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Health Care Reform: What School Mental Health Professionals Need to Know

On March 23, 2010, President Obama signed comprehensive health care reform, the Patient Protection and Affordable Care Act (ACA), into law (P.L. 111-148). This major reform to health care certainly has had and will continue to have profound ramifications for children, adolescents, and families in the United States (U.S.). Prior to the introduction of ACA, it was estimated that 10.5 million youth aged 18 and younger were uninsured (Medical Expenditure Survey Panel, 2010). However, as a result of the implementation of the new health care reform laws, approximately 5 million children and adolescents will be newly covered by health insurance (Children's Health Fund, 2011). Health care access goes beyond simply having health care coverage. It is estimated that 16.9 million children who *are insured* still experience significant barriers to accessing health care, such as high out-of-pocket costs, limited number of available specialists (e.g., mental health professionals), and difficulty arranging logistics (e.g., transportation to and from care; Children's Health Fund, 2011). Health care reform has the potential to significantly reduce such barriers by reducing out-of-pocket costs, increasing specialty care and eliminating logistical barriers to care.

In addition, health care reform has significant implications for the future of health and mental health care provided to children and youth in school-based settings. With greater numbers of children and families seeking accessible health and mental health care, school-based providers are likely to see an increase in demand for their services. In addition, a provision of the ACA authorizes funding to establish and expand school-based health centers, which will significantly increase and enhance access to mental health services in schools. Schools already have become the de facto provider of mental health services to children and adolescents, related to several barriers to accessing traditional community-based care, including lack of available specialists, insurance restrictions, appointment delays and mental health stigma (Committee on School Health, 2004; Farmer, Burns, Philip, Angold, & Costello, 2003; New Freedom Commission on Mental Health, 2003; U.S. Department of Health and Human Services [DHHS], 1999). In fact of children who do receive mental health services, 70% to 80% of them receive those services in schools (Rones & Hoagwood, 2000; Farmer et al., 2003).

What Does Health Care Reform Mean for Children's Mental Health?

The implementation of the ACA will provide access to health care for millions of previously uninsured children and adolescents (Children's Health Fund, 2011). Since its introduction in March 2010, the ACA has begun a decade-long process of ensuring that youth receive important health and mental health services. As some of the provisions pertain specifically to children and adolescents, school mental health professionals should be aware of the changes resulting from this reform, including both the expansion of and potential barriers to available health and mental health services.

Important Changes as a Result of Health Care Reform

Increased Access to Health Care

One of the most important provisions of the ACA as it relates to youth is the increased access to health care services; with some of the changes occurring immediately after the reform was

signed into law in 2010 and with others expected to be in place by 2014. The mechanisms that increase access to overall health care also have the potential to increase access to children's mental health services both within schools and the community (Bazelon Center for Mental Health Law, 2010).

One of the significant changes already implemented allows young adults up to the age of 26 to remain on their parents' private health insurance, or be added to their parents' plan if they were previously not covered (P.L. 111-148). Before this reform, insurance companies could remove enrolled children by age 19. Under the new law, children can remain on their parents' plan even if they are married, not living at home, away attending school, not financially dependent on their parents, and are eligible to enroll in their own employer's health care plan. This is especially important for college-age students, as many students within this age range (i.e., 19-25 years) are uninsured. In fact, since the implementation of this provision, approximately one million young Americans ages 19-25 gained access to health insurance (US DHHS, 2011d).

Pre-existing Conditions

Another important change relates to prohibiting insurance companies from denying coverage to children under the age of 19 due to a pre-existing health or mental health condition (P.L. 111-148). A pre-existing condition is defined as a medical condition that the child developed prior to applying to join the health care plan (U.S. DHHS, 2011b). However, it is usually left up to insurance companies to decide what constitutes a pre-existing condition. Some conditions are more obvious, such as cancer, while others are less clear, such as asthma. Prior to the enactment of ACA, insurance plans could refuse or deny coverage to anyone due to a pre-existing condition, or they could limit the benefits available to the individual. However, under the ACA, plans that cover children can no longer exclude, limit, or deny coverage to children under the age of 19 solely based on a health problem or disability that the child developed prior to applying for or receiving health insurance. This specific provision applies to all job-related health plans as well as individual/private health insurance policies issued after March 23, 2010. Of note, beginning in 2014, these benefits as written in policy now will be extended to Americans of all ages, not just youth under the age of 19. However, despite the promise of this new provision, challenges still remain for many children with chronic illnesses and their families (McGinley & Carey, 2011). Specifically, while health care will be available to children with pre-existing health conditions, these policies might be more expensive and not readily available. For instance, not all insurance companies have to have policies that cover children; however, those companies that do have insurance policies for children and adolescents cannot deny coverage to those with a pre-existing condition.

Preventive Health Care

As a result of ACA, youth and their families will also have access to preventive health care services (P.L. 111-148). This means that private insurance companies are now responsible for covering the preventive services recommended by the Bright Futures Project of the Health Resources and Services Administration (HRSA; The Henry J. Kaiser Family Foundation, 2011). Specifically, insurance companies are now mandated to provide evidence-informed preventive services to children and adolescents. These services include: routine immunizations (i.e., influenza, meningitis, tetanus, HPV, hepatitis A and B, measles, mumps, rubella, varicella), screening services (i.e., depression, diabetes, cholesterol, obesity, various cancers, HIV and sexually transmitted infections, autism, vision impairment, lipid disorders, tuberculosis, certain

genetic diseases), counseling (e.g., drug and tobacco use, nutrition), behavioral and developmental assessments, and providing iron and fluoride supplements. In most cases, these preventive services will be provided at no cost to consumers. However, there are some instances in which the patient would be required to pay a co-pay (e.g., the primary reason for the visit is not the preventive screening).

Expanding Medicaid Coverage

Another important stipulation of the health care reform includes extending insurance coverage for children and adolescents by expanding Medicaid coverage (see information box on pg. 4 for additional details about Medicaid). This new ACA mandate beginning in 2014 requires Medicaid eligibility to be extended to *all children and their parents* whose families' incomes fall at or below 133% of the federal poverty level (P.L. 111-148), or an income of $29,726 for a family of four in 2011(U.S. DHHS, 2011a). Doing so will increase the number of children (and their parents/caregivers) who will be newly eligible to receive Medicaid services (Children's Health Fund, 2011; Bazelon Center for Mental Health Law, 2010). This will allow for unprecedented access to health and mental health services for both children and their parents, and may be the first time that both children and parents qualify for the same insurance programs (Bazelon Center for Mental Health Law, 2010), potentially offering the opportunity for the development of more collaborative, family-oriented service delivery. Under the new law, Medicaid coverage is also extended to vulnerable populations, such as young children, youth in foster care who are aging out of the system (until age 26), and children with a pre-existing chronic health condition (e.g., asthma; P.L. 111-148). Further, these unique populations will have access, most for the first time ever, to preventive services (e.g. routine vaccinations, flu shots, well-child visits), as well as mental health treatment (English, 2010).

Children's Health Insurance Program (CHIP) Reauthorization

In addition to the expansion of Medicaid services, ACA reauthorized the Children's Health Insurance Program (CHIP), which was formally known as the State Children's Health Insurance Program (SCHIP). CHIP provides free or low-cost health coverage for children in families whose income is too low to afford private insurance, but still too high to qualify for Medicaid (Bazelon Center for Mental Health Law, 2010). In most states, children are eligible for CHIP if they are under the age of 19, uninsured, and their family income does not exceed $44,100 per year. CHIP services are available to U.S. citizens and eligible immigrants. This insurance covers the following services: doctor's visits, routine immunizations, emergency room visits, and hospitalizations for little to no out of pocket cost to the consumer (Centers for Medicare & Medicaid Services, 2011). Each state can decide on the specific benefits provided under CHIP, but all states cover the services listed above. Children also have access to free preventive care; however other cost-sharing (e.g., deductible or co-pay) may be required for additional services. CHIP was due to expire in 2013; however ACA reauthorized the program through the year 2019 with funding through 2015. This renewal expands CHIP coverage from 7 million children to 11 million children (Centers for Medicare & Medicaid Services, 2011). Under ACA, states receive enhanced federal match funding to provide for this coverage (The Henry J. Kaiser Family Foundation, 2009). In other words, there is increased federal funding allotted specifically for CHIP, that is distributed at both the national and state levels. The total national allotment from 2009 through 2013 is $69.8 billion. These national allotments are distributed among all 50 states, which provide states with funding for existing CHIP programs as well as funding to increase

enrollment into CHIP programs. Distribution of federal CHIP funds among the states is based largely on states' actual use of and projected need for CHIP funds. Taken together, these important changes set the stage for ensuring that children and adolescents have access to affordable and appropriate health care.

Medicaid and Health Care Reform

What is Medicaid?

Medicaid is a state-administered health insurance program for low-income individuals, families and children, the elderly, and people with disabilities (U.S. DHHS, 2011e). Medicaid pays for a full set of services for children, including preventive care, immunizations, screening and treatment of health conditions, doctor and hospital visits, and vision and dental care. In most instances, these services are provided to families at no cost. Most states do not charge monthly premiums for coverage, and co-payments are usually not more than $5 per visit.

Who is eligible for Medicaid?

The Medicaid program serves approximately 50 million Americans each year, many of whom are working but do not have health insurance coverage through their jobs. All states provide Medicaid to infants and children under age 6 with family incomes up to 133% of the federal poverty level (i.e., $29,726). Medicaid is available in every state for children ages 6 to 19 with family incomes up to 100% of the federal poverty level (i.e., $22,350; Children's Health Fund, 2011).

Are there changes to Medicaid under ACA?

Beginning in 2014, Medicaid eligibility rules will be simpler and more people will have access to health care. Almost all adults under 65 years of age with individual incomes up to $15,000 per year will be eligible for coverage through Medicaid in every state, and couples, pregnant women, and people with disabilities with somewhat higher incomes may also qualify. Children will qualify for coverage at much higher income levels, further ensuring that all children will have health insurance. Other important changes to Medicaid include free preventive care (e.g., routine vaccinations, flu shots, well-child visits, mental health screenings), elimination of policies that deny coverage to children with existing chronic health conditions, and maintaining coverage for youth aging out of foster care until age 26. However it should be noted that some of these eligibility rules and benefits will vary by state, so individuals are encouraged to check the specific benefits and services that are covered in their state.

For more information on Medicaid and/or health care in general, please visit the U.S. Department of Health and Human Services website devoted specifically to health care: http://www.healthcare.gov/foryou/generalinformation/medicaid/index.html

Health Insurance Exchanges

The development of health insurance exchanges will also increase access to health care for youth and their families. A health insurance exchange is a new entity designed to create a more organized and competitive market for health insurance by offering a greater choice of plans, consistent rules for the offering and pricing of insurance, and education for insurance consumers. The development of these communities allows individuals to purchase private health coverage at reduced rates (Wotring & Stroul, 2011). When these exchanges go into effect in 2014, it will allow individuals and families one place where they can browse for private and public health insurance plans (P.L. 111-148). Families can "shop" for a plan that fits their specific needs, and compare prices and options between several different plans. Small businesses or employers will also gain access to a larger variety of health insurance plans at a lower cost, similar to the way large employers and businesses currently operate. Further, each state will be allowed to operate their own exchanges, which will provide flexibility to adapt insurance plans based upon the demands of specific states. As a result of these exchanges, it is estimated that approximately 24 million additional individuals with incomes up to 400% of the federal poverty level will gain access to coverage.

School-based Health Centers

According to the Children's Health Insurance Reauthorization Act of 2009, a School-Based Health Center (SBHC) is defined as "a health clinic that is (a) located in or near a school facility of a school district or board or of an Indian tribe or tribal organization; (b) organized through school, community, and health provider relationships; (c) administered by a sponsoring facility; (d) provides thorough health services to children in accordance with state and local law, including laws relating to licensure and certification; and (e) satisfies such other requirements as a State may establish for the operation of such a clinic." The majority of these clinics are located in high needs areas, with large populations of vulnerable and often underserved youth, further underscoring the importance of the additional funding provided under ACA. Research indicates that 75% of SBHCs have a mental health provider on staff (Strozer, Juszczak, & Ammerman, 2010). Further, mental health care is the number one reason students visit SBHCs with the most common services being crisis intervention, mental health assessment and referrals, screening, and brief therapy (Strozer et al., 2010; Wasczak & Neidell, 1991). A promising provision of ACA to school mental health professionals is the authorization of funding for SBHCs in schools across the United States. In July 2011 the Health Resources and Services Administration (HRSA) put out a press release announcing $95 million of award funding to 278 SBHC programs across the country. These funds were made available under the ACA with the aim of expanding and providing quality health care services in a school setting throughout the nation. Specifically, this award enables SBHCs, who currently serve approximately 790,000 children and adolescents, to increase their capacity by over 50% to serve an additional 440,000 patients (U.S. DHHS, 2011c). As these funds are allocated towards construction, renovation and equipment, this money will go towards establishing new sites and/or upgrading existing SBHCs. With schools serving as a key provider of primary care services, this funding can aid in increasing the number of students able to access health and mental health services. While not an immediate solution to the need to improve access to high quality health care in itself, increasing the number of SBHC facilities is a step in the right direction towards the ultimate goal of increasing school mental health and health care service provision to students and their families.

Potential Barriers to Mental Health Services Under ACA

The changes to health care have significant implications for the delivery of school mental health services. Perhaps the most prominent aspect of ACA as it relates to children's mental health is the increase in the number of students that will be able to access mental health services. With the increased number of families being eligible for Medicaid and other health care financial assistance, as well as additional funding to SBHCs, more children and adolescents will be able to utilize mental health services than ever before.

While there are tremendous opportunities in health care reform as it relates to mental health for students, there are still potential barriers for youth and their families to receive newly available services and funding. For one, the availability of medical and mental health services will vary from state to state. While some states may opt to utilize presumptive eligibility for health care, a state policy that expedites children and families' eligibility for coverage through Medicaid and CHIP (Center for Children and Families, 2011), others may have a process that is far more time-consuming. The advantage of presumptive eligibility is that it enables state-appointed health care providers, schools, community agencies, and other government agencies to screen and temporarily enroll children and pregnant women in Medicaid or CHIP, thus allowing individuals to access needed services faster. However, as of January 2011 only 31 states enacted the policy for pregnant women and just 13 states for children (Heberlein, Brooks, Guyer, Artiga, & Stephens, 2011). As a consequence, families residing in states where there is a less coordinated system of care may be less likely to access health care services and programs in a timely manner. There remains a need for greater communication across state and federal agencies regarding what works for accessing and enrolling families in government health care programs and a commitment from states to prioritize rapid enrollment and access to health care services.

Another challenge for advancing mental health services in SBHCs and in schools is the need for a highly trained workforce with knowledge and skills related to evidence-based practices and programs and effective work with children and families. There is a growing need to advance the training of mental health professionals who are or will be providing mental health services within the schools. As many clinicians have been trained to work in the community, they often encounter challenges and barriers when shifting to the school setting. In addition to a need for a highly trained workforce, there are also barriers for clinicians working in schools. In a recent study by Langley and colleagues (2010), school-based providers reported the top four barriers to providing evidence-based practices were: (1) lack of parent engagement, (2) competing responsibilities (e.g., large caseload, limited time on school campus, school crises), (3) logistical barriers (e.g., time, office space, pulling students from class), and (4) lack of support from teachers and staff. Schools systems can appear chaotic and difficult to navigate, especially for clinicians new to a school district or those lacking training in a school setting. There is a need to provide comprehensive training on the core mental health competencies that have been identified as important for working effectively in schools. The Center for School Mental Health (CSMH) is in the process of developing an online training for outpatient mental health providers who work in schools to ensure they have the requisite knowledge and skills to be successful.

Reducing Health Disparities through ACA

Historically, racial and ethnic minorities, low-income families, and other underserved populations are less likely to access or receive quality health care services, resulting in higher rates of diseases and chronic illnesses (U.S. DHHS, 2011). The ACA aims to reduce disparities across populations by lowering health care costs, increasing the number of individuals' eligibility for Medicaid and CHIP, and providing more prevention and wellness programs to at-risk communities. Below are examples of how ACA policies plan to improve our Nation's current system:

Preventive care

Many insurance plans will cover screening, regular check-ups, and immunizations to help prevent and identify health and mental health problems.

Coordinated care

Health professionals will coordinate services when treating individuals with chronic diseases (e.g., diabetes, kidney disease, heart disease, cancer). In addition, health care workers will make home visits to expectant mothers and newborns in order to reduce infant mortality rates and increase the likelihood of identifying mental health problems early on.

Diversity and cultural competency

Given the discrepancy between cultural groups, initiatives have been expanded to increase the racial and ethnic diversity among health care providers, along with providing cultural competency training (e.g., community outreach, language services) to those working in diverse neighborhoods.

Health care providers for underserved communities

Under ACA there will be increased funding for community and school-based health centers, which will enable increased numbers of youth to access community and school-based health and/or mental health services. These comprehensive health care programs are often located in low-income areas and provide medical and mental health services to all individuals regardless of their financial situation.

Implications for School Mental Health

To best help students and families to access quality health care, including mental health care, it is important that school mental health professionals be aware of the ACA and its implications. Key aspects of ACA and potential roles for school mental health professionals are summarized below.

ACA increases access to health care services beyond just mental health services for children through adults until the age of 26. This means that these youth will, some for the first time ever, have access to medical and dental services. Moreover, these youth can proactively obtain preventive medical care, via services such as well-child visits, vaccinations, or flu shots. School mental health professionals can help to make sure families understand changes to the new law and how it may increase their eligibility for coverage and service provision.

As children must be healthy in order to attend school and benefit from instruction, ensuring that they have access to health care services and resources that will allow that is paramount. Related to this need, school mental health professionals should be aware of the health care and other related resources in their communities (e.g., housing, recreation, food, clothing, mentoring, tutoring) so that they can share information about these programs with families and serve as liaisons. School-based staff should engage in outreach efforts to become familiar with hospitals, programs, agencies, and organizations in the surrounding community, so that they can effectively link families to these services as appropriate. These providers will be more apt to work collaboratively with schools or school mental health professionals with whom they already have on-going relationships (as opposed to sporadic contacts when the school is in need of a particular service or specific information). To facilitate the ease of this process, school mental health professionals can compile a compendium or directory of community resources, which can easily be referenced when working with families to initiate and secure community-based services.

With greater access to health and mental health services, it will be critical for school mental health professionals to collaborate with the school-based health centers and community agencies and programs that are involved in a student's care to ensure comprehensive high quality service delivery. To avoid operating in "silos" across disciplines and systems, it is necessary for school mental health professionals to utilize a team approach to ensure comprehensive service delivery. Engaging in collaborative relationships is beneficial for schools, as doing so maximizes time and resources, as well as lends to increased identification of youth in need, improved treatment engagement/adherence, and improved student outcomes (Anderson-Butcher & Aston, 2004). Youth with medical and/or mental health concerns are typically affected in several different environments such as home, school, and community. Moreover, these youth typically utilize services in more than one system including mental health, primary health, education, child welfare and/or juvenile justice (Wotring & Stroul, 2011). To ensure that youth are receiving the most comprehensive care possible, inter-disciplinary and cross-disciplinary collaboration is crucial. Thus, school mental health professionals should be proactive in initiating these important relationships with community health and mental health providers and with partners in the school building (e.g., school-based health staff, school social worker, school psychologist, school-based outpatient staff). Further, school mental health professionals can take a preventive stance on some health and mental health issues, by partnering with community organizations in family outreach activities related to various health or mental health initiatives.

Under ACA, racially and ethnically diverse groups will have increased access to health care. As such, it will be important that school mental health professionals are prepared to effectively serve these vulnerable and typically underserved populations. School mental health professionals should ensure they are appropriately trained to be culturally and linguistically competent, and sensitive to diversity issues (Mock, 2003). Important topics to consider include: perceptions of and attitudes towards mental health services, mental health stigma, different ideas about what constitutes illness and health, language barriers or constraints (e.g., using a translator, ensuring written material is written without jargon), and developing and implementing culturally sensitive or responsive treatments/interventions (see additional information regarding health disparities in the side box above). It is also important that school mental health professionals, and all school personnel, are aware of the impact of their own culture and worldviews on their interaction with others in cross-cultural situations (Bole Williams, 2006).

Conclusion

The passage of the Affordable Care Act has had and will continue to have profound ramifications for the field of children's mental health. Perhaps most importantly, youth up to the age of 26 will have increased access to health care, including both medical and mental health services. As a result, it is important that school mental health professionals are knowledgeable about the specific provisions that impact the students and families in their schools and communities. Further, given the likely increase in the number of youth and families who will become eligible for, and subsequently seek out, mental health services, it is important that school mental health professionals are equipped with the necessary skills to ensure that they can effectively meet the needs of these youth and their families. The Center for School Mental Health (CSMH) has been charged with developing a curriculum to ensure that outpatient mental health professionals based in schools understand unique aspects and systems issues related to delivering mental health care in school and have the requisite skills to provide high quality, evidence-based services to meet the mental health needs of children and families.

Resources

http://www.healthcare.gov/
This website contains information related to health care and health care reform, and is sponsored by the U.S. Department of Health and Human Services. Individuals can access information related specifically to changes under the new health care reform.

http://www.insurekidsnow.gov/index.html
This resource contains specific information to assist individuals in finding state-specific informa tion about health insurance coverage for children under Medicaid and CHIP.

http://www.samhsa.gov/healthreform/
The Substance Abuse and Mental Health Services Administration website contains a wealth of information specific to health care reform. The website also contains many webinars related to health care reform in general as well as more specific topics that fall under the umbrella of health care reform.

http://csmh.umaryland.edu/resources/CSMH/Health%20Care%20Reform
The Center for School Mental Health website contains information specifically related to health care reform, as well as contains links to other important and helpful resources for understanding health care reform and some of the changes associated with it.

The mission of the Center for School Mental Health is to strengthen policies and programs in school mental health to improve learning and promote success for America's youth.

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