Health Reform Overview for Human Service Providers

International Community Corrections Association Conference
Reno, NV
September 9, 2013

Jon T. Perez, Ph.D.
Regional Administrator, Region IX
SAMHSA

- One of 11 DHHS Grant making agencies, appx. 550 employees
- SAMHSA’s FY 2011-2012 budget is approximately $3.2 billion*

(*FY 2013 operating on CR)
### SAMHSA Budget

#### FY 2009-2014 Program Level

(Dollars in Millions)

<table>
<thead>
<tr>
<th>Year</th>
<th>Budget Authority</th>
<th>PHS Funds</th>
<th>Prevention Funds</th>
<th>Secretary's Transfer</th>
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<tbody>
<tr>
<td>FY 2009</td>
<td>$3,334</td>
<td>$132</td>
<td>$88</td>
<td>$3,599 M</td>
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<td>FY 2010</td>
<td>$3,431</td>
<td>$132</td>
<td>$132</td>
<td>$3,583 M</td>
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<td>FY 2011</td>
<td>$3,379</td>
<td>$130</td>
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<td>FY 2012*</td>
<td>$3,347</td>
<td>$130</td>
<td>$92</td>
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<td>FY 2013**</td>
<td>$3,172</td>
<td>$130</td>
<td>$38</td>
<td>$3,355 M</td>
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<td>FY 2014</td>
<td>$3,348</td>
<td>$165</td>
<td>$58</td>
<td>$3,572 M***</td>
</tr>
</tbody>
</table>

Total Program Level includes: Budget Authority, PHS Evaluation Funds, and Prevention Funds (PPHF).

*FY 2012 represents Full Year CR post rescission.

**FY 2013 represents Full Year CR less rescission, less sequestration.

***FY 2014 includes $1.5 million in data request and publication user fees.
• Difference between FY 2012 and FY 2013 BA funds is $174 million

• Includes $6 million for .2% rescission and $168 million for 5% sequester cut
SAMHSA’S FY 2014 PRINCIPLES

• Maintain Ratio of SA and MH Funding (~ 70/30)

• Manage Reductions to Avoid Terminations/ Reductions of Existing Awards To Extent Possible

• Maintain Support for SAMHSA’s FY 2011-2014 Strategic Initiatives; Target Available Funding for Top Priorities
Behavioral Health: A National Priority

- SAMHSA’s Mission: Reduce the impact of substance abuse and mental illness on America’s communities

- Behavioral health is essential to health
- Prevention works
- Treatment is effective
- People recover
SAMHSA’S Strategic Initiatives

1. Prevention
2. Trauma and Justice
3. Military Families
4. Recovery Support
5. Health Reform
6. Health Information Technology
7. Data, Outcomes & Quality
8. Public Awareness & Support

AIM: Improving the Nation’s Behavioral Health (1-4)
AIM: Transforming Health Care in America (5-6)
AIM: Achieving Excellence in Operations (7-8)
SAMHSA Core Functions

• Leadership and Voice
• Data/Surveillance
• Practice Improvement -- Technical Assistance, Quality Measures, Evaluation/Services Research
• Public Awareness and Education
• Grant-making
• Regulation and Standard Setting
Regional Administrator Roles

SAMHSA Regional Administrators
Department of Health and Human Services Regions
Substance Abuse and Mental Health Services Administration

Regional Administrators

October 2012
Pacific Region

NORTHERN MARIANA ISLANDS

GUAM

YAP

PALAU

CHUUK

POHNPÉI

KOSRAE

HAWAII

Pacific Ocean

AMERICAN SAMOA
Pacific Region
Regional Administrator Roles

Represent the Administrator in the Region
Regional Administrator Roles

Be a member of regional teams including federal, state, and local interests
Health Reform: Quick Overview
Bending the Cost Curve, Lowering Health Care Growth: Must Address Behavioral Health

- Expanded Coverage to Uninsured
- Prevention & Wellness
- Pay for Outcomes, Not Units
- Better Integrated Care
Health Reform: Impact of the Affordable Care Act

• Focus on **primary care** & coordination w/ specialty care

• Emphasis on **home & community-based services**; less reliance on institutional & residential care (health homes)

• Priority on **prevention** of diseases & promoting **wellness**

• Focus on **quality** rather than quantity of care (HIT, accountable care organizations)

• Behavioral health is included – **parity**
SAMHSA Enrollment Toolkits

- http://tiny.cc/GettingReady (GENERAL)
- http://tiny.cc/CommunityPrevention
- http://tiny.cc/ConsumerPeerFamily
- http://tiny.cc/HomelessServices
- http://tiny.cc/CriminalJustice
- http://tiny.cc/TreatmentProviders
SAMHSA Enrollment Coalition Initiative: Getting Ready for the Health Insurance Marketplace

Criminal Justice Transcript

"Making sure that individuals with mental health and substance use conditions have health care coverage is a major priority for criminal justice agencies and organizations and the Substance Abuse and Mental Health Services Administration (SAMHSA). The new Health Insurance Marketplace will provide opportunities for people without health insurance to sign up for the first time beginning in October 2013 for coverage beginning as soon as January 1, 2014."

SAMHSA has teamed up with national organizations whose members/affiliates interact with potentially eligible individuals and their families. Our goal is to help you let the individuals you serve and community members know about their new health insurance options, explain the benefits of enrolling in one of the new plans, and provide basic assistance in helping them apply and connect them with trained assistants in their communities as needed. This toolkit will provide you with resources to learn more..."
CMS Product Ordering Site

http://productordering.cms.hhs.gov/
If you’re a professional learning about the Marketplace and helping people apply, get the latest resources here.

If you’re a consumer ready to learn about and buy health insurance through the Marketplace, visit HealthCare.gov, the official consumer site for the Marketplace.

Partner with us

Get training

Get official resources

Looking for consumer information?

Have questions?

Join us to become a Champion for Coverage

Find the right answers to your questions.
Marketplaces

HealthCare.gov
Health Reform Websites

- SAMHSA Health Reform Overview
  - http://www.samhsa.gov/HealthReform/ (SAMHSA Health Reform Site)
  - http://www.integration.samhsa.gov/ (Healthcare Integration)
  - http://www.samhsa.gov/healthreform/docs/Financing-Focus-062912.pdf (Financing Focus Newsletter)

- U.S. Department of Health and Human Services Fact Sheets
  Information on state-by-state exchange funding & plans

- CMS Exchange Overview: State Exchange Blueprint

- CMS Resources:
Health Reform Websites

• Kaiser Family Foundation Health Reform Gateway
  • http://healthreform.kff.org/

• National Council for Community Behavioral Healthcare
  • http://mentalhealthcarereform.org/

• Coalition for Whole Health
  • http://www.coalitionforwholehealth.org/resources-for-local-advocates/

• The Bazelon Center for Mental Health Law
  • http://www.bazelon.org/Where-We-Stand/Access-to-Services/Health-Care-Reform.aspx
RECENT CMS GUIDANCE

• CMS Final Rule: Strengthening Medicaid and CHIP and New Health Insurance Marketplace, July 2013

• CMS Guidance: Application of Mental Health Parity to Medicaid and Benchmark Plans, January 2013

• Joint CMS and SAMHSA Informational Bulletin Coverage of Children, Youth and Young Adults, May 2013

• Prevention and Early Identification of Mental Health and Substance Use Conditions, March 2013
Health Reform Websites

Tribal Focus

- IHS
  - http://www.ihs.gov/PublicAffairs/DirCorner/docs/Fact_Sheet.pdf

- NIHB

- NPAIHB
  - http://www.npaihb.org/policy/health_reform_the_indian_health_system/
HEALTH REFORM WEBINARS

• Archived webinars at 
  http://www.samhsa.gov/HealthReform/
  
  • SSA/SMHA series on EHB (archived)
  
  • SSA/SMHA series on eligibility/enrollment (archived)
  
  • Learning collaborative series on EHB (archived and forthcoming)
IN 2014: MILLIONS MORE AMERICANS WILL HAVE HEALTH CARE COVERAGE

Currently, 37.9 million are uninsured <400% FPL*

- 18.0 M – Medicaid expansion eligible
- 19.9 M – ACA exchange eligible**
- 11.019 M (29%) – Have BH condition(s)

* Source: 2010 NSDUH
**Eligible for premium tax credits and not eligible for Medicaid
STATE PREVALENCE OF SMI AMONG MEDICAID EXPANSION POPULATION

Line indicates 95% confidence interval

* Suppressed for imprecision
STATE PREVALENCE OF SUD AMONG MEDICAID EXPANSION POPULATION

Line indicates 95% confidence interval
STATE PREVALENCE OF SMI AMONG EXCHANGE POPULATION

Line indicates 95% confidence interval
All 50 states can be found at:

PREVALENCE OF BH CO-MORBIDITIES
(MEDICAID-ONLY BENEFICIARIES W/DISABILITIES)

MEDICARE BENEFICIARIES AGE 65+ WITH SMI AND SUD HAD SIGNIFICANTLY HIGHER MEDICARE SPENDING

Relative Per Capita Medicare Parts A and B Spending For Medicare Beneficiaries Aged 65+, By Number of Chronic Conditions and Severe Mental Illness Status\(^1\), 2010

- All Beneficiaries Aged 65+: 0.89
- 0-1 Chronic Conditions: 2.78
- 2-3 Chronic Conditions: 5.06
- 4+ Chronic Conditions: 7.18

Dotted line represents average Medicare spending for all beneficiaries age 65 and over

Note: Spending is expressed as a multiple of the average Medicare spending for all beneficiaries aged 65+ with and without severe mental illness (SMI). Medicare Part A and B spending includes inpatient and outpatient hospital services, physician visits, home health, skilled nursing facility, durable medical equipment, hospice, and misc. services.

\(^1\) N = 22,166,860 Medicare beneficiaries age 65 and over without SMI, 1,356,980 with SMI, and 12,100 with both SMI and substance use disorder.
Clarifying Multimorbidity for Medicaid Programs to Improve Targeting and Delivering Clinical Services. Presented to SAMHSA, Rockville, MD.
Importance of Integration: BH Impact on Physical Health

- MH problems increase risk for physical health problems & SUDs increase risk for chronic disease, sexually transmitted diseases, HIV/AIDS, and mental illness.

- People with M/SUDs are nearly 2x as likely as general population to die prematurely, often of preventable or treatable causes.

- Cost of treating common diseases higher when a patient has untreated BH problems:
  - Hypertension – 2x the cost
  - Coronary heart disease – 3x the cost
  - Diabetes – over 4x the cost

- M/SUDs rank among top 5 diagnoses associated with 30-day readmission; one in five of all Medicaid readmissions:
  - 12.4 percent for MD
  - 9.3 percent for SUD

Individual Costs of Diabetes Treatment for Patients Per Year

- With behavioral health problems and diabetes
- With diabetes alone

SAMHSA
Mental and substance use disorders rank among top five diagnoses associated with 30-day readmissions, accounting for about one in five of all Medicaid readmissions.
Primary Care and Specialty Coordination—

- 20% of Medicare and Medicaid patients are readmitted within 30 days after a hospital discharge
- Lack of coordination in “handoffs” from hospital is a particular problem
- More than half of these readmitted patients have not seen their physician between discharge and readmission
- Most FQHCs and BH Providers don’t have a relationship
SAMHSA’S HEALTH REFORM FOCUS – 2012 & 2013

- Uniform Block Grant Application 2014-2015
- *Essential Benefits & Qualified Health Plans*
- Enrollment
- *Provider capacity development*
  - Workforce
- Parity
  - MHPAEA/ACA Implementation & Communication
- Continuing Work with Medicaid
  - Health homes, rules/regs, service definitions and evidence, screening, prevention, and PBHCI
  - Quality and Data (including HIT)
Next Steps SAMHSA

➔ Essential Benefits, Enrollment
➔ National Center for Innovation and Financing
➔ Uniform Block Grant Application – TA to states
➔ Service definitions w/ Medicaid (health homes, rules/regs, good and modern services, screening, prevention) and Medicare (dually eligible populations, annual wellness visit)
➔ Primary/Behavioral Health integration
Mental Health Parity and Addiction Equity Act of 2008 and ACA

- Requires group health insurance plans (those with 50 or more insured employees) that offer coverage for MH/SUD to provide those benefits in a way that is no more restrictive than all other medical and surgical procedures covered by the plan.

- DOES NOT require group health plans to cover MH/SUD benefits.

- Parity extended in 2014 through the Affordable Care Act for plans sold through the Affordable Health Exchanges
ESSENTIAL HEALTH BENEFITS (EHB)
10 BENEFIT CATEGORIES

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
Prevention

- **No-cost preventive services for new plans or plans started after September 23, 2010**
  - Includes behavioral health services such as depression screening, alcohol misuse, alcohol and drug screenings for adolescents, and behavioral assessments for children of all ages
- **Community Transformation Grants**
  - Focus on chronic disease prevention
  - 35 grants to implement proven interventions to help improve health and wellness
  - 26 grantees to build capacity by laying a solid foundation for sustainable community prevention efforts
- **National Prevention Strategy**
  - 4 Strategic Directions
    - Healthy and Safe Community Environments
    - Clinical and Community Preventive Services
    - Empowered People
    - Elimination of Health Disparities
  - 7 Priorities – Aimed at Addressing the Leading Causes of Death
    - Tobacco Free Living
    - Alcohol and Other Drug Abuse
    - Mental and Emotional Wellbeing
    - Injury and Violence Free Living
    - Sexual Health
    - Healthy Eating
    - Active Living
- Need Partners in Prevention to Make this Successful
Health Reform: New Opportunities for Prevention

- More people will have insurance coverage.
- Theme: Prevent diseases, promote wellness.
- Integrated care: New thinking—recovery, wellness, role of peers, response to whole health needs.
- Medicare and Medicaid changes.
- Opportunities for behavioral health:
  - Parity: Mental Health Parity and Addiction Equality Act and within Affordable Care Act
  - Tribal Law and Order Act
  - National Action Alliance for Suicide Prevention
DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland  21244-1850

Center for Medicaid and CHIP Services

SMD# 13-002
ACA #25

RE: Affordable Care Act Section 4106
(Preventive Services)

February 1, 2013

Dear State Medicaid Director:

This letter provides guidance to states on section 4106 of the Affordable Care Act. Section 4106(b) establishes a one percentage point increase in the federal medical assistance percentage (FMAP) effective January 1, 2013, for the provision of preventive services identified...

US Preventive Services Task Force
Prevention Recommendations

http://www.uspreventiveservicestaskforce.org/recommendations.htm
State Implementation of Medicaid Expansion

- In June 2012, the Supreme Court held that a state may not lose Federal funding for its existing Medicaid program when it does not implement the Medicaid eligibility expansion.
- States that implement the Medicaid expansion will receive 100% federal funding for the cost of the expansion from 2014-2016, and at least 90% after that.
- There is no deadline for States to decide whether to expand, and many States are still deciding.

  - Individuals with incomes less than 100% FPL who reside in a state that does not implement Medicaid expansion will not be subject to the Shared Responsibility Payment (i.e., tax penalty for not having insurance).
Role of States in Affordable Care Act Implementation

**General**

- Role as payer expanding
- Role in preparing state Medicaid programs now for expansion in 2014 (enrollment, benefit plans, payments, etc.)
- Role in HIT is expanding
- Role in high risk pools unfolding
- Role in insurance exchanges unfolding through HHS
- Role in evaluating state insurance markets and weighing against possible benefits of new exchanges
Role of States in Affordable Care Act Implementation

State substance abuse and mental health agencies

- New kind of leadership required with and by state agencies – (Medicaid, insurance commissioner, HIT coordinator)
- Change in use of block grant dollars (moving demos to practice)
- Supporting communities selected for discretionary grants
Eligible individuals are those with chronic conditions, meaning an individual who is eligible for medical assistance under the state plan or under a waiver of such plan and has at least

- 2 chronic conditions; or
- 1 chronic condition and is at risk of having a second chronic condition; or
- 1 serious and persistent mental health condition

Chronic conditions must include:

- A mental health condition
- A substance use disorder
- Asthma
- Diabetes
- Heart disease
- Being overweight, as evidenced by having a BMI > 25
Substance Abuse and Mental Health Block Grants

- State systems for procurement, contract management, financial reporting and audit vary significantly
- SAMHSA expects states to implement policies and procedures to ensure that block grant funds are used for four purposes: fund priority treatment and support services for individuals without insurance or for whom coverage is terminated for short periods of time
  - Fund priority treatment and support services not covered by Medicaid, Medicare or private insurance for low income individuals and that demonstrate success in improving outcomes and/or supporting recovery
  - Fund primary prevention—universal, selective and indicated prevention activities and services for persons not identified as needing treatment
  - (to collect performance and outcome data to determine the ongoing effectiveness of behavioral health promotion, treatment and recovery support services and to plan the implementation of new services nationwide)
Technical Assistance Centers:
  - *Addiction Technology Transfer Centers (ATTCs)*
  - *Centers for the Application of Prevention Technology (CAPTs)*
  - *Variety of Specialty Centers*
    - NACE, BRSS TACS, Suicide Prevention, etc.
FOCUS: PROVIDERS

SAMHSA Provider Training and Technical Assistance Topics for 2013

- Business strategy under health reform
- Third-party contract negotiation
- Third-party billing and compliance
- Eligibility determinations and enrollment assistance
- HIT adoption to meaningful use standards
- Targeting high-risk providers
Role of Providers

- Develop partnerships with primary care and other specialty care systems—identify what roles they can play in or as medical homes

- Improve their infrastructure
  - *Operations (e.g. billing)*
  - *Electronic health records*
  - *Compliance*

- Developing a competent workforce including use of peers or recovery coaches
Two New Acronyms: QHPs & ECPs

- **QHPs**: Qualified Health Plans – those private health insurance plans that are approved to be sold through a Marketplace.

- **ECPs**: Essential Community Providers – A term used in the ACA to denote providers that serve predominately low-income, medically underserved individuals, such as:
  - *Health care providers defined in Section 340B of the Public Health Service Act and Section 1927(c)(1)(D)(i)(IV) of the Social Security Act*
  - This includes many traditional HRSA providers, including Federally Qualified Health Centers, Ryan White HIV/AIDS providers, critical access hospitals, etc.
Increased Competition for Insured Patients

- When previously-uninsured patients become insured, they will become more attractive to other providers.
- Primary care providers may also face increased competition for **current** Medicaid patients:
  - *Medicaid payments rates for primary care increased significantly (to Medicare levels) for 2013 & 2014, making these patients more attractive to other providers.*
  - *These increases apply to all Medicaid patients, not just those who gain Medicaid in 2014.*
Ensuring that Newly Insured Patients Can Stay with their Current Providers

- Newly-insured patients may join plans that have a specific provider network.
- To ensure that patients have the option to stay with their current provider:
  - *Providers must participate in the networks of the health insurance plans their patients will enroll in (both QHPs & Medicaid managed care plans.)*
  - *Patients should understand that their new insurance may have a specific provider network.*
Insurers are NOT Required to Contract with all Safety Net Providers

- Neither QHPs nor Medicaid managed care plans are required to include all safety net providers in their networks.

- The ACA and implementing regulations require QHPs to include “a sufficient number and geographic distribution of essential community providers, where available, to ensure reasonable and timely access to a broad range of ECPs.”
Changes in how Health Care is Paid for & Delivered
(aka “Payment and Delivery Reform”)

• Health insurers throughout the country – both public and private – are seeking to change the way that health care is paid for and delivered.

• The goals are to:
  • *shift from paying for volume to paying for outcomes*, and
  • *improve care coordination*,
  • *thereby reducing costs and improving quality*.

• *Most of these changes are voluntary & small-scale, but they are spreading rapidly.*
Examples of Payment & Delivery Reforms

- These efforts are taking many forms, such as:
  - *Medicaid* moving additional populations into managed care (e.g., elderly, disabled, homeless)
  - *Primary care* medical homes
  - *Accountable Care Organizations*
  - *Bundled payments*
  - *Global payments*
• Currently undertaking a comprehensive review of code-pairs that can support integration & same-day billing
• Expected outcome: coding/billing information scenarios supporting integration for both Medicare and Medicaid
• Results will:
  • Support use in Medicare
  • Be essential information for provider billing education component
  • Provide basis for dialogue w/ Medicaid programs on allowing specific code pairs
NASADAD Billing Code Reference List

CPT Prevention Code Guide

APPROVED HCPCS AND CPT CODES AND MODIFIERS RELATING TO SUBSTANCE ABUSE TREATMENT, MENTAL HEALTH, AND BEHAVIORAL HEALTH (2005)

Heightened Focus on Program Integrity (aka Fraud and Abuse)

- CMS, States, and private insurers are becoming increasingly active in identifying improper payments.
- It continues to be critically important that providers ensure they are in full compliance with all requirements.
Next Steps Providers/Care Systems

• Be at the table in State EHB Benchmark conversation
• Understand the Marketplaces
• Translate Eligibility into a Consumer-Friendly Environment
• Assure MH/SUD Service Capacity
• Promote Ongoing Service Innovation
The Time to Reach Out to Health Plans is NOW

- QHPs to be offered for 2014 will be asked to finalize their networks within the next several months.

- So providers may want to reach out to health plans now if they want to get into their networks for 2014.
Technical Assistance Center: SAMHSA/HRSA Center for Integrated Health Solutions (CIHS)

In partnership with HHS/Health Resources and Services Administration (HRSA)

- **Goal:** To promote the planning and development of integrated primary and behavioral health care for those with SMI, addiction disorders and/or individuals with SMI and a co-occurring substance use disorder, whether seen in specialty mental health or primary care safety net provider settings across the country.

- **Purpose:**
  - To serve as a national training and technical assistance center on the bidirectional integration of primary and behavioral health care and related workforce development.

[www.centerforintegratedhealthsolutions.org](http://www.centerforintegratedhealthsolutions.org)
Primary and Behavioral Health Care Integration

- Improve the physical health of people with SMI by supporting communities to coordinate and integrate primary care services into publicly funded behavioral health settings
- Grantees will form partnerships to develop or expand their offerings with primary health care services for people with SMI, thus improving overall health status
- Eligible applicants comprise community behavioral health agencies in partnership with primary care providers
FOCUS: WORKFORCE CHALLENGES

- Worker shortages and distribution
- More than one-half of BH workforce is over age 50
- Between 70 to 90 percent of BH workforce is white
- Inadequately and inconsistently trained workers
- Education/training programs not reflecting current research base
- Billing involves increasing licensing & credentialing requirements
- High levels of turnover
- Difficulties recruiting people to field – esp., from minority communities
- Inadequate compensation
- Poorly defined career pathways
Marketing and Outreach

- Motivate people through information by trusted sources that access to insurance, benefits and services is available to them;
- Disseminate information through appropriate channels using appropriate tools; and
- Provide one-on-one assistance for enrollment through defined intermediaries.
FOCUS: ENROLLMENT ACTIVITIES

Consumer Enrollment Assistance (thru BRSS TACS)
- Outreach/public education
- Enrollment/re-determination assistance
- Plan comparison and selection
- Grievance procedures
- Eligibility/enrollment communication materials

Enrollment Assistance Best Practices TA – Toolkits

Communication Strategy – Message Testing, Outreach to Stakeholder Groups, Webinars/Training Opportunities
The Health Insurance Marketplace

- To provide individuals and small businesses
  - Access to affordable insurance options
  - Ability to buy certain private health insurance
  - Access to health insurance information

- Allows apples-to-apples comparison of Qualified Health Plans
How the Marketplace Works

- Coverage to fit individual needs
  - May get a break on costs through a new premium tax credit
    - Advance payment of the premium tax credit to the health plan to help lower your monthly premium
- Unbiased help and customer support provided
- Quality health coverage that meets minimum standards
- Easy to use
Eligibility and Enrollment

- Marketplace eligibility requires you
  - Live in its service area, and
  - Be a U.S. citizen or national, or
  - Be a non-citizen who is lawfully present in the U.S. for the entire period for which enrollment is sought
  - Not be incarcerated
Who’s Eligible for Help Paying for Insurance through the Marketplace?

• To be eligible for premium tax credits and cost-sharing reductions for insurance obtained through the Marketplace, a person may not:
  • be eligible for certain government-sponsored programs (e.g., Medicaid, CHIP, Medicare, TRICARE, etc.)
  • be able to get affordable, minimum value coverage at work (defined as coverage for which the employee’s contribution for an individual policy is less than 9.5% of income, and which has at least a 60% actuarial value); or
  • be eligible for any other coverage that qualifies as “minimum essential coverage” under IRC 5000A(f) (other than coverage in the individual market).
Health Insurance Marketplaces (aka Exchanges)

- By October 1, 2013, every State will have a Marketplace where eligible individuals and small businesses can shop for and purchase private health insurance plans.

- Some Marketplaces will be operated by the Federal government, some by the State, and some via a Federal-State partnership.

- All citizens and lawfully present non-citizens (except the incarcerated) can purchase insurance through the Marketplace.
  - A person cannot be denied due to health status.
When You Can Enroll

- Marketplace Initial Open Enrollment Period Starts October 1, 2013 and ends March 31, 2014
- Annual Open Enrollment Periods after that start on October 15 and ends on December 7
- Special Enrollment Periods available in certain circumstances during the year
Enrollment Assistance

- Help available in each Marketplace
  - Toll-free call center
  - Website
  - Navigator program
  - Enrollment counselors
  - In-Person Asssistors
  - Community-based organizations
  - Agents and brokers (state’s decision)
SAMHSA Enrollment Toolkits Redux

- [http://tiny.cc/GettingReady](http://tiny.cc/GettingReady) (GENERAL)
- [http://tiny.cc/CommunityPrevention](http://tiny.cc/CommunityPrevention)
- [http://tiny.cc/ConsumerPeerFamily](http://tiny.cc/ConsumerPeerFamily)
- [http://tiny.cc/HomelessServices](http://tiny.cc/HomelessServices)
- [http://tiny.cc/CriminalJustice](http://tiny.cc/CriminalJustice)
- [http://tiny.cc/TreatmentProviders](http://tiny.cc/TreatmentProviders)
# Who is Eligible for What?

<table>
<thead>
<tr>
<th>Income level % FPL</th>
<th>For Medicaid?</th>
<th>Eligible: To purchase insurance through Marketplaces?</th>
<th>For insurance purchased through the Marketplace:</th>
<th>Premium Tax Credits</th>
<th>Reduced cost-sharing</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 to 100%</td>
<td>Currently eligible people will generally remain eligible. Individuals with incomes up to 138% FPL will be able to enroll in Medicaid in states that implement Medicaid expansion</td>
<td>Yes</td>
<td>No (Exception: legal immigrants)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>100% - 138%</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes*</td>
<td></td>
</tr>
<tr>
<td>138% - 250%</td>
<td>Generally not (although some States cover some individuals)</td>
<td>Yes</td>
<td>Yes*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>250% - 400%</td>
<td>No</td>
<td>Yes</td>
<td>Yes*</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Above 400%</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Not lawfully present</td>
<td>No (except emergency Medicaid)</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
</tbody>
</table>
Eligible patients would likely benefit from help with:

- **Accessing the eligibility and enrollment system**
  - Individuals can apply online, by phone, by mail, or in-person.
  - Each Marketplace will have assistance programs, including Marketplace Navigators who can help consumers through the enrollment process.
- **Working their way through the application.**

- **Understanding and evaluating factors they should consider when selecting a plan. For example:**
  - Does it cover the Rx I need?
  - Does it include the provider(s) I want to see?
Providers May Want to Focus on Educating & Enrolling their Patients in Insurance

To ensure that their eligible patients can appropriately benefit from these new coverage opportunities, safety net providers may want to:

• **Educate** their patients about their new options, how insurance works, the benefits of having insurance, etc., and

• **Assist** patients with applying for and enrolling in these programs.
Educating Patients about New Health Coverage Options

- **What the options are**: Many individuals who stand to benefit under the 2014 provisions are not aware of their options.
  - A recent study* found that:
    - Among uninsured Americans who are likely to qualify for help paying for coverage through the Marketplace, only 22% were aware of the financial assistance available.
    - Among those likely to qualify for Medicaid under the expansion, only 17% were aware of this possibility.
- **How insurance works**: Many newly-eligible individuals would benefit from education on how insurance works (e.g., how cost-sharing works, how provider networks function, and how insurance may benefit them.)

* Poll by Lake Research Partners, Fall 2012 – available at www.enrollamerica.org
Some Patients Will Still Have Challenges Accessing Coverage

Once these new opportunities are in effect, CBO estimates that there will still be up to 30 million uninsured across the U.S in 2022. They will include:

- Persons who do not have an “affordable” insurance option available to them;
- Persons who choose not to have insurance, either because they are exempted (e.g., members of an Indian Tribe, those with religious objections) or they choose to pay the Shared Responsibility Payment;
- Individuals who are not lawfully present
Need more information about the Health Insurance Marketplace?

- Sign up to get email and text alerts at signup.healthcare.gov
- Updates and resources for partner organizations are available at Marketplace.cms.gov/
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Contact Information

Jon T. Perez, Ph.D.
Regional Administrator, HHS IX
Substance Abuse and Mental Health Services Administration
90 Seventh Street, 8th Floor
San Francisco, CA 94103
415 437 7600
jon.perez@samhsa.hhs.gov