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IMPROVING FINANCING OF CARE for Children & Youth WITH SPECIAL HEALTH CARE NEEDS

The Affordable Care Act and Genetic Conditions: Opportunities and Challenges

HRSA Genetic Services Collaboratives Webinar

June 19, 2013

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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: Newborn screening – as public health funding has shrunk, fee-for-service 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, Maintenance of Effort-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

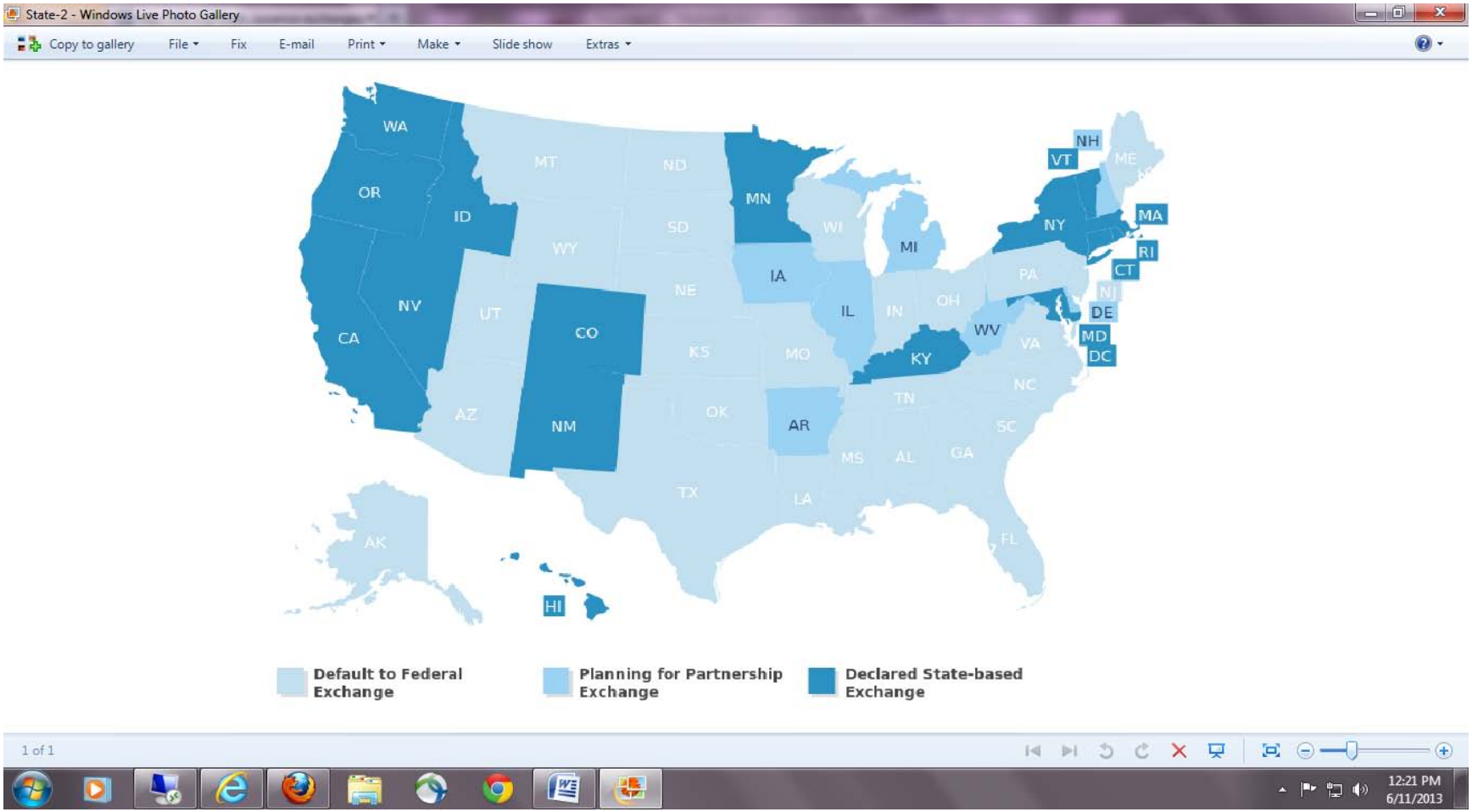
- BENEFITS themselves can still be capped, e.g. 20 physical therapy visits, 15 mental health sessions per year

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

State Decisions For Creating Health Insurance Exchanges, as of May 28, 2013



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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.**

The policy rationale for the EHBs

- Ensure comprehensive coverage (“bang for the buck”)
- Facilitate comparisons between plans to inform consumer/employer choice (apples to apples)
- Increase equity of coverage options between individuals/small businesses and large group employers (leveling the playing field)

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

The devil is in the details....

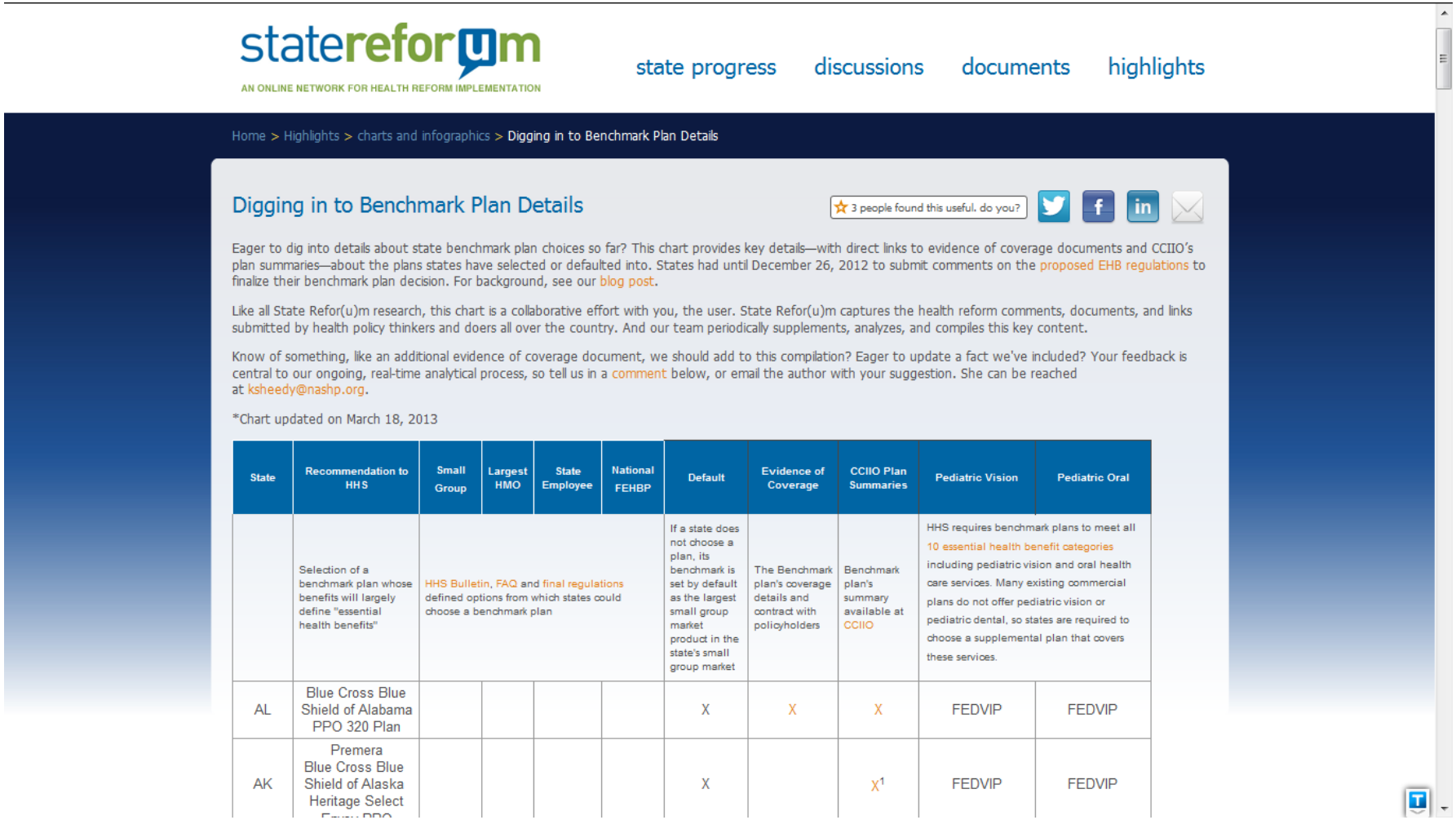
- ACA as passed directed the Secretary of HHS to determine the **scope, duration** and **definition** of benefits under the broad EHB service categories
- Considered the following:
  - Reports from:
    - Institutes of Medicine (IOM)
    - Assistant Secretary for Planning and Evaluation (ASPE) at HHS
    - Department of Labor (DoL).....and others
  - Nationwide “Listening Sessions”

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



http://www.statereforum.org/analyses/state-progress-on-essential-health-benefits

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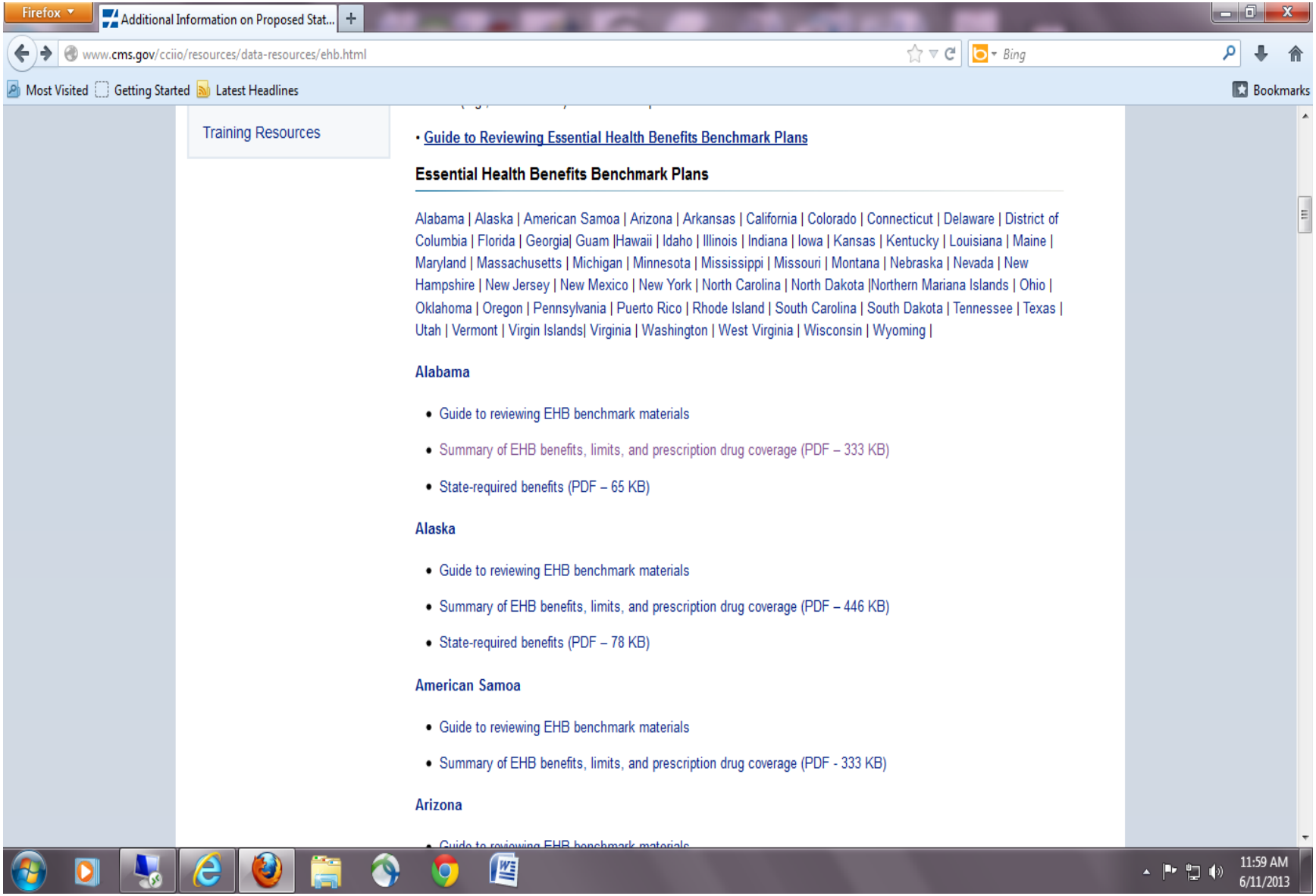

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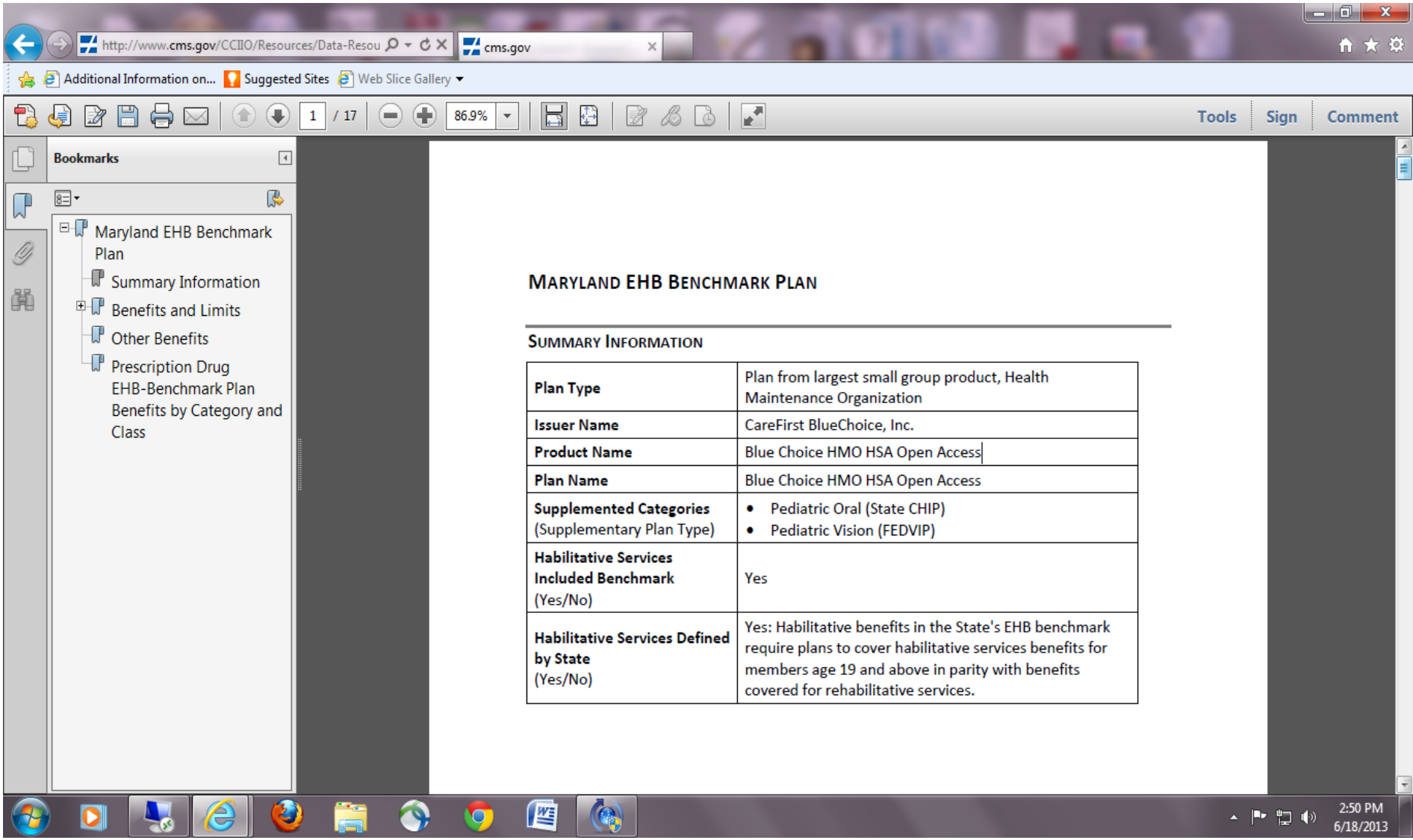

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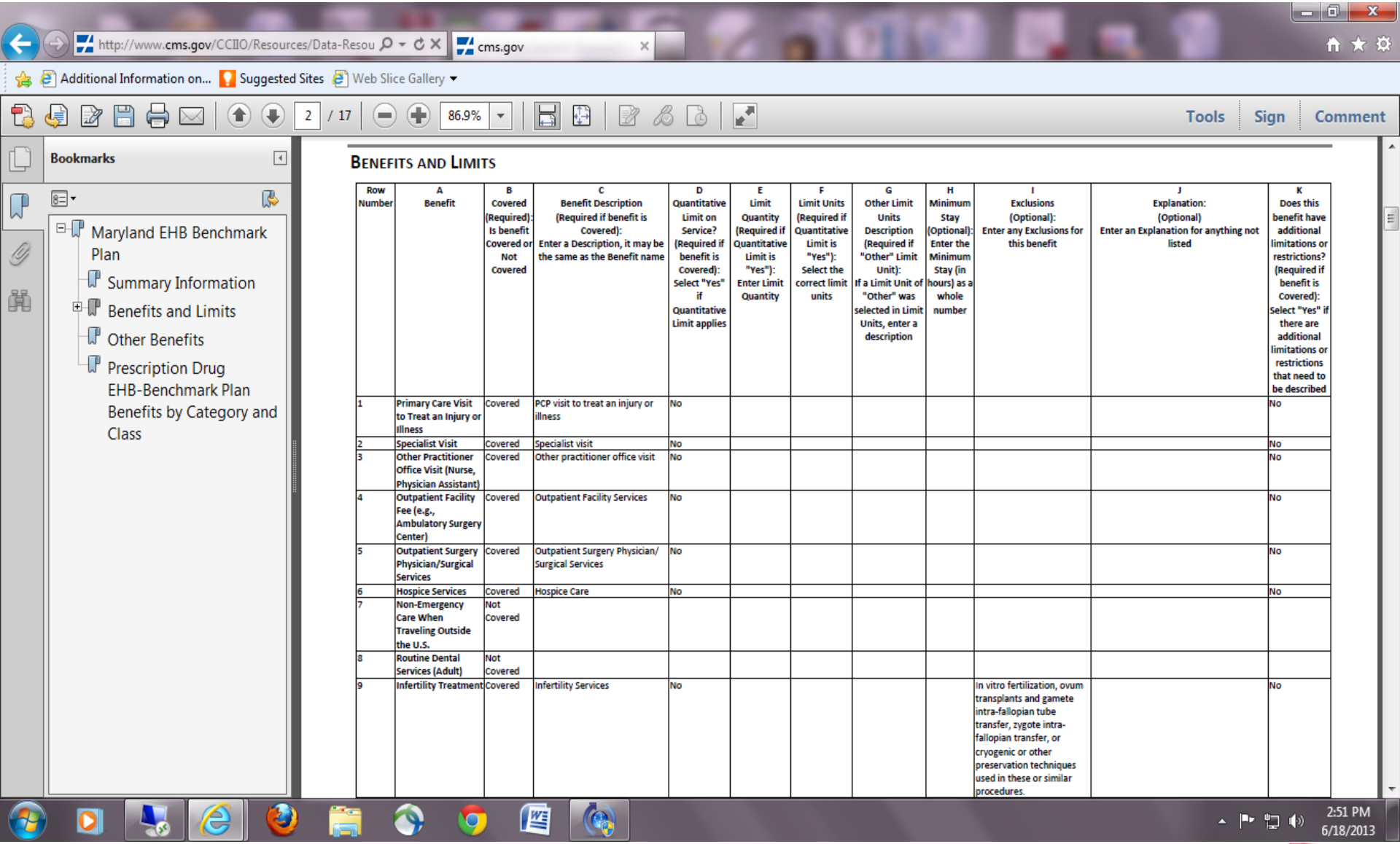

http://www.cms.gov/CCIIO/Resources/Data-Resou
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Additional Information on... Suggested Sites Web Slice Gallery
2 / 17 86.9% Tools Sign Comment
Bookmarks
Maryland EHB Benchmark Plan
Summary Information
Benefits and Limits
Other Benefits
Prescription Drug EHB-Benchmark Plan Benefits by Category and Class
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BENEFITS AND LIMITS

Row Number	A Benefit	B Covered (Required): Is benefit Covered or Not Covered	C Benefit Description (Required if benefit is Covered): Enter a Description, it may be the same as the Benefit name	D Quantitative Limit on Service? (Required if benefit is Covered): Select "Yes" if Quantitative Limit applies	E Limit Quantity (Required if Quantitative Limit is "Yes"): Enter Limit Quantity	F Limit Units (Required if Quantitative Limit is "Yes"): Select the correct limit units	G Other Limit Units Description (Required if "Other" Limit Unit): If a Limit Unit of "Other" was selected in Limit Units, enter a description	H Minimum Stay (Optional): Enter the Minimum Stay (in hours) as a whole number	I Exclusions (Optional): Enter any Exclusions for this benefit	J Explanation: (Optional) Enter an Explanation for anything not listed	K Does this benefit have additional limitations or restrictions? (Required if benefit is Covered): Select "Yes" if there are additional limitations or restrictions that need to be described
1	Primary Care Visit to Treat an Injury or Illness	Covered	PCP visit to treat an injury or illness	No							No
2	Specialist Visit	Covered	Specialist visit	No							No
3	Other Practitioner Office Visit (Nurse, Physician Assistant)	Covered	Other practitioner office visit	No							No
4	Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Covered	Outpatient Facility Services	No							No
5	Outpatient Surgery Physician/Surgical Services	Covered	Outpatient Surgery Physician/ Surgical Services	No							No
6	Hospice Services	Covered	Hospice Care	No							No
7	Non-Emergency Care When Traveling Outside the U.S.	Not Covered									
8	Routine Dental Services (Adult)	Not Covered									
9	Infertility Treatment	Covered	Infertility Services	No					in vitro fertilization, ovum transplants and gamete intra-fallopian tube transfer, zygote intra-fallopian transfer, or cryogenic or other preservation techniques used in these or similar procedures.		No

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State Mandated Benefits (SMB)

- ACA: States must cover cost of SMB that go beyond EHBs
- Rule: SMB in place before 12/31/11 will be considered part of the EHB, so no additional cost to states for them
- Only SMB that impact care, treatment or services apply
- Any limits in original SMB law still applies; only individual plans, for example
- Exchanges will be responsible for ID'ing SMB that go above EHBs; insurers responsible for ID'ing the cost

Maryland - State Required Benefits

Benefit	Name of Required Benefit	Market Applicability	Citation Number
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Outpatient hospital services	Small group	COMAR 31.11.06.03A(3)
Outpatient Surgery Physician/Surgical Services	Care in medical offices, inpatient hospital services and outpatient hospital services	Small group	COMAR 31.11.06.03A (1), (2), and (3)
Hospice Services	Hospice care services	Individual, small group, large group	1. For individual and large group--§ 15-809, Insurance Article; For small group-- COMAR 31.11.06.03A(12)
Infertility Treatment	1. In vitro fertilization; 2. Infertility services	1. Applies to individual and large group; 2. Applies to small group	1. §15-810, Insurance Article; 2. COMAR 31.11.06.03A(18)
Home Health Care Services	Home health care services	1. Individual and large group; 2. Small group	1. § 15-808, Insurance Article; 2. COMAR 31.11.06.03A(11)
Home Health Care Services	Additional home visits following removal of testicle	Individual, small group, large group	For individual and large group--§ 15-832, Insurance Article; For small group--COMAR 31.11.06.03(11)(b)
Emergency Room Services	Emergency services	Small group; HMOs in all markets are required to cover these services	For small group--COMAR 31.11.06.03A(6); For HMOs--§ 19-701(g), Health-General Article
Emergency Transportation/Ambulance	Ambulance services	Small group	COMAR 31.11.06.03A(8)
Inpatient Hospital Services (e.g., Hospital Stay)	Minimum hospitalization and home visits following mastectomy	Individual, small group, large group	For individual and large group-- §15-832.1, Insurance Article; For small group--COMAR 31.11.06.03(11)(b)
Inpatient Hospital Services (e.g.,	Inpatient hospital services	Small group; for HMOs in all markets	For small group--COMAR 31.11.06.03A(2); For

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

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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

Medicaid 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 to 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**

Discussion and Questions

For more information,
please contact us at:

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