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POLICY SERIES

Behavioral Health and the Individual Health Insurance Market

PRESERVING KEY ELEMENTS OF REFORM

Richard G. Frank, Ph.D. and Sherry A. Glied, Ph.D., M.A.

Spring 2017

Dear Reader,

Now is a time of change in health and human services policy. Many of the changes could have profound implications for behavioral health. This paper is one in a series of papers focused on behavioral health policy, particularly addressing ways to continue to make progress.

The past decade has been a time of steady advances in behavioral health policy. For example, we have met many of the objectives related to expanding health insurance coverage for people with behavioral health conditions. Coverage is now expected to be on a par with that available to individuals with any other health conditions, although parity implementation has encountered roadblocks. Coverage of evidence-based treatments has expanded with insurance, but not all of these services are covered by traditional insurance, necessitating other sources of funding, such as from block grants.

Much has improved; much remains to be accomplished.

As funders, The Thomas Scattergood Behavioral Health Foundation and the Peg's Foundation believe that now more than ever philanthropic support in the area of policy is critical to improving health outcomes for all. We ask that you share this paper and the others in the series with your programmatic partners, local, state, and federal decision makers, advocacy organizations, and voters.

We believe that these papers analyze important issues in behavioral health policy, can inform policy-making, and improve health outcomes. We hope these papers help to extend progress and avoid losing ground at a time of change in policy.

Sincerely,

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Rick Kellar, M.B.A.
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Behavioral Health and the Individual Health Insurance Market

PRESERVING KEY ELEMENTS OF REFORM

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1 Introduction

Since October 2008, Americans who need treatment for mental and substance use disorders have seen dramatic improvements in health insurance coverage and financial security. In that month, Congress enacted and President Bush signed into law the Mental Health Parity and Addictions Equity Act (MHPAEA). A year and a half later, in March 2010, the Affordable Care Act (ACA) became law. In the years since full implementation of the ACA, the availability and scope of coverage for mental and substance use disorder treatments have been further enhanced through regulations. Together the MHPAEA and the ACA affect coverage for well over 170 million Americans (1).

The improvements have been especially significant for people with lower incomes and for those who rely on the individual and small group health insurance markets. As described below, these markets underwent significant changes when the ACA's insurance market regulations were implemented in 2014. Coverage changes have allowed more people to use care and have reduced the number of Americans who bear a heavy financial burden for the costs of treatment for mental or substance use disorders. In December 2016, Congress built on this foundation through enactment of the 21st Century Cures Act, which directs more funding to treatment for mental and substance use disorders. To preserve improvements in health insurance coverage, proposals to change the health insurance market should attend to the key elements of reforms established by the MHPAEA, the ACA, and the 21st Century Cures Act.

In this paper, we focus on private health insurance in the individual and small group markets, where reforms have led to important gains in coverage. We address the features of health insurance policy that are essential to preserve and extend the progress made to date. Continued progress in expanding access to care through private insurance markets and creating financial protections against the costs of care for mental and substance use disorders rests on four foundational elements: coverage subsidies, insurance market regulations, mandates on coverage and benefits, and parity and related consumer protections.

These four key policy elements are interlocking. High healthcare costs in the United States, which lead to high health insurance premiums, make health insurance unaffordable for many American families—and this is particularly true for people

with mental and substance use disorders, who have lower average incomes and incur higher treatment costs (for both general medical and behavioral healthcare) than do people without these disorders. Without adequate subsidies, people with mental and substance use disorders will not be able to purchase coverage. At any given level of subsidy, the affordability of coverage for people with these conditions will depend on rating rules. If insurers are permitted to underwrite coverage, exclude specific conditions, or deny coverage altogether, subsidies will not be sufficient to ensure financial protection. If insurers are permitted to choose which benefits to cover in their plans, many will choose to exclude coverage of costly treatments for mental and substance use disorders to avoid treatment costs and to discourage enrollment by people who incur these costs. If individuals are permitted to choose to buy or forego coverage, people who do not anticipate needing services will remain outside the market. Under these scenarios, subsidies and rating rules will enable people with mental and substance use disorders to enter the market, but the coverage that they will be able to buy will be very costly or incomplete. Policies that create strong incentives for all eligible individuals to purchase insurance that meets specific coverage standards will allow a market-based system to provide coverage that includes mental and substance use disorder treatment at reasonable premiums. However, before recent reforms, insurers restricted the use of these treatments by covering them in ways that were not comparable to coverage for general medical conditions. Parity and other consumer protection rules closed those gaps, so that promised benefits are adequate.

Four Foundational Elements to Expanding Access to Care and Creating Financial Protections:

1 / **Coverage subsidies**
2 / **Insurance market regulations**
3 / **Mandates on coverage and benefits**
4 / **Parity and related consumer protections**

2 The Affordable Care Act and the Individual Market

Coverage Subsidies

Before the ACA, health insurance for mental and substance use disorders offered limited protection and left cost as a barrier to treatment. In 2013, before implementation of the ACA's coverage expansions, 44.3 million Americans under age 65 lacked health insurance (2). Of that group, 39.6 million (89%) were between the ages of 18 and 64, and about 20 million of these uninsured adults had incomes between 139% and 400% of the federal poverty level (FPL), the income bracket that qualifies a person for subsidies in the ACA's health insurance marketplaces.[1] Within that group of uninsured individuals, it is estimated that 29.1% had a mental or substance use disorder.

In addition to people with mental and substance use disorders who were uninsured, many more were underinsured. Before implementation of the ACA's insurance market regulations in 2014, policies sold in the individual health insurance market were typically medically underwritten. Insurance issuers evaluated the health status, medical history, and risks of illness of prospective purchasers. The evaluation results determined whether the individual was permitted to purchase insurance and, if so, under what terms (premiums and coverage exclusions). The conditions that were routinely "declinable" included alcohol and drug use disorders and severe mental disorders (schizophrenia, bipolar disorder, eating disorders, etc.). However, studies found that many insurers also declined people with less severe conditions, including situational depression following the death of a spouse (3). People with pre-existing conditions who were permitted to purchase insurance typically faced underwriting (higher premiums) and coverage exclusions.

1. Estimate based on the authors' tabulations of data from the National Survey on Drug Use and Health, conducted annually by the Substance Abuse and Mental Health Services Administration (SAMHSA).

Another reason for underinsurance was the design of coverage itself. Before the ACA's health insurance marketplaces opened in 2014, most individual market insurers had great flexibility in plan design. Plans sold in the individual market in most states were not required to incorporate any particular benefits. In 2011, as the Department of Health and Human Services developed regulations to implement the essential benefits standard, it surveyed this existing, largely unregulated, non-group market using data submitted by health insurance issuers that represented an estimated one-third of enrollment in the individual health insurance market. Those data showed that about 34% of plans did not include any coverage for substance use disorder treatment, and 18% did not provide any coverage for mental healthcare (3).

Finally, prior to the passage of MHPAEA and its extension to the individual and small group markets under the ACA, most plans that did cover treatment for mental and substance use disorders placed strict limits on the extent of coverage. Such coverage most frequently limited the insured individual to 20 outpatient visits per year and 30 inpatient days. Coverage limits left people with serious illnesses facing substantial financial exposure. Insurance parity became complete only when it was coupled with the requirement that plans cover treatment for mental and substance use disorders. Thus the MHPAEA and the ACA together fundamentally changed how the individual health insurance market covers mental and substance use disorders. They did so through coverage subsidies, rating rules, mandates on coverage and benefits, and parity and related consumer protections.

For individuals with lower incomes, the ACA's coverage subsidies to defray the premium costs of purchasing health insurance are available to those with incomes between 100% and 400% of the FPL who purchase coverage through the health insurance marketplaces (subsidies are not available to those who purchase outside the marketplaces).[2] Subsidies are distributed in the form of an Advance Premium Tax Credit (APTC), a refundable tax credit. The amount of the APTC is based on both the individual's income and the cost of less costly local plans. This type of subsidy design has been referred to as a price-linked subsidy.

2. The lower end of the income eligibility range for premium subsidies varies by state according to whether the state has expanded its Medicaid program under the ACA. Under Medicaid expansion, people with incomes up to 138% of the FPL are eligible for Medicaid. In expansion states, the marketplace subsidy range is 139% to 400% of FPL.

Price-linked subsidies tied to a share of income are advantageous because they protect low-income individuals from most of the consequences of premium increases and thus maintain affordability of health insurance for the lowest cost plans and the second lowest cost silver plans (4). Instead, the risk associated with market-wide premium increases under price-linked subsidies is largely borne by taxpayers and higher-income individuals who do not receive subsidies. Under price-linked subsidies, most individuals do not face increases in premiums caused by a deterioration of the insurance market. Therefore, this subsidy structure has the added advantage of making a so-called death spiral in insurance a near impossibility (5).

Insurance Market Regulations

The second key element of the ACA reforms are regulations in the insurance market, particularly the requirement that insurers offer coverage to all applicants (guaranteed issue) and the prohibition of underwriting, which means that all purchasers can buy coverage at the same prices regardless of their health status. In the absence of subsidies and the mandates described below, these requirements would likely lead prospective insurance purchasers who did not anticipate needing healthcare services to forego purchasing coverage altogether or to purchase coverage that excluded key benefits. The rating requirements in combination with the subsidies ensure that coverage will be affordable even to those with health conditions.

Mandates on Coverage and Benefits

The third key element of expanded access centers on the nature of coverage that individuals must purchase. Unless subsidies cover the full cost of care, those who are least likely to use services will remain outside the market, leading to underinsurance and uncompensated care costs (because everyone carries risks of unexpected accidents and illnesses) and to higher premiums for those who do enter the market. If individuals are permitted to choose the benefits included in their health plans, those who do not anticipate needing behavioral health services (or who view these services as carrying a stigma) will forego purchasing that coverage. Because behavioral health problems are often long-term, chronic conditions, the need for these services may be easier to anticipate than the need for other services. In this case, as well, selection of narrower benefits would leave those who forego benefits vulnerable to underinsurance and uncompensated care costs, because they may unexpectedly develop behavioral health problems. This would raise the cost—or even eliminate the availability—of behavioral health benefits for those who remain in the market, which was often the case prior to 2014. To address these problems, the ACA includes an individual responsibility mandate that requires all Americans who can afford coverage to purchase it or pay a tax penalty. It also specifies a set of ten essential health benefits that all participants in the individual insurance market must purchase. One of the categories of essential benefits is "Mental health and substance use disorder services, including behavioral health treatment." Thus, under the ACA, all Americans must hold coverage and that coverage must include behavioral health benefits.

Parity and Related Consumer Protections

The final element of the package focuses on the extent and management of benefits included in the insurance plan. The most important component of this element is parity. The MHPAEA initially applied to employer-based private health insurance that involved 50 or more employees and to Medicaid managed care plans. The MHPAEA established that financial requirements, such as copays and deductibles, and treatment limitations, such as visit limits and care management provisions (e.g., prior authorization and concurrent review), for coverage of treatment for mental and substance use disorders be no more restrictive than those for medical and surgical benefits. The ACA

extended the MHPAEA provisions to the individual and small group health insurance markets and later, through regulations, to the Medicaid market. As a consequence, cost-sharing arrangements and coverage limits must be comparable for treatments of mental health and substance use disorders and care must be managed in a fashion that applies evidence and clinical processes in a similar fashion. In addition to the MHPAEA's parity requirements, the ACA includes other provisions that constrain the ability of insurers to inappropriately narrow benefits. These include the elimination of annual or lifetime limits on the amount of coverage available, the inclusion of provisions that allow consumers to appeal coverage decisions, and requirements for network adequacy, among others.

3 Continuing the Gains in an Improved Individual Health Insurance Market

The population that has gained access to private insurance coverage through changes in the market since 2014 has a disproportionately high need for mental health and substance abuse services. Among those with incomes between 133% and 400% of the FPL, the prevalence of serious mental illness is estimated at 6%, compared with 4.2% for the nation as a whole, and the prevalence of substance use disorders is estimated at 14.6%, compared with 7.8% for the overall population. About 31% of the population potentially covered by the marketplaces has either a mental or a substance use disorder, compared with about 22% of the general population.[3] In the marketplace-eligible population, limited access to care is in part responsible for an overreliance on the criminal justice system to address the problems of people with mental and substance use disorders (6). Likewise, the alarmingly high rates of death and community disruptions associated with opioid use disorders, alongside the troublingly low rates of treatment for these and other substance use disorders, highlights the reasons for adopting policies that expand access to treatment for these conditions.

The four key elements of recent health reforms have made substantial inroads into reducing the failures of coverage and access described above. Maintaining these gains will require holding fast to all four elements. Elimination of any one of them will likely lead markets to unravel and leave those with critical needs for services uninsured or facing significant financial barriers to care. Without income-linked and price-linked subsidies, most people with serious disorders will be unable to afford coverage and markets will be susceptible to selection spirals. Without restrictions

3. Statistics in this paragraph are based on the authors' tabulations of data from SAMHSA's National Survey on Drug Use and Health. The social and economic consequences of having limited health insurance coverage and, therefore, limited access to care in populations with high rates of illness has become apparent, as evidenced by discussions around the recently enacted *21st Century Cures Act*.

on underwriting and issuance, those with disorders will be barred from coverage. Without requirements on participation and benefits, markets will deteriorate and any available coverage is likely to exclude treatment for mental and substance use disorders. Without further consumer protections, these benefits are likely to prove illusory when people most need them.

Maintaining these gains will require holding fast to all four elements. Elimination of any one of them will likely lead markets to unravel and leave those with critical needs for services uninsured or facing significant financial barriers to care.

These elements, however, are only the foundation of a well-functioning private insurance system. More is needed to widen access and raise the quality of treatment. In the context of private insurance, competition over price and quality is the key to these improvements. To increase such competition in the marketplaces, we will need better metrics for behavioral health quality, so that consumers can assess which plans deliver the best care. We will also need better risk adjustment mechanisms, so that plans that deliver high-quality care—and thus attract more consumers who need mental and substance use disorder treatment—profit from their high performance, rather than losing money by attracting individuals with more costly conditions. Finally, competition requires the participation of multiple health plans. Robust competition among plans provides plans with an incentive to maintain quality. It is also critical to keeping prices in check, especially in the context of price-linked subsidies. Because consumers are quite price sensitive, insurers in competitive markets will face strong incentives to price their plans at a level so that individuals will receive full subsidies, and this price competition will, in turn, protect taxpayers from unwarranted premium increases. In the absence of competition, however, price-linked subsidies can lead plans to stint on quality and raise prices—and leave consumers and taxpayers with no recourse.

In summary, well-regulated, competitive private insurance markets have the potential to serve people with mental and substance use disorders well, but that potential requires active intervention. A foundation of key elements has to be in place to guarantee access and prevent market collapse. In addition, there must be robust competition among plans in the insurance market. In the absence of such competition, private insurance marketplaces will not generate efficient outcomes.

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