Judge David L.
BAZELON CENTER
for Mental Health Law
www.bazelon.org

Insurance Market Reforms in the Patient Protection & Affordable Care Act and the Health Care & Education Reconciliation Act

The new health care reform legislation will provide significant new options for people with mental illnesses to gain coverage. The legislation creates a way for lower-income and other uninsured individuals to purchase health insurance, improves Medicaid and other public programs, and makes a number of changes to how the health care system operates. Some provisions in the legislation might prove problematic for people with serious mental illnesses, and exactly how the new law will be implemented will depend on regulations and guidance from federal agencies. Overall, however, this new federal law should have an extremely positive effect for people with mental illnesses.

This paper examines the changes and improvements made by health care reform legislation to the operation of the insurance market through which most Americans obtain health care coverage.

Two laws create the foundation for health care reform. On March 23, 2010, after more than a year of contentious deliberation and debate, the President signed into law the Patient Protection and Affordable Care Act (H.R. 3590); legislation that comprehensively reforms America's health care system. On March 30, the President signed a second bill, the Health Care & Education Reconciliation Act, to amend and enhance certain provisions in the Patient Protection and Affordable Care Act. The second law, necessary for procedural reasons, generally improves on some aspects of the first.

In general, the legislation expands access to insurance coverage, provides increased consumer protections, ensures that consumers receive certain benefits (including mental health and substance abuse coverage), and seeks to control health care costs. The changes do not all occur immediately but take effect over the next several years. The new laws:

- End discriminatory practices too often experienced by individuals with mental illnesses, through the elimination of: lifetime or annual dollar limits, exclusions for preexisting conditions and rates based on health status, gender or occupation;
- Create State-based Health Insurance Exchanges that will serve as a marketplace to assist uninsured individuals and small employers in purchasing private health plans;
- Set limits on out-of-pocket spending, restricting the amount an individual is required to contribute towards the cost of care, which would help ease the burden on people who have frequent needs for health care services, drugs and supplies.

- Require that individuals obtain coverage or pay a penalty;
- Establish standardized benefit packages among the plans offered through the Exchanges that will make it easier to compare and select coverage based on cost and quality information and requires that these packages include mental health and addiction services, and
- Provide tax credits and cost-sharing reductions to assist low-income households with the cost of purchasing insurance.

Consumer Protections

The law protects consumers by prohibiting a number of common insurance practices. Many of these protections (described below) are effective upon or within six months of enactment of the law, allowing consumers to realize immediate benefits from reform.

Lifetime and Annual Limits

Currently, those who purchase insurance through the individual or small group market are often subjected to lifetime and annual limits on mental health treatment, leaving people with mental illnesses burdened with substantial debt if they experience ongoing health and mental health problems and persistent treatment needs.

For plan years that begin after October 1, 2010, insurers are no longer able to establish lifetime limits on essential benefits (described below). This means that insurers will not be able to cap the total amount of dollars that they will pay for essential benefits, such as mental health care, provided throughout the lifetime of an enrollee in the plan. Individuals with chronic diseases, like serious mental illnesses, often reach their lifetime limit within several years due to the high cost of care, and are forced to find ways to pay out-of-pocket or obtain other insurance coverage to receive services.

Beginning in 2014, the law also states that plans cannot place annual limits on essential benefits, meaning that insurers will no longer be able to limit the amount of payments made for services in a plan year. Prior to 2014, however, plans are allowed to establish restricted annual limits on essential benefits. The Department of Health and Human Services (HHS) is tasked with defining what constitutes "restricted annual limits."

Pre-existing Condition Exclusions and Discrimination Based on Health Status

Insurers are prohibited from denying coverage because an individual has a chronic condition, or has been sick in the past. This provision is particularly important for people with mental illnesses, who often fail to qualify, particularly for individual or small-group insurance, because their disorder constitutes a preexisting condition or face lengthy waiting periods or exclusions on coverage for services provided for that preexisting illness. This provision is effective for plans covering individuals under the age of 19 for plan years beginning after October 1, 2010, and for all plans beginning January 1, 2014.

Insurers are also not allowed to set eligibility rules that are based upon health status, medical condition, past medical history, genetic information, and a number of other health status-related criteria.

Guaranteed Issue/Renewal and Rescissions

Insurers must offer coverage to everyone who applies during annual or special enrollment periods, regardless of health status or medical history. Insurers must also renew or continue coverage for beneficiaries who wish to remain enrolled, without regard to their health status or other factors. Additionally, beginning on September 23, 2010 (six months after enactment of the law), insurers are prohibited from rescinding, or cancelling, coverage once a beneficiary is enrolled, except in cases of fraud or abuse.

Limits on Consumers' Out-of-Pocket Costs

The law limits cost-sharing in all plans, and deductible limits on plans sold in the small group market. Out-of-pocket costs cannot exceed the limits for Health Savings Accounts in 2014 (currently $5,950 for an individual and $11,900 for a family). Deductibles for plans in the small group market cannot exceed $2,000 for an individual or $4,000 for families. In 2004, 18% of non-elderly Americans incurred out-of-pocket costs of more than 10% of their income; thus, setting a ceiling on these costs will be extremely beneficial for many.[i]

Fair Health Insurance Premiums

The law indicates that health insurance premium rates in the individual and small group market can only vary on the basis of:

- tobacco use (at a rate of 1.5:1);
- age (3:1);
- family composition; and
- state-defined geographic rating areas

This provision is effective for all plan years beginning after January 1, 2014.

Immediate Access for Individuals with Pre-existing Conditions

The law creates options to help states establish high-risk pools to provide coverage for individuals who have been uninsured for more than 6 months and have been denied coverage based upon pre-existing conditions. These individuals will be able to enroll in a high-risk pool within three months of the legislation's enactment and will fill the gap between enactment and the establishment of Exchanges.

Currently, over 30 states have high-risk pools. Under the reform law, states have the option to establish a new high-risk pool (to operate alongside existing high-risk pools in the states in which

they are already utilized). If the state does not act, HHS will carry out the program in the state. $5 billion has been provided for the establishment of the pools, and the program terminates when Exchanges are operational in 2014.

This provision is particularly important for individuals with mental illnesses, who often fail to qualify for individual or small-group insurance because their disorder constitutes a pre-existing condition.

Services

Qualified Health Plan Defined

A "qualified health plan" under the law is a plan that provides a package of essential benefits and is issued by an insurer that is in good standing in each state in which it is offered, agrees to offer coverage at certain costs, and complies with additional requirements determined by the Secretary.

Essential Benefits

To ensure that consumers who purchase insurance coverage through an Exchange have access to a minimum range of services, the law establishes an essential benefit package.

In order to be a "qualified health plan" (see above) a plan must cover the essential benefit package. The law outlines the major categories of required benefits but HHS will determine and define the exact scope of services to be included in this benefit. However, benefits must at least be equal to the benefits of a typical employer plan. In addition, the benefit must include the following:

- Ambulatory services
- Mental Health and Substance Use Disorder Services (including behavioral health treatments).
- Rehabilitative and habilitative services and devices;
- Prescription drugs;
- Emergency services;
- Preventive and wellness services
- Pediatric services (including oral and vision);
- Hospitalization
- Maternity and newborn care;
- Laboratory Services

Importantly, the coverage of mental health and substance use disorder services must be covered at parity with medical/surgical care; specifically, these benefits must meet standards in federal and state parity laws. Nothing in the law prevents a plan from offering a richer package of benefits.

Consumers will be able to choose between four levels of coverage, based on the portion of the total costs to be borne by the plan. Bronze, Silver, Gold and Platinum plans, will be offered to consumers through the Exchange, with each level having a different actuarial value ranging from 60-90 percent of costs to be borne by the plan and also with different out-of-pocket cost requirements.

For individuals 30 years old or younger, a plan that offers only catastrophic coverage is allowed. These "young invincible" policies must be made available by qualified health plans to both those 30 or younger and to those who would otherwise qualify for the exemption from the individual requirement to purchase health insurance (see below).

Coverage of Preventive Health Services

Preventive health services are vital for people with mental illnesses and substance use disorders. Early identification of both health and mental health problems allows for early intervention which can effectively reduce the burden of disease on individuals, their families and communities. Under the law, plans must provide coverage without cost-sharing requirements for services rated "A" or "B" (strongly recommended or recommended) by the US Preventive Services Task Force, as well as immunizations, and preventive care and screenings for infants, children, adolescents, and women. Screenings for depression and alcohol misuse, as well as for various chronic health disorders (such as diabetes) that people with mental illnesses are often at higher risk of contracting, are among services currently recommended by the Task Force.

Other Insurance Reforms

Coverage Explanations and Disclosures

Insurance plan documents are often complex, rife with fine print and extremely difficult for a lay person to understand. To aid consumers, HHS is required to develop standards for summaries of benefits and explanations of coverage within a year of enactment of the law. These explanations must also be provided in a standard format, be no more than four pages in length and use plain, easily understandable language. They must also use standardized definitions of medical and insurance terms. Insurers are required to begin using standard documentation within two years of enactment of the law.

Insurers must also comply with provisions that afford greater transparency, such as disclosing information on rating practices, and must seek to reduce the cost of health care coverage by, for example, reporting the amount of premium revenues actually spent on clinical services. Beginning in 2011, group plans that spend less than 85% of premium revenues (80% for individual/small group market plans) on clinical services must provide rebates to beneficiaries.

Waiting Periods and Emergency Access

The law precludes waiting periods of more than 90 days to enroll in group health insurance plans, and also prevents insurers from requiring preauthorization or increased cost-sharing for emergency services.

Extension of Dependent Coverage

The law allows dependent children to remain on their parents' health policies until the age of 26. This takes effect for plan years beginning six months after enactment of the bill.

Youth transitioning to adulthood have a difficult time accessing and maintaining coverage, and those with emotional and behavioral disturbances are at greater risk for being uninsured. They may be ineligible for Medicaid coverage because they are living with parents whose income disqualifies them. They are likely to be unemployed or employed in part-time jobs without benefits. Offering the option to extend coverage to 26 will help to lower the uninsurance rate in the 18- 26 age cohort and help more vulnerable youth.

Value

The law contains provisions designed to protect consumers from unreasonable costs, such as allowing HHS to review annually unreasonable increases in premiums for health insurance coverage.

Not all Plans are Subject to all Reforms

It is important to understand that several of the provisions summarized above apply only to new plans purchased after enactment of the law. Group health plans or health insurance coverage in which an individual was enrolled on the date of enactment of the law are "grandfathered" and therefore exempted from some of these provisions, including:

- Discrimination based on health status
- Guaranteed Issue/Renewability
- Fair Health Insurance Premiums
- Essential Benefits Package
- Coverage of required Preventive Health Services (see below)

Provisions that do apply to these existing group health plans or health insurance include those that prohibit:

- Lifetime or annual limits on services included as "essential benefits" (as described below);
- Pre-existing condition exclusions;
- Rescinding coverage;

- Failing to extend coverage to dependents up to age 26.

Individuals who currently have health insurance have the right to maintain that coverage as it existed on March 23, 2010 (date of enactment of the law) if they so choose, providing that the coverage meets the requirements of the law, other than those provisions that do not apply to "grandfathered" plans, as listed above.

Structure for Purchase of Insurance

State-based Exchanges

State-based governmental or nonprofit American Health Benefits Exchanges (Exchanges) are intended to make it easy for consumers to compare and purchase qualified health insurance plans. These Exchanges will be established effective January 1, 2014.

Exchanges are marketplaces where people not who do not have access to coverage through their employers can shop for health insurance (through a state established website) at competitive rates. Initially, Exchanges will serve individuals and small businesses. Large employers will be eligible to purchase coverage through the Exchange beginning in 2017.States will receive federal grants to plan and create Exchanges; funding is available until January 1, 2015 at which time state Exchanges should be self-sustaining. Regional or other Interstate Exchanges may be established if states in which the regional Exchange operates permit operation and if it is approved by the Secretary of Health & Human Services.

Regulations on marketing, network adequacy, accreditation, consumer information, outreach and enrollment and public information will be issued by HHS for the Exchanges. Exchanges will be responsible for ensuring that health plans meet the requirements for a "qualified health plan," including covering essential benefits.

States will qualify health plans to participate in their Exchange, make eligibility determinations of individuals and businesses, administer the subsidies authorized by the law and facilitate consumer assistance.

Exchanges will be required to disclose administrative costs, information on claims payment policies, enrollment, denials, rating practices, out-of-network cost sharing, as well as submit accounting reports to HHS.

Employers and individuals are under no obligation to purchase insurance through the Exchange and can still purchase a health plan offered outside the Exchange. Individuals may enroll in any qualified health plan made available to them. However, the law requires employers that offer health coverage and who make a contribution to an employee's premium to provide "free choice vouchers" so that qualified employees can purchase a qualified health plan through the Exchange. Vouchers must be equal to the contribution that the employer would have made to its own plan, and an employee qualifies if their required contribution under the employer's plan would cost between 8 and 9.8 percent of their income.

Once the Exchanges are operational, plans made available to Members of Congress and their staff must be offered through an Exchange.

In place of a single state Exchange, the law also allows for interstate Health Care Choice Compacts between two or more states so as to allow the purchase of individual health insurance across state lines. In these situations, the insurer must be licensed in each state and meet any consumer protection mandates of the state in which a covered individual resides.

Nonprofit Consumer Co-operatives

In addition to private insurance plans, the law creates the option for consumer-operated nonprofit cooperatives that would also offer insurance. These entities would be new, nonprofit, member-administered health insurance companies that serve individuals in one or more states.

$6 billion will be made available for start-up loans to organizations wishing to establish a non-profit cooperative health plan. Loans must be repaid within 15 years, and co-operatives must comply with federal and state insurance laws (such as guaranteed issue and renewal as described above).

Multi-state Insurance Plans

The federal Office of Personnel Management (OPM) is required to contract with health insurers to offer at least two multi-state (one of which must be non-profit) qualified health plans through Exchanges in each State, similar to the Federal Employees Health Benefits Program. These plans must meet the minimum standards and regulations established for qualified health plans, and States will be allowed to offer additional services provided they assume the resulting additional costs. Similar to co-operatives, multi-state plans must comply with federal and state insurance laws (such as guaranteed issue and renewal as described above).

Individual and Employer Responsibility

Starting in 2014, all citizens and legal residents will be required to have insurance, obtained through their employer, the individual market, an Exchange, public programs (such as Medicare and Medicaid). There are exemptions from this requirement based on hardship or religious reasons, and for Native Americans. Those whose income is at or below the tax filing threshold, and those who were not covered for a period of less than three months during the year are also exempt.

Individuals who fail to purchase insurance will have to pay a penalty. This will be the higher of either: $95 or one percent of their income in 2014; $325 or two percent of income in 2015; and $695 or 2.5 percent of income in 2016. After 2016, the penalty will increase by the annual cost of living. Health insurance coverage status will be reported to the IRS.

The final law does not mandate employers to offer health insurance coverage, but instead it encourages them to do so. Any employer with more than 50 full-time employees that does not offer coverage and has at least one full-time employee receiving the premium assistance tax credit will be subject to a fee of $2,000 per full-time employee per year. Employers with 50 or more full time employees that do offer coverage, but have at least one full-time employee who receives a premium assistance tax credit will have to pay the lesser of $3,000 for each employee receiving assistance, or $2,000 for each full-time employee total. Employers with more than 200

employees who offer insurance coverage must automatically enroll new employees in coverage. All large employers are required to report to HHS whether they offer coverage to full-time employees.

State Options

State Option for a Basic Plan

States will have the opportunity to establish a federally-funded, non-Medicaid state plan for people with incomes above the Medicaid eligibility level, but below 200 percent of the federal poverty level in lieu of offering these individuals coverage through the Exchange. These state plans enable states to offer health care coverage through contracts with private health systems. Participating individuals must not be required to pay higher premiums or cost-sharing than they would under a qualified health plan in the Exchange. These state plans would be required to meet certain benefit standards and premium assistance would be made available for the eligible population.

State Innovation Waiver

Beginning in 2017, state innovation will be encouraged by allowing states to opt out of certain provisions in the legislation through a waiver process. States may apply to HHS for 5-year waivers (permission to be exempt from certain aspects of the law) to provide residents access to quality, affordable insurance plans that are at least as comprehensive as the plans offered through an Exchange.

Help for Consumers

Consumer Information

HHS is required to set up a web-based information portal so consumers can readily identify and compare insurance options in their State. States and health plans are required to provide standardized information to facilitate this process.

Insurers will be required to provide plan enrollees a summary of benefits and coverage, so consumers can accurately understand their plan. They must also follow standards established by HHS when developing these summaries, including presenting plan information in language that is understandable by the average enrollee, ensuring that specific topics such as cost-sharing provisions or a description of benefits are included in the materials, using appropriate definitions of insurance terms, and including insurer contact information. Insurers not in compliance would face a fine of up to $1,000 for each failure to comply.

Consumer Assistance

States will receive federal support to contract with private and public entities to act as navigators to assist consumers purchase through the Exchanges. The navigators will conduct public education, distribute information about enrollment and premium credits, and provide enrollment assistance.

The law also authorizes grants to states to establish, expand and support offices of health insurance consumer assistance, or health insurance ombudsman programs. Such offices will assist consumers with enrollment, resolving problems with obtaining premium tax credits and filing complaints and appeals, as well as educating health insurance consumers on their rights and responsibilities and collecting and monitoring problems encountered by consumers.

Making Coverage Affordable

Tax Credits for Premium Costs and Cost *Sharing Reductions*

To assist individuals meet the mandate that they have insurance, tax credits are authorized to help meet the costs of premiums and to reduce cost-sharing requirements. These are available to lower-income individuals who purchase health insurance through a state Exchange.

After December 21, 2013, individuals will be eligible for the credit if their income is up to 400% of the federal poverty level. Income levels will be verified based on IRS filings from the prior tax year. Credit amounts will be awarded on a sliding scale starting at two percent of income for those at or above 100% FPL to 9.5% of income for individuals with incomes at 300-300% FPL. Individuals who receive coverage through their employer and whose premiums are more than 9.5% of their income will also be eligible to receive premium credits.

The law also reduces cost-sharing for eligible individuals by setting a limit on out-of-pocket costs that will reduce those costs by up to half, depending upon income. The insurance plan's share of costs will be increased to between 94-70%, depending upon a beneficiary's income. Qualified small employers and nonprofit companies will also receive a tax credit for contributions they make to purchase health insurance for their employees.

Efforts to assist consumers with the cost of coverage are particularly important for people with mental illnesses who often have low incomes and poor access to care. For example, a recent study indicated that close to half of individuals with a mental health diagnosis cited that the expenses associated with receiving treatment prohibited them from seeking care.[ii] The subsidies and tax breaks in the health reform law will be critical for this population. However, there are questions as to whether the subsidies and other financial assistance will be sufficient for all who need them.

Advocacy: Emerging Opportunities and Challenges

Although many of the provisions do not go into effect immediately, it is not too early for advocates to begin laying the groundwork in their state and at the federal level for adoption of progressive insurance reforms and regulations. In addition, the amendments made by these laws leave some important gaps that must be addressed.

Opportunities for Advocacy

Impact of new Coverage on Public Mental Health Systems: In time, as these reforms are rolled out, many individuals with serious mental illness who could not previously qualify for Medicaid, Medicare or other public programs nor obtain private insurance will purchase insurance through the new Exchanges. Although the exact definition of the mental health and addictions benefit in Exchange plans is not yet known (because HHS will be defining the details of the benefit) it is not expected that this benefit will be as comprehensive as Medicaid in terms of psychiatric rehabilitation and other intensive community services. Individuals with these policies will have a choice of provider for the services that are covered (most likely outpatient visits and inpatient care). The issue of how to ensure that they also have access to other public mental health system services, and that they both know about and avail themselves of those services is then a significant issue. If and when they do, this will be an influx of new individuals who will need access to services.

- State mental health systems should begin now to consider how individuals covered under Exchange plans are to be informed about the inadequacy of this coverage for people with the more serious mental illnesses. For those individuals who seek care from private providers, using their insurance, there will be a need for transition to a new provider for necessary intensive community services.
    - Advocates should engage with the mental health authority now to begin discussion of this issue and to ensure that plans are made to inform individuals with serious mental illness and their families of what is still available to them through the public mental health system. In addition, mechanisms for smooth transition or collaboration between all providers treating the same individual should be developed.
- As insurance picks up the cost of basic services, this should lift a burden in terms of uncompensated care that the state is now paying for when these individuals have needed emergency services or when they have been enrolled in a community program. The state mental health authority will need these, and potentially other, resources to meet the needs of this population for intensive community services.
    - Advocates should work with the state to identify the resources currently spent on uninsured individuals who use mental health services – this includes using public mental health system services or hospital or emergency room care – and develop a strategy to ensure that these resources are allocated to the mental health system and not transferred to other state purposes.

High Risk Pools: Federal funding is available for states (beginning three months after enactment of the law) for the establishment of high-risk pools for uninsured individuals. These high-risk polls will continue until health reform prohibits insurers from denying people coverage or charging them higher rates based on pre-existing conditions in 2014.

- States have the option to establish their own pools, build onto existing programs that serve the same purpose, or allow the federal government to do so on their behalf.

Individuals with mental illnesses will significantly benefit from these pools, as many are uninsured and able to qualify.

- Advocates should determine the approach their state plans to take and: (1) if the state is creating its own pool, urge that the level of benefits include a reasonable mental health benefit; (2) ensure that the state makes consumers aware of the new option available to them, and (3) provide information directly to consumers about this new benefit.

Federal Definition of Essential Benefits: HHS is tasked with defining the essential benefits that insurance plans must cover. There will be opportunity for public comment on this important issue and the law requires that HHS take into consideration the unique health care needs of people with disabilities and other diverse groups. Although it is most likely that this benefit will have limits, it may be possible to have it include some of the community services needed by individuals with serious mental illness. Evidence-based practices that are well established in the field might be added, such as Assertive Community Treatment, Skills Training related to Supported Employment or Supported Housing, Therapeutic Foster Care for children, etc.

- Advocates should be prepared to comment and influence the development of the essential benefits package. It is important to advocate that people with serious mental illnesses have access to a wide range of quality, comprehensive services and interventions, including rehabilitative services. This particular federal rule should be given high priority by all who wish to see people with serious mental illness have access to high quality community services.

Basic Health Plan: States can create a Basic Health Plan for uninsured individuals with incomes between 133 and 200% of poverty, effective when the state has set up and is running an Exchange. While the plan is "basic" it must cover at least the essential benefits that Exchange plans must include, but can include alternative services such as cost-effective community care. This option has great potential to assist individuals with serious mental illness as it could provide better coverage of necessary services than might the federally-defined essential benefit.

- Advocates should urge the state to immediately consider this option and begin to plan for the benefit package. While other advocates are likely to press for specific coverage, including community mental health services in the package is not increasing state expenditures, as the state is already the primary (and often only) payer of these services for people who are uninsured. The benefit package in any basic plan should include at least some community services for people with serious mental illness (such as skills training, ACT, etc.)

---

[i] Banthin, J.S., Cunningham, P., & Bernard, D.M. (2008). Financial burden of health care, 2001-2004. *Health Affairs, 27*, 188-195.

[ii] Kessler, R.C., Berglund, P.A., Bruce, M.L, Koch, J.R., Laska, E.M., Leaf, P.J., et al. (2001). The prevalence and correlates of untreated serious mental illness. *Health Services Research, 36*, 987-1007.