

What you need to know about **Health Care REFORM**

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Introduction

At this time, trying to explain what the new health care reform law means to people living with mental illness and their families is a challenging and sometimes complicated task. This is a large and complicated law, and much of how this will look in practice is still being negotiated. Naturally, people want to know exactly what this means for them and what they can expect. They need this information in easy-to-understand language and in the simplest format possible.

The reality is that people living with mental illness rely on a broad array of programs that are potentially affected by their health insurance. There are countless provisions in the new law that will impact us. We hope this piece helps to guide and inform you and, as the law changes, there will be several publications on this topic produced and promoted in the coming months available at www.nami.org/healthcare. Understanding more about what this means for you will benefit your ability to navigate your care as the health care system continues to change in the coming months and years.

The New Health Care Reform Law and What It Means for People Living with Mental Illness

It is expected that the new health care law will expand health care coverage to an additional 32 million U.S. citizens and legal immigrants by 2019. This will happen through a combination of state-based private insurance exchanges and a Medicaid expansion. Medicaid is a combined federal and state program that provides funding for health and long-term care services for certain categories of low-income Americans. In addition to these measures, the new law includes a range of insurance market reforms as well as efforts designed to slow the growth of health care costs and improve quality of care.



National Alliance on Mental Illness

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Expanding Coverage through Insurance and Market Reforms

There are a series of immediate changes that become effective on or before Sept. 23, 2010, the six-month anniversary of the new law; most of the expanded insurance coverage requirements and insurance market reforms do not go into effect until 2014. These changes that will be in effect by Sept. 23 include:

- Not allowing plans to deny coverage for children under age 19 for treatment of a medical condition that occurred before the start of the insurance program, or a pre-existing condition exclusion;
- Not allowing the insurance coverage to be cancelled, or prohibition of an insurance rescission;
- Not allowing lifetime limits on coverage;
- Not allowing “new” plans to set limits on annual coverage,
- Requiring new plans to offer free preventive care;
- Requiring plans to offer family coverage for dependents up to age 26;
- Providing small business tax credits of up to 35 percent;
- Providing a \$250 rebate for all Medicare beneficiaries reaching the Part D drug benefit coverage gap (also known as the “doughnut hole”) in 2010, with a 50 percent discount on branded medications that begins in 2011; and
- Creating high risk pools that will be set up by states in June 2010 to offer interim coverage for uninsured people with pre-existing conditions before market reforms go into place 2014. If states do not set up their own high risk pool, a federal fallback will be available.

Expanding Coverage through Medicaid

- Starting in 2014, requiring states to expand Medicaid eligibility up to 133 percent of poverty (effectively 138 percent of poverty with an additional 5 percent “income disregard”). This would mean that annual incomes of about \$14,404 for individuals and \$29,327 for a family of four, regardless of traditional eligibility categories such as SSI (Supplemental Security Income, a U.S. federal program, which can help give financial aid to those with disabilities who qualify) will be eligible for this coverage. This is important because it will include childless adults living with mental illness who qualify. (Note that those newly eligible for Medicaid through this expansion may not receive regular Medicaid benefits and

will likely receive benefits modeled on private insurance packages. However, plans will be required to offer mental health and substance use benefits.);

- Providing a federal mental health insurance parity requirement to those newly eligible for Medicaid;
- Providing enhanced federal match funding (known as FMAP) for those newly eligible for Medicaid, which starts at 100 percent in 2014 and phases down to 90 percent by 2020;
- Offering states the option to expand Medicaid (with regular match) to childless adults beginning April 1, 2010;
- Through the state maintenance of efforts requirement, directing states to maintain their eligibility levels for adults until the U.S. Secretary of Health and Human Services (HHS) deems the exchanges to be fully operational (expected 2014) and for children in Medicaid and state Children’s Health Insurance Programs (CHIP) through September 2019. (This Memorandum of Understanding (MOU) does not apply to benefit levels);
- Requiring existing Medicaid state plan options for covering home and community-based services that will be expanded to include individuals with higher incomes and will cover more services;
- Requiring the removal of benzodiazepines and barbiturates from lists of medications states may exclude from Medicaid coverage;
- Requiring states to maintain CHIP until 2019 at least and funded through 2015; and
- Requiring that primary care providers receive increased Medicaid payment rates to 100 percent of Medicare rates for 2013 and 2014.

Expanding Coverage through State-based Health Insurance Exchanges in 2014

- Setting a new individual mandate requiring most people to obtain insurance, with tax penalties for those who do not do so and exceptions for financial hardship and religious objections;
- Providing premium and cost-sharing assistance to reduce the cost of health insurance for those with incomes up to 400 percent of poverty (\$43,000 for individuals and \$88,000 for family of four);
- Enforcing 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;
- Providing tax credits for insurance costs for small

businesses with no more than 25 employees and average annual wages of less than \$50,000 (with tax-exempt small businesses are also eligible);

- Requiring the establishment of state-based health insurance “exchanges” through which individuals and small businesses can purchase coverage with pooled risk and therefore lower premiums;
- Requiring that mental illness and addiction treatment are included on the list of essential benefits that must be covered in new plans offered to the uninsured through the new state exchanges (rehabilitative services and prescription drugs will also be a required for any health plan offered through an exchange);
- Requiring that all health plans offered through the state-based exchanges comply with the 2008 Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (P.L. 110-343).
- Regarding Medicaid coverage of psychiatric hospitals, establishes a new demonstration program will allow for Medicaid coverage of acute inpatient care provided in private hospitals defined as IMDs – the discriminatory provision in federal Medicaid law that bars federal matching funds for Institutions for Medical Diseases. The demonstration is limited to \$75 million over five years; and
- Providing federal Medicaid funding that will be increased by one percentage point for states that cover immunizations and preventive services endorsed by the U.S. Preventive Services Task Force (USPSTF) for adults with no cost-sharing, with new incentives for beneficiaries to complete healthy lifestyle programs.

Private Insurance Market Reforms

- Prohibiting preexisting condition exclusions in all plans starting in 2014 and sooner for children—six months after enactment. Mental illnesses such as schizophrenia, bipolar disorder and major depression will qualify as pre-existing conditions upon which coverage cannot be denied;
- Requiring that insurers accept every employer and individual that applies—guaranteed issue and renewability—beginning in 2014.
- Beginning in 2014, requiring that premiums no longer be based on health status. Instead, only age, tobacco use, geographic area and family size can be used to adjust premiums, and only within specific limits; and
- Prohibiting lifetime caps on the dollar value of

benefits in all plans starting six months after enactment. (As determined by the U.S. Secretary of HHS, annual limits are restricted until 2014 and prohibited after that.)

Improvements to Care Coordination

- Establishing a new Medicaid state plan option 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 percent federal funding for two years, effective January 2011;
- Establishing a new grant program to support collocation of primary and specialty care services in community-based mental and behavioral health settings;
- Establishing a new grant program to fund community health teams to support primary care practices with combined resources including access to mental health and addiction treatment specialists;
- Establishing a new program at HHS to develop, test and disseminate shared decision-making tools to facilitate collaboration between patients, caregivers and clinicians and treatment decisions that incorporate patient preferences and values; and
- Establishing a new office within the U.S. Center for Medicaid Services (CMS) to better integrate Medicare and Medicaid benefits for dual eligibles (Medicare Part A and/or B recipients who either qualify for a Medicare Savings Programs (MSP) or qualify for Medicaid benefits) and improve coordination between the federal government and states.

Changes to Medicare

- Closing the Medicare Part D “doughnut hole” by providing a \$250 rebate for Medicare beneficiaries in coverage gap in 2010, with completely phasing out this coverage gap by 2020. Starting in 2011, prescription drug companies will begin providing a 50 percent discount for brand-name medications, with the gap narrowing to zero by 2020;
- Providing new annual wellness visit benefits to authorized beneficiaries, providing comprehensive health risk assessment and establishing the creation of personal prevention plan; and
- Requiring that Medicare cover preventive services approved by USPSTF, without cost-sharing.

Other Provisions of Interest:

- Cures Acceleration Network (CAN): Establishing a new program at the National Institute of Health (NIH) to help bridge the scientific “Valley of Death” to fund translational research to move high-need medical cures through the development pipeline faster, cutting the time between scientific discovery and the development of promising new drugs and therapies;
- Melanie Blocker Stokes Postpartum Depression Program: Establishing funding for a new federal initiative to combat postpartum depression through a public education campaign and establishing a new grant program to provide medical and support services for individuals with or at risk of postpartum conditions;
- Centers of Excellence on Depression: Establishing a new Substance Abuse and Mental Health Services Administration (SAMHSA) grant program to develop innovative interventions through services research;
- Comparative Effectiveness Research: Establishing a new independent patient-centered outcomes research institute to prioritize and fund comparative effectiveness research;
- Health Care Workforce Improvements: Establishing a number of new education and training grant and loan repayment programs targeted to mental health and addiction treatment providers (particularly pediatric and child and adolescent specialists) and establishing programs to educate primary care providers about the integration of mental and physical health, chronic disease management and treating vulnerable populations including individuals with mental health or substance use conditions;
- Require CMS to be charged with setting new “conditions of participation” in Medicare for community mental health centers to address fraudulent activity regarding partial hospitalization;
- CLASS Act: Establishing a new voluntary, self-funded public long-term care insurance program that provides cash benefits to purchase non-medical services and supports necessary to maintain community living; and
- Community First Choice Option: establishing a 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.

A Look at Public Mental Health Funding

Public mental health services are shaped by two primary sources of funding: Medicaid and state general fund dollars. About 10 percent of the system is funded by Medicare, federal mental health services block grant funds and county and municipal funds. For youth living with serious mental health conditions, funding for services may also be provided by other sources, including schools and state Children’s Health Insurance (S-CHIP) programs.

Medicaid, which is jointly funded by state and federal money, is a program that provides funding for health and long-term care services for certain categories of low-income Americans. Medicaid has rapidly become the largest source of funding of public mental health services for youth and adults living with mental illness. In fiscal year 2006, the most recent year that data is available, 44 percent of state mental health funding came from Medicaid.

Medicaid is jointly funded with federal and state money. Federal funding is provided at a federal match rate, or Federal Medical Assistance Percentage (FMAP), that ranges from 50-76 percent overall funding, depending upon the economic status of the state.

Eligibility rules for Medicaid are complicated and vary from state to state. In most states, individuals who are eligible for federal Supplemental Security Income (SSI) are automatically eligible for Medicaid. Because each state designs its own Medicaid program, services vary from state to state.

Historically, states have used general mental health funds to fund services for adults and youth who do not qualify for Medicaid. However, states are increasingly using general mental health funds for Medicaid enrollees in order to benefit from federal Medicaid matching funds, thus spending less for individuals who live with serious mental illness who do not qualify for Medicaid.

State mental health budgets are important because they fund needed treatment and supports that are either not covered by Medicaid due to federal rules, such as state hospitalization for working age adults, or because they were not included in the state’s Medicaid plan design. In addition, state mental health budgets provide critical services for people living with mental illness who are uninsured or underinsured or awaiting eligibility for Medicaid.

During budget crises, non-Medicaid community mental health services often suffer disproportionate cuts because officials want to avoid reductions to Medicaid, where cuts are compounded by the additional loss of significant federal matching funds. As a result, eligibility for services for children and adults who are not enrolled in Medicaid may be severely reduced.