NATIONAL COUNCIL
FOR COMMUNITY BEHAVIORAL HEALTHCARE

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Summary of the Major Provisions in the Patient Protection and Affordable Health Care Act

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On March 23, 2010, President Barack Obama signed into law comprehensive health care reform legislation, the Patient Protection and Affordable Care Act. The legislation previously had received approval from the Senate on December 24, 2009, and from the House on March 21, 2010. The following chart provides a summary of the major health insurance market reform, mental health, and addiction provisions of the law.

This document was updated in October 2010 to include information on the effective dates for each provision and the level of funding authorized or appropriated. Appropriated funds have actually been allocated or transferred to the program in question. Authorized funding refers to the level at which Congress has approved funding for the program – but indicates that such funds have not yet been appropriated.

Affordable Care Act (P.L. 111-148, as amended by PL 111-152)			
HEALTH INSURANCE MARKET REFORMS		**Authorization / Appropriations**	**Effective Date**
High-Risk Health Insurance Pool Program	Sec. 1101: Establishes a temporary high-risk health insurance pool program for U.S. citizens and legal immigrants who have a pre-existing condition and have lacked coverage for at least six months. Ensures premium rate limits for the newly insured.	$5 billion appropriated	Begins 90 days after enactment and ends on January 1, 2014
Pre-Existing Medical Conditions	Sec. 2704: Prohibits discrimination by group or individual health plans against individuals who have pre-existing medical conditions or have had illnesses in the past.	N/A	January 1, 2014
Health Insurance for Young Adults	Sec. 2714: Requires group and individual health plans to provide dependent coverage for young adults until age 26.	N/A	September 23, 2010

	Sec. 2004: Creates a new mandatory Medicaid benefit allowing all young adults who previously participated in foster care to qualify for Medicaid and all associated benefits, such as the Early Periodic Screening, Diagnosis, and Treatment Program (EPSDT), until age 25. Applies only to children who have aged out of foster care as of the date of enactment of the legislation.	Mandatory entitlement benefit; no new appropriations necessary	January 1, 2014
Lifetime and Annual Limits on Benefits	Sec. 2711: Prohibits the establishment of lifetime limits on benefits by group and individual health. Sec. 2711: Prohibits the establishment of annual limits on benefits by health. Prior to 2014, allows health plans to impose annual limits on benefits according to regulations determined by the Department of Health and Human Services.	N/A	September 23, 2010 January 1, 2014
Mental Health and Addiction Parity	Sec. 1311(j) and 1563(c)(4): Applies mental health and addiction parity to all health plans.	N/A	January 1, 2014
Public Health Insurance Options	Sec. 1322: Establishes a Consumer Operated and Oriented Plan program to promote the creation of non-profit, member-administered co-operative health insurers to offer small group and individual health plans in all states. Sec. 1324: Requires qualified health plans offered under the CO-OP program, coverage offered through a community health insurance option, and other qualified plans to adhere to all federal and state laws that apply to private insurers.	$6 billion appropriated for start-up grants N/A	Grants may be awarded until July 13, 2013
Individual Responsibility	Sec. 1501(5000A): Requires individuals to maintain minimum essential health insurance for themselves and applicable dependents or pay a penalty of $95 or 1% of taxable income in 2014, $325 or 2% of taxable income in 2015, $695 or 2.5% of taxable income in 2016, and an	N/A	January 1, 2014

	indexed amount in subsequent years. For individuals younger than age 18, reduces penalties by half. Provides exemptions for individuals who cannot afford health insurance, those who have incomes than the tax filing threshold, members of Indian tribes, and those who lack coverage for less than three months in a year.		
Employer Responsibility	Sec. 1513: Requires employers that have more than 50 full-time employees, do not offer health insurance, and have at least one worker who receives premium assistance to make a payment of $2,000 per full-time employee. The first 30 employees are excluded for purposes of calculating the payment. For employers that have more than 50 full-time employees, do offer health insurance, and have at least one worker who receives premium assistance, requires a payment of the lesser of $3,000 per employee who receives premium assistance or $2,000 per the total number of full-time workers. Exempts employers that have 50 or fewer full-time employees from the requirements.	N/A	January 1, 2014
Excise Tax on Health Insurers	Sec. 9001: Imposes an excise tax of 40% on health insurers and health plan administrators for any plan with a premium that exceeds $10,200 for single coverage and $27,500 for family coverage. Applies the tax to the amount of the premium in excess of the threshold. Allows an increase in the amounts of the thresholds in the event that health care costs increase more than expected prior to the implementation of the tax.	N/A	January 1, 2018
Community Living Assistance Services and Supports Program	Sec. 8002: Establishes a voluntary, public long-term care insurance program for the purchase of community living assistance services and supports by individuals who have functional limitations. Provides cash benefits of at least an average of $50 per day but requires the Secretary of HHS to develop an actuarially	Funded by employees' voluntary contributions	Employers may begin offering the program to employees on January 1, 2011. There is a 5-year

	sound benefit plan that ensures solvency of the program for 75 years. Allows for a 5-year waiting period for eligibility of benefits.		waiting period for benefits to take effect.
HEALTH INSURANCE EXCHANGES			
Individual and Small Group Market for Health Plans (Exchanges)	Sec. 1311: Requires the HHS secretary to award grants to states to establish American Health Benefit Exchanges. Sec. 1321: Requires the HHS secretary to establish standards for Exchanges, qualified health plans, reinsurance, and risk adjustment. In the event that the HHS secretary on or before January 1, 2013, determines a state will not have an operational Exchange by 2014, allows the secretary to operate an Exchange in that state.	Appropriates such sums as necessary N/A	Grants must be awarded before January 1, 2015 January 1, 2014
Eligibility for Participation in Exchanges	Sec. 1312: Allows U.S. citizens and legal immigrants who are not incarcerated to participate in Exchanges. In addition, permits small businesses to participate in Exchanges. After 2017, allows large employers to begin to participate in Exchanges.	N/A	January 1, 2014
Outreach and Enrollment Efforts	Sec. 2201: Allows individuals to apply for, and enroll in, Medicaid, CHIP, or Exchanges through Web site administered by states.	N/A	January 1, 2014
Essential Benefits Package (for Health Plans in Exchanges)	Sec. 1302: Requires all health plans in Exchanges to offer essential benefits, which include rehabilitative and habilitative services; and mental health and addiction services, such as behavioral health treatments. Sec. 1311: Allows states to require health plans in Exchanges to offer benefits in addition to the essential benefits.	N/A	January 1, 2014
Cost-Sharing in Exchanges	Sec. 1302: Mandates that annual cost-sharing for health plans in Exchanges cannot exceed $5,000 for individuals and $10,000 for families but does not apply the caps to the cost of	N/A	January 1, 2014

	premiums. For small group health plans in Exchanges, limits deductibles to no more than $2,000 for individuals and $4,000 for families.		
Benefit Package Levels	Sec. 1302: Defines levels of benefits offered by health plans in Exchanges based on the amount of cost-sharing required: Bronze (plans must pay for 60% of costs), Silver (70%), Gold (80%), and Platinum (90%). In the individual market, allows catastrophic-only plans to be offered to individuals who are younger than age 30 or who are exempted from the mandate because of a hardship waiver. Catastrophic coverage must include the essential benefits and at least three primary care visits but may require more cost-sharing.	N/A	January 1, 2014
State Flexibility	Sec. 1332: Allows states to apply for a waiver for up to 5 years of requirements related to Exchanges, qualified health plans, and cost-sharing. Requires states to prove that waivers would provide comprehensive and affordable health insurance to at least a comparable number of residents as Exchanges would provide and that waivers would not increase the federal budget deficit. Sec. 1333: By July 1, 2013, requires the HHS secretary to issue regulations for interstate Health Care Choice Compacts, which can begin operations after 2015. Allows the compacts to offer qualified health plans in all associated states but requires these plans to adhere to the consumer protection and other laws of each of the states.	N/A N/A	January 1, 2017 Compacts may begin January 1, 2016
Premium Assistance Credits, Caps on Out-of-Pocket Costs for Health Plans in	Sec. 1401(36B): Establishes premium assistance credits for individuals and families that have incomes at or less than 400% of the federal poverty level and enroll in health plans in Exchanges. For individuals or families with incomes at or less than 133% of the poverty level, requires that the credits cover premium	N/A	January 1, 2014

Exchanges	costs that exceed 2% of their income. Sec. 1402: Caps standard out-of-pocket costs for health plans in Exchanges at $5,950 for individuals and $11,900 for families. For individuals and families that receive premium assistance credits, lowers the caps on out-of-pocket costs to one-third of the standard level for those with incomes between 100% and 200% of the federal poverty level, one-half of the standard level for those with incomes between 200% and 300% of the poverty level, and two-thirds of the standard level for those with incomes between 300% and 400% of the poverty level.	N/A	January 1, 2014
MEDICAID AND CHIP		**Authorization / Appropriations**	**Effective Date**
Medicaid Expansion	Sec. 2001: Mandates that state Medicaid programs cover all individuals who are younger than age 65 and have incomes at or less than 133% of the federal poverty level. Provides limited Medicaid benefits packages to newly eligible individuals and requires states to design these packages based on rules for benchmark plans established in 2005. These benefit packages must include parity for mental and physical health services, but they are not required to offer the same level of coverage or range of services as traditional Medicaid. From 2014 to 2016, requires the federal government to pay 100% of the cost of Medicaid coverage for newly eligible individuals, with the level of this contribution to decrease to 95% in 2017, 94% in 2018, 93% in 2019, and 90% in subsequent years. Requires states to maintain current Medicaid income eligibility levels until January 1, 2015, but allows for possible exemptions for states with budget deficits. For children, requires states to maintain current Medicaid income eligibility	N/A	January 1, 2014

	levels through December 31, 2015.		
CHIP	Sec. 2101: Requires states to maintain current income eligibility levels for CHIP through September 30, 2019. From 2015 to 2019, provides states with a 23 percentage point increase in their federal CHIP match rates, with a cap at 100%. Sec. 10203: Appropriates funding for FY 2014 and 2015 (CHIP was previously funded only through 2013).	Appropriates $19.147 billion for FY 2014 and $21.061 billion for FY 2015. Appropriates $40 million for outreach and enrollment grants.	N/A
Medicaid Medical Home Pilot	Sec. 2703: Allows states to enroll Medicaid beneficiaries with chronic conditions, which include serious and persistent mental illness, into medical homes as part of pilot projects. Authorizes grants to help states plan and implement these projects.	$25 million authorized	January 1, 2011
Medicaid Accountable Care Organization Pilot Program	Sec. 2706: Establishes a demonstration project that will allow qualified pediatric providers to receive recognition and payments under Medicaid as accountable care organizations, as well as permit ACOs that meet quality of care standards and reduce costs to share in a portion of their savings to the program.	Authorizes such sums as needed	January 1, 2012
Medicaid Emergency Psychiatric Demonstration Project	Sec. 2707: Requires HHS to establish a three-year Medicaid demonstration project to reimburse certain institutions for mental disease for services provided to beneficiaries who are between ages 21 and 65 and require medical assistance to stabilize an emergency psychiatric condition.	$75 million appropriated	October 1, 2011
Medicaid Community-Based Services	Sec. 2401: Establishes a Community First Choice Option through which state Medicaid programs can offer community-based attendant services and supports to beneficiaries who otherwise would require the level of care offered in a hospital, nursing home, or intermediate care facility for the mentally	N/A	October 1, 2011

	retarded.		
	Sec. 2402: Allows states to provide more types of home- and community-based services to Medicaid beneficiaries with higher levels of need through a state plan amendment, rather than a waiver, and to extend full coverage to beneficiaries who receive HCBS under a state plan amendment.	N/A	October 1, 2010
	Sec. 10202: Establishes the State Balancing Incentive Payments Program to increase the proportion of Medicaid beneficiaries who receive long-term care outside of institutional settings. For states that qualify, provides FMAP increases for medical assistance expenditures for long-term care services and supports provided to Medicaid beneficiaries outside of institutional settings.	Not to exceed $3 billion	N/A
MEDICARE		**Authorization / Appropriations**	**Effective Date**
Medicare Part D	Sec. 3301: Requires pharmaceutical companies to provide a 50% discount to Medicare Part D beneficiaries for brand-name medications and biologics purchased in the "donut hole" coverage gap.	N/A	January 1, 2011
	Sec. 3305: Requires HHS to transmit Medicare Part D formulary and coverage information to low-income subsidy beneficiaries who were automatically reassigned to new Part D plans.	N/A	January 1, 2011
	Sec. 3307: Codifies the current six classes of clinical concern.	N/A	Plan year 2011
	Sec. 3309: Eliminates cost-sharing for Medicare beneficiaries who receive care under an HCBS program and otherwise would require institutional care.	N/A	January 1, 2012
Specialized	Sec. 3205: Extends the Special Needs Plan	N/A	January 1, 2011

Medicare Advantage Plans for Special Needs Individuals	program through 2013 and requires SNPs to obtain approval from the National Committee for Quality Assurance. On January 1, 2011, allows HHS to apply a frailty payment adjustment to fully integrated, dual-eligible SNPs that enroll frail Medicare beneficiaries and requires an evaluation of Medicare Advantage risk adjustment for chronically ill beneficiaries. Requires SNPs to obtain approval from the National Committee for Quality Assurance after 2011. After 2012, mandates that dual-eligible SNPs contract with state Medicaid programs. Requires HHS to transition Medicare beneficiaries enrolled in SNPs that do not meet statutory target definitions by January 1, 2013.		
Medicare Accountable Care Organizations	Sec. 3022: Allows ACOs that meet quality of care standards and reduce costs to share in a portion of their savings to Medicare.	N/A	January 1, 2012
Medicare Medical Home Pilot Program	Sec. 3502: Establishes a program to create and fund the development of community health teams to support the creation of medical homes through increased access to comprehensive, community-based, and coordinated care.	Authorizes such sums as needed	January 1, 2012
WORKFORCE AND OTHER PROVISIONS		**Authorization / Appropriations**	**Effective Date**
Co-Location of Primary and Specialty Care in Community-Based Behavioral Health Settings	Sec. 5604: Authorizes $50 million in grants for coordinated and integrated services through the co-location of primary and specialty care in community-based mental and behavioral health settings.	$50 million authorized	Date of enactment
National Health Service Corps	Sec. 5207: Authorizes specific funding amounts for the National Health Service Corps, with funding to increase from $320,461,632 in 2010 to $1,154,510,336 in 2016. After 2016, adjusts funding annually “by the product of (A)	Gradual increase in authorization (see details to the left)	Date of enactment

	one plus the average percentage increase in the costs of health professions education during the prior fiscal year; and (B) one plus the average percentage change in the number of individuals residing in health professions shortage areas designated under section 333 during the prior fiscal year, relative to the number of individuals residing in such areas during the previous fiscal year."		
Training for Behavioral Health Professionals	Sec. 5306: Allows the HHS secretary to award grants to schools for the development, expansion, or improvement of training programs in social work, graduate psychology programs, professional training in child and adolescent mental health, and pre-service or in-service training to paraprofessionals in child and adolescent mental health. Authorizes funding for the grants from 2010 to 2013.	Authorizes $35 million for FY2010-2013 ($8M for social work, $12M for graduate psychology, and $15M for child and adolescent mental health).	Effective date subject to HHS rulemaking
Loan Repayment for Pediatric Behavioral Health Specialists in Underserved Areas	Sec. 5203: Establishes and authorizes funds for a Pediatric Specialty Loan Repayment Program for individuals who are employed in health professional shortage or medically underserved areas for at least two years and provide pediatric medical subspecialty; pediatric surgical specialty; or child and adolescent mental and behavioral health services, which include substance abuse prevention and treatment services.	Authorizes $50 million for FY 2010-2014	Effective date subject to HHS rulemaking
Educating Primary Care Providers About Behavioral Health	Sec. 5405: Establishes and authorizes funds for a Primary Care Extension Program to educate primary care providers about preventive medicine; chronic disease management; mental and behavioral health services, which include substance abuse prevention and treatment services; and evidence-based and evidence-informed therapies and techniques.	Authorizes $120 million each year for FY2011-2012, and such sums as needed for FY2013-2014.	Effective date subject to HHS rulemaking
Community Transformation	Sec. 4201: Authorizes competitive grants to eligible entities for programs that promote	Authorizes such sums as needed	Effective date subject to HHS

Grants	individual and community health and prevent the incidence of chronic disease. Includes programs to prevent or reduce the incidence of mental illness. 20% of these grants must be awarded to rural and frontier areas.	for each of FY2010 through FY2014.	rulemaking
Community Health Workforce Grants	Sec. 5313: Authorizes grants to eligible entities to promote positive health behaviors and outcomes for populations in medically underserved communities through the use of community health workers.	Authorizes such sums as needed for each of FY2010 through FY2014.	Effective date subject to HHS rulemaking
National Health Care Workforce Commission	Sec. 5101: Establishes a National Health Care Workforce Commission to evaluate education and training programs to determine whether they will meet the expected demand for health care workers in the future; identify barriers to improved coordination of these programs at the federal, state, and local levels and recommend proposals to address these issues; and encourage innovations in these programs to address population needs, changes in technology, and other environmental factors.	Such sums as needed	September 30, 2010
Federal Definition of Community Mental Health Centers	In Section 1861 of the Social Security Act, changes the definition of community mental health centers to include a requirement that these facilities provide at least 40% of their services to individuals who do not qualify for benefits under Medicare and excludes from the definition of partial hospitalization services provided by CMHCs or other entities any services provided in the homes of individuals or in inpatient or residential settings.		April 1, 2011