USC School of Social Work
Center for Innovation and Research on Veterans & Military Families

Healthcare for Veterans in the Era of Patient Protection and the Affordable Care Act of 2010

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On June 28, 2012 the United States Supreme Court upheld the Patient Rights and Affordable Care Act (ACA), which was signed into law by President Barack Obama in 2010. The individual mandate and the extension of Medicaid eligibility are the primary components of ACA and have drawn a great deal of attention from the media and public. However, little attention has focused on how ACA will affect veteran healthcare access, particularly for Operations Enduring Freedom and Iraqi Freedom (OEF/OIF) veterans.

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The lack of attention in this area may be due to the fact that the vast majority of veterans are already insured through employer-based insurance or government-sponsored providers such as the Veterans Health Administration (VHA) and TRICARE. Although most veterans are eligible for some form of healthcare coverage, a significant number struggle with lack of access to care and loss of eligibility for such benefits (Himmelstein et al., 2007). A recent study by the Robert Wood Johnson Foundation (2012) estimated that 1.3 million veterans are currently uninsured.

Fifty percent of uninsured veterans with income less than 138% of the Federal Poverty Level are likely to be eligible for Medicaid. An additional 40% of uninsured veterans will be able to purchase affordable individual coverage through government-subsidized health insurance exchanges, regardless of pre-existing conditions (Haley & Kenney, May 2012). Therefore, ACA will undoubtedly have far-reaching effects on veteran healthcare access. This policy brief aims to discuss the anticipated opportunities and challenges that ACA will have for veteran healthcare, particularly with respect to integrated care for both medical and behavioral health.

The Veteran Healthcare System

Veterans have multiple healthcare options. Of the 22 million veterans living in the United States, roughly 90% have some form of health insurance either through their employer, VHA, or other government program such as Medicare or TRICARE. More than 50% of veterans have access to private insurance, while almost 40% are covered by VHA health insurance (Kizer, 2012). Eighty percent of VHA-insured veterans are also covered by other forms of health insurance (Congressional Budget Office, 2010). For veterans who have multiple health insurance plans, deciding what type of healthcare provider to utilize can depend on several factors: cost of services, preference for specific doctors, perceived quality of care, and distance to a local VHA facility (CBO, 2010).

Even though veterans may access multiple systems of care, the VHA—which administers and implements the healthcare program within the U.S. Department of Veterans Affairs—is widely considered the primary healthcare provider for veterans, especially for low-income and disabled veterans. VA-eligible veterans mainly use the VA to receive mental health treatment and other healthcare services, or specifically to receive treatment for service-connected injuries (CBO, 2010). The VHA operates 150 medical facilities throughout the country and more than 900 outpatient clinics that provide a vast

array of medical services to veterans, ranging from marriage counseling to treatment for combat injuries. To deliver these services, the VHA uses a primary care model, including its relatively new Patient Aligned Care Team (PACT) model, which utilizes veteran input while focusing on evidence-based clinical guidelines and information-sharing between service providers (CBO, 2010).

ACA does not change VA eligibility requirements or prescribe changes to the VHA system. However, because the vast majority of VHA-insured veterans are also covered by other insurance plans that *are* affected by ACA, it is likely that the landscape of the veteran healthcare system will change significantly. An influx of VHA-eligible veterans shifting to civilian providers is expected due to ACA's expanded eligibility for programs such as Medicaid (Kizer, 2012). This influx will be in addition to the 650,000 uninsured veterans who will now qualify for other programs such as Medicaid or insurance exchanges under ACA.

When this shift happens, many veterans will transition to civilian providers that may not have the familiarity and clinical background to address veteran-specific issues. Additionally, civilian healthcare providers may not utilize the primary care model used by VHA. For instance, if a VHA-insured veteran utilizes other coverage (i.e. employer insurance) which delivers service with certain payment methods (e.g. fee-for-service), medical providers will be less motivated to treat symptoms related to mental health, including post-traumatic stress disorder (PTSD) or risky alcohol use (Landon, Gill, Antonelli, & Rich, 2010). As a result, there may be a reduction in the continuity of care, which could negatively affect veterans' health outcomes (CBO, 2010). For this reason, it is important to consider how ACA affects continuity and coordination of care for both insured and uninsured veterans.

Continuity and Coordination of Care Under ACA

ACA places strong emphasis on improving the quality of healthcare systems by providing more integrated and coordinated healthcare. ACA deviates from the existing fragmented healthcare system that limits collaboration among care providers, and instead promotes integration of services to treat various health needs that add to traditional, acute, or chronic medical conditions (Landon, et al., 2010). For instance, as of January 1, 2012, the Medicare Shared Savings Program started providing incentives for physicians who want to form an "Accountable Care Organization" (ACO). ACOs are incentivized through ACA to healthcare providers that coordinate care for patients. ACOs that demonstrate they can provide better care at lower costs are rewarded for their efforts (Landon et al., 2010). Government leaders and researchers expect payment-for-performance will induce more coordinated and integrated healthcare, and ultimately lead to improved quality of care (Landon et al., 2010; McClellan, McKethan, Lewis, Roski, & Fisher, 2010).

Integrated/coordinated care aims to enable multiple health professionals—including primary care physicians (PCPs), sub-specialist physicians, nurse practitioners, registered nurses, licensed social workers, and community health workers (whose numbers are increasing in community safety net care systems)—to actively communicate and collaborate in providing optimal quality of care. In addition, the rapid growth in Patient-Centered Medical Homes (PCMH) specifically aims to ensure that patients and caregivers are optimally engaged in patient self-care management. These approaches are increasingly becoming embedded in emerging ACO models (Landon et al., 2010; McCarthy, 2011).

Emerging collaboration between health and behavioral health providers in implementing integrated/coordinated care is specifically aimed at strengthening psychosocial and mental healthcare within a primary care setting (Reiss-Brennan, Briot, Savitz, Cannon, & Staheli, 2010; Unutzer & Park, 2012). Under the current fragmented healthcare system, mental health needs are too often unidentified or inadequately cared for (Cunningham, 2009; Mojtabai, 2009). For instance, Cunningham (2009) found that two-thirds of physicians reported difficulties locating adequate behavioral health services when patients with mental health disorders were detected. Active cooperation

among primary care physicians and behavioral health professionals in treating undetected mental health needs is known to be clinically effective (Woltmann, Grogan-Kaylor, Perron, Georges, Kilbourne, Bauer, 2012) as well as anticipated in ACA; similar collaborations have been found to be cost-effective in previous studies (Reiss-Brennan, Briot, Cannon, & James, 2006; Reiss-Brennan et al., 2010).

Coordinated/Integrated Care and Mental Health Services for Veterans

Following US combat operations in Iraq and Afghanistan, the prevalence of mental health disorders remain a high national security and public health priority. This issue was first recognized when a group of researchers revealed that a fifth of returning servicemembers reported probable clinical mental health disorders, including PTSD, depression, and anxiety; however, only 23 to 40% of them attempted to seek help for their symptoms (Hoge et al., 2004). Even though there is variance with incidence and prevalence figures, a number of studies have suggested adverse consequences arising from mental health risks among veterans (Tanielian & Jaycox, 2008; Thomas et al., 2010; Wells et al., 2012). To address these challenges, the Department of Defense (DoD) and VHA took on several initiatives designed to bolster existing medical treatments and preventive measures for returning servicemembers (CBO, 2010; Hoge, 2011). Recently, the VA announced ambitious plans to recruit 1,600 mental health professionals to address the surging mental healthcare needs of veterans.

The implementation of ACA may result in many veterans moving from VA to civilian providers (Kizer, 2012; Haley & Kenney, 2012; Shen, Hendricks, Wang, Gardner, & Kazis, 2008). Although the VA healthcare system is evaluated as providing integrated and good quality care (Gao et al., 2011; Kizer, 2012), some veterans report negative perceptions about the quality of care in VA settings (Schell & Tanielian, 2011). Additionally, the top reason eligible veterans do not utilize the VA to seek mental health services is a concern that the medical visit and clinical diagnoses would jeopardize their future careers in the military or other jobs requiring a security clearance (Schell & Tanielian, 2011). Given this perception among veterans, many are likely to seek help from civilian providers, especially as ACA expands the eligibility for Medicaid and subsidizes purchase of individual coverage through insurance exchanges. There is also concern that the increase in veterans entering civilian care settings will result in further fragmentation of veteran healthcare (Haley & Kenney, 2012; Kizer, 2012). For example, the VA is widely recognized for its capacity to provide integrated care for medical and behavioral health needs (Gao et al., 2011; Trivedi & Grebla, 2011). However, many civilian health providers lack this coordination between providers and several empirical studies have confirmed that VA providers deliver more coordinated and effective care, compared to non-VA providers (Trivedi et al., 2011).

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Fortunately, as discussed earlier, ACA is making important strides in delivering promising innovations to facilitate coordinated/integrated care that could remedy the fragmented delivery system for veterans (Landon et al., 2010; McClellan et al., 2010). During its early implementation phase, ACA added several provisions that strengthen the role of the primary care physician (PCP) within healthcare delivery and incentivize coordination or integration among healthcare providers. Fragmented healthcare delivery, which is largely operationalized by fee-for-service payment, encounters barriers to facilitating coordination among providers, such as communication about patients' symptoms, providing significant information to patients via phone or not-in-person contact, or conference for non-responding patients (Landon et al., 2010; McClellan et al., 2010; McClellan, 2011; Rosenthal, Landon, Howitt, Song, & Epstein, 2007).

Barriers to the team-based approach among health professionals from different backgrounds are expected to diminish under ACA, which promotes the ideas of patient-centered medical home (PCMH) and ACOs. For instance, the National Committee for Quality Assurance (NCQA) adopted six elements that are expected be part of the PCMH model. These include activities promoting coordination among providers, such as "care management" and "referral tracking and follow-up" (McCarthy, 2011). To strengthen the capacity to manage mental health needs, adopting robust measurement for mental health disorders (e.g. Patient Health Questionnaire-9), paying attention to patients with mental health symptoms, adding care managers and psychiatric consultants to primary care settings, and discriminating attention to patients who do not respond to initial treatment by PCP, are suggested (Unutzer & Park, 2012). In addition, integrated healthcare for both behavioral and medical needs saved $405 per patient and reduced 54% of emergency department use in one year, as compared to usual PCP clinic costs in Utah (B. Reiss-Brennan et al., 2010).

Although ACA supports innovative delivery methods promoting better treatment for behavioral health needs in primary care settings, lack of training for civilian providers about military populations can be a risk factor for quality of care. For instance, a recent study found that civilian PCPs were less likely to be prepared for treating PTSD and other mental health disorders relative to the VA-affiliated providers (Boscarino, Kirchner, Hoffman, Sartorius, & Adams, 2011). Therefore, additional training for collaborating primary care behavioral health professionals is important in providing optimal quality of care after ACA implementation.

Moving Forward

The Affordable Care Act ensures that all Americans will have access to quality, affordable health insurance. However, even after ACA's implementation in 2014, veterans and civilians alike will be challenged in finding the right healthcare option for themselves. Thus, it is important for veterans and their families to have access to knowledgeable individuals within the healthcare system who can provide them with information that will help them manage their healthcare in the best possible way. For OEF/OIF and other veterans and their families, this need for guidance poses a unique challenge for healthcare providers because they need to appreciate both the constellation of healthcare issues often encountered by veterans and military families as well as the unique challenges that this population faces in accessing healthcare.

Behavioral health is proving to be a crucial component of healthcare for veterans and military families. As with many medical conditions, behavioral health conditions are often both chronic and acute, and require continuing care. When mental health and substance abuse disorders are prevented, treated early in their manifestations, or even addressed at later stages of manifestation, the total cost of care is likely to be reduced and overall health improved.

Recommendations

The following are recommendations for community healthcare systems regarding how to approach provision of services to veterans and military families:

1. Veterans and military families share all of the medical and behavioral health problems found in civilian communities, while also manifesting unique clusters of healthcare challenges associated with military service. Therefore, healthcare systems need to devote effort to better understand these unique challenges, which include the risk of suicide, unique clinical presentations from PTSD, various levels of severity of traumatic brain injury (TBI), and substance abuse including alcohol and/or prescription pain medication abuse, as OEF/OIF veterans may be at increased risk for overdose from prescription drug abuse.
2. Adapt or develop healthcare delivery systems' assessment and treatment protocols that address veterans and military families, following the model and materials established by the collaboration between DoD and VHA.

3. Train healthcare providers and administrative staff on military culture and other cultural and social aspects that impact the treatment of veterans and military families.
4. Encourage professional medical and healthcare organizations to communicate with their service delivery members regarding evidence-based healthcare protocols that address veterans and military families.
5. Initiate "Grand Rounds" and other forums of education at Community Medical Centers on the special needs of veterans and military families.
6. Organize clinical services to balance the delivery of cost/labor intensive surgical/ physical restoration and rehabilitation. This would most likely be performed at VHA centers, and family medicine that may be conducted at community treatment centers.
7. Reach out to veterans and military families in order to bridge gaps in awareness of healthcare access. Outreach can embody efficient modalities including web-based approaches, phone, email, and social media; contact can also be initiated through direct engagement at military bases throughout the country.

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