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ASPE ISSUE BRIEF

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How the Affordable Care Act Can Support Employment for People with Mental Illness

Mental illness, like any health concern, can disrupt the ability to work. Less than 20 percent of people who receive publicly funded mental health services are employed, although research consistently demonstrates that, with the right supports, 40-60 percent of people with serious mental illness (SMI) can work. Many of those who do so work part-time, intermittently, or at low wages (Blyler 2003; Bond 2004, 2007; SAMHSA 2011). Unemployment or low levels of work may lead to reliance on disability benefit programs, which gives the social safety net an important role in their lives. Working-age people with psychiatric disorders are the largest and most rapidly expanding group of Social Security Disability Insurance (SSDI) and Supplemental Security Income (SSI) beneficiaries. Currently, 36 percent of SSDI and 60 percent of working-age SSI beneficiaries have a mental illness (SSA 2011a, 2011b), and estimates suggest that less than 4 percent of SSDI beneficiaries exit the program due to earnings within the first ten years of enrollment (Stapleton et al. 2010).

For those with access to mental health care and whose illnesses are responsive to treatment, disruptions to the ability to work are often short-term, allowing them to return to existing jobs and former productivity levels quickly. People who cannot afford treatment, whose treatment is not quickly or fully effective, or whose illness frequently recurs, however, may find that work disruptions due to mental illness result in long-term disability and unemployment. These people require a range of supports in addition to mental health services if they are to return to work quickly and stay at work.

A number of employment programs and services have proven effective at helping people with SMI and other psychiatric disorders find and keep work. In particular, evidence-based supported employment, especially the standardized Individual Placement and Support model, has been shown to be more effective than traditional vocational programs in helping people with SMI obtain competitive employment. Supported employment is a strategy for helping people with disabilities participate in the labor market, in a job of their choosing, with professional support (Bond et al. 2001). Supported employment helps individuals with a variety of characteristics--age, gender, diagnosis, education, and so on--achieve higher rates of competitive employment than those in control groups who have the same characteristics. Job-development services and integration of vocational and clinical services are vital for making supported employment successful.

Evidence-based practices also exist for helping individuals with less severe conditions; for example, Wang et al. (2007) demonstrated that a telephone-based care management program targeted to employees with significant depression significantly improved job retention and hours worked. In a systematic review, Nieuwenhuijsen et al. (2008) found that psychodynamic therapy in combination with tricyclic antidepressant medication reduced sickness absence. Dewa et al. (2003) found that early intervention was significantly associated with a reduced length of disability episode. Burton et al. (2007) found that those who met antidepressant treatment adherence criteria during a three-month acute-phase follow-up period were significantly less likely to have any short-term disability absence. In another study, Adler et al. (2006) concluded that, although clinical interventions improve mental health, additional workplace interventions may be required to improve the performance of depressed employees.

But although these services and supports are critical for preventing or minimizing work disruptions associated with mental illness and for facilitating re-entry into the workforce, not everyone has access to them. People with low incomes, high health care needs, or no insurance may have limited access, if any, particularly if they are not eligible for Medicaid or other public mental health programs. Access is even more limited for people meeting all three of these conditions, such as the nearly 2.5 million Americans with SMI who have incomes under 400 percent of the federal poverty level and are uninsured (Malone 2012). Even for those who are insured, affording mental health and employment-support services may be a challenge since these services are not covered by many health insurance plans (Beronio et al. 2013; Garfield et al. 2010). Enacted in 2010, the Affordable Care Act (ACA) of 2010 (42 USC 2714) expands access to health insurance, including coverage of mental health services, and also has the potential to enhance existing funding options for employment-support services for people with mental illness. In this issue brief, we explore the provisions of the ACA that may enable Americans with mental illness to obtain the mental health treatment and support services they need to continue working or get back to work.

Expanded Options for Health Insurance Coverage

The ACA expands access to both public and private health insurance coverage. The law permits states to extend Medicaid eligibility to individuals based solely upon income and contains a number of provisions that improve access to private insurance, regardless of employment status. Extending health insurance coverage to those who were previously ineligible or unable to purchase it may improve access to mental health services, including employment-support services, which may in turn help people with mental illnesses to sustain their productivity and/or return to work quickly after an episode of mental illness.

The Expansion of Medicaid

The Medicaid program is currently the primary funder of mental health services in the United States (Kaiser Family Foundation 2011). Before the ACA was enacted, Medicaid beneficiaries with mental illness generally qualified for the program due to disability (meaning they met the definition of disability established for the federal SSI program), or

they had dependent children, or they lived in a state that offered coverage to those with extremely low incomes (Bazelon Center 2012). Beginning in January 2014, the ACA provides federal funding for states that choose to expand Medicaid eligibility to include individuals with incomes below 138 percent of the federal poverty level, regardless of disability or parental status (Rosenbaum et al. 2011).[1] This means that people without children and those who do not qualify on the basis of disability may now have access to Medicaid coverage. About 7 percent of those newly eligible for Medicaid are expected to have SMIs, and many more new Medicaid beneficiaries will have mild or moderate disorders (Malone 2012). The effect of this expansion for people with mental illnesses will vary by state, however, as the Supreme Court has ruled that each state can decide whether to expand its Medicaid program (Musumeci 2012).

In states that choose to expand Medicaid as authorized by the ACA, the benefits provided may be different from those offered to individuals eligible for the state's full Medicaid plan. Benefits for the newly eligible do have to cover a full range of essential health benefits defined by the ACA,[2] including mental health and substance use disorder services and rehabilitative and habilitative services (Wishon Siegwarth & Koyanagi 2012). In addition, federal mental health parity requirements apply to these mental health and substance use disorder benefits.

The benchmark plans and alternative benefit plans modeled after them are highly unlikely to cover supported employment. However, under the Social Security Act, some groups are exempt from mandatory enrollment in these "alternative benefit plans" and are entitled to a state's traditional package of Medicaid benefits (Bazelon Center 2012; Wishon Siegwarth & Koyanagi 2012) which sometimes do include supported employment. Exempt groups include, among others, certain institutionalized populations and those considered medically frail or having special medical needs--a category that specifically includes people with SMIs. Thus, newly eligible individuals with SMI may become eligible for supported employment even if those services are not covered in the alternative benefit plan in their state as long as they are covered in the Medicaid benefits specified in the state plan.

Although states are permitted to provide an alternative benefit package to newly eligible adults in non-exempt categories, they have the option of providing the state's full Medicaid package to these individuals (CMS 2012). Many states, in fact, are opting to use their state plan benefits as the coverage they provide to all newly eligible individuals, thereby avoiding the need to determine who qualifies as medically frail and eligible for state plan benefits instead of alternative benefits. Additionally, states may provide different alternative benefit plans targeted to different populations, so they can, if they wish, tailor benefits, including employment-support services to meet the unique needs of people with mental illnesses. States also have the option to provide additional "wraparound" benefits to people in alternative benefit plans (Bazelon Center 2012).

In any case, some aspects of supported employment cannot be covered by Medicaid without a waiver or adoption of the new 1915(i) state plan option described below, and thus additional wraparound funding from block grants and state funds will still be needed in some cases to provide access to these kinds of employment supports.

Enhancements to the Medicaid Program

In addition to expanding access to Medicaid, the ACA introduced new Medicaid options and enhanced existing options that may be used to make employment supports more widely available for people with mental illness, including those who are newly eligible for the program as well as those eligible under pre-ACA rules. The Medicaid Section 1915(i) state plan option is one such option. Added to the Social Security Act by the Deficit Reduction Act of 2005, 1915(i) is an option that states can use to offer home and community-based services (HCBS) to Medicaid beneficiaries, including those with mental illnesses. Prior to 2005, state Medicaid programs primarily provided HCBS through Medicaid Section (1915(c) waivers, which allow states to offer HCBS to beneficiaries who would otherwise require an institutional level of care (Kaiser Family Foundation 2005). But 1915(c) waivers have rarely been used to provide HCBS to people needing them as a result of mental illness because of the requirement that waiver services be cost-neutral[3]--a challenging requirement for states to meet given that inpatient services provided in "institutions for mental diseases" are excluded from Medicaid reimbursement (Bazelon Center 2012). As an alternative to waivers, states that adopt the 1915(i) option are not required to demonstrate cost neutrality (Bazelon Center 2012); this provision expands the opportunity for states to fund HCBS, including employment supports, for people with mental illnesses. Moreover, unlike 1915(c) waivers, 1915(i) permits states to provide HCBS to individuals with incomes up to 150 percent of the federal poverty level without regard to whether such individuals need an institutional level of care (CMS 2010b).

The ACA made a number of changes to Section 1915(i) that may make the option even more useful for states wishing to provide employment and other community-based services to people with mental illnesses. First, the law expanded the types of services states can provide; in addition to services listed in statute, states may now offer "such other services requested by the state as the Secretary may approve" (CMS 2010b). These services could include all elements of a supported employment program (Wishon Siegmarth & Koyanagi 2012). This is significant since some elements of supported employment, including job placement and job coaching activities, cannot otherwise be covered by Medicaid. Additionally, the ACA gave states flexibility to offer different populations different services--varying in amount, duration, type, and scope. This change makes it possible for a state to target a 1915(i) benefit package specifically to persons with mental illness for evidence-based supported employment. The ACA also expanded financial eligibility criteria for 1915(i) services to include a new optional Medicaid eligibility group of individuals with incomes up to 300 percent of the SSI federal benefit rate who are eligible for (though not necessarily enrolled in) HCBS under a 1915(c), 1915(d), or 1915(e) waiver or 1115 demonstration in the state.[4] Another amendment prohibited state waiting lists, which were permitted under the original authority, and required states to offer services statewide to all who are eligible, rather than limiting services to certain areas of the state (CMS 2010b).

Some observers have speculated that several of the ACA's amendments to 1915(i) will deter widespread adoption (Justice 2011); states may be particularly reluctant to accept the prohibition of waiting lists, which eliminates their ability to control costs through enrollment caps. Nevertheless, states have great freedom in designing their needs-

based criteria, which might serve as a lever for states to control eligibility and enrollment--and hence costs--by imposing stringent requirements. In addition, states may have a financial incentive to adopt the 1915(i) option in order to substitute federal Medicaid funds for the state and county funds that many currently use to provide services to adults with mental illness (Bazelon Center 2012). Furthermore, the ability to target particular populations provides new flexibility states can use to offer comprehensive supported employment services while containing the costs by limiting their availability to individuals with very serious mental health conditions. As of April 2014, 14 states had an approved 1915(i) state plan option or plan to implement one in 2014 (Kaiser Family Foundation 2013).

The ACA also promotes the coordination of care for Medicaid beneficiaries, including supportive services for those with mental illnesses, through a handful of care coordination options. One such opportunity is the new Medicaid option to provide health home services to certain Medicaid beneficiaries. The health home model--based on the medical home concept--is intended to enhance coordination of medical care, behavioral health care, and community-based social services and supports for people with chronic illness, and it is therefore highly relevant to people with mental health needs (CMS 2010a). If a state adopts the option, it is initially granted an increased federal matching rate for reimbursing providers that offer health home services[5] to individuals with chronic disorders.[6] Community mental health centers are among the providers that may serve as health homes (CMS 2010a). The care coordination to be provided through health homes creates the opportunity to link Medicaid beneficiaries with SMI to supported employment services as long as those services are covered by the state's Medicaid program--either the state plan, 1915(i) or some other option. In states that include supported employment in the state's Medicaid program, however, supported employment services provided through or coordinated by a health home should be covered by Medicaid for those who meet the needs-based criteria for them.

Expanding Private Coverage

In addition to creating opportunities for states to expand their Medicaid programs, the ACA expands access to private insurance through newly created health insurance exchanges It also makes a number of reforms to the way the private market operates. Both these steps may be beneficial to people with mental illness who are looking for work or who wish to retain their current job. Of those likely to become eligible for insurance through reforms to the private health insurance market, an estimated 6 percent are expected to have a SMI (Malone 2012). Though private plans are somewhat unlikely to cover a full range of employment-support services, increased availability of health insurance and consistent access to appropriate care are critical to a person's ability to maintain health and secure and retain employment. Moreover, there are types of employment supports that may more readily fit in private insurance benefit designs than comprehensive supported employment and that may be more appropriate for the milder forms of mental illness that are more prevalent among people engaged in employment.

In all states, certain people will be able to purchase insurance through a health insurance exchange, also known as the Health Insurance Marketplace, as of October 1,

2013 (HHS 2013a). In 2014, people with incomes between 100 percent and 400 percent of the federal poverty level who are not eligible for coverage through their employer or through public programs like Medicaid are eligible to receive premium tax credits to help them afford insurance through an exchange. Even individuals who are eligible for coverage through an employer can receive premium tax credits if the employer's share of the cost of coverage is less than 60 percent, or if the premium for individual coverage is more than 9.5 percent of the person's income. In addition, to help limit out-of-pocket costs, cost-sharing subsidies are available to individuals with incomes at or below 250 percent of the federal poverty level (Kaiser Family Foundation 2012). In states that do not expand their Medicaid programs, those who are ineligible for Medicaid but who remain below 100 percent of the federal poverty level cannot receive premium tax credits and will likely be unable to afford private insurance on their own (Kaiser Family Foundation 2012).

Until the enactment of the ACA, coverage of mental health and substance use disorder benefits by any private insurers was optional. In addition, federal parity requirements under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008 (Pub.L.No. 110-343, secs. 511-512) applied only to large group insurance plans--defined as those sponsored by employers with more than 50 employees (Sarata 2011). When mental health or substance use disorder services are covered, MHPAEA prohibits plans from imposing stricter financial requirements or treatment limitations on these benefits than they impose on most medical or surgical benefits. The parity requirements apply to both in-network and out-of-network benefits (Sarata 2011).

The ACA expands access to mental health and substance use disorder services and rehabilitative services by requiring any new insurance plans offered in the individual or small-group market, both inside and outside of the exchanges, to cover the ten essential health benefits defined by the ACA (Kaiser Family Foundation 2012).[7] Further, in implementing the essential health benefit provisions of the ACA, the U.S. Department of Health and Human Services (HHS) has finalized regulations that extend federal parity requirements to the mental health and substance use disorder benefits that both small-group and individual plans must include (Beronio et al. 2013).[8]

States have significant latitude in defining the scope of essential health benefits that individual and small-group plans must offer (Wishon Siegwarth & Koyanagi 2012). States can choose a benchmark plan to define essential health benefits (HHS 2013b) and supplement those benefits to meet other ACA provisions including the application of federal parity rules to the mental health and substance use disorder benefits.[9] Parity requirements coupled with the essential health benefit category of rehabilitative and habilitative services may encourage private insurance plans to consider including employment-support services for people with mental illnesses. The population of individuals covered by private insurance is likely to include many individuals with milder mental health conditions than those eligible for Medicaid, often including milder forms of depression and anxiety. Evidence-based practices do exist for helping individuals with these types of conditions; for example, the study cited earlier by Wang and others demonstrated that a telephone-based care management program targeted to

employees with significant depression substantially improved job retention and hours worked (Wang 2007).

Other Insurance Reforms

In addition to expanded access to insurance through Medicaid and health insurance exchanges, other reforms to the private insurance market made by the ACA may assist people with mental illnesses in accessing the services and supports they need to maintain health and the ability to work. Under the ACA, young adults can remain enrolled in a parent's employer-based or individual insurance plan until they reach age 26. This provision is particularly important for young adults who experience mental health symptoms. Young people often work in jobs that do not provide health insurance benefits, and many are unable to afford individual coverage. Unless they meet the Social Security Administration's definition of disability and have low earnings, making them eligible for SSI or SSDI benefits, and unless they live in a state that has expanded Medicaid, most are also ineligible for public health insurance coverage.[10] People with behavioral health conditions often experience their first episode of SMIs or onset of substance use disorders in young adulthood (Kessler et al. 2007). Improved access to private insurance is therefore important to ensure that potentially disabling mental health symptoms are treated as they emerge.

Several other elements of the ACA may also help those with mental illnesses obtain health insurance and the support services they need to maintain employment. First, the law prohibits coverage denials due to an individual's pre-existing conditions (Altarum Institute 2010). Second, the law prohibits annual and lifetime limits on the dollar value of any essential health benefits provided. In addition, the ACA requires insurers to cover preventive services with no cost-sharing, including depression screening and screening and behavioral counseling for alcohol abuse. Finally, employers can no longer use wage levels to determine who within the company will be eligible for health insurance. This means that people who have lower-wage jobs should now have greater ability to gain insurance--which may include needed mental health and substance use disorder services and rehabilitation coverage--through their employers. In general, these reforms should improve access to private insurance coverage for individuals with behavioral health conditions and hopefully encourage employers to also provide access to employments supports that have been shown to improve workplace as well as clinical outcomes.

If providing behavioral health and employment-support services to those experiencing mental illness improves their ability to work and results in increased earnings, transitions between Medicaid and other insurance programs may be inevitable. For example, if the income of an individual newly eligible for Medicaid rises above 138 percent of the federal poverty level because of employment, the individual may no longer qualify for Medicaid coverage and would have to transition to other health insurance coverage (Koyanagi et al. 2011). For people with continuing or recurring mental illnesses, such coverage transitions could seriously disrupt care, since the mental health and employment-support benefits, pharmaceuticals, and providers available under Medicaid would likely differ from those available through employer plans

or the health insurance exchanges. Disruptions in care due to benefit differences could potentially hamper or even reverse progress made in health and employment, possibly resulting in relapse, job loss, and a renewed need and eligibility for Medicaid services or exchange subsidies. The cycle of gaining and losing Medicaid benefits has been referred to as “churning.” To avoid churning and ensure that people with continuing or recurring mental illnesses have uninterrupted access to needed care, states may wish to consider closely aligning their Medicaid and private insurance coverage options.

Looking Ahead

The ACA contains many important provisions that will improve access to health insurance coverage and health care for people with mental illness at risk of being disabled. Although the ACA is likely to expand access to health care services that may be important for maintaining employment, the extent to which private plans and state Medicaid programs will provide people with mental illnesses with supports they need to obtain and maintain employment is unknown. Requirements regarding essential health benefits and parity may encourage employers and private health plans to include employment supports for milder mental health conditions in their benefit packages in light of growing evidence that addressing mental health needs can help improve employment outcomes. Improving access to care regardless of disability status should also encourage individuals with more serious conditions to seek employment instead of remaining on SSDI in order to maintain their health care coverage.

Before the ACA, many people with chronic mental illness could obtain health insurance only by qualifying for SSDI or SSI on the basis of disability--that is, by proving that they could not work. Although these income support programs generally qualify beneficiaries for Medicare (SSDI) or Medicaid (SSI), beneficiaries who earn more than a set amount (called “substantial gainful activity” or SGA) may no longer qualify for income benefits and the health care coverage associated with them. The linkage between SSI/SSDI and Medicaid and Medicare eligibility, therefore, may encourage people with SMI and other disabilities to work less than they otherwise would in order to maintain critical health insurance benefits. Because the ACA begins to break this link, more people with SMI may be able to work without risking loss of the care needed to maintain their mental health. These individuals might lose income support if they engage in SGA, but employment is also likely to offer them substantial gains in mental health recovery and overall well-being. Moreover, increased employment among people with chronic mental illnesses and other disabilities has the additional advantage of potentially helping address the financing challenges of the SSI and SSDI programs. In order to enable individuals with behavioral health conditions to more fully achieve their employment potential, strategies are needed to build upon the opportunities in the ACA for improving access to employment supports.

Endnotes

1. The law expands eligibility to 133 percent of the federal poverty level. A 5 percent income disregard established in the ACA effectively raises this limit to 138 percent.

2. Essential health benefits include the following: 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.

3. Cost neutrality means that waiver services offset institutional costs that would have been incurred to Medicaid absent the waiver.

4. Section 1915(d) and 1915(e) waivers provide HCBS to individuals 65 and older and to children under age 5 who were infected with HIV at birth, currently have AIDS, or were dependent on heroin, cocaine, or PCP at birth, as long as those children would otherwise require institutionalization. Section 1115 demonstrations are experimental or pilot Medicaid programs approved for a five-year period that can be renewed for an additional three years.

5. Services provided by a health home must include comprehensive care management, care coordination and health promotion, comprehensive transitional care from inpatient to other settings, individual and family support, referral to community and social support services when needed, and the use of health information technology when appropriate and feasible.

6. Individuals must: (1) have at least two chronic conditions; (2) have one chronic condition and be at risk for another; or (3) have one serious and persistent mental health condition.

7. Grandfathered plans are exempt from this provision, meaning that individuals covered by a plan with grandfathered status may remain without mental health benefits.

8. The ACA defines small-group coverage as that sponsored by employers with fewer than 100 employees for non-federal governmental plans. For group health plans and health insurance issuers subject to the Employee Retirement Income Security Act of 1974 and the Internal Revenue Code, those with 50 or fewer employees remain exempt.

9. A benchmark plan may be: (1) the largest plan by enrollment in any of the three largest products in the state's small-group market; (2) any of the three largest state employee health benefit plan options by enrollment; (3) any of the three largest national Federal Employees Health Benefits Program plan options by enrollment; or (4) the largest insured commercial health maintenance organization in the state. In states that fail to select a plan, a default option will be used.

10. In most states, SSI eligibility automatically qualifies an individual for Medicaid. To be eligible for SSI based on disability, one must have a physical or mental impairment that results in an inability to perform SGA, and that can be expected to result in death or has lasted or is expected to last for at least 12 months. In general, individuals who do not receive SSI but seek Medicaid coverage based on disability must prove they have an impairment that prevents them from performing SGA for at least a year. SSDI eligibility

automatically qualifies an individual for Medicare, but eligibility for SSDI benefits requires a work history through which the applicant has paid SSDI taxes, and many young people have not yet worked enough to qualify. Moreover, Medicare eligibility does not begin until 24 months of SSDI benefit receipt, leaving many young people with serious mental health care needs uninsured during an extended period of disability.

References

Adler, D., T. McLaughlin, W. Rogers, H. Chang, L. Laptisky, and D. Lerner. "Job deficits due to depression." *American Journal of Psychiatry*, 2006, pp. 1569-1576.

Altarum Institute. "Analysis of Affordable Care Act in Relation to the Employment of Persons with Disabilities." Ann Arbor, MI: Altarum Institute, 2010.

Bazelon Center. "Take Advantage of New Opportunities to Expand Medicaid Under the Affordable Care Act." Washington, DC: Judge David L. Bazelon Center for Mental Health Lay, July 2012. Available at http://www.bazelon.org/LinkClick.aspx?fileticket=cwAuDZLEmQI%3D&tabid=619. Accessed August 29, 2013.

Beronio, K., R. Po, L. Skopec, and S. Glied. "Affordable Care Act Expands Mental Health and Substance Use Disorder Benefits and Federal Parity Protections for 62 Million Americans." Washington, DC: HHS, Office of the Assistant Secretary for Planning and Evaluation, ASPE Research Brief, February 2013.

Blyler, C.R. "Understanding the employment rate of people with schizophrenia: Different approaches lead to different implications for policy." In *Principles of Experimental Psychopathology: Essays in Honor of Brendan A. Maher*, edited by M.F. Lenzenweger and J.M. Hooley. Washington, DC: Americans Psychological Association, 2003.

Bond, G.R. "Supported employment: Evidence for an evidence-based practice." *Psychiatric Rehabilitation Journal*", 27(4), Spring 2004, pp. 345-359.

Bond, G.R., D.R. Becker, R.E. Drake, C.A. Rapp, N. Meisler, A.F. Lehman, M.D. Bell, and D.R. Blyler. "Implementing supported employment as an evidence-based practice." *Psychiatric Services*, 52(3), March 2001, pp. 313-322.

Bond, G.R., M.P. Salyers, J. Dincin, R.E. Drake, D.R. Becker, V.V. Fraser, and M. Haines. "A randomized controlled trial comparing two vocational models for persons with severe mental illness." *Journal of Consulting and Clinical Psychology*, 75(6), December 2007, pp. 968-982.

Burton, W.N., C-Y. Chen, D.J. Conti, A.B. Schultz, and D.W. Edington. "The association of antidepressant medication adherence with employee disability absences." *American Journal of Managed Care*, 2007, pp. 105-112.

Centers for Medicare and Medicaid Services (CMS). "Essential Health Benefits in the Medicaid Program." Baltimore, MD: CMS, State Medicaid Director Letter #12-003 ACA #21, November 20, 2012.

CMS. "Health Homes for Enrollees with Chronic Conditions." Baltimore, MD: CMS, State Medicaid Director Letter #10-024 ACA #12, 2010a.

CMS. "Improving Access to Home and Community-Based Services." Baltimore, MD: CMS, State Medicaid Director Letter #10-013 ACA #4, August 6, 2010b.

Congressional Budget Office. "Estimates for the Insurance Coverage Provisions of the Affordable Care Act Updated for the Recent Supreme Count Decision." Washington, DC: Congressional Budget Office, July 2012. Available http://www.cbo.gov/publication/43472. Accessed August 29, 2013.

Dewa, C.S., J.S. Hoch, E. Lin, M. Paterson, and P. Goering. "Pattern of antidepressant use and duration of depression-related absence from work." *British Journal of Psychiatry*, 2003, pp.507-513.

Garfield, R.L., J.R. Lave, and J.M. Donohue. "Health reform and the scope of benefits for mental health and substance use disorder services." *Psychiatric Services*, 61(11), 2010, pp. 1081-1086.

HHS. "Key Features of the Affordable Care Act by Year." Washington, DC: HHS. Available at http://www.hhs.gov/healthcare/facts/timeline/timeline-text.html. Accessed August 27, 2013a.

HHS. "Patient Protection and Affordable Care Act; Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation: Final Rule." *Federal Register*, 78(37), February 25, 2013b.

Justice, D. "Implementing the Affordable Care Act: New Options for Medicaid Home and Community Based Services." State Health Policy Briefing, October 2011. Available at http://www.nashp.org/sites/default/files/LTSS_SCAN-FINAL-9-29-10.PDF. Accessed August 29, 2013.

Kaiser Family Foundation. "Section 1915(c) Home and Community-based Services State Plan Option." Washington, DC: Kaiser Family Foundation, June 2013. Available at http://kff.org/medicaid/state-indicator/section-1915i-home-and-community-based-services-state-plan-option/. Accessed August 30, 2013.

Kaiser Family Foundation. "Explaining Health Care Reform: Questions About Health Insurance Subsidies." Washington, DC: Kaiser Family Foundation, July 2012. Available at http://kaiserfamilyfoundation.files.wordpress.com/2013/01/7962-02.pdf. Accessed August 29, 2013.

Kaiser Family Foundation. "Implementing New Private Health Insurance Market Rules." Washington, DC: Kaiser Family Foundation, January 2013. Available at http://kaiserfamilyfoundation.files.wordpress.com/2013/02/8399.pdf. Accessed August 29, 2013.

Kaiser Family Foundation. "Mental Health Financing in the United States: A Primer." Washington, DC: Kaiser Family Foundation, 2011. Available at http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8182.pdf. Accessed August 29, 2013.

Kaiser Family Foundation. "Strategies to Keep Consumers Needing Long-Term Care in the Community and Out of Nursing Facilities." Washington, DC: Kaiser Family Foundation, 2005. Available at http://kaiserfamilyfoundation.files.wordpress.com/2013/01/strategies-to-keep-consumers-needing-long-term-care-in-the-community-and-out-of-nursing-facilities-report.pdf. Accessed August 29, 2013.

Kessler, R.C., G.P. Amminger, S. Aguilar-Gaxiola, J. Alonso, and T.B. Ustun. "Age of onset of mental disorders: A review of recent literature." *Current Opinion in Psychiatry*, 20(4), 2007, pp-359-364.

Koyanagi, C., R.L. Garfield, J. Howard, and B. Lyons. "Medicaid Policy Options for Meeting the Needs of Adults with Mental Illness Under the Affordable Care Act." Washington, DC: Kaiser Commission on Medicaid and the Uninsured, April 2011. Available at http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8181.pdf. Accessed August 29, 2013.

Malone, K. "Behavioral Health Needs of the Newly Eligible and Enrollment Assistance Best Practices." Minneapolis, MN: National Governors Association Conference, *Planning for Expansion Populations* presentation, April 19-20, 2012. Available at http://www.nga.org/cms/home/nga-center-for-best-practices/meeting--webcast-materials/page-health-meetings-webcasts/col2-content/main-content-list/planning-for-expansion-populatio.html. Accessed August 26, 2013.

Musumeci, M. "A Guide to the Supreme Court's Affordable Care Act Decision." Washington, DC: Kaiser Family Foundation, July 2012. Available at http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8332.pdf. Accessed August 29, 2013.

Nieuwenhuijsen, K., U. Bültmann, A. Neumeyer-Gromen, A.C. Verhoeven, J.H. Verbeek, and C.M. Feltz-Cornelis. "Interventions to Improve Occupational Health in Depressed People." *Cochrane Database of Systematic Reviews*, November 1, 2008.

Rosenbaum, S., J. Teitelbaum, and K. Hayes. "The Essential Health Benefits Provisions of the Affordable Care Act: Implications for People with Disabilities." New York, NY: Commonwealth Fund, March 2011. Available http://www.commonwealthfund.org/~/media/Files/Publications/Issue%20Brief/2011/Mar/1485_Rosenbaum_essential_hlt_benefits_provisions_ACA_disabilities_reform_brief_v2.pdf. Accessed August 29, 2013.

Sarata, A.K. "Mental Health Parity and the Patient Protection and Affordable Care Act of 2010." Washington, DC: Congressional Research Service, 2011.

Social Security Administration (SSA). "Annual Statistical Report on the Social Security Disability Insurance Program, 2010." SSA Publication #13-11827, August 2011a. Available at http://www.ssa.gov/policy/docs/statcomps/di_asr/2010/di_asr10.pdf.

SSA. "SSI Annual Statistical Report, 2010." SSA Publication #13-11827, August 2011b. Available at http://www.ssa.gov/policy/docs/statcomps/ssi_asr/2010/ssi_asr10.pdf.

Stapleton, D., S. Liu, D. Phelps, and S. Prenovitz. "Work Activity and Use of Employment Supports Under the Original Ticket to Work Regulations: Longitudinal Statistics for New Social Security Disability Insurance Beneficiaries." Washington, DC: Mathematica Policy Research, December 2010. Available at http://www.ssa.gov/disabilityresearch/documents/TTW5_7_DICohort_rev.pdf.

Substance Abuse and Mental Health Services Administration (SAMHSA). "State Estimates of Substance Abuse and Mental Disorders from the 2010-2011 NSDUH: Results and Details Tables." Available at http://www.samhsa.gov/data/NSDUH/2k11State/NSDUHsae2011/Index.aspx.

Wang, P.S., G.E. Simon, J. Avorn, F. Azocar, E.J. Ludman, J. McCulloch, M.Z. Petukhava, and R.C. Kessler. "Telephone screening, outreach, and care management for depressed workers and impact on clinical and work productivity." *JAMA*, 298(12), 2007, pp. 1401-1411.

Wishon Siegwarth, A., and C. Koyanagi. "The Affordable Care Act: Improved options for North Carolinians with mental illnesses." *North Carolina Medical Journal*, 73(3), 2012, pp. 240-243.

This Brief was written by Allison Wishon Siegwarth and Crystal Blyler from Mathematica Policy Research. It explores the provisions of the Affordable Care Act that may enable Americans with mental illness to obtain the mental health treatment and support services they need to continue working or get back to work.

This Brief was prepared under contract #HHSP23337003T between the U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, Office of Disability, Aging and Long-Term Care Policy and Mathematica Policy Research. For additional information about this subject, visit the DALTCP home page at http://aspe.hhs.gov/office_specific/daltcp.cfm or contact the ASPE Project Officer, Kirsten Beronio, at HHS/ASPE/DALTCP, Room 424E, H.H. Humphrey Building, 200 Independence Avenue, S.W., Washington, D.C. 20201, Kirsten.Beronio@hhs.gov

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