



The Affordable Care Act: Opportunities and Challenges

30th Meeting of the Secretary's
Advisory Committee on Heritable
Disorders in Newborns and Children

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The Catalyst Center

- **Funded by** the Division of Services for Children with Special Health Needs, Maternal and Child Health Bureau (MCHB)
- **The National Center dedicated to the MCHB outcome measure:** “...all children and youth with special health care needs have access to adequate health insurance coverage for the care they require”.
- Provides **applied research and technical assistance** support to MCH stakeholders



Intersection between Public Health and Insurance Coverage in Financing Genetic Services

- Public Health: population health surveillance/improvement
- Insurance Coverage: protection against individual financial risk
 - Example: NBS – as public health funding has shrunk, FFS billing has increased

A step in the right direction...

- The Patient Protection and Affordable Care Act of 2010 (Pub. L. 111-148)
signed into law March 23, 2010
- The Health Care and Education Reconciliation Act (Pub. L. 111-152)
signed into law March 30, 2010

*Together, they're known as the
Affordable Care Act or ACA*



Major Areas of Focus in the ACA

- Insurance reforms (“Patient’s Bill of Rights” - consumer protections)
- New or expanded pathways to coverage (Medicaid expansion, MOE, Marketplaces), paired with Individual Mandate (everyone has to have coverage)
- Cost and Quality Provisions



Insurance Reform Provisions – Selected Examples

- Prohibition against denying coverage based on a **pre-existing condition**
- **Dependent coverage** for youth up to age 26 on their parent's plan, effective 2010
- No **rescission** of coverage regardless of the cost or amount of services used, effective 2010



Insurance Reform Provisions II

- **Guaranteed issue** and **guaranteed renewal**, effective 2014
- Section 2705 - **prohibition against discrimination** based on health status: explicitly lists “genetic information” among the health status factors that cannot be used in considering eligibility or coverage, effective 2014



Insurance Reform Provisions III

Annual and Lifetime Benefit Limits

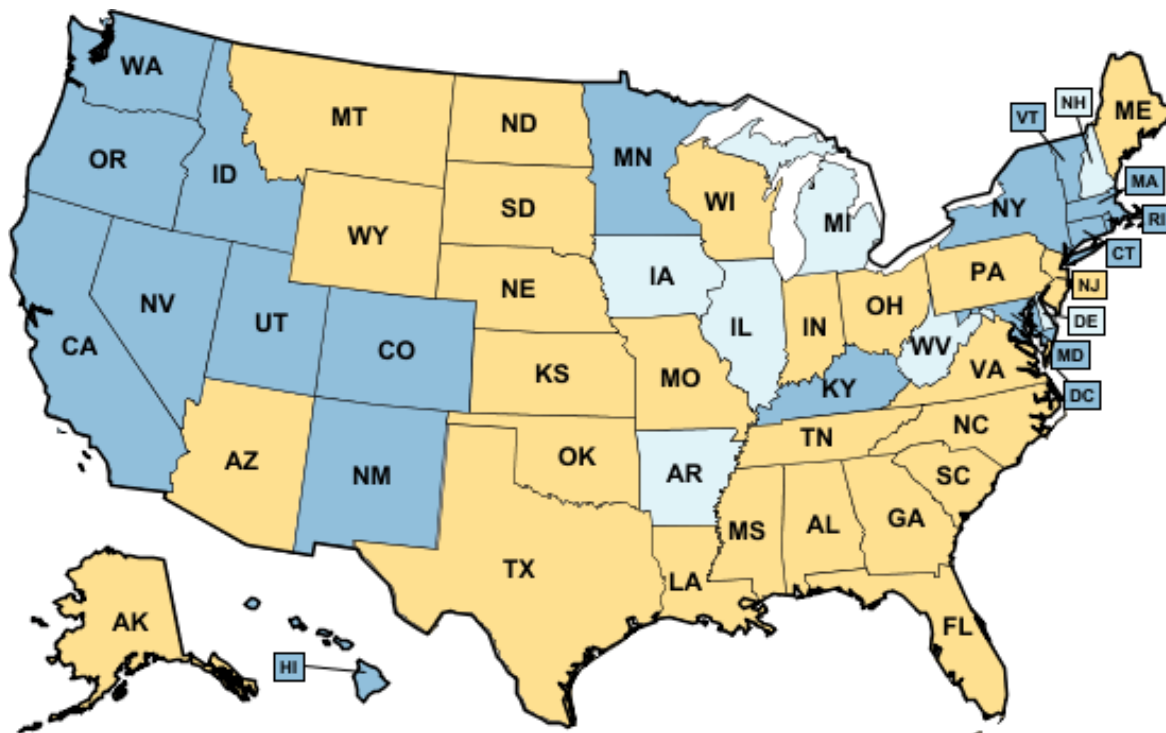
- Effective Now
 - No more lifetime benefit caps for existing or new plans
 - No annual benefit cap of less than \$2 million for plans starting on or after 9/23/12
- Effective Jan. 2014
 - No annual benefit cap allowed at all
- BENEFITS themselves can still be capped, e.g. 20 physical therapy visits, 15 mental health sessions per year

New and Expanded Pathways to Coverage

The State Exchanges or “Marketplace”

- Opening January 1, 2014 in each state
- Choice of different individual policies and small group (<100 employees) plans
- Help for consumers in choosing a plan – comparison website, navigators, assisters
- Tax credits and subsidies up to 400% FPL





Default to Federal Exchange

Declared State-based Exchange

Planning for Partnership Exchange

State Decisions For Creating Health Insurance Exchanges, as of March 21, 2013: Exchange Decision



statehealthfacts.org

Your source for state health data

CATALYST
CENTER



Essential Health Benefits (EHB)

Goes into effect: January 1, 2014

Section 1302

ACA requires that individual and small group plans include “essential health benefits”, including those offered through the Marketplace.

Plans covering large groups (100 or more employees) and grandfathered plans are exempt, as are self-funded plans.

Requirements under ACA

- The scope of benefits must reflect those covered by a “**typical**” employer plan
- The EHB definition cannot “make coverage decisions, determine reimbursement rates, establish incentive programs, or design benefits in ways that **discriminate against individuals because of their age, disability, or expected length of life**”



Requirements under ACA, con't

- The EHBs must take into account the health needs of diverse population groups
- Must include benefits under 10 broad service categories
- The benefits must be balanced among the 10 categories

EHB service categories

- Ambulatory care
- Emergency services
- Hospitalization
- Laboratory services
- Maternity and newborn care
- Pediatric services, including oral and vision care
- Preventative and wellness services, and chronic disease management
- Rehabilitative and habilitative services and devices
- Prescription drugs
- Mental health and substance abuse services; including behavioral health



12/16/11 EHB Benchmark Bulletin

Instead of one standard benefit package for all state Exchange and individual/small group market plans, HHS authorized states to choose one of the following four kinds of current plans to use as a model or benchmark....



The four benchmark options

- Any of the three largest small-group plans in the state by enrollment;
- Any of the three largest state employee health plans by enrollment;
- Any of the three largest federal employee health benefits program plan options by enrollment; OR
- The largest insured commercial non-Medicaid HMO plan operating in the state



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Digging in to Benchmark Plan Details

★ 3 people found this useful. do you?



Eager to dig into details about state benchmark plan choices so far? This chart provides key details—with direct links to evidence of coverage documents and CCIIO’s plan summaries—about the plans states have selected or defaulted into. States had until December 26, 2012 to submit comments on the [proposed EHB regulations](#) to finalize their benchmark plan decision. For background, see our [blog post](#).

Like all State Refor(u)m research, this chart is a collaborative effort with you, the user. State Refor(u)m captures the health reform comments, documents, and links submitted by health policy thinkers and does all over the country. And our team periodically supplements, analyzes, and compiles this key content.

Know of something, like an additional evidence of coverage document, we should add to this compilation? Eager to update a fact we’ve included? Your feedback is central to our ongoing, real-time analytical process, so tell us in a [comment](#) below, or email the author with your suggestion. She can be reached at ksheedy@nashp.org.

*Chart updated on March 18, 2013

State	Recommendation to HHS	Small Group	Largest HMO	State Employee	National FEHBP	Default	Evidence of Coverage	CCIIO Plan Summaries	Pediatric Vision	Pediatric Oral
	Selection of a benchmark plan whose benefits will largely define "essential health benefits"	HHS Bulletin, FAQ and final regulations defined options from which states could choose a benchmark plan				If a state does not choose a plan, its benchmark is set by default as the largest small group market product in the state's small group market	The Benchmark plan's coverage details and contract with policyholders	Benchmark plan's summary available at CCIIO	HHS requires benchmark plans to meet all 10 essential health benefit categories including pediatric vision and oral health care services. Many existing commercial plans do not offer pediatric vision or pediatric dental, so states are required to choose a supplemental plan that covers these services.	
AL	Blue Cross Blue Shield of Alabama PPO 320 Plan					X	X	X	FEDVIP	FEDVIP
AK	Premera Blue Cross Blue Shield of Alaska Heritage Select PPO					X		X ¹	FEDVIP	FEDVIP

<http://www.statereform.org/analyses/state-progress-on-essential-health-benefits>

State Mandated Benefits

- ACA requires states to pay for benefits mandated by state law that go beyond the scope of the EHBs
- Any state mandated benefit passed before 12/31/11 that falls within the selected benchmark plan will be included in the EHB for that state at no additional cost to the state



The Medicaid expansion

- Would have required all states to allow non-disabled, non-pregnant **adults** ages 19-64 to enroll – this is a **new population**
- It also raised the income level to 138% FPL for ALL populations (new & existing)
- The Supreme Court said the penalty to states for not complying is coercive
- The expansion is still allowed, but as a state option, not a requirement



Expanding children's Medicaid income eligibility is NOT an option

- The Supreme Court's ruling applies only to the **new population** of adults
- Children are an existing Medicaid-eligible population; in 2014, maximum family income will increase to 138% FPL
- No change in states with higher income eligibility levels till 2019 (MOE)
- Children in separate CHIP programs with family income <138% move to Medicaid



Income Eligibility Limits for Children in Medicaid and CHIP

Table 1A
Income Eligibility Limits and Other Eligibility Features of Children's Health Coverage
January 2012

State	Medicaid for Infants Ages 0-1 ¹ (Percent of the FPL)		Medicaid for Children Ages 1-5 ¹ (Percent of the FPL)		Medicaid for Children Ages 6-19 ¹ (Percent of the FPL)		Separate CHIP Ages 0-19 ² (Percent of the FPL)	Lawfully-Residing Immigrants Covered without 5-Year Wait (ICHIA Option) ³	Dependent Coverage of State Employees in CHIP ⁴
	Medicaid (Title XIX) Funding	CHIP (Title XXI) Funding	Medicaid (Title XIX) Funding	CHIP (Title XXI) Funding	Medicaid (Title XIX) Funding	CHIP (Title XXI) Funding			
Total							38	24	9
Alabama ⁴	▲ 133%		133%		100%		300%		Y
Alaska	150%	175%	150%	175%	150%	175%			
Arizona ⁵	140%		133%		100%		200% (closed)		
Arkansas	133%	200%	133%	200%	100%	200%			Y
California ^{6,7}	200%		133%		100%		250%	Y	
Colorado ⁸	133%		133%		100%		250%		
Connecticut ⁹	185%		185%		185%		300%	Y	
Delaware	185%	200%	133%		100%		200%	Y	
District of Columbia ¹⁰	185%	300%	133%	300%	100%	300%		Y	
Florida ^{9,11}	185%	200%	133%		100%		200%		
Georgia ^{4,12}	▲ 185%		133%		100%		235%		Y
Hawaii	185%	300%	133%	300%	100%	300%		Y	
Idaho	133%		133%		100%	133%	185%		
Illinois ^{3,10,12,13,14}	▲ 133%	200%	133%		100%	133%	200% (300%)	Y	
Indiana	200%		133%	150%	100%	150%	250%		
Iowa	133%	300%	133%		100%	133%	300%	Y	
Kansas ¹⁵	150%		133%		100%		238%		
Kentucky ⁴	▲ 185%		133%	150%	100%	150%	200%		Y
Louisiana	133%	200%	133%	200%	100%	200%	250%		
Maine ^{9,12}	185%		133%	150%	125%	150%	200%	Y	
Maryland	185%	300%	133%	300%	100%	300%		Y	
Massachusetts ^{14,16}	185%	200%	133%	150%	114%	150%	300%	Y	
Michigan ¹⁷	185%		150%		150%		200%		

<http://www.kff.org/medicaid/upload/8272.pdf>

Cost and Quality Related Provisions

- Increase in Medicaid primary care reimbursement rates to match the Medicare rate
- Demand (more insured) vs. Supply (provider shortages)
 - Investment in National Health Service Corps
- Accountable Care Organizations (ACOs) – the medical home “neighborhood)
- Health homes for Medicaid enrollees with specific chronic conditions (Section 2703)



Section 2703 of the ACA: Health Homes

State plan amendment (optional)

- Mechanism for financing select medical home components
 - Primary goal: integration and coordination of physical and behavioral health and long term supports
 - Available to states beginning January 1, 2011
 - Exclusions based on age not permitted
 - Waiver of comparability 1902(a)(10)(B)
 - Waiver of statewideness 1902(a)(1)

Eligibility Criteria

Medicaid enrollees with:

- two or more chronic conditions;
- one condition and the risk of developing another;
- or at least one serious and persistent mental health condition

How are chronic conditions defined?

By statute, they include:

- Mental health condition;
 - Substance abuse disorder;
 - Asthma;
 - Diabetes;
 - Heart disease; and,
 - Being overweight (as evidenced by a BMI of > 25).
- *States may add other chronic conditions in their State Plan Amendment for review and approval by CMS.*

What services/supports are included?

- Comprehensive Care Management;
- Care coordination;
- Health promotion;
- Comprehensive transitional care from inpatient to other settings;
- Individual and family support;
- Referral to community and social support services;
- Use of health information technology, as feasible and appropriate

Enhanced Federal Match

Enhanced reimbursement

- 90% FMAP – only for health home services/supports
- First 8 fiscal quarters that SPA is in effect (2 years)
- Okay to implement in increments (start with one geographic area, for example, then move to another. “Clock resets”)

Provider Types

- A designated provider;
- A team of health professionals; or
- A health team

Preventative Services

Section 2713

For people covered by new* employer-sponsored or individual plans/policies, the following services must be covered without co-pays, co-insurance or deductibles being charged or collected

*created after March 23, 2010

Recommendations of the United States Preventive Services Task Force (USPSTF)

<http://www.healthcare.gov/center/regulations/prevention/taskforce.html>

Recommendations of the Advisory Committee on Immunization Practices (ACIP)

adopted by CDC

<http://www.cdc.gov/vaccines/recs/acip/>

Bright Futures: Comprehensive Guidelines Supported by the Health Resources and Services Administration (HRSA)

Bright Futures Recommendations for Pediatric Preventive Health Care

<http://brightfutures.aap.org/pdfs/AAP%20Bright%20Futures%20Periodicity%20Sched%20101107.pdf>

HRSA's Women's Preventive Services: Required Health Plan Coverage Guidelines

<http://www.healthcare.gov/center/regulations/womensprevention.html>



Recommendations of the Secretary's Advisory Committee on Heritable Disorders in Newborns and Children

<http://www.hrsa.gov/heritabledisorderscommittee/SACHDNC.pdf>

Fully-insured and self-funded plans are required to provide coverage without cost-sharing for these screenings in the first plan/policy year that begins on or after May 21, 2011



Summary

- ACA offers historic opportunities, for example:
 - Improved access to universal, continuous, affordable coverage
 - Increased attention and investment in public health/primary care/prevention
- It doesn't do everything for everyone, for example:
 - Exemptions to provisions (grandfathered and self-funded plans)
 - Essential health benefits built on existing coverage
- Long-term sustainability of state and federal funding a significant concern
- **Need for safety net still critical**



For all you do....thank you!



Discussion and Questions



For more information,
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