The Affordable Care Act and Mental Health Services

The Patient Protection and Affordable Care Act, more commonly known as the Affordable Care Act (ACA), was enacted by the 111th U.S. Congress and signed into law by President Barack Obama on March 23, 2010. It is a heavily debated and controversial law aimed at expanding health care coverage and access for millions of uninsured or underinsured Americans. Its goals include increasing the quality and affordability of health care by setting minimum standards for public and private insurers to offer basic insurance plans at comparable costs for comparable coverages. Most of its major provisions were implemented by January 2014; others will be phased in by 2020 (Table).

PUBLIC OPINION

Polls indicate that U.S. citizens generally support health care reform, and some Americans believe the ACA did not go far enough (Barry & Huskamp, 2011). Provisions, such as guaranteed issue for pre-existing conditions and continued coverage for children until age 26, are popular regardless of party affiliation. Other provisions, particularly individual and employer mandates, which require purchase of health care insurance, are widely opposed by conservative groups. Many supporters of the law believe that the ACA will become more popular as benefits of the law take effect, closing the current gaps in health care access and affordability.

MENTAL HEALTH PARITY

Parity means that individuals with mental health illness or substance abuse will receive insurance benefits equivalent to those provided for physical disease or injury (Roll, Kennedy, Tran, & Howell, 2013). The ACA expands these benefits and parity protections to 62 million Americans, helping make mental health care accessible and affordable (Frank, Beronio, & Glied, 2014). Parity legitimizes depression, schizophrenia, and substance abuse as illnesses requiring reasonable treatment and follow up. Previous legislation intended to address parity included the Mental Health Parity Act, which was signed into law by President Bill Clinton on September 26, 1996, and the Mental Health Parity and Addiction Equity Act (2008), which was enacted during the George W. Bush administration. However, neither of these laws met their intended aims. Insurers circumvented parity protections by imposing maximum outpatient visits and coverage capitations for inpatient care. New parity regulations guarantee that cost sharing and service limits must be the same for physical and mental illnesses. Under the ACA, insurers are required to charge similar deductibles and copayments for mental health treatment, refrain from applying more stringent preauthorization rules, and stop limiting the number of provider visits or hospital days (Barry & Huskamp, 2011).

MEDICAID EXPANSION

Medicaid is the primary source through which low-income individuals receive mental health care, and its cost is shared by federal and state governments. By gaining Medicaid coverage, formerly uninsured individuals become healthier (Hill, Abdus, Hudson, & Seldon, 2014). One way the ACA aimed to increase the number of low-income Americans who are insured was by expanding Medicaid eligibility nationwide. However, a 2012 U.S. Supreme Court decision permitted states to opt out of the eligibility expansion, which was to be heavily financed by the federal government (Perkins, 2013). Twenty-four states (many of which are similar to my home state of Texas, which has a Republican governor and Republican-controlled legislature) opted to forgo a total of $61.9 billion in federal revenues rather than expand their Medicaid programs (Knopf, 2012). Concerned about future cost, these states refused to participate despite the fact that the federal government agreed to pay 100% of the Medicaid expansion cost for 3 years. Without expanded Medicaid eligibility, individuals with severe mental illness are left with no coverage, and as their symptoms worsen, they have no place to turn except for homeless shelters and county jails (Perkins, 2013).

PROVIDER SHORTAGE

Despite ACA reforms designed to increase mental health parity, access and affordability of care are threatened by a shortage of mental health professionals, particularly those trained in.
Guest Editorial

Major Provisions of the Affordable Care Act

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<th>Provision</th>
<th>Explanation</th>
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<tr>
<td>Guaranteed issue</td>
<td>Prohibits insurers from denying coverage to individuals with pre-existing conditions.</td>
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<td>Continued coverage</td>
<td>Allows financially dependent children to remain on their parents’ health insurance until age 26.</td>
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<td>Actuarial rating adjustments</td>
<td>Oblige insurers to offer the same premium price paid by other insurers of the same age and geographical location regardless of gender.</td>
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<td>Health insurance exchanges</td>
<td>Operate as the primary pathway for individuals and small businesses to compare and purchase insurance policies in an “open” market.</td>
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<td>Individual mandate</td>
<td>Requires all citizens not covered by an employer-sponsored or public insurance program to purchase an approved policy or pay a penalty.</td>
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<tr>
<td>Employer mandate</td>
<td>Requires a business with 50 or more employees to offer health insurance to its full-time employees or pay a penalty.</td>
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<td>Federal subsidies</td>
<td>Provide several types of aid to ensure implementation of other provisions. For example, low-income individuals receive subsidies to purchase insurance policies they could not afford otherwise; in addition, small business owners receive tax deductions to subsidize health insurance for their employees, and states are entitled to billions of dollars in subsidies to expand Medicaid eligibility for their low-income citizens.</td>
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The ACA, pejoratively called Obamacare by its opponents, holds much promise for mental health parity in the United States. Obstacles along the way include resistance to Medicaid expansion and a provider shortage that impedes access to mental health services.

REFERENCES


Patient Protection and Affordable Care Act, 42 U.S. Code § 18001 (2010).


Charles A. Walker, PhD, RN
Professor
Harris College of Nursing and Health Sciences
Texas Christian University
Fort Worth, Texas
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