Coverage Expansions and Health Reform for Mental Health Care

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Overview

- Introduction
- Context
- Baseline Coverage
- Coverage Expansion and its Implications
- Delivery System Reform
- Concluding Observations

Three Cornerstones of Reform

- Increased coverage through expansion of public programs (Medicaid)
- Reform and redesign of insurance markets
- Delivery system and payment reform

Uninsured Individuals with Mental Disorders

	No Mental Disorder	Severe Mental Illness	Other Mental Disorder
Uninsured	11.4%	20.4%	18.2%
Private	63.2%	34.5%	57.3%
Medicare	19.7%	21.5%	14.4%
Medicaid	2.3%	16.0%	7.1%
Other	3.4%	7.6%	3.0%

Percentage of Uninsured Individuals with Substance Use Conditions

	Substance Dependence	Substance Abuse
Whole Population	28.5	23.6
Uninsured under 100% poverty	36.3	41.2
Uninsured 100-199% poverty	44.4	38.8

Data Source: National Survey of Drug Use and Health, 2005-2006

Context

- Mental Health Parity and Addictions Equity Act (MHPAEA)
  - Enacted 2008
  - Regulations Issued 1/2010
- CHIP Reauthorization Requires Parity in Coverage
- Parity Guidance for Medicaid (forthcoming)

Key Elements of Health Care Coverage Expansion in 2014

- Establishment of state-based health plan “exchanges” for individuals and small businesses (up to 100 employees)
- Medicaid Expansion to 133%FPL
- Individual responsibility to maintain “minimum essential coverage”
- Premium and cost-sharing subsidies for those at 133% to 400% of poverty
- Penalties for employers with >50 employees that do not offer coverage and at least one employee receives a subsidy to access coverage

Health Insurance Exchanges

- Reorganize individual and small group markets
- Exchanges will certify plans as qualified
- To be qualified plans must meet essential benefits requirements and other marketing and quality requirements
- Scope of benefits must be equal to typical employer plans
- The Mental Health Parity and Addiction Equity Act applies

Essential Benefit Package

Ambulatory

Emergency

Hospitalization

Maternity/ Newborn

Mental health and substance abuse

Pediatric

Prescription drugs

Rehab and Habilitative

Laboratory services

Preventive/Wellness

Private Insurance Reforms

- Preexisting condition exclusions prohibited (2014) and for children (Sept 2010).
- Guaranteed issue and renewability (2014)
- Premiums may no longer be based on health status (2014)
- Lifetime caps on benefits prohibited (Sept 2010) and annual limits are restricted (prohibited 2014).
- Required coverage of dependent children up to age 26 (Sept 2010)

Medicaid Expansion

- New Mandatory Eligibility Group to 133% FPL
  - Income limit: $14,404 for individuals and $29,326 for families of four
  - Regardless of traditional eligibility categories (thus including childless adults)
  - No asset test
  - Mandatory by January 2014
  - Optional beginning April 1, 2010 (at any level up to 133%FPL)

Medicaid Expansion

- Enhanced federal funding for those newly eligible for Medicaid: starts at 100 % federal in 2014, 2015, 2016 and phases down to 90% federal by 2020.
- States that already expanded to 100% FPL, funding phases up starting in 2014 (equivalent by 2019 – 93% and in 2020 90%)
- Current optional expansion – at regular matching rate – states that had already expanded can shift some of cost onto federal government

Impact of Coverage Expansions on Individuals with MH/SUD

- Out of 9.5 million non-elderly adults with mental health or substance use disorders (MH/SUD) who are currently uninsured, **5.4 million would gain coverage** (based on CBO uptake assumptions)
- About **one third** of individuals with MH/SUD who gain coverage would be **covered under Medicaid** compared to only 23.4% of their counterparts without these disorders.
- **Small percentage** (about 3%) likely to access **coverage through exchanges**

Medicaid Expansion – Benefit Package

- Not necessarily full Medicaid benefits
- Benchmark coverage instead – private insurance models established in CHIP statute
- Amended to include mental health and prescription medications as mandatory
- Wellstone/Domenici Parity Law applies
- As of 2014, benchmark coverage must also comply with essential benefit package requirements for state health insurance exchanges (also includes substance abuse)

Medicaid Expansion – Benefit Package

- Concern for higher need population with benefits modeled after private/employer plans
- But certain groups **exempt** from benchmark package including people with disabilities (regardless of SSI eligibility), duals, institutionalized individuals, medically needy, parents on TANF

Delivery System Reforms and Mental Health

- Integration
- Prevention
- Work Force
- Payment and Organizational Change

Delivery System Reform: MH/SUD & General Health Integration

- Medicaid health home option (2011)
  - Definition of chronic condition determining eligibility for benefit includes MH and SUD
- Grants to support co-location of primary and specialty care in community behavioral health centers (2010)
- Grants for community health teams

Delivery System Reform: Prevention

- National Prevention, Health Promotion, Public Health Council – ONDCP Director is a member
  - Annual report to Congress to include national priorities on MH, SUD and behavioral health
- National Prevention and Public Health Fund ($7 billion FY 2010 -2015, then $2 billion a year)
- Grants for early childhood home visitation ($1.5 billion over five years to states)
- Grants for school-based health centers

Delivery System Reform: Prevention

- Medicare annual wellness visit – CMS proposed rule includes depression screening
- Elimination of co-pays and mandatory coverage of clinical preventive services in Medicare and private plans including depression screening
- Medicaid incentive for states to cover with no cost-sharing clinical preventive services including depression screening

Other Delivery System Changes

- Changes to Medicaid home- & community-based services option (sec.1915(i))
  - should facilitate use for people with MH/SUD
- Medicaid Inpatient Psychiatric Care Demo
  - 3 year state projects, $75 million, starting 2011
  - to reimburse private psych hospitals for emergency psychiatric stabilization
- Payment bundling and accountable care organization demonstration programs

Work Force Development

- Education and training grants and loan repayment programs targeted to mental health and addiction treatment providers
- Programs to educate primary care providers about integration of mental and physical health and treating vulnerable populations including individuals with MH/SUD
- Increased Medicaid reimbursement for primary care providers – Medicare rates for 2013 & 2014

Conclusions

- Health Reform for Mental Health Care is a historic event on par with the creation of Medicare, Medicaid and SSI in the 1960s and early 1970s
- The ACA represents a milestone in the integration of mental health into the health care mainstream
- The reforms are challenging to implement BUT the ex ante status quo was unacceptable
- The cornerstones of reform are grounded in the mainstream of health policy thinking

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