The Affordable Care Act and Behavioral Health Care:

Ethical Questions & Opportunities

Dominic Sisti, PhD

Assistant Professor
Department of Medical Ethics & Health Policy
University of Pennsylvania

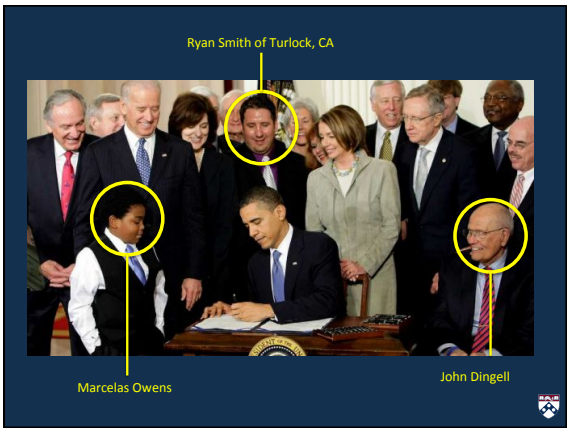
www.scattergoodethics.org

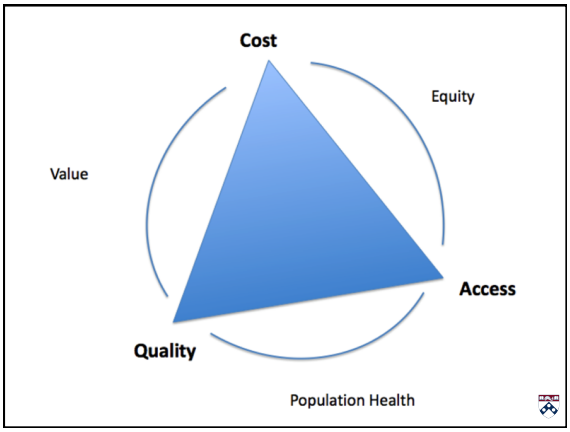
Overview

A. Context: The ACA and Behavioral Healthcare
   1. Policy Landscape
   2. Insurance reform
   3. Payment reform

B. Philosophical & Ethical Challenges
   1. What is a 'mental disorder'?
   2. Behavioral healthcare as an "essential" benefit – what are the limits?

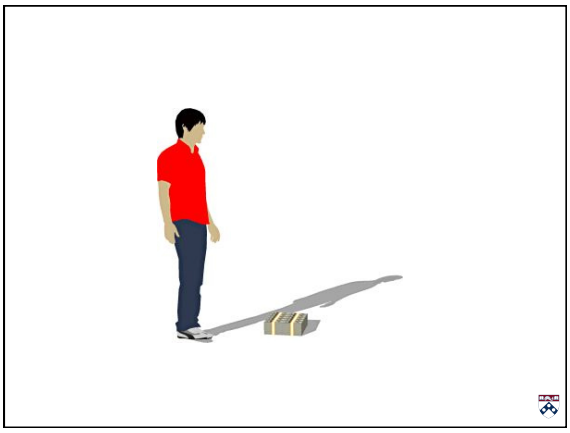
C. Clinical & Ethical Opportunities
   1. Broadening coverage
   2. Integrative care, ACO's & medical homes
   3. Alignment with Recovery-oriented service
   4. New research & training

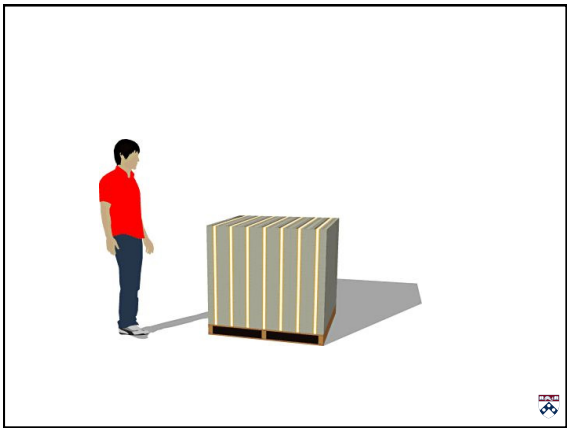


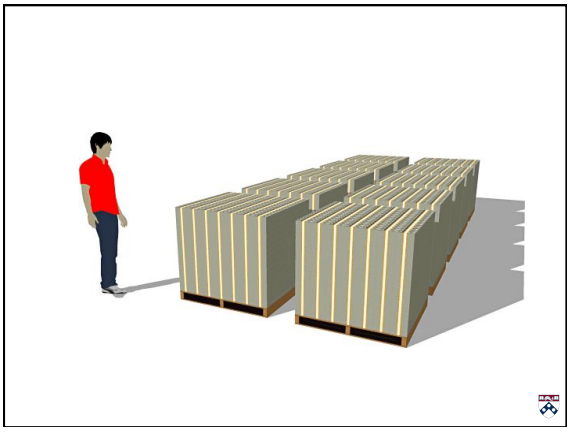


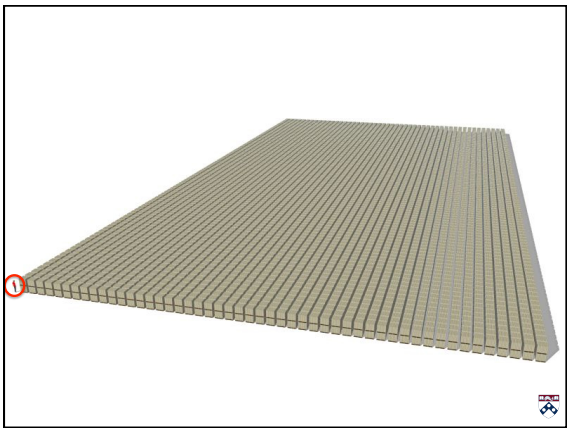
$2.6 Trillion

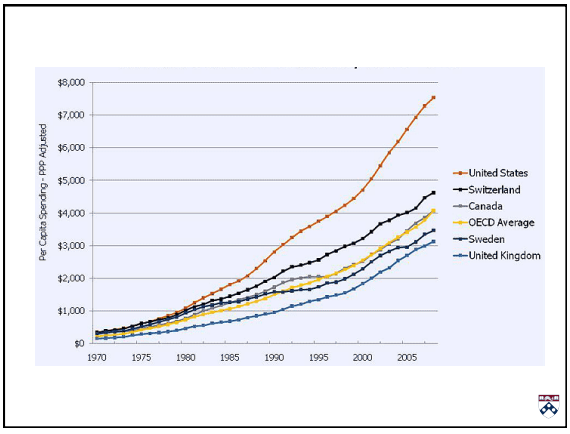
(2010)

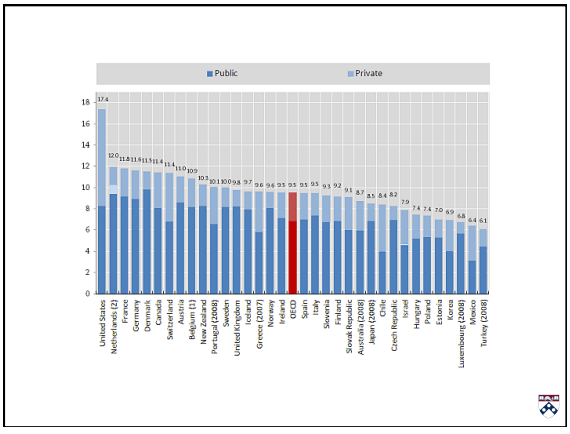


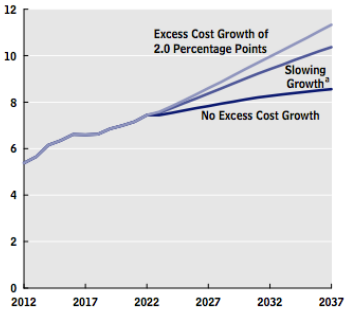







Per Capita Spending - PPP Adjusted
$8,000
$7,000
$6,000
$5,000
$4,000
$3,000
$2,000
$1,000
$0
1970
1975
1980
1985
1990
1995
2000
2005
United States
Switzerland
Canada
OECD Average
Sweden
United Kingdom

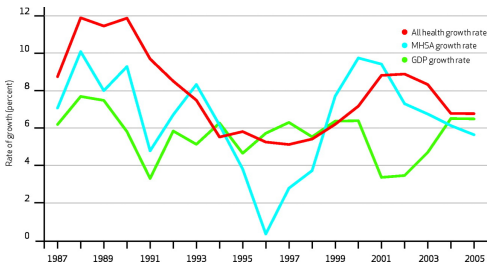

Public
Private
18
16
14
12
10
8
6
4
2
0
17.4
12.0
11.8
11.6
11.5
11.4
11.4
11.0
10.3
10.3
10.0
9.8
9.7
9.6
9.6
9.5
9.5
9.5
9.5
9.3
9.2
9.1
8.7
8.5
8.4
8.2
7.9
7.4
7.4
7.0
6.9
6.8
6.4
6.1
United States
Netherlands (1)
France
Germany
Denmark
Canada
Switzerland
Austria
Belgium (1)
New Zealand
Portugal (2008)
Sweden
United Kingdom
Iceland
Greece (2007)
Norway
Ireland
OECD
Spain
Italy
Slovenia
Finland
Slovak Republic
Australia (2008)
Japan (2008)
Chile
Czech Republic
Israel
Hungary
Poland
Estonia
Korea
Luxembourg (2008)
Mexico
Turkey (2008)



Source: Congressional Budget Office.

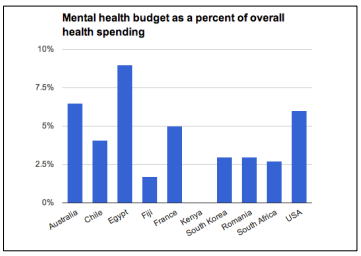
Mental Healthcare Expenditures

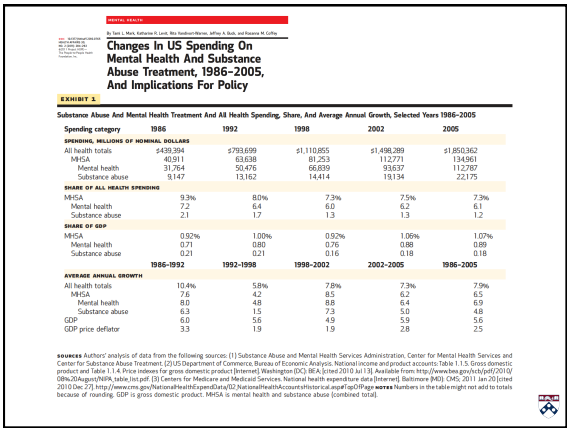
Annual Expenditure Growth Rates, All Health, Mental Health And Substance Abuse, And Gross Domestic Product (GDP), 1986–2005.



Mark T L et al. Health Aff 2011;30:284-292

HealthAffairs





MENTAL HEALTH

By Tami L. Mark, Katharine R. Levit, Rita Vandivort-Warren, Jeffrey A. Buck, and Florence M. Coffey

Changes In US Spending On Mental Health And Substance Abuse Treatment, 1986–2005, And Implications For Policy

EXHIBIT 1

Substance Abuse And Mental Health Treatment And All Health Spending, Share, And Average Annual Growth, Selected Years 1986–2005

Spending category	1986	1992	1998	2002	2005
SPENDING, MILLIONS OF NOMINAL DOLLARS					
All health totals	$439,394	$793,699	$1,110,855	$1,498,289	$1,850,362
MHSA	40,911	63,638	81,253	112,771	134,961
Mental health	31,764	50,476	66,839	93,637	112,787
Substance abuse	9,147	13,162	14,414	19,134	22,175
SHARE OF ALL HEALTH SPENDING					
MHSA	9.3%	8.0%	7.3%	7.5%	7.3%
Mental health	7.2	6.4	6.0	6.2	6.1
Substance abuse	2.1	1.7	1.3	1.3	1.2
SHARE OF GDP					
MHSA	0.92%	1.00%	0.92%	1.06%	1.07%
Mental health	0.71	0.80	0.76	0.88	0.89
Substance abuse	0.21	0.21	0.16	0.18	0.18
	1986–1992	**1992–1998**	**1998–2002**	**2002–2005**	**1986–2005**
AVERAGE ANNUAL GROWTH					
All health totals	10.4%	5.8%	7.8%	7.3%	7.9%
MHSA	7.6	4.2	8.5	6.2	6.5
Mental health	8.0	4.8	8.8	6.4	6.9
Substance abuse	6.3	1.5	7.3	5.0	4.8
GDP	6.0	5.6	4.9	5.9	5.6
GDP price deflator	3.3	1.9	1.9	2.8	2.5

SOURCES Authors' analysis of data from the following sources: (1) Substance Abuse and Mental Health Services Administration, Center for Mental Health Services and Center for Substance Abuse Treatment. [2] US Department of Commerce, Bureau of Economic Analysis. National income and product accounts Table 1.1.5, Gross domestic product and Table 1.1.4, Price indexes for gross domestic product [Internet]. Washington (DC): BEA; [cited 2010 Jul 13]. Available from: http://www.bea.gov/scb/pdf/2010/08%20August/NIPA_table_list.pdf. [3] Centers for Medicare and Medicaid Services. National health expenditure data [Internet]. Baltimore (MD): CMS; 2011 Jan 20 [cited 2010 Dec 27]. http://www.cms.gov/NationalHealthExpendData/02_NationalHealthAccountsHistorical.asp#TopOfPage **NOTES** Numbers in the table might not add to totals because of rounding. GDP is gross domestic product. MHSA is mental health and substance abuse (combined total).

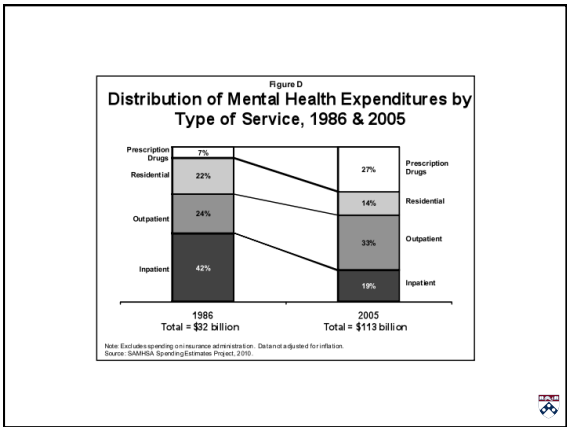
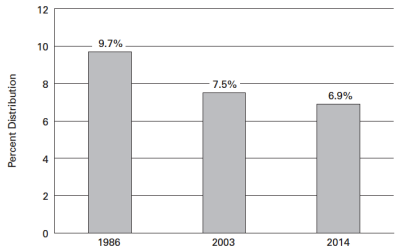


Figure D

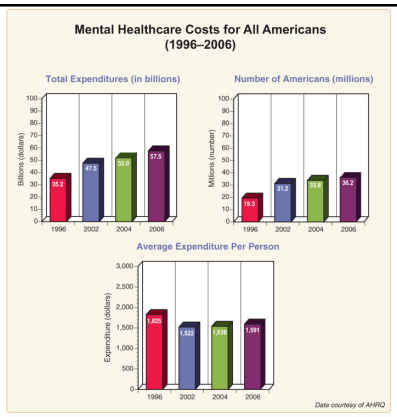
Distribution of Mental Health Expenditures by Type of Service, 1986 & 2005

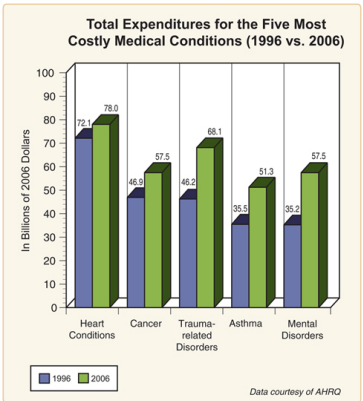
Note: Excludes spending on insurance administration. Data not adjusted for inflation.
Source: SAMHSA Spending Estimates Project, 2010.

Figure 2.1: MHSA Expenditures as a Percent of Total Health Care Expenditures: 1986, 2003, and 2014

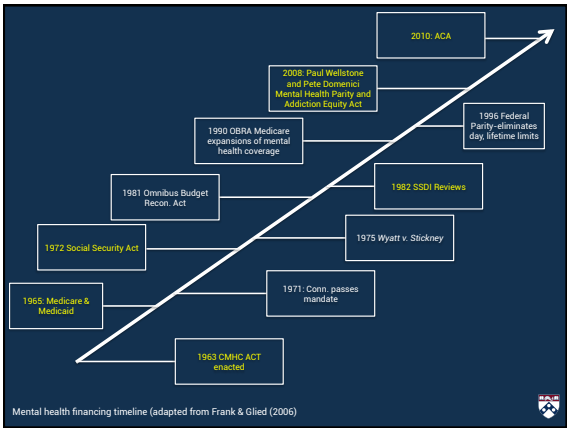


Substance Abuse and Mental Health Services Administration. 2008. "Projections of National Expenditures for Mental Health Services and Substance Abuse Treatment," DHHS Publication No. SMA 08-4-326





Behavioral Healthcare: Payment and Coverage



Mental health financing timeline (adapted from Frank & Glied (2006)

A side note: Mental health funding post-Sandy Hook

- States are putting on hold plans to slash mental health budgets. (PA and UT)
- NC plans to expand case worker numbers, after severe cuts
- Kansas, which cut mental health spending by 12% from 2008 to 2011, announced this month a new $10 million program aimed at identifying mental health dangers.

http://www.newsobserver.com/2013/01/23/2627547/after-shootings-states-rethink.html

Table 1

Prereform coverage of behavioral health services, by payer[a]

Category and service[b]	Blue Cross/ Blue Shield[c]	Medicare[d]	Medicaid[e]	Other state funding[f]	Other federal funding[g]
Prevention					
Screening for alcohol misuse (USPSTF recommended)[h]	X	^	/	X	
Screening for depression (USPSTF recommended)[h]	X	X	/	X	
Screening for illicit drug use	X	^	/	X	
Screening for suicide risk			/	X	
Treatment					
Diagnostic tests, psychological testing	X	X	X	X	
Outpatient psychotherapy for mental health and substance abuse	X	X	X	X	
Inpatient hospitalization for a mental or substance use disorder	X	X	X	X	
Partial hospitalization for a mental or substance use disorder	X	X	X	X	
Inpatient detoxification	X	X	X	X	
Outpatient detoxification	X	X	X	X	
Pharmacological therapy	X	X	X	X	
Medication management	X	X	X	X	
Opioid treatment			X	X	
Short-term residential care for a mental or substance use disorder			X	X	
Long-term residential care for a mental or substance use disorder			X	X	
Case management or intensive case management for a mental or substance use disorder			X	X	
Crisis intervention for a mental or substance use disorder			X	X	
Supportive services					
Housing assistance				X	X
Vocational training or support			Limited	X	X
Income assistance				X	X
Nonemergency transportation services			X	X	
Peer support services			X	X	
Collateral services or family support services			X	X	
Home-based support services			X	X	

Garfield, et al. "Health Reform and the Scope of Benefits for Mental Health and Substance Use Disorder Services," in *Health Reform: A Primer for Psychiatrists*. APA Press.

Table 2

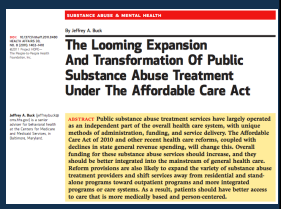
Postreform behavioral health benefits under various coverage sources[a]

Coverage source	Defined behavioral health benefits
Medicare	Prereform rules for Medicare benefits
Medicaid	Traditional (nonexpansion) enrollees: prereform rules for Medicaid benefits
	Expansion enrollees: benchmark or benchmark-equivalent coverage (must cover at least essential benefits package)
Private coverage outside an exchange[b]	Existing grandfathered plans: prereform benefits
	New and nongrandfathered plans: mental health and substance use disorder services, including behavioral health treatment, as defined by the essential benefits package (set at the scope of services available in a typical employer plan)
Private coverage through an exchange	Mental health and substance use disorder services, including behavioral health treatment, as defined by the essential benefits package (set at the scope of services available in a typical employer plan)

Garfield, et al. "Health Reform and the Scope of Benefits for Mental Health and Substance Use Disorder Services," in *Health Reform: A Primer for Psychiatrists*. APA Press.

Substance Abuse & ACA

- A tale of two systems
  - Mental health/Medical Insurance versus Substance abuse services
- Unique service structure will change with ACA.
  - Essential Health Benefit
  - Payment of benefits identical to medical treatment
  - Medicaid expansion—expanded numbers mean more substance abuse treatment
    - Federal funding will increase; state funding decrease or stay the same
  - Medical homes
- Structural changes
  - Consolidation
  - Medicalization
  - Integration
  - Deinstitutionalization



SUBSTANCE ABUSE & MENTAL HEALTH

By Jeffrey A. Buck

The Looming Expansion And Transformation Of Public Substance Abuse Treatment Under The Affordable Care Act

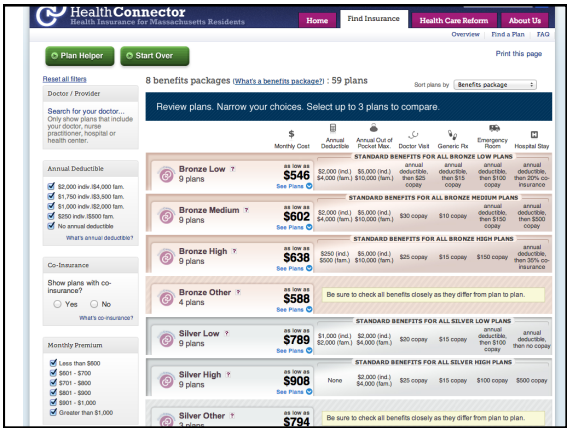
ABSTRACT Public substance abuse treatment services have largely operated as an independent part of the overall health care system, with unique methods of administration, funding, and service delivery. The Affordable Care Act of 2010 and other recent health care reforms, coupled with declines in state general revenue spending, will change this. Overall funding for these substance abuse services should increase, and they should be better integrated into the mainstream of general health care. Reform provisions are also likely to expand the variety of substance abuse treatment providers and shift services away from residential and stand-alone programs toward outpatient programs and more integrated programs or care systems. As a result, patients should have better access to care that is more medically based and person-centered.

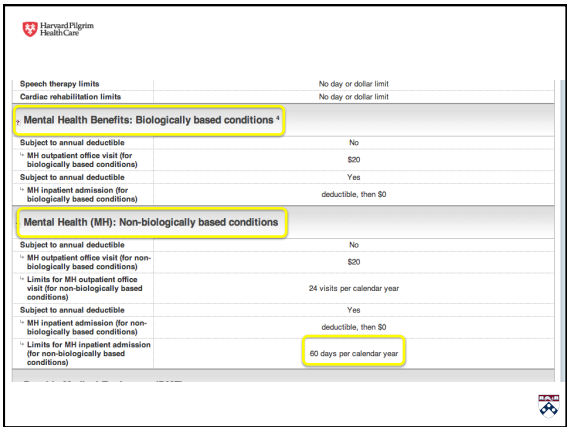
Essential Health Benefits

- Plans must provide 10 essential health benefits (§ 1302)

  (A) Ambulatory patient services.
  (B) Emergency services.
  (C) Hospitalization.
  (D) Maternity and newborn care.
  (E) Mental health and substance use disorder services, including behavioral health treatment.
  (F) Prescription drugs.
  (G) Rehabilitative and habilitative services and devices.
  (H) Laboratory services.
  (I) Preventive and wellness services and chronic disease management

- Secretary has deferred definition of essential benefits to states
  - Benchmark = 'typical employer'
  - Might be pegged to FEHB (good) or State's small group insurers or HMO plan (not-so-good)
- Example: California has designated as its "Essential Health Benefits" benchmark plan the Kaiser Foundation Small Group HMO 30





Type of Plan	Must offer MH/SUD?	Parity applies?
Plans sold in Exchanges (Qualified Health Plans)	✓	✓
Individual market (not sold in the Exchanges)	✓[1]	✓
Small group market (not sold in the Exchanges)	✓[1]	⊘[2]
Large group market (not sold in the Exchanges)	⊘	✓[3]
Traditional Medicaid, fee-for-service	⊘	⊘
Traditional Medicaid, managed care	⊘	✓[3]
Benchmark Medicaid for newly eligible, FFS	✓	Partially[4]
Benchmark Medicaid for newly eligible, mgd care	✓	✓

Unless otherwise noted, all requirements are effective January 1, 2014.

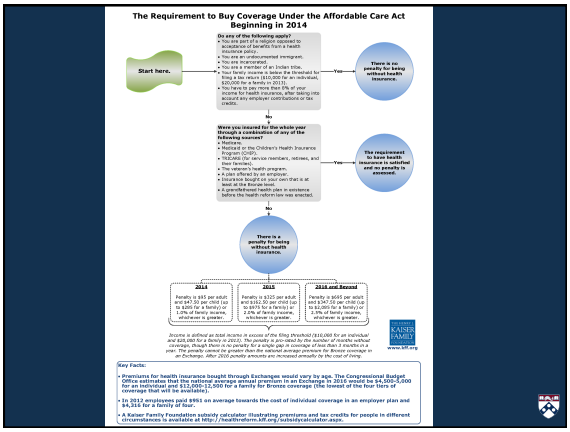
1. Applies to ***new*** plans only

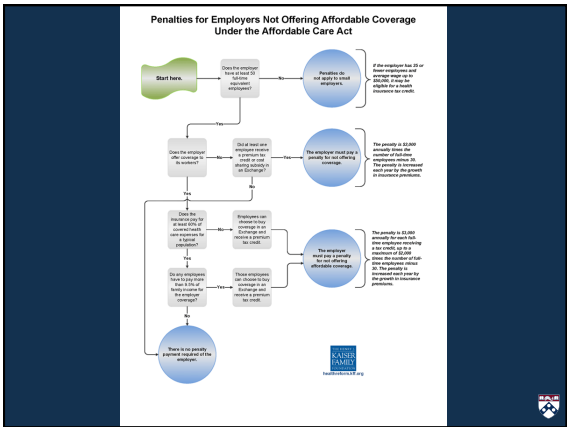
2. While the ACA requires plans sold in the small group market to cover the Essential Health Benefits (which include MH/SUD), it does not explicitly expand the 2008 parity law to apply to these plans.

3. Already in effect under the 2008 Mental Health Parity and Addictions Equity Act

4. Required to comply with federal parity law on treatment limitations and cost-sharing requirements, but not required to comply with parity law on annual/aggregate limits or in/out-of-network limitations. This is likely because these types of limitations are less applicable to FFS plans than to managed care.

http://mentalhealthcarereform.org/coverage-of-mental-health-and-substance-use-services-under-the-aca/





POLITICO Pro

By DAVID NATHER | 7/30/13 5:02 AM EDT

Mythbusters: Obamacare edition

"The IRS will have access to your medical records." *False*

"You'll never know if your information is safe" *Plausible*

"Your health care costs will double" *False*

"Just sit back and enjoy the benefits" *False*

"Obamacare is going to cost your favorite restaurant $1 million" *Plausible*

"You can't chose your own doctor." *False*

Overview

A. Context: The ACA and Behavioral Healthcare
   1. Policy Landscape
   2. Insurance reform
   3. Payment reform

B. Philosophical & Ethical Challenges
   1. What is a 'mental disorder'?
   2. Behavioral healthcare as an "essential" benefit – what are the limits?

C. Clinical & Ethical Opportunities
   1. Broadening coverage
   2. Integrative care, ACO's & medical homes
   3. Alignment with Recovery-oriented service
   4. New research & training

What is 'mental disorder'

- Three *broad* categories of philosophical theories:
  - *Naturalism*
  - *Normativism*
  - *Hybrid Theories*
- Each theoretical position will have different policy ramifications

Big Ethical Questions

- With infinite needs and limited resources, how should we set limits?
- How are considerations of personal responsibility morally relevant?
- What are the limits of responsibility for persons who are mentally ill (i.e. the mad vs. bad problem)?
- When is it appropriate to treat someone without their consent (i.e. liberty vs. capacity issues)

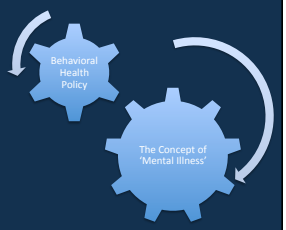
} *What is mental disorder?*

What is mental disorder?

- Key question, the answer to which much will depend:
  - Essential benefits
  - Coverage
  - Formularies
  - Disability
  - Accommodation
  - Exculpation/Blameworthiness

'Mental Illness' through the years

- Definition has shifted within US policy over past 100 years, oscillating between:
  - Narrow definition: Cover & treat most severe
  - Broad definition: Provide more care for more people
- 'State Care Acts'
  - New York in 1890 and Massachusetts in 1904
  - States built asylums, local gov'ts paid for episodes of care
  - Cost shifting occurred:
    - Local gov'ts redefined dementia and other age-related conditions as 'insanity'
    - Moved elderly from almshouses to asylums



(Goldman and Grob, *Health Affairs*, 2006)

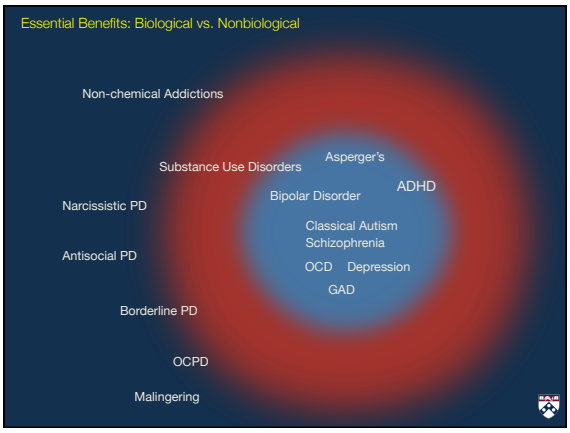
Essential Health Benefits

The ethics of essential health benefits

- Insurance requires pooling risks and resources for the greater good
  - Who decides what should be included as an essential benefit?
  - How ought decisions be negotiated in a pluralistic multi-cultural society?
  - Moral judgment often accompanies these choices.
- The Catholic institutions and contraception controversy
  - "Why should I pay for something I find immoral?"
  - Self-insurance
- Behavioral health care will be similarly scrutinized
  - "Why should I pay for a 'junkie's' expensive treatment?"
  - "Why should I pay for my employee's problem gambling treatments?"

Harvard Pilgrim Health Care

Speech therapy limits	No day or dollar limit
Cardiac rehabilitation limits	No day or dollar limit
Mental Health Benefits: Biologically based conditions [4]	
Subject to annual deductible	No
[4] MH outpatient office visit (for biologically based conditions)	$20
Subject to annual deductible	Yes
[4] MH inpatient admission (for biologically based conditions)	deductible, then $0
Mental Health (MH): Non-biologically based conditions	
Subject to annual deductible	No
[4] MH outpatient office visit (for non-biologically based conditions)	$20
[4] Limits for MH outpatient office visit (for non-biologically based conditions)	24 visits per calendar year
Subject to annual deductible	Yes
[4] MH inpatient admission (for non-biologically based conditions)	deductible, then $0
[4] Limits for MH inpatient admission (for non-biologically based conditions)	60 days per calendar year



Overview

A. Context: The ACA and Behavioral Healthcare
   1. Policy Landscape
   2. Insurance reform
   3. Payment reform

B. Philosophical & Ethical Challenges
   1. What is a 'mental disorder'?
   2. Behavioral healthcare as an "essential" benefit – what are the limits?

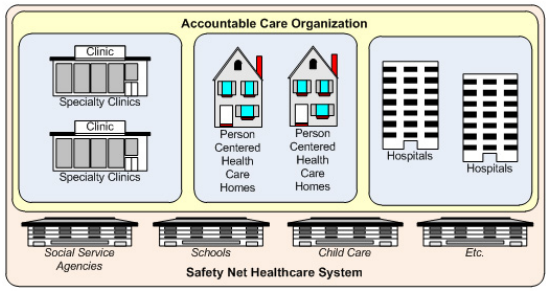
C. Clinical & Ethical Opportunities
   1. Broadening coverage
   2. Integrative care, ACO's & medical homes
   3. Alignment with Recovery-oriented service
   4. New research & training

Broadening coverage, increasing resources

- 2008 National Survey on Drug Use and Health:
  - 4.9 million uninsured people were classified as having serious psychological distress in the past year and that
  - 5.5 million were classified as having substance dependence or abuse disorders in the past year.

Thus, millions of people with mental illness and substance use disorders could benefit from improved access to insurance coverage.

Mark, TL, et al. Changes in US Spending on Mental Health and Substance Abuse Treatment , 1996-2005, and Implications for Policy. Health Affairs. February, 2011.



http://mentalhealthcarereform.org/changes-to-healthcare-services-organization-funding-delivery/

Client-centered & recovery-oriented care

- ACA authorizes and incentivizes recovery-oriented care delivery
  - Client centered medical homes
  - Community based care
  - Integrated services for mental illness and substance abuse
  - Supported employment
  - Better coordination between mental healthcare providers and primary care

New Freedom Commission Goals (2003)	SAMHSA Principles of Recovery & System Elements (2005/2009)	Philadelphia Department of Behavioral Health Goals	PPACA Selected Provisions
1. Mental health is essential to overall health	• Recovery is holistic. • Recovery exists on a continuum of improved health and wellness.	• Provide integrated services • Holistic approaches toward care	§1302 Essential health benefits §2001 Medicaid expansion (mental healthcare - actuarial equivalence) §2702 Guaranteed availability of coverage exclusion §2704 Prohibition of preexisting condition §3107 Extension of physician fee schedule mental health add-on §5306 Mental and behavioral health education and training grants
2. Mental healthcare is consumer and family driven	• There are many pathways to recovery. • Recovery is self-directed and empowering. • Support by peers and allies • Systems anchored in the community	• Community inclusion, partnership, collaboration • Person and family-directed approaches • Family inclusion and leadership • Develop inclusive collaborative service teams and processes	§2401 Community First Choice Option §3502 Patient centered medical homes §3506 Program to facilitate shared decision making §5604 Co-locating primary and specialty care in community based mental health settings §3510 Patient navigator program §3022 Medicare shared savings program (ACO)
3. Disparities in mental healthcare must be addressed	• Recovery is holistic. • Recovery has cultural dimensions. • Recovery involves addressing discrimination and transcending shame and stigma. • Recovery involves (re)joining and (re)building a life in the community.	• Person-first (culturally competent) approaches.	§5306 Mental and behavioral health education and training grants §5307 Cultural competency training

New Freedom Commission Goals (2003)	SAMHSA Principles of Recovery & System Elements (2005/2009)	Philadelphia Department of Behavioral Health Goals	PPACA Selected Provisions
4. Mental health screening, assessment, and referral becomes common practice	• Recovery is holistic. • Recovery is self-directed and empowering.	• Develop inclusive collaborative service teams and processes	§3107 Extension of physician fee schedule mental health add-on §4003 Clinical and community preventative services §5405 Primary care extension program
5. Mental healthcare is delivered and research is accelerated	• Recovery is self-directed and empowering. • Recovery is holistic. • Recovery has cultural dimensions. • Outcomes-driven & research-based	• Empirically informed approaches	§2705 Medicaid global payment §2707 Medicaid emergency demonstration project §3107 Extension of physician fee schedule mental health add-on §4201 Community transformation grants §5306 Mental and behavioral health education and training grants §6301 PCORI §10410 Centers of excellence for depression
6. Technology is used to access mental healthcare & information	• There are many pathways to recovery. • Recovery is self-directed and empowering. • Ongoing monitoring and outreach		[see HITECH enacted in 2009 as part of ARRA] §1561 HIT enrollment standards §3506 Program to facilitate shared decision making §3510 Patient navigator program

Wrapping up…

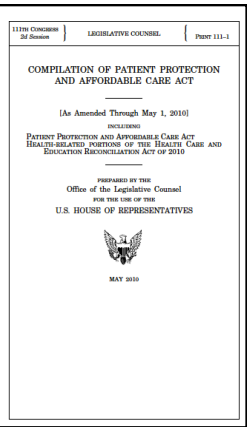
- ACA will change mental healthcare delivery
- The ACA will amplify particular ethical and philosophical challenges.
- Lots of complicated provisions, so don't lose sight of the key ethical goals that I believe are implicit within the ACA:
  - To improve the lives of individuals and families suffering with mental illness.
  - To empower caregivers with better tools to treat mental illness
  - To advocate for the powerless.

Acknowledgments

The Thomas Scattergood Behavioral Health Foundation

Members of the Department of Medical Ethics & Health Policy

Thanks…
- Ezekiel Emanuel, MD, PhD
- J. Sanford Schwartz, MD
- Stephanie Hales, JD
- Rebecca Johnson, MA
- Andrew Siegel, MD
- Marna Barrett, PhD
- Phyllis Solomon, PhD
- Anne Barnhill, PhD
- Katherine Buckley



111TH CONGRESS, 2d Session | LEGISLATIVE COUNSEL | PRINT 111-1

COMPILATION OF PATIENT PROTECTION AND AFFORDABLE CARE ACT

[As Amended Through May 1, 2010]

INCLUDING

PATIENT PROTECTION AND AFFORDABLE CARE ACT
HEALTH-RELATED PORTIONS OF THE HEALTH CARE AND EDUCATION RECONCILIATION ACT OF 2010

PREPARED BY THE
Office of the Legislative Counsel
FOR THE USE OF THE
U.S. HOUSE OF REPRESENTATIVES

MAY 2010

Thank You