

## **Healthcare Reform and Behavioral Health**

### **Part 1: A Sea Change**

“To improve the golden moment of opportunity, and catch the good that is within our reach, is the great art of life.” ~ Samuel Johnson (1709-1784)

Healthcare reform is a flexible recipe for a major transformation, a sea change, in how healthcare services will be delivered. Across the nation – from community to federal levels – organizations are rallying to respond and prepare for its mandates. “Reform of the health care system will be complex, challenging, and laden with competing priorities,” states John O'Brien, SAMHSA's senior advisor for behavioral health financing. “The next three years will provide the foundation for the newly reconfigured health care system for many years.” (SAMHSA, 2010).

“What we see as we look into the future to 2014,” says Barbara Mauer, a national consultant on the impact of reform on the behavioral health industry, “is there are two forces coming together – healthcare reform and the passage of parity – that change almost everything about the assumptions we’ve had for organizing and delivering services.” Mauer (2010) was addressing Washington State’s *Behavioral Health and Primary Care Integration Collaborative*.

Integration – long a core theme in behavioral health – has now been swept to a broader arena as part of a multi-faceted national strategy for change. Integration, in the context of reform, is considered a means to more efficiently and effectively deliver care; therefore, for reform to achieve optimum success, all providers must be equally involved in planning and partnering for change.

With an eye to implications for behavioral health, this three part series will examine key strategies and components of healthcare reform, including driving forces, emerging concepts and models, and examples and suggestions to help providers prepare.

#### **The Affordable Care Act**

In March of 2010 President Obama signed into law the *Patient Protection and Affordable Care Act* and the *Health Care and Education Reconciliation Act of 2010*, together referred to as the Affordable Care Act (ACA). ACA builds on the Wellstone and Domenici Mental Health Parity and Addiction Equity Act of 2008, and together the groundbreaking acts combine to create a playing field where behavioral health is equal to physical health, and more Americans than ever in history will be able to access mental health and addictions services.

In fact, it bears such good news for consumers that planners and providers are being challenged – and quickly – to expand, transform, and rethink how behavioral health services will be delivered. This means new opportunities for stakeholders, especially those that embrace the idea of change and are willing to work within the emerging new paradigm for healthcare integration.

#### **4 Key Goals + 4 Key Strategies**

The overarching goals of reform are to make healthcare more accessible, affordable, efficient, and effective. Toward these goals, key strategies address four major areas: 1) coverage

expansion, 2) insurance reform 3) delivery system redesign, and 4) payment reform. Also, in a major shift for healthcare, reform recognizes prevention as integral to improving and maintaining health, with provisions for prevention cutting across strategies.

### **Coverage Expansion and Insurance Reform**

Reform provisions are being enacted from 2010 through 2018, with most to occur by 2014. When fully implemented HCR is expected to expand coverage to an estimated 32 million currently uninsured Americans, meaning about 95% of the legal population would be covered (U.S. Government, 2010). Also, those currently covered will experience expanded and improved benefits. The following summarizes some key components of expansion and insurance reform that are particularly relevant for behavioral health:

- **Provisions prohibit insurers from denying coverage to people with pre-existing conditions, charging higher premiums based on health status, placing caps (annual or lifetime) on coverage, and dropping patients from plans (the practice of “rescission” often done due to high medical expenses).** Consumer protection reforms are critical for individuals seeking or in recovery, many of whom are currently denied benefits due to pre-existing conditions.
- **The Wellstone/Domenici Parity Act combined with specific components of HCR legislation essentially creates a situation where parity laws will cut across all payers.** The idea behind parity legislation is to remove treatment limits or financial requirements on mental health or substance abuse treatment benefits that are not imposed for physical ailments. Parity laws now not only apply to large employers (Parity Act), but to Medicaid benefits (Parity Act and reform legislation), and individual and small group policies in new state “Health Insurance Exchanges” (reform legislation). Also, parity in Medicare coverage is being phased in by the Medicare Improvements Act (MIPPA) and Medicare Modernization Act of 2003.
- **In 2014 reform will expand Medicaid eligibility to include all individuals under the age of 65 (including childless adults) who have an income up to 133% of the Federal Poverty Level (FPL); newly eligible parents and childless adults are eligible for essential health or “benchmark” benefits that include MH/SUD services at parity.** The National Council for Community Behavioral Healthcare (Mauer, 2010) estimates that with HCR about 16 million people will gain coverage through Medicaid by 2019 (an increase of about 46 percent, though this will vary by state). Medicaid expansion also means that many people who currently lose and regain Medicaid due to changing circumstances (e.g., related to disability and/or incarceration) will now have continuous coverage.
- **Beginning in 2014, individuals will be required to obtain basic health insurance coverage (be it through individual or employer policy, Medicaid, Medicare, military, or the Veterans Administration).** By 2019, with HCR, about 16 million currently uninsured Americans will have gained coverage through private or other insurance, an increase of about 8% (Mauer, 2010). Those without coverage will pay a fee to help offset the costs of caring for uninsured Americans; some, who can show they really can't afford insurance, may be deemed exempt. (This law is facing legal challenges; some challenges have been overturned and others are pending.)

- **By 2014 states will be required to have “Insurance Exchanges” in place. Exchanges will include state-subsidized plans (up to 400% of FPL on a sliding fee); and all plans in Exchanges must cover essential health or "benchmark" benefits that include MH/SU services at parity.** The goal of Exchanges is to give small businesses and individuals not covered by employers a central place to shop for plans, set rules related to coverage and exclusions, help inform choice by grouping plans into standard categories based on generosity of coverage, and streamline the application process. Also, it is hoped that increased transparency related to coverage differences may spur competition and help drive down costs. (Note: States will have latitude in establishing the scope of "benchmark" benefits, so it will be important to keep an eye on how MH/SA benefits are included.)
- **MH/SUD prevention strategies and efforts are included in the bill’s chronic disease initiatives.** For example, co-payments and other forms of cost-sharing are being removed for services such as screening for depression, drug and alcohol misuse, and smoking cessation efforts. Also, a new Prevention and Public Health Fund will support proven programs that foster health, such as those for smoking cessation and to combat obesity.
- **Increasing the behavioral health workforce is a high-priority in the bill’s National Workforce Strategy section.** HCR has broad implications for the behavioral health workforce, not just in terms of capacity, but related to need for training and education to fulfill shifting or new roles (as we’ll discuss more in Part 3 of the series).

### **“Key Facts” - Implications for Behavioral Healthcare**

According to the 2009 National Survey on Drug Use and Health, of an estimated 22.5 million Americans 12 or older classified with substance abuse or dependence in the past year, only about 4.3 million received treatment in 2009 (a much smaller percentage than those treated for other chronic diseases, such as diabetes, hypertension, or asthma). A huge treatment gap also exists for mental health. Considered in light of HCR provisions, the following "key facts" (SAMHSA 2010; SAMHSA News 2010) help illustrate how reform addresses these gaps, and the huge implications it bears for service demand:

- Of the 32 million more uninsured Americans expected to be covered by 2014, between 20 to 30% (6 to 10 million) will have a mental or substance use disorder.
- Among the currently uninsured aged 22–64 with family income below 150 percent of FPL, 32.4 % have illicit drug or alcohol dependence/abuse or mental illness.
- People with serious behavioral health problems may not be employed and thus lack the insurance coverage that often goes along with employment. For example, individuals with a mental health disorder are twice as likely to be uninsured than those without a mental disorder.
- An increase in screening for MH/SU misuse and disorders will raise demand for brief and specialty treatment.

### **Service Delivery Redesign and Cost Reform**

It is a painful paradox that reform is occurring at a time of crisis at state and national levels. Reform, however, does include provisions and funding to help states and communities

experiment with promising delivery-system models that aim to bend a rising "cost curve" while improving quality and outcomes through a more integrated approach. At the heart of reform is a shift away from fragmented, episodic approaches toward integrated chronic-care models. The following are a few key examples (which we'll discuss at more length in Part 2 of the series):

- *Beginning in January, 2011, states can apply to add a "health home" option to their Medicaid coverage (including, as encouragement, a "sweetener" of a 90 percent federal match for the first two years).* The general idea is patients (particularly those with chronic conditions) would have a "home base" for care where integrated teams (such as a doctor, nurse, pharmacist, and/or behavioral health providers) would collaborate to handle basic care and coordinate care with specialists and hospitals. Some states have already been piloting "health home" models.
- *Expanding on the team concept HCR incentivizes Medicare/Medicaid programs to establish Accountable Care Organizations (ACOs), large partnerships integrating provider groups – e.g. PCPs, MH/SUD and other specialists (some gathered in health homes), and hospitals – who would share responsibility for a patient's care from beginning to end. Being in a large group would help lower costs and risks related to service delivery.*
- *Health Homes and ACOs will experiment with payment reforms aimed at bringing down the cost curve, while improving care.* An emerging model is a three-layered design mixing 1) case or capitated payments (based on membership) to cover ongoing prevention, intervention, and interdisciplinary care coordination; 2) fee for service; and 3) bonuses related to cost and quality performance.

## **Timeline**

Given the magnitude of HCR provisions the timeline of 2010 through 2018 is short, with major provisions being enacted by 2014. Some are already occurring. For example, young adults can now be covered on their parents' plans until age 26; co-payments and/or deductibles have been removed for some preventative services; and in some cases restrictions related to pre-existing conditions, and annual and lifetime limits have been lifted. SAMHSA News (2010) includes a descriptive, but brief, timeline; the National Council for Community Behavioral Healthcare (2010) has crafted a comprehensive table of events; and the U.S. Government (2010) offers an interactive timeline and a great deal of other information on HCR.

## **Conclusion/Next Issue**

Now is the time for planners and providers to become involved in reform so that behavioral health emerges as a strong partner in a more integrated system. Part 2 of this series will focus on emerging concepts and models (e.g., Patient-Centered Health Homes), and how the national discussion is shifting toward "bi-directional integration", including the integration of primary care into behavioral health.

For the title box:

***Part 2: Service Delivery Redesign and Payment Reform***

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