Mental Health in Health Care Reform

Senator Connie Lawson

Majority Floor Leader

Indiana State Senator, District 24

Stephen C. McCaffrey, JD

President & Chief Executive Officer

Mental Health America of Indiana

MHA
Mental Health America

Mental Health in Health Care Reform

The Patient Protection and Affordable Care Act (ACA) is expected to expand health care coverage to an additional 32 million citizens and legal immigrants by 2019 through a combination of state-based private insurance exchanges and a Medicaid expansion.

MHA
Mental Health America

Expanding Coverage

The new law will greatly expand access to health care coverage including mental health care and substance use treatment primarily through the following provisions:

- In 2014, Medicaid will expand to 133% of the federal poverty level
- An individual mandate will require most individuals to obtain insurance.
  - The individual mandate is required to ensure healthy individuals obtain insurance, **pooling the risks of healthy participants with individuals with health disorders like mental illness and substance use.**

MHA
Mental Health America

State Exchanges

The pooling of risk is made possible through the creation of Exchanges

The Affordable Care Act requires the establishment of state-based health plan "Exchanges" by January 1, 2014 through which individuals and small businesses can purchase coverage with pooled risk and thus lower premiums.

- States are to create "American Health Benefit Exchanges" and "Small Business Health Options Program (SHOP) Exchanges" to be administered by a governmental agency or non-profit organization through which small businesses (up to 100 employees) and individuals can purchase insurance.

MHA
Mental Health America

Mental Health and Addiction

- **Mental health care and addiction treatment are included on the list of essential benefits that must be covered in new plans offered to the uninsured through the exchanges.**
  - But the specifics of what these essential benefits will include remain in question. These benefits (and others on essential list including rehabilitative services, prescription drugs, preventive services, etc) will be further defined by the Secretary and include opportunities for public comment.
  - The state can decide to enhance the benefit package
- **In addition, the Mental Health Parity and Addiction Equity Act applies to these health insurance plans.**

MHA Mental Health America

Mental Health and Addiction Parity

Parity means that mental health and substance abuse must be provided in a way that is no more restrictive than medical benefits

MHA
Mental Health America

Benefit Equity

- **Treatment limitations imposed on mental health and substance use benefits**

  (e.g., frequency of treatment, number of visits, number of days, or similar limits on scope or duration of treatment)

  may NOT be more restrictive than those imposed on medical and surgical benefits.

- **Plans that provide Out-of-Network coverage under the medical and surgical benefit must provide ON PAR Out-of-Network coverage under the mental health and substance use benefit.**

- **Criteria for medical necessity determinations and the reason for any denial must be made available to contracted providers or the plan participant or beneficiary upon request.**

MHA
Mental Health America

Financial Equity

- **Financial requirements** imposed on mental health and substance use benefits (e.g., deductibles, co-payments, coinsurance, out-of-pocket expenses) **may NOT be more restrictive** than those imposed on medical and surgical benefits.
- **There can be NO separate cost-sharing requirements or treatment limitations that are applicable only to mental health and substance use benefits.**
- **Plans are prohibited from using "separate but equal deductibles."** In other words, mental health and substance use disorders and medical and surgical benefits must add up together towards the same, combined deductible.

MHA Mental Health America

Parity and State Laws

- Where there is a state parity law or state mandate, the Federal Parity law serves as the floor and state laws must be enhanced to reach the federal floor.
- State laws that require more than the federal law are NOT preempted.

MHA
Mental Health America

Medicaid Expansion

- **In 2014, Medicaid will expand to 133% of the federal poverty level**
  - ($14,404 for individuals; $29,327 for families of four) regardless of traditional eligibility categories (thus including childless adults).
- **Those newly eligible for Medicaid through the expansion will not receive regular Medicaid benefits**
  - instead benefits modeled on private insurance packages.
- **Mental health and substance use benefits that are required of plans offered through the Exchanges will apply to those newly eligible for Medicaid through the expansion.**
- **Federal parity requirements will also apply to those newly eligible for Medicaid.**

MHA
Mental Health America

Private Insurance Market Reforms

- **Preexisting condition exclusions [including mental health] are prohibited in all plans starting in 2014 for adults and six months after enactment (September 23, 2010) for children.**
  - Insurers must accept every employer and individual that applies - guaranteed issue and renewability - beginning in 2014.
- **Beginning in 2014, premiums may no longer be based on health [or mental health] status**
  - instead only age, tobacco use, geographic area, and family size.
- Lifetime caps on the dollar value of benefits are prohibited in all plans starting six months after enactment and annual limits are restricted (as determined by the Secretary) until 2014 and prohibited after that.
- All plans are required to cover preventive services within six months after enactment (September 23, 2010).
- The Secretary is directed to establish a temporary high risk insurance pool within 90 days of enactment to provide coverage to people with preexisting conditions unable to access coverage. Individuals in the high risk pool will be transitioned into the state exchanges in 2014, when they are established and insurers are no longer able to discriminate based on preexisting conditions.

MHA Mental Health America

Care Coordination

- **A new Medicaid state plan option has been established to permit Medicaid enrollees with at least two chronic conditions or at least one serious mental health condition to designate a provider (which could be a community mental health center) as a health home.**
  - This option will be subject to 90% federal funding for two years, effective in January 2011.
- **A new grant program has been established to support co-location of primary and specialty care services in community-based mental and behavioral health settings.**
  - **Another grant program will be available to fund community health teams to support primary care practices with interdisciplinary resources including access to mental health and addiction treatment specialists.**
- A new program has been set up at HHS to develop, test, and disseminate shared decision-making tools to facilitate collaboration between patients, caregivers, and clinicians and incorporation of patient preferences and values into treatment decisions.
- ACA establishes a new office within CMS to better integrate Medicare and Medicaid benefits for dual eligibles and improve coordination between the federal government and states.

MHA
Mental Health America

Prevention

- A National Prevention, Health Promotion, and Public Health Council has been established to coordinate federal activities and develop a national strategy. Headed by the Surgeon General, the Council is gaining input from stakeholders in developing the strategy.
- ACA established a Prevention and Public Health Fund with significant funding ($7 billion for FY 2010 through 2015 and $2 billion each year after that) for prevention and public health programs.
- A new community transformation grant program will be established to support delivery of community-based prevention and wellness services.
- Home visitation will be promoted with $1.5 billion in grant funding for early childhood home visitation programs.
- **ACA sets up a new grant program to fund school-based health clinics - $50 million for each fiscal year 2010 through 2013 - with explicit direction that clinics are to include mental health and substance use assessments, treatment and referrals.**
- Provisions in the new law give employers more flexibility to lower premiums or offer other incentives for employees who participate in wellness programs. Grants are also authorized for small employers that establish wellness programs.
- New annual wellness visit benefit is authorized for Medicare beneficiaries- providing comprehensive health risk assessment and creation of personal prevention plan. Additionally, Medicare is directed to cover preventive services approved by US Preventive Services Task Force (USPSTF) and without cost-sharing. Depression screening is an approved service by the USPSTF.
- Federal Medicaid funding will be increased by one percentage point for states that cover immunizations and preventive services endorsed by USPSTF for adults with no cost-sharing, including depression screening.
- Incentives will be established in Medicaid for beneficiaries to complete healthy lifestyle programs.

MHA Mental Health America

Behavioral Health Provisions

- ***Postpartum Depression:*** **ACA funds a new federal initiative to combat postpartum depression through a public education campaign and a new grant program to provide medical and support services for individuals with or at risk of postpartum conditions.**
- ***Centers of Excellence on Depression*: A grant program was established to develop innovative interventions through services research.**
- ***Medicaid Coverage of Psychiatric Hospitals*: This demonstration program will allow Medicaid coverage of private inpatient psychiatric facilities (i.e., IMDs). $75 million is available for 5 years.**
- *Closing the Medicare Part D doughnut hole:* ACA makes available a $250 rebate for Medicare beneficiaries in the coverage gap in 2010, and phases out the gap by 2020. Drug companies are to provide a 50% discount for brand-name medications filled in the gap beginning in 2011.
- *Comparative Effectiveness Research:* New independent Patient-Centered Outcomes Research Institute was established to prioritize and fund comparative effectiveness research.
- ***Workforce:*** **ACA included a number of new education and training grants and loan repayment programs targeted to mental health and addiction treatment providers (particularly pediatric and child and adolescent specialists). Programs to educate primary care providers about integration of mental and physical health, chronic disease management, treating vulnerable populations including individuals with mental health or substance use conditions were also included.**
- **ACA directs the Secretary to develop new conditions of participation in Medicare for community mental health centers to address fraudulent activity regarding partial hospitalization.**
- Funding for community health centers is increased to $11 billion between FY 2011 and 2015.
- *CLASS Act:* This provision establishes a national, voluntary long term care insurance program providing cash benefit to purchase non-medical services and supports necessary to maintain community living.
- ***Community First Choice Option:*** **ACA establishes a new state option in Medicaid to provide community-based attendant supports and services for individuals with disabilities who would otherwise require institutional care including in institutions for mental diseases.**
- **ACA requires removal of benzodiazepines and barbiturates from list of medications states may exclude from Medicaid coverage.**

MHA
Mental Health America

Major State Responsibilities

- States are to create "American Health Benefit Exchanges" and "Small Business Health Options Program (SHOP) Exchanges" to be administered by a governmental agency or non-profit organization through which small businesses (up to 100 employees) and individuals can purchase insurance.
- Grants will be made available to states for establishing the Exchanges - amounts to be specified by the Secretary of HHS.
- Federal government will contract with insurers to offer at least two multi-state plans in each Exchange but states can require benefits in addition to the essential benefits package be provided to enrollees of a multi-state qualified health plan offered in such state.
- States can enter "health care choice compacts" with other states to pool individual market plans but these plans would be subject to the laws and regulations (including consumer protection standards) of the purchaser's home state.
- An additional $30 million in grants is available to states to establish and operate offices of health insurance consumer assistance and ombudsman offices. States must collect data and report on the types of problems encountered by consumers.
- The temporary high risk pool may be carried out through contracts with the states or nonprofits.
- States are responsible for enrolling newly eligible beneficiaries into Medicaid no later than Jan 2014 and states have the option to expand enrollment as early as 2011.
- States are directed to maintain current Medicaid and CHIP eligibility levels for children until 2019 and for adults until Exchanges are operational.
- **States are directed to simplify enrollment processes for Medicaid and CHIP and conduct outreach to educate and enroll vulnerable populations into Medicaid or CHIP including individuals with mental health or substance use conditions as well as facilitate enrollment in Exchange plans and subsidy programs for those found not eligible for Medicaid or CHIP.**

MHA
Mental Health America

Essential Benefit Package

The federal government will create a floor of essential benefits that must be included in the expanded Medicaid benefits and the state health insurance exchanges.

- States will be allowed to provide coverage above those basic levels established by the Secretary.
  - **State legislators must advocate at the state level for a robust essential benefit package in order to ensure that the new benefits are meaningful and address the needs of individuals with mental illnesses and addiction disorders.**
- **Behavioral health services should be available and provided in such a way that individuals can move through the system and access various benefits based on their level of need and personal goals.**
- **The services fall into four major categories:**
  - **traditional services,**
  - **psychosocial rehabilitation services,**
  - **preventative services, and**
  - **ancillary services.**

MHA Mental Health America

Comprehensive Services

Traditional Mental Health Services

- *Inpatient Services (including residential services for children, detox and other services for individuals with substance use conditions)*
- *Medication Services*
- *Psychotherapy Services*
- *Case Management Services*
- *Crisis Intervention Services*
- *Screening, Assessment and Treatment Planning*

Psychosocial Rehabilitation Services

- Individual and Group Rehabilitation services
- Supported Employment
- Supported Education
- Life Supports (housing, access to transportation, life skills)
- Financial Planning/Money Management
- Peer Support Services

Preventative Services

- Screening and Early Intervention
- Targeted Prevention
- Wellness and Health Promotion Services

Ancillary Services

- Respite care for family members
- Consultation between health care providers

Advocacy Strategies

In order to realize the true potential of the new health reform law and ensure that the modern behavioral health system is developed in an appropriate way to serve the needs of individuals with mental illnesses–

State legislators must monitor and be engaged in the implementation process.

- State legislators must advocate for robust mental health and substance use services as essential benefits for the Exchanges, as these will be the basis for the essential benefits in the Medicaid expansion plans.
- State legislators must work with the state insurance commissioner, health department, Medicaid director, mental health and substance use authority, and governor's office to provide feedback and advice regarding the interests of the behavioral health community.
  - May require legislation

MHA
Mental Health America

Legislation

HEALTHCARE IMPLEMENTATION ADVISORY COMMISSION

- Sec. 1. As used in this chapter, “commission” refers to the Healthcare Implementation Advisory Commission.
- Sec. 2. The Healthcare Implementation Advisory Commission is established.
- Sec. 3. The commission shall evaluate the obligations and options presented to the state by the Affordable Care Act, and shall provide recommendations to advise implementation of this Act to the appropriate division or department of state government.
- Sec. 4. The commission consists of twenty-seven (27) members determined as follows:
  (a) The speaker of the house of representatives and the president pro tempore of the senate shall each appoint two (2) legislative members, who may not be from the same political party, to serve on the commission.
  (b) The governor shall appoint thirteen (23) lay members, not more than seven (12) of whom may be from the same political party, to serve on the commission as follows:
- (1) One individual representing AARP;
- (2) **One individual representing Mental Health America;**
- (3) One individual representing the Primary Health Care Association;
- (4) One individual representing the Health Care Association;
- (5) One individual representing the Association of Homes and Services for the Aging;
- (6) One individual representing the Arc;
- (7) One individual representing the Minority Health Coalition;
- (8) One individual representing the Association of Area Agencies on Aging;
- (9) One individual representing the Association for Home and Hospice Care;
- (10 One individual representing the State Medical Association;
- (11) One individual representing Covering Kids and Families;
- (12) One individual representing the Hospital Association;
- (13) One individual representing Anthem;
- (14) One individual representing the Association of Health Plans;
- (15) One individual representing the Chapter of the American Academy of Pediatrics;
- (16) One individual representing the Nurses Association;
- (17) One individual representing the American Cancer Society;
- (18) One individual representing the March of Dimes;
- (19) One individual representing the Chamber of Commerce;
- (20) One individual representing the Pharmaceutical Research and Manufacturers of America;
- (21) **One individual representing the Council of Community Mental Health Centers;**
- (22) One individual representing the National Association of Social Workers;
- (23) One individual representing the American Heart Association.
  Sec. 5. The chairman of the legislative council shall designate a legislative member of the commission to serve as chairperson of the commission.
- Sec. 6. The commission shall operate under the policies governing study committees adopted by the legislative council.
  Sec. 7. The affirmative votes of a majority of the members appointed to the commission are required for the commission to take action on any measure, including final reports.
  Sec.8. The commission shall meet:
- (a) at the call of the chairperson as often as necessary. However, the commission shall meet at least quarterly.

Mental Health America

Legislation continued

Sec. 9. In carrying out its duties, the commission shall consider pertinent studies concerning health care and take testimony from experts and advocates in the health care field.

Sec. 10. The commission shall establish subcommittees to study and recommend action, which shall include at least the following:

(1) Aging health issues.

(2) Children's health issues.

(3) Women's health issues.

(4) Mental health and Addictions issues.

(5) Disability issues.

(6) Insurance and Financing.

(7) Disparities, including but not limited to issues of access to health care regardless of race, ethnicity, gender, language, or geography.

The subcommittees may include Committee members and other individuals appointed by the Commission.

Sec. 11. The commission shall submit recommendations to the governor and the House and Senate Health Committees by the following dates:

(1) The commission shall submit interim recommendations, on an as needed basis, but not later than each of the following dates:

(a) July 1, 2011.

(b) July 1, 2012.

(c) July 1, 2013.

(2) Not later than September 1, 2014, the commission shall submit final recommendations.

Mental Health America