American Hospital Association

Coverage

Background

Implementation of the *Patient Protection and Affordable Care Act* (ACA) will provide access to health care coverage to many Americans who are unable to afford coverage. The Congressional Budget Office (CBO) estimates that the ACA will extend coverage to approximately 32 million uninsured people, or about 94 percent of legal residents. Three elements of health care reform – the individual mandate, expansion of Medicaid and the creation of state health insurance exchanges with public subsidized coverage – will help achieve this level of coverage.

AHA View

Implementation of the ACA's coverage provisions must occur in a thoughtful and transparent manner where the views of all stakeholders are considered. Since much of the implementation falls to state governments, the AHA is working closely with state hospital associations to develop resources to better equip hospitals to engage in these state-level discussions. These tools can be found on the AHA's website under "Health Reform Moving Forward."

Enrollment. Ensuring that people enroll in the health insurance programs available to them is critical to achieving the increased coverage the ACA envisions. The AHA is participating in a diverse coalition that includes insurers, providers and advocacy groups that will encourage enrollment through the exchanges and Medicaid. The coalition, "Enroll America," was launched in September 2011 and focuses on state-based enrollment initiatives and best practices. Visit www.enrollamerica.org to learn more and get involved.

Individual Mandate. The individual mandate requires that by January 1, 2014 individuals, with some exceptions, secure the minimum essential health insurance coverage through either their employer, the state health insurance exchange or a public program, such as Medicaid, Medicare or the Children's Health Insurance Program, or pay a penalty. The constitutionality of this mandate is being reviewed by the Supreme Court with its decision expected this June. The AHA has filed several friend-of-the-court briefs in support of the constitutionality of the individual mandate. On the issue of severability, if the individual mandate is ruled unconstitutional, the AHA advocates for the Supreme Court, not the lower courts, to decide whether other parts of the ACA can go forward. Should the individual mandate be thrown out, the AHA believes the Supreme Court also should eliminate the ACA's provisions that cut hospitals' Medicare and Medicaid payments over a 10-year period.

Medicaid. The ACA expands Medicaid eligibility to all legal residents earning up to 133 percent of the federal poverty level (FPL), about $14,483 for a single adult or $29,725 for a family of four. The federal government will largely finance this expansion. The CBO estimates that half of the 32 million newly insured under the ACA will get their coverage through Medicaid expansion.

States are required to maintain levels of Medicaid eligibility in place as of March 23, 2010. States that have already expanded coverage to 133 percent of the FPL and beyond can seek a waiver from this requirement if they can demonstrate hardship. The Department of Health and Human Services (HHS) has released final rules implementing the ACA changes to Medicaid eligibility requirements related to health insurance exchanges and how income is calculated for purposes of eligibility. The Supreme Court also is reviewing the constitutionality of the ACA's provision to expand Medicaid. Earlier this year, the AHA filed an amicus brief in support of the law's Medicaid expansion.

Exchanges, Essential Benefits and Insurance Reform. HHS has consulted with the National Association of Insurance Commissioners (NAIC), the Institute of Medicine (IOM) and state governments to help define essential benefits, the medical loss ratio and premium rate review, as well as shape implementation policy around the state health insurance exchanges. The AHA continues to work with the NAIC, IOM and HHS, and other key stakeholders. Below is a discussion of key issues:

State Health Insurance Exchanges. The AHA believes that state-level health insurance exchanges should be flexible enough to accommodate local conditions. Exchanges need to create an efficient and effective private insurance marketplace for consumers – one that encourages private insurers to participate – while balancing key objectives of pooling risk and managing public subsidies. Exchanges should focus initially on the basic elements needed to allow the new marketplace to develop, starting small in both size and scope. HHS has issued final rules that provide guidance to states on the exchange functions and qualified health plan (QHP) certification. (QHPs are plans that can be sold within exchanges.) While the final rules grant states flexibility in the establishing exchanges, the AHA remains concerned that HHS has not given states sufficient guidance on provider network adequacy and stakeholder engagement.

Essential Health Benefits (EHBs). The AHA is concerned that the efforts to date on defining EHBs may undermine one of the fundamental tenants of the ACA – that is, to extend meaningful and affordable coverage to millions of people who are currently uninsured or underinsured. The definition of EHBs is critical to determining whether the health coverage purchased is actually meaningful. The IOM's work on this subject and the recent issuance of the Center for Consumer Information and Insurance Oversight's (CCIIO) *EHB Bulletin* suggest that in the struggle to balance affordability with the comprehensiveness of health benefits, the recommendations consistently tilt in favor of affordability.

The IOM recommended tying EHBs to the typical, small employer health plan, and the CCIIO's sub regulatory *EHB Bulletin* builds on the IOM recommendation by allowing states to choose from four "benchmark" health plans that reflect

the scope of services offered by a "typical employer plan" in that state. Those benchmarks already reflect limitations on services and significant deductibles, coinsurance and copayments.

The AHA recommends that the EHBs package for health plans that participate in state insurance exchanges cover a broad range of services, including medical, psychiatric, rehabilitative, dental, vision, pharmaceutical, preventive and hospice services. In addition, the package should be driven by the needs of the individual, be generally available and adhere to accepted professional guidelines. The AHA suggests a three-pronged framework for assessing which benefits to include:

- Are the benefits responsive to individual needs?
- Do the benefits take affordability into account?
- Are the benefits easily understood and transparent?

Furthermore, the AHA strongly believes that an open and transparent process should govern the establishment of EHBs as well as any future updating and change to EHBs.