

Mental Health

POSITION

ANA supports coverage of inpatient and outpatient mental health services as a standard benefit. ANA encourages parity for mental health and physical illness services. We support adequate funding for SAMHSA and NIMH programs, including clinical training, research and research training, service demonstration, and substance abuse and prevention programs. In addition, ANA advocates for legislation that eliminates barriers to coverage of mental health care for people who have low incomes or live in medically underserved areas.

BACKGROUND

Mental illness and addictive disorders cause personal, economic and social upheaval for individuals and families. Millions of Americans suffer from diagnosable mental disorders involving disabilities in employment, attendance at school, or independent living. According to the National Institute of Mental Health in 2005, “an estimated 26.2 percent of Americans ages 18 and older — about one in four adults — suffer from a diagnosable mental disorder in a given year.ⁱ When applied to the 2004 U.S. Census residential population estimate for ages 18 and older, this figure translates to 57.7 million people.ⁱⁱ In 2005, approximately 46.4 percent of the population was diagnosed with one or more disorder.”

Only 36 percent of those with a mental disorder were receiving treatment. Direct and indirect expenses, including long-term care, Social Security disability, lost productivity and health care expenditures reach into the hundreds of billions. Mental healthcare costs alone tallied \$135 billion in 2005, as stated in a 2011 Health Affairs article.

The Paul Wellstone Mental Health and Addiction Equity Act of 2007 enacted in October, 2008 prohibits treatment limits or the imposition of financial requirements on mental health and substance-related disorder benefits in group health plans which are not similarly imposed on medical and surgical benefits. The Act does not specify which conditions must be covered; it only states that mental health coverage should have parity with medical coverage. However, final regulations have yet to be released.

Moreover, language from the Paul Wellstone Act was incorporated into the Affordable Care Act (ACA) signed into law in March 2010 as well as the following provisions:

- A new Medicaid state plan option to permit enrollees with at least one serious and persistent mental health condition to designate a provider as a health home;
- A new demonstration project to provide Medicaid payments to mental institutions for adult enrollees who require stabilization of an emergency condition;
- A workforce provision which supports development of interdisciplinary mental and behavioral health training programs; and
- Support for development of training programs that focus on primary care models that integrate physical and mental health services.

RATIONALE

Mental illness often carries with it a stigma causing many with disorders to fail to get treatment, or prevents health care suppliers from providing adequate coverage for those suffering with mental illness. The restructuring of mental health services and research programs will necessitate increased attention to ensure that funding for essential mental health research and service programs continues and expands to meet the growing needs.

ⁱ Kessler RC, Chiu WT, Demler O, Walters EE. Prevalence, severity, and comorbidity of twelve-month DSM-IV disorders in the National Comorbidity Survey Replication (NCS-R). *Archives of General Psychiatry*, 2005 Jun;62(6):617-27.

ⁱⁱ U.S. Census Bureau Population Estimates by Demographic Characteristics. Table 2: Annual Estimates of the Population by Selected Age Groups and Sex for the United States: April 1, 2000 to July 1, 2004 (NC-EST2004-02) Source: Population Division, U.S. Census Bureau Release Date: June 9, 2005.
<http://www.census.gov/popest/national/asrh/>