The New Health Care Reform Law:
A Summary of Provisions of Interest to Mental Health Advocates

The Patient Protection and Affordable Care Act (PPACA) (Pub.L. 111-148) is expected to expand health care coverage to an additional 32 million citizens and legal immigrants by 2019 through a combination of state-based private insurance exchanges and a Medicaid expansion. In addition, the new law includes a number of reforms to curb harmful insurance company practices as well as provisions to slow the growth of health care costs and improve quality of care.

Expanding Coverage:

The new law will greatly expand access to health care coverage including mental health care and addiction treatment primarily through the following provisions:

- Individual mandate requiring most to obtain insurance -- with tax penalties for those who do not comply and exceptions for financial hardship and religious objections

- Premium and cost-sharing subsidies to reduce the cost of health insurance (for those with incomes up to 400% of poverty ($43,000 for individuals and $88,000 for family of four))

- Penalties for employers with more than 50 employees that do not offer coverage and have at least one employee who receives a subsidy to access coverage

- Tax credits for insurance costs for small businesses with no more than 25 employees and average annual wages of less than $50,000 (tax-exempt small businesses are also eligible)

- Establishment of state-based health plan "exchanges" by 2014 through which individuals and small businesses can purchase coverage with pooled risk and thus lower premiums

- Expansion of Medicaid to 133% of poverty ($14,404 for individuals; $29,327 for families of four) regardless of traditional eligibility categories (thus including childless adults)

Mental health care and addiction treatment are included on the list of essential benefits that must be covered in new plans offered to the uninsured through the exchanges.

These benefits (and others on essential list including rehabilitative services, prescription drugs, preventive services, etc) will be further defined by the Secretary and include opportunities for public comment.

The Mental Health Parity and Addiction Equity Act is expanded to apply to health insurance plans offered to small businesses and individuals.

Other Medicaid Changes:

Those newly eligible for Medicaid through the expansion will not receive regular Medicaid benefits – instead benefits modeled on private insurance packages.

But a mandate that the mental health and substance use benefits that are required of plans offered through the Exchanges will apply to those newly eligible for Medicaid through the expansion.

The federal parity requirements will also apply to those newly eligible for Medicaid.

Enhanced federal funding for those newly eligible for Medicaid: starts at 100 % federal and phases down to 90% federal by 2020.

States have the option to expand Medicaid (with regular match) to childless adults beginning April 1, 2010.

State maintenance of effort requirement directs states to maintain their eligibility levels for adults until the Secretary of HHS deems the exchanges to be fully operational (expected 2014) and for children in Medicaid and CHIP through September 2019. (This MOE does not apply to benefit levels.)

Existing Medicaid state plan option for covering home and community-based services is expanded to include individuals with higher incomes and to cover more services.

The Children's Health Insurance Program is maintained until 2019 at least and funded through 2015.

Primary care providers will receive increased Medicaid payment rates to 100% of Medicare rates for 2013 and 2014.

Private Insurance Market Reforms:

Preexisting condition exclusions are prohibited in all plans starting in 2014 and sooner for children --six months after enactment.

Insurers must accept every employer and individual that applies - guaranteed issue and renewability – beginning in 2014.

Beginning in 2014, premiums may no longer be based on health status – instead only age, tobacco use, geographic area, and family size.

Lifetime caps on the dollar value of benefits are prohibited in all plans starting six months after enactment and annual limits are restricted (as determined by the Secretary) until 2014 and prohibited after that.

All plans are required to cover preventive services within six months after enactment.

Secretary is directed to establish a temporary high risk insurance pool within 90 days of enactment to provide coverage to people with preexisting conditions unable to access coverage.

New law requires coverage of dependent children up to age 26 for all individual and group policies – effective six months after enactment.

Existing plans are exempt from new benefit standards but subject to many of these reforms.

Improvements to Care Coordination:

New Medicaid state plan option established to permit Medicaid enrollees with at least two chronic conditions or at least one serious mental health condition to designate a provider (which could be a community mental health center) as a health home – 90% federal funding for two years, effective Jan 2011.

New grant program established to support co-location of primary and specialty care services in community-based mental and behavioral health settings.

New grant program to fund community health teams to support primary care practices with interdisciplinary resources including access to mental health and addiction treatment specialists.

New program set up at HHS to develop, test, and disseminate shared decision-making tools to facilitate collaboration between patients, caregivers, and clinicians and incorporation of patient preferences and values into treatment decisions.

PPACA establishes a new office within CMS to better integrate Medicare and Medicaid benefits for dual eligibles and improve coordination between the federal government and states.

Prevention:

A National Prevention, Health Promotion, and Public Health Council will be established to coordinate federal activities and develop a national strategy.

PPACA funds a Prevention and Public Health Fund ($7 billion for FY 2010 through 2015 and $2 billion each year after that) for prevention and public health programs

A new community transformation grant program will be established to support delivery of community-based prevention and wellness services.

Home visitation will be promoted with $1.5 billion in grant funding for early childhood home visitation programs.

PPACA sets up a new grant program to fund school-based health clinics - $50 million for each fiscal year 2010 through 2013 – with explicit direction that clinics are to include mental health and substance use assessments, treatment and referrals.

Provisions in the new law give employers more flexibility to lower premiums or offer other incentives for employees who participate in wellness programs.

Grants are authorized for small employers that establish wellness programs.

New annual wellness visit benefit is authorized for Medicare beneficiaries- providing comprehensive health risk assessment and creation of personal prevention plan.

Medicare is directed to cover preventive services approved by US Preventive Services Task Force (USPSTF) and without cost-sharing.

Federal Medicaid funding will be increased by one percentage point for states that cover immunizations and preventive services endorsed by USPSTF for adults with no cost-sharing

Incentives will be established in Medicaid for beneficiaries to complete healthy lifestyle programs.

Other Provisions of Interest:

Postpartum Depression: Funds new federal initiative to combat postpartum depression through public education campaign and new grant program to provide medical and support services for individuals with or at risk of postpartum conditions.

Centers of Excellence on Depression: grant program to develop innovative interventions through services research.

Medicaid Coverage of Psychiatric Hospitals: Demonstration program to allow Medicaid coverage of private inpatient psychiatric facilities (i.e., IMDs) - $75 million available for 5 years.

Closing the Medicare Part D doughnut hole: $250 rebate for Medicare beneficiaries in coverage gap in 2010 and phase out of gap by 2020; drug companies to provide 50% discount for brand-name medications filled in the gap beginning 2011.

Comparative Effectiveness Research: New independent Patient-Centered Outcomes Research Institute established to prioritize and fund comparative effectiveness research

Workforce: a number of new education and training grants and loan repayment programs targeted to mental health and addiction treatment providers (particularly pediatric and child and adolescent specialists) and programs to educate primary care providers about integration of mental and physical health, chronic disease management, treating vulnerable populations including individuals with mental health or substance use conditions.

PPACA directs the Secretary to develop new conditions of participation in Medicare for community mental health centers to address fraudulent activity regarding partial hospitalization.

Funding for community health centers is increased to $11 billion between FY 2011 and 2015.

CLASS Act: establishes a national, voluntary long term care insurance program providing cash benefit to purchase non-medical services and supports necessary to maintain community living.

Community First Choice Option: establishes new state option in Medicaid to provide community-based attendant supports and services for individuals with disabilities who would otherwise require institutional care including in institutions for mental diseases.

Removal of benzodiazepines and barbiturates from list of medications states may exclude from Medicaid coverage.

Major State Responsibilities:

States are to create "American Health Benefit Exchanges" and "Small Business Health Options Program (SHOP) Exchanges" to be administered by a governmental agency or non-profit organization through which small businesses (up to 100 employees) and individuals can purchase insurance.

Grants will be made available to states for establishing the Exchanges – amounts to be specified by the Secretary of HHS.

Federal government will contract with insurers to offer at least two multi-state plans in each Exchange but states can require benefits in addition to the essential benefits package be provided to enrollees of a multi-state qualified health plan offered in such state.

States can enter "health care choice compacts" with other states to pool individual market plans but these plans would be subject to the laws and regulations (including consumer protection standards) of the purchaser's home state.

Additional $30 million in grants to be available to states to establish and operate offices of health insurance consumer assistance and ombudsman offices and states must collect data and report types of problems encountered by consumers.

Temporary high risk pool may be carried out through contracts with the states or nonprofits.

States are responsible for enrolling newly eligible beneficiaries into Medicaid no later than Jan 2014 and states have option to expand enrollment as early as 2011.

States are directed to maintain current Medicaid and CHIP eligibility levels for children until 2019 and for adults until Exchanges are operational.

States are directed to simplify enrollment processes for Medicaid and CHIP and conduct outreach to educate and enroll vulnerable populations into Medicaid or CHIP including individuals with mental health or substance use conditions as well as facilitate enrollment in Exchange plans and subsidy programs for those found not eligible for Medicaid or CHIP.