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## The Affordable Care Act and Mental Health

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The Patient Protection and Affordable Care Act (ACA) of 2010 provides the opportunity to expand health insurance coverage for individuals and businesses through private insurance as well as Medicaid. The ACA includes provisions that benefit millions of individuals with mental health and substance use (MH/SU) conditions. For example, beginning in 2014, insurers will no longer be able to deny coverage or raise premium costs for mental health conditions or other health status or health history factors. The ACA also will require from 2014 forward that the majority of both private and Medicaid health plans include mental health and substance abuse coverage that is on par with other medical benefits.

To better understand how the ACA affects those with mental and substance use disorders in Texas, it is helpful to first review some basic background on mental illness and substance use, and the public and private mental health and substance use services and systems in Texas.

### Mental Health Basics: Why Access to Treatment Matters

Mental *health* is an essential characteristic factor of every Texans' overall well-being that can affect their work productivity, decision-making and ability to learn. Mental *illness* is defined as a disturbance in an individual's cognitions, emotions, or behaviors that can cause significant dysfunction.<sup>1</sup> *Substance abuse* and mental illness often co-occur, though not necessarily, because one illness causes the other.<sup>2</sup> Mental illness and substance use—often referred to together as “behavioral health”—range from mild to severe, temporary or chronic, and are mostly treatable with effective medications and clinical interventions.

However, untreated mental illness and substance abuse can lead to a lower quality of life during childhood and adulthood, linked to under-achievement in school, involvement with criminal justice, and suicide.<sup>3</sup> Individuals with serious mental illness are also more likely to have other medical conditions such as diabetes and heart disease, and as a result have a shorter life expectancy than individuals without a mental illness. Individuals with mental illness, especially untreated depression, are likely to miss more workdays and be less productive on average than individuals who do not have a mental illness.<sup>4</sup>

Additionally, a parent's untreated or undertreated mental illness is likely to create a disruptive family environment that may foster poverty or child maltreatment.<sup>5</sup>

Therefore, making sure Texans with mental and substance use disorders have health coverage and access to supportive services helps to promote their overall well-being, as well as that of their families, employers and communities.

## **Profile: Mental Health and Substance Use in Texas**

### *Adults*

In 2012, of the 17 million working-age adults (ages 18 to 64 years) in Texas:

- More than 3.7 million (22 percent) had some type of mental disorder, defined as one which mildly impairs functioning.
- Another 848,000 adults (5 percent) in Texas had a Serious Mental Illness (SMI), which substantially impairs functioning in one or more major life activities.<sup>6</sup>
- Another 441,000 adults (2.6 percent) had a Serious and Persistent Mental Illness, which includes disorders that are often chronic and lifelong, such as schizophrenia.<sup>7</sup>
- The Texas Department of State Health Services (DSHS) estimated that in 2010 more than 1.7 million Texas adults had a chemical dependency, most commonly to alcohol.

### *Children and Adolescents*

Behavioral health statistics for children and adolescents use different terms and varying age ranges. Of the nearly 3.2 million Texas children between ages 9 to 17 years in 2012:

- 634,000 children/adolescents (about 20 percent of that age group) had some type of diagnosable mental disorder.
- An additional 159,000 children/adolescents had a Serious Emotional Disturbance (SED) that includes emotional, mental and behavioral disorders that frequently result in significant functional impairment in home and/or school activities.
- Mental health disorders among children are more common and those with SED are higher than major physical conditions, such as asthma and diabetes.<sup>8</sup>
- DSHS estimated that in 2010 more than 174,000 Texas adolescents (ages 12 to 17) had a chemical dependency.<sup>9</sup>

## **Insurance Coverage for Texans with Behavioral Health Conditions**

Access to public or private health insurance is a big factor in whether an individual with behavioral health needs will receive treatment. Persons with mental illness show up in high proportions among low-income Americans with no insurance. In fact, individuals with mental illness are twice as likely to be uninsured as individuals without a mental illness.<sup>10</sup> Individuals with untreated or undertreated SMI and SED are often among the highest consumers of multiple specialized state and county services such as child welfare, public health systems, special education, and/or the criminal and juvenile justice systems. This kind of cross utilization of services due to lack of consistent treatment is both costly to taxpayers, and often results in a lack of continuity and lower quality, less effective care for the mental health consumer.

In Texas, individuals with mental illness are affected by not only the national uninsured trends for MH/SU consumers described above, but also by our state's especially high barriers to insurance coverage. For many years, Texas has had the highest percentage of uninsured and in fact, in 2011, approximately 6.1 million Texans (23.8 percent of the total) of all ages were uninsured, including an estimated 1.2 million children.<sup>11</sup> Even for persons without mental illness, lower quality of life, increased morbidity and mortality, and higher financial burdens are often the consequences of not having health insurance.<sup>12</sup> Additionally, Texans are much less likely than Americans overall to get coverage through employment; only 50.6 percent of Texans obtained health insurance through their employer or as a dependent in 2011, compared to the national average of 55 percent.<sup>13</sup> Adding to the high-uninsured rate is the lack of free or low-cost public insurance through Medicaid for low-income working-age adults (19-64). Today, state-imposed Medicaid limits mean only a small fraction of the parents of over 2.5 million children on Medicaid qualify for coverage themselves. In addition, federal Medicaid law excludes adults without children at home unless they are fully disabled, seniors, or pregnant. As a result, many low-income mental health consumers whose conditions fall short of full disability benefits are left with no health coverage.

## **Behavioral Health Parity Law and Policy**

Access to behavioral health care is not just a matter of having health insurance; it also requires an adequate scope of covered benefits in a health plan. For many years, benefits for MH/SU services were not included in many health plans. In addition, when an employer did choose to offer mental health care coverage as a part of the employer-sponsored plan, MH/SU conditions were typically capped at a much lower level of coverage than that for physical conditions. As a result, people who needed MH/SU services either were limited to what insurance covered, or exposed to high costs if they accessed services beyond the coverage limits.

## **Federal Parity Law and Rules**

To reduce the disparity in mental health coverage in the private insurance market, the U.S. Congress has passed two parity acts.

- The Mental Health Parity Act of 1996 established requirements with respect to lifetime and annual limits for mental health benefits offered through employer-based health insurance plans. This Act did not apply to substance abuse benefits.
- The Wellston-Domenici Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008 requires that group plans (51+ full-time employees) that choose to provide MH/SU benefits, and all Medicaid managed care plans, must ensure that the coverage for those benefits is no more restrictive than the coverage terms for medical/surgical services.

**Importantly, MHPAEA did not require that any health plan include MH/SU benefits, only that those that do include them must treat them on par with other medical care benefits.**

Specifically, the Act:

- Eliminates annual and lifetime dollar limits on MH/SU treatments;
- Prohibits having greater financial requirements (e.g. copays) and treatment limitations (e.g., number of outpatient visits) for MH/SU disorders than for medical services
- Requires that plans that offer medical/surgical benefits at lower costs to the patients from “in-network” providers must also offer MH/SU benefits on the same terms from in-network providers.

Federal agencies (U.S. Departments of Health and Human Services, Labor, and Treasury) responsible for the application of parity laws released Interim Final Rules in February 2010, most of which took effect on April 5, 2010. The President recently announced, in response to gun violence events and related concerns about access to mental health services, that his administration is committed to finalizing mental-health-parity regulations governing how existing group health plans that offer mental health services must cover them at parity.<sup>14</sup> In 2011, the Texas Department of Insurance also adopted rules reflecting the new financial and treatment limitation provisions of the MHPAEA.<sup>15</sup>

The federal rules provide robust and thorough definitions, plus implementation guidance related to financial and treatment limits for which parity is required. Two provisions of the regulations are especially important. The first says that beneficiaries’ required financial contributions, including deductibles and out-of-pocket limits, must be aggregated for medical/surgical and MH/SU benefits. In other words, medical and MH/SU out-of-pocket costs must be subject to a single combined deductible, and count towards a single combined out-of-pocket limit. Second, the rules make it clear that parity applies not only to “Quantitative Treatment Limitations” but also to “Non-Quantitative Treatment Limits” (NQTL). NQTLs are treatment limitations that are not expressed numerically, but still limit the scope and duration of benefits such as requiring pre-authorization of services, utilization reviews, medical necessity standards, and “fail-first” policies. Federal rules do not prohibit the use of these NQTLs, but they do require that those limits must be applied on the same terms to medical and MH/SU benefits, and so cannot be used to effectively limit behavioral health benefits to a greater degree than medical care.

## Texas Law and Rules

Texas law mandates that large group plans (50 or more full-time employees) must provide benefits for specified serious mental illnesses (SMI) and other disorders, such as bipolar disorders, depression in childhood and adolescence, schizophrenia and schizoaffective disorders, and other psychotic disorders.<sup>16</sup> SMI coverage must include at least 45 inpatient days and 60 outpatient visits annually, and no lifetime limits on the number of inpatient days or outpatient visits are allowed. Small and large group health plans must also provide coverage for the treatment of chemical dependency.<sup>17</sup> These Texas mandates do not apply to small group plans, individual plans, or Consumer Choice Health Benefits Plans.<sup>18</sup> TDI reports that the average annual premium cost per enrollee was \$20.09 for SMI benefits and \$9.01 for chemical dependency benefits in 2008-2009 (latest year for which data are available).<sup>19</sup>

Private insurance MH/SU benefits in Texas today typically include screening and assessment, outpatient, and inpatient services as well as psychiatric day hospitalization (see Table 1 below).<sup>20</sup> As discussed below, even with the application of parity laws and rules, the average private insurance MH/SU array of benefits is generally less robust and tailored to the needs of persons with chronic behavioral health needs than those available from Medicaid.

Table 1. Current Mental Health and Substance Use Services and Coverage

Mental Health and Substance Use Treatment Services	Private Insurance+	Local MHMRA	Medicaid^	Medicaid Expansion
<b>Prevention Screening &amp; Assessment</b> (Alcohol Misuse, Depression, Illicit Drugs,	✓	✓	✓	✓
<b>Outpatient</b> (Counseling and Medication management)	✓	✓	✓	✓
<b>Inpatient</b>	✓	✓	✓♦	✓
<b>Partial Hospitalization</b>	✓	✓	✓	✓
<b>Residential Care</b> (short and long)		✓	✓	
<b>Crisis Intervention</b>		✓	✓	
<b>Housing Assistance</b>		✓	✓	
<b>Peer Support Services</b>		✓	✓	
<b>Home-based Support Services</b>		✓	✓	
<b>Vocational Training and Support</b>		✓	✓	
<b>Rehabilitative Services</b>		✓	✓	
<b>Case Management</b>	●	✓	✓	
^ Texas Medicaid –current services + Based on Blue Cross/Blue Shield Plan Choice PPO plan ♦ Excludes services in an Institution for Mental Disease (IMD) for persons 22-64 yr ● Special feature within the Texas Health Insurance Pool for those who are authorized				
Texas Health Insurance Pool. High Deductible Health Plan: HSA-Qualified Policy for Individual Major Medical Coverage – Outline of Coverage				

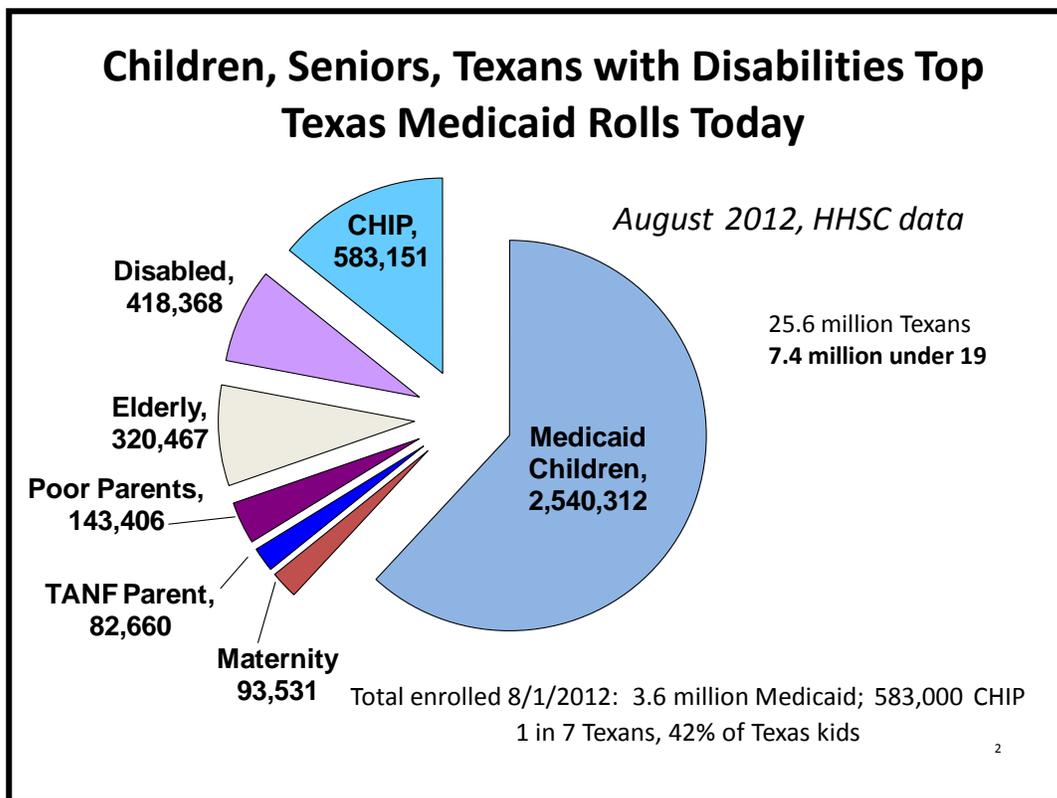
## Behavioral Health Law and Policy: Public Systems in Texas

The Texas public mental health and substance use system includes the Health and Human Services Commission (HHSC) system of public insurance through Medicaid and CHIP, and the

Department of State Health Services (DSHS) systems of care, provided by Local Mental Health Authorities and NorthSTAR in the Dallas area.

**The Texas Medicaid** program provides general medical services as well as a broader and more robust range of clinical and support services for individuals with SMI and substance abuse disorders than is usually available through private insurance (see Table 1 above). Many Americans with such severe chronic mental health diagnoses that they are unable to work and considered disabled qualify for Medicaid, which is why Medicaid programs historically have offered more of the kinds of services needed by these individuals.

More than 270,000 Texas children and adults received MH/SU Medicaid services in 2011, which is a 25 percent increase over 2008.<sup>21</sup> This number would be even higher if more Texas adults were covered by Medicaid. Today, consumers of the MH/SU services in Texas Medicaid are largely children in poverty and adults on SSI.



The **Children's Health Insurance Program (CHIP)**, public insurance for children with incomes above Medicaid limits but below 200 percent of the federal poverty line, also provides substance abuse and mental services, but benefits are more like the spectrum of services typically offered through private insurance.<sup>22</sup>

The **DSHS system** provides community-based outpatient and support services, crisis services and intense inpatient treatment services to adults, children, and adolescents. The system operates as a behavioral health safety net for the uninsured poor, and for the state-defined "priority population."

Texas statute mandates that state dollars can only fund DSHS MH/SU services for adults (a different standard is applied to ages 17 and under) who are medically indigent and who have certain diagnoses. Therefore, DSHS by design serves those with the most debilitating conditions and/or those in crisis. To receive services in the DSHS mental health system, an adult must have at least one of the "Big 3 diagnoses": schizophrenia, major depression, or bipolar disorders. The criteria for children and adolescents to be served are not diagnosis specific, but instead say children (ages 3-17 years) must exhibit serious emotional, behavioral, or mental disturbance, have a serious functional impairment, and/or be at risk of disrupting their living or childcare environment as a result of their psychological symptoms.<sup>23</sup>

In 2010, DSHS served approximately 157,000 of the estimated 407,000 adults (unduplicated) Texans with one of the "Big 3" diagnoses. Of those served, only 40 percent were Medicaid recipients who likely qualify for disability under the Supplemental Security Income (SSI) programs, which automatically qualifies participants for Texas Medicaid. DSHS also served just over 45,000 children and adolescents in 2010, out of more than 170,000 estimated to have a severe emotional disturbance (SED), of whom 83 percent served were Medicaid participants.<sup>24</sup> The fact that Medicaid covers more than twice the share of the children served at DSHS MH programs than of the adults is again related to Texas Medicaid's very limited coverage of non-disabled adults.

## Substance Abuse Services

Substance abuse services are also available for the adults and adolescents who qualify within the Texas Medicaid and DSHS systems.

Although such services have been a covered **Medicaid** benefit for adolescents (20 years and under) participating in Medicaid for some time, substance abuse services for adults are relatively new to Texas Medicaid. In 2009, the Texas Legislature directed HHSC to provide comprehensive substance abuse services to adults with a substance use disorder and who otherwise qualify for Medicaid (i.e. low-income elderly; individuals with disabilities; pregnant women; women with breast or cervical cancer; and parents participating in or with incomes near the level of Temporary Assistance for Needy Families). Medicaid substance abuse services include assessment, detoxification (ambulatory and residential), residential treatment, outpatient treatment, and medication-assisted therapy (e.g. Methadone treatment).<sup>25</sup> As indicated above,

only adults in special categories qualify for the Texas Medicaid program; therefore, very few adults whose conditions fall short of full disability are currently able to access these substance abuse services.

To receive substance abuse services from **DSHS**, an individual must meet financial eligibility requirements, which are fully funded for individuals with an income at or below 200 percent of poverty or a sliding-scale fee for incomes above 200 percent. The substance abuse priority population for adults and adolescents ages 13-21 yrs. set by federal policy (the Substance Abuse and Mental Health Services Administration, SAMHSA, under the US Department of Health and Human Services), prioritizes services for pregnant intravenous users, pregnant substance users, and intravenous users. Those who do not meet one of these clinical criteria are placed on a wait-list for treatment of alcohol, illicit and prescription drugs abuse/dependence.<sup>26</sup> DSHS recently reported that nearly one in four Texans placed on the waiting list never received services.<sup>27</sup> DSHS' substance abuse services include screening and assessment, residential treatment, outpatient services, ambulatory detox for adults, and treatment for co-occurring psychiatric and substance abuse disorders for adults and adolescents.

## Patient Protection and Affordable Care Act of 2010

The ACA calls for significantly greater access to health care services, and improved quality of care and associated patient outcomes in the private and public systems. These opportunities will especially help those with chronic conditions, including mental illness and substance abuse. Prior to the ACA's implementation, Americans with a history of illness or injury were often charged higher health insurance premiums. Anyone with a pre-existing condition, including mental illness, who lacked access to a group plan could be denied coverage in the "individual" marketplace (i.e., purchasing an individual or family health plan directly from an insurer). In 2007, illness and medical bills were associated with 62 percent of all personal bankruptcies in the U.S., and over three-quarters of those medical bankruptcies were to debtors who had private health insurance—but that coverage was limited in ways that exposed them to catastrophic expenses.<sup>28</sup> A fundamental goal of the law is for citizens who contribute a portion of their income to health care to be guaranteed access to quality care, while also being protected from financial ruin or loss of coverage. The law also removes risk avoidance as a tool for profitability within the private insurance market, and requires insurers to instead compete based on benefits value, customer service, and care management.<sup>29</sup>

### *ACA 2014 Private Insurance Market Reforms: Texans with MH/SU Conditions Cannot Be Denied or Charged More for Insurance, Can Get Sliding-Scale Help with Premiums*

Most insured Americans and Texans obtain their health coverage through an employer-based plan. The ACA preserves the dominant role of employer-sponsored insurance (ESI) but makes significant changes to private health insurance markets. A number of reforms are already in

place: review of premium rate hikes, ending pre-existing condition denials and exclusions for children, requiring at least 80 percent of premiums to be spent on health care, shrinking Medicare's "donut hole" drug costs, and allowing children to remain on a family policy up to age 26. But even greater changes to the private market will launch in January 2014, establishing new minimum standards for health coverage and providing new sliding-scale financial assistance to individuals without access to affordable ESI, and tax credits for small employers.<sup>30</sup>

To foster an open, understandable and fairly priced market, the ACA establishes Health Insurance Exchanges in 2014. Exchanges should facilitate insurance purchasing for individuals and small employers by providing a central and transparent place for consumers to choose plans. New market rules will encourage insurers inside the exchange and out to compete on quality and price, by requiring that no one can be denied coverage or charged more based on health history or status (limited age-based rate variations will be allowed).<sup>31</sup> The new model of sliding-scale help and guaranteed coverage will level the playing field for consumers with chronic conditions and low to moderate incomes, who were previously not able to enter the private market. The ACA gives states choices in how to design their exchange, as well as the option not to create an exchange. Texas, so far, has not chosen to implement an exchange<sup>32</sup> and therefore, defaults (along with another 24 states) the responsibility to the federal government to operate a "federally facilitated exchange."<sup>33</sup>

### *ACA's 2014 Essential Health Benefits: Plans Must Cover MH/SU Treatment*

The essential health benefits (EHB) standard in the ACA raises the bar for health plans by requiring many plans to cover MH/SU services, which will improve the opportunity for early intervention and continuous treatment for this vulnerable population. Under the ACA, individual market and small employer plans in 2014 will be required to meet new minimum standards for the benefits they cover. Each plan must include a package of 10 EHBs including mental health and substance abuse services; hospitalization; prescription drugs; rehabilitative and habilitative services; preventive and wellness services and chronic disease management; ambulatory patient services; emergency services; maternity and newborn care; laboratory services; and pediatric services, including oral and vision care. Additionally, the law explicitly outlines that the EHBs must "take into account the needs of diverse segments of the population, including...persons with disabilities."<sup>34</sup>

The Secretary of Health and Human Services (HHS) gave each state the authority to choose an existing insurance plan to act as a specific benchmark for service package (though the benchmark must be augmented if needed to include the ten basic categories). Because Texas did not select a benchmark, it will adopt the default standard, defined by HHS as the small group plan with the largest enrollment in the state. In Texas, the Blue Cross Blue Shield Preferred Provider Organization (PPO) plan is the default EHB benchmark<sup>35</sup> (see Table 2)

Table 2. Proposed Texas Benchmark Plan

PROPOSED TEXAS EHB BENCHMARK PLAN								
Benefit	Covered benefit	Benefit Description	Quantitative Limit on Service	Limit Quantity	Limit Units	Other Limit Units Description	Explanation	Additional limitations or restrictions
Mental/Behavioral Health Outpatient Services	Covered	MH/SU Service	Yes	25	Visits per year			
Mental/Behavioral Health Inpatient Services	Covered	MH/SU Service	Yes	10	Days per year			No
Substance Abuse Disorder Outpatient Services	Covered	MH/SU Service	Yes	3	Other	Series of Treatment per lifetime	Inpatient and Outpatient series of treatment limit combined.	No
Substance Abuse Disorder Inpatient Services	Covered	MH/SU Service	Yes	3	Other	Series of Treatment per lifetime	Inpatient and Outpatient series of treatment limit combined.	No

Source: Centers for Medicare and Medicaid Services; Center for Consumer Information and Insurance Oversight (2012). Proposed Texas EHB Benchmark Plan.

*ACA Extends Parity Laws in 2014:  
MH/SU Benefits Cannot be More Restricted than Medical*

Although the Texas default EHB benchmark plan currently limits the number of MH/SU services, Texas’ 2014 EHB standard will be altered to ensure parity, and in 2014 most health plans will also be subject to the MHPAEA parity standards. The ACA provides a significant victory for individuals with mental health and substance use disorders by extending the provisions of federal parity to:

- Qualified Health Plans (more below);
- Medicaid benchmark and benchmark-equivalent plans (plans meeting the minimum standards for benefits under ACA’s Medicaid expansion to US citizens up to 133 percent of the federal poverty income level); and
- All plans offered through the individual market.<sup>36</sup>

The ACA directs that all exchanges will offer only accredited plans, called Qualified Health Plans (QHP). QHPs must include the EHBs and meet other market-reform guidelines, including adhering to federal parity laws. Individuals and small groups in 2014 will be able to buy plans both inside and outside the exchange, and all coverage sold to individuals and small employers from that point forward must meet the EHB standards, whether inside or outside the exchange. In short, these plans must provide MH/SU benefits equal to medical benefits.<sup>37</sup> Applying any

limits to MH/SU benefits that are more restrictive than for medical benefits will be prohibited, including higher out-of-pocket financial requirements; more limited treatments; preauthorization of services; fail-first policies;<sup>38</sup> utilization reviews; or a narrower application of “medical necessity” definition.

Access to behavioral health services will be further enhanced in 2014 by the interaction of the EHBs and parity requirements with the enhanced coverage of preventive services (including screenings and assessments for depression, alcohol misuse, and drug use) with no out-of-pocket cost to patients that took effect September 2010. Parity requirements and EHB will ensure that when MH/SU needs are detected through screening, treatment will be possible.

New federal guidelines, released November 2012, would eliminate a potential failure to fully extend the federal mental health parity requirements to certain small employer plans. Prior to the ACA, the MHPAEA exempted small employers with 50 or fewer workers from the requirement to provide MH/SU benefits that meet parity. However, the Congressional Research Service (CRS) reports that the ACA created confusion because it did not explicitly repeal the MHPAEA’s small employer exemption from parity, and therefore seemed to continue it. In addition, within the same section of the ACA, the definition of small employer is expanded to firms employing 1 to 100 employees (with the state option to cap at 50 employees in 2014 and 2015), creating concerns that even more employers would be exempt from providing MH/SU benefits.<sup>39</sup> The CRS report also points out that, prior to the November 2012 proposed rules, it was unclear as to whether the small employer exemptions would apply “in the same manner and to the same extent” to the QHPs sold inside or outside of the exchange. At this time, it appears that all non-grandfathered small group plans (i.e., 1-50 or 100 employees) will be subject to parity, since EHBs must meet parity standards, whether sold inside or outside of the exchange. The proposed federal rule will require small group markets to cover MH/SU benefits at parity.<sup>40</sup>

#### *Other ACA Provisions Improve Access to MH/SU Treatment for Privately Insured*

Beyond the EHB and parity provisions reviewed above, other provisions of the ACA are now, or will in 2014 be beneficial for privately insured individuals with MH/SU and/or other chronic conditions. Of particular importance are the following provisions.<sup>41</sup>

- **Prohibits denial of coverage due to preexisting conditions** – this provision became effective in 2010 for all children, and expands to all individual and group plans for adults in 2014.
- **Temporary High-Risk Pool** – In 2010 ACA established new pools in every state where uninsured individuals with pre-existing conditions may be eligible to purchase coverage.<sup>42</sup> The Pre-existing Condition Insurance Plan (PCIP) in Texas is federally administered, and only available to individuals who have been uninsured for at least six months.

- Allows families to **continue dependent coverage** for their young adult children up to age 26 in all individual and group policies. This can be particularly important for young adults because half of the cases of youth with SED begin by age 14 and three-quarters have onset by the age of 24.<sup>43</sup>
- **Prohibits lifetime limits** on the dollar value of coverage. (Effective 2010.)
- **Prohibits insurers rescinding coverage** due to illness. (Effective 2010.)
- **Strengthens the appeals process** for all plans, including the right to appeal decisions made by an insurer to an outside, independent decision-maker.
- **Provides funding for state Consumer Assistance Offices** that help consumers understand their rights and file appeals. Texas established a consumer assistance office in 2010, but it was closed when Texas failed to seek available, ongoing funding in 2012.
- **Requires an easy-to-read summary of benefits** from all health plans for “shoppers” and enrollees and a uniform glossary in several languages. (Effective 2012)
- **Prohibits barriers to access of out-of-network emergency room services** .
- Permits the policyholder and dependents to **choose any available participating primary care providers**, including pediatricians.

## ACA’s Medicaid Expansion and Behavioral Health

A core component to ensure coverage for low-income families under the ACA is to broaden the minimum eligibility requirements for Medicaid, allowing all non-elderly U.S. citizen adults with incomes at or below 133 percent of the federal poverty income line to qualify for the program (children under 19 are already covered in every state).<sup>44</sup> Most of the parents of the 2.5 million children enrolled in Texas Medicaid today are themselves uninsured and ineligible for Medicaid, as are other low-income adults without children at home.

Under the ACA, today’s uninsured would have new options for public and private insurance. The poorest uninsured would have access to Medicaid with national standards for limits on out-of-pocket costs. Persons ineligible for Medicaid and with incomes above the poverty line could apply to the new Health Insurance Exchanges for sliding-scale help with premiums and out-of-pocket costs. The Supreme Court ruled that the expansion of Medicaid was a policy decision to be made by the states. ***A state that does not implement the Medicaid expansion in 2014 will leave the poorest uninsured without any pathway to coverage.***

If on the other hand, the Medicaid option is implemented, these US citizen parents and other equally poor uninsured adults will qualify for Medicaid benefits as set forth by the ACA. This option for the poorest also will have a special impact on uninsured Texans with MH/SU conditions, who are over-represented in the potential ACA Medicaid low-income coverage group because their untreated or under-treated behavioral health conditions are linked to lower employability and lower earning power.

## ACA Medicaid: Mental Health Benefits and Cost Offsets for Texas Cities and Counties

City and county officials, health care providers, economists, and chambers of commerce have noted the very large potential economic and social benefits to Texas communities if Texas accepts the federal option. ***City and county governments could reduce local-dollar spending on the E.R. and jail costs associated with untreated and under-treated behavioral health conditions if Medicaid coverage were extended and substantial numbers of Texas adults gained ongoing coordinated care for their MH/SU needs.***

The state's funding obligation for these adults' health care under Medicaid would be zero from 2014-2016, 5 percent-7 percent from 2017-2019, and 10 percent thereafter, the fiscal benefit to the state economy and to local communities is immense. The Texas HHSC has projected that:

- In 2014-2015, state administrative costs to cover the US citizen adults to 133 percent of poverty would be about \$310 million, drawing over \$8 billion in federal match.
- Over a decade, \$9 billion in Texas funds would draw \$79 billion in federal match.

These projections demonstrate the magnitude of the potential economic benefit of Medicaid expansion in Texas to the state and local government's budgets, while ensuring that millions of individuals with mental health and substance abuse disorders have health care coverage.

Other noteworthy potential benefits for Texans with MH/SU conditions, local governments, and their communities are:

- **Foster Care:** Starting in 2014, the ACA requires Medicaid coverage (with full EPSDT<sup>45</sup> benefits) for children up to age 26 who were in foster care when they turned 18. This will provide a stronger continuum of care for these youth and young adults, who have much higher than average behavioral health needs.
- **Family Therapy:** A large share of parents of children in families where Child Protective Services interventions have occurred would gain Medicaid coverage and be able to access the ongoing therapies they need to break family cycles of abuse or neglect. Today, local governments are limited to small and inadequate "pots" of funding to provide parents with services; if Texas expands Medicaid, many more families will be served effectively and counties will see savings on both the direct services and from reduced recidivism.
- **Jail cost offsets:** If Texas expands Medicaid, most inpatient hospital stays by inmates could be billed to Medicaid. This would reduce local jail costs, and allow limited local resources to be redirected to improving continuity of MH/SU care for inmates with behavioral health conditions.

## What Medicaid MH/SU Benefits Would Look Like if Texas Expands Medicaid

States that expand Medicaid coverage for their poor US citizen adults will not be required to provide the traditional Medicaid benefit package, but can instead model benefits for the new group after one of three private insurance products, or a fourth, “Secretary-approved benchmark” under federal law. In addition, states are allowed to choose different benchmarks for the private coverage EHBs and the Medicaid EHBs. Importantly, just as with private insurance described above, the Medicaid benchmarks chosen are also subject to the EHB and MHPAEA parity standards, and must be amended and supplemented accordingly.

Federal Medicaid guidance (November 2012) indicates that the process of amending Medicaid benchmarks to meet the EHB and parity requirements will roughly parallel the steps used for the private market EHBs. The guidance also notes that:

- A special Medicaid definition of “habilitative services” required in the EHBs will be published;
- States accepting the Medicaid expansion may be allowed to have more than one benchmark plan to define EHBs for different segments of the Medicaid population, “appropriate to meet the needs of targeted populations,” which would allow for targeted benefits designed to meet the needs of enrollees with MH/SU diagnoses; and
- Existing federal Medicaid law will still require all benchmark plans in Medicaid to cover comprehensive pediatric services consistent with EPSDT.

As mentioned earlier, because Medicaid serves Texans with the most serious and persistent mental disorders (typically qualified for SSI disability benefits), it includes some services not usually found in private health plans, such as case management and rehabilitative services. However, states are only required to provide Medicaid benefits on a similar scope of services as the private insurance benefits for the ACA’s adult Medicaid expansion population.<sup>46</sup> Even with the full implementation of the federal parity law, the expansion group may not automatically gain access to some of these benefits because there are not equivalent general medical services to these MH/SU support services.<sup>47</sup> It will be up to Texas to craft a benefit package that is appropriate for the needs of mental health consumers under an ACA Medicaid expansion.

**Increased Substance Abuse Treatment Access.** The expansion of Medicaid to the nonelderly adult population will also greatly increase access to medically necessary treatment for low-income adults with substance abuse disorders. Under the current Texas Medicaid program, adults only receive substance abuse services if they first qualify for Medicaid due to other qualifying criteria such as major disability (including serious mental illness) or pregnancy. Typically, a substance abuse disorder alone will not qualify as the primary basis for a disability determination that would qualify an adult for SSI (low-income-based disability benefits) and therefore, Medicaid. Under the Medicaid expansion, any US citizen adult under 133 percent of poverty would be able to access substance abuse treatment services.<sup>48</sup>

## Other ACA Provisions will Enhance Medicaid MH/SU Services

Other provisions of the ACA allow several options for states to increase community living opportunities for the elderly and individuals with disabilities who are Medicaid recipients by providing an increase in the federal Medicaid match rate to help states increase community-based services and supports. At this time, Texas Medicaid officials intend to participate in two options that will benefit individuals with mental illness and substance abuse disorders.

First, Texas is one of eight states with an approved application to participate in the **Balancing Incentive Payments (BIP) program**. BIP provides a significant financial incentive to promote access to community-based long-term services and supports, earning qualifying states a 2 to 5 percent increase in their federal match for Medicaid Home- and Community-Based Services (HCBS) costs from October 2011 through September 2015. The BIP provisions of ACA require states to structurally transform their long-term care system to be more efficient by creating a person-centered assessment and care plan as well as improving quality measurement and oversight.<sup>49</sup> States must institute these changes:

- **“No Wrong Door”/Single Entry Point system** – enables consumers to access eligibility determinations and services through a single entry point;
- **Conflict-free Case Management** – States will establish conflict of interest standards to assure that entities that will develop individual service plans and conduct case management will be independent of the entities that provide direct services; and
- **Standardized Assessment Instrument** – must be used statewide to determine eligibility for all long-term services and to direct consumers to appropriate services.

The BIP program enables Texas to strengthen the long-term services and supports system by enhancing community-based services as well as access to these services to help people remain in their homes and communities. The enhanced Medicaid funding will also provide the opportunity to establish regional Crisis Intervention Teams, which will deter admissions into institutions for people with intellectual disability and co-occurring mental illness (dual-diagnosis).<sup>50</sup>

The second ACA opportunity is the **1915 (i) State Plan Amendment**, which allows states to create a new statewide Medicaid eligibility category to offer long-term supports and services before individuals need institutional care, and without a capped waiver. Specifically, the Act permits states to target services such as case management, rehabilitative services, and day treatment based on the needs of specific populations (e.g., mental health and substance abuse). States using the option cannot limit the number of eligible participants, in contrast to the long wait lists that Texas community care waivers have today. ACA allows states the option to increase financial eligibility criteria to incomes up to three times the Supplemental Security Income Federal benefit rate ( $\$710 \times 3 = \$2,130$  in 2013); this is the same upper income limit

used today in Texas Medicaid for eligibility for long-term services and supports under waivers, in institutional settings, and in the Community Attendant Program.<sup>51</sup>

DSHS has proposed to launch a new program under this new flexibility, focused primarily on promoting supported housing and comprehensive support services for adult Texans after extended stays in State Hospitals, with a smaller allotment for supportive housing for persons in substance abuse recovery. The agency has requested more than \$7.9 million General Revenue as part of Exceptional Item #8 of the 2014-2105 budget request to provide the state Medicaid match that will draw another \$12.7 million in federal funds.<sup>52</sup> The agency projects that the 1915(i) state plan initiative, along with the other projects in the Exceptional Item, will bring a potential net “return on investment” to Texas of more than \$23.2 million (we will clarify GR or all funds, net or gross, and best numbers).<sup>53</sup>

A third Medicaid MH demonstration project option established by the ACA is currently not in development in Texas. The **Medicaid Emergency Psychiatric Demonstration option** is an effort to test whether Medicaid programs can support higher quality care at lower costs. Current federal law prohibits federal Medicaid payments for inpatient services at institutions (e.g., hospitals, nursing facilities, classified in Medicaid regulations as Institutions for Mental Disorders or IMDs) that primarily provide treatment services for individuals with mental illness who are ages 21-64 years old. This policy effectively prevents Medicaid coverage for long-term psychiatric hospitalizations of adults. This exclusion also too often results in delayed acute psychiatric treatment, as Medicaid patients needing inpatient care can only access that care through general hospital emergency departments where they often must wait for a limited number of beds. The demonstration project option allows states to test allowing private freestanding psychiatric hospitals to receive reimbursements for acute psychiatric needs provided to adult Medicaid enrollees. In 2011, Centers for Medicare and Medicaid Services announced the project in which eleven states were permitted to participate beginning July 2012. CMS will provide up to \$75 million in federal Medicaid matching funds to these states over three years.<sup>54</sup> CMS is required to submit a report to Congress at the end of 2013 that independently analyzes the effectiveness and cost efficiency of the demonstration project. At that point, Congress will determine whether to expand the Medicaid reimbursement model nationally.<sup>55</sup> With the expanded coverage of adults available under the ACA in 2014, a major change in how Medicaid delivers inpatient psychiatric care would be very important to state mental health systems.

## RECAP: Key Observations on the ACA and Access to MH/SU Care in Texas

The ACA, public mental health and substance abuse systems policies, and Medicaid policy are all complex. Below, we identify key findings from this review of their intersection, as well as several major unanswered MH/SU policy issues that are important to watch in the months and years ahead.

- The combined effect of ACA's standards for Essential Health Benefits and the extension of MH/SU parity to most private and public insurance plans in 2014 should significantly increase access to adequate treatment of these conditions for all insured persons.
- However, in Texas a significant share of insurance coverage gains under ACA will only be achieved if state officials accept the expansion of adult Medicaid coverage, which is projected to cover at least 1.1 million additional uninsured low-income adults.
- If ACA's MH/SU standards are fully implemented—including Medicaid expansion to cover the poorest uninsured adults—Texans at all incomes will have better access to ongoing primary and preventive care, and those with MH/SU treatment needs will be able to get early, affordable, and ongoing care. As a result, local and state governments can expect both reduced demand for ER-based care and potential reductions in incarcerations of adults with MH/SU conditions.
- Other major ACA-related gains in MH/SU care access include special Medicaid coverage for former foster care youth up to age 26; access of most family members in protective service interventions to services; the elimination of lifetime benefit caps; and in 2014 the elimination of denial of coverage or higher pricing of coverage due to a history of MH/SU diagnosis or treatment.
- Texas is now testing some new ACA Medicaid policies that may further improve access to MH/SU care for current Medicaid enrollees, and other options being tested across the country may be available to Texas in the future.

## Issues to Watch: MH/SU and the ACA

### Questions Re: MH/SU Parity and Essential Health Benefits

- As noted, final federal MH/SU parity rules related to the MHPAEA are expected within months of this report, and it is not known to what extent they might alter the current rules.
- Important decisions remain to be made about how to define true parity between MH/SU services and other physical medical care, as the kinds of services in use are often not comparable across the sectors.
- In addition, it remains to be seen what the spectrum of covered MH/SU services will include for adults under the ACA Medicaid expansion. Clearly, benchmark Medicaid benefits that are subject to parity and the EHB standard will be more robust than today's typical employer plan. However, it is not yet known whether they will include or even improve on the types of intensive MH services provided to today's Medicaid MH consumers.

## Incarcerated Persons with MH/SU Conditions

If Texas expands Medicaid, ongoing access to care could reduce incarceration rates of Texans with mental illness, and jails would also be able to shift some hospital costs to Medicaid. To maximize ongoing access to care and potential resulting savings, both state and county criminal justice systems should build or improve on systems to keep incarcerated persons connected to public or private coverage to the greatest degree allowed under the law.

- One bill under current consideration (HB 37 Menendez, 83<sup>rd</sup> Legislature) would “suspend” rather than terminate Medicaid eligibility for incarcerated Texans, to allow a more rapid re-start of benefits and ongoing therapy upon release.
- The National Association of Counties also recommends that counties begin coordinating activities to enroll and retain health coverage for residents operated by their health and human services divisions, with the jail systems. Because under the ACA, private insurance coverage under the health insurance exchanges in 2014 stays in effect until conviction for a crime, county costs of care for persons incarcerated pending disposition of charges could be reduced, making it more affordable to provide robust ongoing MH care to jail residents.<sup>56</sup>

## Integration of MH/SU and other Medical Care

The ACA encourages greater integration of behavioral health services into medical homes and systems of care, and various models of integration have shown success in improved care and outcomes and reduced costs for more than a decade. In Texas, Regional Healthcare Partnerships (RHPs) under the Medicaid 1115 “Transformation” waiver have undertaken a wide range of activities under the broad heading of behavioral-physical health integration. Still missing, however, is an inventory and comparison of all Texas projects that are identified as integrating MH/SU care, and there is no recognized common definition or minimum standard for integration of care. Advocates and providers have identified addressing this gap in analysis as a priority.

## Mental Health Provider Workforce

With baby boomers needing more care and the legislature cutting medical education, Texas faces a shortage of health care providers. Expanding Medicaid would help address the workforce shortage. With less uncompensated care, Texas would be a more attractive place to practice medicine, and Texas would have more resources to train and pay providers. Additionally, the ACA did create the Mental and Behavioral Health Education and Training Grants Program, which seeks to boost the number of social workers and psychologists who work with Americans in rural areas, military personnel, veterans, and their families, but the total funding awarded is modest compared to the need, and the Texas Legislature cut or eliminated most health professional training programs in 2011. Limited coverage of behavioral health

services coupled with low reimbursement rates to providers still pose significant barriers to building an adequate behavioral health workforce.

For more information about mental health and substance abuse policy issues in Texas:

- [Texas Department of State Health Services – Mental Health and Substance Abuse services](#)
  - [Comprehensive Analysis of Public Behavioral Health System - Rider 71 \(81st session\)](#)
- [Hogg Foundation for Mental Health](#)
  - [A Guide to Understanding Mental Health Systems and Services in Texas](#)
- [Texas Association of Substance Abuse Programs](#)

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- <sup>47</sup> Garfield, R., Lave, J., Donohue, J. (2010). Health Reform and the Scope of Benefits for Mental Health and Substance Use Disorders. *Psychiatric Services*.
- <sup>48</sup> Buck., J. (2011). The Looming Expansion And Transformation Of Public Substance Abuse Treatment Under The Affordable Care Act. *Health Affairs*, 30, no.8 (2011):1402-1410. doi: 10.1377/hlthaff.2011.0480
- <sup>49</sup> Centers for Medicare and Medicaid Services. (2012). State Medicaid Director letter: State Balancing Incentive Payment Program. [downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/11-010.pdf](http://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/11-010.pdf)
- <sup>50</sup> Texas Department of Aging and Disability Services. (2012). Balancing Incentive Program Application. Retrieved from: [www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Support/Balancing/Downloads/Texas-Application.pdf](http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Support/Balancing/Downloads/Texas-Application.pdf)
- <sup>51</sup> U.S. Social Security Administration. (2012). Fact Sheet: 2013 Social Security Changes. [www.ssa.gov/pressoffice/factsheets/colafacts2013.htm](http://www.ssa.gov/pressoffice/factsheets/colafacts2013.htm)
- <sup>52</sup> Originally numbered Exceptional Item 7, this item was re-numbered Exceptional Item 8 in the State Health Services presentation to the Texas Senate Finance Committee, January 30, 2013.
- <sup>53</sup> Texas Dept. of State Health Services. (September 12, 2012). Draft of DSHS Exceptional Item #8; Texas Department of State Health Services. (January 30, 2013). Presentation to the Senate Finance Committee. [www.dshs.state.tx.us/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=8589974508](http://www.dshs.state.tx.us/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=8589974508) .
- <sup>54</sup> Centers for Medicare and Medicaid Services. (2012). Fact Sheet: Medicaid Emergency Psychiatric Demonstration. [www.cms.gov/apps/media/press/factsheet.asp?Counter=4301&intNumPerPage=10&checkDate=&checkKey=&srchType=1&numDays=3500&srchOpt=0&srchData=&keywordType=All&chkNewsType=6&intPage=&showAll=&pYear=&year=&desc=&cboOrder=date](http://www.cms.gov/apps/media/press/factsheet.asp?Counter=4301&intNumPerPage=10&checkDate=&checkKey=&srchType=1&numDays=3500&srchOpt=0&srchData=&keywordType=All&chkNewsType=6&intPage=&showAll=&pYear=&year=&desc=&cboOrder=date)
- <sup>55</sup> Centers for Medicare and Medicaid Services. (2011). Medicaid Emergency Psychiatric Demonstration: Demonstration Design and Solicitation. [http://innovation.cms.gov/Files/x/MedicaidEmerPsy\\_solicitation.pdf](http://innovation.cms.gov/Files/x/MedicaidEmerPsy_solicitation.pdf)
- <sup>56</sup> National Association of Counties, *County Jails and the Affordable Care Act: Enrolling Eligible Individuals in Health Coverage*; [www.naco.org/programs/csd/Documents/Health%20Reform%20Implementation/County-Jails-HealthCare\\_WebVersion.pdf](http://www.naco.org/programs/csd/Documents/Health%20Reform%20Implementation/County-Jails-HealthCare_WebVersion.pdf) ; March 2012.