community Survey (ACS) on each state's non-elderly population, number of non-elderly uninsured, and number of non-elderly uninsured with incomes below 138% of the FPL. Multiplying these estimates from the ACS by the appropriate percentages in Table 1 leads to the estimates reported in Table 2.

Table 1. Share of adults in non-expansion states aged 18-64 who had any mental illness (AMI) or substance use disorder (SUD) in the past year, 2010-2014

States	Share with AMI and SUD		
	Full Population	**Uninsured Population**	**Uninsured Population with Income Below 138% FPL**
Alabama	25.7	34.0	30.3
Florida	23.7	25.8	27.7
Georgia	23.3	25.1	25.0
Idaho	31.1	36.6	39.0
Kansas	25.5	30.3	31.3
Louisiana**	25.2	28.8	29.5
Maine	26.8	30.1	*
Mississippi	26	30.9	33.8
Missouri	26.6	31.2	34.2
Nebraska	26.2	30.3	31.3
North Carolina	22.6	22.3	26.7
Oklahoma	28.9	29.0	33.2
South Carolina	25.7	30.4	32.4
South Dakota	25.5	28.3	*
Tennessee	28	38.8	35.8
Texas	23.4	24.9	23.2
Utah	28	33.6	40.0
Virginia	25.8	31.9	34.8
Wisconsin	26.1	32.4	*
Wyoming	27.3	33.2	30.2
Total	**24.9**	**27.8**	**28.4**

Source: SAMHSA analysis of 2010-2014 National Survey on Drug Use and Health
Notes: These estimates do not include the institutional population (e.g., hospitals and prisons), and may therefore be low.
* Value suppressed due to low precision.
** Louisiana plans to expand its Medicaid program starting July 1, 2016.

As Table 2 shows, in 2014, an estimated 1.9 million uninsured people with a mental illness or substance use disorder lived in states that have not yet expanded Medicaid under the Affordable Care Act and had incomes below 138% of the FPL, the income limit for Medicaid coverage under expansion. Some in this group had incomes between 100 and 138% of the federal poverty level, meaning they had the option to pay premiums to purchase coverage through the Marketplace. In addition, some very low-income parents may have had access to Medicaid coverage. Other than Wisconsin, no non-expansion state covers childless adults, and the median

parent eligibility limit is about 40% of the federal poverty level.[4] But many in this group fall into the "coverage gap" and would gain access to health insurance only if their states expanded Medicaid, and others would gain access to more affordable coverage.

Table 2. Estimated number of adults in non-expansion states aged 18-64 who had any mental illness (AMI) or substance use disorder (SUD) in the past year, 2014

States	Full Population	Uninsured Population	Uninsured Population with Income Below 138% FPL
Alabama	754,000	181,000	85,000
Florida	2,800,000	726,000	309,000
Georgia	1,445,000	343,000	159,000
Idaho	296,000	67,000	30,000
Kansas	440,000	76,000	34,000
Louisiana**	712,000	176,000	81,000
Maine	221,000	35,000	*
Mississippi	463,000	118,000	61,000
Missouri	976,000	184,000	91,000
Nebraska	295,000	47,000	21,000
North Carolina	1,366,000	256,000	144,000
Oklahoma	666,000	145,000	71,000
South Carolina	748,000	176,000	87,000
South Dakota	128,000	20,000	*
Tennessee	1,120,000	270,000	114,000
Texas	3,830,000	1,047,000	406,000
Utah	482,000	94,000	42,000
Virginia	1,323,000	244,000	102,000
Wisconsin	924,000	116,000	*
Wyoming	98,000	20,000	6,000
Total	**19,107,000**	**4,352,000**	**1,908,000**

Source: SAMHSA analysis of 2010-2014 National Survey on Drug Use and Health; 2014 American Community Survey; ASPE calculations.
Notes: These estimates do not include the institutional population (e.g., hospitals and prisons), and may therefore be low.
* Value suppressed due to low precision.
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Medicaid Expansion and Access to Behavioral Health Care

Untreated behavioral health conditions have serious effects on individuals' lives and on health care spending. For example, co-occurring psychiatric conditions and chronic medical conditions are associated with significantly more expensive care due in large part to poor self-care and more acute episodes of needed healthcare (Blount, et al., 2007). These circumstances are in part reflected by the fact that people with serious mental illness have an average life expectancy that is shorter than for those without these conditions (Druss, Zhao, Von Esenwein, Morrato, & Marcus, 2011).

[4] For details on state eligibility levels, see Kaiser Family Foundation, "Where Are States Today? Medicaid and CHIP Eligibility Levels for Adults, Children, and Pregnant Women," March 2, 2016, http://kff.org/medicaid/fact-sheet/where-are-states-today-medicaid-and-chip/.

Research has consistently found that there are substantial delays from the time that a first episode of serious mental illness occurs and when people receive treatment for this condition (Mueser, et al., 2015). In the case of schizophrenia, this delay can worsen outcomes, while early comprehensive treatment can improve prognosis and is cost-effective (Rosenheck, et al., 2016). In 2014, among the 43.6 million adults with a mental illness, 55% did not receive mental health services in the past year; 31.5% of the 9.8 million adults with serious mental illness did not receive mental health services; and among the 21.5 million individuals who met criteria for a substance use disorder, only 11% received treatment (NSDUH, 2014).[5]

Table 3. Adults in non-expansion states aged 18-64 who received any treatment for mental illness or substance use disorder (excluding self-help groups) in the past year by uninsured, 2010-2014

States	Percentage of Insured Population Receiving Treatment for Mental Illness or Substance Use Disorder	Percentage of Uninsured Population Receiving Treatment for Mental Illness or Substance Use Disorder
Alabama	15.5	13.6
Florida	14.9	8.8
Georgia	15.8	9.5
Idaho	18.2	17.4
Kansas	17.0	13.6
Louisiana*	14.1	10.1
Maine	24.2	13.6
Mississippi	15.5	11.2
Missouri	18.5	15.8
Nebraska	17.1	14.1
North Carolina	18.5	13.0
Oklahoma	17.1	14.7
South Carolina	16.9	11.7
South Dakota	16.9	15.1
Tennessee	18.6	16.9
Texas	14.0	9.4
Utah	20.1	16.1
Virginia	17.9	15.6
Wisconsin	17.5	18.8
Wyoming	17.6	16.0
Total	**16.4**	**11.5**

Source: SAMHSA analysis of 2010-2014 National Survey on Drug Use and Health.
* Louisiana plans to expand its Medicaid program starting July 1, 2016.

Unsurprisingly, the uninsured also had lower treatment rates than the insured.[6] While 16.4% of individuals 18-64 that were insured in non-expansion states received treatment for mental illness or a substance use disorder,[7] among the uninsured in this age category, only 11.5% received treatment (see Table 3). This is despite the fact that the uninsured had higher rates of substance use disorder and mental illness. Lack of affordability was the most prevalent reason that

[5] This includes individuals 65 and older.
[6] As defined by having received treatment in the last 12 months.
[7] This excludes self-help groups.

individuals who are uninsured cited for not accessing treatment among those that thought they needed treatment in the last year and did not get it (over half, compared to 32% of the insured).[8]

Medicaid expansion can improve access to treatment for people with behavioral health needs. Among low-income adults, Medicaid expansion is associated with a reduction in the unmet need for mental health and substance use disorder treatment (Wen, Druss, & Cummings, 2015). Adjusting for differences in state programs, researchers found that among low income individuals with a serious mental illness, the likelihood of mental health treatment was 30% greater for individuals enrolled in Medicaid (Han, Gfroerer, Kuramoto, Ali, Woodward, & Teich, 2015). This finding is consistent with historical research, indicating that the utilization of mental health services is responsive to prices which are generally lower with insurance (Meyerhoefer & Zuvekas, 2010), and those with coverage through Medicaid are far more likely to get treatment.

Table 4. Projected effects on health outcomes if state expands Medicaid

State	Reduction in Number of People Experiencing Symptoms of Depression	Additional People Reporting Good, Very Good, or Excellent Health
Alabama	16,000	24,000
Florida	69,000	100,000
Georgia	36,000	52,000
Idaho	5,000	8,000
Kansas	7,000	10,000
Louisiana*	18,000	26,000
Maine	4,000	5,000
Mississippi	13,000	18,000
Missouri	17,000	25,000
Nebraska	4,000	6,000
North Carolina	29,000	42,000
Oklahoma	12,000	17,000
South Carolina	15,000	21,000
South Dakota	2,000	3,000
Tennessee	16,000	24,000
Texas	101,000	147,000
Utah	6,000	9,000
Virginia	16,000	24,000
Wisconsin	2,000	3,000
Wyoming	1,000	2,000
Total	**371,000**	**540,000**

Source: Council of Economic Advisers, 2015
* Louisiana plans to expand its Medicaid program starting July 1, 2016.

Depression is the most common psychiatric condition in the United States, affecting approximately 7% of the adult population at any time (Bishop, Ramsay, Casalino, Bao, Pincus, & Shortell, 2016). Access to Medicaid can increase the number of people who enter treatment for depression so that they and their families can experience a better quality of life. In addition to

[8] SAMHSA analysis of 2014 National Survey of Drug Use and Health. This included responses of couldn't afford cost, insurance didn't cover or not enough health insurance coverage.

the increased probability of individuals receiving treatment post-Medicaid expansion (Wen, Druss, & Cummings, 2015), Medicaid coverage has been found to reduce the probability of positive screening for depression in a randomized experiment of expanded Medicaid coverage in Oregon (Baicker, et al., 2013). This decreased probability is likely in part due to increased access to treatment, but may also reflect the increased financial security provided by Medicaid coverage. Using results from the Oregon experiment, a 2015 analysis by the Council of Economic Advisers projected that if the states that have not expanded Medicaid in 2015 had done so, there would be fewer people experiencing symptoms of depression. Table 4 below lists the Council of Economic Advisers estimates for the states that have still have not expanded Medicaid as of March 2016.[9]

After interviewing officials from six expansion states, the Government Accountability Office (GAO) found that Medicaid expansion had resulted in greater availability of behavioral health treatment. State officials noted that formerly uninsured individuals now had more options for care. For example, in Kentucky individuals were no longer limited to state-funded community mental health centers. Officials in Nevada noted that there were fewer delays in receiving care, and officials in West Virginia reported an increased availability of prescription drugs for individuals with behavioral health conditions (GAO, 2015).

One recent study focused on the relationship between a state's Medicaid expansion status and the growth in supply of physicians waivered to prescribe buprenorphine for opioid dependence from 2013-2015. The study found that states that had expanded their Medicaid programs and had state-based exchanges had higher growth in the supply of buprenorphine –waivered physicians than states that had not expanded their programs (Knudsen, Lofwall, Havens, & Walsh, 2015). This finding may bode well for the impact of Medicaid expansion on meeting the treatment needs of those with opioid use disorder.

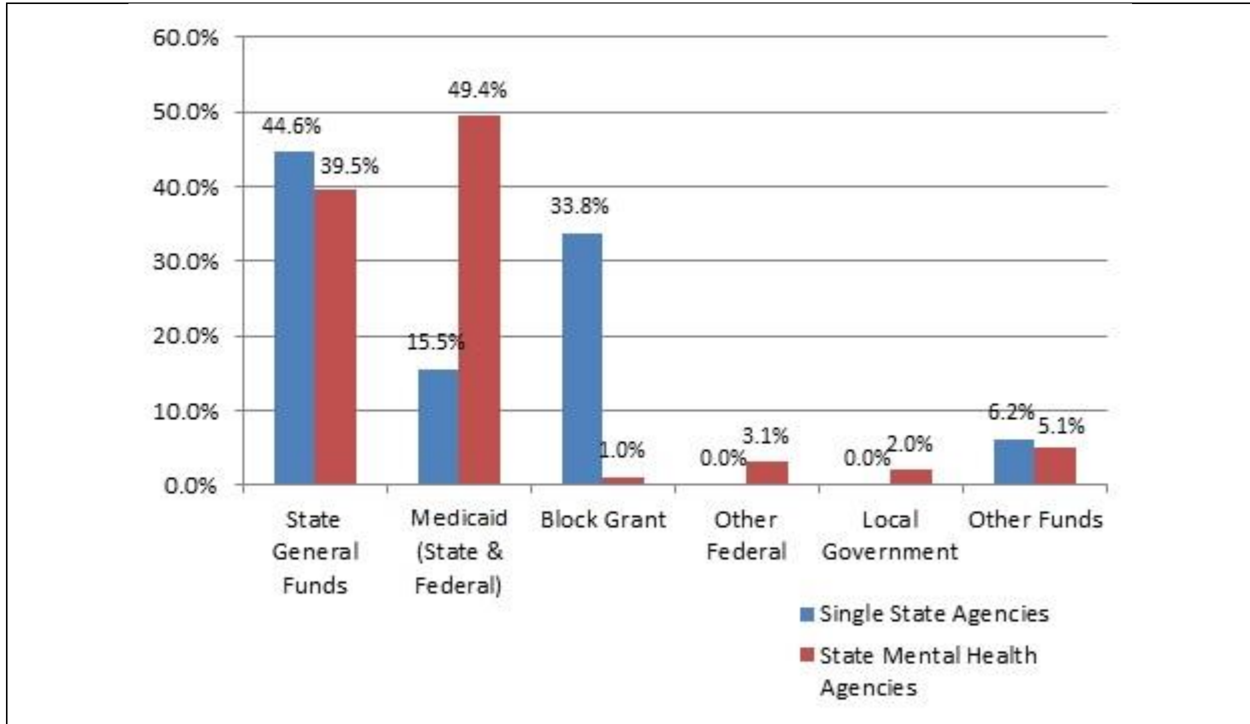
Behavioral Health and State Budgets

States spent more than $44.2 billion providing mental health and substance use disorder services in 2012.[10] State government general revenues were the largest source of funding for agencies that addressed substance use disorders, and, after Medicaid, they were the second largest funder of mental health services. Other sources of funds for treatment include SAMHSA block grants and local government funding (SAMHSA, 2015, see Figure 1, which shows funding sources for mental health agencies and single state agencies separately).

[9] Louisiana will expand Medicaid starting in July 2016.

[10] This amount represents the funding for single state agencies (SSAs) and state mental health agencies (SMHAs) which are the state government organizations responsible for planning, organizing, delivering, as well as monitoring mental health and substance use disorder services in each state.

Figure 1. Funding sources for state mental health agencies and single state agencies, FY 2012



Source: SAMHSA, 2015.

The Affordable Care Act (ACA) and the Mental Health Parity and Addiction Equity Act (MHPAEA) have already increased coverage of behavioral health conditions (Ali M. , Teich, Woodward, & Han, 2014). These changes are likely to lessen the number of individuals that require state and charitable support in order to receive treatment (Dorn & Francis, 2015). The ACA and the MHPAEA, which were enacted in 2010 and 2008 respectively, expand the financing, insurance eligibility and service coverage for mental health and substance abuse services (Beronio, Po, Skopec, & Glied, 2013). The coverage provisions from the ACA and MHPAEA took effect largely in 2014 and 2011 respectively. Mental health parity requirements in Medicaid managed care programs also expanded coverage of services in many states. For example, while Medicaid covered rehabilitative services that typically included substance use disorder treatment, in some states, prior to 2014, this coverage did not typically include more extensive benefits such as intensive day treatment, residential treatment or inpatient detoxification.

Beyond expanded coverage to individuals with behavioral health conditions, there were positive impacts on the budgets of states that expanded Medicaid as states no longer needed to use some of their general funds to pay for behavioral health treatment for the uninsured. While state behavioral health budgets saw state funding cuts during the recession, those that expanded Medicaid were able to find savings to restore former budget cuts, or increase general fund saving. Connecticut, Nevada and Washington State reduced their state general funds required for behavioral health (Dorn & Francis, 2015; GAO, 2015). Several states that expanded Medicaid reported that they expected reductions in general funds needing to be allocated to the

uninsured for treatment ranging from $7 million to $190 million in 2015 (Bachrach, Boozang, & Glanz, 2015).[11,12] States that choose to expand Medicaid may achieve significant improvement in their behavioral health programs without incurring new costs. State funds that currently provide direct support for behavioral health treatment of people that are uninsured would become available to meet other needs, including those in the behavioral health area if states were to expand Medicaid and cover this segment of the uninsured population. Key behavioral health investments may include prevention and early intervention programs for mental and substance use disorders.

The effects that Medicaid expansion would have on state budgets are likely to vary. States provide different levels of funding and services for behavioral health conditions. Some states that have not expanded Medicaid have Medicaid waivers in place that may meet some of the uninsured low-income population's needs (GAO, 2015). There is also great variability in the amount of services that are currently provided that would not be covered by Medicaid. Depending on current programming, Medicaid expansion may allow some states to enhance the continuum of care for behavioral health, including expanding recovery, peer and employment supports. States may face restrictions in redirecting funding, and reprogramming within behavioral health may be a requirement in some instances, due to federal or state requirements. For example, maintenance of effort requirements, which are part of SAMHSA's block grants, require states to maintain behavioral health funding at the level of the two year period prior to receipt of the grant.

In addition to impacts on state budgets, increased budget flexibility could also come from redirected Substance Abuse Prevention and Treatment Block Grants (SABG) and Mental Health Block Grant (MHBG) funding that formerly went to treating the uninsured. These funds could now go towards meeting a multitude of other needs, including workforce development, screening, prevention programs and provision of a continuum of care, not all of which is covered by Medicaid. Some block grant funding will remain as a safety net for individuals who continue to be uninsured (for example, enrollment in Medicaid is likely to remain low for some hard-to-reach individuals, see Woodward, 2016). Nonetheless, Medicaid expansion may free up other funding streams to provide more prevention and early intervention services, and "wraparound" services that are often not covered by Medicaid (Cannon, Burton, & Musumeci, 2015).

OTHER BENEFITS

Beyond the direct impacts on behavioral health treatment and spending, there is a great deal of evidence examining the intersection between behavioral health and other issues that may be of significance to states.

[11] The estimates reported are for the states of Washington and Michigan respectively.
[12] Researchers interviewed officials from eight states – Arkansas, Colorado, Kentucky, Michigan, New Mexico, Oregon, Washington and West Virginia. Of these states, only Arkansas, Kentucky, Michigan, and Washington broke out behavioral health spending. We also include New Mexico's reported savings included in their state budget and reported in Cross-Call, 2015.

Other Medical Costs

Medicaid expansion provides the opportunity to address the complicated physical and behavioral health needs of those it covers. Behavioral health conditions are costly to treat and are also associated with other medical costs. More than 68% of adults with mental illness are reported to have at least one general medical disorder, which is a substantially higher rate than for individuals without mental illness (Druss & Reisinger Walker, 2011). Improved access to care would improve the health and well-being of this population and in some cases produce savings. For example, for individuals with depression and diabetes, researchers found that improved treatment of depression not only led treated individuals to fewer days with depression, but also resulted in lower overall outpatient medical costs (Simon, et al., 2007).

Employment Productivity

Approximately 85% of uninsured families have one or more employed family members, with 73% having at least one full-time worker (The Kaiser Commission on Medicaid and the Uninsured, 2015). Behavioral health disorders affect the productivity of workers and have an impact on employer costs. Workers are more productive when they receive needed behavioral health treatment. Depression, which is one of the most prevalent mental health conditions, is associated with up to three times more short-term disability days for depressed workers compared to other employees (Kessler, et al., 1999). Indeed, average sick days from depression exceed the number of sick days due to hypertension, back problems, diabetes or heart disease (Druss, Rosenheck, & Sledge, 2000).

Treatment can improve worker productivity. Research studies have found reductions in the number of workers with substance use disorders who missed work, were late for work, were less productive than usual or had a conflict with management or a coworker after employees accessed specialized treatment (Jordan, Grisson, Alonzo, Dietzen, & Sangsland, 2008). Substance use disorder treatment was associated with $5,366 annually in employer savings from reduced absenteeism alone.[13] The overall economic benefit, including reduced absenteeism, improved productivity and reduced conflict, was $8,205 annually per worker with substance use disorder.[14]

Homelessness

Medicaid expansion offers states the opportunity to cover a significant proportion of individuals experiencing homelessness, many of whom have significant behavioral health conditions. Reducing homelessness improves community stability and reduces state costs across multiple service systems. Research indicates that individuals experiencing homelessness who frequently use emergency departments are more likely to be diagnosed with either mental illness or substance use disorder (Ku, Scott, Kertesz, & Pitts, 2010). Even in states that have expanded coverage, individuals experiencing homelessness are more likely to continue to have frequent emergency department visits, with homeless individuals with co-occurring mental illness and substance use disorders at greatest risk for hospitalization (Lin, Bharel, Zhang, O'Conneel, &

[13] Based on an average salary of $45,000 per year.
[14] Assuming a 50% fringe benefit rate on the $45,000 salary.

Clark, 2015). Much research has focused on the effectiveness of "supportive housing" which pairs affordable housing with health, behavioral health and supportive services for individuals who are experiencing homelessness. Supportive housing has been shown to be effective at maintaining housing stability. While Medicaid does not cover the housing costs, the health care, behavioral health care and supportive services can be covered through a state Medicaid program.[15] Supportive housing as an intervention has been shown to significantly reduce health care expenditures (Wright, Vartanian, Li, Royal, & Matson, 2016).

Criminal Justice Costs

An indirect effect of improved access to behavioral health treatment through Medicaid expansion may be reductions in criminal justice costs and increased provision of behavioral health treatment in behavioral health specialty settings that are best able to provide these services. An estimated 56% of state prisoners, 45% of federal prisoners, and 64% of jail inmates are affected by a mental health problem (US Department of Justice, Office of Justice Programs, 2006). On a typical day, over one million people with mental illness are in jail, in prison, on probation or parole (Odgers, et al., 2009). Additionally, 68% of inmates in jails and 50% of inmates in state prisons have diagnosable substance use disorders (Prins, 2014).

Medicaid expansion presents an opportunity to cover formerly incarcerated individuals, many of whom would meet the eligibility requirements. Facilitated enrollment in Medicaid (such as starting an application while in prison) and support for services following incarceration can make a significant difference in the health of this population, by improving individuals' ability to obtain health services that promote their well-being. Enrollment in Medicaid can also reduce recidivism among former inmates (Morrissey, Cuddeback, Cuellar, & Steadman, 2007).

There is evidence that state and local spending is reduced when Medicaid coverage is offered to the criminal justice population. After Washington State expanded state funding for substance abuse treatment to low-income individuals frequently involved with the criminal justice system, arrests declined by 17%, 18% and 33% for three different study groups, and resulted in almost $3 savings from criminal justice costs for every $1 invested in treatment. At the same time, medical expenditures went down (Mancuso & Felver, 2009). Specifically, this reduction in arrests saved local law enforcement, jails, courts, state corrections agencies, and crime victims $9,000 to $18,000 for each person treated, for a total of $275 million (Guyer, Bachrach, & Shine, 2015). In addition, when inpatient care is provided outside prison settings, states can claim federal matching funds for care provided in community mental health institutions. Six states that have implemented Medicaid expansion or are planning for an expansion, have estimated annual savings from using Medicaid to cover inmates' inpatient care ranging from $2.1 million to $19.2 million (Guyer, Bachrach, & Shine, 2015).

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[15] See CMS Information Bulletin, June 26, 2015 "Coverage of Housing-Related Activities and Services for Individuals with Disabilities." https://www.medicaid.gov/federal-policy-guidance/downloads/CIB-06-26-2015.pdf.

CONCLUSION

Medicaid expansion under the Affordable Care Act can greatly improve the quality of life for state residents by improving access to treatment for behavioral health needs. Formerly uninsured individuals below 138% of the federal poverty level will generally be eligible for Medicaid coverage if states choose to expand. Among this population, there is great need for treatment, as approximately 30% have either a mental illness, substance use disorder or both. Not only will more of these individuals be likely to receive treatment, but this coverage expansion may reduce other medical costs, increase employment productivity and lower overall rates of depression. In some instances, individuals will be able to receive Medicaid covered treatment in place of state general revenue-funded treatment, possibly allowing for improvements in behavioral health programs at no new additional cost to the state. An influx of new funds may allow for screening and prevention programs that may better meet the behavioral health needs of state populations and further improve behavioral health programs. There is also compelling evidence of numerous other benefits associated with treatment of behavioral health disorders, such as reduced criminal justice costs.

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This Issue Brief, authored by Judith Dey, Emily Rosenoff and Kristina West (ASPE) and Mir M. Ali, Sean Lynch, Chandler McClellan, Ryan Mutter, Lisa Patton, Judith Teich and Albert Woodward (SAMHSA), presents information about the potential benefits of expanding Medicaid in the area of behavioral health. For additional information about this subject, visit the DALTCP home page at https://aspe.hhs.gov/office-disability-aging-and-long-term-care-policy-daltcp or contact the authors at HHS/ASPE/DALTCP, Room 424E, H.H. Humphrey Building, 200 Independence Avenue, S.W., Washington, D.C. 20201 (Judith.Dey@hhs.gov or Emily.Rosenoff@hhs.gov).