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for Mental Health Law

How Will
Health Reform
Help People with
Mental Illnesses?

An analysis of the Affordable Care Act passed by Congress in 2010 and how it
will affect people with psychiatric disabilities

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How Will Health Reform Help People with Mental Illnesses?

It's important for people with serious mental illnesses, including those who rely on the public mental health system for services, to know how the health care reform law will affect them. After health reform, will they have better access to the services and supports they need to recover?

Community integration and recovery for people with psychiatric disabilities, while unique for each individual, require that a set of basic needs be met. A safe, secure place to live, enough income for life's necessities, recreational opportunities, social contact and a sense of purpose are all part of recovery. High on the list, and affecting most of the other areas, is good health.

The Affordable Care Act, the health reform legislation passed by Congress in 2010, addresses both the lack of access to health care and the quality of the care that is provided in both public and private health systems. The law will offer significant new options for people with mental illnesses and affect their ability to integrate fully into their communities. However, this law does not directly address the current failings of the public mental health system.

This paper examines the health reform law and its impact on opportunities for community integration for people with psychiatric disabilities.

Overview

The law will enable most people who are now uninsured to get insurance, resulting in health care coverage for over 90% of Americans. The law *requires* people to have health insurance. People with lower incomes will receive subsidies to help them meet the cost of this insurance. More people will be eligible for Medicaid, including, for the first time, low-income, single childless adults. The law also contains incentives for employers to provide insurance (small businesses are exempted).

The law requires that health plans meet certain standards and cover mental health and substance abuse services. Other standards address quality-of-care issues, emphasize prevention and have provisions to improve efficiencies in health care delivery.

Access to Private Health Insurance

Most Americans have access to health care through a private health insurance plan — either one purchased by or through their employer or a plan they have purchased themselves. However, many people with psychiatric disabilities are either covered by a public program, such as Medicaid or Medicare, or have no health coverage at all.

Approximately 90% of people with serious mental illnesses are unemployed. This means they do not have an employer-based health insurance plan. If they try to purchase their own insurance, they find many barriers. Currently, insurers can refuse to sell or renew policies based on a person's health or mental health, deny coverage for any pre-existing condition (thereby failing to pay for ongoing mental health treatment), or issue a policy with limits on the length of covered treatment. Even when such policies can be found, they are often extremely expensive and do not provide good coverage.

The Affordable Care Act addresses these fundamental problems and will significantly improve access to health and mental health care for people with psychiatric disabilities. Under this law:

- | Health insurers will have to sell and renew policies to all who apply (called "guaranteed issue and renewal").
- | Insurers cannot deny coverage for a pre-existing condition.
- | No health plan can have a lifetime or annual limit on certain benefits.
- | Insurers cannot charge people with poor health more than others — premiums (the amount a person pays to have insurance) may only vary by a limited amount and only on the basis of a few factors (tobacco use, age, geographic area and family size).
- | Health insurers cannot discriminate based on a person's mental or physical disability.
- | Young adults (up to age 26) must be allowed to remain on their parents' health insurance, if their parents so desire.

These provisions will greatly improve access to quality health care and to mental health care for people with psychiatric disabilities who either have no insurance today or have insurance that is very limited or very expensive. The law does not require that individuals lose their existing health care coverage.

The law gradually phases in the new requirements. Many of the changes occur as early as this year, but some provisions will be expanded in steps over a longer period. In order to cover all Americans and ensure that insurance is affordable, the law requires people to purchase insurance. This will be enforced through a new tax penalty on individuals who do not have acceptable coverage, although people who cannot afford a policy will be exempt from this penalty.

The law requires employers with 50 or more employees to pay the federal government a fee for any employees who receive premium subsidies and prohibits employee-eligibility waiting periods longer than 90 days.

Access to Medicaid

Medicaid is designed to meet the needs of people with low incomes and those who have significant disabilities. For mental health, Medicaid covers a wide range of community services that can aid in recovery, including skills training, employment-related services and supported housing, as well as therapy and medications. Its package of services is much broader than the typical private insurance plan. As a result, coverage under Medicaid is often a better option for people with psychiatric disabilities.

Currently, not everyone who needs Medicaid is eligible for the program. Medicaid does not cover most single adults who do not qualify either through disability or as caretakers of children. The law expands Medicaid eligibility to cover this group and other low-income people who are not now eligible under their state Medicaid plan.

The new health reform law expands coverage to everyone with income below 133% of the federal poverty level, beginning no later than 2014.¹ To prevent states from taking people off Medicaid in order to pay for this new group, states are required to keep their current eligibility rules until 2014.² This means that if the state already covers people with incomes above 133% of poverty, those people will still be eligible for Medicaid. However, beginning in 2011, states that are experiencing a budget deficit are allowed to scale back eligibility for certain non-disabled people over 133% of poverty.

The law does not provide the same benefits to everyone. Children and families will be given full Medicaid coverage, but many childless adults with incomes below 133% of poverty could have a much more limited, benchmark benefit. Some people who fall into this newly eligible income range are exempted from the benchmark coverage provision. These groups include pregnant women, people who are disabled, dual Medicare-Medicaid recipients, people who are eligible only because they are in an institution, the medically frail and those with special medical needs, people who qualify for long-term care services, children in foster care and children receiving foster care or adoption assistance, and parents receiving welfare benefits.

This limited benefit must include at least the benefits to be required of private insurance plans, but need not cover all Medicaid services. As a result, individuals with psychiatric disabilities could lack access to the rehabilitation and recovery-focused services normally available to Medicaid recipients. Instead, they might only have coverage of inpatient hospital care and outpatient medications and therapy. Parity for mental health and substance abuse is also required, so these reduced Medicaid plans could not have limits on necessary mental health and substance abuse services.

Expanded Medicaid coverage will be of great benefit to all single childless adults with psychiatric disabilities. Generally, this group can qualify for Medicaid only if receiving federal Supplemental Security Income (SSI) disability benefits. However, many individuals with psychiatric disabilities either fail to qualify for SSI because the rules are so strict or choose not to apply. The law eliminates the SSI requirement for people with incomes under 133% of the federal poverty level. As this requirement often prevents people with psychiatric disabilities from receiving health care, these expansions of Medicaid are very important.

The law also allows states to extend Medicaid coverage, including all benefits and Early and Periodic Diagnosis and Treatment (EPSDT) requirements, to foster children who have aged out of the foster care system, up to the age of 26 beginning in 2014.

Purchasing Insurance

To help people compare plans and purchase health insurance, the law creates new entities in states called Exchanges (this paper will use that term). State-based Exchanges will act as a broker or middleman, through which an individual or a small employer will be able to

purchase a plan. Individuals can purchase coverage through the Exchange, or choose to keep their current insurance or go outside the Exchange to purchase a policy.

The Exchanges must be established effective on January 1, 2014. Individuals and small employers can purchase insurance through these Exchanges and, beginning in 2017, large employers can also purchase through the state Exchange. The law also allows states to establish regional or other interstate Exchanges.

Individuals who now lack insurance, including people with psychiatric disabilities, will benefit from these Exchanges in several ways. The effect of the rules the law places on policies sold through the Exchanges will be to significantly lower the price of good health coverage. There are estimates that an individual would save significant amount per year in health insurance premiums, even if they do not qualify for subsidies. The savings will be even greater for those who receive subsidies.

The Exchanges will also make it easier for consumers to compare health plans and make a good choice. Additionally, all plans that participate in the Exchange will have to meet certain requirements, among them providing coverage of mental health and substance abuse services and offering insurance that meets the standards listed above (see bullets under Access to Private Health Insurance). Finally, health plans sold through the Exchange will have to meet certain basic standards regarding benefits, marketing, network adequacy and other consumer protections (see below).

The law also allows states to set up a state plan for individuals with incomes between 133% and 200% of poverty who do not qualify for Medicaid. These plans must meet the criteria required of private insurance plans offered through the Exchange with respect to benefits and consumer protections.

The law also sets up nonprofit, consumer-owned cooperatives to offer alternatives to private plans. The law provides funds to set up such cooperatives, which would then compete through the Exchanges with the private plans. The law also requires the Office of Personnel Management (OPM) to contract with health insurers to offer at least two multi-state qualified health plans through Exchanges in each state, similar to the Federal Employees Health Benefits Program.

Benefits

All plans offered through the Exchanges must cover at least a minimum range of services defined by the federal government. The law includes a summary of the services that must be covered, but leave the details to an administrative entity. Plans can, however, have differences in the amount of out-of-pocket payments required (see below).

The law requires that plans sold through the Exchanges include mental health and substance abuse services, and that these be at parity with medical/surgical coverage. The law states that mental health and substance use disorder services must meet the minimum standards for parity in both federal and state law, “including ensuring that any financial requirements and treatment limitations...comply with [federal parity law requirements].”

The law’s minimum range of services also includes rehabilitative and habilitative services.

Plans will also have to cover hospitalization, emergency department services, outpatient services, prescription drugs and preventive services. There can be no cost-sharing for prevention services.

The law will be of great benefit to people with psychiatric disabilities because, for the first time, consumers could be sure that any health plan they purchase (through the Exchange system) will cover mental health and substance abuse services on a par with coverage for medical/surgical services. The law also requires health plans to cover rehabilitation and habilitation services. However, this is not defined. It is therefore not yet clear whether psychiatric rehabilitation services will be included in all health plans. However, at a minimum, all plans could be expected to offer medications, therapy and inpatient hospital care.

Differences in Health Plans Offered

Although every plan must meet federal standards for the services it covers, the law allows plans to differ in the amount they charge consumers. This means that premiums a person must pay to purchase insurance might be different and also the amount of cost-sharing required when services are used might not be the same in all plans.

The law requires health plans to offer four levels of benefits — the differences being the amount of cost-sharing required. All plans in all four levels will still have to meet the requirements described above for the benefit package, including the mental health and substance use services requirements. The law also creates a special plan for young adults under age 30, which would cover catastrophic health care costs.

These plans will have very high deductibles, but they will protect young people from having to pay extremely high costs for health care in any one year.

The law also requires health plans to have an adequate network of providers to serve the people they enroll. This could be especially important for those who use mental health services since some health plans now severely restrict the number of providers in their networks, making it hard to get timely appointments.

The Exchanges will give people with psychiatric disabilities the opportunity to pick the health plan that best suits their needs, based on the level of out-of-pocket payments they feel able to make and the premiums they are willing to pay. This will make it significantly easier for people with mental illnesses to purchase insurance.

Assistance in Picking a Plan

Choosing a health insurance plan can be confusing. The law therefore attempts to provide help in this process. Under the law, the Exchanges will provide information and assistance to help consumers compare plans so they can make an appropriate choice. This will include information on benefits, premiums, cost-sharing, quality, provider networks and consumer satisfaction with each plan.

The law mandates the development and use of uniform documents to describe coverage in order for consumers to more easily understand the terminology and compare plans. These documents must be written in non-technical language that is easy for the average person to

understand, use standard definitions of terms, include information on the dollar amounts of cost-sharing, and explain exceptions, reductions and limitations on coverage and other important information.

The law also authorizes grants to states to establish, expand and support offices of health insurance consumer assistance, or health insurance ombudsman programs. These offices will assist consumers with enrollment, resolving problems with obtaining premium tax credits and filing complaints and appeals, as well as educating health insurance consumers on their rights and responsibilities and collecting and monitoring problems encountered by consumers.

Health plan descriptions can be very confusing and everyone will benefit from having help in choosing a plan. The concept of navigators will be of great benefit to these consumers, particularly those who do not have case managers to help them.

Affordability/Subsidies

Some people will not be able to afford any of the plans but have incomes that are too high to qualify for Medicaid. The law provides for subsidies to individuals and families who are unlikely to be able to purchase a plan.

The law provides for premium subsidies to help individuals with incomes of 400% of the federal poverty level or less (in 2009, \$43,000 for individuals and \$88,000 for families of four) buy insurance. The amount is different based upon income, with those who have the lowest income receiving the highest subsidies. There is also a limit on the percentage of income that these individuals would have to pay to purchase insurance. Small employers are also eligible for premium subsidies.

An important provision in the law limits the total of out-of-pocket costs for individuals and families with incomes up to 400% of poverty. Those with the lowest incomes will pay a share of no more than 6% of their health care costs; this rises in steps so that people with incomes at 400% of poverty would pay no more than 30% of costs.

Limiting out-of-pocket spending is critical for people with any serious illness. For individuals with mental illnesses who require regular care, co-payments mount up quickly and can present significant financial problems.

Whether the proposed caps and the other affordability provisions of the law are sufficient to make care accessible is still a question, but clearly limiting total out-of-pocket spending is vital to ensure that access to care is affordable.

Prevention and Wellness

The law places an emphasis on prevention by limiting cost-sharing for prevention services, promoting increased research into effective prevention strategies and expanding prevention services.

The law sets up a Prevention and Wellness Trust to fund prevention activities and develop a national prevention and wellness strategy. The law also requires the federal government to undertake reviews of existing preventive services that should be implemented at the

community level. The new emphasis on prevention will include attention to mental health, and the federal Substance Abuse and Mental Health Services Administration will be involved in development of the national strategy. Employers will receive grants for implementing qualified wellness programs and Medicare and Medicaid would cover only proven preventive services, which would not require cost-sharing by the consumer.

The law amends Medicaid to promote coverage of preventive services that meet certain standards of effectiveness. There can be no cost-sharing for these Medicaid services. Tobacco-cessation products and services must also be covered.

Medicare will cover a comprehensive health- risk assessment and the creation of a personalized prevention plan. Under the law, individuals who successfully complete specific healthy lifestyle programs targeting risk factors such as tobacco use or high blood pressure will be eligible for incentives.

The law also creates a National Prevention, Health Promotion and Public Health Council to develop a national strategy for disease prevention and health promotion and to improve the public health system. Additionally, the law establishes separate task forces on both clinical and community preventive services to review scientific evidence about preventive services and give providers technical assistance and recommendations on best practices. Other prevention-oriented grants are authorized by the law, which will also increase funding for research on evidence-based prevention practices.

People with serious mental illnesses are at great risk for many preventable diseases. Increased access to services that can prevent diabetes, heart disease and cancer could greatly improve the lives of people with severe mental illnesses. Numerous studies show that co-payments deter people from getting preventive care, and are particularly a problem for people with little discretionary income, including those with psychiatric disabilities. Research on successful prevention strategies is also critical to determine how best to prevent and intervene in the course of mental illnesses.

Integration of Mental Health with Health Care

The law supports new ways of delivering health care that give consumers access to more coordinated services.

The law create health care homes in Medicaid for people who have more than one chronic condition. These entities will provide comprehensive care management, coordination and referrals to appropriate community services. Consumers with serious, chronic mental illnesses are eligible for these health care home services, and community mental health centers are among the providers that may qualify to be a health care home.

Health, or medical homes provide primary health care services and coordinated linkage with specialty care. For people with psychiatric disabilities, a medical home could be a community mental health agency that offers primary care services on site. Where these programs exist, they have been found very effective in treating the medical and mental health needs of individuals with serious mental illnesses in a coordinated way. Community agencies, such as community mental health centers, could qualify as medical homes under this program.

The law also includes \$50 million for grants from the Substance Abuse and Mental Health Services Administration for co-locating primary care on-site in community mental health agencies. This will also provide coordinated and integrated services. It will similarly encourage health plans to provide more comprehensive care through medical homes and other approaches, such as case management, care coordination and chronic disease management.

Under the law, other innovations, like Community Health Teams, will be established to develop integrated provider teams that include primary care providers and specialists, such as mental health providers. These teams will be patient-centered and holistic and include community programs and approaches to promote wellness.

Effective integration of medical and mental health care helps to promote the best outcomes. For mental health consumers, integrated care can reduce the health disparities that result in the death of people with serious mental illnesses 25 years earlier, on average, than the general population.

Improvements to Medicaid

In addition to addressing the need for everyone to have access to health care coverage, law makes important changes to the Medicaid program, including several that will have an impact on people with psychiatric disabilities.

The Affordable Care Act requires coverage of tobacco-cessation programs and products. Individuals with psychiatric disabilities smoke at rates two times higher than other people and have high mortality rates from lung cancer and stroke as a result. Access to tobacco-cessation products might help them give up smoking.

The law also includes a new voluntary long-term care insurance program, The Community Living Assistance Services and Support (CLASS) Act, that will help address both Medicaid's institutional bias and individuals' need to impoverish themselves in order to receive necessary care services and supports.

The Affordable Care Act encourages better care of individuals who are eligible for both Medicare and Medicaid by making prescription drugs more affordable. Access to medications in the class of benzodiazapines and barbiturates, currently included in the list of excludable drugs in Medicaid, is improved. The law also includes provisions to streamline the Medicaid application process. Currently, the enrollment process is protracted and complex and often deters eligible individuals from applying. Streamlining it will lower barriers to enrollment by people with psychiatric disabilities.

The law includes a new Medicaid state plan option to provide for community-based attendant services and support services to individuals who are eligible for nursing home, ICF/MR or other institutional-level of care, complementing the goals of the Supreme Court's *Olmstead* decision. It also improves upon an existing state plan option to cover home and community-based services to encourage states to make greater use of this option.

Changes to Medicare

The law also makes significant changes to Medicare. It addresses the gap in coverage under Medicare Part D (prescription drug coverage), which occurs after consumers have purchased drugs that cost up to a certain amount. At that point, the consumer must pay the entire cost of the medication until out-of-pocket costs reach a certain level (this is often called the “donut hole”). Then their Part D coverage resumes. Beginning in 2010, the Affordable Care Act will provide assistance to people who are in the donut-hole coverage gap. It provides a \$250 rebate for each person who spends money while in the gap in 2010. The law gradually improves coverage for those in the donut hole by decreasing consumers’ share of their donut-hole drug costs until it reaches 25%— which is the same percentage they are responsible for before reaching the donut hole. The reduction begins in 2011 and will be completely phased in to 25% for all drugs in 2020, eliminating the donut hole altogether.

A significant proportion of people on Medicare because of a disability have psychiatric disabilities and are on Medicare because they receive Social Security Disability Insurance. Their income tends to be low and the “donut hole” is a serious burden for them. The changes to the Part D benefit will prove very helpful for them.

The law also eliminates cost-sharing for certain prevention services under Medicare.

Quality Improvement

Improving the quality of the services delivered by our health care system is a priority in health reform. In addition to the changes in Medicare and Medicaid, described above, the bills all include a focus on quality.

The law will encourage best practices in the delivery of health care by creating a National Strategy for Quality Improvement to improve the delivery of health care services, patient health, outcomes and population health. The strategy will identify priorities that have the greatest potential for improving the health outcomes, efficiency, and patient-centeredness of health care for all populations, including children and vulnerable populations. There would be a focus on high-cost chronic diseases, such as mental illnesses.

The law also funds research to compare different treatments to determine which are most effective.

The law encourages improved health care quality through various initiatives in the Medicare and Medicaid programs. It directs the Department of Health and Human Services (HHS) to focus on improving quality. It establishes a Patient-Centered Outcomes Research Institute to support research on improving quality, appropriateness and effectiveness of health care services. Results will be available to consumers as well as clinicians and the public. The law also encourages mechanisms that link payment to outcomes, to reward good practice. HHS will receive additional resources to develop the national quality strategy and establish an interagency federal working group on quality care.

The Affordable Care Act includes incentives for coordinated care across a range of health care settings and the testing of new patient-centered payment methods to encourage evidence-based, coordinated care, particularly under Medicare.

The law also encourages research, screening, education and treatment of postpartum depression, establishes Centers for Excellence in Depression, authorize grants to promote positive health behaviors and outcomes, encourages coordinated and integrated health care, and promote interdisciplinary training of mental health professionals.

There is a great need to improve the quality of services for people with psychiatric disabilities. These provisions in the law will be of substantial help to individuals with psychiatric disabilities. While mental disorders are not specifically mentioned in the law's quality assurance section, it is extremely likely that they would be a significant focus of a quality improvement initiative. This is because mental health disorders are the leading cause of disability for individuals between ages 15 and 44. In addition, serious mental illness is costly to treat, results in significant losses in productivity as people are unable to work, and increases other government costs like disability benefits, housing subsidies, social services, etc.

The research into effective services included in the bills would also be likely to include a focus on evaluating mental health services so as to improve care, particularly since the prestigious Institute of Medicine recently listed a number of behavioral health disorders and treatments among its top 100 priorities for comparative effectiveness research.

Conclusion

Overall the law will greatly benefit individuals with psychiatric disabilities by:

- | Expanding access to health insurance coverage (through both private plans and Medicaid) and making it more affordable and quality-driven.
- | Setting standards for health insurance policies so as to protect consumers.
- | Setting minimum requirements regarding services that health plans must cover and including mental health and substance abuse services in that mandate.
- | Making changes to Medicaid and Medicare that will benefit people with disabilities, including individuals with psychiatric disabilities.
- | Encouraging more coordinated primary care and specialty mental health care, promoting preventive services, fostering workforce development initiatives, and making other changes designed to improve the quality and availability of services that people receive.

Notes

1. In 2009, \$16,200 for individuals and \$33,100 for a family of four.
2. State eligibility rules must not be more restrictive than they were on June 16, 2009.
3. In 2009, \$14,400 for individuals and \$29,300 for a family of four.