

# The Affordable Care Act: Improved Options for North Carolinians with Mental Illnesses

Allison A. Wishon Siegwarth, Chris Koyanagi

**The Affordable Care Act, the health reform law enacted in 2010, offers new options to improve the quality of and access to mental health care for North Carolinians. This commentary will discuss provisions of the law that have the potential to enhance the lives of individuals with mental illnesses.**

**T**he North Carolina Division of Mental Health, Developmental Disabilities and Substance Abuse Services estimates that 393,151 adults living in North Carolina have a serious, disabling mental illness and that 246,230 children and youth have a serious mental, behavioral, or emotional disorder [1]. Countless other North Carolinians experience mental health conditions that are less severe but may nonetheless significantly affect their quality of life [2]. Individuals with mental illnesses often have difficulty accessing appropriate services because of problems with insurance. Private insurance frequently does not cover mental disorders or limits access to care, offering only a narrow range of services. In addition, public mental health systems have suffered from major budget cuts and outdated service arrays for many years.

The Affordable Care Act (ACA), the health reform law passed in March of 2010, has the potential to address a range of problems and needs experienced by individuals with mental illnesses [3]. This commentary will discuss some of the provisions of the act that have the most potential to improve the quality and availability of care for North Carolinians with mental disorders.

## Essential Health Benefits

Historically, one of the greatest barriers to care for individuals with mental illnesses has been inability to obtain insurance coverage for mental health services. The ACA aims to address insurance access issues in the private insurance market by establishing state-based Health Benefit Exchanges through which individuals and small businesses may purchase insurance coverage. Insurers who wish to offer plans through the exchanges must cover certain specific categories of services collectively termed the essential health benefits (EHB) package. Mental health and substance use disorder services must be covered, and, importantly, must be covered at parity with medical and surgical care to meet standards in federal and state parity laws.

Insurers must also cover preventive and rehabilitative services which could include screening for mental health conditions and psychiatric rehabilitation services. The law also prohibits defining the benefit package in a way that would discriminate against individuals with disabilities, including mental illnesses. Certain insurance purchased outside the exchanges need not provide coverage for the full range of essential benefits. Additionally, the EHB requirement does not apply to plans in effect on the date of enactment of the ACA ("grandfathered" plans) for as long as the plan does not change substantially and maintains its "grandfathered" status.

The Secretary of Health and Human Services has discretion to define the EHB, but the law requires that the scope of these benefits equal that provided under a "typical" employer plan. The US Department of Health and Human Services (DHHS) has released guidance to states on the EHB package; however, instead of creating a comprehensive federal standard, as many policymakers and advocates expected, DHHS has offered states great latitude in defining the EHB using a "benchmark" approach [4]. This approach allows states to select an existing health plan in the state to use as a benchmark to determine the scope of services for their exchange plans.

States may select one of the three largest small-employer plans, state or federal employee plans, or the largest health maintenance organization (HMO) plan offered in the state to serve as their benchmark. States must supplement the plan if it fails to include any of the essential benefits required under the law. This is particularly relevant for mental health services, as coverage for these services is often offered minimally or not at all in small-employer plans.

Currently, most of the small-employer plans that states may select are not subject to the federal mental health parity law and will therefore need to be altered to comply with the EHB parity requirement. The Mental Health Parity and Addiction Equity Act of 2008 requires employer plans

---

Electronically published June 7, 2012.

Address correspondence to Ms. Allison Wishon Siegwarth, The Judge David L. Bazelon Center for Mental Health Law, 1101 15th St, Ste 1212, Washington, DC 20005 (allisonw@bazelon.org).

**N C Med J. 2012;73(3):240-243.** ©2012 by the North Carolina Institute of Medicine and The Duke Endowment. All rights reserved.  
0029-2559/2012/73323

that cover more than 50 employees to ensure that financial requirements and treatment limitations applicable to mental health or substance use disorder benefits are no more restrictive than the requirements or limitations applied to medical and surgical benefits [5].

The benchmark approach to defining the EHB package is likely to result in marked variability in mental health coverage in exchange plans across the country. It is moreover quite complex for states, which must select a benchmark plan and evaluate its details in order to add benefits that are missing to comply with the nondiscrimination rule and mental health parity. When the process is complete, however, individuals and small businesses will have ready access to health insurance (with subsidies available for many).

### Medicaid Benchmark Benefits

In addition to making reforms in the private health insurance market, the ACA also makes important changes to the federal-state Medicaid program. Beginning in 2014, Medicaid eligibility will be expanded to cover all individuals with incomes at or below 133% of the federal poverty level established by the DHHS. This means that people will soon qualify for Medicaid based solely on financial factors; individuals will no longer need to meet criteria for one of the specific Medicaid eligibility categories, such as having dependent children or receiving Supplementary Security Income. Those newly eligible will include a substantial number of individuals with significant mental health care needs, including currently homeless individuals, whose needs for both health and mental health care are substantial.

Many states, including North Carolina, have provided little or no Medicaid coverage for adults without children. The North Carolina Division of Medical Assistance estimates that between 500,000-600,000 North Carolinians are expected to enroll in Medicaid as a result of the Medicaid expansion [6]. Medicaid will be the primary source of coverage for individuals with mental illnesses who gain insurance under the ACA, because these individuals are more likely to have low incomes than are those without mental illnesses [7].

States have been given flexibility with respect to the covered benefits for newly eligible Medicaid beneficiaries. At a minimum, benefits must cover the same services as the state's EHB package for exchange plans. As long as they meet this minimum requirement, states may define a very different, and potentially more limited Medicaid benefit for newly eligible adults than for others on the program (children have special protection under the ACA and would be entitled to all Medicaid-covered services). However, this flexibility also allows states to offer the full or even an enhanced state Medicaid plan to newly eligible adults. States have had the flexibility to provide different benefits for other groups enrolled in the Medicaid program for several years, but few have chosen to do so and some have provided expanded, not reduced, benefits [8].

Some people who fall into the newly eligible income range may also qualify for the program under current Medicaid rules. These individuals may enroll in the state's standard Medicaid plan, which will generally offer a broader and more appropriate array of the critical mental health, rehabilitation, and long-term care services needed by individuals with serious mental illnesses. States have an obligation to assess individuals as they apply for the program to determine whether they meet the eligibility rules for the regular program or are to be enrolled in a benchmark plan [9].

Although it is impossible to predict how states will use this flexibility, it may be that the administrative complexity of assessing individuals for and operating a separate, benchmark plan will be very burdensome. The additional complexity of two parallel Medicaid programs would also be onerous for providers and beneficiaries. Without question, some individuals in the newly eligible group will require intensive community mental health services and supports that are covered in standard Medicaid but are unlikely to be covered in a benchmark plan based on private insurance. Unless these services are covered under Medicaid, states may be forced to pay for them out of state funds. Providing full standard Medicaid will facilitate a more streamlined administrative process and will ensure that states are able to draw down federal funds for services that may otherwise have to be funded solely with state dollars.

### Additional Opportunities

Many of the protections and reforms provided by the Affordable Care Act will benefit children, individuals with mental illnesses, and providers of mental health care in North Carolina. A few of the Medicaid provisions that are particularly well situated to enhance the lives of people with mental illnesses are discussed below.

**New options for home- and community-based services.** The ACA amends a key provision in Medicaid that allows states to provide home- and community-based services as a regular state plan option, instead of only allowing those services through a complex waiver as provided for under section 1915(c) of the Social Security Act. The state plan option provided for under section 1915(i) offers states the potential to cover a wide range of services and supports that can enable individuals with serious mental illnesses to reside in their communities. Originally authorized in 2005 [10], section 1915(i) bases eligibility for services on function—not on risk of institutionalization, as is required under a waiver. This permits states to provide services and supports to individuals with mental illnesses of all ages and prevents states from being required to ensure that services are provided at less cost than institutional care.

Before health reform was enacted, only a handful of states utilized section 1915(i). However, several important changes were made to this section by the ACA, which may make the option more appealing to states, advocates, or potential beneficiaries. States are now permitted to have

more than one 1915(i) state plan option and are allowed to target 1915(i) services to specific populations, such as to individuals with serious mental illnesses. The range of services that may be provided has also been expanded to include any service that could be approved under a waiver. And under the ACA, states must provide services statewide without waiting lists or limits on the number of individuals eligible to receive 1915(i) services.

Section 1915(i) is now an important option for meeting the needs of children and adults with mental illness. States may cover a broad array of evidence-based, recovery-focused mental health services, such as peer support, respite care, all of the costs associated with supported employment programs, supportive housing (possibly including deposits and first month's rent), and other supports. Using a section 1915(i) state plan option, states may be able to get federal Medicaid funding for services that are now being paid for solely with state funds. The option also encourages the use of innovative reimbursement strategies, such as paying for services in a bundled manner through daily or case rates, instead of traditional fee-for-service payment methodologies. Together with the Rehabilitation Option, 1915(i) allows states to fund a comprehensive system of care for individuals with mental illnesses. The Medicaid Rehabilitation Option is a category of Medicaid services that allows states to provide certain rehabilitative services, and is primarily used to furnish mental health services to individuals in their communities. There are, however, restrictions on the types of services that may be covered under the option. Using the Rehabilitation Option in tandem with 1915(i) allows states to fund a comprehensive system of care for individuals with mental illnesses [11]. To date, 8 states (not including North Carolina) have an approved section 1915(i) state plan option in place [12].

**Medicaid "health homes."** The ACA creates a new Medicaid state option to fund health homes, which are intended to improve the quality of care for Medicaid beneficiaries with chronic conditions, including mental illnesses. States may allow certain people with chronic conditions, or those with a serious and persistent mental health condition, to designate a provider as their "health home."

Health homes provide comprehensive care coordination and other supportive services. Community mental health centers are specifically listed in the law as eligible for designation as a health home. Such arrangements allow necessary primary care services and linkages to specialty care to be provided through the mental health agency where an individual is receiving regular services, thus offering maximum care coordination and management of co-occurring physical illnesses, which people with mental illnesses have an increased risk of experiencing [13, 14]. Mental health professionals may also participate as part of any health home clinical team.

North Carolina has received a health home planning grant from the federal government and has submitted a state plan

amendment seeking to enable the state to provide health home services statewide through the Community Care of North Carolina program [15].

## Challenges Ahead

The ACA is a lengthy statute with many innovative provisions that can improve Medicare, Medicaid, quality of care, cost controls, and private insurance coverage. The inclusion of mental health and substance use disorder services at parity in the EHB and the infusion of many aspects of the law with opportunities to improve the quality of mental health care signal a clear recognition of the importance and effectiveness of addressing the mental health needs of Americans who have mental illnesses. In order to ensure that individuals with mental illnesses fully benefit from these reforms, it will be important for stakeholders to advocate for robust mental health benefits in the exchange plans and, most importantly, in Medicaid. The potential of the ACA will only be realized if states take full advantage of the innovative options in the law, such as the Medicaid section 1915(i) state plan option and the Medicaid option to provide health homes. **NCMJ**

**Allison A. Wishon Siegwarth, MHS** policy analyst, The Judge David L. Bazelon Center for Mental Health Law, Washington, D.C.

**Chris Koyanagi** policy director, The Judge David L. Bazelon Center for Mental Health Law, Washington, D.C.

## Acknowledgments

We thank Sophie Stern of the Bazelon Center for her assistance with manuscript preparation.

Potential conflicts of interest. A.A.W.S. and C.K. have no relevant conflicts of interest.

## References

1. North Carolina Division of Mental Health, Developmental Disabilities and Substance Abuse Services. State of North Carolina Community Mental Health Services Block Grant Application for FY 2012-2013. Approved July 19, 2011:18. <http://www.ncdhhs.gov/mhddsas/statspublications/Reports/Financialandstatisticalreports/BlockGrants/MHBsfy12plan-draft.pdf>. Accessed April 14, 2012.
2. Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration. The NSDUH Report: State Estimates of Adult Mental Illness. Rockville, MD: Substance Abuse and Mental Health Services Administration; October 6, 2011. [http://www.samhsa.gov/data/2k11/WEB\\_SR\\_078/State\\_Estimate\\_Adult\\_Mental\\_Illness.pdf](http://www.samhsa.gov/data/2k11/WEB_SR_078/State_Estimate_Adult_Mental_Illness.pdf). Accessed April 14, 2012.
3. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010).
4. Center for Consumer Information and Insurance Oversight, Center for Medicare and Medicaid Services. Essential Health Benefits Bulletin. Washington, D.C.: US Department of Health and Human Services; December 16, 2011. [http://ccio.cms.gov/resources/files/Files2/12162011/essential\\_health\\_benefits\\_bulletin.pdf](http://ccio.cms.gov/resources/files/Files2/12162011/essential_health_benefits_bulletin.pdf). Accessed April 14, 2012.
5. Public Health Service Act, 42 USC §300GG-26 (2006).
6. Implementation of the Patient Protection and Affordable Care Act in North Carolina. Interim Report. North Carolina Institute of Medicine. March 2011. <http://www.nciom.org/wp-content/uploads/2011/03/HR-Interim-Report.pdf>. Accessed May 2, 2012.
7. Garfield RL, Zuvekas SH, Lave JR, Donohue JM. The impact of national health care reform on adults with severe mental disorders. *Am J Psychiatry*. 2011;168(5):486-494.
8. US Department of Health and Human Services. Children's Health Insurance Program Reauthorization Act: 2011 Annual Report on the Quality of Care for Children in Medicaid and CHIP. <http://www.medicare.gov/Medicaid-CHIP-Program-Information/By-Topics/>

Quality-of-Care/Downloads/2011\_StateReporttoCongress.pdf. Accessed April 14, 2012.

9. Medicaid Program; Eligibility Changes Under the Affordable Care Act of 2010. Final rule. To be codified at 42 CFR Parts 431, 435, and 457. Federal Register. 2012;77(57):17144-17217. <http://www.gpo.gov/fdsys/pkg/FR-2012-03-23/html/2012-6560.htm>. Accessed April 14, 2012.
10. Deficit Reduction Act of 2005, 42 USC §1305 (2006).
11. Social Security Act, 42 USC §1396d(a)(13) (2012).
12. The Bazon Center for Mental Health Law. The Affordable Care Act at Year Two. March 2012. <http://bazelon.org/LinkClick.aspx?filetic>

ket=vluo7GUqOaA%3d&tabid=77. Accessed April 14, 2012.

13. Thielke S, Vannoy S, Unützer J. Integrating mental health and primary care. *Prim Care*. 2007;34(3):571-592, vii.
14. Dickey B, Normand SL, Weiss RD, Drake RE, Azani H. Medical morbidity, mental illness, and substance use disorders. *Psychiatr Serv*. 2002;53(7):861-867.
15. Integrated Care Resource Center. State-by-State Health Home State Plan Amendment Matrix: Summary Overview. [http://www.chcs.org/usr\\_doc/State\\_by\\_State\\_HH\\_SPA\\_matrix\\_-\\_2812.pdf](http://www.chcs.org/usr_doc/State_by_State_HH_SPA_matrix_-_2812.pdf). Accessed April 14, 2012.

