

## **AFFORDABLE HEALTH CHOICES ACT: ASSESSING ITS POTENTIAL TO PROMOTE THE HEALTH AND WELL-BEING OF PEOPLE WITH MENTAL ILLNESSES**

On June 9, 2009, Senate Health, Education, Labor and Pensions (HELP) Committee unveiled the *Affordable Health Choices Act*, a draft proposal to reform health care. Mark-up of the legislation has begun. As drafted for the Committee, the bill includes:

- Premium subsidies for individuals and families with household income up to 500% of the federal poverty level (FPL) and small business tax credits to encourage small employers to provide health insurance;
- New Medicaid eligibility for adults up to 150% FPL , effectively eliminating the need for states to obtain a special Medicaid waiver to cover low income adults who do not meet categorical requirements—e.g., qualify for disability or are parents of dependent children living in the household;
- Health insurance market reforms that eliminate discriminatory insurance practices that have made it difficult or impossible for individuals with high health care service needs—including people with serious mental illnesses—to obtain health coverage;
- Requirements for individuals to obtain health insurance if an affordable plan is available, and a requirement that employers offer coverage to their workers or instead pay fees to the government;
- Federal minimum benefit requirements for health insurance coverage, with many details left to an expert advisory panel;
- The establishment of a national voluntary long-term care program for purchasing coverage for community living assistance services and supports;
- Expanded comparative effectiveness research to foster adoption of best practices and leave behind outmoded forms of treatment; and
- Health-system related reforms (including the promotion of prevention/wellness, chronic care management, health workforce development) to promote better value in health care.

See a summary of the bill (<http://www.bazelon.org/issues/healthreform/HELPsection-by-section6-10-09.doc>) and the actual bill ([http://help.senate.gov/BAI09A84\\_xml.pdf](http://help.senate.gov/BAI09A84_xml.pdf)) as drafted for the committee. This document specifically focuses on how this bill would affect individuals with mental health care needs.

### **Mental Health and Substance Abuse Parity**

The legislation would require health plans covered by the law to provide mental health, substance abuse and rehabilitation services. The details on the scope of benefits and the terms and conditions that will apply, however, are left to the US Secretary of Health and Human Services (HHS), guided by a new Medical Advisory Committee that is responsible for making recommendations about benefits, affordability, and other issues. There is no guarantee that people purchasing plans through this new system would have parity in their mental health benefits.

Last year's enactment of the Wellstone-Domenici Parity Act, requiring mental health and substance abuse parity in employer-sponsored group plans of 50 or more, set a standard for non-discrimination in

insurance coverage that was expected to be followed with parity requirements in health reform. This is not the case, however, with the HELP Committee draft bill. Without explicit language requiring parity in coverage, it is likely that many plans to cover the uninsured will have limits on mental health in-patient and out-patient benefits. The failure to guarantee parity could perpetuate a system of fragmented care that fails to meet the mental health needs of the uninsured.

As health care reform progresses, it will be important to advance the case for parity, acknowledging the effectiveness of mental health and substance abuse treatment and emphasizing the economic analyses that link effective treatment to beneficial outcomes and savings in health care and other systems.

## **Insurance Reforms**

To end discriminatory practices and make coverage more affordable, the bill includes insurance market reforms that are positive steps to help individuals with mental illnesses acquire insurance at a fairer price.

Health plans will not be allowed to have lifetime and annual benefit limits.

Annual and lifetime limits do nothing to avoid preventable health care costs but instead shift costs from the insurer to individuals, public programs and other purchasers. People with mental illnesses have been seriously hurt by arbitrary and discriminatory limits on mental health care. By prohibiting lifetime or annual limits, this bill will be of great benefit to people with serious mental illnesses.

Health plans will not be allowed to reject applicants for coverage based on their health status, exclude coverage for pre-existing conditions or deny subscribers the option to renew their policies.

Some states have already prohibited these practices. In states where these practices are allowed, individuals with mental illnesses are either denied insurance altogether or are unable to obtain coverage for pre-existing conditions. In some poorly regulated markets, subscribers who develop health and/or mental problems are dropped from plans once they start filing claims. These unfair practices exacerbate the problems of individuals at a time when they are most vulnerable.

Health plans will have limits on premium rate variation and will be prohibited from varying rates on the basis of health status.

The draft bill would allow premium costs within a geographic region to vary by not more than two to one, based on family composition, the value of the benefits package, and age. One or more members of the committee proposed other options—such as allowing greater rate variation, not regulating rate variation at the federal level at all or charging individuals who use tobacco or who do not maintain good health habits higher premiums.

The options mentioned would make coverage less affordable for people with serious mental illnesses. While the last option may have a public health intention, the likely effect would be to contribute to greater stress levels and deterioration in functioning in a population that is significantly more likely to use tobacco and have greater difficulties managing weight and adhering to exercise regimens than people generally. These problems should be viewed as complicating health problems that may require behavioral support and encouragement in order to bring about change.

The bill would set a standard that insurers must meet for the percentage of premiums that must be spent on medical care vs. administration, marketing and profits.

Insurers that do not meet this standard (sometimes called a medical loss ratio) would be required to provide rebates to enrollees.

Setting a standard for medical loss ratios and requiring rebates if the standard is not met will benefit all consumers by increasing the amount of money available for care. It will help preserve the integrity of the marketplace and is expected to help set a higher standard for protecting the public and guarding against profiteering.

### Dependent coverage.

Dependents will be permitted to remain on parents' policies until age 26.

Youth who are transitioning to adulthood are a segment of the population that has a most difficult time accessing and maintaining coverage, and those with emotional and behavioral disturbances are at greater risk for being uninsured. They may be ineligible for Medicaid coverage because they do not meet the standards for disability, even though they have significant functional impairments or because they are living with parents whose income disqualifies them. They are likely to be unemployed or employed in part-time jobs without benefits. Their parents, who might be able to afford the cost of keeping them on the family policy, will be hard-pressed to find an affordable policy in the individual market. Offering the option to extend coverage to 26 will help to lower the uninsurance rate in the 18-26 age cohort, subsequently helping more vulnerable youth.

## **Medicaid**

While some states cover low-income adults through Medicaid waiver mechanisms, these individuals are not entitled to Medicaid unless they qualify on the basis of disability or because they have dependent children in their home. As a result, many low income adults with serious mental illnesses are unable to qualify for Medicaid. While the Senate committee of jurisdiction for Medicaid is the Finance Committee, which has not yet released its bill, the HELP Committee offered its direction by proposing to extend Medicaid to all adults up to 150% of the FPL.

As proposed, the federal government would provide 100% federal funding of the additional costs of enrolling these newly eligible individuals until 2015. Then from 2015 to 2020, this 100% subsidy would be phased out and states would receive federal matching funds at regular levels after 2020. For states that increased eligibility for adults not meeting categorical eligibility requirements prior to enactment, the HELP committee proposal includes an increased match rate to recognize their earlier efforts to increase coverage. States would be required to maintain levels of eligibility to beneficiaries currently enrolled in Medicaid. This is important because as states have been suffering from the economic crisis, the temptation is to cut beneficiaries from the program.

There is every rationale for including low-income, childless adults at par with other individuals on Medicaid. Their health and mental health suffer from an inability to obtain affordable care. The lack of coverage leads them to delay acute care needs as well as preventive services. Fairness would dictate that the eligibility level for this group should be the same as for adults with dependent children, after adjusting for family size. People with serious mental illnesses need the full Medicaid service array that

includes benefits that are not covered in typical insurance plans (such as psychiatric rehabilitation services) but are covered in Medicaid.

## **Affordable Choices**

Gateways to coverage: Each state will have an Affordable Health Benefit Gateway under the HELP Committee legislation, established either by the state or by the US Department of Health & Human Services. The Gateway facilitates the purchase of health insurance coverage, providing assistance to individuals and small employer groups. In addition to private health plans, a proposed public insurance plan option would also be offered through a Gateway.

Under the plan, the Secretary of Health & Human Services would be charged with issuing regulations and policies for marketing, network adequacy, consumer information, outreach and enrollment and public information. Alternative options mentioned in the draft bill include a suggestion to allow multiple competing exchanges and to minimize the potential regulatory role of the Gateways.

Gateways would be responsible for ensuring that health plans offering coverage meet standards established by the Secretary. They would qualify health plans for participation, determine eligibility of individuals and businesses, administer subsidies and facilitate consumer assistance. Health plans would be required to provide standardized information so that the marketplace is fair to consumers, providers and plans.

States would receive federal support to contract with private and public entities to act as navigators to assist those seeking quality and affordable coverage through Gateways. The navigators will conduct public education activities, distribute information about enrollment and premium credits, and provide enrollment assistance.

Gateways and navigators are important components of this proposal, providing an organized system and the support needed for consumers to access coverage. These components ensure that individuals and small businesses have unbiased information, decision support and enrollment assistance, as well as guard against fraud, abuse and unethical or unlawful practices.

Making coverage more affordable: To reduce the economic burden of health care on vulnerable Americans, low income and moderate income Americans who enroll in plans through the Gateways will be eligible for premium credits. Credits are provided on sliding scale, so that those with the lowest incomes receive the most help. Credits would phase out when people's incomes reach 500% of FPL. Geographic variation may be allowed to account for higher costs of goods and services in certain areas. Limits would be placed on out-of-pocket costs, linked to a percentage of family income. Gateways, which will provide information on health insurance options, would also administer these credits.

Eligible small employers would be permitted to access tax credits based on the number of full time employees, the proportion of employees provided health insurance and on employee wages. Credits phase out with increasing business size, so the firms with 26 or more workers are ineligible. Credits also phase out with average wages, so firms with average wages above \$40,000 are ineligible. Credits are increased for those firms that did not previously offer coverage, and decreased for those that did.

Credits for individuals and businesses can be important to expanding coverage but the effectiveness of these mechanisms will depend on the extent to which these cost offsets are sufficient to really make policies affordable. It is especially important to factor both premium contributions and other cost-sharing requirements in calculations about whether coverage is affordable. Otherwise, people with high mental health care needs, people with disabilities, and those with other expensive conditions will be unable to afford their care.

## **Voluntary Insurance for Home and Community-Based Living Assistance**

This provision would set up the Community Living Assistance Services and Supports (CLASS) program, a national voluntary insurance program to help people pay for support services that would allow them to remain in their own homes and avoid moving into nursing homes. Financed through voluntary payroll deductions (with opt-out enrollment similar to Medicare Part B), this program will remove barriers to independence and choice by providing a cash benefit to individuals unable to perform two or more functional activities of daily living. People would enroll in the program during their working years and begin paying premiums. To collect benefits, a person would have had to pay premiums for at least five years.

The large risk pool created will make long-term care coverage more affordable and reduce incentives for people with severe impairments to qualify for Medicaid. Participants in the program who become disabled would receive cash benefits (no less than an average of \$50 per day) for non-medical services, such as housing modifications, assistive technologies, personal assistance services, transportation), counseling and other supports to help them maintain independence.

The benefit would be modest — not less than \$50 a day — but it could be used to cover a wide range of services. Premiums would average \$65 a month, below the current cost of most private coverage for people in their 50s and 60s. For students and young workers, premiums would be as low as \$5 a month.

This provision addresses a big gap in coverage for people who develop functional impairments due to physical or mental health conditions, allowing them to continue to live in their home or apartment. It is also designed to change reimbursement policies that favor institutional care over home-based care. Many of the people with mental illnesses who are currently in nursing homes or residential care facilities do not need to be there and would function better if supported in the community. The cost-savings are potentially dramatic. For example, the cost of housing and assertive community treatment for a person with a serious mental illness in New York City is roughly \$22,500, while a community residential facility is about \$60,000.

## **Health Quality and Delivery System Reform**

Promoting preventive care: Health insurance policies would not be allowed to impose more than minimal cost-sharing for certain preventive services deemed to be clinically effective and cost-effective by the U. S. Preventive Services Task Force.

Numerous recent studies have shown that co-payments deter people from getting preventive care. Co-payments are a particular problem for people with little discretionary income, including those with mental illnesses. 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.

Promoting quality and integration. Plans will be required to provide financial incentives for doctors that provide more comprehensive care through medical homes and for services such as case management, care coordination, chronic disease management, hospital discharge planning (pre- and post discharge assistance), wellness and health promotion activities, activities to improve patient safety and reduce medical errors, as well as culturally- and linguistically-appropriate care. Other innovations, like Community Health Teams, are designed to support the development of an integrated team of providers that includes primary care providers, specialists, other clinicians and licensed integrative health professionals. These teams are patient-centered and holistic and include community programs and approaches to promote wellness and healthy lifestyles.

Effectively integrated medical and mental health care will help to promote the best outcomes and the greatest value for health care spending. These quality initiatives will be a benefit to all. For mental health consumers they have the potential to profoundly reduce the health disparities that are currently experienced by this population.

National strategy for quality improvement in health care: Health outcomes, as well as quality initiatives to improve them, vary widely across the country. The National Strategy aims to reduce geographic variations in care quality and reduce health disparities while improving the delivery of health care services, patient health outcomes, and population health.

Half of people with serious mental illnesses do not receive any treatment, and another 25 percent receive treatment that is not consistent with evidence-based guidelines (*Health Affairs*, May/June 2009). An estimated 20-30 percent of all health care in the US falls into the categories of overuse, underuse and misuse based on the best available evidence.<sup>1</sup> In the mental health sector, outmoded practices persist and specific evidence-based practices—such as multi-systemic therapy, cognitive behavior therapy, assertive community treatment (ACT), illness self-management and recovery, and supported housing and employment—are slow to be adopted, despite their proven superiority to some traditional service modalities. Change will require a concerted effort by health plans, provider organizations, quality specialists, consumers and others to demand accountable health care organizations. Changing practices will require training, implementation support and system incentives to promote evidence-based practices.

Program to Facilitate Shared Decision Making: Educational tools will be developed, tested, and disseminated to help patients and caregivers understand their treatment options. Materials will assist patients in deciding with their provider what treatments are best for them based on these beliefs and preferences, options, scientific evidence, and other circumstances. Providers will be educated on the use of these tools. Quality measures related to utilization of these tools, as well as methods for obtaining input from patients and caregivers, will be developed.

Consumers of mental health services, as well as people with other disabilities, have long argued “nothing about us without us” to indicate the core concept of self-determination. Recognizing that the individual has to maintain independence and self-agency, concepts like shared decision-making and advance directives are fundamental. Increasingly, health care providers understand that the best

outcomes are achieved when patients are engaged with their own care and supported with education and coaching. Innovations like shared-decision-making, self-management strategies and personal health records allow consumers to become meaningfully involved and will contribute to more effective health system reform.

## **Improving the Health of the American People**

Modernizing Disease Prevention in Public Health Systems: The bill aims to promote access to preventive health and wellness services for all Americans, regardless of age, gender, ethnicity, or physical or cognitive ability. It would create a national strategy for disease prevention, health promotion, and improvement of the public health system. These goals would be achieved by:

- Establishing a National Prevention, Health Promotion and Public Health Council to provide coordination and leadership of prevention, wellness, and health promotion practices and national strategies for the promotion of health for individuals;
- Creating a Prevention and Public Health Investment Fund to provide for, expand and sustain prevention and public health programs including prevention research and health screenings;
- Instituting a Preventive Services Task Force to focus on a population-based, public health approach to prevention by reviewing the scientific evidence about clinical preventive services to develop and update recommendations for the health care community. This Task Force would also be charged with identifying gaps in research and developing additional topic areas for review, disseminating recommendations, and providing technical assistance to the health care community; and
- Implementing a national public-private partnership for a prevention and health promotion outreach and education campaign to raise public awareness of health improvement across the life span.

Creating an effective national public health-based prevention strategy will substantially benefit individuals with mental illnesses. 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. Community-based mental health promotion is fundamental to overall prevention and wellness strategies. Promoting research on evidence-based prevention strategies and encouraging a health care climate that recognizes the benefits of prevention will foster the development and implementation of successful strategies across the country. Public outreach and education about mental illnesses will reduce stigma, inform individuals of treatment options, and encourage more people to access critical treatment services.

Increasing Access to Clinical Preventive Services: The bill would increase access to essential services necessary to promote prevention and good health. To promote access in underserved communities and for underserved populations, it would create:

- The “Right Choices Program,” a grant program to states that funds outreach to the uninsured and provides a health risk appraisal and a care plan that includes recommendations for lifestyle changes, immunizations and referrals to community-based resources. Health risk appraisals would assist with the identification of health and mental health problems and referral of uninsured populations to appropriate community-based services. This program is intended to fill the gap until the time that Gateways are operational and coverage for the uninsured is obtainable.

- Grants for school-based health clinics, with preference given to areas that have shortages of primary care and mental health services for children and adolescents. The core services of these school-based clinics include comprehensive primary health services, which are defined in the bill as including “mental health assessments, crisis intervention, counseling, treatment, and referral to a continuum of services.” Children spend a significant portion of their day at school, making schools ideal places to locate necessary mental health services, allow for collaboration between schools and local mental health agencies, and link children with appropriate services within the community.

Creating Healthier Communities: This provision encourages health improvement in the community through lifestyle and environmental changes. It would authorize, among other initiatives:

- The Community Transformation Grant Program, providing competitive grants to state and local government and community-based organizations for the implementation, evaluation, and dissemination of proven evidence-based community preventive health activities in order to reduce chronic disease rates, address health disparities, and develop a stronger evidence base of effective prevention programming.
- Healthy Aging, Living Well Grants to state and local health departments for five-year pilot programs that provide public health community interventions, screenings, and, where necessary, clinical referrals for individuals who are between 55 and 64 years of age. These grants would facilitate the delivery of interventions to improve nutrition, increase physical activity, reduce tobacco and other substance use, improve mental health, and promote healthy living.

Community-based prevention strategies and wellness promotion programs that assist people with chronic diseases would be beneficial for individuals with mental illnesses as they are at greater risk than others for chronic health conditions such as heart disease and diabetes.

Support for Prevention and Public Health Information: The bill would encourage public health research activities focused upon prevention, including funding for research on evidence-based practices relating to prevention, translating research to practice, identifying effective strategies for coordinating public health services in community settings and studying the public health workforce. Data on specific socio-economic factors, including disability status, will be required to detect and monitor trends in health disparities.

Research on prevention is critical to determine the best prevention and early intervention strategies for mental disorders. Funding is also critical in order to explore and promote innovative, effective mental illness prevention practices. Data on disabilities, including mental health-related disability, is rarely collected in national health studies, preventing accurate assessment of health disparities for individuals with disabilities.

## **Health Care Workforce**

Increasing the supply of the health care workforce: The bill would improve access to health services through the planning and implementation of strategies to address capacity issues and gaps in the workforce. These strategies include tuition reimbursement and other incentives for medical students, nursing students, pediatric specialists (including qualified child and adolescent psychiatrists,

psychologists, social workers, and other behavioral health providers), public health professionals, and allied health professionals.

Mental health care, like physical health care, is experiencing a workforce crisis that must be addressed to ensure continued access to vital treatment and rehabilitative services. The Health Resources and Services Administration Shortage Designation Branch reports that as of March 31, 2009, there are more than 3,000 communities or areas experiencing shortages in mental health practitioners that affect over 80 million individuals.

Enhancing health care workforce education and training: The bill would establish training grants for primary care providers in family medicine, general internal medicine, general pediatrics, and physician assistantship in order to build capacity in primary care. Funding for advanced nursing education, as well as training on cultural competency, prevention and public health, and caring for individuals with disabilities, is also provided.

Mental health and behavioral health education and training grants would be established to support:

- the recruitment, education, and clinical experience of students in social work programs;
- the development and implementation of interdisciplinary training of students in psychology to foster provision of mental health services;
- internships or field placement programs in child and adolescent mental health in specified fields; and
- training of paraprofessional child and adolescent mental health workers.

Grants would also be awarded to promote the use of community health workers in vulnerable communities and for other initiatives, like perinatal home visits for the promotion of maternal and child health.

A primary care extension program would be established to support and educate primary care providers about evidence-based practices, prevention and health promotion services, chronic disease management and mental health. Primary care providers would collaborate with community-based “Health Extension Agents” to implement patient-centered medical homes and other collaborative care activities.

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<sup>i</sup> Strite, S. and Stuart, M.E. What is an evidence-based, value-based health care system? [Physician Executive, Jan-Feb, 2005](#) .