Efforts at Mental Healthcare and Substance Abuse Treatment Reform

Megan Honingford*

I. INTRODUCTION

Often lost in the healthcare debate is the treatment and long-term care of mentally ill individuals or individuals with substance abuse. As general healthcare reform has been proposed and typically defeated and forgotten, mental healthcare reform has been tied to its fate. Given the impacts of mental illness on physical health, work productivity, public safety, and quality of life, mental healthcare deserves to be seen as an integral part of our overall health and a necessary part of our healthcare considerations. Mental illness can often be chronic and treatment can be costly, so universal coverage is imperative in the mission to provide care for all those who need it. Previous administrations and legislatures have made various efforts to reform healthcare, as well as mental healthcare, with varying success and failure. The Patient Protection and Affordable Care Act (the PPACA)\textsuperscript{1} offers the most significant reform since the creation of Medicare. However, while the PPACA largely provides for mental healthcare under the same provisions as traditional healthcare, there are still practical barriers to access that must be overcome. But like traditional healthcare, there are paths available for moving toward universal coverage of mental healthcare.

* Juris Doctor Candidate, Loyola University Chicago School of Law, Class of 2014. Ms. Honingford is a staff member of Annals of Health Law.

II. IMPORTANCE OF MENTAL HEALTH

Although at times mental illness seems invisible or disconnected from most people’s realities, it touches a great portion of society. A 2005 study found that more than one in four Americans will experience a mental disorder in a given year. In addition, while the correlation is not defined, it is clear that one’s mental health often affects his physical state. Mental illness has a high comorbidity with physical illnesses and greater mortality rates. In a study of 600 patients admitted to Ohio public mental health hospitals who had died in a year, the mean age at death was just 47.7 years, and the leading cause of death was heart disease. Those suffering from bipolar disorder and schizophrenia are also at a higher risk for cancer. In addition to physical ailments, those suffering from mental illness are at a much higher risk of injury than the general population. These higher risks and comorbidities translate into more care and a larger burden on our hospitals, emergency rooms, and insurance systems. As such, mental healthcare should be considered an integral part of our overall healthcare system.

In a given year, 26.2% of American adults will suffer from a diagnosable mental illness. While not all of these disorders are severe, the loss in

5. Id.
6. WORLD FED’N FOR MENTAL HEALTH, supra note 3.
7. Emma E. McGinty et al., Injury Risk and Severity in a Sample of Maryland Residents with Serious Mental Illness, INJURY PREVENTION (June 2, 2012).
productivity that even mild cases cause is reason enough to consider mental healthcare an essential part of our healthcare system. While mental healthcare has been a consideration in almost all the efforts to reform healthcare in the 20th century, it must be made a priority in the goal of universal coverage.

III. EFFORTS TO REFORM HEALTHCARE AND EXPAND ACCESS

The push for universal healthcare coverage began with Teddy Roosevelt, who campaigned for workers’ health insurance in 1912. Three years later, Progressive party reformers campaigned for mandatory health insurance in the form of a state-based plan. Even as far back as both of these unsuccessful attempts at reform, people generally supported the idea of universal coverage, but did not support any proposed plan for how to achieve it, a conundrum still seen in public polling today. The next major push for healthcare reform took place under Franklin Roosevelt’s administration in the midst of the Depression when sickness first became a leading cause of poverty. Though Social Security and unemployment insurance were passed into law, universal healthcare was not. After the Depression, efforts under Truman’s administration diverged from state-based plans towards national plans, but Congress failed to implement these

10. Debbie Lim et al., Lost Productivity Among Full-Time Workers with Mental Disorders, J. OF MENTAL HEALTH POL‘Y. AND ECON, 139, 145 (2000).
12. Id.
13. Id.
16. Id.
as well.\textsuperscript{17}

Alongside the early 20th century efforts at universal healthcare, the field of mental health made significant strides in treatment, understanding of disorders, patient rights, and technology.\textsuperscript{18} Social reformers fought for better conditions in mental institutions, and more extreme practices, like lobotomies, were phased out.\textsuperscript{19} Until the 1960s, virtually all mental healthcare was provided by either private hospitals, which were paid for with private insurance or cash, or by state-run and state-funded inpatient institutions.\textsuperscript{20} The 1946 National Mental Health Act provided some federal money for the states to implement their mental healthcare systems, but these hospitals were still largely state-funded.\textsuperscript{21}

As the post-war economy boomed, employer health benefits were deemed non-taxable, and more and more people began to be covered by group health plans offered by their employers.\textsuperscript{22} The push for national healthcare lost steam and reform efforts focused mainly on providing coverage for the elderly and poor.\textsuperscript{23} President Kennedy’s efforts to provide coverage for seniors\textsuperscript{24} were realized under Johnson’s administration with the passing of Medicare for the elderly, along with Medicaid for the poor.\textsuperscript{25}

Meanwhile, the Eisenhower-commissioned Joint Commission on Mental

\begin{enumerate}
\item \textsuperscript{17} Id. at 3.
\item \textsuperscript{18} See generally Allison M. Foerschner, \textit{The History of Mental Illness: From “Skull Drills” to “Happy Pills,”} \textsc{Student Pulse} 3 (2010), http://www.studentpulse.com/articles/283/the-history-of-mental-illness-from-skull-drills-to-happy-pills (last visited October 29, 2012).
\item \textsuperscript{19} Id.
\item \textsuperscript{20} Milton F. Shore, \textit{Community Mental Health: Corpse or Phoenix? Personal Reflections on an Era}, 23 \textsc{Prof. Psychol. - Res. & Prac.} 257, 257 (2006).
\item \textsuperscript{22} Hoffman, \textit{supra} note 11, at 3.
\item \textsuperscript{23} Id. at 3.
\item \textsuperscript{24} Id. at 5.
\item \textsuperscript{25} Id. at 4.
\end{enumerate}
Health submitted its final report in 1961.\(^{26}\) The report made two major recommendations: that care for the severely mentally ill should become the major priority in mental healthcare and that community mental healthcare centers should be established.\(^{27}\) Federal efforts focused on the latter, which led to the Community Mental Health Act, providing federal money to the states with mandates to create community-based treatment centers, an action that has been largely credited with the widespread deinstitutionalization of the mentally ill.\(^{28}\) While the Community Mental Health Act was aimed at moving the country towards a national mental healthcare system, it inadvertently led to cuts in state mental healthcare budgets\(^{29}\) and the demise of inpatient treatment in favor of community-based outpatient services that were not yet fully established or funded. In 1968, the Act was amended to mandate treatment of substance abuse at community centers.\(^{30}\)

Healthcare reform efforts continued, and under President Nixon, legislators generated broad support for reform and Congress came closer than it ever had to passing universal healthcare coverage, but competing proposals, political interference, and the Watergate scandal slowed the process to an eventual halt.\(^{31}\) President Carter proposed a plan that would allow for private insurance through employers, expand coverage of the aged and poor, and create a public corporation that would provide for everyone else, but this failed in the face of recession.\(^{32}\)

The mental healthcare system created under the Community Mental

\(^{26}\) Shore, \textit{supra} note 20, at 258.
\(^{27}\) SMUCKER, \textit{supra} note 21, at 7.
\(^{28}\) Shore, \textit{supra} note 20, at 259.
\(^{29}\) SMUCKER, \textit{supra} note 21, at 9.
\(^{30}\) \textit{Id.} at 17
\(^{31}\) Hoffman, \textit{supra} note 11, at 5-6.
\(^{32}\) \textit{Id.} at 6.
Health Act remained largely in place until President Reagan’s Omnibus Budget Reconciliation Act converted funding for mental health services into block grants to states and essentially ended any further federal involvement in the system.\textsuperscript{33} Reagan did attempt to normalize drug-free workplaces and employer-based support for addiction by issuing an executive order to implement Employee Assistance Programs for rehabilitation of any federal employee found to be using illegal drugs.\textsuperscript{34}

Later, President George H.W. Bush fielded several proposals for reform and he himself supported tax credits and purchasing pools.\textsuperscript{35} The Clinton administration made the biggest push for reform to that point and succeeded in expanding Medicaid coverage for children but not in achieving significant reform.\textsuperscript{36}

From the time of Reagan’s changes through the 1990s, private mental health insurance was largely unregulated and mental health coverage was generally not as comprehensive as traditional healthcare coverage.\textsuperscript{37} Mental health plans typical included an arbitrary lifetime limit on care.\textsuperscript{38} Lifetime limits on mental healthcare were required to be equitable with those on medical treatment by the Mental Healthcare Parity Act of 1996.\textsuperscript{39} Further integration of the two, and inclusion of addiction care, was achieved through the Paul Wellstone and Pete Domenici Mental Health Parity and

\begin{thebibliography}{9}
\bibitem{33} Smucker, \textit{supra} note 21, at 18.
\bibitem{34} Exec. Order No. 12,564, 3 C.F.R.-224 (Sept. 15, 1986).
\bibitem{35} Hoffman, \textit{supra} note 11, at 7.
\bibitem{36} \textit{Id.} at 7.
\bibitem{37} Chris Koyanagi, \textit{Can We Learn From History? Mental Health in Healthcare Reform, Revisited}, 60 Psychiatric Serv. 17, 18 (2009).
\bibitem{38} \textit{Id.}
\end{thebibliography}
Addiction Equity Act of 2008.\textsuperscript{40}

These efforts were largely accepted by both the public and mental healthcare providers, but universal coverage was still not realized due to the fact that these measures applied only to those who already received employer-based coverage. While Medicaid and Medicare offered coverage to their subscribers, those who were not eligible for coverage through either of these pathways were left uncovered, an issue common among those with severe mental illness who were employable, but only in part-time positions that did not offer health insurance.\textsuperscript{41} In addition, many individuals who may have been eligible to receive mental healthcare through either program fell through the cracks and remained outside the system because of the isolating nature of their conditions.\textsuperscript{42} Many sufferers of severe mental illnesses like schizophrenia simply do not have the mental faculties or the family or social support network to find care.\textsuperscript{43}

IV. MENTAL HEALTHCARE UNDER THE PPACA

The PPACA proves to be the most meaningful healthcare reform since the creation of Medicare and Medicaid, and these reforms encompass the world of mental healthcare. Under the PPACA, mental illnesses and addictions will be considered pre-existing conditions that cannot constitute a basis for denying coverage.\textsuperscript{44} Mental healthcare will also be considered an

\begin{itemize}
  \item \textsuperscript{41} Su Liu & Sarah Croake, How are the Experiences of Individuals with Severe Mental Illness Different from Those of Other Medicaid Buy-In Participants?, MATHEMATICA POL’Y RES., INC. 1 (2010).
  \item \textsuperscript{44} Richard A. Friedman, Good News for Mental Illness in Health Law, N.Y. TIMES,
essential benefit, which means most private plans will be required to offer at least some coverage, a provision that was not part of either the 1996 or 2007 legislation. Additionally, the allowance for children up to age twenty-six to remain on a parent’s insurance plan is a boon for mental healthcare, considering that nearly seventy-five percent of serious psychiatric disorders emerge by age twenty-five.

The greatest proportion of mental healthcare expenditures comes from private insurers, with out-of-pocket payments accounting for just 2.7% less. Together, these two sources account for 52.5% of mental healthcare spending. Two ideas can be inferred from this fact: that the people who consume the bulk of mental healthcare (those with employee benefits or the ability to pay cash for care) are not who our society typically thinks of as the mentally ill, and that at least some of those who we typically think of as severely mentally ill (those with disorders so severe they cannot be employed and are destitute) are not getting the care they likely need.

Assuming that those who use private insurance or pay out-of-pocket for their mental healthcare are not destitute, it is likely that this treatment is for illnesses such as anxiety, depression, eating disorders, ADHD in children, and some addictions. Care for these disorders, especially in less severe and debilitating cases, is often centered on outpatient therapy and medication.

Under new the PPACA provisions, those patients with private insurance

---

46. Friedman, supra note 44.
47. Sundararaman, supra note 8, at 9.
48. Id. at 9.
will likely be able to continue their care and will not be denied benefits if they switch insurers.

V. CONTINUED OBSTACLES TO CARE

Currently, the most common obstacles to universal access to mental healthcare are lack of enrollment, continued disparity resulting in inadequate coverage, and practicality in rural and other areas underserved by mental health professionals and facilities.\(^{51}\) Furthermore, although the Mental Healthcare Parity Act and the Mental Health and Addiction Equity Act required lifetime limits on mental healthcare to be equitable with those on physical healthcare, costs for mental healthcare can often far exceed limits imposed by private insurance plans, leaving those who pass their limits but do not qualify for Medicaid or Medicare essentially uninsured. This is largely due to fundamental differences in mental and medical care and the difficulty for regulators to establish parity between the two.\(^{52}\)

Given the often highly publicized but not necessarily widely-held\(^{53}\) opposition facing the PPACA and universal healthcare in general,\(^{54}\) efforts to expand mental healthcare coverage will likely be met with similar opposition. The President and legislators would be wise to emphasize the importance of mental healthcare coverage for those in the community who use private insurance and encourage people to ask their employers for insurance plans that include comprehensive mental healthcare. From an employer’s viewpoint, providing employees with access to mental

\(^{51}\) Sundaraman, supra note 8, at 13.

\(^{52}\) Id. at 15.

\(^{53}\) Zengerle, supra note 14.

healthcare will likely boost productivity and decrease turnover.\footnote{55}{Leah Carlson Shephard, *Mental Health Parity can Boost Productivity and Retention*, 21 EMPLOYEE BENEFIT NEWS 36, 37 (2007).}

Furthermore, with the consistently growing number of Americans taking psychiatric prescription drugs,\footnote{56}{Brendan L. Smith, *Inappropriate Prescribing*, 43 MONITOR ON PSYCHOL. 36, 36 (2012).} along with growing controversy surrounding the possibility of over-prescription,\footnote{57}{Id. at 38.} patients and mental health professionals alike may push towards more psychosocial therapy and less medication. This approach, while perhaps more effective and beneficial to patients’ health, would be more costly\footnote{58}{Id. at 36 (Many patients on antidepressants are prescribed them by their primary care physician and never see a mental health professional, so the only cost associated is the prescription itself).} and would necessitate the need for more comprehensive coverage.\footnote{59}{Id. As the number of people taking prescription psychiatric medicine climbs, the stigma of common mental illnesses such as depression and anxiety lessens, and comprehensive coverage likely will become more expected among those who receive benefits from their employers.}

The mental healthcare community is in a position to make this fact known and to lobby on behalf of comprehensive coverage through employee benefit plans.

Turning to those patients who pay for mental healthcare through Medicare and Medicaid,\footnote{60}{SUNDARARAMAN, supra note 8, at 9. (Medicaid and Medicare account for 32.6% of mental healthcare expenditures).} studies show that severe mental illness is more prevalent in those with lower socioeconomic status, many of whom are presumably on Medicaid.\footnote{61}{THE COUNCIL OF STATE GOVERNMENTS JUSTICE CENTER, *Facilitating Medicaid Enrollment for People with Serious Mental Illnesses Leaving Jail or Prison: Key Questions for Policymakers Committed to Improving Health and Public Safety*, 3 (2011). http://consensusproject.org/documents/0000/1141/Key_Questions_final.pdf (last visited Oct. 29, 2012).} Given the nature of severe diseases like bipolar disorder and schizophrenia, sufferers can go years without employment and, consequently, without insurance coverage.\footnote{62}{Liu & Croake, supra note 40.} Medicaid and Medicare under
the PPACA will continue to provide mental healthcare to these patients, but the Supreme Court’s ruling that the federal government cannot require states to adopt new Medicaid provisions may result in many patients not being eligible for Medicaid in states that choose not to adopt the new standards. Even more sufferers of severe mental illness, who likely would have been Medicaid-eligible had the Supreme Court held the provisions mandatory, would then be isolated from the mental health system entirely.

To expand access to isolated patients and those who find themselves excluded from Medicaid under the new provisions, legislators and mental healthcare reformers must reach out to the public to raise awareness of the importance of comprehensive mental healthcare and ask for voter support to encourage their states to adopt the Medicaid expansion.

VI. CONCLUSION

The complex connections between mental illness and physical well-being, as well as societal ills like poverty and violence, are often overlooked in our debate over healthcare reform, but mental health is critically important to the efforts to expand health coverage. Many voters may favor measures that expand access to rehabilitative mental healthcare rather than the current system that pushes the non-violent homeless, poor, and addicted into the prison system and eventually back to the street. Indeed, the apparent rise in incidents of mass violence by perpetrators who often have

65. Friedman, supra note 44.
had a history of mental health issues has prompted the beginnings of a cultural discussion on improving access to mental healthcare.67

With the PPACA likely to stay in place, the stigma of mental illness dissipating, and the need to provide a more efficient alternative for treating the severely mentally ill growing, the time is ripe for universal mental healthcare coverage to be realized.

67. SUNDARARAMAN, supra note 8, at 1.