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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Boston University School of Public Health
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
<table>
<thead>
<tr>
<th>Essential Health Benefits (EHB)</th>
<th>Section 1302</th>
</tr>
</thead>
<tbody>
<tr>
<td>Goes into effect: January 1, 2014</td>
<td>ACA requires that individual and small group plans include “essential health benefits”, including those offered through the Marketplace.</td>
</tr>
<tr>
<td></td>
<td>Plans covering large groups (100 or more employees) and grandfathered plans are exempt, as are self-funded plans.</td>
</tr>
</tbody>
</table>
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
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
## Digging in to Benchmark Plan Details

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 CMS’s plan summaries—about the plans states have selected or defaulted into. States had until December 26, 2012 to submit comments on the proposed EHS regulations to finalize their benchmark plan decision. For background, see our blog post.

Like all State Reformer research, this chart is a collaborative effort with you, the user. State Reformer captures the health reform comments, documents, and links submitted by health policy thinkers and doers 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 isheedy@nsfhp.org.

*Chart updated on March 18, 2013*

<table>
<thead>
<tr>
<th>State</th>
<th>Recommendation to EHS</th>
<th>Small Group</th>
<th>Large HMO</th>
<th>State Employee</th>
<th>National FEHBP</th>
<th>Default</th>
<th>Evidence of Coverage</th>
<th>CMS Plan Summaries</th>
<th>Pediatric Vision</th>
<th>Pediatric Oral</th>
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<tr>
<td>AL</td>
<td>Blue Cross Blue Shield of Alabama PPO 320 Plan</td>
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<td>FEDVIP</td>
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<td>AK</td>
<td>Premier Blue Cross Blue Shield of Alaska Heritage Select PPO</td>
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<td>FEDVIP</td>
<td>FEDVIP</td>
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</table>

http://www.statereforum.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**

<table>
<thead>
<tr>
<th>State</th>
<th>Medicaid for Infants Ages 0-1&lt;sup&gt;1&lt;/sup&gt; (Percent of the FPL)</th>
<th>Medicaid for Children Ages 1-5&lt;sup&gt;1&lt;/sup&gt; (Percent of the FPL)</th>
<th>Medicaid for Children Ages 6-19&lt;sup&gt;1&lt;/sup&gt; (Percent of the FPL)</th>
<th>Separate CHIP Ages 0-19&lt;sup&gt;2&lt;/sup&gt; (Percent of the FPL)</th>
<th>Lawfully Residing Immigrants Covered Without 5-Year Wait (CHIP Option)&lt;sup&gt;3&lt;/sup&gt;</th>
<th>Dependent Coverage of State Employees in CHIP&lt;sup&gt;4&lt;/sup&gt;</th>
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<tbody>
<tr>
<td>Total</td>
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</tr>
<tr>
<td>Alabama&lt;sup&gt;5&lt;/sup&gt;</td>
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<td>133%</td>
<td>100%</td>
<td>90%</td>
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<tr>
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<tr>
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<tr>
<td>Connecticut&lt;sup&gt;9&lt;/sup&gt;</td>
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<td>185%</td>
<td>300%</td>
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<td>District of Columbia&lt;sup&gt;10&lt;/sup&gt;</td>
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<tr>
<td>Florida&lt;sup&gt;11,12&lt;/sup&gt;</td>
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<td>200%</td>
<td>133%</td>
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<td></td>
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<tr>
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<td>200%</td>
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<tr>
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<td>300%</td>
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<td>Idaho</td>
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<td>133%</td>
<td>133%</td>
<td>185%</td>
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<tr>
<td>Illinois&lt;sup&gt;3, 11, 12, 13, 14&lt;/sup&gt;</td>
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<td>200%</td>
<td>133%</td>
<td>200% (300%)</td>
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<tr>
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<td>133%</td>
<td>150%</td>
<td>250%</td>
<td></td>
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<tr>
<td>Kentucky&lt;sup&gt;4&lt;/sup&gt;</td>
<td>▲ 185%</td>
<td>200%</td>
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<td>200%</td>
<td>Y</td>
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<tr>
<td>Louisiana</td>
<td>133%</td>
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<td>200%</td>
<td></td>
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</tr>
<tr>
<td>Maine&lt;sup&gt;16, 12&lt;/sup&gt;</td>
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<td>133%</td>
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<td>Michigan&lt;sup&gt;17&lt;/sup&gt;</td>
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<td>150%</td>
<td>150%</td>
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</table>
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, please contact us at:

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