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R2R 2011 HEALTH REFORM SHOW

(Music) The Substance Abuse and Mental Health Services Administration presents the *Road to Recovery*. This programming aims to raise awareness about substance use and mental health problems, highlight the effectiveness of treatment and that people can and do recover. Today's program is Health Reform: What It Means for People With Substance Use and Mental Disorders.

Ivette Torres: Hello, I am Ivette Torres and welcome to another edition of the *Road to Recovery*. Today we will be talking about health reform and what it means to people with substance use and mental disorders. Joining us in our panel today are Deb Beck, president, Drug and Alcohol Service Providers Organization of Pennsylvania; Dr. Richard Frank, professor of Health Economics, Department of Health Care Policy, Harvard Medical School; Patrick Hendry, senior director of Consumer Advocacy, Mental Health America; John O'Brien, senior advisor for Behavioral Health Financing, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services. John, health care reform, why was it necessary? What benefits are we going to see out of it?

John O'Brien: Well, Ivette, we have about 50 million individuals in this country who don't have any insurance at any given point in a year. A number of them use emergency

rooms and/or hospitals, and that has a very significant cost for both people who have insurance as well as employers who pay for insurance. We spend about $17.2 billion on uncompensated care for those individuals. We also know that there is a significant number of people with substance use disorders who have benefits and don't access care, but there are a significant number of individuals who can't access care because they don't have insurance benefits.

Torres: And Richard, what are the major ways the Affordable Care Act will affect the behavioral health system?

Richard Frank: The behavioral health aspects of the Affordable Care Act are based on sort of three principles. One is coverage and parity, two is integration of behavioral health and health care, and the third is prevention. And, in part because the people with behavioral health disorders have had a much higher rate of being uninsured than the rest of the population, you can expect a disproportional impact on the behavioral health community because of the coverage expansions coupled to parity.

Torres: And let's talk a little bit more about the Mental Health Parity and Addiction Equity Act, Richard. Expand a little bit on, particularly, the types of links that are going to be made with the ACA.

Frank: The Wellstone-Domenici Parity Act, which passed in 2008, went into effect in early 2010. What it does is it really provides fairness and coverage along two dimensions. First, it requires that the standard benefits in an insurance plan be the same for the medical surgical side as it is for the behavioral health side. And so, right away that means that copayments, deductibles, limits will be the same. It does a second thing, which is equally important, which is it says that if you are going to manage care, that is okay and you can manage it differently, but you have to base it on the same clinical criteria, the same evidence, and the same logic that you use to make all your other management decisions. And in that sense, what it is doing is it's demanding fairness on the management side, as well as on the benefits side, which is really revolutionary. And the Affordable Care Act adopts parity as one of its key principles that connects throughout the Act. It connects in the exchanges, it connects in Medicaid expansion, it

connects in the essential benefits part of the Affordable Care Act.

Torres: And Patrick, what does that mean for the consumer?

Patrick Hendry: That is the big question, really, I think. We are still discussing that throughout the country. We know that parity is something that we have worked hard for for a long, long time and we assume that, as it becomes more prevalent and really fully enacted, that that will be a great benefit to people receiving health care. I mean, for years we had people receiving Medicare without parity, where they paid a higher rate for mental health care than they did for their traditional health care rates.

But as far as how the ACA is going to play out in terms of improving mental health care and substance abuse, too, I think we are still trying to figure out where we are at the table. I just came from Louisiana and we had a several-day discussion about how do, especially in the smaller States that are not so well organized, how do we get to the table to work out these details about how underintegrated health care [is], that mental health is not going to still be kind of a stepchild.

Torres: And Deb, for someone in the community that is working with the individuals that need to get into recovery and that are currently in a treatment program or that are in recovery from substance use or mental disorders, what is the major point that we need to share with those individuals?

Deb Beck: Well, I just have got to start by saying one in four families has somebody with a drug and alcohol problem and this is a progressive, always-fatal illness if it goes unchecked. So, trying to begin to deal with this issue in a larger way through insurance is literally life-and-death important. I kind of want to sidestep a bit your question because I think there are several features of the Affordable Health Care Act that hold out a lot of hope. Now we are worried, as you are, on how do consumers access some of these things. That pathway is not entirely clear to us at this point.

But, the elimination of pre-existing condition clauses has been an issue and a nettlesome one for our population. Also, the issue of you can't get thrown off your insurance if you start to use it was something we have seen in the

drug and alcohol field. Those two changes alone I think are extremely helpful.

Torres: John, it seems like there are a lot of moving parts to this effort, and what is SAMHSA doing to basically get the word out so that people are connected to what is going on and they really take action when they are supposed to?

O'Brien: Good question. We have been doing a number of things over the last 18 months, specifically around infomercials, initially around parity before the regulations came out. And then, as the regulations came out last year, we provided more detailed information, both in terms of traditional ways—Webinars and presentations—as well as tip sheets around parity to try to get the information out. We have 140 million people who are affected by parity. That's good. What is a little challenging is how to reach a significant portion of those individuals who, for most, parity is probably too technical of a term for them.

And, generally when we talk to employers, especially large employers, they say they have done a lot of effort to try to educate folks about parity, but the fact remains is that people really don't pay attention to these benefits until

they almost have to use them, in most cases. So we are working with employers, we are working with our internal communications staff, external communications staff, to try to really figure out what is the best way to be able to get as much information to as many people around parity as possible.

Torres: There are lots more that we need to learn about this effort and we will be right back.

[Music]

MS: For more information on *National Recovery Month*, to find out how to get involved, or to locate an event near you, visit the *Recovery Month* Web site at recoverymonth.gov.

Bryan Gibb, Director of Public Education for The National Council for Community Behavioral Healthcare, discusses the mission of his organization.

Bryan Gibb: The mission of the National Council for Community Behavioral Healthcare is to, through our membership, to reach out to individuals who may not have access to behavioral health services or may not know that those services are available to them. And mental health first aid is a way that we can teach the general public about mental illness and how they can help.

Gretchen Willis, a teacher collaborator in the Fairfax County, Virginia, Public School System, provides her input on the need for mental health first aid training.

Gretchen Willis: We have signs everywhere about how to recognize if someone is having a stroke. But I have never heard anyone come out and say these are things to recognize that someone in your family might be mentally ill and, even further, what to do about it.

Senora Simpson Ph.D., Assistant Professor at the Howard University Department of Physical Therapy, discusses the importance and benefits of treating mental health problems.

Senora Simpson: It is a mental health issue, so no matter what the drug of choice is, it is still a problem, and we have to get people to recognize that it's still a mental health problem that can be addressed and can be treated. If we can get on that front edge, I believe that we can reduce the total cost in health care.

Torres: Let's talk a little bit about how many people—we had mentioned it earlier, Deb—but how many people are actually uninsured, specifically in the behavioral health area?

Beck: The data coming from the Federal Government points to 50 million people not having any kind of coverage. And people with untreated drug and alcohol problems or

unaddressed mental illnesses have a hard time accessing benefits or thinking that through. If I am really in the throes of an active addiction, I may not think about how to sign up for Medicaid or how to sign up for the health exchanges. So there's this big group we've got to do something with. We are really concerned about it.

I think the good news is the Affordable Health Care Act includes drug and alcohol and mental health, both. The problem is we're going to have to do a lot of work to help this particular population access the coverage. The coverage is there, no question, but we're dealing with a patient population that has a very difficult time getting through the hoops.

Torres: Patrick?

Hendry: I have worked in a number of rural States in the south where the coverage typically had been that about 60 to 65 percent of people were either covered by Medicaid, Medicare, or VA, which left us with a substantial number of people who were not covered. And I think, even as we cover these 32 million, we'll still have a very large amount of people who are not covered by any type of insurance benefit

and, therefore, we're still looking either to the States to pick that up through their general revenue or, I think the new plan is hopefully that the block grants will expand to pick up some of that slack, if I am correct.

Torres: John?

O'Brien: That is exactly right. I mean, we know 5 years later in Massachusetts that there are a significant number of individuals, especially on the substance abuse side or looking at the mental health side as well, that are still unenrolled in their insurance program in their exchanges. And there's a variety of reasons why those folks are still unenrolled. Some of it is education information about what does insurance mean, some of it is the way that people come on and off insurance. And so I think the Massachusetts experience is going to be very helpful as we begin to think about the exchanges in other States.

Torres: You have mentioned exchanges and that was just going to be my next question. We have talked about the Medicaid component of it. How do other people that do not meet that criteria, how are they going to access services? I will start with you, John.

O'Brien: For those individuals that were greater than 133 percent and under 400 percent of the Federal poverty level will have the opportunity through the exchange program in States and perhaps at the national level to be able to receive an insurance benefit through a qualified health plan.

Torres: Well, let's dissect that exchange program. What is that about?

O'Brien: Well, it's going to have a number of functions. Obviously, one of the major functions is an enrollment function, so the ability to be able to provide information to people about how to enroll in insurance; provide information to people about what are the qualified health plans; to identify, recruit, screen the qualified health plans that will be offering the benefit. And again, making sure that, as the qualified health plans get up and running, that they actually do what they are supposed to do.

Torres: Richard?

Frank: The idea behind the exchange is to sort of give to the larger U.S. population the same benefits that people who are Federal employees, State employees, or who work for a large employer get. And that means if you think about what those organizations do for you, first of all, they purchase at a very low administrative cost. Second of all, they sift through the benefit books and other things and they put fairly easy-to-understand tables and charts together that will help people make choices. They will also make sure that the plans to participate are qualified, have been vetted, adhere to quality standards, and the like.

Torres: Sort of a good seal.

Frank: Exactly. And so, just like Harvard University, in my case, screens out a lot of the plans that aren't that desirable, so will the exchanges sort of help consumers get to the right kind of place and offer them choice and offer them information for making good choices.

Torres: And John, you were saying that your experience with Massachusetts has been a positive one with the exchanges?

O'Brien: Well, I think it has been a positive one with the exchanges, but we still have a number of people who are still unenrolled. And so that is a little bit disturbing, given what we are trying to accomplish here in terms of getting as many people enrolled as possible. Whether it be a paper process, because not everyone has a computer, whether it will actually be ways to enroll via Web, etc., are all strategies that are on the table. But I think for our populations, we are going to have to be a little bit more creative than perhaps a commercial population. Using providers, using consumer advocacy groups, using recovery organizations to get the word out and maybe help people understand what insurance does for them and then understand the process.

Torres: And I really want to come back to all of those consumer issues because there is yet another layer to the ACA, which is the whole issue of electronic records, that I would like to get into. We'll be right back.

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Torres: John, I want to go back to our previous panel dialogue on the difficulty to reach people. What are some positive best practices that we can implement?

O'Brien: There's a few States, and maybe Richard has a little bit more details on that, but there's also Rhode Island, who actually is thinking about using its SOAR program, S-O-A-R program, as a way to be able to think about enrolling individuals. The SOAR program was very helpful in terms of getting people who qualified for Medicaid but weren't enrolled in Medicaid to actually enroll in Medicaid.

Torres: And it's a definitive program where people can call and get assistance and people will talk them through the system?

O'Brien: Yes. And actually even work with them face to face, work with them to walk through the applications, meet them even in the places where they have to complete the applications.

Torres: Very good. Any other best practices, Richard?

Frank: Well, I think the philosophy is trying to meet people where they are. The idea is to recognize that people who are in that under 133 percent of the poverty line who are currently uninsured tend to be single, childless adults. They tend to be very poor. Half of those people are under 50 percent of the poverty line, so they are extremely poor, very often homeless or have unstable housing and, disproportionately, don't necessarily speak English as their first language. So I think what has developed is some strategies to trying to kind of touch these people where you are likely to find them. So you go to shelters, you go to Latino community organizations and you don't just focus on the health and the behavioral health sectors, that you reach out more broadly to the larger social service sector.

Beck: Well, if I may take it a step further. In our State, we are in the process of going through comprehensive training. The front door, again, is often the outpatient and residential treatment programs. The treatment programs don't understand the relationship between the State law, the Parity Act, and the Affordable Health Care Act. So, that is what we are doing is we're going door to door and providing comprehensive training. And I think all States need to do that. There's an awful lot of misinformation out

there. Even the insurers themselves are confused and may misrepresent, inadvertently, what the benefit is. I can't tell you how important this is. It is actually somewhat simpler than one might imagine. People do show up in time of crisis in all of these places. And if our front doors are not thoroughly trained in the interrelationship between all of those laws, it's not going to work. We've got to do this.

Torres: There's a whole notion that we started to talk about, which is the electronic health records. Richard, I want you to address that. Is that primarily being done not only because of the technology is there, but do we stand to save a substantial amount if people begin to allow their records to be exchanged?

Frank: There are a couple of motivations for doing that. First of all, coordinating care, preventing bad medication interactions, preventing errors have been very tightly linked to the ability to sort of organize information and communicate it quickly. So, really, that is I think the jumping off point for the electronic medical record. The fact that it might also save money by avoiding duplication,

etc., is I think also hoped for, and there is sort of some suggestions that that might occur.

But even if it didn't save money, it's an important thing to do based on quality, on preventing mortality, preventing morbidity. The Federal Government started off by focusing really on doctors and acute care hospitals. There is a report to Congress due very soon that will assess what needs to be done to bring long-term care providers, home health agencies, behavioral health providers into that type of program. And so, really, it's being done in multiple waves, just out of the size of the problem.

Torres: And Patrick and Deb, for the consumer, this is going to be mean what?

Beck: Well, we're worried in the drug and alcohol side and grateful for the efforts going on between SAMHSA, Legal Action Center. We are kind of grateful that this is moving slowly, with careful consideration of each wave. Our folks sometimes don't come to help because they are afraid somebody will find out they have a problem, so this has to be handled with extraordinary sensitivity.

Hendry: It's the same thing with the mental health consumer community. There's actually a large division because some people really do see the benefit of having a single health care record that contains all the needed information. But there's also a lot of history behind the mental health consumer movement that has left a lot of people very bitter and not trusting of the system. So we actually, we have many different names that we call ourselves as people who receive mental health services. Some call themselves survivors. And generally when they use the word survivor, they don't mean surviving their mental illness, they mean surviving the mental health system.

So when you have that kind of division, it definitely sets up a problem for getting buy-in to the idea that there is going to be this central record. The other area where it really is going to have a big effect is among returning vets and National Guard and Reserve and on-duty military people because they are so concerned, particularly the people who are still on duty, that if they go someplace for assistance, there is going to be this record there that is going to ruin their career. And so the anonymity part of it is extremely important to them.

Torres: So we have to look for safeguards and we also have to look for a lot of public education of the potential patients as they are going into the system, and we will be talking a little bit about that when we come back.

FS: Before, addiction and depression kept me from living my life. Now, every step I take in recovery benefits everyone. Join the voices for recovery. For information and treatment referral for you or someone you love, call 1-800-662-HELP. That's 1-800-662-4357. Brought to you by the U.S. Department of Health and Human Services.

Torres: John, has does ACA shift this focus into prevention and wellness, and what is that going to mean?

O'Brien: The prevention and wellness is prominently highlighted throughout the Affordable Care Act. There are a number of provisions that I think are worth talking about. Obviously the establishment of the National Prevention Council, which was established, I believe, at the beginning of this year, has a number of people on it that are actually knowledgeable about substance abuse and mental health. There is the Prevention and Public Health Trust Fund, which was started in 2010 at $500 million last year that grows

over the next couple of years to, I believe, $2 billion. Then most recently the Center for Disease Control has just released their community transformation grants that have a fairly significant focus, obviously on prevention, but also prevention of substance use, alcohol use, and tobacco use.

Torres: Very good. And Patrick, what does that mean for the behavioral health care? How do we do prevention in the context of public health within the behavioral health care system?

Hendry: When we talk about prevention and behavioral health, it is almost like we are talking about a different thing to a large degree because we are certainly not talking about preventing people from having an illness. What we are talking about is preventing people going into crisis, generally, and into a deeper end of services. So it's really, really critical that we put a lot of emphasis on prevention and recovery, resiliency-based programs in mental health because the difference in cost and services between somebody coming into a system and receiving the aid they need at the beginning that will help keep them out of the hospitals and the crisis units can be as high as 10 to 1. And we have seen the exact opposite happening with all

the cuts going on on the State levels because they are cutting the front end first. It is easier to cut these recovery-based programs because they know they need to keep those hospital beds. The problem is, every time they do that, they need to keep more hospital beds.

Torres: Deb?

Beck: Also, the untreated alcohol and drug problems drive medical costs in unwanted ways. They just drive up all kinds of health care costs. This illness is so co-occurring with a whole host of very expensive medical conditions. So, once you develop a plan where there is benchmark coverage in every area of insurance—whether it's Medicaid, the exchanges, the group health plans—you are raising the possibility of cutting down on an enormous amount of unwanted health care spending. Just think one fetal alcohol syndrome birth that was preventable.

The ACOA is also sprinkled with screening, early screening, and that's how we get out the population who is currently uninsured is to do the early screening and intervention, catch people's addiction earlier in the disease, and then the benchmark plans provide for the treatment of it. We

should be, if we did this thoroughly, able to cut down on other medical spending. That is major prevention stuff, in my book.

Torres: John?

O'Brien: I think screening is incredibly important. However, I think trying to get primary care professionals to do screening in a way that really allows them to identify substance use or mental health conditions is critically important.

Torres: I know that we have SBIRT, which does a great job of screening patients at every sector of the health care system for mental health and for addiction treatment. There's also another program that we have, which is the community transformation grants. John, do you want to talk a little bit about that and what they will do?

O'Brien: Sure, they were released in May of this year. They are for States and local communities. Their primary focus obviously is on prevention, prevention of a variety of activities. One of those activities is around focus on emotional health. Within the emotional health category,

there are a number of activities that are specifically focused on preventing alcohol use, substance use.

Torres: And just so that we have touched base, let's review some of the places where individuals can go and get help, because there are so many pieces to this. Richard, you were talking about the Office of National Coordinator?

Frank: Yes. Inside of the Department of Health and Human Services there's an office that is in charge of all the health information technology, and they give grants to States, and they have worked with individual providers to sort of really bolster the expansion and the responsible use of health information technology. And they are very sensitive to the issues of behavioral health consumers that were brought up. And so it is really that office, the Office of National Coordinator for Health Information Technology where people should contact with these issues.

Torres: But John, there is also other offices that provide the consumer with information as to how to reach the exchanges, talk about the health homes, talk about all of the other components, correct?

O'Brien: Yes. Out of the Office of the Secretary, out of HHS, there is a Web site, a very good Web site around the Affordable Care Act. It is also being populated now with information that is State specific about what is being covered and insurance companies within those States. SAMHSA also has a Web site on health reform and within that Web site we talk about parity, we talk about the health homes, we talk about the grant opportunities that I just talked about, and a variety of other issues as well.

Torres: And I want to thank you for being here. I want to remind our audience that *National Recovery Month* is every September. Our information package this year is on health care reform issues, so I hope that the leaders in communities take a look at it and organize events and activities around getting information out to the public about the new health care reform and the ACA. Thank you for being here.

[Music]
The *Road to Recovery* Television and Radio series educates the public about the benefits of treatment for substance use and mental health problems as well as recovery programs for individuals, families, and communities. Each program engages a panel of experts in a lively discussion of recovery issues and successful initiatives from across the country.
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