NATIONAL Center on Domestic Violence, Trauma & Mental Health

The Affordable Care Act and Mental Health Care Coverage: Implications for Survivors and Opportunities for Advocates

A Question & Answer with Sarah Steverman, Director of State Policy, Mental Health America (Fall 2012)[1]

Access to health and mental health care is a critical issue for survivors of domestic violence, many of whom experience the health and mental health consequences of abuse. The Affordable Care Act (ACA)—while it does not guarantee comprehensive healthcare coverage for all Americans—has the potential to make some significant improvements in access to mental health coverage as well as to increase access to health care for people diagnosed with mental illness or who are experiencing psychiatric disability. It is therefore important for those working in the DV field to stay informed of the potential benefits of the ACA for survivors as well as to partner with mental health advocates to take advantage of opportunities created by the ACA to advocate for health and mental health care.

As the ACA shifts access to health and mental health care in this country, the DV field may also have opportunities to advocate for a broader reform agenda—for a health and mental health system that is truly trauma informed and responsive to the needs of domestic violence survivors and their children.

NCDVTMH asked Sarah Steverman, Director of State Policy at Mental Health America, to answer a few questions related to the benchmark benefits and essential benefits provisions of the ACA. Her responses are summarized below:

Mental health and substance abuse disorder treatment is one of the ten "essential health benefits" designated under the ACA. That means that every insurance plan that is sold through the insurance exchanges must provide coverage for these services. But who decides what must be covered?

Each state will have an insurance exchange, or a marketplace where consumers can go to purchase health insurance in a transparent way. As you stated, mental health and substance abuse disorder treatment must be offered in all of the plans sold in the exchange. Some states will operate their own exchanges and some will rely on the federal government to operate them, but each state will have the opportunity to determine exactly what types of coverage will be required of plans sold through their exchange, within the guidelines provided by the ACA and the

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federal Department of Health and Human Services (HHS). HHS will ultimately need to approve states' plans, but states will have flexibility in their determination of the coverage requirements within each of the essential benefit categories.

Any plan provided in the exchange, however, will be required to comply with the 2008 Mental Health Parity and Addiction Equity Act. This statute requires plans to offer mental health and substance abuse disorder treatment at parity with, or equal to, the coverage offered for medical/surgical benefits. The details of the parity requirements that were included in the law and a subsequent regulation from the federal government will serve as a minimum requirement for the mental health and substance use benefits offered in the exchange plans.
Given the flexibility that states have to determine coverage and the need to scrutinize states' plans for their compliance with parity, advocacy by the mental health, substance use, and DV communities at the state level is crucial. State and local advocates, with the assistance of national level partners, should be assessing their states' plans for mental health and substance use coverage, and promote the inclusion of services that are comprehensive and include prevention, early intervention, and trauma-informed treatment.

By September 30, 2012, states are required to select their benchmark benefit plans. What is the significance of the benchmark plan?

A benchmark plan is an insurance plan that has already been established that will serve as the basis for the plans offered in the state exchanges. HHS has provided states with ten possible plans to choose from in order to use as the benchmark. The chosen plan must cover each of ten essential health benefits (EHB) specified in the ACA, including mental health and substance disorder services, or else the missing benefits must be added. States have the option of choosing from one of the three largest small group plans in the state by enrollment, one of the three largest state employee health plans by enrollment, one of the three largest federal employee health plan options by enrollment, or the largest HMO plan offered in the state's commercial market by enrollment. If these plans do not include all of the ten essential health benefits and meet parity requirements, those benefits

Under the Affordable Care Act, insurance plans sold through the exchanges must provide coverage for the following services:

1. Ambulatory patient services
2. Emergency services
3. Hospitalization
4. Maternity and newborn care
5. Mental health and substance use disorder services, including behavioral health treatment
6. Prescription drugs
7. Rehabilitative and habilitative services and devices
8. Laboratory services
9. Preventive and wellness services and chronic disease management
10. Pediatric services, including oral and vision care

must be added before it can serve as the benchmark. Additionally, if a state fails to make that selection by September 30th, HHS will use the largest small group plan in the state as the default benchmark plan.

Mental health advocates spent the summer assessing the ten benchmark plan options in their states and determining which plan will provide the best standard for people with mental health and substance use conditions. After states submit their plan selections to HHS at the end of the month, advocates will have the opportunity to take a closer look at the selected benchmark plan and advocate for the addition of covered benefits in order to bring the benchmark plan into compliance with the ten essential benefits and federal parity requirements. The mental health and substance use community will be interested in partnering with the DV community to ensure that the final benchmark used for all plans participating in the exchange is adequate and comprehensive.

Will the essential health benefit and federal parity requirements apply to all insurance plans? Are Medicaid plans required to comply as well?

All plans sold on the individual or small business market will be required to comply with the exchange requirements. Insurance companies will not be allowed to offer a less comprehensive plan outside the exchange, which could result in plans being sold to consumers without a full understanding of which services are not covered or the fees that might apply when treatment is accessed.

As those states that will be participating in the Medicaid expansion programs begin to establish their plans for expanding Medicaid coverage to all individuals who make between 0-133% of the federal poverty level, they will be utilizing a benchmark plan to determine covered services. Although the benchmark plan used for this may be different from the one used in the exchange, there will be a standard established in each state to require mental health and substance abuse disorder benefits to be offered at parity to the Medicaid expansion population. Further guidance on these requirements is forthcoming from the federal government, and states will be expected to make more decisions about the design of the plans. The mental health, substance use, and DV communities should be aware of opportunities to be involved in the plans for the Medicaid expansion benefits.

What can the DV field do to support the efforts of mental health advocates working to make sure that the essential health benefits for mental health and substance abuse services are comprehensive?

The mental health community welcomes any and all partners who are interested in advocating for comprehensive mental health and substance use coverage as part of ACA implementation particularly with regard to states' EHB plans. The Coalition for Whole Health (CWH), of which Mental Health America (MHA) is a part, has developed **EHB Consensus Principles and Service Recommendations** that

endorse full and comprehensive coverage. CWH member chapters and affiliates, including MHA affiliates in 39 states, are using these recommendations at the state level to advocate for their benchmark plan. DV advocates who are interested in getting involved can contact the **MHA affiliate in their state**, view **MHA's health reform resources**, consult **CWH local and state resources**, or track your state's implementation progress at **http://www.statereforum.org**. We [at Mental Health America] look forward to the involvement of the DV community in our work to implement the ACA in a way that is meaningful to those who need mental health and substance use services.

For more information about the Affordable Care Act, see the following resources:

- Kaiser Family Foundation, Summary of Coverage Provisions in the Affordable Care Act, at **http://www.kff.org/healthreform/8023.cfm**
- Center on Budget Priorities, Health Reform: **http://www.cbpp.org/research/index.cfm?fa=topic&id=71**
- National Health Law Program, Health Reform: **http://www.healthlaw.org/index.php?option=com_content&view=article&id=456&Itemid=212**