

Health Care Reform & Mental Health Parity

What Are the Benefits for Families?

The health care reform bills signed into law in 2010 will provide expanded health care coverage; define minimum benefit packages; require coverage for preventive services with no cost-sharing; extend parity to new types of plans; require individuals to be insured; and add new consumer protections for health coverage. While regulatory and implementation processes may affect the way these provisions apply once implemented, taken together, health care reform and mental health parity will expand access to needed mental health services.

EXPANDING HEALTH CARE COVERAGE

Health care reform expands access to coverage in a number of ways. In all, more than 30 million additional people are expected to obtain coverage.

Individual Mandate

Individuals are required to have health insurance beginning in 2014. Individuals who do not obtain private or public health coverage or qualify for a hardship exemption will face a tax penalty in 2014.

Tax Credits to Purchase Coverage in Exchange & Limits on Cost Sharing

Families with incomes between 133 and 400 percent of the Federal Poverty Level (FPL), who are both lacking coverage and legally residing in the U.S. will be provided with tax credits to purchase coverage in the Exchange, a newly created marketplace for health insurance. Families in these income brackets will also be protected by limits on cost-sharing and out-of-pocket maximums. This takes effect in 2014.

New Eligibility for Medicaid Coverage

All individuals making up to 133 percent of the FPL will be eligible to enroll in Medicaid, the nation's publicly funded health care program for low-income individuals, beginning in 2014.

Extended Funding for Children's Coverage

The Children's Health Insurance Program (CHIP), which provides insurance for children in low-income households not eligible for Medicaid, was extended with enhanced federal funding through 2015.

Coverage for Youth Formerly in Foster Care

Young people formerly served by the foster care system for a total of at least six months will be eligible for Medicaid until age 25. This takes effect in 2019.

Family Coverage for Young People until Age 26

Children will become eligible to remain on their parents' existing health coverage policy until age 26. This applies for all plans offering dependent coverage, but for "grandfathered" plans (plans through which a group or individual obtained a health policy prior to the passage of health care reform), eligibility is subject to the child not having access to their own employer-sponsored coverage. Takes effect six months after enactment.

Coverage of Children with Preexisting Conditions

For children up to age 19, all group health plans will be prohibited from denying coverage for a preexisting condition, effective within six months of enactment.

"Health insurance reform is designed to prevent any child from being denied coverage because he or she has a preexisting condition . . . I am preparing to issue regulations in the weeks ahead ensuring that the term "preexisting condition exclusion" applies to both a child's access to a plan and to his or her benefits once he or she is in the plan."

Kathleen Sebelius, Secretary of Health and Human Services

Coverage of Adults with Preexisting Conditions

For adults, all group health plans will be prohibited from denying coverage due to a preexisting condition beginning in 2014.

Interim High-Risk Pool for Adults

Within 90 days of enactment, the Secretary of Health and Human Services (HHS) will establish a high-risk pool for adults who have a preexisting condition and have not had health coverage for the previous six months. This will provide coverage until 2014, when the protections outlined above take effect.

NEW CONSUMER PROTECTIONS

These protections will apply to all private health insurance plans.

No Caps on Lifetime or Annual Benefits

Six months after enactment, all health plans except grandfathered individual plans will be barred from imposing a lifetime benefit limit or an unreasonable annual limit as determined by the Secretary of HHS. As of 2014, annual limits will be entirely prohibited for these health plans.

Rescission Prohibited

Rescission, where a health insurer retroactively cancels coverage – often when an individual is sick and incurring high costs, is prohibited for all plans except in the case of fraud. This is effective in September 2010.

Coverage Waiting Periods Limited to 90 Days

No waiting period for health coverage shall exceed 90 days. This takes effect in 2014.

Insurers Must Spend a Minimum Amount on Care, Prevention, and Wellness or Provide Rebates

Beginning in 2010, all health plans except self-insured plans will be required to report the proportion of losses to earned premiums, as well as the percentage of premiums they expend on health care, prevention/wellness activities and other non-claims costs. Starting in 2011, plans failing to spend a minimum percentage of premiums on care, prevention and wellness must issue rebates.

Review and Justification of Premium Increases

Beginning in 2010, the Secretary of HHS will establish a process for reviewing increases in health plan premiums. Any proposed increases must be published on the insurer's website and plans with increases deemed to be excessive may be prohibited from participation in the Exchange.

NEW BENEFIT STANDARDS FOR PLANS

Highlighted below are just a few of the many new benefit standards that will apply to certain types of private plans. Those highlighted will have an important impact on access to mental health screening and services. See details under each heading as to which plans will have to comply.

Transparency in the Appeals Process

New health plans will have to establish an effective system of internal and external appeals to allow covered individuals to challenge coverage denials. The Secretary of HHS will issue guidance as to

appropriate processes. This takes effect six months after enactment.

Access to Free Preventive Services

All new health plans will be required to offer access to certain preventive services for free, i.e., without cost sharing, for covered individuals. This takes effect six months following enactment or on January 1, 2011 for most plans. "Grandfathered" plans are not required to comply.

For children and adolescents, this includes services recommended by the United States Preventive Services Task Force (USPSTF); immunizations recommended by the Centers for Disease Control and Prevention; and screenings and services recommended by the Health Resources and Services Administration in the American Academy of Pediatrics' *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*.

***This means that annual depression screening for adolescents and young adults will be a covered service under new health plans because it is recommended by the USPSTF.**

Essential Benefits Defined

All health benefit packages offered through the Exchange or in the small group and individual market will have to meet minimum coverage standards and include the following essential benefits:

- hospitalization
- ambulatory, or out-patient, services
- **preventive and wellness services***
- emergency services
- prescription drug coverage
- rehabilitative and habilitative services and devices
- **mental health and substance abuse services, including behavioral health treatment**
- chronic disease management
- maternity and newborn care
- pediatric services, including oral and vision care
- laboratory services.

Mental Health Parity Protections Extended

The mental health and substance abuse services included as an essential benefit for plans in the Exchange will be subject to mental health parity protections. Health care reform also will newly extend parity protections to previously exempt types of adult Medicaid coverage.

Mental Health Parity

Federal mental health parity laws passed in 1996 and 2008 provide protections for families purchasing a health insurance plan that offers mental health coverage. The laws require that limits on mental health and substance abuse benefits be no more restrictive than limits placed on medical/surgical benefits.

Health care reform interacts with parity to expand how and to whom these protections will apply.

Which Health Plans are Subject to Parity?

Federal mental health and substance abuse parity protections currently apply to employee plans covering 51 or more employees, as well as to managed care organizations serving CHIP and adult Medicaid beneficiaries.

As a result of health care reform, mental health parity protections are expected to newly apply to all plans offered in the Exchange. Parity also will now apply to all adult Medicaid coverage.

Stronger State Parity Protections Prevail

Some states have stronger mental health parity protections than those provided by federal law. In those instances, the state protections apply.

Application for Cost Exemption from Parity

Plans otherwise subject to mental health parity that exceed a specified increase in costs are eligible to apply for a one-year exemption.

PARITY PROTECTIONS

No Annual or Lifetime Benefit Limits

The 1996 parity law prohibited insurers from imposing more restrictive lifetime or annual benefit limits on mental health coverage as compared with medical/surgical coverage. The 2008 law updated this protection to extend to substance abuse benefits, which were previously excluded from federal parity protections.

Health care reform will prohibit all group and new health insurance plans from placing lifetime benefit caps on plans beginning in 2011 and from placing limits on annual benefits beginning in 2014. This means that lifetime and annual limits on mental health or substance abuse services also will be prohibited in these plans beginning in 2011 and 2014, respectively.

Separate Deductibles Prohibited

Health plans subject to mental health parity are prohibited from having separate deductible requirements for mental health or substance abuse services. All health care spending counts toward a single deductible amount.

Separate Co-Pay Amounts Prohibited

Any co-pay amount imposed on mental health or substance abuse benefits must be no more than the predominate amount applied to substantially all medical/surgical benefits.

Equitable Management of Access to Services

Any quantitative limitations applied to the number of visits or days of treatment must be no more restrictive than those predominately applied to substantially all medical/surgical benefits. Other means of benefit restrictions, such as medical management standards, prescription formularies, and step-down therapy requirements, must be applied equitably as well.

Scope of Services

The Interim Final regulations issued to clarify the 2008 parity law have said that if benefits are offered in the following six categories for medical/surgical services, they must be offered for mental health or substance abuse: inpatient in-network; inpatient out-of-network; outpatient in-network; outpatient out-of-network; emergency services; and prescriptions. If a plan does not have a mental health provider network, all providers are considered in-network.

Continuing Guidance on Parity and Health Reform

Final rules for implementation of the 2008 parity law have not yet been issued and may address scope of services in further detail. Implementation of the new health care reform laws also is likely to necessitate additional guidance with regard to parity.

“Our work didn’t end when President Obama put down his pen. In some ways, it’s just begun. We have a great law. Now, we have to carry it out effectively.”

Kathleen Sebelius, Secretary of Health and Human Services

Health care reform will be subject to regulatory guidance on numerous points as it is implemented and our understanding is likely to evolve during that process. However, mental health parity and health care reform will certainly expand the number of individuals able to access important preventive care and mental health services.