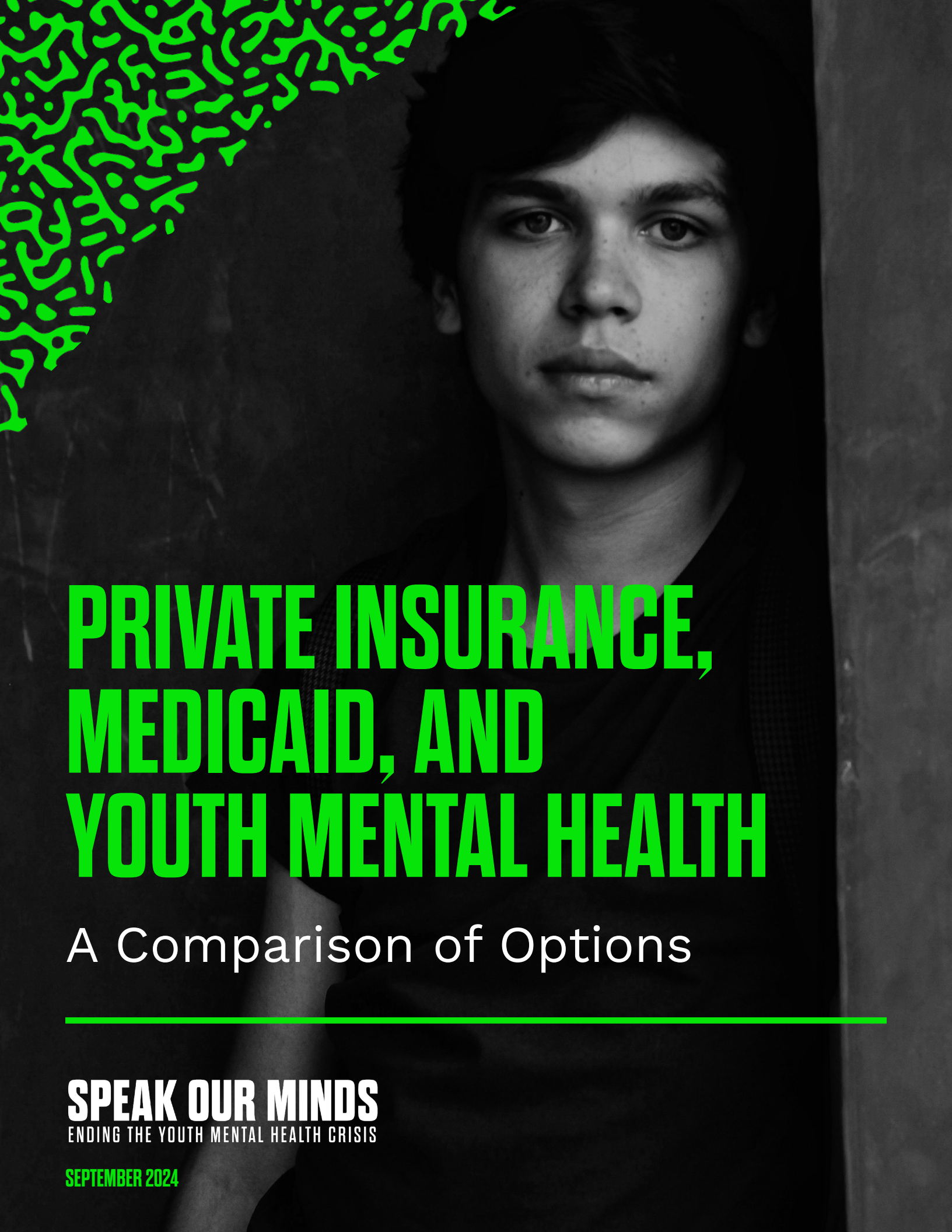


PRIVATE INSURANCE, MEDICAID, AND YOUTH MENTAL HEALTH

A Comparison of Options

SPEAK OUR MINDS
ENDING THE YOUTH MENTAL HEALTH CRISIS

SEPTEMBER 2024

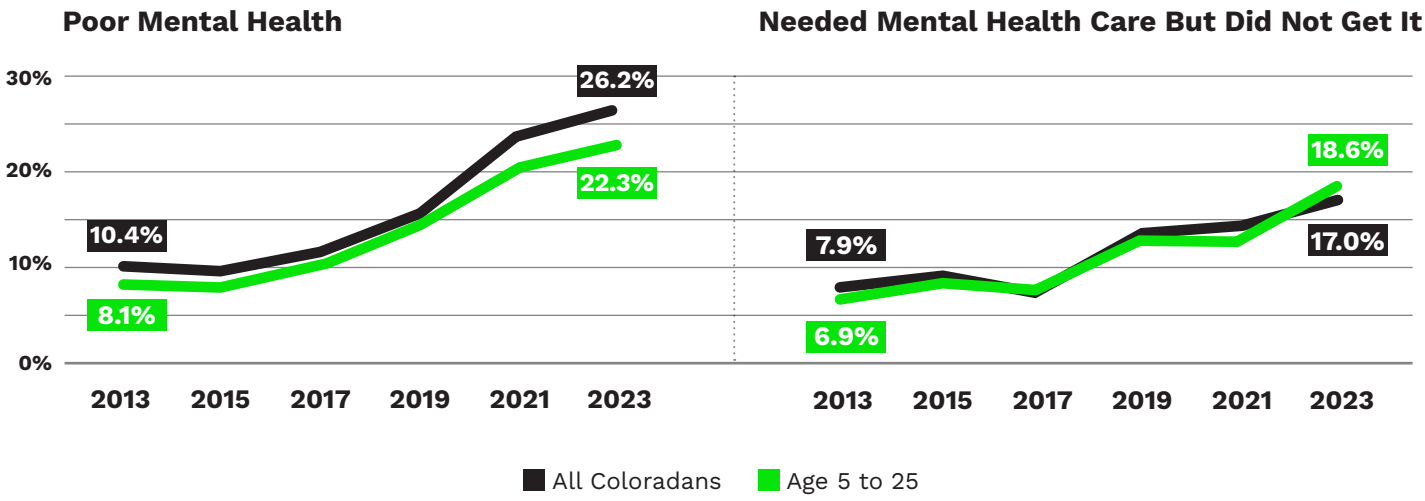
INTRODUCTION

The mental health of Colorado's youth is getting worse. So is their access to mental health care.

In 2023, 22.3% of Coloradans age 5 to 25 reported poor mental health, defined as experiencing at least eight days of poor mental health in the previous month. That's about a threefold increase over the past decade. Additionally, 18.6% of young people said they needed mental health care but didn't get it in the past year — also nearly triple the number from a decade ago.[1] An analysis by Mental Health America ranks Colorado 44 in the nation on a composite measure of seven components of mental illness and access to care.[2]

The youth mental health crisis has many causes and will require multiple solutions. This report focuses on one aspect of the issue — insurance coverage. Speak Our Minds, an organization that focuses on creating an effective system of care to address the youth mental health crisis, contracted with the Colorado Health Institute (CHI) to compare mental health coverage between private insurance and Medicaid in the state. While this paper concentrates on insurance, it is important to recognize that insurance is not the sole factor — or necessarily the most critical factor — in addressing the crisis. Comprehensive reform efforts must also tackle social and economic influences on health, the mental health workforce, and the need for a well functioning system of care.

Figure 1. Mental Health Status and Access for Coloradans Age 5 to 25, 2013 to 2023



Source: Colorado Health Access Survey[29]

Speak Our Minds commissioned this report to learn whether the American private insurance system is capable of covering behavioral health services for children and youth on par with the benefits that Medicaid is required by law to provide.

In brief, the answer is a qualified no. The regulatory structure and financial incentives of private insurance create a system of benefits that is less comprehensive than Medicaid, especially when it comes to the prevention, screening, and early diagnosis of mental health issues.

CHI reached this conclusion based on a broad literature review and five key informant interviews with state and national experts in private insurance and Medicaid. (See Appendix for interview summaries.)

This report begins with a description of federal requirements for the behavioral health benefits that states must provide for children and youth in their Medicaid programs. It then assesses the relative strengths of Medicaid and private insurance in terms of:

- Regulatory structures
- Financial incentives
- The mental health workforce

The report continues with a discussion of the political and policy options for expanding public coverage, specifically examining a potential Medicaid buy-in for youth mental health. A buy-in would allow people who are not eligible for traditional Medicaid to pay premiums to Medicaid for coverage of youth behavioral health services, rather than getting that coverage through their private health insurer. The report concludes with a look at the broader issues of youth mental health.

TAKEAWAYS FROM KEY INFORMANT INTERVIEWS

The Colorado Health Institute conducted five key informant interviews for this report. This is a synthesis of the top themes that emerged in all or most of the interviews. The appendix contains a summary of each interview.

Medicaid and private insurance are built differently, and these differences produce different strengths and weaknesses in behavioral health care.

- Private insurance tends to focus on high-acuity care, with time-limited, clearly defined services for which providers can be reimbursed.
- Medicaid offers a broader spectrum of benefits. By law, it provides all children with Early and Periodic Screening, Diagnostic and Treatment (EPSDT).
- Advocates find it easier to organize around Medicaid reform because it is a government program designed for a specific population.
- Regulation of private insurance is splintered between the states and the federal government, depending on the type of insurance plan. States have less control over private policies than they do over Medicaid.

Differing incentives and constraints drive decision-making in private insurance and Medicaid.

- Medicaid has cost constraints because state budgets are finite, but its top concerns are legal and political — the need to provide mandated benefits and to satisfy lawmakers and advocates.
- Private insurers have legal requirements, too, such as parity laws and essential health benefits. But companies' primary concern is their own financial health and, for publicly held companies, creating shareholder value.

The inadequate size of the behavioral health workforce acts as the biggest constraint on the system, regardless of the payer.

- Expanding the size of the clinical workforce will take a long time. The workforce especially needs providers from varied backgrounds with the cultural competence to treat a diverse population.
- Medicaid has experience with paying behavioral health paraprofessionals, such as peer supporters, to extend the reach of the workforce.
- Private insurers tend to shy away from paraprofessionals in favor of credentialled providers.

A Medicaid buy-in for youth behavioral health is worth exploring.

- Businesses that provide health insurance to their employees would have reasons to favor a Medicaid buy-in, because it might be cheaper and provide better coverage for their employees' families.
- No one has modelled the costs of this idea.
- Medicaid's lower reimbursement rates could make the buy-in program affordable, but low rates could keep providers from participating in the system.

AN OVERVIEW OF MEDICAID BENEFITS

Medicaid is the most common payer for mental health services for both adults and children.[3] Almost half of all children in the United States receive their health insurance through Medicaid. As of March 2024, more than 37.5 million people were enrolled in Medicaid or the Children's Health Insurance Program (CHIP) in the 49 states and the District of Columbia that reported child enrollment. (The number includes parents and pregnant people enrolled in CHIP.)[4] Medicaid's behavioral health services for children and adolescents are included in the program's overall benefit package for children, known as Early and Periodic Screening, Diagnostic and Treatment services, or EPSDT.

Passed by Congress in 1967, EPSDT includes a more robust set of benefits than Medicaid offers to adults. It aims to make sure children receive early detection and care to treat health problems while they are young. EPSDT covers regular health and developmental screenings on a schedule set by individual states, as well as additional screenings suggested by a provider, teacher, or other professional. When a screening indicates a need for further evaluation, EPSDT requires a quick referral for diagnosis. For children who need treatment, EPSDT provides coverage for any medically necessary service.

In behavioral health, the federal EPSDT guide for states requires coverage for treatments including:

- Community-based crisis services, such as mobile crisis teams and intensive outpatient services
- Mental health and substance use treatment, including in nontraditional settings such as at school or home
- Medication management
- Counseling and therapy
- Rehabilitative equipment

For children whose initial screenings indicate significant emotional and behavioral conditions, EPSDT covers Intensive Home and Community-Based Services (IHCBS) such as rehabilitation and case management.

For all these services, EPSDT also includes care for chronic conditions. Services under the benefit do not need to provide a cure — only to ameliorate a condition.[5]

Does Private Insurance Have an EPSDT-like Requirement?

Children covered under private insurance face a different system when they need mental and behavioral health services. While private insurance policies do have minimum coverage requirements in federal and state law, they have nothing like Medicaid's EPSDT requirement. Screening options are more limited for children with private coverage. Private insurance tends to focus on higher acuity care, the type of care specialists and doctors can bill for.

In theory — but not necessarily in practice — Medicaid offers a richer set of behavioral health benefits.

"Kids on Medicaid, in theory, should do better than kids on commercial [insurance], because the list of covered services is broader and less subject to interpretation. It's much easier and clearer for Medicaid to pay for early intervention than for commercial insurers," said one insurance expert interviewed for this report.

PRIVATE COVERAGE AND ITS DIFFERENCES FROM MEDICAID

Regulatory Structure

Unlike private insurance, Medicaid was built from the start to help vulnerable populations. As a government program, it's inherently political. Advocates find it far easier to lobby for policy changes in Medicaid than in private insurance. This dynamic partly explains why Medicaid embraces innovative services — such

as policies to address social determinants of health — more so than private insurance. One of the key political requirements for Medicaid is EPSDT. Federal law requires every state's Medicaid program to offer EPSDT benefits.

But the regulation of private insurance policies is more fragmented. Coverage mandates differ depending on the state and the insurance market. State insurance commissioners regulate the individual, small-group, and fully insured markets. Self-insured plans are governed by federal law and therefore cannot be regulated by the state. This mix of regulators makes it all but impossible to create a standard set of mental health benefits among all private insurance policies.

Policymakers enacted parity laws to address this misalignment. Parity laws mandate that insurers offer equivalent benefits for behavioral and physical health. At the federal level, the Mental Health Parity and Addiction Equity Act of 2008 aims to ensure that private group health plans cover mental health services the same way as physical health, including the number of covered visits, cost-sharing, and annual and lifetime coverage limits.[6] The Affordable Care Act (ACA) of 2010 extended parity requirements to the individual market. In 2015, a federal rule imposed parity requirements on Medicaid and CHIP plans.[7] Several states also have their own parity laws that apply to the individual, small-group, and fully insured large-group markets.

However, parity laws do not set an absolute minimum requirement for mental health coverage. Instead, they require coverage relative to the quality of physical health benefits a plan offers. An insurance policy with poor mental health benefits would pass a parity test if its physical health benefits were equally meager.[8]

The nature of behavioral health care means parity laws are difficult to enforce. Unlike physical health conditions, such as a broken leg, where there are clear and routine procedures, behavioral health conditions lack a standardized approach. As one insurance expert interviewed for this report said, if a patient goes to the doctor with a mole that doesn't look right, the automatic next step in the system is a biopsy. There is no equivalent routine procedure for many behavioral conditions.[9]

A 2019 study found the federal parity law brought only small changes in the use of mental health services and no increase in the use of mental health care or decrease in out-of-pocket costs.[10]

Beyond parity legislation, the ACA tightened regulations on private insurers. It included mental health and substance use services as essential health benefits that every health plan must cover. And it established medical loss ratios, requiring insurers to spend 80% or more of the premiums they collect on patient care. These requirements have improved the quality of mental health coverage for many Americans relative to policies offered before the ACA.

However, neither parity laws nor the ACA have led to a system of private insurance benefits that matches EPSDT.

Financial Incentives

As a public entitlement program, Medicaid does not have the same financial incentives as private insurance. While Medicaid must manage costs due to limited state budgets, it is an entitlement program operated jointly by the state and federal governments, and the federal government provides significant funding. In contrast, private insurers are driven by the need to turn a profit or, for nonprofits, to cover their annual expenses. This financial pressure results in benefit packages that focus on episodic, high-acuity care, rather than screening and early intervention.[11]

Stakeholders point out that private carriers may be disincentivized to promote behavioral health screenings because more screenings can lead to more diagnoses and subsequent treatment costs that the carrier would need to cover. Even if a company wanted to provide screenings for all its customers, doing so would put it at a financial disadvantage to its competitors because it would have to

raise premium prices to cover the cost of additional care. If a state decides it wants to have private insurers pay for more mental health screenings, it will need to make public policy to put all carriers on a level playing field — at least in the markets it can regulate.[12]

However, insurers, businesses, and political leaders often oppose mandates to cover additional services because they can drive up the price of health insurance for consumers.[13] In 2020, for example, Colorado Governor Jared Polis vetoed a bill to require insurers to pay for alternatives to opioids for pain management. He cited the potential of new mandatory benefits to increase the price of insurance for consumers. He has voiced similar concerns about other mandatory benefits, such as fertility treatments.[14]

Workforce Questions

The question of who pays for mental health services — private insurers or Medicaid — matters little if there are not providers to accept payment and deliver care. The behavioral health workforce is simply too small to meet current demands. A 2018 study found that more than half of U.S. counties do not have a practicing psychiatrist.[15] Some 122 million Americans live in a designated shortage area for mental health professionals. The country needs more than 6,100 more providers to close the gap, according to the U.S. Health Resources and Services Administration.[16]

Even where psychiatrists are available, they often do not accept any form of insurance. Some studies attribute this choice to lower reimbursement from payers for mental health services relative to physical health,[17] or the fact that the large demand and lack of supply for psychiatrists means they do not have to bother with the hassle of working with third-party payers.[18] Whatever the cause, the result is that patients often have to pay for mental health services out of their own pockets. Those who can't afford private payments often face long wait times at clinics that accept their insurance.

Licensed clinicians alone cannot meet

MEDICAID MANAGED CARE:

A COMPLICATING FACTOR

The comparison between private insurance and Medicaid becomes muddied when states introduce traits of the private system to their Medicaid programs through managed care. In these cases, private organizations — often the same insurance companies that operate on the private market — administer Medicaid on behalf of the state.

In Colorado, for example, the Medicaid Accountable Care Collaborative works through contracted organizations known as Regional Accountable Entities (RAEs). Providers have complained about cumbersome paperwork and payment delays from the RAEs.[30] Nationally, the Government Accountability Office (GAO) found that children in Medicaid managed care plans may have a hard time getting access to EPSDT services. GAO recommended the Centers for Medicare and Medicaid Services provide better oversight of prior authorization requirements for EPSDT services in Medicaid managed care plans.[31]

A Medicaid expert interviewed for this report said the program does not do a good job in attracting behavioral health providers. Even when a state's Medicaid program pays providers a similar rate to commercial carriers, the managed care groups that administer Medicaid may pay lower rates and add paperwork burdens for providers.

the demand for mental health services. Paraprofessionals, such as peer supports, can help. Medicaid already has mechanisms to reimburse paraprofessionals.[19] However, private carriers are reluctant to pay paraprofessionals out of a concern for quality. Carriers see licensed providers as a higher-quality option with lower risks, according to an insurance expert interviewed for this report.[20]

Despite these concerns, the Colorado Division of Insurance urged private carriers in 2023 to pay pre-licensed professionals for services in mental health and substance use disorder treatment, if they work under the supervision of a licensed provider.[21]

INITIAL THOUGHTS ON A MEDICAID BUY-IN

Medicaid offers advantages in youth mental health from its regulatory and incentive structure. This raises the question of whether to design a system that makes Medicaid coverage for youth behavioral health more broadly available for anyone, possibly through a Medicaid buy-in program. This report does not attempt to answer that question comprehensively. However, people interviewed during CHI's research said the idea could be politically feasible to influential groups, including businesses and perhaps even insurance carriers.

For this discussion, a Medicaid buy-in would allow private insurance customers to purchase a full range of behavioral health services for children and youth through their state's Medicaid program, while private insurance would continue to cover all other services.

Medicaid eligibility expansion was a political flashpoint in the years before and after the ACA passed. A public option for people to buy coverage from Medicare or Medicaid also faced strong opposition. This history suggests that a Medicaid buy-in could be controversial. However, the debate over Medicaid eligibility is less heated today; only 10 states have not expanded Medicaid eligibility under the ACA.[22] The American Academy of Pediatrics (AAP), the country's largest association of pediatricians, has called for an even broader expansion of Medicaid coverage than a mental health buy-in. In 2023, the AAP published a policy statement supporting universal eligibility for all Medicaid services for anyone under age 26, with an opt-out for families preferring private plans.

> *Medicaid specifically has several characteristics that make it a strong program for children, such as no waiting or special enrollment periods and no copays, entitlement to services for all eligible applicants, and coverage of all medically necessary services via the Early and Periodic Screening, Diagnostic, and Treatment benefit."* [23]

State Medicaid systems already operate buy-in programs for disabled children and adults (see sidebar). These have been operating for years with little controversy.

Considerations for Employers

If employers were to offer EPSDT-like coverage — either by choice or mandate — their health insurance costs would go up. Research for this paper did not uncover any studies specifying an exact change, but the price would rise. As one expert interviewed for this paper said, "As for the scope of services private plans cover, if you're going to add more requirements to what insurers must cover, then premiums will have to go up."

Even at the current level of benefits, private insurance prices have been increasing for years for both employers and workers. KFF has surveyed U.S. employers since 1999 and found premium and out-of-pocket cost increases every year (see Figures 2, 3, and 4).

Figure 2. Average Annual Premiums for Employer-Sponsored Health Insurance, Single and Family Coverage, 1999-2023

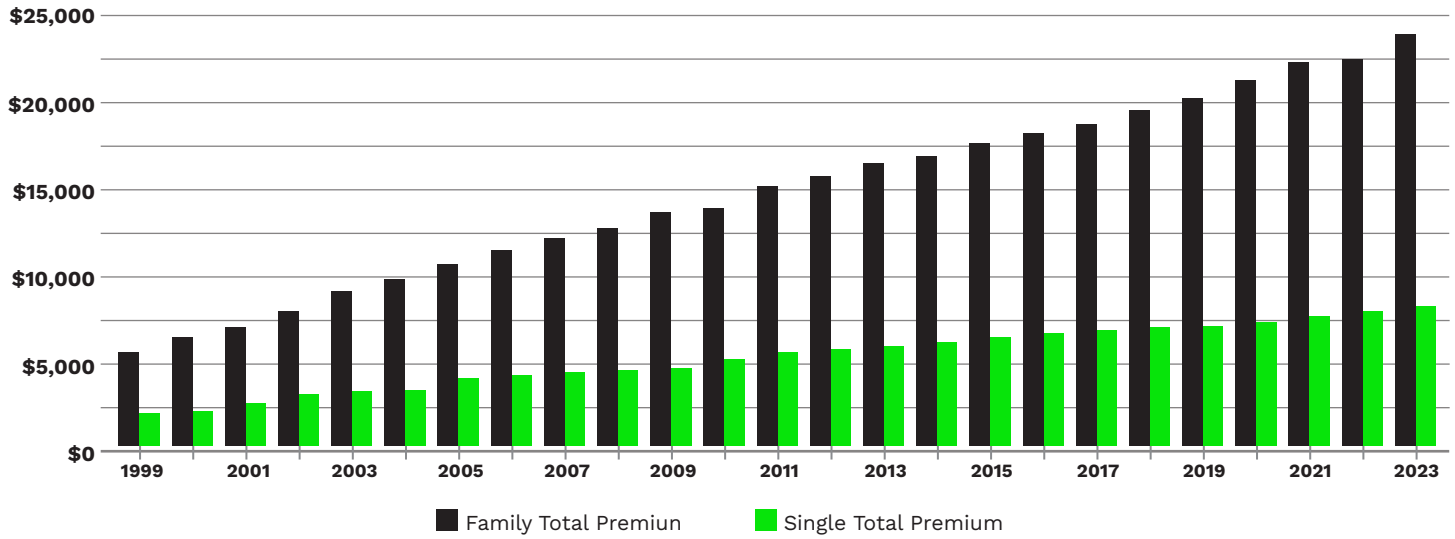


Figure 3. Average Annual Employer Contributions per Worker to Health Insurance, Single and Family Coverage, 1999-2023

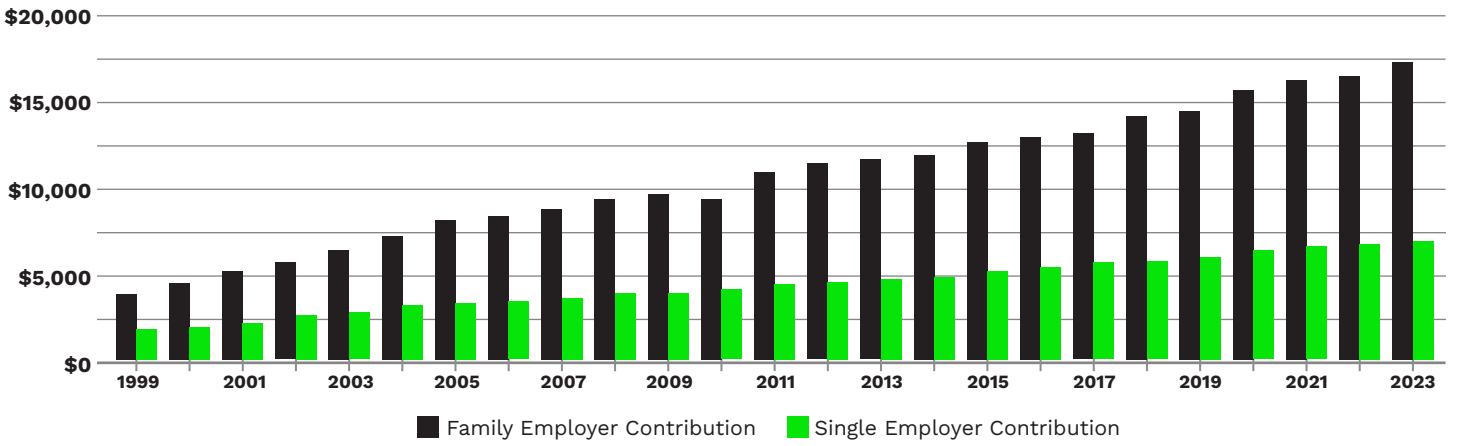
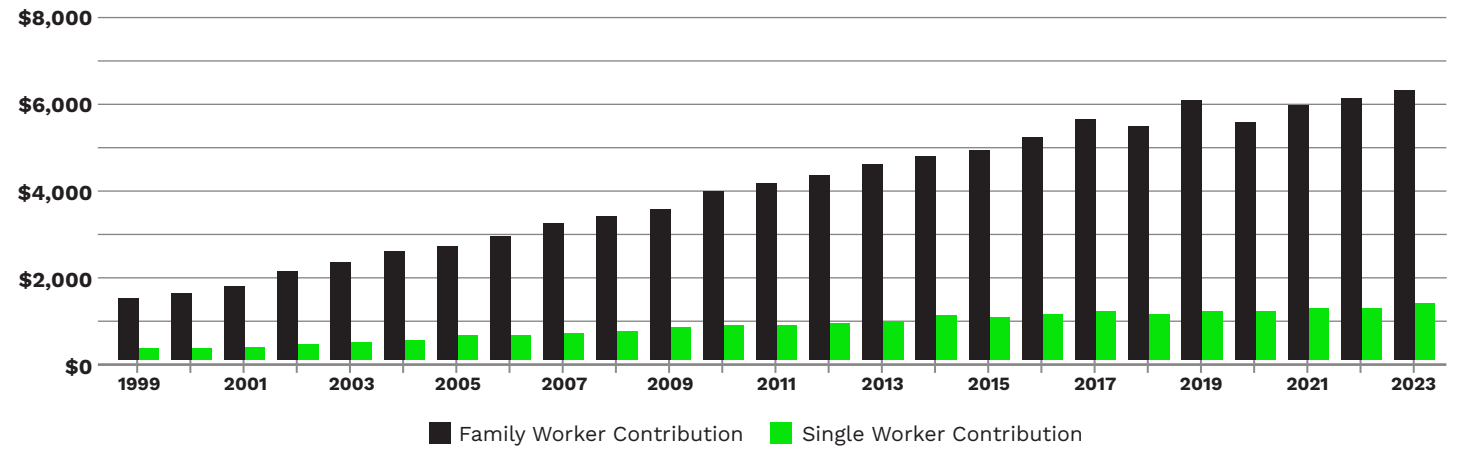


Figure 4. Average Annual Worker Contributions to Health Insurance, Single and Family Coverage, 1999-2023



Source for Figure 2, 3, and 4: KFF Employer Health Benefits Survey, 2023[32]

Given these dynamics, a Medicaid buy-in for youth behavioral health could be an attractive and more affordable solution for employers. Experts suggest that, from a business perspective, both employers and insurers might prefer to shift customers with high-cost care needs to the state Medicaid program. Since businesses offer health insurance as a benefit, they are invested in ensuring their employees have access to the best possible services.[24]

In 2023, three quarters of employers in a national survey (77%) reported increased mental health issues, such as depression, anxiety and substance use disorder, among their workers and their dependents.[25]

The number increased dramatically from 2022, when 44% of employers reported the same. The survey did not report mental health concerns by age. Employers are trying to increase access to mental health care by lowering cost barriers and increasing options for care, according to the survey report. [26]

An insurance industry leader interviewed for this report did not immediately reject the idea of a youth behavioral health buy-in. But this person pointed out a number of challenges the plan would face, including gaining federal approval.[27]

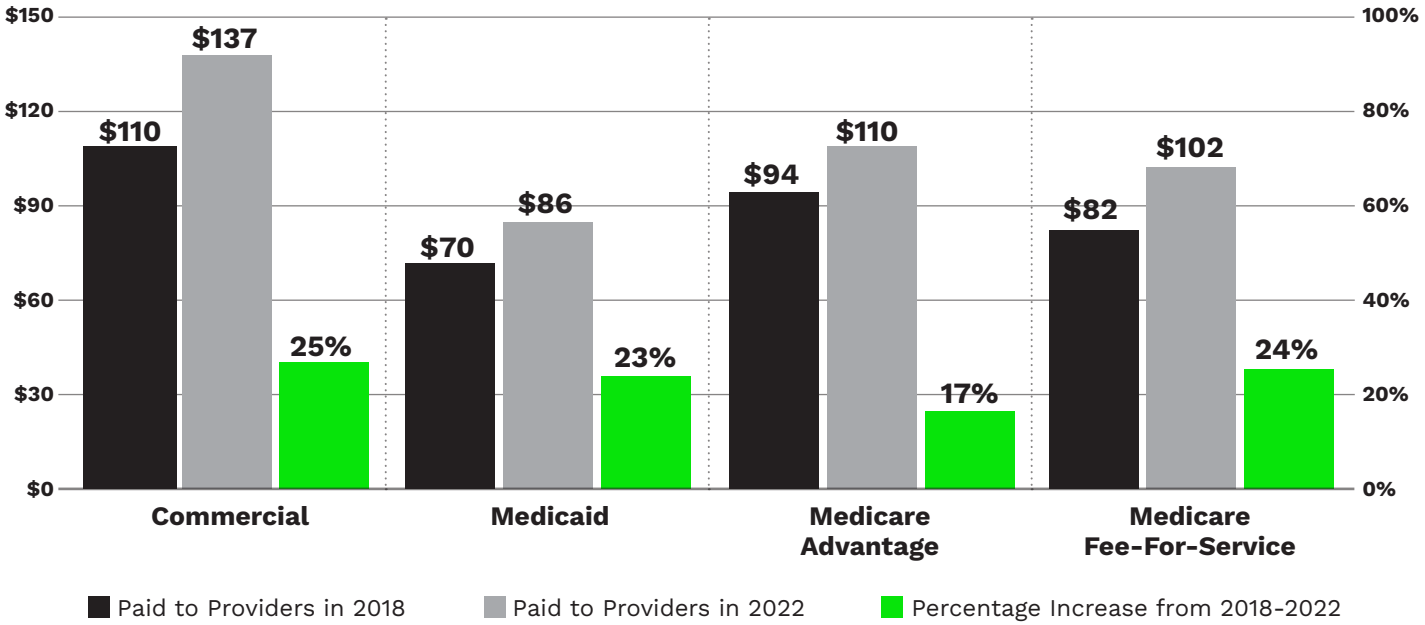
Estimating the Cost of a Medicaid Behavioral Health Buy-in

Research for this report did not turn up any studies of the potential cost or savings of a youth behavioral health Medicaid buy-in. There is reason to think a Medicaid buy-in would save money for families and businesses that provide health insurance. Private coverage tends to pay providers more than Medicare and Medicaid, and data show this pattern holds true for mental health services in Colorado. Private insurers paid providers an average of $137 for a 45-minute therapy session in 2022, compared with $86 paid by Medicaid (see Figure 5).

A reliable cost comparison between Medicaid and private coverage is beyond the scope of this report. However, a behavioral health expert said the general method would be to

Figure 5. Therapy Provider Reimbursement by Payer in Colorado, 2018 and 2022

How much are providers typically paid for a 45-minute therapy session (CPT®90834) and have payments changed since 2018?



Source: Center for Improving Value in Health Care[33]

find private carriers who offer a richer set of youth behavioral health benefits and compare their fee schedules to Medicaid. The difference could be extrapolated to the whole population after adjusting for known differences in demographics between the Medicaid and private insurance populations.

The Colorado Division of Insurance could arrange for such a study at the request of a state legislator. Colorado Revised Statute 10-16-155 gives the Division authority to commission up to six actuarial reviews per year of proposed health care legislation. Legislators must request these reviews. The majority party in each chamber can request two reviews, and the minority party can request one. Crucially, the statute requires insurance carriers to provide data for the study at the actuaries' request.

Challenges to a Medicaid Buy-in

A buy-in for youth behavioral health would need to overcome several challenges:

- **Workforce.** Many licensed behavioral health professionals operate on a cash-pay basis and do not take any type of insurance. Providers say Medicaid rates are especially low, and they might recoil from any plan to expand the number of people covered by Medicaid.[28]
- **Integration.** Payers and providers have spent years trying to integrate behavioral health care into the primary care setting. Those efforts would be complicated by introducing a new payer — Medicaid — for behavioral health to work alongside private coverage for physical health.
- **Managed care.** Finally, a Medicaid buy-in would not necessarily help families avoid problems associated with private insurance, because many states rely on private companies to manage their Medicaid programs (see sidebar on Medicaid managed care).

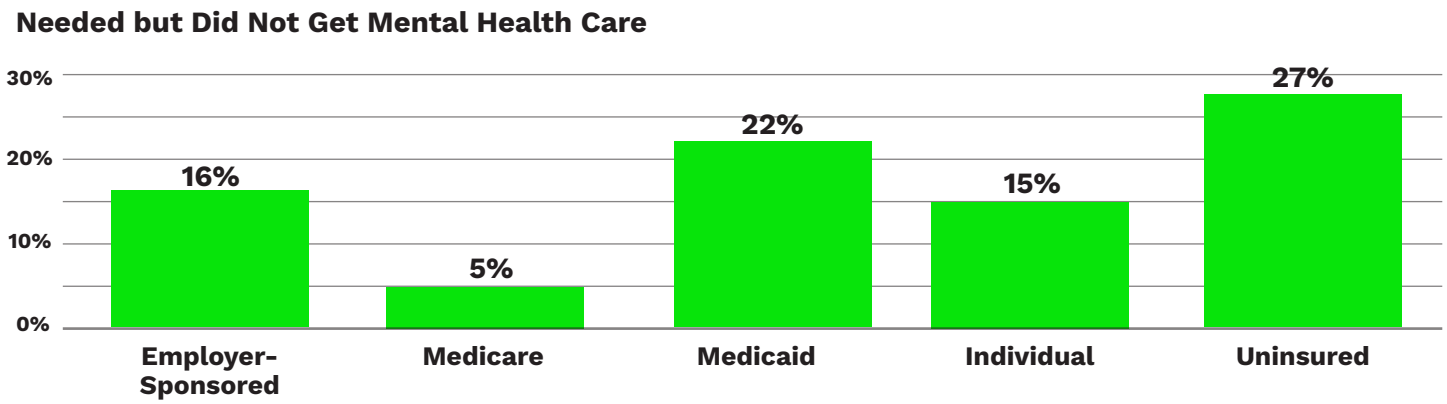
Medicaid Buy-Ins:

The Katie Beckett Precedent

The Katie Beckett program is a Medicaid coverage option created for children under 19 who have severe, chronic disabling conditions or complex medical needs, including mental illness. These children live at home but would require institutional care without Medicaid payment for home-based services. Their families make too much money to qualify for Medicaid membership. Eligibility for the Katie Beckett program is determined by the child's clinical requirements and their own income and resources, rather than those of their parents. Every state except Tennessee offers a Katie Beckett waiver or a comparable program.[34]

How does this relate to mental health? The Katie Beckett program showcases that some children need care on a daily basis. This can include children diagnosed with a disabling mental health condition whose families face high cost-sharing and service limits imposed by their insurance providers. The Reagan administration created the Katie Beckett program in 1981, and it has operated with little partisan controversy for more than four decades. It could provide a template for states considering a Medicaid buy-in for mental health, potentially helping children access the care they need.

Figure 6. Unmet Mental Health Care Needs by Insurance Status, Coloradans Age 5 and Older, 2023



Source: Colorado Health Access Survey[35]

THE BROADER CONTEXT OF THE YOUTH MENTAL HEALTH CRISIS

As stated in the introduction, the difference between public and private insurance is not the only consideration in solving the youth behavioral health crisis.

This paper looks at Medicaid in its ideal state, with the assumption that the EPSDT law is perfectly applied to behavioral health services. The reality in most states is much different from the ideal. Several states have settled or lost class action lawsuits for failing to provide adequate mental health services to children and youth, including California, Illinois, Massachusetts, Iowa, and Colorado.

Survey results show access-to-care problems in Medicaid. Coloradans with private coverage were less likely to report needing but not receiving mental health care than those who use Medicaid (see Figure 6). However, the Medicaid population also faces heightened economic challenges compared with people on private insurance, which can partially explain the discrepancy in access to care. Moreover, uninsured people reported the most unmet needs for mental health care, showing that insurance coverage of any sort is an important first step in getting care.[35]

The lack of providers is a critical piece of the problem. This report shows that Medicaid has tools at its disposal to help build up the provider workforce. However, it's unlikely the workforce could ever grow enough to address the youth mental health crisis in a purely clinical context. Broader thinking is needed.

Social stressors such as poverty, racism, climate change, social media, and the COVID-19 pandemic also contribute to the mental health crisis. The answers to these challenges will require more resources than any Medicaid program or insurance company can provide on its own.

CONCLUSION

Structurally, state Medicaid programs offer greater promise in addressing behavioral health needs for children and youth than most private insurance plans. Medicaid's EPSDT benefit provides a comprehensive set of services to support children and youth with behavioral health needs. While the concept of a Medicaid buy-in for youth behavioral health is appealing, Medicaid programs have had a mixed record in meeting their EPSDT obligations, and Medicaid managed care systems can sometimes diminish the advantages of Medicaid compared to private insurance.

Ultimately, the payer question is just one aspect of the problem. A comprehensive solution to the youth behavioral health crisis will require effort from all sectors of society.

APPENDIX: KEY INFORMANT INTERVIEW SUMMARIES

Below are summaries from five key informant interviews CHI conducted for this report. CHI promised interview subjects anonymity so they could speak candidly about their professional field. Questions differed slightly for each interview, but they all addressed the central question of this report:

Are there built-in limits of commercial insurance that prohibit it from providing comprehensive mental health coverage for youth? If so, what are they?

Interview Summary 1: Two Former State Medicaid Officials

Date: May 3, 2024

Differences between private coverage and Medicaid: Many families struggle to get services through commercial providers for more complicated services. The benefits are not the same between private and Medicaid, partially because of EPSDT. Commercial insurance doesn't have to help patients get those services; they just need to pay for it.

Most states provide more robust oversight of Medicaid than they do the commercial insurance market. In Arizona, for example, the Medicaid department has more than 70 employees organizing information, holding plans accountable, and overseeing grievances. The state's insurance regulation department has a much smaller staff and does not provide the same level of oversight. Parity laws exist, but state regulators tend to lack the expertise and staff to closely examine plans' provider networks and behavioral health benefits. Most state insurance commissioners don't see this as their job. They focus on financial oversight of carriers.

The way you change systems is through data. There is data on grievances and appeals. There's not as much data in the private space about what is performing well and whether there are shortcomings. Often, you get more granularity in the Medicaid space.

Workforce: The behavioral health workforce affects both private insurance and Medicaid, but Medicaid has more options to address it. Paraprofessionals can create more capacity, and Medicaid has ways to pay for paraprofessionals, social workers, and case managers, while private plans tend not to. However, all realistic solutions to the workforce shortage are long-term.

Interview Summary 2: Private Insurance Association Official

Date: May 3, 2024

Differences between private coverage and Medicaid: Carriers comply with all parity laws at all levels. It's up for debate whether the current parity system is robust enough. Insurers take criticism for prior authorization requirements, but they have to do this because health care is expansive. Some private insurers do prior authorization only for intensive inpatient care.

There's a lot of discussion about parity, but physical to mental health isn't an apples-to-apples comparison. Our health system has a lot more experience with physical health. If a patient comes in for a mole that doesn't look right, the next step is a biopsy. We don't have the same automatic steps for mental health.

As for the scope of services private plans cover, if you're going to add more requirements to what insurers must cover, then premiums will have to go up.

Medicaid buy-in for youth behavioral health: This insurance representative did not express immediate opposition to the idea, but they said they would need a lot more details. Also, the buy-in would need

federal approval and cooperation from providers.

Workforce: The behavioral health provider shortage impairs insurers' ability to help people get care. But the shortage also applies to Medicaid. It's more acute in rural areas. Providers say that insurers are too hard to work with, and that's an understandable argument. But there have to be quality checks and credentialling. Policymakers need to incentivize people to go to medical school and get people into rural areas. We especially need more diverse providers to improve the cultural competency of the workforce.

Scope of practice is another issue. It becomes a quality-of-care issue. We're in a new era of mental health treatment, with people more willing to seek treatment. But how do you measure quality? Carriers only want to pay for services from credentialled providers, not paraprofessionals. In our desperation to expand the workforce, we might be cutting corners by relying on untrained providers.

Interview Summary 3: Medicaid Behavioral Health Consultant

Date: June 5, 2024

Differences between private coverage and Medicaid: Medicaid is, in theory, good at covering early intervention services. It allows for a variety of services that private insurance does not, such as high-fidelity wraparound services, case management to cover social determinants of health, and peer mentoring.

Private insurance does not do much wraparound and does not provide case management for social determinants. However, private insurance is often superior to Medicaid at the high-acuity end. Private carriers are more efficient about authorizing psychiatric testing without prior authorization. Acute services are covered and are less restrictive.

Medicaid buy-in for youth behavioral health: Businesses would entertain this idea. There already is a Medicaid buy-in for people with certain disabilities [the Katie Beckett waiver]. Several years ago, there was talk about opening Medicaid to a buy-in for anyone. The idea probably would be wildly popular. But if the buy-in program would be managed by the same commercial payers who handle Medicaid managed care, then the program would run into the same problems that currently afflict Medicaid — namely billing problems for providers and low reimbursement rates.

Workforce: We don't have enough providers — especially providers from diverse backgrounds. The behavioral health provider community is small, and they talk to each other a lot. News travels fast. A Medicaid buy-in would have to be designed well and be provider-focused. Providers would have to be paid well and quickly. Currently, a lot of providers out there want nothing to do with Medicaid. Because they are so in demand, they can start an all cash-pay business and not have to worry about billing third parties.

Interview Summary 4: Former State Insurance Regulator and Health Policy Expert

Date: May 23, 2024

Differences between private coverage and Medicaid: There is nothing about the private insurance system that would prevent a carrier from offering EPSDT-like benefits. But there's not a lot of financial incentive for insurers to do so. You don't make money as an insurer by providing a lot of screening and diagnosis, because when you do, you find more problems that you have to pay for. Any carrier that did so would be at a competitive disadvantage to

other insurers, so if we want insurers to do this, we will need to make public policy that sets an even playing field for everyone.

However, it's getting harder and harder to set minimum benefits at the state level because so many employers self-insure, and those plans are not subject to state regulation.

Kids on Medicaid, in theory, should do better than kids on private insurance, because the list of covered services is broader and less subject to interpretation. It's much easier and clearer for Medicaid to pay for a service like early intervention than for private insurers.

Medicaid buy-in for youth behavioral health: We have a precedent for a Medicaid buy-in with the Katie Beckett program. She and her parents successfully argued that she was eligible for disability-related services covered by Medicaid but not private insurance. The difference with a behavioral health waiver is that, in theory, commercial insurance is supposed to offer behavioral health services, whereas the Katie Beckett program was dealing with services private plans did not offer.

From a business standpoint, the young people who could be covered under a Medicaid buy-in are the kind of patients that businesses and insurers would love to lose because they're more expensive. Employers also want to know that their employees can get access to services, so they might embrace a Medicaid buy-in.

However, pricing the buy-in would be a challenge. Medicaid's expertise is not in setting premiums and copays and such.

Many other state agencies should be involved in a buy-in, too, including child welfare. Providers usually are licensed by different state agencies than Medicaid.

Interview 5: Behavioral Health Policy Expert

Date: July 31, 2024

Differences between private coverage and Medicaid: No major legal barriers that would keep commercial insurers from being able to offer services on par with Medicaid. However, there are fundamental differences in the design of Medicaid versus private insurance plans. Medicaid was built from the ground up to help vulnerable populations. There are politics involved in designing benefits. Advocates get involved. This is a reason why Medicaid has leading-edge programs that private insurance often lacks.

A key issue on the Medicaid side is its reimbursement rate. Providers are not thrilled with reimbursement from any type of payer, but Medicaid's low reimbursement rates act as bandwidth restrictor to finding an adequate supply of providers to treat all the Medicaid members who need care. The elephant in the room is the supply of labor. There are not enough providers, and many providers don't take any form of insurance.

Medicaid buy-in for youth behavioral health: This person was not aware of any study on the cost of providing EPSDT-level benefits in the private insurance system. Any health benefit pricing exercise comes down to modelling severity and frequency. How would the medical system treat someone, and how frequently would a patient use this service? The first step in such a study would be to survey insurance carriers to see if anyone is providing comparable services. If so, you could compare private costs to the Medicaid fee schedules and adjust for the different demographics of Medicaid members compared to private insurance customers.

The Colorado Department of Regulatory Agencies can commission a certain number of cost studies per year for policies under consideration at the legislature. These studies must be requested by a legislator. Each of the two major parties gets to commission a certain number of studies per year. The state contracts this work out to actuaries.

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