



## **America's Health Future Act of 2009: Assessing the Impact for Individuals with Mental Illness**

On September 16, 2009, the Senate Finance Committee released its Chairman's Mark, a proposal recommended by the committee chairman to be considered in a markup, of the America's Healthy Future Act; a bill to reform America's health care system. Critics of the Mark quickly demanded changes to several provisions in the bill, and a second, modified version of the Mark was issued on September 22, 2009. The bill was subsequently debated, amended and passed by the Senate Finance Committee with a vote of 14-9 on October 13, 2009. The bill addresses a range of coverage and delivery system reforms to promote access to affordable coverage and better value and quality in health care. Included among the provisions are:

- Insurance reforms that end discriminatory practices too often experienced by individuals with mental illnesses, such as exclusions for pre-existing conditions and rates based on health status, gender or occupation.
- State Health Insurance Exchanges that would serve as a marketplace to assist uninsured individuals and small employers in purchasing private health plans.
- Standardized benefit packages that would make it easier for purchasers to select coverage based on cost and quality information.
- Expansion of Medicaid to children and pregnant women with incomes at or below 133 percent of the Federal Poverty Level.
- Extension of limited Medicaid coverage to childless adults with incomes at or below 133 percent of the Federal Poverty Level.
- A minimum benefit plan that includes mental health and addiction services.
- Tax credits to assist low-income households with the cost of purchasing insurance.
- Establishment of out-of-pocket spending limits, restricting the amount an individual is required to contribute towards the cost of care, which would help ease the burden on people who have frequent needs for health care services, drugs and supplies.
- A requirement that individuals obtain coverage or pay a penalty.

## **Insurance Market Reforms**

### **Individual and Small Group Markets**

The individual market is typically where those that do not have access to health insurance through their employer purchase health insurance. The small group market consists of employers with 2-50 (and in some states up to 100) employees. Although they apply to both the individual and small group markets, these rules would be phased in over a period of up to five years beginning on July 1, 2013 for groups with 2-50 employees (small groups). Individuals and small groups who currently have coverage may keep their plans if desired.

The Finance bill proposes to reform the Individual and Small Group markets by:

- Requiring insurers to offer and renew insurance coverage for all who apply (guaranteed issue and renewal);
- Prohibiting the denial of coverage on the basis of pre-existing conditions;
- Prohibiting health insurers from taking away health coverage; and
- Specifying that premium rates can only vary on the basis of tobacco use, age, and family composition at ratios ranging from 1to 4:1, and on the basis of State-defined geographic rating areas.

The insurance reforms mentioned would make it easier for people with mental illness to purchase affordable, quality insurance. Currently, in states where insurers can refuse to sell or renew policies based on health status, and where coverage can be denied for pre-existing conditions, coverage may be impossibly expensive, filled with significant gaps in coverage or simply unobtainable. Individuals with mental illnesses who purchase insurance through the individual market are often subjected to lifetime and annual limits on their mental health treatment, leaving them burdened with substantial debt if they experienced on-going health and mental health problems and persistent treatment needs. They have not been afforded the financial protection that insurance was intended to provide.

Because these reforms do not go into effect immediately, the Finance proposal also offers timely assistance to uninsured individuals who have been denied coverage based upon pre-existing conditions by allowing them to enroll in a high-risk pool within a year of enactment of the legislation. This provision is particularly important for individuals with mental illness who often fail to qualify for individual or small group insurance because their disorder constitutes a pre-existing condition. This measure will ensure that many individuals with mental illness need not wait to benefit from the insurance market reforms scheduled to go into effect several years in the future.

### *State Health Insurance Exchanges*

In order to facilitate easy comparison and purchase of health insurance plans by individuals and small groups, separate individual and small group (SHOP) state-based “exchanges” will be established, effective July 1, 2010. All plans offered by private insurers in the individual and small

group markets that operate nationally, regionally, statewide, or locally must be made available in state exchanges if the insurer is licensed by a state. Federal funding would initially be available to finance state exchanges, but exchanges will be required to be self-sustaining in future years. Exchange plans will only be made available to legal U.S. residents, and the bill as amended instructs states to allow small businesses up to 100 employees to purchase coverage through the SHOP exchange beginning in 2015. Firms with more than 100 employees will be allowed to purchase coverage through the SHOP exchange beginning in 2017. This phase-in approach is similar to that proposed in other pending House and Senate bills.

Additionally, the development of interstate “health care choice compacts” would allow insurance companies to offer insurance to individuals and small groups across state lines. Allowing the purchase of health insurance over state lines may initially sound reasonable. However, the bill indicates that companies selling insurance over state lines are only required to abide by the insurance laws governing the state in which the insurance is sold, thus encouraging insurers to relocate and sell insurance from states that have the fewest and weakest consumer protections and regulations in place.

The Finance bill as amended also prohibits plans with annual and lifetime limits as well as “mini medical” (plans with limited benefits and low annual caps) would be prohibited from being offered in the state exchanges in the years 2010-12.

#### *State Opt-Out*

The Finance bill as amended in markup encourages state innovation by allowing states to opt out of certain provisions in the proposed legislation through a waiver process. States may apply for waivers (permission to be exempt from certain aspects of the law) by applying to the Secretary of Health and Human Services to provide health care coverage that is at least as ample as is required under the state health insurance exchanges. In order to be eligible to receive a waiver, states must show that the state plan will ensure that all residents have access to quality, affordable insurance plans that are at least as comprehensive as those plans in the exchange.

#### *State Option for a Basic Plan*

Beginning on July 1, 2013, the Finance bill as amended in markup also gives states the opportunity to establish a federally funded, non-Medicaid state plan for people with incomes above the Medicaid eligibility level, but below 200 percent of the Federal Poverty Level. These state plans would be funded by the federal government and allow states to offer health care coverage through contracts with private health systems. State plans would be required to meet certain benefit standards, and premium assistance would be made available for the eligible population.

## Making Coverage Affordable

### *Benefits*

Four benefit categories: Bronze, Silver, Gold, and Platinum, would be offered to consumers through each state exchange. Each plan would have a different value and different out-of-pocket costs with an upper limit on out-of-pocket costs of the Health Savings Account (HAS) current law limit (\$5,950 for individuals and \$11,900 for families in 2010). All plans within the exchanges would be required to meet minimum policy rate and premium-setting standards and offer a minimum set benefit package, which would include mental health services. Small employers purchasing coverage through the exchange would be required to offer a plan with a deductible not exceeding \$2,000 for an individual or \$4,000 for a family. The Senate Finance Committee bill requires that the plans sold through the exchange include mental health and addiction services as well as rehabilitative and habilitative services, and requires that mental health and substance use disorder services meet the minimum standards for parity in both federal and state law.

Also under the Finance draft, insurers would be prohibited from requiring beneficiaries to pay part of the cost for preventive care services, except in cases of value-based-insurance design.<sup>1</sup> Additionally, the bill as amended instructs the Secretary of Health and Human Services to define and update the categories of covered services within each benefit class annually through a transparent process that permits public comment and input. The Secretary may also not define a package that is more extensive than the typical employer plan as certified by the Centers for Medicare and Medicaid Services. In the Finance bill, an additional “young invincible” policy would be made available to those 25 years old or younger and to those who would otherwise qualify for the exemption from the individual requirement (see below) and offering only catastrophic coverage. Separate, and lower, out-of-pocket limits are established by the bill for individuals falling between 100 and 400 percent of the Federal Poverty Level.

The Finance Committee has *not* included a public plan option to be offered through state exchanges, but authorizes \$6 billion to fund the Consumer Operated and Oriented Plan (CO-OP), or new, non-profit, member-administered health insurance companies that serve individuals in one or more states and will compete in the individual and small group insurance markets.

### *Premium Tax Credits*

Tax credits for meeting the costs of insurance premiums will be made available to certain eligible individuals in order to assist with the costs of purchasing health insurance through a state exchange beginning in 2013. Tax credits will be refundable and payable in advance directly to the insurer. Individuals would be eligible for the credit if their income is up to 400% of the Federal

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<sup>1</sup> Value-based insurance design (VBID) -- A benefit design that identifies clinically beneficial preventive screenings, lifestyle interventions, medications, immunizations, diagnostic tests and procedures, and efficacious treatments for which cost-sharing (co-payments or coinsurance and deductibles) should be eliminated or reduced due to their high value and effectiveness.

Poverty Level; income levels will be verified by information received from the IRS from the prior tax year. The bill would also provide a tax credit for qualified small employers and non-profit companies for contributions to purchase health insurance for its employees.

#### *Requirement to Purchase Insurance*

Starting in 2013, all American citizens and legal residents would be required to purchase coverage through the individual market, public programs such as Medicare and Medicaid, or through their employer unless they are eligible for an exemption due to hardship, religious reasons, are Native American, or are at or below 100% of the Federal Poverty Level. Individuals who fail to purchase insurance would have to pay a penalty tax. The bill does not mandate employers to offer health insurance coverage, however those employers with more than 50 employees that do not offer coverage would be required to pay a fee for each employee that receives a premium tax credit (see above) for health insurance purchased through a state exchange.

## **Medicaid**

The bill proposes the following changes to Medicaid:

- Limited coverage would be extended through a new eligibility category to non-elderly, non-pregnant individuals (childless adults) who are otherwise ineligible for Medicaid.
- Effective in 2014, the bill establishes a new mandatory minimum Medicaid income eligibility level for all non-elderly individuals – children, parents, and childless adults – of 133 percent of the Federal Poverty Level (\$30,000 a year for a family of four, or \$14,400 for an individual in 2009).
- Childless adults with incomes between 100 and 133 percent of the Federal Poverty Level would be guaranteed only a limited benefit package designed by the state which would follow rules for benchmark plans set up by the Deficit Reduction Act (DRA) of 2005.
- Improves access to Home and Community Based Services (HCBS) for low income individuals in need of long care, and creates incentives for states to offer HCBS as alternatives to institutional care for disabled individuals who require long term care services and supports.

Low-income adults, including those with serious mental illness, are generally not entitled to Medicaid unless they qualify on the basis of disability or because they have dependent children living in their household. Allowing adults to qualify solely on economic factors is a long over-due change that will significantly improve access among low-income individuals with disabilities. Without coverage, the uninsured are much more likely to forego needed care and preventive services, resulting in health and mental health emergencies that take their toll on health and finances. Extending Medicaid coverage to individuals at 133% of the population and to individuals who do not qualify based upon disability or dependent status has the potential to increase access to mental health treatment, and will therefore increase cost-savings.

However, the limited benefit package in the bill for childless adults between 100 and 133 percent of the Federal Poverty Level is of grave concern. The “benchmark” package referred to does not necessarily include mental health care, and entirely fails to include addiction services. Even if

mental health care is included, coverage will be far more limited than in Medicaid, and rehabilitation services are particularly at risk of not being covered at all.

### *Prescription Drug Coverage*

Although the original Finance Committee proposal released by the Chairman included a mandated prescription drug benefit for Medicaid beneficiaries, subsequent amendment has removed this provision from the bill. However, many states already provide prescription drug benefits to eligible individuals in State Medicaid programs.

### *Individuals with Dual Eligibility*

The bill establishes an Office of Coordination for Dual Eligible Beneficiaries to be responsible for leading efforts to align Medicare and Medicaid policies for dual eligibles, or those who are entitled to Medicare Part A and/or Part B and are also eligible for some form of Medicaid benefit. The proposal also makes prescriptions more affordable for dual eligibles who are receiving Home and Community Based Services by making their prescription co-payments equal to those of dual eligibles who reside in long-term care facilities.

### *Enrollment:*

The bill also attempts to improve access to and enrollment in Medicaid for eligible individuals by requiring state Medicaid programs develop an enrollment website and further streamline the application process. The bill also requires the Secretary of HHS to provide guidance to states with regard to best practices to promote the enrollment of vulnerable populations in Medicaid and CHIP. Application for three subsidy programs, Medicaid, CHIP and tax credits, would be made using a single, simplified form than can be filed online, in person, or by mail or telephone.

The enrollment process for Medicaid coverage is protracted and complex, which often deters eligible individuals from applying. This process is particularly difficult for individuals with serious mental illness whose symptoms may impair thought and functioning. Streamlining the enrollment process will decrease barriers to enrollment and effectively encourage individuals with mental illness to apply.

### *Therapeutic Foster Care*

The finance bill as amended ensures that the health reform legislation does not preclude states from covering therapeutic foster care services under Medicaid. Therapeutic foster care (TFC), a cost-effective and evidence based practice, provides an intensive therapeutic living environment for a child with a behavior disorder who requires out-of-home care. TFC offers a structure and supervision by a specially trained family for one or two children at a time, and is a vital service for children who would otherwise be placed in restrictive hospital or residential treatment programs. Additionally, the bill provides a statutory definition of therapeutic foster care.

### *A Comparison*

The scope of Medicaid reforms proposed in the Finance Committee bill is much narrower than that found in the House health reform bill, HR 3200. While the Finance Committee legislation only offers a limited benefit package to childless adults, HR 3200 extends full, comprehensive

Medicaid coverage to all beneficiaries and grants access to the full spectrum of Medicaid services such as critical rehabilitation services.

The House bill also requires state Medicaid programs to cover preventive services that are recommended by the U.S. Preventive Services Task Force and that are appropriate for Medicaid beneficiaries. It also prohibits states from imposing cost-sharing on these services, and provides an enhanced federal matching rate for the cost of such services. The Finance Committee bill only mandates coverage for tobacco cessation programs for pregnant women.

Recent research indicates that co-payments deter people from seeking preventive care. Co-payments are a particular problem for people with little discretionary income, including some with mental illness. Removing the cost-sharing barrier would help divert people from emergency rooms and crisis services if they can access more cost-effective prevention and early intervention services. People with serious mental illnesses receive little or substandard care for their physical health and die, on average, 25 years sooner than the general population. A regular source of primary care and preventive services is vitally important.

#### *State Children's Health Insurance Program*

The bill as amended does not immediately change the Children's Health Insurance Program (CHIP). States would be required to maintain their current CHIP eligibility level until December 31, 2019, but would be free to expand current income eligibility levels to include more children at any time. Beginning in 2014, states would receive a higher matching rate to help finance the continuation of their CHIP programs.

#### *Medicaid Quality Measures and Improvements*

The bill instructs the Secretary of Health and Human Services to develop with the state an initial set of health care quality measures specific to adults who are eligible for Medicaid. The bill would also encourage innovative payment strategies by funding a Medicaid bundled payment demonstration project in up to eight states. Unlike fee-for-service payment methods in which each service provided is priced and paid for separately, bundled payments, also known as "case rates" or "episode-based payment," allow a single payment for all services related to a treatment or condition, providing an incentive to reduce the number of services that have no or minimal benefit. An amendment to the bill also establishes a Medicaid Global Payments demonstration project available to up to five states that would allow the states to test capitation payment methods, where a specific dollar amount per member per month is paid to providers or organizations of providers for which they provide specific services, regardless of the quantity of services necessary to meet the health needs of the defined population.

#### *Medicaid Emergency Psychiatric Care Demonstration Project*

The Finance committee bill as amended provides \$75 million for up to eight states to develop three-year demonstration projects that would allow non-governmental freestanding psychiatric hospitals to receive federal Medicaid matching payments for emergency psychiatric treatment provided in psychiatric hospitals. Currently, psychiatric hospitals are required to provide such emergency services under the Emergency Medical Treatment and Active Labor Act, but they are

prohibited from receiving federal matching payments because of rules that preclude Institutions for Mental Disease (IMDs) from receiving federal Medicaid reimbursement.

### *Addressing Health Disparities*

The bill would require federal health programs to uniformly collect data on race, ethnicity, gender and disability to help program administrators and researchers work to end disparities among these groups.

### *Early Childhood Visits*

The bill adds a new section to Title V of the Social Security Act that would require states, as a condition for receiving the Maternal and Child Health block grant, to conduct needs assessments to determine which communities are most at risk for poor maternal and child health and have few quality home visitation programs. The assessment would also evaluate the state's capacity to provide necessary and appropriate services to communities at risk. The bill also establishes a new state grant program for early childhood home visitation. Grantees under this new program would be required to meet certain performance and quality standards and outcomes.

This provision encourages one of the most promising areas of mental health prevention and intervention: improving the social and emotional development of very young children and identifying early mental health problems in infants and toddlers. Approximately 20 percent of children will develop a mental health disorder that leads to functional impairments, and abused and neglected infants demonstrate a number of troubling symptoms such as post-traumatic stress, cognitive dysfunction, greater aggressiveness and more fear in response to angry interactions between adults.<sup>i</sup> Mental disorders are increasingly being identified in younger and younger children as our understanding improves. Home visiting programs have demonstrated positive results by lessening the effects of maternal depression and child maltreatment, by effectively improving the mother-infant relationships and by increasing infant scores on cognitive tests and measures of social functioning.<sup>ii</sup>

The bill would also require states to cover tobacco cessation services for pregnant women with no cost-sharing requirements.

## **Medicare**

The bill includes a number of changes to Medicare, including:

- Assisting Medicare beneficiaries who experience the coverage gap (explanation of coverage gap needed), or “donut hole,” that plagues the Medicare Part D program by establishing a discount program for beneficiaries enrolled in Part D and who have drug spending that falls into the gap. This program would allow individuals with low to moderate incomes to receive a 50 percent discount on the price of brand-name upon reaching the coverage gap.
- Extending the Medicare Improvements for Patients and Providers Act (MIPPA) provision that increased payments for certain Medicare mental health services;
- Extending the Medicare Advantage Special Needs Plans authority through December 31, 2013;

- Extending the Medicare Rural Hospital Flexibility Program grants used by rural health care providers to improve the quality of health care and strengthen health care networks until 2012.

Because Medicare already has relatively high-cost sharing requirements and no overall limits on out-of-pocket spending, provisions that lessen the financial burdens, like addressing the coverage gap in Part D and increasing low-income subsidies, are important to ensure that beneficiaries are not forced to choose between filling vital prescriptions, seeing the doctor and paying for other necessities. The bill improves the Part D prescription drug program by providing a discount program for beneficiaries who have spent enough on prescriptions to reach the “donut hole,” or the gap in coverage that occurs when an individual has reached an initial prescription drug coverage limit, thus requiring them to pay 100% of the cost of prescription drugs until reaching the qualifying out-of-pocket limit upon which catastrophic coverage kicks in.

The bill also aims to combat Medicare fraud and abuse as well as ensure Medicare sustainability. It would create an independent Medicare Commission to submit proposals to Congress to improve quality and extend Medicare’s sustainability and also includes a series of provisions to prevent fraud or waste, supporting the detection and prosecution of fraud.

## **Promoting Disease Prevention and Wellness**

### *Medicare*

The bill would entitle all Medicare beneficiaries access to a primary care visit during which a comprehensive health risk assessment to identify chronic diseases, urgent health needs, and risk factors that can be altered would be available. Beneficiaries would be eligible for these wellness visits once a year, and no co-payment of a deductible would apply. The bill would also encourage Medicare beneficiaries to receive preventive services by eliminating cost-sharing for prevention services recommended by the U.S. Preventive Services Task Force. Additionally, \$100 million over five years would be set aside to establish an initiative that would provide incentives to Medicare beneficiaries who successfully complete specific healthy lifestyle programs that target risk factors such as tobacco use or high blood pressure.

Encouraging a national focus on prevention and wellness strategies will substantially benefit individuals with mental illness. Prevention and early identification of both health and mental health problems allows for early intervention which can reduce the burden of disease on individuals, their families and communities. Wellness promotion programs that aim to prevent and mediate the effects of chronic disease are particularly important for those with serious mental health disorders, who are also more likely than others to have chronic disorders, such as heart disease and diabetes. Again, individuals with serious mental illness die, on average, 25 years earlier than the general population. This may be the result of gaps in services and treatments, as well as inadequate attention to and assistance for changing harmful health habits that contribute to chronic disorders.

The elimination of cost-sharing, or co-payments, for preventive services is important for preventing avoidable health disparities and addressing problems early when the effects of diseases and conditions can be better managed. Research indicates that co-payments deter people from seeking preventive care, and co-payments present particular challenges for people with little discretionary income, including those with mental illnesses.

## *Medicaid*

The bill establishes a new Medicaid state plan option that would allow beneficiaries with at least two chronic conditions or those with at least one chronic condition and at risk of developing another chronic condition to designate a provider as their “health home.” These health homes would be required to meet certain standards, and provide specific services, including comprehensive care management, care-coordination, and referrals to appropriate community services. Notably, an amendment was passed during the markup process that guarantees that Medicaid enrollees suffering from at least one serious and persistent mental health condition qualify to receive services under this state plan option. The bill was also amended to include community mental health centers among providers and agencies that may qualify to become health homes.

Collaborative care models that entrust one entity with the comprehensive management and coordination of an individual’s care have been found in over 35 randomized controlled trials to be effective in treating mental illness. It is therefore essential that behavioral health specialists be included in any medical home effort. Public mental health policies have long endorsed organized systems of care, which are critical to improving the quality of care. Such systems offer an opportunity for prevention and early intervention and can form a basis for improving quality and making care more affordable. In an ideal collaborative care model, primary care and behavioral health professionals can be co-located and offer enhanced services, such as easy access to mental health treatment for those with other serious or chronic illnesses whose recovery is impaired by a co-occurring mental health disorder and, for more complex cases, improved referral and linkage with community mental health specialty care. Thus, community behavioral health centers, which often serve as the only source of care for individuals with severe mental illnesses, provide ideal medical homes for individuals with mental health disorders, allowing individuals to receive coordinated primary care services in familiar, comfortable locations.

## **Transforming the Health Care Delivery System**

The bill encourages improved health care quality through a variety of initiatives, including promoting payment mechanisms that link payment to outcomes and reward doctors and providers for achieving good patient outcomes. Additional resources would also be made available to the Department of Health and Human Services (HHS) to strengthen the quality measure development processes to improve quality, inform patients and purchasers, and updating payments under federal health programs. Specifically, the Secretary would be directed to develop a national quality strategy, as well as establish an interagency working group on health care quality.

### *Encouraging Development of New Patient Care Models*

The bill encourages providers to improve patient care and reduce costs by allowing high-quality providers that coordinate care across a range of health care settings to share in savings they achieve to the Medicare program. The bill also establishes an Innovation Center within the Centers for Medicare & Medicaid Services (CMS) with the authority to test new patient-centered payment models that encourage evidence-based, coordinated care. A National Pilot Program on Payment Bundling would also be developed to provide incentives to providers who are jointly accountable for an entire episode of care to coordinate patient care across all health services.

## Patient-Centered Outcomes Research

The bill seeks to ensure the quality of health care by establishing a private, non-profit corporation known as the Patient-Centered Outcomes Research Institute to establish national priorities for and to conduct, support and synthesize research relevant to the quality, appropriateness and effectiveness of health care services. The Institute would also be charged with disseminating research findings to patients, clinicians and the public to help inform health care decisions.

A recent report issued by the Institute of Medicine (IOM) listed a number of behavioral health disorders and treatments among its top 100 priorities for a new national investment in comparative effectiveness research. Although many evidence-based, effective treatments exist for mental health and substance use disorders, therapies that are less or not effective continue to be used in a variety of treatment settings; fewer than 25% of individuals with serious mental illness receive appropriate care (Health Affairs, May/June 2009). Outdated practices persist and specific evidence-based practices are slow to be adopted, despite their proven superiority to some traditional service modalities. A systematic review of data regarding mental health and substance use disorder treatments will inform and encourage improvements in practice and prevention efforts.

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i Department of Health and Human Services (1999). *Mental health: A report of the Surgeon General*. Rockville, MD: Department of Health and Human Services.

ii Cicchetti, D. & Toth, S. (2004). Child maltreatment. *Annual Review of Clinical Psychology*, 1, 409-438; Cummings, E.M. & Davies, P.T. (1999). Depressed parents and family functioning: Interpersonal effects and children's functioning and development. In T. Joiner & J.C. Coyne (Eds.), *The interactional nature of depression* (p 299-327). Washington, DC: American Psychological Association.