

MEMORANDUM

TO: Regional Steering Committee on Homelessness and Housing

FROM: HomeBase

RE: Health Care Reform and Homelessness: The Patient Protection and Affordable Care Act and the Mental Health Parity and Addiction Equity Act

DATE: July 23, 2010

INTRODUCTION

2010 is a watershed year for health care reform. On March 23, 2010, President Obama signed the Patient Protection and Affordable Care Act (“PPACA”), a comprehensive federal health care reform law that will take effect over the next four years. In addition, the Mental Health Parity and Addiction Equity Act (“MHPAEA”), which requires group health plans and group health insurers to treat mental health and substance use disorder benefits equally to medical and surgical benefits, went into effect for plan years beginning October 3, 2009 or thereafter, and the interim final rule released by the Departments of Treasury, Labor and Health and Human Services (“HHS”), became effective for all plan years beginning on or after July 1, 2010.

The PPACA and MHPAEA have important implications for people experiencing homelessness, especially for those with mental health/substance abuse/co-occurring disorders. This memorandum provides an overview of the primary components of the PPACA and MHPAEA and highlights the provisions relevant to clients and homeless service providers.

OVERVIEW OF THE PPACA

The PPACA contains three key reforms: consumer protection provisions, measures to control health care costs, and an expansion of health insurance coverage. Among the consumer protection provisions are: no pre-existing conditions denials, yearly caps on out of pocket expenses, no cost-sharing for preventative care, no annual or lifetime limits on the dollar value of health benefits, and no rescissions for the seriously ill. A few key examples of cost-containing measures include abolishing underwriting—thereby forcing insurers to compete based on cost and quality rather than risk selection—shifting from a fee-per-service to pay-by-performance model, and investing in prevention, bulk purchasing, and information technology.

Of primary importance to people who are homeless or at risk of becoming homeless, however, are: (1) the expansion of health insurance coverage; (2) increased spending for community health clinics; and (3) efforts to integrate primary and behavioral health care.

A. *Expansion of Health Insurance Coverage*

The PPACA aims to provide wider health insurance coverage through three mechanisms: (1) employer-based coverage; (2) the health insurance exchange, an attempt to give uninsured individuals the support and protections which would allow them to purchase insurance on the market; and (3) Medicaid coverage. It is estimated that, with implementation of all three mechanisms, about 96% of Californians will be insured by 2014.

1. Employer-Based Coverage

For employer-based coverage, the PPACA distinguishes between large employers (over 50 FTE) and smaller ones. Small employers are largely exempt from the new regulations, but are instead incentivized to provide insurance to their employees through tax credits of up to 35% of premiums. Large employers, on the other hand, are required to “cover or pay”—i.e., provide coverage for their full-time (working an average of 30 hours per week or more), non-seasonal workers (working at least 120 days per year), or pay a flat amount for each uncovered full-time, non-seasonal employee and each employee who is forced to pay more than 9.5% of his or her taxable income on premiums. Another notable provision for employers is that imposing waiting periods of more than 90 days on their employees before providing coverage is now banned.

2. Health Insurance Exchange

For uninsured households making over 133% but under 400% of the federal poverty level, the PPACA provides a progressive, refundable tax credit to be used for insurance premiums on health insurance exchanges, market-based mechanisms that allow the exchanges to negotiate group rates for participating individuals and families. In addition, the PPACA provides additional protections for all independent purchasers of health insurance, whether on the health insurance exchange or not. These include: no pre-existing condition denials; a limit on age-based premium differentials of 3:1 (i.e., an older person’s premiums cannot be more than 3 times those of a younger person); a ceiling on out-of-pocket costs (\$5,950 for individuals), and a ban on lifetime or annual coverage limits.

3. Medicaid

The single largest insurance coverage provision in the PPACA, however, is the expansion of Medicaid coverage. It is estimated that over 2 million Californians will become eligible when these provisions go into effect in 2014. In short, the PPACA reduces the eligibility criteria for Medicaid to just income and immigration status. Anyone under age 65 who makes less than 133% of the federal poverty level (just under \$15,000 for individuals and under \$25,000 for a family of 3 in 2009) and is either a U.S. citizen or a legal immigrant who has been in the country for more than five years will be Medicaid-eligible.

When this provision goes into effect in 2014, the federal government will cover 100% of the health care costs of the newly eligible Medicaid recipients. That percentage will gradually decrease to 90% in 2020 and thereafter. The PPACA also allows for states to phase in early enrollments for people who will become newly eligible in 2014; the details of how California will implement this early expansion component is currently being discussed in the California legislature.

For states with perpetual budget crises like California, the PPACA's maintenance of effort provision—which prohibits states from reducing Medicaid or Children's Health Insurance Program ("CHIP") eligibility, increasing premiums or enrollment fees, or otherwise restrict enrollment, and penalizes violators by withdrawing all federal matching funding for the entire Medicaid program until the violations are corrected—protects the newly insured from the vagaries of state politics.

While the Medicaid provisions will not go into effect until 2014, certain provisions of the PPACA are already in place, including: a prohibition on pre-existing condition denials for children, the prohibition on rescissions, the ability of parents to include children of up to 26 years of age under dependent coverage, and registration of up to 30,000 slots for California's high-risk pool, a high-risk insurance pool that offers subsidized premiums to people with pre-existing conditions and who have been uninsured for at least six months.

B. Community Health Center Funding

Another PPACA provision that has already gone into effect is the Community Health Center Fund, which provides \$11 billion in additional funding for the Community Health Center ("CHC") program and the construction and renovation of community health centers over the next five years. California is expected to receive approximately \$250 million from the Health Center Fund per year.

New Community Health Center Fund appropriations become available on October 1, 2010. Specifically, the Fund appropriates \$9.5 billion for CHC program activities, including operating investments, and \$1.5 billion for the construction and renovation of CHCs, with the goal of doubling the number of people served by community health clinics nationwide by 2016.

The PPACA also authorized two additional sources of potential funding for community health centers: the Prevention and Public Health Fund and an additional \$34 billion for Section 330 grants for FY 2010-2015.

The Prevention and Public Health Fund appropriates \$15 billion over the next ten years to support prevention and public health. While intended primarily for preventive health, on June 16, HHS announced the allocation of the first \$250 million from the Fund for primary care workforce development, and it appears that HHS may continue to draw from this Fund to address the projected shortages of trained health care workers.

Public Health Service Act Section 330 grants provide funding to federally-qualified health centers (FQHCs), including community health centers, migrant health centers, health care for the homeless programs, and public housing primary care programs, to provide care to underserved populations. Recipients, however, must otherwise qualify as a FQHC, the requirements of which are numerous, including: serving an underserved area or population, charging for services on a sliding fee scale, providing comprehensive services, and having in place a user-majority board of directors.

Drawing from the Community Health Center Fund, the Prevention and Public Health Fund, and Section 330 grant funding, community health clinics should be able to expand capacity dramatically over the next five years.

C. Efforts to Integrate Primary and Behavioral Health Care

The PPACA also contains several provisions that are aimed at integrating primary and behavioral health care. For instance, the PPACA defines “essential health benefits” to include mental health and substance abuse disorder services—i.e., behavioral health services are included among a limited number of benefit categories that cannot be limited by insurance plans under any circumstance.¹ Additionally, the PPACA has introduced a series of programs and demonstrations implementing integrated care, including the Medicaid State Plan Amendment for Health Homes, the Emergency Psychiatric Demonstration, and the provision authorizing co-locating services in community-based mental health settings

Under the Medicaid State Plan Amendment for Health Homes, set to begin January 1, 2011, states may utilize a state plan amendment to provide health home services for eligible individuals with chronic conditions. Eligible individuals must have two chronic conditions (mental health condition, substance use disorder, asthma, diabetes, heart disease, or obesity), one chronic condition and risk of another, or a serious and persistent mental health condition. Home health providers may be, among others, a rural clinic, a community health center, a community mental health service, or a home health agency, and eligible services include comprehensive care management, care coordination and health promotion, comprehensive transitional care, patient and family support, referral to community services, and use of health information technology to link services. Twenty-five million dollars have been set aside for the program at the regular Federal Medical Assistance Percentages (“FMAP”).

Under the Emergency Psychiatric Demonstration Project, a state may make payments to a non-publicly owned institution for mental diseases for medical assistance to individuals between 21 and 65 years old who require medical assistance to stabilize an emergency medical condition. Seventy-five million dollars have been appropriated for this project. Additionally, the PPACA authorized appropriations of \$50 million for grants to community

¹ While the PPACA generally prohibits annual and lifetime caps on health benefits, it does allow dollar value limits on specific covered benefits that are not “essential health benefits,” to the extent that those limits are not otherwise prohibited under applicable federal or state law.

mental health programs to establish demonstration projects for co-locating primary and specialty care in community-based mental and behavioral health settings.

Other integrated care programs include an unfunded program to provide grants for demonstration projects for up to ten state-based nonprofit public-private partnerships to provide access to comprehensive health care services to the uninsured at reduced fees, and a requirement that HHS award competitive grants to establish national Centers of Excellence for Depression, which will collaborate to better coordinate and improve access to mental health care.

D. Implications for Clients and Homeless Service Providers

While the expansion of Medicaid coverage means that by 2014 almost all homeless individuals and families will have health care coverage, there are a few downsides. First, the exclusion of undocumented immigrants from coverage means that health care services for that portion of the homeless population will continue to be neglected. Second, the PPACA's exclusion of newly arrived immigrants from Medicaid coverage has prompted Medi-Cal, which currently covers all eligible legal immigrants regardless of their arrival date, to exclude this group as well in order to align California practice with federal law. Finally, the PPACA doesn't address the issue of barriers to access—while more people experiencing homelessness will be covered by Medicaid, homeless individuals and families will still have difficulty registering for Medicaid due to, among other factors, the complicated application process and identification requirements (which are intended to screen out undocumented immigrants but will also exclude many people experiencing homelessness).

Similarly, while the new funding streams for community health clinics will increase clinics' capacity to treat low-income patients, including people experiencing homelessness, the increase in funding (e.g., \$250 million per year from the Community Health Center Fund for California) may not keep pace with the anticipated increase in demand for primary care, as millions of Californians become newly insured.

Lastly, the success of health care reform in California will largely depend on how it is implemented by the state legislature and on regulations set by the California Medicaid director. While the implementation details in California have not been finalized, Appendix A outlines the different bills currently in the California State Legislature pertaining to health care reform.

DISCUSSION QUESTIONS

What does health reform mean to your programs and your agencies?

What does Medicaid coverage mean for your clients?

Are you affiliated with a clinic that has a track record getting homeless patients onto Medicaid and becoming their primary care home?

What is your role in connecting people experiencing homelessness to health care? How will the PPACA affect this role?

What implementation details are most important to you? What would you like to see the California State Legislature change or improve?

OVERVIEW OF THE MHPAEA

The Mental Health Parity and Addiction Equity Act of 2008 requires group health plans and health insurance issuers to ensure that financial requirements and treatment limitations applicable to mental health or substance use disorder benefits are no more restrictive than the predominant requirements or limitations applied to substantially all medical/surgical benefits. The MHPAEA supplements prior provisions under the Mental Health Parity Act of 1996, which required parity with respect to aggregate lifetime and annual dollar limits for mental health benefits.

A. The Nuts and Bolts of the MHPAEA

The MHPAEA applies to plans sponsored by private and public sector employers with more than 50 employees, including self-insured as well as fully insured arrangements. The MHPAEA also applies to health insurance issuers who sell coverage to employers with more than 50 employees. The MHPAEA does not mandate that a plan provide mental health (“MH”)/substance use disorder (“SUD”) benefits. Rather, if a plan provides medical/surgical and MH/SUD benefits, it must comply with the MHPAEA’s parity provisions.

Under the MHPAEA, if a plan or issuer that offers medical/surgical and MH/SUD benefits imposes “financial requirements” (such as deductibles, copayments, coinsurance and out of pocket limitations), the financial requirements applicable to MH/SUD benefits can be no more restrictive than the “predominant” financial requirements applied to “substantially all” medical/surgical benefits. The MHPAEA regulations provide that the “predominant/substantially all” test applies to six classifications of benefits on a classification-by-classification basis:

- * Inpatient, in-network
- * Inpatient, out-of-network
- * Outpatient, in-network
- * Outpatient, out-of-network
- * Emergency care
- * Prescription drugs

Similar parity requirements apply to treatment limitations. “Treatment limitations” mean limits on the frequency of treatment, number of visits, days of coverage, or other similar limits on the scope or duration of treatment.

The MHPAEA regulations clarify that treatment limitations may be quantitative or non-quantitative. Quantitative treatment limitations are subject to the same general test as the financial requirements. Thus, if a quantitative treatment limitation (such as a limit on the number of visits) applies to MH/SUD benefits, the limitation can be no more restrictive than the predominant treatment limitations that apply to substantially all medical/surgical benefits. As in the case of the parity rules with respect to financial requirements, the parity rules for quantitative treatment limitations are applied on a classification-by-classification basis.

The regulations include a separate parity requirement for non-quantitative treatment limitations (such as medical management standards, methods for determining usual, customary and reasonable charges, formulary design for prescription drugs, and exclusions based on failure to complete a course of treatment). A non-quantitative treatment limitation may not be imposed with respect to MH/SUD benefits in a classification unless the factors used in applying the limitation are comparable to, and applied no more stringently than, the factors used in applying the limitation to medical/surgical benefits in the classification.

B. Implications for the Homeless and Homeless Service Providers

For providers whose services include MH/SUD services, the MHPAEA could have wide-reaching implications. Once the PPACA’s insurance coverage provisions become effective in 2014, millions of people experiencing homelessness or those at risk of becoming homeless will become eligible for Medicaid. While Medicaid is not an issuer of health insurance, Medicaid Managed Care plans are subject to the MHPAEA. To the extent that such plans provide both medical/surgical and MH/SUD benefits, the MHPAEA would require the plans to treat the two equally.

FUNDING THE TREATMENT OF CO-OCCURRING DISORDERS

The expansion of Medicaid coverage will not be effective until 2014, and even with Medicaid, communities will need to locate additional sources of funding for the treatment of SM/HUD and COD. This section provides an overview of two such sources: the Community Mental Health Services Block Grant and the Substance Abuse Prevention and

Treatment Block Grant (“SAPTBG”).

The Mental Health Services Block Grant, administered by the Center for Mental Health Services (“CMHS”) of the Substance Abuse and Mental Health Services Administration (“SAMHSA”), provides funding and technical assistance to State Mental Health Authorities for a variety of purposes: to finance mental health services, to organize mental health planning councils, and to develop and implement plans for community-based mental health service systems. In particular, CMHS requires that states develop a comprehensive public mental health system that has as one of its goals to move care for adults with severe mental illness and children with severe emotional disturbances from costly and restrictive inpatient hospital care to the community.

In FY 2009-2010, California received just under \$54 million in block grant funding. The State Department of Mental Health administers the block grant and allocates the funds to 58 local county mental health agencies, largely based on the Cigarette and Tobacco Products Surtax fund formula. The reporting requirements imposed upon each county mental health agency include: an annual application or expenditure plan; an annual cost report; quarterly financial reports; and a Federal Grant Detailed Provider Budget and one-page data sheet for each program.

The Substance Abuse Prevention and Treatment Block Grant Program, or SAPTBG Program, is a federal formula grant awarded by SAMHSA’s Center for Substance Abuse Treatment (“CSAT”) to a single agency in each state to support and develop projects aimed at preventing substance abuse or to facilitate the rehabilitation and treatment of substance abusers. The grants are distributed through a statutory formula, based upon specified economic and demographic factors.

States must set aside at least 20% of SAPTBG funds for programs for individuals who do not require treatment for substance abuse, 5% for HIV early intervention services, and at least \$15.5 million for treatment services for pregnant women and mothers with dependant children. Other requirements include services for HIV and tuberculosis for persons already receiving treatment for alcohol and drug abuse, and the development of a capacity management and waiting list system for intravenous drug users and pregnant women.

In California, the Department of Alcohol and Drug Programs (“ADP”) is the state agency designated to receive SAPTBG funds. The ADP distributes the funds through agreements with each county. If a county fails to expend its allocated amount from each SAPTBG award set-aside, the unexpended funds must be returned to the state, which then returns the funds to CSAT. Counties are also prohibited from using SAPTBG funds for certain programs, including most inpatient hospital substance abuse programs, cash payments to intended service recipients, most capital projects, major medical equipment purchases, financial assistance to any entity other than a public or non-profit private entity, or needle/syringe exchanges.

DISCUSSION QUESTIONS

Which of your programs and agencies are affected by the MHPAEA?

For those programs and agencies, what are some of the concerns about the MHPAEA, especially in conjunction with the expansion of Medicaid coverage?

Among your programs and agencies providing behavioral health services, which are accessing Community Mental Health Services Block Grants and SAPTBG funding?

What are the barriers to accessing such funding sources?

What are additional funding sources for providers of behavioral health services?

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