

*Silver Linings Playbook:*  
The Affordable Care Act  
and  
Advancing Mental Health

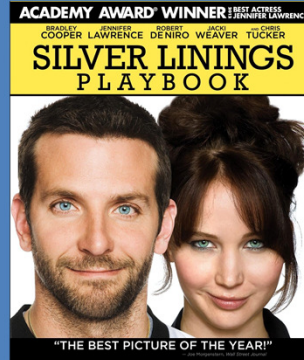
Presentation by Susan Dentzer  
Senior Policy Adviser to the Robert Wood Johnson Foundation  
Mental Health America's 2014 Annual Conference  
September 11, 2014

This Presentation At A Glance

- Why ACA resembles *Silver Linings Playbook*
- Implementation successes to date
- Remaining challenges
- What it all means for mental/behavioral health and care



If you read the book or saw the movie...you know that



Pat Solitano – former patient in psychiatric hospital (a/k/a “the bad place”)– wants to

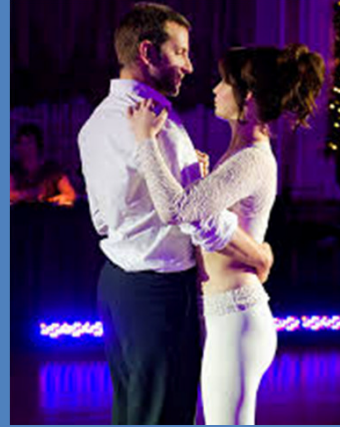
- Be slim and muscular
- Be erudite
- See the Philadelphia Eagles win
- Get his ex-wife Nikki back



“This is what I learned at the hospital. You have to do everything you can, you have to work your hardest, and if you do, you have a shot at a silver lining.”

## Parallels to ACA

- It isn't delusional: We are seeing, and will see, many silver linings come out of ACA implementation
- These include coverage expansion, healthier people, forced change on delivery system, including to become better integrated with mental/behavioral health
- But we shouldn't delude ourselves that there is much more to be done on many counts.



## Silver Lining #1: Coverage Expansion and Insurance Market Reforms



## Coverage Expansion

- In first open enrollment period 2013-2014, **more than 8 million** selected a plan through the federally facilitated Marketplace (healthcare.gov)
- Surveys show about **½ formerly uninsured**
- **3 million** young adults stayed on parents' coverage
- Estimated **7.2 million total** have gained coverage through Medicaid and Children's Health Insurance Program
- Enrollment in marketplaces continued beyond open enrollment period, with **at least 1 million** more people enrolling on exchanges
- Sources: ASPE issue brief; Health Reform Monitoring Survey, "Increase in Medicaid Under the ACA Reduces Uninsurance, According to Early Estimates," June 25, 2014; also "Missed Opportunities: The Consequences of State Decisions Not to Expand Medicaid," Council of Economic Advisers, July 2014; Medicaid & CHIP June 2014 Monthly Applications, Eligibility Determinations, and Enrollment Report, medicaid.gov

## Commonwealth Fund Survey, July 2014

- **Estimated 9.5 million fewer uninsured US adults** after first open enrollment period under ACA
- Uninsured rate of adults ages 19 to 34 fell from 28 percent to 18 percent; **5.7 million fewer younger adults** now uninsured
- **60 percent** of people with newly acquired coverage visited a doctor, hospital or paid for a prescription
- **6 in 10** of those would not have been able to afford care prior to becoming uninsured
- Source: S. R. Collins, P. W. Rasmussen, and M. M. Doty, *Gaining Ground: Americans' Health Insurance Coverage and Access to Care After the Affordable Care Act's First Open Enrollment Period*, The Commonwealth Fund, July 2014.

## Need for Expanded Benefits in Mental Health and Substance Use Coverage

- Prior to coverage expansion, 1 in 4 uninsured adults had a mental health condition, a substance use disorder, or both
- About 1 in 3 people with insurance obtained through individual market had no coverage for substance use disorder services
- About 1 in 5 had no coverage for mental health services, including inpatient crisis intervention and stabilization
- Source: ASPE Issue Brief, "Affordable Care Act Expands Mental Health and Substance Use Disorder Benefits and Federal Parity Protections for 62 Million Americans," at [www.aspe.hhs.gov/health/reports/2013/mental/rb\\_mental.cfm](http://www.aspe.hhs.gov/health/reports/2013/mental/rb_mental.cfm)

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## Consumer Protections Now In Place for All Health Insurance

|  |  |
|--|--|
| <b>Accessibility</b>                     |  |
| Guaranteed issue                         | Requires insurers to accept every individual who applies for coverage. <sup>a,b</sup>  |
| Dependent coverage                       | Requires plans that already provide dependent coverage to make it available until a child turns age 26.  |
| Rescissions                              | Prohibits plans from retroactively cancelling coverage, except in the case of a subscriber's fraud or intentional misrepresentation of material fact, and requires prior notice to the insured.  |
| <b>Affordability</b>                     |  |
| Rating requirements                      | Prohibits health insurance rates to vary based solely on four factors: family composition, geographic area, age, and tobacco use.  |
| <b>Frequency</b>                         |  |
| Preexisting-condition exclusions         | Prohibits insurers from imposing preexisting-condition exclusions with respect to coverage.  |
| Essential health benefits                | Requires coverage of 10 categories of essential benefits: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care. <sup>a,b</sup> |
| Actuarial value                          | Requires plans to meet a minimum actuarial value standard of at least 60 percent of total plan costs, requires plans to meet one of four actuarial value tiers: bronze (60%), silver (70%), gold (80%), or platinum (90%). <sup>a,b</sup>  |
| Annual cost-sharing limits               | Requires insurers to limit annual out-of-pocket costs, including copayments, coinsurance, and deductibles. <sup>a,b</sup>  |
| Annual dollar limits                     | Prohibits annual limits on the dollar value of essential health benefits. <sup>a</sup>   |
| Lifetime dollar limits                   | Prohibits lifetime limits on the dollar value of essential health benefits.  |
| Preventive services without cost-sharing | Requires coverage of specified preventive health services without cost-sharing, such as copayments, coinsurance, and deductibles, when the insured uses an in-network provider. <sup>a</sup>   |
| <b>Transparency</b>                      |  |
| Summary of benefits and coverage         | Requires insurers to provide standardized, easy-to-understand summaries of the benefits, cost-sharing, limitations, and exclusions of a plan; summaries must include specific coverage examples that illustrate how the plan covers common benefits scenarios.   |

source: "Implementing the Affordable Care Act: State Action to Reform the Individual Health Insurance Market". By Justin Giovannelli, Kevin Lucia And Sabrina Corlette, Commonwealth Fund, July 2014 .

## Essential Health Benefits

- Outpatient and inpatient care; emergency services
- Pregnancy-related services
- Mental health and substance use disorder services, including behavioral health treatment, counseling, and psychotherapy
- Prescription drugs; lab tests
- Services and devices to help you recover if you are injured, or have a disability or chronic condition. This includes physical and occupational therapy, speech-language pathology, psychiatric rehabilitation, and more.
- Preventive services including counseling, screenings, vaccines; care for managing a chronic disease
- Pediatric services, including dental

## Parity Extension

- HHS regulations applied federal parity rules (under Mental Health Parity and Addiction Equity Act of 2008) to mental health and substance use disorder benefits included in the Essential Health Benefits
- In effect, meant that all individuals in individual and small-group markets who were not in “grandfathered” plans had mental and substance use benefits comparable to medical/surgical benefits
- Sources: Source: ASPE Issue Brief, “Affordable Care Act Expands Mental Health and Substance Use Disorder Benefits and Federal Parity Protections for 62 Million Americans,” at [www.aspe.gov](http://www.aspe.gov); also, Kaiser Family Foundation 2013 Employer Health Benefits Annual Survey [www.kaiserfamilyfoundationfiles.wordpress.com/2013/08/8465-employer-health-benefits-2013\\_section\\_13.pdf](http://www.kaiserfamilyfoundationfiles.wordpress.com/2013/08/8465-employer-health-benefits-2013_section_13.pdf)

## Who Benefited from ACA: Mental Health and Substance Use Disorder Coverage

|  | Individuals who will gain mental health, substance use disorder, or both benefits under the Affordable Care Act, including federal parity protections | Individuals with existing mental health and substance use disorder benefits who will benefit from federal parity protections | Total individuals who will benefit from federal parity protections as a result of the Affordable Care Act |
|--|---|--|---|
| Individuals currently in individual plans  | 3.9 million   | 7.1 million  | 11 million  |
| Individuals currently in small group plans | 1.2 million   | 23.3 million   | 24.5 million  |
| Individuals currently uninsured            | 27 million  | n/a  | 27 million  |
| <b>Total</b>                               | <b>32.1 million</b>   | <b>30.4 million</b>  | <b>62.5 million</b>   |

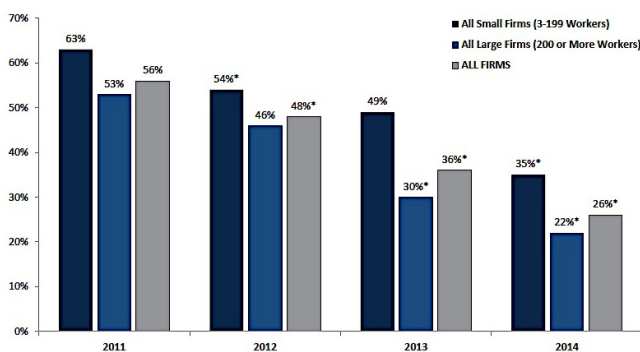
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## Parity Extension

- However - those in “grandfathered” individual or small group plans (below 50 employees) have neither EHB’s nor parity protections
- Most grandfathered plans are expected to be dropped in coming years, but how many remain unknown
- In 2013, for firms with fewer than 50 workers, roughly half of covered workers were in a grandfathered health plan
- Bottom line: for some indeterminate period of time, there will remain thousands of plans out there that neither cover the essential health benefits nor have parity
- Sources: Source: ASPE Issue Brief, “Affordable Care Act Expands Mental Health and Substance Use Disorder Benefits and Federal Parity Protections for 62 Million Americans,” at [www.aspe.gov](http://www.aspe.gov), also, Kaiser Family Foundation 2013 Employer Health Benefits Annual Survey [www.kaiserfamilyfoundationfiles.wordpress.com/2013/08/8465-employer-health-benefits-2013\\_section\\_13.pdf](http://www.kaiserfamilyfoundationfiles.wordpress.com/2013/08/8465-employer-health-benefits-2013_section_13.pdf)

## Grandfathered Plans Dropping in Number

Percentage of Covered Workers Enrolled in Plans Grandfathered Under the Affordable Care Act (ACA), by Firm Size, 2011-2014



\* Estimate is statistically different from estimate for the previous year shown ( $p < .05$ ).  
 NOTE: For definitions of Grandfathered health plans, see the introduction to Section 13.  
 SOURCE: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2011-2014.





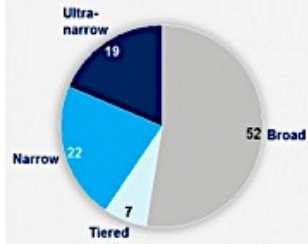
## Broad vs. Narrow Networks

### Consumers are being offered a wide range of network types

#### Distribution of 2014 individual exchange networks by network breadth<sup>1</sup>

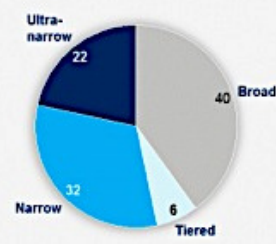
##### Across the U.S.

% of networks across all tiers (n = 2,366)



##### In the largest city of each U.S. state

% of networks across all tiers (n = 309)



SOURCE: McKinsey Center for U.S. Health System Reform/McKinsey Advanced Healthcare Analytics analysis of publicly available rate filings and carrier information, HHS database

Date as of 02/24/2014

<sup>1</sup> Broad networks: more than 70 percent of hospitals within a rating area are participating; narrow networks: 31 to 70 percent of hospitals within a rating area are participating; ultra-narrow networks: 30 percent or less of hospitals within a rating area are participating; tiered networks: narrowing is introduced when the payor puts different hospitals into different tiers with different co-payment requirements.

## Affordability

- Individuals choosing silver plans tended to select the lowest or second-lowest cost plan (65 percent)
- Premium tax credits average **\$4,152**
- Nearly 7 in 10 of individuals who selected a plan with tax credits through the federally facilitated Marketplace have coverage that **costs \$100 or less per month (after credits)**
- Average premium = \$69/month
- Source: ASPE Research Brief, Amy Burke et al, "Premium Affordability, Competition, and Choice in the Health Insurance Marketplace, 2014," June 18, 2014.

## High Cost-Sharing for Consumers in Exchange Plans

- Exchange plans at lower tiers impose high cost-sharing on individuals before they reach their out-of-pocket maximums

|                                       | Silver  |         |         | Bronze  |         |         |
|---------------------------------------|---------|---------|---------|---------|---------|---------|
|                                       | Lowest  | Highest | Average | Lowest  | Highest | Average |
| Deductible                            | \$1,500 | \$5,000 | \$2,550 | \$2,000 | \$6,350 | \$5,150 |
| Pharmacy Coinsurance for Tier 3 and 4 | 10%     | 50%     | 40%     | 20%     | 60%     | 40%     |
| Primary Care Visit                    | \$5     | \$50    | \$30    | \$15    | \$60    | \$39    |

More than double the average deductible in an employer-provided plan

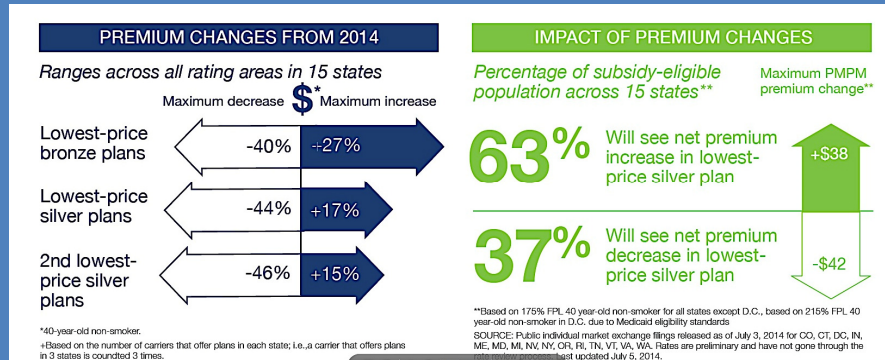
Source: Avalere Health

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## More Affordability Challenges?

- Catastrophic plans also available for people under 30 and people with hardship exemptions
- Premiums may be 20% lower, but deductibles = \$6350 for individuals, \$12,700 for family
- Proposals for "copper" plans to be added to existing four metal tiers of actuarial value; would have even higher deductibles and cost sharing requirements than bronze plans (though subsidies available to those with lower incomes to offset these)

## Preliminary 2014 Open Enrollment Outlook: McKinsey Study



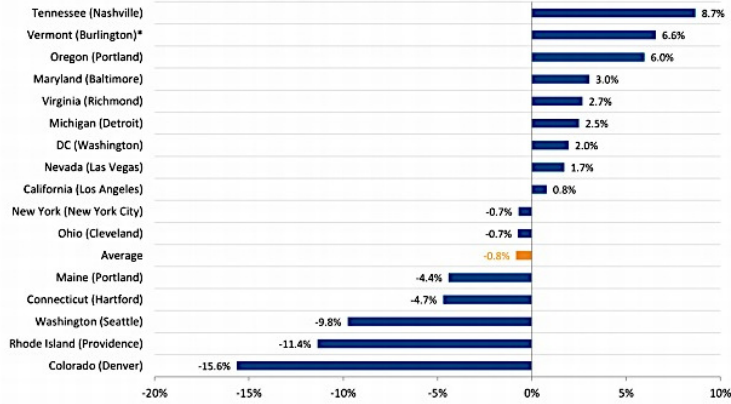
## Premium Changes in 2014-2015: Kaiser Family Foundation Study

- Premium changes for lowest-cost bronze plan and two lowest-cost silver plans in 16 major cities
- Second lowest-cost silver plan is benchmark plan for calculating tax credits; also, people with incomes below 250% of FPL are eligible for cost sharing subsidies only if they enroll in a silver plan
- **In general, individuals will pay slightly less to enroll in the second-lowest cost silver plan in 2015 as they did in 2014**
- Premium changes **vary substantially within and across states**

## Kaiser Study, Premiums in 2014-2015

### Silver Premium Percent Change from 2014 to 2015

Second-lowest-cost silver before tax credits, where 2015 filings are available as of September 3, 2014



Source: Kaiser Family Foundation analysis of insurance company rate filings to state regulators for 2015 Marketplace premiums.

Notes: Vermont rates do not reflect modifications from the state's review (2015 rates were lowered on September 2, but final filings are not yet available). Filings in CA, CO, CT, MD, MI, OH, OR, RI, TN, and most of WA are final; other state's filings are still preliminary and may be subject to change. Premium changes are at the rating area level (groups of neighboring counties) and some plans may not be available in all cities or counties within the rating area.



## Kaiser Family Foundation Study, 2014-2015 Exchange Premiums in Cleveland, OH

| Marketplace Premiums After Tax Credit<br>Ohio Rating Area 11 (Cleveland) |   |                         |  |                         |   |                         |
|--|---|-------------------------|--|-------------------------|---|-------------------------|
|  | Single Adult<br>25 years old<br>\$25,000/year |                         | Family of Four<br>40 year olds & two kids<br>\$60,000/year |                         | Retired Couple<br>60 year olds<br>\$30,000/year |                         |
|  | 2014  | 2015                    | 2014   | 2015                    | 2014  | 2015                    |
| 2nd Lowest Silver Before Tax Credit                                      | \$195   | \$194                   | \$744  | \$739                   | \$1,056   | \$1,048                 |
| Tax Credit Amount  | \$51  | \$51                    | \$335  | \$331                   | \$900   | \$900                   |
| <b>2nd Lowest Silver After Tax Credit</b>                                | <b>\$144</b>                                  | <b>\$143</b><br>(-1.1%) | <b>\$409</b>   | <b>\$407</b><br>(-0.5%) | <b>\$150</b>                                    | <b>\$148</b><br>(-1.5%) |
| Lowest Bronze Before Tax Credit  | \$146   | \$134                   | \$533  | \$383                   | \$787   | \$830                   |
| Lowest Bronze After Tax Credit   | \$94  | \$102<br>(+8.3%)        | \$220  | \$254<br>(+15.3%)       | \$0   | \$0<br>(N/A)            |

\*NOTES: Premiums are at rating area level and insurers are grouped by parent company. Kaiser Permanente exited and four insurers entered in 2015 (Assurant, Coordinated Health, Premier, UnitedHealth).

SOURCE: <http://www.insurance.ohio.gov/Company/Pages/RecordsRequest.aspx>

## Medicaid Cost-Sharing

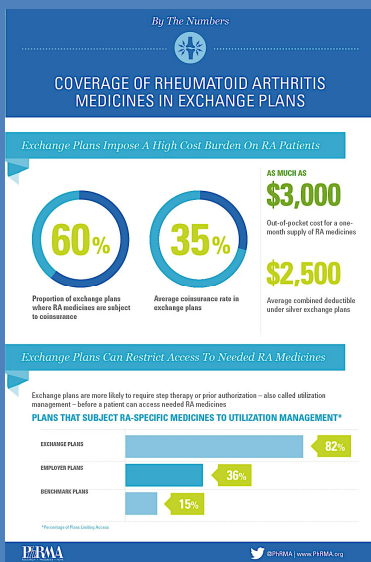
| Updated Medicaid Cost Sharing Rules                           |  |   |   |
|---|--|---|---|
|   | Individuals with Family Income $\leq$ 100% FPL | Individuals with Family Income 101-150% FPL           | Individuals with Family Income >150% FPL                          |
| Outpatient Services (physician visit, physical therapy, etc.) | \$4  | 10% of cost the agency pays                           | 20% of cost the agency pays                                       |
| Inpatient Stay  | \$75   | 10% of total cost the agency pays for the entire stay | 20% of total cost the agency pays for the entire stay             |
| Drugs   |  |   |   |
| Preferred Drugs   | \$4  | \$4   | \$4   |
| Non-Preferred Drugs   | \$8  | \$8   | 20% of cost the agency pays                                       |
| Non-emergency Use of the Emergency Department                 |  |   |   |
| Non-emergency Use of the Emergency Department                 | \$8  | \$8   | Cannot Equal or Exceed the Amount the Agency Pays for the Service |

Source: CMS

## Who Signed Up?

- Many younger adults: Exchange enrollment in a number of states was in younger demographic (18-34 years) – e.g., Washington
- Some sick: Kaiser Family Foundation Survey shows that, among those who signed up for exchange coverage, 1 in 5 rate their health as fair or poor
- “Sick Drawn to New Coverage in Health-Law Plans” - *Wall Street Journal*, June 20 2014
- Enrollees ‘showing higher rates of serious health conditions than other insurance customers, according to an early analysis of medical claims [from Inovalon]...
- ‘Among those health-law marketplace enrollees who have seen a doctor or other health-care provider in the first quarter of this year, around 27% have significant health issues such as diabetes, psychiatric conditions, asthma, heart problems...’

# Concerns about drug coverage



- Milliman Study for PhRMA: Silver plans nearly four times more likely to have a single combined deductible for medical and pharmacy benefits
- Member cost-sharing for pharmacy benefits is 130 percent higher than for typical employer-sponsored plan
- Plans concerned about specialty pharma prices

# What Happened To Those Who Became Covered?

- More adults reported having a personal doctor
- They had fewer had difficulties paying for medical care



THE NEW ENGLAND JOURNAL OF MEDICINE

SPECIAL REPORT

### Health Reform and Changes in Health Insurance Coverage in 2014

Benjamin D. Sommers, M.D., Ph.D., Thomas Mosca, B.B.A., Kenneth Finkelstein, Ph.D., Munira Z. Gupta, M.P.H., Amy Burke, Ph.D., and Audrey M. McDevell, M.S.

**Open enrollment under the Affordable Care Act (ACA), the most ambitious attempt to expand health coverage in the United States in decades, began October 1, 2013. The law offers Medicaid to citizens and qualified legal immigrants with incomes at or below 138% of the federal poverty level in participating states and tax credits for private insurance purchased via marketplace for persons not eligible for Medicaid coverage under the ACA in targeted low-income adults (19 to 40% of the poverty level). The effect of these provisions on insurance coverage and access to care is of critical policy interest.**

**Methods**

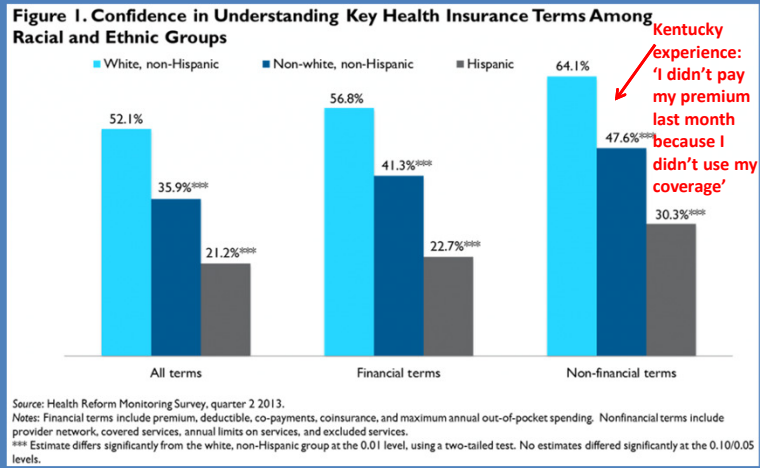
**ANALYTIC APPROACH** We used three approaches to test for associations between the ACA open-enrollment period and coverage changes, using the largest national daily panel on health issues, the Gallup-Healthways Well-Being Index (WBI). First, we assessed coverage changes in the fourth quarter of 2013 and the first two quarters of 2014, using multivariate regression to adjust for the promising trend and potential confounders such as employment, income, and demographic characteristics.

**Second, we tested for differential effects in the subgroups most likely to gain insurance coverage under the ACA. As noted above, the ACA affects all states, however, coverage gains should vary according to income and state decisions regarding Medicaid expansion. Newly available subsidized coverage under the ACA is targeted to low-income adults (19 to 40% of the poverty level) in states expanding Medicaid and middle-income adults (19 to 40% of the poverty level) in all states. Adults with income that is greater than 40% of the poverty level may experience coverage changes due to the routine certification of listed application process for uninsured persons (private plans) and other regulations, but those who were previously eligible for Medicaid's benefits are likely to be similar than for other additional questions in how quickly any coverage gains will lead to improved access to care.**

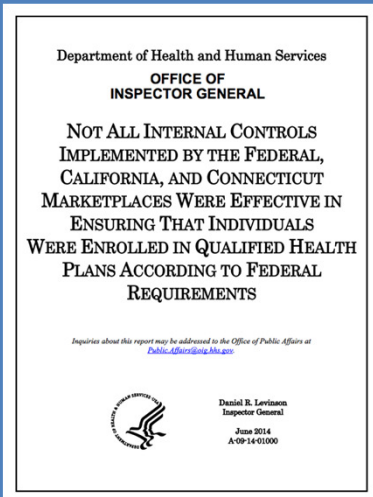
**Third, we tested for an association between survey-reported coverage changes and state-level estimates of enrollment and Medicaid enrollment statistics from the Department of Health and Human Services (HHS). Although 2013 enrollment statistics capture data both on persons who were**

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## Many confused about health insurance



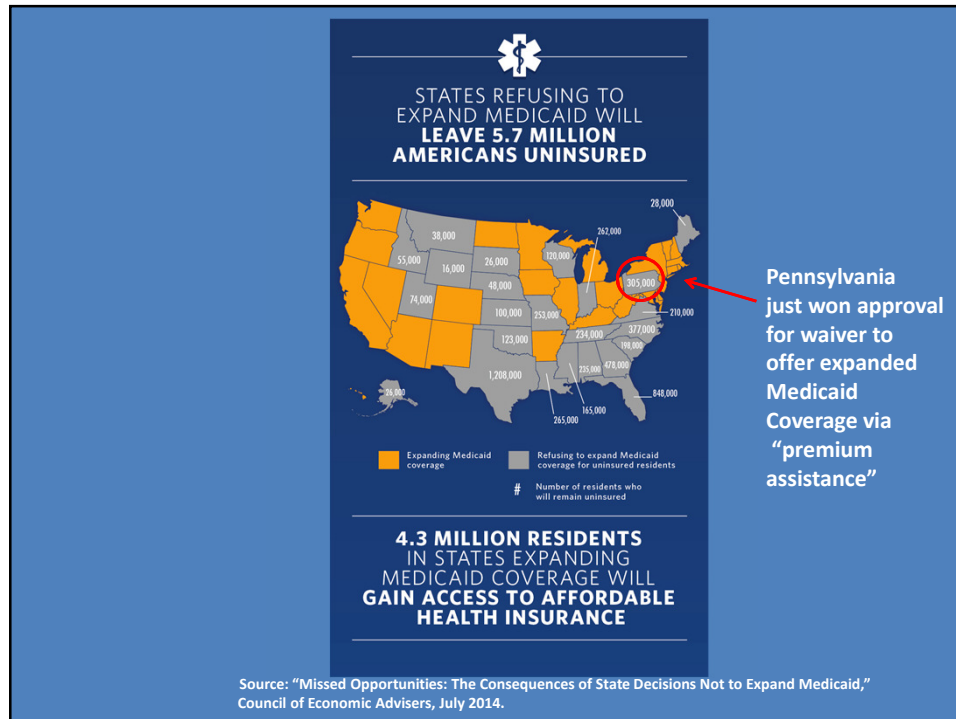
## Problematic sign-ups?



- 89% of inconsistencies (Social Security numbers, e.g.) between data submitted by applicants and that in Federal Data Hub unresolved
- Some internal controls, such as verifying legal presence in US, didn't meet requirements (and some number may have enrolled illegally)

## Coverage Expansion: The Remaining Cloud for the Nation...Medicaid

- In states that had expanded Medicaid by June 2014, Medicaid and CHIP enrollment rose by **more than 18.5 percent** compared to July-September 2013 baseline period
  - In states that did not expand Medicaid, Medicaid and CHIP enrollment rose by **4 percent**
  - Many low-income adults in particular remain uninsured, including in states that expanded Medicaid
- Sources: ASPE issue brief; Health Reform Monitoring Survey, "Increase in Medicaid Under the ACA Reduces Uninsurance, According to Early Estimates," June 25, 2014; also "Missed Opportunities: The Consequences of State Decisions Not to Expand Medicaid," Council of Economic Advisers, July 2014. Also "Medicaid & CHIP June 2014 Monthly Applications, Eligibility Determinations, and Enrollment Report," medicaid.gov

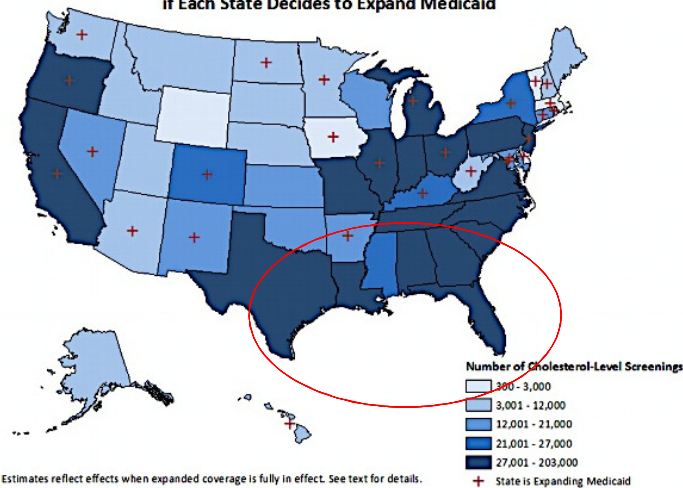




## Medicaid Non-Expansion

- 23 states have so far declined to expand in any way
- Will have passed up \$88 billion in federal funding in 2014-2016
- About 2/3 of uninsured rural residents live in states that have not expanded Medicaid
- Rural individuals more likely to fall into “coverage gap” (below 100% FPL; no access to exchanges and premium subsidies, unlike those at 100-138% of FPL)
- Particularly an issue for residents of Alabama, Mississippi, Maine, South Dakota
- Source: Kaiser Commission on Medicaid and Uninsured May 2014 Issue Brief, “The Affordable Care Act and Insurance Coverage in Rural Areas,” by Vann R. Newkirk II and Anthony Damico.

**Figure 3. Projected Annual Number of Additional Cholesterol-Level Screenings if Each State Decides to Expand Medicaid**



## Medicaid and the Incarcerated

- Roughly 12 million jailed in US annually; **6 in 10 meet criteria for mental illness**
- Estimated **1 in 5 in federal and state prisons** have serious mental illness
- Jails and prisons sometimes the first place they have sustained access to health care
- **About 1 in 3 released from jails** could enroll in Medicaid in expansion states
- About **1 in 5** could enroll in exchange coverage with subsidies



Source: M Regenstein, S Rosenbaum, "What the Affordable Care Act Means for People With Jail Stays," Health Affairs, 33, no. 3, 448-454

## The Remaining Clouds/Concerns

- How many will remain uninsured? Probably at least 20 million, including
  - Those who are exempted from mandate on unaffordability or other grounds
  - The undocumented
- How much care will those with high deductibles and copays be able to afford? Will they need to seek inexpensive or free sources of care?

## The Remaining Clouds/Concerns

- How much access do the newly insured have – particularly to primary care providers?
  - CMS conducting new national survey of adult Medicaid beneficiaries' access beginning in fall 2014
  - HHS has recently announced \$400 million in new funding for community health centers and health clinics
- What will be effect on those In grandfathered health plans who lack access to mental health benefits and parity?

## Silver Lining #2: With Better Access to Care and Shift to Population Health Focus, People May Be Healthier



## Chronic Illness and its Costs

- Chronic diseases (diabetes, cardiovascular, some cancers, etc.) account for 84% of U.S. health care spending
- Chronic illnesses of those under age 65 = 67% of health care spending
- If trauma is added (assault, attempted suicide, motor vehicle accidents), about 80% of total spending is for people under age 65

Source: Moses H et al, "The Anatomy of Health Care in the United States," JAMA

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## Many Aging Baby Boomers Are in Bad Shape

- In 2008, 41 percent of those born between 1946 and 1964 had three or more chronic conditions
- 51 percent had one or two chronic conditions
- Only 8 percent had no chronic conditions
- 72% of men and 67% of women were overweight or obese
- Source: "65+ in the United States: 2010," Current Population Reports, U.S. Census Bureau for National Institutes of Health, by Loraine A. West, Samantha Cole, Daniel Goodkind, and Wan He, June 2014.

## Rising Mortality, Declining Life Expectancy For Many

- Comparison of trends in male and female mortality rates from 1992–96, and from 2002–06, in 3,140 US counties.
- Female mortality rates **increased in 42.8 percent of counties**, while male mortality rates increased in only 3.4 percent.
- Factors associated with areas that had lower mortality: higher education levels; low smoking rates

• Source: DA Kindig, ER Cheng, "Even As Mortality Fell In Most US Counties, Female Mortality Nonetheless Rose In 42.8 Percent Of Counties From 1992 To 2006." *Health Affairs*, March 2013

## Depression and the 65+ Population

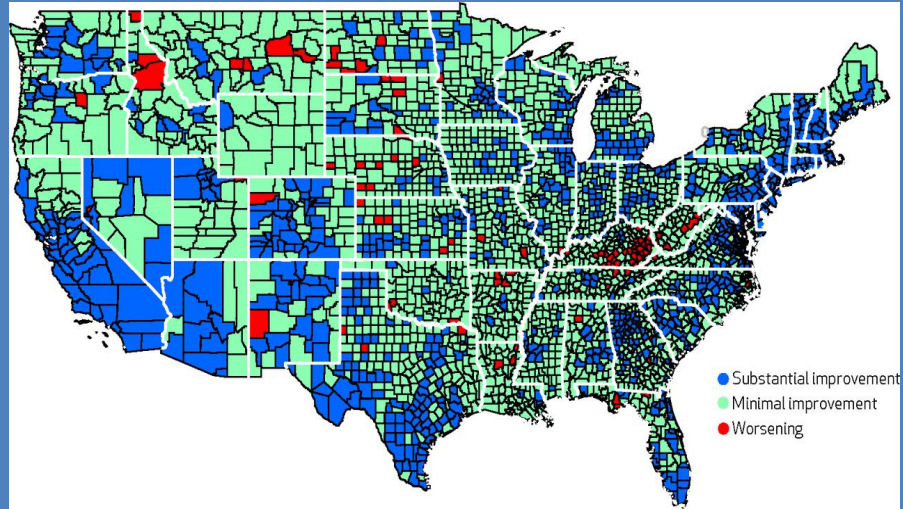
### Percentage of Population Aged 65 and Over With Clinically Relevant Depressive Symptoms by Age and Sex: 2008

| Age group             | Both sexes | Men  | Women |
|-----------------------|------------|------|-------|
| 65 and over . . . . . | 13.6       | 10.7 | 15.7  |
| 65 to 69 . . . . .    | 12.3       | 9.7  | 14.5  |
| 70 to 74 . . . . .    | 11.9       | 9.6  | 13.7  |
| 75 to 79 . . . . .    | 13.8       | 10.1 | 16.5  |
| 80 to 84 . . . . .    | 14.6       | 9.9  | 17.6  |
| 85 and over . . . . . | 18.3       | 18.9 | 17.9  |

Notes: The definition of "clinically relevant depressive symptoms" is four or more symptoms out of a list of eight depressive symptoms from an abbreviated version of the Center of Epidemiological Studies Depression Scale (CES-D) adapted by the Health and Retirement Study (HRS). The CES-D scale is a measure of depressive symptoms and is not to be used as a diagnosis of clinical depression. A detailed explanation concerning the "four or more symptoms" cut-off can be found in the following documentation, <<http://hrsonline.isr.umich.edu/docs/userg/dr-005.pdf>>. Proportions are based on weighted data using the preliminary respondent weight from HRS 2008. The reference population for these data is the civilian noninstitutionalized population.

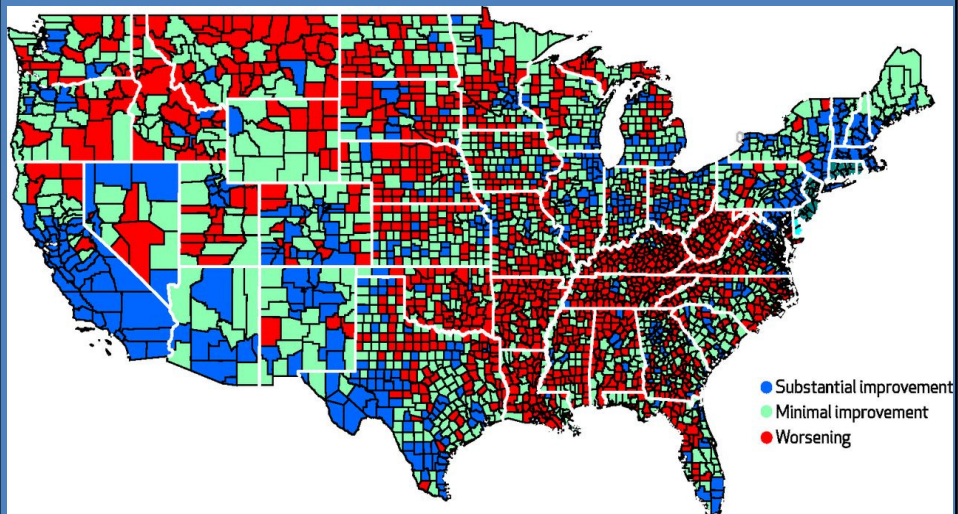
Source: Federal Interagency Forum on Aging-Related Statistics, 2012; Health and Retirement Study, 2008.

### Change In Male Mortality Rates From 1992–96 To 2002–06 In US Counties.



© Kindig D A , and Cheng E R Health Aff 2013;32:451-458

### Change In Female Mortality Rates From 1992–96 To 2002–06 In US Counties



Kindig D A , and Cheng E R Health Aff 2013;32:451-458


## Silver Lining: Growing focus on “population health”

- An approach that treats the entire population – not just of the patients in the hospital, but of the community -- as the “patient.”
- The application of strategies, interventions and policies that address a community’s, region’s or nation’s most pressing health concerns.
- A call for unifying our extremely well funded health care system with our woefully underfunded public health system to address these needs.
- Source: “Population Health Implications of the Affordable Care Act: Workshop Summary” Institute of Medicine, 2013

## Hospitals’ New Roles in Population Health

- New requirements under ACA on tax-exempt hospitals and health systems
- To retain 501(c)(3) [tax exempt] status, organization must conduct a “community health needs assessment” at least every three years
- Must adopt implementation strategy to meet the community health needs identified through the assessment
- Penalty: \$50,000 excise tax for each year that a tax-exempt hospital subject to these provisions fails to satisfy requirement


## Focus on the “Upstream” Determinants of Health



|                      |  |   |
|----------------------|--|---|
| <b>Social Milieu</b> | <ul style="list-style-type: none"> <li>Economic stability</li> <li>Clean air, soil, and water</li> <li>Peace, mutual respect, and equity</li> </ul>                            | <ul style="list-style-type: none"> <li>Appreciation of cultural arts</li> <li>Ease of travel and communications</li> </ul>  |
| <b>Community</b>     | <ul style="list-style-type: none"> <li>Adequate levels of economic and social development</li> <li>Access to quality schools</li> <li>Access to quality health care</li> </ul> | <ul style="list-style-type: none"> <li>Safe, walkable neighborhoods</li> <li>Accessible, affordable, nutritious foods</li> <li>Safe, affordable transportation options</li> </ul> |
| <b>Family</b>        | <ul style="list-style-type: none"> <li>Healthy, supportive relationships</li> <li>Smoke-free living environment</li> <li>Safe and secure shelter</li> </ul>                    | <ul style="list-style-type: none"> <li>Access to nutritious foods</li> <li>Child, elder, and disabled care assistance</li> </ul>  |
| <b>Individual</b>    | <ul style="list-style-type: none"> <li>Active living</li> <li>Nutritious diet</li> <li>Resilient</li> </ul>  | <ul style="list-style-type: none"> <li>Perceives self-worth</li> <li>Practices prevention; avoids harm</li> </ul>   |

Source: Office of Health Equity, California Department of Public Health, 2013

## Silver Lining #3: Law is Forcing Health System Change – And Possibly Moderating Cost Growth and Improving Sustainability of System





## The First-Ever National Quality Strategy

- 1 Make care safer by reducing harm caused in the delivery of care
- 2 Strengthen person and family engagement as partners in their care
- 3 Promote effective communication and coordination of care
- 4 Promote effective prevention and treatment of chronic disease
- 5 Work with communities to promote healthy living
- 6 Make care affordable

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## Goals of Payment and Delivery System Innovation

Improving value and affordability

### Old Model

- Reward unit cost
- Inadequate focus on care efficiency and patient centeredness
- Payment for unproven services; limited alignment with quality

### New Model

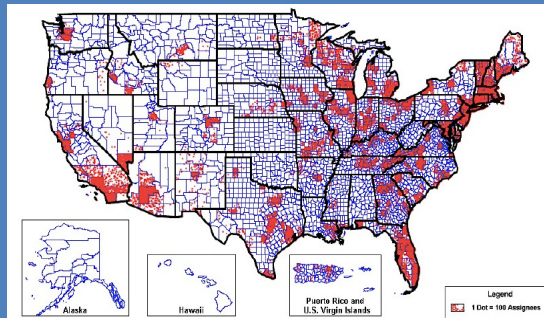
- Reward health outcomes and population health
- Lower cost while improving patient experience
- Improve quality, safety, and evidence

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## Example: Medicare ACOs

Geographic Distribution  
of ACO Population

Estimated 5.5 million Medicare beneficiaries now have care coordinated by 343 Medicare Shared Savings Plan and 32 Pioneer ACOs



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## ACO's in Medicaid

- Underway or about to launch in Alabama, Colorado, Maine, Massachusetts, Minnesota, Oregon, Texas, Utah, and Vermont
- Formation of integrated or collaborative networks
- Promoting integrated care for Medicaid beneficiaries with physical and behavioral health needs

## ACOs Version 2.0

### Opportunities and challenges of a lifelong health system

- Goal of system to optimize health outcomes and lower costs over much longer time horizons
- Payers, including Medicare and Medicaid, increasingly responsible for care for longer periods of time
- Health trajectories modifiable and compounded over time
- Importance of early years of life

Source: Halfon N, Conway PH. The Opportunities and Challenges of a Lifelong Health System. NEJM 2013 Apr 25; 368,17:1569-1571

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## Other Innovations: Banishing the Silos

- Institute of Medicine concluded nearly two decades ago that having separate primary care and behavioral health systems led to worse health outcomes and higher total spending
- By some estimates, as many as 7 in 10 patients **leave medical settings without receiving treatment for their behavioral health conditions**
- Obvious solution: Integration of behavioral health and primary care
- Payment reforms as well as delivery reforms critical



Source: S Klein and M Hostetter, "In Focus: Integrating Behavioral Health and Primary Care," Commonwealth Fund, at [www.cmwf.org](http://www.cmwf.org)

## Integration Innovations: CMS/CMMI

- Testing COMPASS model (for Care Of Mental, Physical, and Substance-Use Syndromes)
- \$18 million demonstration project
- Consortium of health care systems and plans, including Kaiser Permanente Southern California and May Clinic, under Institute for Clinical Systems Improvement (Minnesota)
- Primary Care practice-based care manager meets weekly with a consulting psychiatrist and internist to review care of patients with depression and diabetes and/or coronary artery disease
- Early results: positive outcomes in control of hemoglobin A1C levels and blood pressure
- Source: CMS

## Other Integration Innovations: Dual Eligibles

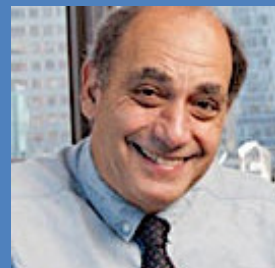
- States testing various ways to integrate care for those eligible for both Medicare and Medicaid (chiefly low-income elderly and disabled)
- One in five duals have high needs for long term services and supports, accounting for about 60 percent of all expenditures and 72 percent of Medicaid expenditures
- Includes individuals with severe physical disabilities, developmental disabilities, serious mental illness; many also clients of state departments of mental health or developmental services or Area Agencies on Aging support networks

## Other Integration Innovations: Dual Eligibles

- Example: Massachusetts' "One Care" program in Medicaid
- Commonwealth Care Alliance in Massachusetts uses social workers and psychologist to conduct behavioral health assessments; provide consultation, education and support to primary care teams
- Care coordinators work with hospitals to help oversee care for patients admitted for mental health/substance abuse treatment

## Story of Mary J.

- Recounted by Bob Master, head of Commonwealth Care Alliance, MA
- Mary J: has cerebral palsy, spastic quadriplegia, severe dysarthria (throat muscle spasticity causing significant speech and swallowing problems), mild intellectual impairments, insulin dependent diabetes and a seizure disorder
- No primary care relationship; frequent hospitalizations for predictable complications, such as pneumonia
- One 14-month stay in a Medicaid-funded post-acute rehabilitation hospital following an episode of pneumonia
- "There are [at least] 1.8 million stories like Mary's out there."





## Integration Innovations

- “Social accountable care organization” – Medicaid demonstration project in Hennepin County, Minnesota (Minneapolis)
- 6,000 enrollees
- 45% have chemical dependencies; 42% have mental health needs
- 32% have unstable housing; 30% suffer from at least two chronic diseases
- Model includes assigning a single care coordinator to each member; also social workers; on-site behavioral health counselors; licensed alcohol and drug counselors; employment counselor

## “Employment Pays” Program, Hennepin Health, Hennepin County, MN



Where does all of this leave us?



### In Summary...ACA Clouds and Silver Linings

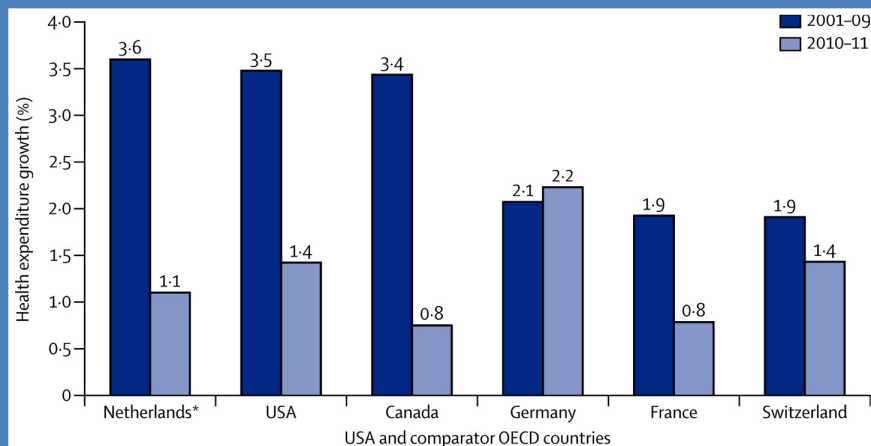
- **Coverage broadened**, but not as much as it could be given Medicaid non-expansion; **essential health benefits** include mental health care and **parity** applies
- Plan premiums **affordable**, although they will rise for some in 2014
- Deductibles and copays for many are high and possibly **unaffordable**; particular problem with pharmaceutical drugs
- Those in **"grandfathered"** small group and individual plans still **lack access to essential health benefits including mental health/substance abuse coverage and not covered by parity**



## In Summary...ACA Clouds and Silver Linings

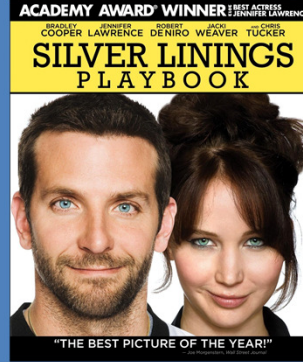
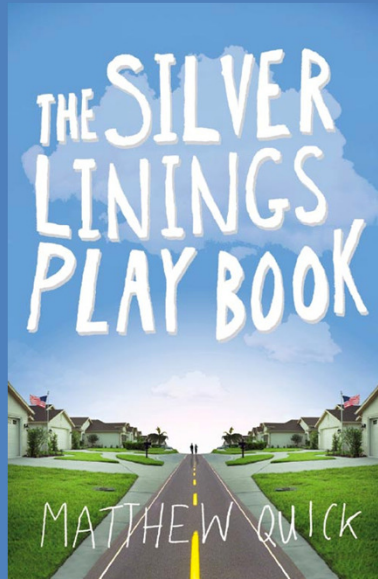
- Delivery system **transforming**, but slowly
- Serious health challenges remain for much of US population; population health approaches beginning to address
- Growing realization that very common **comorbidities** among physical and behavioral health issues driving up costs substantially and resulting in low-value care
- As a result, although community mental health remains fragmented and underfunded, **Integration** of primary care and behavioral health is under way
- **New delivery and payment models focused on outcomes are facilitating transition**

## Impact on Cost?



Source: Lorenzoni L, Belloni A, Sassi F, "Health-care expenditure and Health Policy In the USA versus other high-spending OECD Countries," *The Lancet*, 2014; 384:83-92

To go back to the book and movie...



There are clouds and silver linings...

...And there is you!





GO EAGLES!!!

## Questions or Comments?

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