



Behavioral Health is Essential To Health • Prevention Works • Treatment is Effective • People Recover

Behavioral Health Treatment Needs Assessment Toolkit for States

ACKNOWLEDGMENTS

This report was prepared for the Substance Abuse and Mental Health Services Administration (SAMHSA) by Truven Health Analytics Inc, formerly the Healthcare business of Thomson Reuters, under SAMHSA IDIQ Prime Contract #HHSS283200700029I, Task Order #HHSS283200700029I/HHSS28342002T with SAMHSA, U.S. Department of Health and Human Services (HHS). Kevin Malone served as the Contracting Officer Representative.

PUBLIC DOMAIN NOTICE

All material appearing in this report is in the public domain and may be reproduced or copied without permission from SAMHSA. Citation of the source is appreciated. However, this publication may not be reproduced or distributed for a fee without the specific, written authorization of the Office of Communications, SAMHSA, HHS.

ELECTRONIC ACCESS AND COPIES OF PUBLICATION

This publication may be downloaded at http://store.samhsa.gov. Or, call SAMHSA at 1-877-SAMHSA-7 (1-877-726-4727) (English and Español).

RECOMMENDED CITATION

Substance Abuse and Mental Health Services Administration. Behavioral Health Treatment Needs Assessment Toolkit for States. HHS Publication No. SMA13-4757. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2013.

ORIGINATING OFFICES

Office of Policy, Planning, and Innovation, Substance Abuse and Mental Health Services Administration, 1 Choke Cherry Road, Rockville, MD 20857.

HHS Publication No. SMA13-4757

Printed in 2013

TABLE OF CONTENTS

I.	Overview	. 5
II.	Why Assess the Need for Behavioral Health Services?	. 6
III.	Case Studies on the Use of Behavioral Health Needs Assessments	. 7
	Wisconsin Case Study: Possible Implications of Not Conducting a Needs Assessment	. 7
	Maryland Case Study: Using Data to Inform Planning	. 8
	Washington State Case Study: Using Data to Inform Planning	. 8
IV.	Existing Behavioral Health Conditions: Prevalence and Utilization Estimates	. 9
	Behavioral Health Conditions Prevalence Estimates	. 9
	Behavioral Health Utilization Estimates	17
V.	Methods for Estimating Behavioral Health Service Need and Use	33
	National Survey of Drug Use and Health Data as a Resource for System Planning	33
	Instructions for Using the NSDUH (R-DAS) to Estimate Behavioral Health Prevalence and Service Use	35
	Instructions for Using the NSDUH Data Portal to Estimate Behavioral Health Prevalence and Service Use	37
	Instructions for Using the American Community Survey to Estimate the Number of People Who Will Enroll in Insurance Expansions	
	Key Considerations	40
VI.	Methods for Estimating County-Level Behavioral Health Service Need and Use	42
VII.	Conclusion	43

LIST OF TABLES

Table 1: Prevalence of Behavioral Health Conditions in Past Year Among Adults Aged 18–64 Years 10
Table 2: Prevalence of Behavioral Health Conditions in Past Year Among Adults Aged 18–64 Years with Current Medicaid Coverage, by State
Table 3: Prevalence of Behavioral Health Conditions in Past Year Among Adults Aged 18–64 Years Who Are Uninsured and Have Annual Family Incomes < 139 Percent of Federal Poverty Level, by State 13
Table 4: Prevalence of Behavioral Health Conditions in Past Year Among Adults Aged 18–64 Years Who Are Uninsured and Have Annual Family Incomes Between 133 and 399 Percent of Federal Poverty Level, by State
Table 5: Receipt of Mental Health and Substance Use Treatment in Past Year Among Adults Aged 18–64 Years18
Table 6: Receipt of Mental Health and Substance Use Treatment in Past Year Among Adults Aged 18–64 Years with Medicaid Coverage, by State19
Table 7: Receipt of Mental Health and Substance Use Treatment in Past Year Among Adults Aged 18–64 Years Who Are Uninsured and Have Annual Family Incomes < 139 Percent of Federal Poverty Level, by State
Table 8: Receipt of Mental Health and Substance Use Treatment in Past Year Among Adults Aged 18–64 Years Who are Uninsured and Have Annual Family Incomes Between 133 and 399 Percent of Federal Poverty Level, by State25
Table 9: Adults Aged 18–64 Years Who Have Annual Family Incomes < 139 Percent of Federal Poverty Level, by Insurance Status, Nationally and by State29
Table 10: Adults Aged 18–64 Years Who Have Annual Family Incomes Between 133 and 399 Percent of Federal Poverty Level, by Insurance Status, Nationally and by State31

I. Overview

The Behavioral Health Treatment Needs Assessment Toolkit is intended to provide states and other payers with information on the prevalence and use of behavioral health services; step-by-step instructions to generate projections of utilization under insurance expansions; and factors to consider when deciding the appropriate mix of behavioral health benefits, services, and providers to meet the needs of newly eligible populations. The Toolkit was developed by the Substance Abuse and Mental Health Services Administration (SAMHSA).

The Toolkit provides guidance on key questions that states and other payers may need to answer regarding behavioral health treatment needs and service use. It also summarizes how several states have approached planning for newly eligible populations. The Toolkit provides estimates of the prevalence of behavioral health disorders and use of behavioral health services among populations who are currently uninsured and may become eligible for insurance. Finally, the Toolkit includes a section that describes how users can access and analyze other data on behavioral health needs by particular subpopulations within states, income groups, insurance status groups, and age groups.

Consistent with the use of data required in SAMHSA's Block Grant applications,¹ and in conjunction with the Department of Health and Human Services (HHS) National Quality Strategy² and the National Behavioral Health Quality Framework (NBHQF),³ this Toolkit describes how state mental health and substance abuse authorities can use data to plan for the quality of health and behavioral health care nationally and within states, communities, territories, and tribes. There are three broad aims on which states are asked to focus to improve the quality of health and behavioral health care nationally:

- **Better Care:** Improve the overall quality, by making behavioral health care more person-, family-, and community-centered, reliable, accessible, and safe.
- Healthy People/Healthy Communities: Improve the behavioral health of the U.S. population by supporting proven interventions to address behavioral, social, cultural, and environmental determinants of positive behavioral health in addition to delivering higher quality behavioral health care.
- **Affordable Care:** Increase the value of behavioral health care for individuals, families, employers, and governments.

The Toolkit highlights ways in which planning efforts can leverage the National Survey on Drug Use and Health (NSDUH), sponsored by SAMHSA in the U.S. Department of Health and Human Services. The survey is the primary source of information on the use of illicit drugs, alcohol, and tobacco in the civilian, noninstitutionalized population of the United States aged 12 years or older. In recent years, it has also included information on mental health conditions and use of mental health and substance abuse services. The NSDUH can be used to develop national- and state-level estimates, overall and by particular subpopulations affected by new program and insurance expansions.

5

¹ FY 2014-2015 Block Grant Application; Community Mental Health Services Plan and Report; Substance Abuse Prevention and Treatment Plan and Report. Available at: http://www.samhsa.gov/grants/blockgrant/docs/BGapplication-100312.pdf.

² National Strategy for Quality Improvement in Healthcare. Available at: http://www.ahrq.gov/workingforquality/.

³ National Behavioral Health Quality Strategy. Available at: http://www.ahrq.gov/workingforquality/nqs/nqsplans5.htm#samsha.

Section II of this report provides a background of the need for quantitative tools and data in assessing behavioral health needs among populations eligible for new coverage opportunities. Section II also provides examples of the types of questions that a state policymaker or payer could answer with needs assessment data.

Section III provides a series of brief case studies from Wisconsin, Maryland, and Washington describing how those states have utilized similar data and processes for assessing behavioral health needs among populations eligible for new coverage programs.

Section IV provides state-level estimates of the prevalence of behavioral health conditions—serious mental illness (SMI), serious psychological distress (SPD), substance use disorders (SUD) and use of behavioral health services—among specific populations within states. Specifically, data are provided for adults aged 18 to 64 years overall. These adults currently are covered by Medicaid and currently are uninsured and have income levels that would make them eligible for the Medicaid expansion or Affordable Insurance Exchanges.

Section V includes step-by-step instructions on how to develop state-level estimates of the prevalence of behavioral health conditions and current use of behavioral health services for particular populations using the NSDUH via an online tool or by obtaining the dataset. Also discussed are factors that need to be considered in generating estimates, such as how gaining insurance may influence utilization rates and assumptions about participation rates. This section also provides national and state population estimates from the American Community Survey, which are widely used to create state- and countylevel population estimates by insurance and income.

Finally, Section VI describes how data can be utilized to create county-level estimates of the prevalence of behavioral health conditions and use of treatment services.

Why Assess the Need for Behavioral Health Services? II.

There is a significant need for quantitative tools and data on which to base mental health and substance abuse system planning.⁴ This is particularly true now, as the Affordable Care Act provides insurance coverage for millions of currently uninsured Americans and stimulates a myriad of new delivery system re-designs. Many of those who will be newly insured and affected by these innovations have low incomes and may have significant unmet needs for mental health and substance abuse treatment. 6 Key decisions regarding the appropriate mix of services, the adequacy of existing provider networks and workforce, licensing, quality measurement, contracting, etc., must be informed by data to avoid unintended problems with access, costs, and ultimately population health. For example, data can be used to help:

Plan for targeted use of funds from state general revenue, the federal substance abuse prevention and treatment block grant, and federal mental health block grant;

⁴ Leff HS, Hughes DR, Chow CM, Noyes S, Ostrow L. A Mental Health Allocation and Planning Simulation Model: A Mental Health Planner's Perspective. In: Handbook of Healthcare Delivery Systems. July 2009.

 $[\]underline{http://www.hsri.org/files/Mental\%20 Health\%20 Allocation\%20 and \%20 Planning\%20 Simulation\%20 Model-Final-PDF version.pdf.}$ ⁵ Elmendorf DW. Congressional Budget Office: Letter to the Honorable Nancy Pelosi. March 20, 2010. Available at:

http://www.cbo.gov/ftpdocs/113xx/doc11379/AmendReconProp.pdf.

⁶ McAlpine DD, Mechanic D. 2000. Utilization of Specialty Mental Health Care Among Persons with Severe Mental Illness: The Roles of Demographics, Need, Insurance, and Risk. Health Services Research: 35(1):277-292. Available at: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1089101/pdf/hsresearch00009-0110.pdf.

- Plan for service needs of newly eligible individuals;
- Plan for development of adequate and sufficient networks of providers in qualified health plans;
- Plan for Medicaid Benchmark plan⁷;
- Plan for outreach and enrollment assistance;
- Assist the state in evaluating the impact that its outreach, eligibility determination, enrollment, and re-enrollment systems will have on eligible individuals with behavioral health conditions;
- Identify any additional quality measures to be monitored.

III. Case Studies on the Use of Behavioral Health Needs Assessments

a. Wisconsin Case Study: Possible Implications of Not Conducting a Needs Assessment

Wisconsin expanded its Medicaid Program under an 1115 Demonstration with the Centers for Medicare & Medicaid Services (CMS) to include single adults at 200 percent or less of the federal poverty level starting in 2009. As part of the agreement, the program—called BadgerCare Plus Core—had to be budget- or cost-neutral with respect to the use of federal payments. As part of the expansion to single adults, a special benefit package of services was developed for eligible individuals. The service package was more limited than that covered in the existing Wisconsin Medicaid programs. For mental health services, the benefit package covered psychotropic medications and outpatient visits, but only if they were provided by a psychiatrist. It did not include psychotherapy or medications provided by other mental health clinicians including social workers, psychologists, or advance practice nurses. No needs assessment was done for this particular service area or population.

As the program was implemented, it became apparent that the benefits covered were not adequate to meet the needs of the enrollees. BadgerCare Plus Core psychiatrists and clinics, particularly in the Milwaukee area, became inundated with requests for medication-only appointments. Appropriate treatment, particularly for first time-patients, should include an initial outpatient screening and assessment and often a referral to outpatient counseling and therapy prior to any medication assessment. However, these services—and coverage of the types of non-physician, mental health clinicians who would provide them—were not reimbursable under the BadgerCare Plus Core service package.

Although the inadequacy of the benefit package became apparent relatively quickly after the program began, revising the BadgerCare Plus Core benefits and eligible service providers after the program had been initiated was a complex and time-consuming process because it was a 1115 Demonstration. Thus,

⁷ Medicaid. Benchmark Benefits. Available at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Benchmark-Benefits.html.

this example illustrates the importance of anticipating the need for particular services and provider types prior to a program expansion.

b. Maryland Case Study: Using Data to Inform Planning

Maryland's experience with a primary care program for low-income adults coupled with thoughtful use of patient claims and authorization data have helped prepare the state for a likely Medicaid expansion. Maryland has access to years of historical claims data that have enabled the state to conduct analyses of costs and utilization by age group, diagnoses, and eligibility criteria over time. The state used the data to generate projections and characteristics of the population that will be newly Medicaid eligible in 2014. This information is important in developing cost estimates for the likely expansion and in preparing to meet the behavioral health needs of the newly eligible population. The data have also informed decisions in the Maryland Legislature. In 2013, Maryland increased payment rates for Medicaid patients to match those of Medicare not only for primary care providers, but for all physicians in an effort to incentivize behavioral health service providers, including psychiatrists. Finally, the data have informed Maryland's decision to move forward in implementing telemedicine statewide to accommodate the needs of individuals in rural areas.

Maryland anticipates that enrollment of newly eligible individuals will be gradual. The state will conduct targeted outreach efforts in jails, prisons, and state hospitals to increase Medicaid enrollment as soon as possible upon release. Maryland is hopeful that continuous data monitoring and provider incentives will equip the state to deliver appropriate behavioral health services to newly covered low-income adults.

c. Washington State Case Study: Using Data to Inform Planning

Washington has utilized data to help begin to assess and prepare for an expanded Medicaid program in 2014. Washington's integrated client database—which contains mental health, Temporary Assistance for Needy Families (TANF), chemical dependency, medical and child welfare, corrections, and jail utilization data—has been critical in helping identify individuals at high risk and high need as part of the Medicaid expansion. The data have also been critical in designing Washington's health homes state plan amendment.

Washington is also continuing to utilize data to inform important budgetary decisions to ensure that the state is prepared to provide behavioral health services to the newly eligible population. The current Medicaid managed care medical contracts have outpatient visit limits (12 visits for adults and 20 visits for children); however, to comply with mental health parity, visit limits will be removed for the newly eligible Medicaid population in 2014. Currently, the state is leaning toward eliminating visit limits for currently enrolled Medicaid beneficiaries in order to have aligned benefit packages. The projected enrollment and utilization estimates under expanded Medicaid program have identified an increased need for behavioral health providers, particularly psychiatrists. In addition to provider capacity for the newly eligible population, additional provider demand for the currently eligible Medicaid population is likely. The state is currently working to determine how to better incorporate behavioral health services into primary care; data can help inform allocation of resources at the state and county levels.

IV. Existing Behavioral Health Conditions: Prevalence and Utilization Estimates

In this section, we provide national- and state-level estimates of the prevalence of mental health and substance use conditions for current adult Medicaid enrollees (ages 18–64 years), as well as for the populations that would be eligible for state Medicaid expansions and health insurance exchanges. We begin by describing the eligibility criteria for the populations that will be covered and how they align with the prevalence estimates.

Beginning in 2014, the Affordable Care Act extends Medicaid coverage to all individuals aged 19 through 64 years with incomes up to 133 percent of the federal poverty level (FPL), or \$14,856 for an individual and \$30,656 for a family of four (based on the 2012 FPL). The eligibility for the adult group also includes a 5 percent income disregard, leading to an effective FPL of 138 percent. Children are currently eligible and will remain eligible for either Medicaid or the Children's Health Insurance Program (CHIP) at higher income levels, based on the eligibility standards already in effect in their state. In the following set of tables, we provide national- and state-level estimates of the prevalence of mental health and substance use conditions for the current adult Medicaid enrollees and currently uninsured adults with incomes that would make them eligible for state Medicaid expansions (i.e., < 139 percent of FPL). Individuals with employer-sponsored insurance and individual insurance may also obtain Medicaid coverage, although the majority of new enrollees are expected to be currently uninsured. The focus of the estimates provided here is on this population.

In addition to extending Medicaid coverage, the Affordable Care Act will provide subsidies for low- and medium-income people (between 100 percent and 400 percent of FPL) to buy health insurance as well as penalties for individuals who fail to obtain health insurance. The Affordable Care Act will also launch the creation of state health insurance exchanges to provide access to information for potential consumers and to a range of health insurance plans. The Affordable Insurance Exchanges are targeted to those who are not enrolled in Medicaid, Medicare, or affordable employer-based plans. As with the analysis of the Medicaid expansion population, in the following tables we focus on adults aged 18 to 64 years who are currently uninsured and have incomes that would make them eligible for the subsidies (i.e., incomes between 133 and 399 percent of FPL).

Behavioral Health Conditions Prevalence Estimates

Table 1 presents national prevalence estimates of serious mental illness (SMI), serious psychological distress (SPD), and substance use disorder (SUD) among adults aged 18 to 64 years who are either currently enrolled in Medicaid, who are uninsured and have incomes less than 139 percent of FPL, or who are uninsured and have incomes between 133 percent and 399 percent of FPL.¹⁰ The estimates are based on the pooled 2008–2011 National Survey on Drug Use and Health (NSDUH).

⁸ Centers for Medicare and Medicaid Services. Assuring Access to Affordable Coverage: Medicaid and the Children's Health Insurance Program Final Rule. Available at http://www.medicaid.gov/AffordableCareAct/Provisions/Downloads/MedicaidCHIP-Eligibility-Final-Rule-Fact-Sheet-Final-3-16-12.pdf.

⁹ We focus on the range of 133–399 because of the assumption that those with < 133 percent of FPL would enroll in Medicaid. ¹⁰ See Section V for more detailed definitions of measures.

Tables 2–4 present the same estimates by state. **Table 2** presents the prevalence of SMI, SPD, and SUD for current Medicaid enrollees aged 18 to 64 years by state. **Table 3** present similar data for adults aged 18 to 64 years who are uninsured and have incomes less than 139 percent of FPL by state. **Table 4** displays prevalence percentages for adults aged 18 to 64 years who are uninsured and have incomes between 133 percent and 399 percent of FPL by state.

The estimates reveal that among those who are uninsured and have incomes less than 139 percent of FPL, nationally, 7.1 percent have a serious mental illness, 14.9 percent have serious psychological distress, and 13.6 percent have a substance use disorder. Among those who are uninsured and have incomes between 133 and 399 percent, 6.1 percent have a serious mental illness, 13.5 percent have serious psychological distress, and 14.3 percent have a substance use disorder. There is variation among the states in the prevalence of behavioral health conditions, although the confidence intervals around the estimates are often wide.

Table 1: Prevalence of Behavioral Health Conditions in Past Year Among Adults Aged 18–64 Years

	SMI Population (%)	95% CI	SPD Population (%)	95% CI	SUD Population (%)	95% CI
National population ^a	5.5	(5.4 - 5.7)	11.6	(11.3 - 11.8)	10.3	(10.1 - 10.5)
Medicaid population ^b	11.7	(10.9 - 12.5)	21.9	(21.0 - 22.9)	11.9	(11.2 - 12.7)
Adults aged 18–64 years who are uninsured and whose family income is < 139 percent of FPL ^c	7.1	(6.6 - 7.8)	14.9	(14.1 - 15.7)	13.6	(12.8 - 14.4)
Adults aged 18–64 years who are uninsured and whose family income is between 133 and 399 percent of FPL ^d	6.1	(5.5 - 6.6)	13.5	(12.8 - 14.3)	14.3	(13.5 - 15.1)

SOURCE: National Survey on Drug Use and Health, 2008–2011.

^a The national population is defined as adults aged 18–64 years in the U.S.

^b The Medicaid population is the number of adults aged 18–64 years with current Medicaid coverage, including those who have dual eligibility for Medicare and Medicaid.

^cThese individuals would be eligible for the Medicaid expansion population.

^dThese individuals would be eligible for subsidies and may enroll in the Affordable Insurance Exchanges.

Table 2: Prevalence of Behavioral Health Conditions in Past Year Among Adults Aged 18–64 Years with Current Medicaid Coverage, by State

State	SMI Population (%)	95% CI	SPD Population (%)	95% CI	SUD Population (%)	95% CI
Alabama	11.7	(7.0 - 18.7)	20.2	(15.0 - 26.6)	6.8	(3.8 - 11.9)
Alaska	9.5	(4.4 - 19.5)	14.0	(7.9 - 23.7)	12.6	(7.9 - 19.6)
Arizona	15.1	(9.1 - 23.9)	24.0	(17.8 - 31.5)	16.1	(11.3 - 22.3)
Arkansas	16.0	(10.2 - 24.3)	24.3	(17.5 - 32.6)	10.5	(6.9 - 15.6)
California	7.8	(5.8 - 10.4)	15.3	(12.6 - 18.5)	9.0	(7.1 - 11.3)
Colorado	12.5	(5.9 - 24.5)	31.3	(20.8 - 44.0)	15.2	(8.8 - 25.0)
Connecticut	7.5	(4.6 - 12.1)	23.1	(15.1 - 33.7)	17.0	(10.8 - 25.8)
Delaware	12.8	(9.3 - 17.5)	23.4	(18.4 - 29.1)	15.1	(11.3 - 19.9)
District of Columbia	3.5	(2.1 - 5.8)	10.8	(7.8 - 14.8)	16.0	(11.4 - 21.9)
Florida	8.6	(6.5 - 11.4)	19.6	(16.2 - 23.5)	12.1	(9.3 - 15.5)
Georgia	15.7	(7.8 - 29.2)	22.2	(13.1 - 35.0)	12.0	(6.3 - 21.5)
Hawaii	12.2	(7.4 - 19.6)	20.3	(14.4 - 27.9)	16.1	(11.2 - 22.7)
Idaho	17.4	(10.0 - 28.6)	30.6	(21.0 - 42.1)	14.2	(8.0 - 23.9)
Illinois	9.4	(7.3 - 12.0)	18.0	(15.3 - 21.1)	10.3	(8.3 - 12.7)
Indiana	22.0	(15.5 - 30.3)	30.9	(23.4 - 39.6)	11.0	(5.8 - 19.8)
lowa	18.3	(12.6 - 25.8)	32.7	(25.1 - 41.3)	12.9	(7.6 - 21.2)
Kansas	15.9	(7.5 - 30.8)	26.0	(15.8 - 39.8)	11.3	(6.5 - 18.8)
Kentucky	14.9	(9.3 - 23.0)	25.8	(17.3 - 36.6)	10.9	(5.1 - 21.5)
Louisiana	9.1	(5.8 - 14.1)	21.7	(16.3 - 28.1)	10.2	(6.7 - 15.2)
Maine	12.1	(8.6 - 16.7)	21.8	(17.6 - 26.7)	11.8	(8.8 - 15.6)
Maryland	8.9	(4.4 - 17.1)	21.4	(15.0 - 29.7)	14.7	(8.8 - 23.3)
Massachusetts	12.8	(8.4 - 19.1)	18.0	(13.7 - 23.2)	17.3	(12.1 - 24.0)
Michigan	10.8	(8.8 - 13.3)	23.5	(20.2 - 27.1)	12.6	(10.2 - 15.4)
Minnesota	13.0	(9.5 - 17.4)	20.8	(15.6 - 27.2)	14.4	(9.9 - 20.5)
Mississippi	8.7	(5.7 - 13.2)	19.3	(15.0 - 24.4)	5.5	(3.1 - 9.6)
Missouri	22.4	(14.7 - 32.7)	35.4	(26.6 - 45.3)	12.4	(7.9 - 18.9)

Medicaid population is the number of adults aged 18–64 years with current Medicaid coverage, including those who have dual eligibility for Medicare and Medicaid.

Table 2 continued: Prevalence of Behavioral Health Conditions in Past Year Among Adults Aged 18–64 Years with Current Medicaid Coverage, by State

State	SMI Population (%)	95% CI	SPD Population (%)	95% CI	SUD Population (%)	95% CI
Montana	14.0	(8.9 - 21.4)	22.6	(15.7 - 31.4)	20.4	(14.3 - 28.2)
Nebraska	9.9	(4.7 - 19.5)	23.2	(15.0 - 34.1)	10.5	(5.8 - 18.2)
Nevada	27.7	(16.4 - 42.6)	34.5	(22.2 - 49.2)	23.0	(9.4 - 46.2)
New Hampshire	26.5	(17.0 - 38.9)	43.5	(30.9 - 57.1)	9.5	(5.9 - 15.1)
New Jersey	10.7	(6.9 - 16.2)	22.1	(13.9 - 33.3)	15.9	(9.6 - 25.3)
New Mexico	11.7	(7.8 - 17.1)	24.5	(18.5 - 31.7)	15.8	(11.4 - 21.5)
New York	9.5	(7.7 - 11.8)	20.9	(18.4 - 23.5)	11.5	(9.6 - 13.6)
North Carolina	8.0	(4.2 - 14.9)	24.4	(16.5 - 34.5)	11.4	(6.6 - 19.0)
North Dakota	4.9	(3.1 - 7.7)	16.8	(11.9 - 23.2)	14.9	(9.1 - 23.3)
Ohio	16.1	(13.6 - 19.0)	26.0	(22.9 - 29.3)	14.6	(12.1 - 17.4)
Oklahoma	7.8	(4.2 - 14.0)	18.1	(12.6 - 25.3)	11.2	(7.2 - 17.1)
Oregon	25.0	(15.9 - 37.0)	35.1	(25.0 - 46.7)	17.9	(11.4 - 27.0)
Pennsylvania	15.7	(12.6 - 19.5)	27.7	(23.6 - 32.2)	15.6	(12.0 - 20.1)
Rhode Island	13.2	(8.3 - 20.4)	24.3	(17.5 - 32.7)	12.8	(8.4 - 19.0)
South Carolina	7.9	(4.1 - 14.8)	14.3	(9.8 - 20.3)	11.0	(6.3 - 18.6)
South Dakota	5.5	(2.2 - 13.0)	25.2	(14.9 - 39.2)	26.7	(15.4 - 42.0)
Tennessee	16.2	(11.1 - 23.1)	25.4	(19.8 - 32.0)	10.7	(6.9 - 16.2)
Texas	7.9	(5.6 - 10.9)	17.4	(14.1 - 21.4)	9.1	(6.7 - 12.2)
Utah	24.8	(13.9 - 40.2)	45.6	(32.5 - 59.3)	9.8	(5.7 - 16.1)
Vermont	19.0	(14.0 - 25.2)	29.2	(23.4 - 35.7)	18.3	(13.2 - 24.7)
Virginia	8.0	(5.0 - 12.7)	20.0	(11.9 - 31.7)	7.3	(4.2 - 12.1)
Washington	17.8	(9.6 - 30.6)	27.4	(21.3 - 34.5)	9.3	(4.8 - 17.3)
West Virginia	17.7	(10.9 - 27.4)	31.9	(24.1 - 40.9)	11.7	(6.4 - 20.7)
Wisconsin	15.1	(10.1 - 22.0)	29.3	(22.1 - 37.5)	13.6	(8.9 - 20.5)
Wyoming	14.9	(10.1 - 21.3)	22.7	(16.7 - 30.2)	17.3	(11.3 - 25.6)

Medicaid population is the number of adults aged 18–64 years with current Medicaid coverage, including those who have dual eligibility for Medicare and Medicaid.

Table 3: Prevalence of Behavioral Health Conditions in Past Year Among Adults Aged 18–64 Years Who Are Uninsured and Have Annual Family Incomes < 139 Percent of Federal Poverty Level, by State

State	SMI Population (%)	95% CI	SPD Population (%)	95% CI	SUD Population (%)	95% CI
Alabama	16.2	(10.4 - 24.3)	24.0	(16.5 - 33.4)	10.6	(7.0 - 15.7)
Alaska	3.8	(1.9 - 7.5)	18.6	(12.0 - 27.5)	15.2	(9.1 - 24.3)
Arizona	7.1	(4.0 - 12.4)	13.8	(8.8 - 20.9)	19.4	(13.9 - 26.4)
Arkansas	10.3	(6.7 - 15.5)	22.8	(17.3 - 29.4)	11.7	(8.4 - 16.0)
California	5.0	(3.7 - 6.6)	11.2	(9.0 - 13.7)	9.7	(7.7 - 12.1)
Colorado	4.7	(2.1 - 10.0)	12.4	(7.2 - 20.5)	12.5	(8.1 - 18.8)
Connecticut	12.2	(5.0 - 26.8)	20.0	(10.0 - 36.0)	24.5	(14.4 - 38.5)
Delaware	13.0	(6.0 - 25.7)	20.2	(11.8 - 32.2)	10.9	(6.9 - 16.9)
District of Columbia	7.0	(2.9 - 15.6)	13.7	(6.8 - 25.8)	30.5	(19.0 - 45.1)
Florida	7.7	(5.6 - 10.4)	14.9	(12.4 - 17.9)	11.3	(9.2 - 13.7)
Georgia	3.8	(2.1 - 6.9)	11.4	(7.4 - 17.3)	11.4	(7.2 - 17.7)
Hawaii	3.7	(1.5 - 8.8)	9.2	(4.5 - 18.0)	15.4	(8.4 - 26.5)
Idaho	13.3	(8.4 - 20.4)	22.7	(16.7 - 30.1)	22.3	(15.0 - 31.8)
Illinois	5.4	(3.7 - 7.7)	12.5	(9.8 - 16.0)	13.6	(11.0 - 16.6)
Indiana	17.1	(12.0 - 23.9)	24.3	(18.6 - 31.1)	21.1	(15.8 - 27.5)
lowa	9.9	(4.7 - 19.5)	19.2	(11.8 - 29.8)	14.7	(10.0 - 21.0)
Kansas	6.4	(2.8 - 13.9)	14.0	(8.4 - 22.4)	12.6	(7.8 - 19.8)
Kentucky	10.0	(6.6 - 14.8)	19.2	(14.6 - 24.8)	13.8	(9.3 - 20.0)
Louisiana	7.4	(4.5 - 12.0)	16.5	(12.0 - 22.3)	18.8	(13.7 - 25.3)
Maine	9.3	(4.2 - 19.4)	17.9	(10.6 - 28.6)	17.8	(9.8 - 30.2)
Maryland	2.4	(0.9 - 6.1)	11.4	(4.6 - 25.5)	9.8	(5.4 - 17.1)
Massachusetts	†N/A	†N/A	10.4	(4.0 - 24.3)	25.7	(11.0 - 49.1)
Michigan	8.3	(6.2 - 10.9)	18.7	(15.4 - 22.5)	16.2	(13.3 - 19.7)
Minnesota	16.9	(7.7 - 33.4)	26.6	(15.3 - 42.0)	15.4	(9.2 - 24.7)
Mississippi	10.1	(6.6 - 15.0)	19.5	(15.7 - 24.1)	9.5	(6.8 - 13.1)
Missouri	7.9	(4.7 - 13.0)	15.3	(11.1 - 20.8)	14.8	(9.4 - 22.6)

[†]N/A denotes insufficient sample size (<4 for the numerator and <30 for the denominator) and was suppressed according to SAMHSA guidelines.

Table 3 continued: Prevalence of Behavioral Health Conditions in Past Year Among Adults Aged 18–64 Years Who Are Uninsured and Have Annual Family Incomes < 139 Percent of Federal Poverty Level, by State

State	SMI Population (%)	95% CI	SPD Population (%)	95% CI	SUD Population (%)	95% CI
Montana	7.3	(4.2 - 12.2)	15.7	(11.0 - 21.8)	19.2	(13.4 - 26.6)
Nebraska	9.1	(5.1 - 15.8)	24.2	(14.5 - 37.5)	17.2	(10.1 - 27.8)
Nevada	4.0	(2.0 - 7.9)	11.4	(6.1 - 20.4)	14.3	(8.5 - 22.9)
New Hampshire	9.2	(4.5 - 17.8)	13.1	(7.9 - 20.9)	19.4	(11.6 - 30.6)
New Jersey	4.3	(1.1 - 15.4)	7.5	(2.9 - 18.1)	9.2	(4.5 - 17.9)
New Mexico	5.0	(3.3 - 7.4)	14.7	(9.4 - 22.0)	8.9	(5.9 - 13.3)
New York	4.0	(2.6 - 6.3)	12.1	(8.8 - 16.3)	12.9	(9.5 - 17.2)
North Carolina	3.6	(1.7 - 7.5)	11.4	(6.8 - 18.5)	12.5	(9.2 - 16.8)
North Dakota	6.9	(3.3 - 13.9)	14.0	(8.2 - 22.8)	20.0	(12.6 - 30.1)
Ohio	12.4	(9.0 - 16.8)	24.7	(19.8 - 30.3)	20.4	(16.6 - 24.9)
Oklahoma	7.3	(4.3 - 12.0)	17.5	(12.0 - 24.9)	14.0	(9.6 - 19.9)
Oregon	10.6	(6.2 - 17.5)	20.7	(14.1 - 29.3)	15.5	(9.9 - 23.4)
Pennsylvania	6.3	(4.1 - 9.7)	15.1	(11.5 - 19.6)	18.9	(14.3 - 24.5)
Rhode Island	8.2	(4.0 - 16.2)	15.9	(9.3 - 25.9)	21.1	(13.6 - 31.1)
South Carolina	11.4	(6.4 - 19.4)	20.3	(13.5 - 29.3)	19.1	(13.1 - 27.1)
South Dakota	5.7	(2.6 - 12.1)	20.5	(11.9 - 32.9)	19.0	(11.7 - 29.3)
Tennessee	6.9	(3.8 - 12.0)	18.7	(13.5 - 25.2)	18.4	(12.9 - 25.7)
Texas	5.9	(4.5 - 7.7)	11.4	(9.6 - 13.5)	10.8	(9.0 - 13.0)
Utah	14.2	(8.8 - 22.0)	24.4	(18.6 - 31.4)	8.2	(4.6 - 14.5)
Vermont	14.1	(7.8 - 24.3)	23.3	(15.0 - 34.4)	20.3	(12.6 - 31.0)
Virginia	9.3	(4.8 - 17.2)	20.3	(13.5 - 29.4)	18.3	(11.2 - 28.4)
Washington	7.0	(3.0 - 15.5)	11.4	(6.6 - 18.9)	21.7	(13.9 - 32.1)
West Virginia	11.8	(7.1 - 19.1)	23.7	(17.3 - 31.4)	16.0	(11.4 - 21.9)
Wisconsin	10.4	(4.7 - 21.7)	17.6	(9.7 - 29.6)	13.4	(8.7 - 20.2)
Wyoming	11.6	(5.7 - 21.9)	17.1	(10.3 - 27.1)	12.4	(7.6 - 19.6)

Table 4: Prevalence of Behavioral Health Conditions in Past Year Among Adults Aged 18–64 Years Who Are Uninsured and Have Annual Family Incomes Between 133 and 399 Percent of Federal Poverty Level, by State

State	SMI Population (%)	95% CI	SPD Population (%)	95% CI	SUD Population (%)	95% CI
Alabama	8.7	(5.2 - 14.2)	20.4	(14.0 - 28.8)	12.8	(8.0 - 19.8)
Alaska	9.6	(5.1 - 17.2)	13.7	(8.5 - 21.4)	14.8	(10.1 - 21.3)
Arizona	4.1	(2.2 - 7.3)	17.4	(11.2 - 25.9)	14.6	(10.0 - 20.7)
Arkansas	10.2	(6.0 - 16.9)	21.1	(14.6 - 29.6)	13.5	(9.1 - 19.5)
California	5.0	(3.5 - 7.1)	11.9	(9.6 - 14.7)	13.8	(11.3 - 16.7)
Colorado	5.9	(2.1 - 15.9)	13.9	(7.1 - 25.2)	24.4	(15.9 - 35.5)
Connecticut	3.0	(1.0 - 8.1)	9.6	(5.3 - 16.9)	15.1	(9.4 - 23.4)
Delaware	3.5	(1.5 - 7.6)	7.5	(4.3 - 12.8)	13.8	(9.1 - 20.5)
District of Columbia	7.0	(2.6 - 17.5)	10.6	(5.3 - 20.0)	19.7	(9.2 - 37.4)
Florida	4.9	(3.6 - 6.8)	10.3	(8.2 - 13.0)	13.7	(11.3 - 16.6)
Georgia	2.1	(0.6 - 7.5)	5.1	(2.5 - 10.1)	11.3	(6.3 - 19.5)
Hawaii	12.2	(5.0 - 26.6)	13.7	(6.3 - 27.2)	17.5	(10.2 - 28.3)
Idaho	12.7	(7.5 - 20.8)	20.1	(13.4 - 29.0)	11.0	(7.2 - 16.3)
Illinois	6.8	(4.9 - 9.3)	14.7	(12.0 - 17.9)	16.2	(13.3 - 19.5)
Indiana	6.7	(4.0 - 11.1)	16.0	(11.0 - 22.8)	8.6	(5.3 - 13.6)
lowa	6.0	(2.8 - 12.5)	13.1	(8.4 - 19.9)	15.4	(9.1 - 25.0)
Kansas	8.6	(4.4 - 16.1)	15.8	(10.6 - 22.9)	18.1	(11.8 - 26.8)
Kentucky	7.8	(4.4 - 13.6)	13.7	(8.8 - 20.7)	10.6	(6.0 - 18.1)
Louisiana	5.6	(3.3 - 9.4)	14.8	(10.3 - 20.8)	12.1	(7.9 - 18.1)
Maine	1.5	(0.7 - 3.5)	9.4	(4.8 - 17.7)	12.6	(8.0 - 19.1)
Maryland	3.3	(1.5 - 7.1)	9.2	(5.4 - 15.2)	12.0	(7.2 - 19.2)
Massachusetts	9.3	(2.6 - 28.1)	17.9	(9.0 - 32.5)	18.1	(8.8 - 33.7)
Michigan	7.2	(5.4 - 9.5)	15.3	(12.4 - 18.7)	17.6	(14.6 - 21.0)
Minnesota	9.6	(5.1 - 17.2)	18.9	(11.1 - 30.2)	16.9	(10.2 - 26.7)
Mississippi	8.5	(4.9 - 14.3)	15.7	(10.7 - 22.4)	11.4	(7.2 - 17.6)
Missouri	9.4	(5.5 - 15.5)	14.2	(9.6 - 20.4)	8.3	(5.3 - 12.7)

Table 4 continued: Prevalence of Behavioral Health Conditions in Past Year Among Adults Aged 18–64 Years Who Are Uninsured and Have Annual Family Incomes Between 133 and 399 Percent of Federal Poverty Level, by State

State	SMI Population (%)	95% CI	SPD Population (%)	95% CI	SUD Population (%)	95% CI
Montana	5.7	(3.0 - 10.5)	15.4	(9.7 - 23.8)	15.3	(10.4 - 21.9)
Nebraska	10.7	(6.0 - 18.5)	20.0	(13.7 - 28.3)	19.3	(12.1 - 29.2)
Nevada	7.8	(4.6 - 12.8)	12.9	(8.9 - 18.3)	18.5	(12.9 - 25.9)
New Hampshire	5.7	(3.2 - 10.1)	14.3	(9.3 - 21.3)	16.7	(11.1 - 24.3)
New Jersey	8.7	(4.1 - 17.5)	14.2	(8.4 - 22.8)	11.5	(6.8 - 18.8)
New Mexico	7.9	(4.7 - 12.8)	11.5	(7.8 - 16.7)	19.2	(14.1 - 25.5)
New York	5.1	(3.7 - 7.2)	11.2	(8.8 - 14.0)	12.6	(9.6 - 16.4)
North Carolina	4.8	(2.6 - 8.8)	11.8	(8.2 - 16.6)	13.4	(8.6 - 20.3)
North Dakota	7.4	(3.5 - 15.3)	15.7	(8.7 - 26.6)	22.0	(13.3 - 34.1)
Ohio	7.9	(5.4 - 11.3)	16.2	(12.8 - 20.3)	18.7	(15.1 - 22.9)
Oklahoma	7.8	(4.0 - 14.6)	17.8	(12.9 - 24.1)	19.5	(11.8 - 30.6)
Oregon	6.7	(3.3 - 13.2)	12.7	(8.3 - 19.0)	16.4	(10.8 - 24.3)
Pennsylvania	4.3	(2.7 - 6.8)	14.6	(11.1 - 19.0)	16.1	(12.8 - 20.0)
Rhode Island	13.0	(7.2 - 22.3)	27.3	(19.1 - 37.4)	29.6	(21.4 - 39.3)
South Carolina	3.5	(1.7 - 6.7)	17.6	(12.3 - 24.4)	14.0	(9.2 - 20.8)
South Dakota	5.2	(2.2 - 11.6)	12.3	(6.4 - 22.3)	16.1	(9.2 - 26.9)
Tennessee	4.2	(2.1 - 8.3)	15.1	(8.8 - 24.9)	19.6	(12.6 - 29.2)
Texas	5.5	(4.2 - 7.3)	12.6	(10.3 - 15.3)	12.6	(10.1 - 15.7)
Utah	9.6	(5.3 - 16.7)	15.4	(10.2 - 22.5)	10.7	(6.7 - 16.7)
Vermont	10.7	(6.2 - 17.8)	20.2	(12.5 - 30.9)	12.0	(7.5 - 18.6)
Virginia	7.3	(3.6 - 14.3)	19.2	(11.8 - 29.7)	23.2	(14.4 - 35.0)
Washington	6.4	(3.4 - 11.9)	14.5	(9.7 - 21.3)	10.6	(6.8 - 16.3)
West Virginia	9.3	(5.0 - 16.4)	18.1	(11.5 - 27.4)	8.9	(5.4 - 14.4)
Wisconsin	12.0	(5.7 - 23.6)	17.8	(10.2 - 29.2)	13.5	(8.8 - 20.2)
Wyoming	8.9	(5.2 - 14.8)	17.6	(12.7 - 23.9)	15.5	(11.1 - 21.4)

Behavioral Health Utilization Estimates

Table 5 displays national behavioral health services utilization estimates for:

- All adults in the United States (aged 18 to 64 years)
- Adult Medicaid enrollees (aged 18 to 64 years)
- Adults who are uninsured and have annual family incomes < 139 percent of FPL (the likely Medicaid expansion population)
- Adults who are uninsured and have annual family incomes between 133 and 399 percent of FPL (the likely Affordable Insurance Exchanges expansion population).

Tables 6–8 present state-level estimates for the same populations. **Table 6** presents state-level behavioral health utilization estimates for current adult Medicaid enrollees (aged 18 to 64 years). **Table 7** presents state-level behavioral health utilization estimates for adults who are likely to enroll in the Medicaid expansion. **Table 8** presents similar information for adults who are likely to enroll in the Affordable Insurance Exchanges expansion.

The tables show the percentage of beneficiaries in the last year who used:

- 1. Any mental health treatment (e.g., inpatient, outpatient, or prescription drugs)
- 2. Any inpatient or outpatient mental health treatment
- 3. Any substance abuse treatment
- 4. Any inpatient mental health treatment
- 5. Any outpatient mental health treatment
- 6. Any prescription drug treatment for mental health
- 7. Any specialty substance abuse facility treatment

Estimates were based on the 2008-2011 National Survey on Drug Use and Health (NSDUH). To reflect the uncertainty in the utilization estimates, all estimates are presented with confidence intervals.

Table 5: Receipt of Mental Health and Substance Use Treatment in Past Year Among Adults Aged 18-64 Years

	Any MH Treatment		Any Inpatient or Outpatient MH Treatment		Any SA Treatment		Any Inpatient MH Treatment		Any Outpatient MH Treatment		Any Prescription Medication for MH		Any Specialty SA Facility Treatment	
	%	95% CI	%	95% CI	%	95% CI	%	95% CI	%	95% CI	%	95% CI	%	95% CI
National population ^a	14.4	(14.1 - 14.6)	7.6	(7.4 - 7.8)	1.9	(1.8 - 2.0)	0.8	(0.8 - 0.9)	7.3	(7.1 – 7.5)	12.1	(11.8 – 12.4)	1.2	(1.1 - 1.3)
Medicaid population ^b	24.0	(22.9 - 25.1)	14.7	(13.8 - 15.6)	4.4	(3.9 - 4.9)	3.3	(2.9 - 3.8)	13.6	(12.8 - 14.5)	20.7	(19.7 - 21.7)	3.4	(2.9 - 3.8)
Adults aged 18–64 years														
who are uninsured and														
whose family income is < 139 percent of FPL ^c	8.9	(8.2 - 9.7)	4.9	(4.4 - 5.6)	3.4	(3.0 - 3.8)	0.9	(0.7 - 1.1)	4.5	(4.0 - 5.1)	7.4	(6.7 - 8.1)	2.3	(1.9 - 2.6)
Adults aged 18–64 years	0.9	(6.2 - 9.7)	4.9	(4.4 - 5.0)	5.4	(3.0 - 3.6)	0.9	(0.7 - 1.1)	4.5	(4.0 - 5.1)	7.4	(0.7 - 0.1)	2.5	(1.9 - 2.0)
who are uninsured and														
whose family income is														
between 133 and 399														
percent of FPL ^d	9.0	(8.3 - 9.8)	4.3	(3.9 - 4.8)	2.8	(2.5 - 3.3)	0.7	(0.5 - 0.9)	4.1	(3.6 - 4.5)	7.5	(6.9 - 8.2)	1.8	(1.5 - 2.2)

National population is defined as adults aged 18–64 in the U.S.

Abbreviation: CO, confidence interval; FPL, federal poverty level; MH, mental health; SA, substance abuse.

^b Medicaid population is the number of adults aged 18–64 years with current Medicaid coverage, including those who have dual eligibility for Medicare and Medicaid.

^cThese individuals would be eligible for the Medicaid expansion population.

^d These individuals would be eligible for subsidies and may enroll in the Affordable Insurance Exchanges.

Table 6: Receipt of Mental Health and Substance Use Treatment in Past Year Among Adults Aged 18–64 Years with Medicaid Coverage, by State

State Any N		Ou		Any Inpatient or Outpatient MH Treatment Any SA Treatment		Any Inpatient MH Treatment		Any Outpatient MH Treatment		Any Prescription Medication for MH		Any Specialty SA Facility Treatment		
	%	95% CI	%	95% CI	%	95% CI	%	95% CI	%	95% CI	%	95% CI	%	95% CI
Alabama	21.0	(14.1 - 30.2)	13.3	(7.2 - 23.3)	3.0	(1.1 - 7.9)	2.2	(0.6 - 7.6)	13.1	(7.0 - 23.2)	17.0	(11.3 - 24.6)	3.0	(1.1 - 7.9)
Alaska	19.0	(11.6 - 29.7)	13.1	(7.2 - 22.7)	8.1	(4.5 - 14.3)	†N/A	†N/A	13.1	(7.2 - 22.7)	15.2	(8.2 - 26.4)	4.9	(2.4 - 9.8)
Arizona	23.5	(15.6 - 33.6)	18.1	(11.0 - 28.2)	4.3	(2.4 - 7.7)	1.5	(0.7 - 2.9)	17.3	(10.3 - 27.6)	19.3	(12.2 - 29.0)	3.8	(1.8 - 7.6)
Arkansas	29.5	(20.5 - 40.3)	16.9	(10.2 - 26.6)	5.9	(2.6 - 12.6)	3.9	(1.4 - 10.3)	14.6	(9.0 - 22.7)	27.7	(18.8 - 38.9)	2.9	(0.9 - 9.2)
California	14.9	(11.9 - 18.6)	9.8	(7.4 - 12.9)	2.8	(1.8 - 4.3)	2.8	(1.6 - 5.0)	8.9	(6.6 - 11.9)	11.7	(9.1 - 15.0)	1.7	(0.9 - 3.3)
Colorado	29.5	(19.3 - 42.3)	15.4	(8.2 - 27.0)	5.5	(2.7 - 10.8)	6.9	(3.0 - 15.3)	15.4	(8.2 - 27.0)	26.9	(17.0 - 39.8)	3.1	(1.5 - 6.4)
Connecticut	23.1	(16.5 - 31.3)	18.2	(12.8 - 25.1)	8.0	(4.4 - 13.9)	3.0	(0.6 - 14.3)	18.2	(12.8 - 25.1)	17.9	(11.4 - 26.9)	7.4	(4.0 - 13.5)
Delaware	23.5	(18.2 - 29.8)	16.0	(10.2 - 24.1)	9.2	(5.5 - 14.9)	1.9	(0.9 - 4.0)	15.9	(10.2 - 24.1)	21.4	(16.5 - 27.3)	8.3	(4.7 - 14.0)
District of Columbia	13.5	(9.3 - 19.0)	10.5	(6.5 - 16.5)	12.3	(7.9 - 18.7)	1.1	(0.4 - 3.0)	10.3	(6.3 - 16.4)	10.5	(6.8 - 15.9)	9.6	(5.3 - 16.7)
Florida	21.5	(17.7 - 26.0)	12.6	(9.4 - 16.5)	3.0	(1.9 - 4.7)	3.8	(2.2 - 6.4)	10.1	(7.4 - 13.5)	17.7	(14.2 - 21.9)	1.8	(1.1 - 3.2)
Georgia	26.1	(16.9 - 38.0)	19.5	(11.2 - 31.7)	4.8	(1.5 - 13.8)	7.3	(3.3 - 15.5)	17.2	(9.2 - 30.0)	24.3	(15.2 - 36.7)	†N/A	†N/A
Hawaii	20.2	(13.8 - 28.6)	14.9	(9.5 - 22.6)	3.6	(1.5 - 8.4)	3.6	(1.1 - 10.8)	14.3	(9.0 - 21.8)	16.0	(10.1 - 24.5)	2.0	(0.6 - 6.4)
Idaho	38.3	(27.3 - 50.6)	18.2	(11.6 - 27.4)	5.4	(2.4 - 12.0)	†N/A	†N/A	18.2	(11.6 - 27.4)	36.1	(25.1 - 48.8)	4.9	(1.9 - 11.8)
Illinois	17.6	(14.9 - 20.6)	9.4	(7.5 - 11.6)	3.9	(2.6 - 5.8)	2.2	(1.4 - 3.6)	8.9	(7.1 - 11.2)	15.3	(12.8 - 18.3)	3.0	(1.9 - 4.8)
Indiana	28.4	(20.6 - 37.9)	16.7	(11.2 - 24.2)	5.1	(2.6 - 10.0)	3.5	(1.2 - 9.4)	16.6	(11.1 - 24.2)	27.5	(19.7 - 37.0)	3.8	(1.8 - 8.1)
lowa	36.1	(28.0 - 45.2)	22.1	(15.7 - 30.1)	3.0	(1.3 - 6.5)	6.4	(3.2 - 12.2)	21.8	(15.5 - 29.8)	34.3	(26.2 - 43.5)	1.8	(0.6 - 5.0)
Kansas	24.7	(15.2 - 37.6)	13.5	(7.1 - 24.3)	6.8	(3.3 - 13.7)	5.3	(1.7 - 15.6)	11.0	(5.7 - 20.3)	21.4	(12.7 - 33.7)	6.3	(3.0 - 12.7)
Kentucky	28.3	(20.2 - 38.0)	17.0	(10.6 - 26.0)	3.0	(1.3 - 6.8)	3.7	(1.7 - 8.2)	16.7	(10.4 - 25.7)	25.4	(17.4 - 35.4)	1.9	(0.7 - 5.0)
Louisiana	20.0	(14.4 - 27.2)	11.0	(7.4 - 16.1)	0.9	(0.4 - 2.2)	2.6	(1.2 - 5.3)	8.7	(5.4 - 13.7)	17.4	(12.1 - 24.3)	0.6	(0.2 - 1.9)
Maine	37.0	(31.6 - 42.8)	24.6	(19.4 - 30.6)	5.0	(3.1 - 8.0)	1.9	(1.0 - 3.7)	24.2	(19.0 - 30.4)	31.6	(26.7 - 37.0)	3.9	(2.1 - 7.0)

Medicaid population is the number of adults aged 18-64 years with current Medicaid coverage, including those who have dual eligibility for Medicare and Medicaid.

†N/A denotes insufficient sample size (<4 for the numerator and <30 for the denominator) and was suppressed according to SAMHSA guidelines.

Table 6 continued: Receipt of Mental Health and Substance Use Treatment in Past Year Among Adults Aged 18–64 Years with Medicaid Coverage, by State

State	Any M	H Treatment	Out	Inpatient or patient MH reatment	Any S	A Treatment	•	patient MH eatment	•	utpatient MH eatment	•	Prescription cation for MH	•	Specialty SA ty Treatment
	%	95% CI	%	95% CI	%	95% CI	%	95% CI	%	95% CI	%	95% CI	%	95% CI
Maryland	20.2	(12.7 - 30.6)	14.1	(7.5 - 25.0)	9.0	(3.3 - 22.2)	6.5	(2.6 - 15.5)	12.3	(6.4 - 22.4)	14.9	(8.4 - 25.0)	7.7	(2.5 - 21.5)
Massachusetts	25.0	(18.3 - 33.2)	18.6	(12.7 - 26.6)	5.3	(3.2 - 8.6)	1.9	(0.8 - 4.8)	18.5	(12.6 - 26.5)	19.7	(14.2 - 26.7)	3.9	(2.3 - 6.6)
Michigan	22.5	(19.3 - 26.0)	12.9	(10.6 - 15.6)	6.6	(4.6 - 9.2)	2.9	(1.9 - 4.4)	11.7	(9.4 - 14.3)	18.9	(15.8 - 22.4)	4.7	(3.1 - 7.2)
Minnesota	36.9	(29.0 - 45.6)	21.3	(15.9 - 27.9)	5.5	(2.9 - 10.3)	3.4	(1.4 - 8.3)	19.5	(14.3 - 25.9)	32.2	(24.0 - 41.8)	3.3	(1.6 - 6.6)
Mississippi	18.2	(13.3 - 24.3)	6.2	(3.7 - 10.1)	1.5	(0.5 - 4.4)	2.0	(0.7 - 5.3)	5.9	(3.5 - 9.9)	17.3	(12.5 - 23.6)	1.0	(0.2 - 4.2)
Missouri	36.5	(27.6 - 46.4)	29.2	(19.6 - 41.0)	1.3	(0.5 - 3.0)	6.3	(3.2 - 12.0)	28.4	(18.7 - 40.7)	33.8	(24.9 - 44.0)	1.2	(0.5 - 2.8)
Montana	28.3	(18.9 - 40.1)	16.3	(9.4 - 26.8)	5.9	(2.5 - 13.5)	3.2	(0.9 - 11.3)	14.1	(8.1 - 23.3)	26.6	(16.8 - 39.5)	5.6	(2.2 - 13.4)
Nebraska	35.5	(23.6 - 49.4)	18.9	(10.4 - 31.9)	1.9	(0.6 - 5.6)	2.9	(0.9 - 8.8)	17.6	(9.3 - 30.8)	30.9	(19.6 - 45.2)	†N/A	†N/A
Nevada	28.3	(16.3 - 44.6)	22.3	(11.9 - 37.9)	6.1	(2.3 - 15.5)	10.1	(3.5 - 25.4)	16.9	(8.1 - 31.9)	21.8	(11.3 - 38.0)	5.8	(2.0 - 15.5)
New Hampshire	48.9	(36.9 - 61.1)	35.0	(22.9 - 49.3)	6.4	(3.6 - 10.9)	5.2	(1.8 - 14.4)	34.6	(22.7 - 48.7)	43.6	(30.7 - 57.3)	4.5	(2.5 - 7.9)
New Jersey	17.0	(10.0 - 27.4)	9.9	(5.8 - 16.4)	8.7	(4.2 - 17.2)	1.5	(0.6 - 3.9)	9.3	(5.0 - 16.4)	16.3	(9.4 - 26.9)	7.4	(3.4 - 15.4)
New Mexico	22.4	(16.2 - 30.2)	14.5	(9.8 - 20.9)	4.5	(2.4 - 8.4)	3.7	(1.6 - 8.3)	13.5	(8.9 - 19.8)	19.1	(13.4 - 26.6)	1.9	(0.7 - 4.9)
New York	20.4	(17.5 - 23.7)	14.3	(11.8 - 17.2)	5.1	(3.5 - 7.4)	3.8	(2.5 - 5.7)	13.1	(10.7 - 16.1)	16.1	(13.5 - 19.3)	4.9	(3.3 - 7.2)
North Carolina	21.7	(14.5 - 31.2)	12.4	(7.2 - 20.5)	3.9	(1.5 - 9.7)	3.8	(1.5 - 8.9)	9.6	(5.5 - 16.3)	18.7	(12.3 - 27.3)	3.0	(1.0 - 8.2)
North Dakota	21.9	(13.6 - 33.3)	13.8	(7.1 - 25.1)	3.3	(1.2 - 8.7)	1.4	(0.3 - 6.0)	13.5	(6.8 - 25.0)	20.6	(12.6 - 31.9)	2.9	(0.9 - 9.0)
Ohio	31.7	(27.6 - 36.2)	18.8	(15.8 - 22.3)	5.1	(3.5 - 7.3)	4.0	(2.5 - 6.4)	17.7	(14.7 - 21.2)	29.4	(25.1 - 34.0)	3.3	(2.1 - 5.1)
Oklahoma	23.5	(16.4 - 32.4)	14.7	(9.1 - 22.9)	2.7	(0.7 - 9.9)	2.8	(1.1 - 7.0)	14.0	(8.5 - 22.1)	21.4	(14.8 - 29.9)	2.7	(0.7 - 10.0)
Oregon	41.3	(32.6 - 50.7)	21.6	(14.1 - 31.6)	9.1	(4.7 - 17.2)	†N/A	†N/A	19.3	(12.4 - 28.8)	31.9	(23.5 - 41.8)	8.5	(4.2 - 16.6)
Pennsylvania	35.3	(30.7 - 40.2)	19.9	(16.1 - 24.3)	6.7	(4.5 - 9.8)	3.4	(1.9 - 6.1)	19.1	(15.4 - 23.5)	32.1	(27.5 - 37.2)	5.9	(3.8 - 9.1)
Rhode Island	36.5	(27.7 - 46.3)	23.2	(16.4 - 31.6)	4.2	(2.2 - 8.0)	6.0	(3.0 - 11.6)	22.9	(16.2 - 31.4)	32.4	(24.0 - 42.1)	4.1	(2.1 - 8.0)

Medicaid population is the number of adults aged 18–64 years with current Medicaid coverage, including those who have dual eligibility for Medicare and Medicaid.

†N/A denotes insufficient sample size (<4 for the numerator and <30 for the denominator) and was suppressed according to SAMHSA guidelines.

Table 6 continued: Receipt of Mental Health and Substance Use Treatment in Past Year Among Adults Aged 18–64 Years with Medicaid Coverage, by State

State	Any M	H Treatment	Out	Inpatient or patient MH reatment	Any S	A Treatment	•	patient MH eatment		utpatient MH eatment	•	Prescription cation for MH	•	Specialty SA ty Treatment
	%	95% CI	%	95% CI	%	95% CI	%	95% CI	%	95% CI	%	95% CI	%	95% CI
South Carolina	23.7	(16.8 - 32.3)	13.0	(8.7 - 19.1)	0.7	(0.2 - 2.8)	4.4	(1.8 - 10.2)	12.4	(8.1 - 18.5)	22.5	(15.7 - 31.2)	0.7	(0.2 - 2.8)
South Dakota	36.1	(23.5 - 51.0)	13.0	(6.7 - 23.9)	7.4	(3.2 - 16.2)	1.4	(0.6 - 3.2)	12.5	(6.2 - 23.5)	32.0	(20.1 - 46.6)	3.8	(1.5 - 9.1)
Tennessee	26.1	(20.3 - 32.9)	14.5	(10.1 - 20.3)	2.5	(1.2 - 5.0)	3.3	(1.5 - 7.4)	13.1	(9.1 - 18.7)	24.9	(19.2 - 31.6)	1.9	(0.8 - 4.3)
Texas	20.8	(16.4 - 25.9)	10.1	(7.2 - 14.2)	2.5	(1.2 - 5.0)	2.0	(1.0 - 3.9)	9.8	(7.0 - 13.7)	18.0	(14.0 - 23.0)	1.0	(0.4 - 3.0)
Utah	45.3	(31.7 - 59.6)	35.0	(22.8 - 49.6)	5.1	(2.2 - 11.5)	2.6	(0.7 - 8.7)	33.7	(21.7 - 48.3)	37.0	(24.7 - 51.4)	2.0	(0.7 - 5.4)
Vermont	35.4	(28.7 - 42.8)	19.9	(14.0 - 27.4)	9.3	(5.5 - 15.4)	3.9	(2.1 - 7.2)	18.8	(13.2 - 26.1)	31.5	(25.4 - 38.4)	5.6	(3.5 - 8.7)
Virginia	27.0	(19.4 - 36.3)	17.3	(9.7 - 28.8)	†N/A	†N/A	3.4	(1.4 - 8.2)	14.7	(8.2 - 25.0)	24.6	(17.1 - 34.1)	†N/A	†N/A
Washington	36.1	(26.8 - 46.7)	18.5	(13.6 - 24.8)	6.1	(2.5 - 14.3)	3.4	(1.4 - 8.2)	16.7	(11.6 - 23.3)	29.6	(21.2 - 39.5)	5.6	(2.1 - 14.0)
West Virginia	35.3	(27.0 - 44.7)	20.1	(12.8 - 30.0)	9.3	(4.2 - 19.3)	6.8	(2.5 - 17.0)	19.3	(12.4 - 28.9)	32.5	(24.6 - 41.4)	7.0	(2.7 - 16.8)
Wisconsin	31.0	(22.5 - 40.9)	13.4	(8.7 - 19.8)	5.2	(2.7 - 9.7)	1.6	(0.6 - 3.8)	13.0	(8.4 - 19.5)	28.0	(20.7 - 36.7)	4.3	(2.1 - 8.7)
Wyoming	31.1	(21.8 - 42.2)	22.1	(14.3 - 32.6)	11.1	(6.2 - 19.0)	3.2	(1.2 - 8.0)	21.0	(13.2 - 31.6)	29.0	(20.5 - 39.3)	10.5	(5.7 - 18.5)

Medicaid population is the number of adults aged 18–64 years with current Medicaid coverage, including those who have dual eligibility for Medicare and Medicaid.

+N/A denotes insufficient sample size (<4 for the numerator and <30 for the denominator) and was suppressed according to SAMHSA guidelines.

Table 7: Receipt of Mental Health and Substance Use Treatment in Past Year Among Adults Aged 18–64 Years Who Are Uninsured and Have Annual Family Incomes < 139 Percent of Federal Poverty Level, by State

State	Any M	H Treatment	Outp	npatient or atient MH eatment	Any S	A Treatment	•	patient MH eatment	•	utpatient MH eatment	-	Prescription cation for MH	•	Specialty SA ty Treatment
	%	95% CI	%	95% CI	%	95% CI	%	95% CI	%	95% CI	%	95% CI	%	95% CI
Alabama	14.2	(9.1 - 21.6)	7.7	(3.5 - 16.2)	5.4	(3.0 - 9.7)	1.3	(0.5 - 3.4)	7.2	(3.1 - 15.8)	11.8	(7.0 - 19.4)	4.1	(2.0 - 8.2)
Alaska	6.6	(3.4 - 12.2)	3.9	(1.6 - 9.0)	2.7	(0.8 - 8.5)	†N/A	†N/A	3.8	(1.5 - 8.9)	3.9	(1.8 - 8.5)	2.2	(0.7 - 6.9)
Arizona	5.7	(2.8 - 11.6)	2.2	(0.7 - 6.5)	4.3	(2.1 - 8.6)	†N/A	†N/A	2.0	(0.6 - 6.5)	4.4	(1.9 - 9.9)	†N/A	†N/A
Arkansas	10.7	(7.0 - 16.1)	5.2	(2.7 - 9.9)	1.5	(0.7 - 3.3)	0.6	(0.2 - 1.9)	5.1	(2.6 - 9.8)	10.0	(6.3 - 15.4)	1.1	(0.4 - 3.0)
California	4.3	(3.0 - 6.1)	2.9	(1.8 - 4.4)	3.6	(2.4 - 5.4)	0.5	(0.2 - 1.4)	2.5	(1.6 - 4.1)	2.7	(1.8 - 4.2)	2.2	(1.3 - 3.7)
Colorado	6.0	(2.9 - 11.7)	4.7	(1.9 - 11.0)	2.5	(0.8 - 7.8)	†N/A	†N/A	4.6	(1.9 - 10.9)	5.4	(2.5 - 11.3)	2.3	(0.6 - 7.8)
Connecticut	8.8	(3.0 - 23.4)	6.6	(1.8 - 21.3)	†N/A	†N/A	†N/A	†N/A	†N/A	†N/A	6.3	(1.5 - 22.2)	†N/A	†N/A
Delaware	5.3	(1.3 - 19.1)	4.9	(1.1 - 19.4)	4.0	(0.7 - 21.0)	†N/A	†N/A	4.9	(1.1 - 19.4)	†N/A	†N/A	†N/A	†N/A
District of Columbia	3.6	(1.4 - 8.7)	2.6	(0.8 - 7.8)	0.6	(0.2 - 2.2)	†N/A	†N/A	†N/A	†N/A	1.7	(0.5 - 5.0)	†N/A	†N/A
Florida	7.9	(5.7 - 10.8)	4.3	(2.8 - 6.7)	3.8	(2.4 - 5.9)	1.1	(0.6 - 2.0)	3.8	(2.3 - 6.1)	6.7	(4.7 - 9.3)	2.0	(1.1 - 3.6)
Georgia	8.6	(5.2 - 14.0)	5.6	(2.0 - 14.8)	†N/A	†N/A	†N/A	†N/A	5.5	(1.9 - 14.8)	7.2	(4.3 - 11.8)	†N/A	†N/A
Hawaii	†N/A	†N/A	†N/A	†N/A	†N/A	†N/A	†N/A	†N/A	†N/A	†N/A	†N/A	†N/A	†N/A	†N/A
Idaho	17.2	(10.4 - 27.0)	11.2	(6.5 - 18.6)	7.5	(3.5 - 15.4)	†N/A	†N/A	11.2	(6.5 - 18.6)	14.6	(8.3 - 24.3)	4.5	(1.7 - 11.5)
Illinois	6.9	(4.9 - 9.6)	4.5	(3.0 - 6.8)	2.8	(1.7 - 4.7)	1.6	(0.8 - 3.5)	3.8	(2.5 - 5.9)	4.6	(3.0 - 6.8)	1.8	(1.1 - 3.1)
Indiana	22.3	(14.5 - 32.7)	10.3	(5.6 - 18.0)	6.4	(3.2 - 12.3)	3.9	(1.4 - 10.3)	8.3	(4.7 - 14.2)	18.0	(11.0 - 28.1)	2.8	(1.3 - 5.9)
lowa	11.5	(5.8 - 21.4)	6.5	(3.2 - 12.7)	3.3	(1.5 - 6.8)	†N/A	†N/A	6.3	(3.2 - 12.4)	9.7	(4.6 - 19.5)	2.4	(1.0 - 5.9)
Kansas	10.5	(5.6 - 18.7)	5.8	(2.3 - 14.0)	1.6	(0.4 - 6.6)	†N/A	†N/A	5.6	(2.1 - 13.9)	9.5	(4.7 - 18.3)	†N/A	†N/A
Kentucky	11.3	(7.4 - 17.0)	5.4	(3.1 - 9.4)	4.7	(2.4 - 9.1)	0.8	(0.2 - 2.4)	4.7	(2.5 - 8.8)	10.5	(6.5 - 16.4)	3.1	(1.3 - 7.4)
Louisiana	8.6	(6.1 - 12.2)	5.1	(3.4 - 7.7)	2.7	(1.2 - 6.0)	1.2	(0.4 - 3.6)	4.4	(3.0 - 6.5)	6.8	(4.4 - 10.4)	2.0	(0.8 - 5.0)
Maine	7.3	(3.0 - 16.5)	2.2	(0.7 - 6.4)	†N/A	†N/A	†N/A	†N/A	1.9	(0.6 - 6.2)	6.6	(2.6 - 16.1)	†N/A	†N/A

[†]N/A denotes insufficient sample size (<4 for the numerator and <30 for the denominator) and was suppressed according to SAMHSA guidelines.

Table 7 continued: Receipt of Mental Health and Substance Use Treatment in Past Year Among Adults Aged 18–64 Years Who Are Uninsured and Have Annual Family Incomes < 139 Percent of Federal Poverty Level, by State

State	Any M	H Treatment	Outp	npatient or atient MH eatment	Any S	A Treatment	•	patient MH eatment	•	utpatient MH eatment	•	Prescription cation for MH	,	Specialty SA ty Treatment
	%	95% CI	%	95% CI	%	95% CI	%	95% CI	%	95% CI	%	95% CI	%	95% CI
Maryland	4.6	(1.5 - 12.8)	4.6	(1.5 - 12.8)	†N/A	†N/A	†N/A	†N/A	2.6	(0.6 - 9.8)	3.8	(1.1 - 12.3)	†N/A	†N/A
Massachusetts	13.6	(4.9 - 32.4)	†N/A	†N/A	†N/A	†N/A	†N/A	†N/A	†N/A	†N/A	8.8	(2.5 - 26.1)	†N/A	†N/A
Michigan	9.4	(6.9 - 12.5)	4.9	(3.2 - 7.5)	4.4	(3.0 - 6.3)	1.1	(0.4 - 3.0)	4.6	(2.9 - 7.1)	8.1	(5.8 - 11.2)	3.5	(2.3 - 5.3)
Minnesota	11.0	(5.8 - 20.1)	7.6	(3.2 - 16.8)	2.3	(1.0 - 5.2)	†N/A	†N/A	6.6	(2.6 - 15.7)	9.0	(4.1 - 18.4)	2.3	(1.0 - 5.2)
Mississippi	9.3	(5.0 - 16.7)	4.1	(1.8 - 9.0)	1.3	(0.5 - 3.4)	†N/A	†N/A	4.1	(1.8 - 9.0)	9.0	(4.7 - 16.5)	†N/A	†N/A
Missouri	16.2	(8.5 - 28.7)	6.3	(3.2 - 12.1)	4.7	(1.8 - 11.9)	1.3	(0.5 - 3.4)	5.4	(2.5 - 11.3)	14.4	(7.1 - 27.0)	4.7	(1.8 - 11.9)
Montana	11.2	(6.8 - 17.9)	3.5	(1.5 - 7.8)	3.7	(1.6 - 8.0)	1.3	(0.6 - 3.0)	2.8	(1.1 - 7.2)	9.5	(5.6 - 15.6)	3.1	(1.2 - 7.8)
Nebraska	14.4	(8.7 - 23.0)	5.5	(2.7 - 11.0)	1.9	(0.7 - 5.1)	†N/A	†N/A	5.4	(2.6 - 10.8)	11.6	(6.6 - 19.6)	†N/A	†N/A
Nevada	9.2	(4.2 - 19.1)	3.7	(1.4 - 9.4)	2.2	(0.8 - 5.7)	†N/A	†N/A	3.7	(1.4 - 9.4)	7.9	(3.5 - 17.1)	1.2	(0.3 - 4.4)
New Hampshire	7.5	(4.2 - 13.0)	5.9	(3.0 - 11.1)	6.7	(2.4 - 17.4)	†N/A	†N/A	5.9	(3.0 - 11.1)	4.5	(1.9 - 10.1)	6.7	(2.4 - 17.4)
New Jersey	4.3	(0.9 - 17.7)	4.1	(0.8 - 18.0)	†N/A	†N/A	†N/A	†N/A	3.8	(0.7 - 18.5)	3.7	(0.6 - 18.8)	†N/A	†N/A
New Mexico	7.9	(4.2 - 14.4)	4.9	(2.2 - 10.8)	6.8	(3.8 - 11.8)	1.2	(0.3 - 4.1)	4.3	(1.7 - 10.2)	6.7	(3.4 - 12.9)	3.9	(2.0 - 7.2)
New York	6.7	(4.2 - 10.6)	4.3	(2.3 - 7.8)	3.3	(1.7 - 6.1)	1.1	(0.3 - 3.8)	4.0	(2.1 - 7.6)	5.5	(3.3 - 9.1)	3.0	(1.5 - 5.9)
North Carolina	8.3	(4.9 - 13.9)	4.5	(2.2 - 8.8)	2.5	(1.3 - 4.8)	0.9	(0.3 - 2.3)	4.0	(1.9 - 8.3)	8.0	(4.6 - 13.7)	2.0	(0.9 - 4.4)
North Dakota	7.4	(3.1 - 16.6)	4.3	(1.2 - 14.2)	1.7	(0.6 - 5.1)	†N/A	†N/A	4.3	(1.2 - 14.2)	4.8	(1.9 - 11.6)	1.7	(0.6 - 5.1)
Ohio	16.9	(12.3 - 22.9)	11.1	(7.3 - 16.6)	5.8	(3.8 - 8.7)	1.0	(0.4 - 2.2)	10.4	(6.7 - 15.8)	15.0	(10.5 - 20.8)	5.3	(3.4 - 8.1)
Oklahoma	9.6	(5.9 - 15.0)	4.1	(2.0 - 8.2)	4.2	(2.1 - 8.2)	†N/A	†N/A	3.9	(1.9 - 8.1)	8.8	(5.4 - 14.2)	2.8	(1.2 - 6.5)
Oregon	15.4	(9.0 - 25.1)	9.8	(4.3 - 20.7)	4.8	(2.2 - 9.9)	†N/A	†N/A	9.8	(4.3 - 20.7)	8.0	(4.3 - 14.4)	4.4	(1.9 - 9.9)
Pennsylvania	11.4	(7.8 - 16.4)	7.4	(4.8 - 11.4)	4.7	(2.7 - 8.2)	1.8	(0.7 - 4.7)	6.2	(3.9 - 9.9)	7.8	(4.7 - 12.7)	3.9	(2.1 - 7.2)
Rhode Island	7.1	(3.2 - 15.3)	4.9	(1.9 - 11.8)	7.2	(2.2 - 20.8)	†N/A	†N/A	3.5	(1.3 - 9.2)	4.8	(1.9 - 11.9)	6.9	(2.1 - 20.9)

[†]N/A denotes insufficient sample size (<4 for the numerator and <30 for the denominator) and was suppressed according to SAMHSA guidelines.

Table 7 continued: Receipt of Mental Health and Substance Use Treatment in Past Year Among Adults Aged 18–64 Years Who Are Uninsured and Have Annual Family Incomes < 139 Percent of Federal Poverty Level, by State

State	Any M	H Treatment	Outp	npatient or atient MH eatment	Any S	A Treatment	•	patient MH eatment	•	utpatient MH eatment	•	Prescription cation for MH	•	Specialty SA ty Treatment
	%	95% CI	%	95% CI	%	95% CI	%	95% CI	%	95% CI	%	95% CI	%	95% CI
South Carolina	14.4	(8.9 - 22.6)	5.2	(2.9 - 9.2)	4.7	(2.2 - 9.7)	1.4	(0.4 - 5.4)	5.0	(2.7 - 9.0)	14.1	(8.6 - 22.4)	4.0	(1.7 - 9.1)
South Dakota	19.5	(12.5 - 29.1)	9.9	(5.7 - 16.8)	2.4	(0.6 - 9.0)	3.4	(1.0 - 10.7)	8.1	(4.2 - 14.9)	17.6	(11.2 - 26.7)	†N/A	†N/A
Tennessee	10.3	(7.1 - 14.7)	5.4	(3.0 - 9.5)	1.8	(0.7 - 4.5)	†N/A	†N/A	5.2	(2.8 - 9.3)	9.4	(6.3 - 13.8)	†N/A	†N/A
Texas	7.4	(5.5 - 9.8)	3.3	(2.1 - 5.1)	2.2	(1.4 - 3.2)	0.7	(0.4 - 1.4)	3.1	(1.9 - 4.8)	6.1	(4.5 - 8.3)	1.2	(0.7 - 1.9)
Utah	11.5	(6.3 - 20.1)	6.1	(2.4 - 14.6)	3.1	(1.6 - 6.0)	†N/A	†N/A	6.1	(2.4 - 14.6)	10.8	(5.6 - 19.6)	1.1	(0.3 - 4.1)
Vermont	10.5	(4.9 - 21.2)	7.0	(2.4 - 18.9)	5.8	(2.7 - 12.0)	†N/A	†N/A	7.0	(2.4 - 18.9)	5.1	(2.3 - 11.0)	†N/A	†N/A
Virginia	12.5	(6.7 - 22.1)	8.6	(3.9 - 17.8)	1.3	(0.4 - 4.5)	†N/A	†N/A	7.7	(3.3 - 16.8)	10.1	(5.0 - 19.6)	†N/A	†N/A
Washington	10.9	(5.0 - 22.3)	6.6	(2.6 - 16.0)	4.7	(1.8 - 11.9)	†N/A	†N/A	6.2	(2.3 - 15.6)	8.9	(4.1 - 18.5)	4.1	(1.4 - 11.6)
West Virginia	19.2	(12.6 - 28.2)	6.9	(3.4 - 13.6)	4.5	(2.0 - 9.8)	0.6	(0.2 - 1.4)	6.8	(3.2 - 13.7)	18.5	(11.9 - 27.7)	3.2	(1.5 - 6.8)
Wisconsin	9.5	(5.2 - 16.9)	5.9	(2.6 - 12.8)	7.5	(3.2 - 16.6)	†N/A	†N/A	5.8	(2.5 - 12.7)	9.5	(5.2 - 16.8)	6.2	(2.2 - 16.1)
Wyoming	13.3	(8.2 - 20.7)	5.3	(2.7 - 10.4)	2.3	(0.9 - 5.7)	†N/A	†N/A	5.3	(2.6 - 10.4)	12.1	(7.3 - 19.3)	1.1	(0.3 - 4.1)

[†]N/A denotes insufficient sample size (<4 for the numerator and <30 for the denominator) and was suppressed according to SAMHSA guidelines.

Table 8: Receipt of Mental Health and Substance Use Treatment in Past Year Among Adults Aged 18–64 Years Who are Uninsured and Have Annual Family Incomes Between 133 and 399 Percent of Federal Poverty Level, by State

State	Any M	IH Treatment	Outp	npatient or atient MH eatment	Any S	A Treatment	•	patient MH eatment	-	utpatient MH eatment	-	Prescription cation for MH	-	Specialty SA ity Treatment
	%	95% CI	%	95% CI	%	95% CI	%	95% CI	%	95% CI	%	95% CI	%	95% CI
Alabama	10.5	(5.4 - 19.4)	7.3	(2.9 - 17.3)	3.4	(1.1 - 10.2)	†N/A	†N/A	7.3	(2.9 - 17.3)	10.1	(5.1 - 19.0)	2.1	(0.5 - 7.9)
Alaska	4.8	(2.6 - 8.5)	3.1	(1.7 - 5.5)	3.5	(1.5 - 8.1)	†N/A	†N/A	3.1	(1.7 - 5.5)	2.7	(1.0 - 6.9)	2.4	(1.0 - 5.5)
Arizona	6.9	(3.2 - 14.2)	†N/A	†N/A	1.4	(0.4 - 4.0)	†N/A	†N/A	†N/A	†N/A	6.9	(3.2 - 14.2)	†N/A	†N/A
Arkansas	19.3	(11.6 - 30.4)	4.8	(1.8 - 12.2)	2.9	(1.1 - 7.4)	†N/A	†N/A	4.8	(1.8 - 12.2)	19.2	(11.5 - 30.2)	2.0	(0.6 - 6.8)
California	7.1	(5.2 - 9.6)	3.3	(2.2 - 5.0)	1.9	(1.0 - 3.3)	0.5	(0.1 - 1.9)	3.0	(1.9 - 4.5)	5.0	(3.4 - 7.3)	1.2	(0.6 - 2.6)
Colorado	9.9	(4.6 - 19.9)	5.3	(2.7 - 10.4)	2.3	(1.0 - 5.1)	†N/A	†N/A	5.0	(2.4 - 10.1)	7.4	(2.9 - 17.7)	0.8	(0.3 - 2.6)
Connecticut	8.3	(3.5 - 18.4)	0.9	(0.2 - 3.8)	3.6	(1.5 - 8.1)	†N/A	†N/A	0.9	(0.2 - 3.8)	7.3	(2.8 - 17.8)	1.7	(0.5 - 5.8)
Delaware	7.8	(3.9 - 15.0)	5.4	(2.5 - 11.3)	1.6	(0.7 - 3.8)	†N/A	†N/A	5.4	(2.5 - 11.3)	6.4	(2.8 - 14.0)	1.4	(0.6 - 3.6)
District of Columbia	11.0	(4.6 - 24.3)	6.7	(2.3 - 17.8)	2.3	(0.5 - 9.2)	†N/A	†N/A	†N/A	†N/A	8.6	(2.9 - 22.9)	†N/A	†N/A
Florida	7.5	(5.7 - 9.8)	3.3	(2.2 - 5.0)	2.5	(1.5 - 4.0)	0.7	(0.3 - 1.6)	3.1	(2.0 - 4.7)	7.1	(5.3 - 9.3)	1.9	(1.0 - 3.3)
Georgia	2.5	(1.2 - 4.9)	2.0	(0.8 - 4.9)	2.2	(0.7 - 6.6)	†N/A	†N/A	1.7	(0.6 - 4.6)	0.9	(0.4 - 2.1)	0.7	(0.2 - 2.4)
Hawaii	10.6	(4.3 - 23.8)	8.0	(2.9 - 20.3)	†N/A	†N/A	†N/A	†N/A	†N/A	†N/A	†N/A	†N/A	†N/A	†N/A
Idaho	16.2	(9.6 - 26.2)	8.5	(4.3 - 15.9)	5.7	(1.9 - 15.9)	†N/A	†N/A	8.5	(4.3 - 15.9)	15.6	(9.0 - 25.8)	2.0	(0.9 - 4.5)
Illinois	8.3	(5.9 - 11.5)	3.3	(2.1 - 5.1)	1.8	(1.1 - 3.1)	0.3	(0.1 - 0.6)	3.1	(2.0 - 4.9)	6.8	(4.6 - 10.0)	1.4	(0.8 - 2.5)
Indiana	9.6	(5.8 - 15.5)	6.3	(3.2 - 11.8)	2.4	(0.8 - 6.8)	†N/A	†N/A	6.3	(3.2 - 11.8)	8.4	(4.9 - 14.1)	†N/A	†N/A
Iowa	12.6	(6.8 - 22.2)	6.0	(2.7 - 12.7)	3.4	(1.4 - 8.4)	†N/A	†N/A	6.0	(2.7 - 12.7)	9.3	(4.4 - 18.7)	2.6	(0.9 - 7.4)
Kansas	16.5	(10.9 - 24.2)	10.8	(6.0 - 18.7)	1.9	(0.6 - 5.8)	†N/A	†N/A	10.8	(6.0 - 18.7)	12.7	(7.5 - 20.8)	0.6	(0.2 - 2.2)
Kentucky	6.9	(4.3 - 10.9)	3.8	(1.5 - 9.3)	3.4	(1.9 - 5.8)	†N/A	†N/A	3.3	(1.3 - 8.3)	6.4	(3.9 - 10.2)	†N/A	†N/A
Louisiana	7.0	(4.2 - 11.4)	3.6	(1.6 - 7.6)	1.6	(0.5 - 4.8)	†N/A	†N/A	3.2	(1.3 - 7.7)	6.5	(3.7 - 11.0)	1.6	(0.5 - 4.8)
Maine	10.9	(7.4 - 15.9)	5.5	(3.2 - 9.2)	3.1	(1.2 - 8.0)	†N/A	†N/A	4.2	(2.5 - 7.0)	8.5	(5.0 - 14.2)	1.2	(0.2 - 6.1)

[†]N/A denotes insufficient sample size (<4 for the numerator and <30 for the denominator) and was suppressed according to SAMHSA guidelines.

Table 8 continued: Receipt of Mental Health and Substance Use Treatment in Past Year Among Adults Aged 18–64 Years Who are Uninsured and Have Annual Family Incomes Between 133 and 399 Percent of Federal Poverty Level, by State

State	Any M	H Treatment	Outp	npatient or atient MH eatment	Any S	A Treatment	•	patient MH eatment	-	utpatient MH eatment	-	Prescription cation for MH	-	Specialty SA ty Treatment
	%	95% CI	%	95% CI	%	95% CI	%	95% CI	%	95% CI	%	95% CI	%	95% CI
Maryland	5.8	(2.8 - 11.3)	3.6	(1.7 - 7.7)	3.2	(1.1 - 8.8)	†N/A	†N/A	3.3	(1.5 - 7.3)	4.3	(1.8 - 9.7)	3.2	(1.1 - 8.8)
Massachusetts	13.6	(6.7 - 25.7)	7.1	(3.2 - 15.0)	†N/A	†N/A	†N/A	†N/A	6.5	(2.8 - 14.5)	13.0	(6.4 - 24.7)	†N/A	†N/A
Michigan	9.4	(7.0 - 12.6)	4.5	(2.9 - 7.0)	4.0	(2.6 - 6.0)	1.0	(0.5 - 2.2)	4.1	(2.5 - 6.6)	7.7	(5.6 - 10.4)	2.8	(1.7 - 4.5)
Minnesota	11.5	(4.2 - 27.7)	8.7	(2.5 - 26.0)	†N/A	†N/A	†N/A	†N/A	8.7	(2.5 - 26.0)	11.2	(4.0 - 27.6)	†N/A	†N/A
Mississippi	11.5	(6.8 - 18.9)	7.3	(3.5 - 14.6)	2.4	(0.9 - 6.4)	1.7	(0.4 - 6.9)	5.8	(2.7 - 11.7)	9.8	(5.8 - 16.2)	1.4	(0.5 - 4.2)
Missouri	12.7	(6.9 - 22.3)	4.8	(2.4 - 9.1)	5.1	(1.9 - 13.2)	†N/A	†N/A	4.8	(2.4 - 9.1)	11.9	(6.2 - 21.6)	1.7	(0.6 - 5.2)
Montana	14.1	(8.8 - 21.9)	3.0	(1.4 - 6.2)	4.2	(2.2 - 7.8)	†N/A	†N/A	2.9	(1.4 - 6.1)	13.3	(8.1 - 21.1)	3.9	(1.9 - 7.7)
Nebraska	17.6	(11.6 - 25.8)	8.3	(4.4 - 15.2)	4.7	(1.8 - 11.9)	†N/A	†N/A	6.7	(3.5 - 12.5)	15.0	(9.5 - 22.8)	3.7	(1.3 - 10.5)
Nevada	6.1	(3.7 - 10.0)	1.4	(0.4 - 4.3)	4.8	(2.2 - 10.1)	0.5	(0.1 - 1.4)	0.9	(0.2 - 4.5)	5.1	(3.0 - 8.6)	3.4	(1.3 - 8.7)
New Hampshire	14.6	(9.9 - 20.9)	8.3	(4.5 - 14.9)	3.1	(1.1 - 7.9)	†N/A	†N/A	8.0	(4.2 - 14.6)	11.0	(6.3 - 18.5)	3.0	(1.1 - 7.9)
New Jersey	10.7	(5.3 - 20.6)	6.5	(2.8 - 14.5)	3.2	(1.0 - 9.7)	1.8	(0.4 - 7.5)	6.0	(2.4 - 14.2)	9.1	(4.1 - 19.0)	†N/A	†N/A
New Mexico	7.4	(3.7 - 14.3)	4.7	(2.1 - 10.1)	4.8	(2.4 - 9.5)	†N/A	†N/A	4.7	(2.1 - 10.1)	6.1	(2.8 - 12.8)	0.8	(0.2 - 2.6)
New York	4.5	(3.0 - 6.8)	3.2	(1.9 - 5.2)	3.1	(1.4 - 6.4)	0.6	(0.2 - 1.9)	3.1	(1.9 - 5.2)	3.6	(2.3 - 5.6)	1.8	(0.6 - 5.6)
North Carolina	9.5	(5.7 - 15.4)	3.8	(1.9 - 7.4)	5.3	(2.9 - 9.4)	†N/A	†N/A	3.8	(1.9 - 7.4)	8.0	(4.9 - 12.9)	1.7	(0.5 - 6.2)
North Dakota	9.0	(5.0 - 15.6)	5.3	(2.3 - 11.7)	3.3	(1.1 - 9.6)	†N/A	†N/A	4.5	(1.8 - 10.9)	5.6	(2.8 - 10.9)	2.0	(0.5 - 7.4)
Ohio	11.0	(8.2 - 14.7)	6.5	(4.3 - 9.8)	3.5	(2.1 - 5.7)	0.7	(0.3 - 1.5)	6.1	(3.9 - 9.3)	8.3	(6.1 - 11.2)	2.7	(1.6 - 4.5)
Oklahoma	12.7	(7.7 - 20.3)	3.2	(1.4 - 7.1)	3.4	(1.5 - 7.5)	†N/A	†N/A	3.2	(1.4 - 7.1)	10.3	(5.7 - 17.7)	3.2	(1.3 - 7.4)
Oregon	14.4	(9.0 - 22.2)	6.7	(3.6 - 12.1)	5.0	(1.8 - 13.2)	0.8	(0.2 - 2.9)	6.2	(3.3 - 11.6)	11.6	(6.6 - 19.6)	4.7	(1.6 - 13.1)
Pennsylvania	12.4	(9.0 - 16.9)	7.1	(4.4 - 11.2)	4.5	(2.7 - 7.4)	1.1	(0.4 - 3.1)	6.8	(4.2 - 11.0)	9.5	(6.7 - 13.5)	3.1	(1.7 - 5.7)
Rhode Island	17.2	(10.9 - 26.1)	7.8	(3.1 - 17.9)	8.1	(4.6 - 13.9)	4.4	(1.1 - 16.7)	7.3	(2.8 - 17.9)	15.4	(9.2 - 24.5)	5.9	(2.8 - 12.2)

[†]N/A denotes insufficient sample size (<4 for the numerator and <30 for the denominator) and was suppressed according to SAMHSA guidelines.

Table 8 continued: Receipt of Mental Health and Substance Use Treatment in Past Year Among Adults Aged 18–64 Years Who are Uninsured and Have Annual Family Incomes Between 133 and 399 Percent of Federal Poverty Level, by State

State	Any Mi	l Treatment	Outp	npatient or atient MH eatment	Any S	A Treatment	•	patient MH eatment	•	utpatient MH eatment	•	Prescription cation for MH	•	Specialty SA ty Treatment
	%	95% CI	%	95% CI	%	95% CI	%	95% CI	%	95% CI	%	95% CI	%	95% CI
South Carolina	10.4	(5.4 - 19.1)	5.1	(2.4 - 10.5)	†N/A	†N/A	†N/A	†N/A	5.1	(2.4 - 10.5)	9.1	(4.4 - 17.9)	†N/A	†N/A
South Dakota	13.7	(6.8 - 25.7)	1.6	(0.7 - 3.8)	3.7	(1.3 - 10.0)	†N/A	†N/A	1.6	(0.7 - 3.8)	12.7	(6.0 - 24.9)	3.1	(1.0 - 9.8)
Tennessee	12.0	(6.7 - 20.5)	3.4	(1.6 - 7.0)	3.3	(1.4 - 7.5)	†N/A	†N/A	2.4	(1.1 - 5.4)	12.0	(6.7 - 20.5)	2.6	(1.0 - 6.5)
Texas	7.2	(5.3 - 9.6)	3.3	(2.3 - 4.8)	1.0	(0.5 - 1.8)	0.9	(0.4 - 1.8)	2.9	(2.0 - 4.3)	6.2	(4.4 - 8.5)	0.5	(0.2 - 1.3)
Utah	13.5	(8.9 - 20.1)	7.3	(3.6 - 14.5)	4.6	(2.2 - 9.3)	†N/A	†N/A	7.2	(3.4 - 14.5)	9.3	(5.7 - 14.9)	3.6	(1.6 - 8.3)
Vermont	12.2	(6.6 - 21.6)	7.2	(3.4 - 14.6)	1.9	(0.8 - 4.7)	†N/A	†N/A	7.2	(3.4 - 14.6)	8.7	(4.3 - 16.9)	1.4	(0.4 - 4.4)
Virginia	16.4	(9.2 - 27.5)	6.9	(3.1 - 14.6)	8.9	(3.7 - 20.1)	†N/A	†N/A	6.7	(2.9 - 14.5)	13.8	(7.5 - 24.1)	8.3	(3.3 - 19.7)
Washington	6.5	(3.2 - 12.8)	3.0	(1.1 - 8.0)	2.9	(1.2 - 6.7)	†N/A	†N/A	3.0	(1.1 - 8.0)	3.7	(1.5 - 9.3)	1.2	(0.3 - 4.1)
West Virginia	13.7	(8.2 - 22.0)	6.5	(3.0 - 13.5)	1.2	(0.3 - 4.5)	†N/A	†N/A	6.5	(3.0 - 13.5)	11.7	(6.5 - 20.0)	†N/A	†N/A
Wisconsin	17.8	(9.9 - 30.0)	10.0	(4.5 - 20.6)	3.3	(1.0 - 10.3)	†N/A	†N/A	9.4	(4.1 - 20.1)	16.4	(9.0 - 28.1)	2.3	(0.5 - 10.1)
Wyoming	13.2	(9.2 - 18.5)	8.9	(5.6 - 13.9)	3.1	(1.7 - 5.5)	†N/A	†N/A	8.8	(5.6 - 13.8)	10.0	(7.0 - 14.2)	2.5	(1.2 - 5.0)

[†]N/A denotes insufficient sample size (<4 for the numerator and <30 for the denominator) and was suppressed according to SAMHSA guidelines.

Tables 9 and 10 are based on the 2011 American Community Survey and display estimates of the number of adults who meet the income criteria that would make them eligible to enroll in the Medicaid and Affordable Insurance Exchanges expansions, by insurance status.

Nationally, there are approximately 18.7 million uninsured adults with incomes < 139 percent of FPL, an additional 10.1 million with employer-based health insurance, 3.3 million with non-employer based insurance, 2.0 with other public insurance, and 12.6 currently with Medicaid coverage.

CMS estimates that by 2016, an additional 24 million people will be enrolled in Medicaid, the majority of whom will have been uninsured previously. Among the approximately 18 million adults who are currently uninsured and would become eligible for Medicaid, CMS estimates that 95 percent would enroll in Medicaid. In contrast, CMS estimates that by 2016, of the additional 24 million people who will be enrolled in Medicaid, only 2–3 million (8.3 to 12.5 percent) will have employer-sponsored health insurance and will enroll to obtain supplemental coverage through Medicaid. Participation rates are assumed to be higher for persons who will be eligible for Medicaid with non-group insurance. For example, the Urban Institute estimates that 85 percent of new Medicaid eligibles with non-group insurance will enroll in Medicaid. However, only about 3 million individuals with incomes less than 139 percent of FPL have non-group insurance. The NSDUH data indicate that the prevalence of SMI, SPD, and SUD is similar among those with incomes < 139 percent of FPL with private insurance and who are uninsured.

Nationally, there are approximately 19.3 million uninsured adults with incomes between 133 and 399 percent of FPL, an additional 45 million with employer-based health insurance, 5.4 million with non-employer based insurance, 2.9 with other public insurance, and 5.7 currently with Medicaid coverage. CMS estimates that by 2016, approximately 19 million people will be enrolled in the exchanges. Under the legislation, individuals with an offer of employment-based coverage generally will be ineligible for exchange subsidies. Thus, most individuals who receive subsidies and insurance through the exchanges will be uninsured (although the extent to which employers will stop providing insurance over the long run is a source of uncertainty and debate).

¹¹ Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Statistics Group. National Health Expenditures Projections 2010 – 2020. Available at: https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Data-and-

¹² Centers for Medicare & Medicaid Services. Medicaid Program; Eligibility Changes under the Affordable Care Act of 2010 (CMS-2349-F). Final Regulatory Impact Analysis. Available at: http://www.medicaid.gov/AffordableCareAct/Provisions/Downloads/MedicaidEligibilityFinalRule Regulatory-Impact-

Analysis.pdf.

Analysis.pdf.

Holahan J., Buettgens M., Carroll C., Dorn S. The Urban Institute. The Cost and Coverage Implications of the ACA Medicaid Expansion: National and State-by-State Analysis. Kaiser Commission on Medicaid and the Uninsured. November 2012. Available at: http://www.kff.org/medicaid/upload/8384.pdf.

Table 9: Adults Aged 18–64 Years Who Have Annual Family Incomes < 139 Percent of Federal Poverty Level, by Insurance Status, Nationally and by State

State	Employer-based Health Insurance	Direct-purchase Health Insurance	Medicaid	Other Public Insurance	Uninsured†
United States	10,151,024	3,331,468	12,621,579	1,974,795	18,705,110
Alabama	192,035	64,817	181,722	56,266	347,467
Alaska	12,988	1,117	22,607	6,831	33,205
Arizona	188,528	62,701	381,201	38,952	434,948
Arkansas	115,728	28,921	107,363	28,535	231,245
California	1,078,984	455,956	1,708,007	186,874	2,517,590
Colorado	148,057	72,829	172,373	35,970	265,071
Connecticut	101,337	24,467	161,416	13,381	93,152
Delaware	33,413	6,476	39,286	3,913	25,146
District of Columbia	40,156	12,102	44,831	3,470	19,914
Florida	515,901	204,646	646,365	138,785	1,577,102
Georgia	386,533	94,903	292,208	85,929	872,733
Hawaii	43,424	12,369	47,830	18,900	35,669
Idaho	61,798	29,384	44,186	9,642	98,726
Illinois	390,148	130,593	526,514	66,690	672,156
Indiana	258,952	63,005	220,682	36,239	398,100
lowa	137,978	33,437	100,590	11,008	110,895
Kansas	112,953	31,926	65,195	20,060	155,761
Kentucky	153,124	43,305	213,737	40,732	319,314
Louisiana	155,058	60,450	190,311	41,165	381,276
Maine	38,119	11,521	91,844	7,423	46,054
Maryland	156,378	46,451	173,527	23,829	184,478
Massachusetts	246,406	94,013	376,155	14,462	85,127
Michigan	348,620	98,292	541,730	43,903	527,439
Minnesota	167,314	59,894	225,727	16,135	149,609
Mississippi	124,896	27,501	150,278	28,076	264,654
Missouri	207,978	68,607	219,580	48,618	363,663

[†]These individuals would be eligible for the Medicaid expansion population.

Table 9 continued: Adults Aged 18–64 Years Who Have Annual Family Incomes < 139 Percent of Federal Poverty Level, by Insurance Status, Nationally and by State

State	Employer-based Health Insurance	Direct-purchase Health Insurance	Medicaid	Other Public Insurance	Uninsured†
Montana	33,343	16,627	25,082	5,847	68,442
Nebraska	73,135	26,098	44,352	7,979	81,256
Nevada	92,040	18,791	60,024	20,016	211,027
New Hampshire	46,308	10,698	27,926	4,291	42,006
New Jersey	190,445	54,401	252,724	25,541	362,863
New Mexico	65,074	22,469	98,992	16,434	176,370
New York	604,743	246,890	1,219,405	72,200	730,631
North Carolina	361,767	117,239	361,173	106,891	685,664
North Dakota	29,091	14,433	13,784	4,057	24,538
Ohio	387,957	105,288	555,337	71,911	587,013
Oklahoma	133,873	35,415	122,772	38,170	314,145
Oregon	144,919	59,218	165,517	20,868	253,123
Pennsylvania	439,556	162,133	542,511	55,491	502,119
Rhode Island	39,890	20,441	44,077	6,761	41,449
South Carolina	182,704	46,702	190,283	54,001	358,217
South Dakota	29,542	10,387	21,573	5,450	38,038
Tennessee	212,524	65,535	307,943	53,869	433,575
Texas	789,048	182,711	716,666	169,750	2,319,063
Utah	98,096	35,146	65,397	8,056	149,825
Vermont	26,753	6,053	35,166	1,956	11,285
Virginia	270,954	84,706	197,835	93,174	370,603
Washington	201,412	75,293	225,308	56,625	366,946
West Virginia	66,184	18,484	95,439	21,857	132,909
Wisconsin	195,300	51,265	274,322	23,979	210,975
Wyoming	19,560	5,362	12,706	3,833	22,534

[†]These individuals would be eligible for the Medicaid expansion population.

Table 10: Adults Aged 18–64 Years Who Have Annual Family Incomes Between 133 and 399 Percent of Federal Poverty Level, by Insurance Status, Nationally and by State

State	Employer-based Health Insurance	Direct-purchase Health Insurance	Medicaid	Other Public Insurance	Uninsured†
United States	45,003,899	5,416,326	5,727,115	2,861,812	19,272,997
Alabama	775,097	105,212	62,186	67,884	244,715
Alaska	73,960	7,760	11,709	14,149	63,356
Arizona	893,827	116,326	160,660	65,873	414,300
Arkansas	463,653	54,977	52,684	41,716	214,089
California	4,640,808	697,182	843,229	222,458	2,948,753
Colorado	688,136	121,579	71,234	57,247	320,107
Connecticut	397,358	49,595	85,204	17,366	141,139
Delaware	139,973	9,587	26,547	8,053	36,434
District of Columbia	67,280	9,268	25,167	2,244	14,838
Florida	2,523,532	379,303	311,072	203,007	1,644,960
Georgia	1,449,468	158,091	117,411	127,491	727,507
Hawaii	234,051	20,347	24,142	35,401	36,496
Idaho	268,163	47,487	18,775	18,566	103,029
Illinois	1,904,584	195,761	260,140	76,155	724,820
Indiana	1,144,767	93,410	96,162	49,051	384,965
lowa	556,588	72,926	46,782	14,980	110,986
Kansas	480,564	65,568	28,009	34,150	144,679
Kentucky	721,602	74,022	71,647	62,727	234,748
Louisiana	615,032	83,625	80,905	52,219	318,083
Maine	210,917	23,133	37,988	12,608	68,862
Maryland	725,068	92,249	105,926	42,758	252,507
Massachusetts	855,803	107,026	265,575	23,712	125,116
Michigan	1,633,006	179,665	203,919	63,942	484,692
Minnesota	848,900	120,320	101,267	30,645	195,903
Mississippi	462,799	53,390	56,061	44,715	188,299
Missouri	1,009,040	116,462	81,740	68,600	319,621

[†]These individual are eligible for subsidies and may enroll in the Affordable Insurance Exchanges.

Table 10 continued: Adults Aged 18–64 Years Who Have Annual Family Incomes Between 133 and 399 Percent of Federal Poverty Level, by Insurance Status, Nationally and by State

State	Employer-based Health Insurance	Direct-purchase Health Insurance	Medicaid	Other Public Insurance	Uninsured†
Montana	151,707	26,158	9,765	13,126	76,840
Nebraska	309,563	52,358	16,577	21,620	89,621
Nevada	459,537	38,031	35,062	28,630	234,424
New Hampshire	196,548	18,174	14,598	11,603	61,073
New Jersey	1,030,580	102,481	141,134	40,214	505,571
New Mexico	265,661	31,835	45,485	25,060	164,622
New York	2,545,399	255,531	633,056	100,503	984,185
North Carolina	1,446,864	196,046	137,488	160,042	625,217
North Dakota	103,999	22,695	6,402	5,283	26,066
Ohio	1,996,156	186,097	161,044	97,025	564,194
Oklahoma	583,054	57,261	47,779	54,294	249,504
Oregon	586,543	93,626	58,080	27,537	256,909
Pennsylvania	2,079,428	248,513	224,175	75,734	546,597
Rhode Island	155,719	14,042	19,233	5,582	50,369
South Carolina	747,340	73,538	67,519	84,785	293,792
South Dakota	128,463	28,225	5,528	13,167	36,873
Tennessee	1,055,603	128,077	113,423	80,737	392,675
Texas	3,338,654	326,972	348,716	247,319	2,283,862
Utah	520,466	56,626	27,268	14,574	149,296
Vermont	98,849	9,100	25,883	4,722	23,550
Virginia	1,111,304	127,488	71,428	135,053	416,151
Washington	948,180	134,335	93,835	89,608	408,469
West Virginia	302,948	17,007	35,418	24,315	115,556
Wisconsin	977,934	105,516	137,077	35,416	218,051
Wyoming	79,424	12,323	5,001	8,146	36,526

[†]These individual are eligible for subsidies and may enroll in the Affordable Insurance Exchanges.

V. Methods for Estimating Behavioral Health Service Need and Use

This section describes methods that states can employ to generate prevalence and utilization estimates to support planning efforts. An overview of the National Survey on Drug Use and Health (NSDUH) is provided, as well as step-by-step instructions on how to access the data. In addition, information on how to access and use the American Community Survey is also provided.

National Survey of Drug Use and Health Data as a Resource for System Planning

The National Survey of Drug Use and Health (NSDUH) is a unique data source for determining the prevalence of behavioral health conditions and use of behavioral health services. NSDUH is sponsored by the Substance Abuse and Mental Health Services Administration (SAMHSA), in the U.S. Department of Health and Human Services. NSDUH collects information from residents of households and noninstitutional group quarters (e.g., shelters, rooming houses, dormitories) and from civilians living on military bases. The survey excludes homeless persons who do not live in shelters, military personnel on active duty, and residents of institutional group quarters such as jails and hospitals. NSDUH employs a state-based design with an independent, multistage area probability sample within each state and the District of Columbia, which allows for state-level estimates. Approximately 70,000 interviews are completed each year. The survey collects data by administering questionnaires to a representative sample of the population through face-to-face interviews at the respondent's place of residence. For more information on the NSDUH see http://www.samhsa.gov/data/NSDUH.aspx.

Measures of Behavioral Health Need

Estimates of the prevalence of behavioral health conditions within a state can provide an important baseline for planning efforts. Three measures that may be useful, in particular, are the prevalence of:

- Serious mental illness
- Serious psychological distress
- Substance use disorder

These measures are described briefly below.

<u>Serious Mental Illness</u>: Respondents to the NSDUH meet the criteria for SMI in the past year if they have had a diagnosable mental, behavioral, or emotional disorder (excluding developmental and substance use disorders) of sufficient duration to meet diagnostic criteria specified within the 4th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV) that has resulted in serious functional impairment that substantially interferes with or limits one or more major life activities. Adult NSDUH respondents' mental illness is determined based on modeling their responses to questions on distress (Kessler-6 [K6] scale) and impairment (truncated version of the World Health Organization Disability Assessment Schedule [WHODAS]).¹⁴

_

¹⁴ Beginning in 2008, this indicator is based on both distress and impairment and is not comparable with SMI variables prior to 2008, when SMI was only based on distress. Recoded variables were defined from these items to measure psychological distress and SMI as well as suicide ideation in the past year. These variables include total scores from the psychological distress and impairment scales, the predicted probability of SMI, and indicators of various levels of mental illness.

<u>Serious Psychological Distress</u>: Respondents are determined to have SPD if they have a score of 13 or higher on the Kessler-6 (K6) scale. The Kessler-6 (K6) scale consists of six questions that gather information on how frequently adult respondents experienced symptoms of psychological distress during the past month or during the one month in the past year when they were at their worst emotionally. These questions ask about the frequency of feeling (1) nervous, (2) hopeless, (3) restless or fidgety, (4) sad or depressed, (5) that everything was an effort, and (6) no good or worthless. The NSDUH measure of serious psychological distress results in larger prevalence estimates than the SMI.¹⁵

<u>Substance Use Disorder</u>: An adult is defined as having a SUD if they meet the criteria for abuse or dependence for illicit drugs or alcohol. Abuse of illicit drugs or alcohol is defined as meeting one or more of the four criteria for abuse included in the DSM-IV. Dependence on illicit drugs or alcohol is defined as meeting three out of seven dependence criteria (for substances that included questions to measure a withdrawal criterion) or three out of six dependence criteria (for substances that did not include withdrawal questions) for that substance, based on criteria included in DSM-IV. Additional criteria for alcohol and marijuana dependence since 2000 included the use of these substances on 6 or more days in the past 12 months.

Measures of Behavioral Health Service Use

As noted above, behavioral health condition prevalence rates provide an important starting point for understanding a population's potential need for treatment. However, many individuals with a diagnosable mental or substance use condition will never seek treatment.¹⁶ Furthermore, many individuals without a diagnosable mental or substance use condition, such as those whose conditions are in remission or are asymptomatic, may still need maintenance treatment to remain well.

The NSDUH includes a number of measures of behavioral health utilization that can be helpful in projecting behavioral health services utilization under new programs. For example, among the types of services captured on the NSDUH are the following measures:

- Receipt of any mental health treatment
- Receipt of any inpatient mental health treatment
- Receipt of any outpatient mental health treatment
- Receipt of any treatment at any location for illicit drug or alcohol use
- Receipt of any prescription medication for mental health treatment
- Receipt of substance use (illicit drug or alcohol) treatment at a specialty facility

Other more specific types of utilization measures are also available, such as receipt of treatment at an inpatient rehabilitation facility and doctor's office. It should be noted, however, that the NSDUH sample sizes may be too small to accurately estimate the number of persons using some specific types of services at the state level, even after pooling multiple years of survey data.

-

¹⁵ The measure of serious psychological distress is based on the K6 scale. For a description and properties of the K6 scale, see Kessler RC, Barker PR, Colpe LJ, et al., Screening for serious mental illness in the general population. *Archives of General Psychiatry* 2003;60(2):184–189.

¹⁶ Substance Abuse and Mental Health Services Agency. *Results from the 2010 National Survey on Drug Use and Health: Mental Health Findings*. NSDUH Series H-42, HHS Publication No. (SMA) 11-4667. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2012. Available at: http://www.samhsa.gov/data/NSDUH/2k10MH Findings/2k10MHResults.pdf.

In the next section, we present step-by-step instructions for generating state- or county-level behavioral health prevalence and service use estimates using the NSDUH to inform decisions about system planning.

Instructions for Using the NSDUH (R-DAS) to Estimate Behavioral Health Prevalence and Service Use

To determine the prevalence of behavioral health conditions and current behavioral health services utilization among populations that could be eligible for new programs and insurance expansions, a starting point is to analyze the NSDUH data using the Substance Abuse and Mental Health Data Archive (SAMHDA) Restricted-Use Data Analysis System (R-DAS).

The R-DAS allows researchers to produce custom frequencies and crosstabs of state-level data using restricted-use data files. All output is considered public use, and any data that do not meet disclosure limitations are automatically suppressed. The R-DAS for NSDUH data is available at: http://www.icpsr.umich.edu/icpsrweb/content/SAMHDA/rdas.html.

States can develop prevalence and utilization estimates using the following steps:

- Log on to the R-DAS website using an account from MyData, Google, or Facebook. Create a
 MyData account by going to the R-DAS website
 (http://www.icpsr.umich.edu/icpsrweb/content/SAMHDA/rdas.html) and then click on "Create
 a new MyData account." Fill out all fields in the form and click "Submit."
- 2. Once your account information has been submitted, stay on the current webpage. Go to the top of the current web page and hover your mouse icon over the red tab "Analyze Online." Scroll down and then click on "Analyze Online with R-DAS."
- 3. Several data files are currently available for analysis, including 8-year (2002–2009), 4-year (2002–2005, 2006–2009), or 2-year files (2002–2003, 2004–2005, 2006–2007, 2008–2009, 2010–2011). Select the file of interest by clicking on the appropriate folder. Carefully review the documentation for the data file of interest, including the study scope, description, and methodology, documentation on producing correct estimates, and codebook. We also recommend that you review the variable crosswalk.
- 4. Once you have determined which data file to use,¹⁷ click on the data file name. A menu will unfold that displays "Online Analysis: R-DAS." Click on "R-DAS." For the purpose of this demonstration, we selected the NSDUH 2-year R-DAS Files.
- 5. The login page will be displayed. Click on "ICPSR MyData." Enter the email address and password you used to setup your MyData account. Then, click the "Log In" button.

35

¹⁷ Determination of which R-DAS file is most appropriate is based on the user's analytic needs. For example, the 2-year file may provide insufficient sample sizes; therefore, users may need to use the 4- or 8-year files. R-DAS files may contain different variables based on the availability and consistency of variables across years covered. In addition, not all variables from the full restricted-use data files are included in R-DAS.

- 6. The Terms of Use page will be displayed. Carefully review the Terms of Use and select "I Agree" at the bottom of the page. You will then be taken to the NSDUH 2-Year R-DAS online analysis web page.
- 7. Once you are on the NSDUH 2-Year R-DAS analysis web page, review the documentation at the bottom of the page, including FAQs on R-DAS, Study Home Page, and the information available on Getting Started and Recoding Variables.
- 8. In the ROW box, enter the variable for the behavioral health condition or service of interest. Note that the presence of condition is indicated by variable name(1). Each variable must be entered in the ROW box as a separate data run.

a. Serious mental illness: SMIYR¹⁸

b. Serious psychological distress: SPDYAJ_B¹⁹

c. Substance use disorder: ABODILAL

d. Receipt of any mental health treatment: AMHTXRC3

e. Receipt of any inpatient mental health treatment: AMHINP2

f. Receipt of any outpatient mental health treatment: AMHOUTP3

g. Receipt of any treatment at any location for illicit drug or alcohol use: TXILLALC

h. Receipt of any prescription medication for mental health treatment: AMHRX2

i. Receipt of substance use (illicit drug or alcohol) treatment at a specialty facility: SPILLAC

- 9. In the COLUMN box, enter STATE. If the entire table is suppressed because one or more cells in the table have too few cases, restrict the analysis to only the state(s) of interest using the SELECTION FILTER box (see below).
- 10. In the CONTROL box, enter populations you wish to compare. A separate table is produced for each category of a CONTROL variable. The variable POVERTY2 will enable comparison between the following predetermined poverty classifications: (1) <100% of federal poverty threshold, (2) 100-199% of federal poverty threshold, (3) >=200% of federal poverty threshold. An alternative option is to use the continuous variable POVPER to classify into specific categories as appropriate. For example, to recode as <139% of federal poverty threshold enter, POVPER(r: 0-138 "<139"). Note that it if the poverty classifications have overlapping values, such as the values presented in this Toolkit (<138% and 133-399%), the system will automatically place the overlapping cases in only the first category; thus, separate data runs must be completed for each poverty classification.
- 11. In the SELECTION FILTER box, enter multiple filters as appropriate for your analysis. For example, you can restrict the analysis to individuals who are aged 18–64 years and uninsured: AGE(18–64), IRINSUR(2). It is also necessary to include the year pair indicator, as a filter variable, to generate appropriately weighted results.²⁰ For example, the 2-year 2008–2009 file

1

¹⁸ The variable for SMI (SMIYR) is relatively new and is based on responses to questions from standard instruments that measure the individuals' symptoms and functioning. As a result of the changes in coding, if you are conducting this analysis in R-DAS, it is only possible to use the 2008–2009 or 2010–2011 2-year file for estimates using this definition of SMI. The Center for Behavioral Health Statistics and Quality (CBHSQ) will be updating the SMI variable in late 2013. The revised variable will be SMI U. The revised variable should be used once it is available.

¹⁹ Note: this variable is available only in the later 2- and 4-year R-DAS files.

²⁰ Inter-University Consortium for Political and Social Research. Institute for Social Research, University of Michigan. Available at: http://www.icpsr.umich.edu/icpsrweb/SAMHDA/studies/34482/datasets/1/sda/variable?var=YRPRIND&sda_id=18235.

is indicated by YRPRIND(4). Lastly, if you are restricting the analysis to particular state(s), enter STATE, with the FIPS code(s) of interest in parentheses, separated by commas.

- 12. The "Column" box will already be checked. Click "Run the Table."
- 13. A results screen will appear with the prevalence estimates. On the left side of the results screen, under "Revise the Display," you may make modifications to the way in which the output is displayed. We recommend selecting to display 95 percent confidence intervals by checking the appropriate box. After making any modifications to the display, click "Revise Display." Note that any data that do not meet disclosure limitations will be suppressed automatically.

Additional Notes on Using the R-DAS

Several data options are available for analysis, including 8-year (2002–2009), 4-year (2002–2005, 2006–2009), or 2-year files (2002–2003, 2004–2005, 2006–2007, 2008–2009, 2010–2011). Determination of which R-DAS file is most appropriate should be based on the user's analytic needs. For example, the 2-year file may provide insufficient sample sizes; therefore, users may need to use the 4- or 8-year files. Additionally, users must determine what variables they require and in which years they are available. In all analyses using the 2- and 4-year files, the variable indicating the years of data should be used either as a variable in the table or as a filter variable used to subset the data file. Users should not combine multiple years of data because the weights have been developed for the specific year combinations on the files. Users should carefully review the coding manual and documentation to determine whether their analyses can be supported and any use limitations.

To reflect the uncertainty in the prevalence estimates, all results should be presented with confidence intervals. It should be noted that, in some instances, the cell sizes may be so small that the results will be suppressed automatically. Because relatively small NSDUH samples form the basis of the behavioral health prevalence estimates for some states, you may need to include multiple data years to generate accurate estimates.

If you have any questions, please contact the SAMHDA Help Desk via telephone (888-741-7242) or email (samhda-support@icpsr.umich.edu).

Instructions for Using the NSDUH Data Portal to Estimate Behavioral Health Prevalence and Service Use

There are limitations to the types of analyses that the R-DAS, as currently designed, can support. For example, the first release will not support regressions or sub-state estimates. Moreover, some years or variables may not be available. In order to further expand access to NSDUH restricted-use data, SAMHSA has also developed a Data Portal.

The Data Portal provides authorized researchers with secure virtual access to confidential data via a virtual desktop for approved research projects. The data remain in a central repository and cannot be locally downloaded, copied, or saved. Further, all output have to undergo disclosure analysis before the researcher can remove them from the system. Currently, 2004 to 2011 NSDUH are available.

The Data Portal includes SAS (SAS Institute; Cary, NC), SPSS (IBM Corp; Somers, NY), Stata, Microsoft[®] Office, and other software for analysis, but there is no query system provided, thus users will need to be

facile with one of these statistical software packages. The Data Portal access requires completion of an application process and is subject to project approval.

Analysts interested in applying for access to the Data Portal should carefully review the application materials available at www.icpsr.umich.edu/icpsrweb/content/SAMHDA/dataportal.html. As part of the application process, applicants must determine what variables are needed for the proposed project. Much of the information on variables is available through the codebooks for the public-use files. The combined examination of the public-use data codebook with complete frequency distributions, and the questionnaires, may help analysts decide whether the public-use file meets their research purposes or whether the restricted-use NSDUH confidential data are needed. Additional information on the variables available through the data portal is available at

http://www.icpsr.umich.edu/icpsrweb/content/SAMHDA/dataportal.html. States can also contact the Center for Behavioral Health Statistics and Quality (CBHSQ) at

http://www.samhsa.gov/data/data_request.aspx for more information on approximate sample sizes (exact sample sizes are confidential).

For each research project, the organization(s) must complete and submit the Application for Access to Confidential Data. The Application must clearly outline the nature of the proposed research project, as well as the specific information and categories of variables needed and how this information will be used. Only the data requested in the application and approved as part of the signed Agreement will be provided for use in the Data Portal. Any additional data must be requested and approved through a formal, signed amendment to the Agreement. After the application is approved, CBHSQ, the Principal Project Officer, and the Receiving Organization Representative must sign the Confidential Data Use and Nondisclosure Agreement. Then each research team member must complete confidentiality training and sign a notarized Designation of Agent and Affidavit of Nondisclosure form agreeing to abide by Confidential Information Protection and Statistical Efficiency Act (CIPSEA) requirements and the Confidential Data Use and Nondisclosure Agreement.

Additional information about the NSDUH Data Portal, including the application materials, is available at www.icpsr.umich.edu/icpsrweb/content/SAMHDA/dataportal.html.

Instructions for Using the American Community Survey to Estimate the Number of People Who Will Enroll in Insurance Expansions

The NSDUH can provide states with information on the percentage of a given population with a behavioral health disorder and the percentage that use particular behavioral health services. The NSDUH also includes population counts (based on population weights) that can be used to project the numbers of individuals who will need and use services.

However, states may want to consider whether to obtain the population count information from an alternative source and limit use of the NSDUH to generating the population proportions. In particular, the American Community Survey (ACS) is a frequently used source for estimates of the number of individuals who would become eligible under the Affordable Care Act Medicaid expansion and Affordable Insurance Exchanges. The 2011 ACS included interviews with 2.1 million people living in households and 148,500 people living in group quarters (versus about 280,000 interviewed over the four years of NSDUH data). Because the number of interviews in the ACS is much larger than the number from the NSDUH, the counts of the uninsured will be stronger when using the ACS, particularly in the

smallest states.²¹ The ACS also includes county-level data for states interested in generating county-level counts.

Information above on the prevalence and likely use of behavioral health services from the NSDUH can be applied to estimates of the number of people who are likely to enroll in particular programs or insurance expansions, such as under the Medicaid expansion and Affordable Insurance Exchanges in each state or by county.

There are two methods to access the ACS data, which are detailed below.

- 1. The Public Use Microdata Samples (PUMS) ACS data can be downloaded directly in SAS® or CSV format from: http://www.census.gov/acs/www/data_documentation/2011_release/. Once you have downloaded the data, use similar criteria and assumptions to identify the population(s) of interest as above in the NSDUH (e.g., adults aged 18-64 years who are uninsured and have incomes less than 139 percent of FPL and adults aged 18-64 years who are uninsured and have incomes between and including 133 percent and 399 percent of FPL, respectively). First, restrict the population to the age group of interest. Next, FPL can be determined by the ACS poverty status recode variable (POVPIP), which is based on annual income as reported on the survey and measures the percent of poverty threshold. Then, identify uninsured individuals on the ACS using the Insured/Any Health Insurance Coverage Status variable (HICOV=2). If you are interested in obtaining information on subcategories of the insured (HICOV=1), additional information is available using the variables HINS1-HINS7. Please note that it is necessary to deduplicate using the following (or alternative) hierarchy: (1) insurance through a current or former employer or union (HINS1=1); (2) insurance purchased directly from an insurance company (HINS2=1); (3) Medicaid (HINS4=1); (4) other public insurance: Medicare, TRICARE or other military health, Veterans Affairs (VA), and Indian Health Service (HINS3=1 or HINS5=1 or HINS6=1 or HINS7=1). Note that the ACS PUMS is a weighted sample, and weighting variables must be used to generate accurate estimates and standard errors. The PUMS file includes both population weights and household weights. Population weights (PWGTP) should be used to generate statistics about individuals.
- 2. An alternative mechanism to access the ACS data is via the U.S. Census Bureau American FactFinder. From the American FactFinder homepage (http://factfinder2.census.gov), click on the "Advanced Search" tab on the top of the page. On the left side of the screen, click the "Topics" icon to expand. Then, click "Databases" at the bottom and select the American Community Survey dataset of interest to add it to the search options. For the purpose of this example, we selected the 2011 ACS 1-year estimates. Next, click on "People" at the top of the "Select Topics" box to expand the selection criteria. Expand the "Insurance Coverage" option and select "Health Insurance." Expand the "Age & Sex" option and select "Age." Expand the "Poverty" option and select "Poverty." Close the "Select Topics" box. On the left side of the screen, click the "Geographies" icon to expand and use the drop down menu to select the geographic level of analysis (e.g., United States, state, county). Then, highlight the geographic areas of interest and click "Add to Your Selections." Tables with the data of interest will appear under the search results. For the purpose of this example, we select the link to "Health Insurance Coverage Status and Type by Ratio of Income to Poverty Level in the Past 12 Months

²¹ Additional information and data from the ACS are available at the CMS website on Census Data to Target the Uninsured. http://cms.gov/Outreach-and-Education/Outreach/HIMarketplace/Census-Data-.html?no_redirect=true.

39

_

by Age." Note that the age, poverty, and health insurance categories are predetermined and recoding is not possible. Depending on your poverty range of interest, you may need to add estimates of poverty categories for adults aged 18–64 years. Also note that if you select the link to "Health Insurance Coverage Status and Type by Ratio of Income to Poverty Level in the Past 12 Months by Age," the health insurance coverage subcategories (e.g., employer-based health insurance, direct-purchase health insurance, Medicare coverage, and Medicaid/means-tested public insurance) are not mutually exclusive and, therefore, sum to more than the total population with health insurance coverage. As a result, if you are interested in population estimates for these populations, we recommend that you follow step 1 above.

- 3. To estimate the number of individuals, multiply the prevalence rate of behavioral health condition or percentage of behavioral health service of interest from the NSDUH by the number of individuals in the ACS who are eligible for the Medicaid expansion and Affordable Insurance Exchanges (or other population of interest).
- 4. Analysts then may want to make adjustments to the estimates to take into account "take-up rates" and elasticity of demand²² with respect to insurance coverage.

Key Considerations

In this section, we discuss some other considerations that states may wish to consider in using the NSDUH data for service planning.

<u>Defining Eligibility</u>: The first step in determining the behavioral health needs and projected utilization rates of a particular population that will enroll in a new program or insurance expansion is to define the eligibility criteria of that program. As discussed below, two commonly used eligibility criteria in program and insurance expansions are income and age.

<u>Income</u>: The eligibility for the new Affordable Care Act insurance expansions is primarily determined by a person's federal poverty level (FPL), which takes into account their state of residence, family income, and family size. FPL varies depending on family size and by state; thus, one should consider these factors in assigning the U.S. Department of Health and Human Services guideline values to particular individuals in the survey.²³

Age: Analysts may wish to consider the behavioral health treatment needs for children and adult separately because children and adults typically differ in: (1) types of mental health and substance use conditions, (2) the measures available for identifying behavioral health needs, and (3) available insurance programs. In particular, many low-income children are eligible for and enrolled in the Children's Health Insurance Program (CHIP). Finally, it is important to note that the NSDUH does not include children younger than 12 years, and not all behavioral health measures are available for children aged 12 to 17 years.

<u>Take-up Rates</u>: Projections of the number of individuals in newly established programs must take into account the fact that not everyone who is eligible for a public or private insurance program will enroll.

²² Elasticity of demand is the degree to which demand for a good or service is a function of change in price.

²³ Office of the Assistant Secretary for Planning and Evaluation. Prior HHS Poverty Guidelines and Federal Register References. Available at: http://aspe.hhs.gov/poverty/figures-fed-reg.cfm.

The take-up rate is the percentage of those who are eligible for a particular program and actually enroll in that program.

In terms of the Medicaid expansion, CMS assumed that states will facilitate enrollment in the Medicaid expansion and that ultimate participation rates in the Medicaid expansion would be achieved in 2015, with 80 percent of the ultimate rate achieved in 2013 and 90 percent achieved in 2014. ²⁴ In contrast, the Congressional Budget Office estimated that 57 percent of uninsured people who gain Medicaid eligibility will enroll in the program nationally, whereas a 75 percent take-up rate was used by the Urban Institute. ^{25,26,27 28}

The Effect of Insurance Coverage on Utilization Rates: In projecting utilization rates under a new program, states must be aware that current behavioral health use rates may change once a population gains insurance coverage. A large body of research finds that once people move from being uninsured to insured, they use more medical care and incur higher medical care costs. The extent of the increase is often called elasticity of demand or an induction factor. Estimating the exact amount by which use will increase once people become insured is equal parts "art" and "science." Given the uncertainty around the exact amount of increase, we suggest that policymakers use a range of estimates. A reasonable baseline estimate, which has been cited by CMS in their recent regulatory impact analysis, comes from the expansion of Oregon's Medicaid program.²⁹ In 2008, Oregon conducted a lottery to expand access to uninsured adults with incomes below 100 percent of FPL. Approximately 10,000 randomly selected low-income adults were newly enrolled in Medicaid. The evaluation is particularly strong because it was able to compare outcomes for those who won the lottery with outcomes for those who applied but did not win, and it contains an estimate of the benefits of Medicaid coverage. Evaluators found that Medicaid coverage increases the probability of using outpatient care by 35 percent, of using prescription drugs by 15 percent, and of hospital admissions by 30 percent. 30 Overall, they estimate that the increased health care use from enrollment in Medicaid translates into about a 25-percent increase in total annual health care expenditures. Although these estimates are useful as baseline assumptions, utilization rates for particular behavioral health services and providers may differ from the overall medical care utilization rates, and the rates will be influenced by the types of insurance benefits offered.

²⁴ Centers for Medicaid & Medicare Services. Offices of the Actuary. Estimated Financial Effects of the "America's Affordable Health Choices Act of 2009" (H.R. 3200), as Reported by the Ways and Means Committee. October 21, 2009. Available at: http://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ActuarialStudies/Downloads/HR3200_2009-10-21.pdf
²⁵ Elmendorf DW. Congressional Budget Office, letter to Speaker Pelosi. March 20, 2010. Table 4. Available at: http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/113xx/doc11379/amendreconprop.pdf.

Holahan J, Headen I. Medicaid Coverage and Spending in Health Reform: National and State-by State Results for Adults at or Below 133 percent FPL. The Henry J. Kaiser Family Foundation, May 2010. Available at: http://obamacarefacts.com/obamacaredocs/medicaid-expansion-kkf.pdf.

Holahan J, Buettgens M, Carroll C, Dorn S, The Urban Institute. The Cost and Coverage Implications of the ACA Medicaid Expansion: National and State-by-State Analysis. November, 2012. Available at: www.urban.org/uploadedPDF/412581-The-ACA-Medicaid-Expansion-in-Washington.pdf.

²⁹ Centers for Medicare & Medicaid Services. Medicaid Program; Eligibility Changes under the Affordable Care Act of 2010. (CMS-2349-F) Final Regulatory Impact Analysis. March 2012. Available at: http://www.medicaid.gov/AffordableCareAct/downloads/CMS-2349-F-RegulatoryImpactAnalysis.pdf.

³⁰ Finkelstein A, Taubman S, Wright B, et al. The Oregon Health Insurance Experiment: Evidence from the First Year. National Bureau of Economic Research Working Paper No. 17190, July 2011. Available at: http://www.nber.org/papers/w17190.

VI. Methods for Estimating County-Level Behavioral Health Service Need and Use

For large states and states that organize their behavioral health systems within county governments, determining the need for and use of mental health and substance abuse services at the county level may be particularly important. For example, California consists of 58 counties with considerable variation in structure and capacity from one county to another. Thus, insurance expansions may have very different implications for service planning in different counties.

At this time, however, the availability of accurate county-level prevalence and utilization estimates is limited by the relatively small samples sizes captured in national surveys of behavioral health, such as the NSDUH.³¹ In addition, although one can create synthetic estimates by projecting state-level estimates to counties by adjusting for demographic differences, the accuracy of the resulting estimates cannot be determined and may be poor. Thus, to develop county-level estimates, we recommend that states use state-level utilization data for the particular sub-population of interest and assume that the utilization rates apply to the population within the county.

The following is an example of the development of county-level estimates for enrollment in the Medicaid Expansion under the Affordable Care Act in 2014, using Alameda County, California:

- 1. Use the 2011 American Community Survey to determine that in Alameda County, California there are approximately 201,203 individuals aged 18–64 years who are less than 139 percent of FPL, of which 69,128 are uninsured.
- 2. Assume that 95 percent of those who are uninsured and eligible will enroll: 65,672.
- 3. Determine the prevalence rates. According to the state-level NSDUH estimates for California, the prevalence rate for SMI, SPD, and SUD among adults aged 18-64 years who are uninsured and have annual family incomes less than 139 percent of FPL is approximately 5.0 (CI: 3.7-6.6), 11.2 (CI: 9.0-13.7) and 9.7 (CI: 7.7-12.1) percent, respectively.
- 4. Assume that the majority of enrollees will be uninsured; thus, multiply 65,672 by the prevalence rates to determine the number of people with SMI, SPD, and SUD in Alameda County who are likely to enroll in the Medicaid Expansion. Note that although the prevalence rates are not the same as utilization rates, they may be useful as an indicator of "need" and potentially "unmet need":
 - SMI: 5.0% x 65,672 = 3,284
 SPD: 11.2% x 65,672 = 7,355
 - SUD: 9.7% x 65,672 = 6,370

5. Next, examine current utilization rates among the same population. According to the NSDUH estimates, the utilization rates for mental health services among adults aged 18–64 years who are uninsured and have annual family incomes less than 139 percent of FPL are:

Any mental health (MH) treatment use: 4.3% (Cl: 3.0 – 6.1)
 Any inpatient MH treatment: 0.5% (Cl: 0.2 – 1.4)
 Any outpatient MH treatment: 2.5% (Cl: 1.6 – 4.1)
 Any prescription for MH medication: 2.7% (Cl: 1.8 – 4.2)

6. Calculate the number of individuals who are newly enrolled and who may use mental health services in Alameda County, California during the course of a year:

o Any MH treatment: 4.3% x 65,672 = 2,824

_

³¹ SAMHSA is currently evaluating the feasibility of releasing a county-level R-DAS for large counties.

o Any inpatient MH treatment: $0.5\% \times 65,672 = 328$ o Any outpatient MH treatment: $2.5\% \times 65,672 = 1,642$ o Any prescription for MH medication: $2.7\% \times 65,672 = 1,773$

- 7. Adjust the utilization rates by assuming any induction factors. As described above, a reasonable assumption is that once people become insured, the probability of hospital admission will increase by 30 percent, of using outpatient care by 35 percent, and of using prescription drugs by 15 percent.³² We assume that any mental health care will increase by 25 percent, based on the data reviewed above showing that overall costs increased by 25 percent and because it is in between the low and high increases among various MH services. A range of estimates can be created by using alternative assumptions.
- 8. Recalculate the number of individuals who are newly enrolled and who may use mental health services in Alameda County, California during the course of a year using the induction factor:

Any MH treatment: 1.25 x 2,824 = 3,530
 Any inpatient MH treatment: 1.30 x 328 = 427
 Any outpatient MH treatment: 1.35 x 1,642 = 2,216
 Any prescription for MH medication: 1.15 x 1,773 = 2,039

9. Calculate the increase in mental health service use during the course of a year (Step 8 minus Step 6):

Any MH treatment: 706
 Any inpatient MH treatment: 99
 Any outpatient MH treatment: 574
 Any prescription for MH medication: 266

VII. Conclusion

This Behavioral Health Treatment Needs Assessment Toolkit provides guidance on how states and other payers can address key questions regarding the expected level of need for and use of behavioral health services that might be offered to newly eligible populations. The Toolkit provides readily available estimates of the prevalence of behavioral health disorders and use of behavioral health services among populations who are likely to be eligible for insurance or other waiver expansion. The Toolkit also describes how users can access and analyze the NSDUH to obtain additional or more tailored information on behavioral health needs by particular sub-populations within states, income groups, insurance status groups, and age groups. Also discussed are factors that need to be considered in generating estimates, such as how gaining insurance may influence utilization rates and assumptions about participation rates.

-

³² Finkelstein A, Taubman S, Wright B, et al. The Oregon Health Insurance Experiment: Evidence from the First Year. National Bureau of Economic Research Working Paper No. 17190, July 2011. Available at: http://www.nber.org/papers/w17190.

Authors

Truven Health Analytics

Tami Mark, Ph.D.

Lauren Wier, M.P.H.

Andriana Hohlbauch, M.P.H.

John Easterday, Ph.D.

Human Services Research Institute

David Hughes, Ph.D.

Technical Assistance Collaborative

Steve Day

RTI International

Michael Penne, M.P.H.

Alexander Cowell, Ph.D.

Substance Abuse and Mental Health Services Administration

Kevin Malone

Suzanne Fields, MSW, LICSW

Reviewers

Substance Abuse and Mental Health Services Administration

Jonaki Bose

National Academy for State Health Policy (NASHP)

Neva Kaye

Sonya Schwartz, M.S.



SAMHSA's mission is to reduce the impact of substance abuse and mental illness on America's communities