The Affordable Care Act and Genetic Conditions: Opportunities and Challenges

HRSA Genetic Services Collaboratives Webinar

June 19, 2013

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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: 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
<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>
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<tr>
<td></td>
<td>Plans covering large groups (100 or more employees) and grandfathered plans are exempt, as are self-funded plans.</td>
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</tbody>
</table>
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”
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 CCEO’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 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 ksheedv@nashp.org.

*Chart updated on March 18, 2013*

<table>
<thead>
<tr>
<th>State</th>
<th>Recommendation to EHS</th>
<th>Small Group</th>
<th>Large/ Med HMO</th>
<th>State Employee</th>
<th>National FEHB*</th>
<th>Default</th>
<th>Evidence of Coverage</th>
<th>CCEO Plan Summaries</th>
<th>Pediatric Vision</th>
<th>Pediatric Oral</th>
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</thead>
<tbody>
<tr>
<td>AL</td>
<td>Selection of a benchmark plan whose benefits will largely define “essential health benefits”</td>
<td>HHS Bulletin, FAQ and final regulations defined options from which states could choose a benchmark plan</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>FEDVIP</td>
<td>FEDVIP</td>
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<tr>
<td>AK</td>
<td>Blue Cross Blue Shield of Alabama PPO 320 Plan</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>FEDVIP</td>
<td>FEDVIP</td>
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</table>

The Center for Consumer Information & Insurance Oversight

Additional Information on Proposed State Essential Health Benefits Benchmark Plans

Background

Beginning in 2014, the Affordable Care Act requires non-grandfathered health plans to cover essential health benefits (EHB), which includes items and services in the following ten benefit categories: (1) ambulatory patient services; (2) emergency services; (3) hospitalization; (4) maternity and newborn care; (5) mental health and substance use disorder services including behavioral health treatment; (6) prescription drugs; (7) rehabilitative and habilitative services and devices; (8) laboratory services; (9) preventive and wellness services and chronic disease management; and (10) pediatric services, including oral and vision care. The essential health benefits should be equal in scope to a typical employer health plan.

In the Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation Final Rule ("EHB Rule"), HHS defines EHB based on state-specific EHB benchmark plans. This page contains information on EHB benchmark plans for each of the 50 states, the District of Columbia (D.C.), and the U.S. territories. Two documents are provided for each EHB benchmark plan in the 50 states, D.C. and Puerto Rico: (1) a summary of the plan’s specific benefits and limits, and list of covered prescription drug categories and classes; and (2) state-required benefits.
Guide to Reviewing Essential Health Benefits Benchmark Plans

Essential Health Benefits Benchmark Plans


Alabama

- Guide to reviewing EHB benchmark materials
- Summary of EHB benefits, limits, and prescription drug coverage (PDF – 333 KB)
- State-required benefits (PDF – 65 KB)

Alaska

- Guide to reviewing EHB benchmark materials
- Summary of EHB benefits, limits, and prescription drug coverage (PDF – 446 KB)
- State-required benefits (PDF – 78 KB)

American Samoa

- Guide to reviewing EHB benchmark materials
- Summary of EHB benefits, limits, and prescription drug coverage (PDF – 333 KB)

Arizona

- Guide to reviewing EHB benchmark materials
# Maryland EHB Benchmark Plan

## Summary Information

<table>
<thead>
<tr>
<th>Plan Type</th>
<th>Plan from largest small group product, Health Maintenance Organization</th>
</tr>
</thead>
<tbody>
<tr>
<td>Issuer Name</td>
<td>CareFirst BlueChoice, Inc.</td>
</tr>
<tr>
<td>Product Name</td>
<td>Blue Choice HMO HSA Open Access</td>
</tr>
<tr>
<td>Plan Name</td>
<td>Blue Choice HMO HSA Open Access</td>
</tr>
<tr>
<td>Supplemented Categories (Supplementary Plan Type)</td>
<td>Pediatric Oral (State CHIP)</td>
</tr>
<tr>
<td>Habilitative Services Included Benchmark (Yes/No)</td>
<td>Yes</td>
</tr>
<tr>
<td>Habilitative Services Defined by State (Yes/No)</td>
<td>Yes: Habilitative benefits in the State's EHB benchmark require plans to cover habilitative services benefits for members age 19 and above in parity with benefits covered for rehabilitative services.</td>
</tr>
<tr>
<td>Benefit Number</td>
<td>Benefit</td>
</tr>
<tr>
<td>----------------</td>
<td>---------</td>
</tr>
<tr>
<td>1</td>
<td>Primary Care Visit to Treat an Injury or Illness</td>
</tr>
<tr>
<td>2</td>
<td>Laboratory Visit</td>
</tr>
<tr>
<td>3</td>
<td>Other Practitioner Office Visit (nurse, Physician Assistant)</td>
</tr>
<tr>
<td>4</td>
<td>Outpatient Facility Fee (e.g., Ambulatory Surgery Center)</td>
</tr>
<tr>
<td>5</td>
<td>Outpatient Surgery Physician/Surgical Services</td>
</tr>
<tr>
<td>6</td>
<td>Hospice Services</td>
</tr>
<tr>
<td>7</td>
<td>Non-Emergency Care When Traveling Outside the U.S.</td>
</tr>
<tr>
<td>8</td>
<td>General Dental Services (Adult)</td>
</tr>
<tr>
<td>9</td>
<td>Infertility Treatment</td>
</tr>
</tbody>
</table>
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

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Name of Required Benefit</th>
<th>Market Applicability</th>
<th>Citation Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient Facility Fee (e.g., Ambulatory Surgery Center)</td>
<td>Outpatient hospital services</td>
<td>Small group</td>
<td>COMAR 31.11.06.03A(3)</td>
</tr>
<tr>
<td>Outpatient Surgery Physician/Surgical Services</td>
<td>Care in medical offices, inpatient hospital services and outpatient hospital services</td>
<td>Small group</td>
<td>COMAR 31.11.06.03A (1), (2), and (3)</td>
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<tr>
<td>Hospice Services</td>
<td>Hospice care services</td>
<td>Individual, small group, large group</td>
<td>1. For individual and large group--§ 15-809, Insurance Article; For small group-- COMAR 31.11.06.03A(12)</td>
</tr>
<tr>
<td>Infertility Treatment</td>
<td>1. In vitro fertilization; 2. Infertility services</td>
<td>1. Applies to individual and large group; 2. Applies to small group</td>
<td>1. §15-810, Insurance Article; 2. COMAR 31.11.06.03A(18)</td>
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<tr>
<td>Home Health Care Services</td>
<td>Home health care services</td>
<td>1. Individual and large group; 2. Small group</td>
<td>1. § 15-808, Insurance Article; 2. COMAR 31.11.06.03A(11)</td>
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<tr>
<td>Home Health Care Services</td>
<td>Additional home visits following removal of testicle</td>
<td>Individual, small group, large group</td>
<td>For individual and large group--§ 15-832, Insurance Article; For small group--COMAR 31.11.06.03A(11)(b)</td>
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<tr>
<td>Emergency Room Services</td>
<td>Emergency services</td>
<td>Small group; HMOs in all markets are required to cover these services</td>
<td>For small group--COMAR 31.11.06.03A(6); For HMOs--§ 19-701(g), Health-General Article</td>
</tr>
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<td>Emergency Transportation/Ambulance</td>
<td>Ambulance services</td>
<td>Small group</td>
<td>COMAR 31.11.06.03A(8)</td>
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<tr>
<td>Inpatient Hospital Services (e.g., Hospital Stay)</td>
<td>Minimum hospitalization and home visits following mastectomy</td>
<td>Individual, small group, large group</td>
<td>For individual and large group-- §15-832.1, Insurance Article; For small group--COMAR 31.11.06.03A(11)(b)</td>
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<tr>
<td>Inpatient Hospital Services (e.g., Hospital Stay)</td>
<td>Inpatient hospital services</td>
<td>Small group; for HMOs in all markets</td>
<td>For small group--COMAR 31.11.06.03A(2); For</td>
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</table>
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>
<thead>
<tr>
<th>State</th>
<th>Medicaid for Infants Ages 0-1 (Percent of the FPL)</th>
<th>Medicaid for Children Ages 1-5 (Percent of the FPL)</th>
<th>Medicaid for Children Ages 6-19 (Percent of the FPL)</th>
<th>Separate CHIP Ages 6-19 (Percent of the FPL)</th>
<th>Lawfully Residing Immigrants Covered Without 5-Year Wait (CHIP Option)</th>
<th>Dependent Coverage of State Employees in CHIP</th>
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<tbody>
<tr>
<td>Alabama</td>
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<td>Maine</td>
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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

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
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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The Catalyst Center is funded under cooperative agreement #U41MC13618 from the Division of Services for Children with Special Health Needs, Maternal and Child Health Bureau, Health Resources and Services Administration, U.S. Department of Health and Human Services.

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