American Hospital Association®

Enhancing Coverage

Background

The Patient Protection and Affordable Care Act (ACA) will provide access to health care coverage to many Americans who previously were unable to afford it. Set to begin Jan. 1, 2014, the ACA's main coverage improvements are based on three elements of health care reform – the individual mandate, expansion of Medicaid, and the creation of state and federal health insurance exchanges with financial subsidies for qualifying individuals. The Congressional Budget Office (CBO) originally projected that the ACA would extend coverage to 32 million uninsured people, or about 94 percent of legal residents. While the Supreme Court of the United States (SCOTUS) in 2012 upheld the constitutionality of the individual mandate, the court ruled that the federal government could not force states to expand their Medicaid programs or risk losing all of their Medicaid funding. It is now left to the states to decide whether to expand coverage through Medicaid. As a result, according to recent CBO projections, 5 million fewer people will get coverage through the ACA reforms – a drop to 27 million gaining coverage, or about 92 percent of legal residents. The undocumented, or non-legal, immigrant population residing in the U.S will remain uninsured for the foreseeable future.

AHA View

The AHA believes that implementation of the ACA's coverage provisions must occur in a thoughtful and transparent manner where the views of all stakeholders are considered. Yet, the administration has been "fast-tracking" rules and guidance to prepare for 2014. We continue to urge the administration to allow sufficient time for notice and public comment. Much of this guidance and rulemaking has granted a remarkable level of flexibility to state governments by allowing them to make their own decisions on major implementation questions. Since much of the implementation falls to state governments, the AHA continues to work closely with state hospital associations and hospitals to provide resources and tools to assist these state-level coverage discussions. The AHA will continue to monitor the ACA's promise of coverage improvements as state governments decide whether they will expand their Medicaid program, and what role they will play in state-based or federally facilitated health insurance exchanges.

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 a founding member of Enroll America, a collaborative organization working with partners that span the gamut of health coverage stakeholders – health insurers, hospitals, doctors, pharmaceutical companies, employers, consumer groups, faith-based organizations, civic organizations, and philanthropies – to engage many different voices in support of an easy, accessible and widely available enrollment process. Enroll America is focused on state-based enrollment initiatives, best practices and other tools to encourage enrollment through the health insurance exchanges and Medicaid. Visit www.enrollamerica.org to learn more.

Individual Mandate. The individual mandate requires that by Jan. 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 (CHIP), or pay a penalty. However, because the SCOTUS decision, in effect, gives states the choice to expand their Medicaid program, some low-income individuals may be left without coverage under Medicaid, particularly individuals with incomes below 100 percent of the federal poverty line (FPL) – the income threshold for coverage eligibility through the exchanges. The Internal Revenue Service recently announced that it will create an exception for individuals who are eligible for Medicaid but live in states that do not expand their Medicaid programs so these individuals are not subject to penalties for failing to secure coverage.

Medicaid. The ACA required that states expand Medicaid eligibility to all legal residents earning up to 133 percent of FPL (138 percent of FPL with a 5 percent income disregard), or about $15,282 for a single adult and $31,322 for a family of four. The federal government largely finances this expansion, by covering 100 percent of the cost of coverage for the first three years, phasing down to 90 percent in 2020 and beyond. By 2022, the Medicaid program is expected to add 12 million more enrollees as a result of the ACA expansion. This is 4 million fewer Medicaid beneficiaries than originally projected due to the SCOTUS decision. As of March 2013, 17 states and the District of Columbia have declared that they will expand their Medicaid programs with another eight states leaning in favor. Twelve states have declared they will not expand, another nine states are leaning against and the remaining four states are undecided.

Health Insurance Exchanges. Health insurance exchanges are central to coverage expansion and access. The exchanges are not insurance companies and do not offer insurance products that they develop and underwrite themselves. They are marketplaces through which, beginning in 2014, individuals (who do not have an offer of qualifying and affordable coverage from their employers) and small businesses may purchase coverage from private insurance companies. Individuals who purchase coverage through an insurance exchange may be eligible to receive federal subsidies that make the insurance more affordable. In addition, there are special temporary tax credits available to certain very small employers to provide coverage to their employees.

States have the flexibility to decide the nature of the exchanges in their state. The following chart outlines the three options for states: state-based exchange (SBE); state-federal partnership exchange (SPE); or federally facilitated exchange (FFE) run by the federal government. In each option, either the state or the federal government has the overall responsibility for operating the exchange, but each option allows certain tasks to be performed by either the state or the federal government.

Exchange Options for States		
Type of Exchange	**Level of Government Responsible Overall for Operations**	**Flexible Functions**
State-based	State	State may use federal government services for: • Premium tax credit & cost sharing reduction • Exemptions from tax penalties • Risk adjustment program • Reinsurance program
State-Federal Partnership	Federal	State can accept responsibility for: • Management • Consumer assistance
Federally Facilitated	Federal	State may elect to operate: • Reinsurance program • Medicaid and CHIP eligibility determinations

As of March 2013, 17 states and the District of Columbia have declared their intention to create a state-based exchange, seven states have asked to form a partnership exchange, and the remaining states will have federally facilitated exchanges, at least initially (see chart below).

Exchange Type	State
State-based	CA, CO, CT, DC, HI, ID, KY, MD, MA, MN, NV, NM, NY, OR, RI, UT, VT, WA
State-Federal Partnership	AR, DE, IL, IA, MI, NH, WV
Federally Facilitated	AL, AK, AZ, FL, GA, IN, KS, LA, ME, MO, MS, MT, NE, NJ, NC, ND, OH, OK, PA, SC, SD, TN, TX, VA, WI, WY

Source: Kaiser Family Foundation, www.kff.org

Exchanges have to be ready to accept enrollees beginning Oct. 1, 2013 through March 31, 2014 (the initial open enrollment season), and be fully operational on Jan. 1, 2014. A number of rules have yet to be finalized, and one of the biggest open questions is exactly how will the FFEs operate.

Qualified Health Plans (QHPs). QHPs are the plans that will be sold within the exchanges. The 17 states and the District of Columbia that have moved ahead with establishing state-based exchanges are adopting a range of approaches to controlling how many QHPs will be offered to consumers through the exchange. The most liberal approach is that of a clearinghouse where all QHPs are allowed to participate; the most restrictive approach is for the exchange to be an active purchaser with the ability to limit the number and/or types of plans that can participate. Little is known, at this point, regarding how many QHPs will be in the SPE or the FFE.

Essential Health Benefits (EHB). The ACA requires that a set of EHB requirements be established against which health plans in the small group and individual markets can be compared. The EHB package must offer a robust set of benefits that cover 10 general categories. The levels of coverage are defined based on their actuarial equivalence to the benchmark: Bronze Level (60 percent), Silver Level (70 percent), Gold Level (80 percent) and Platinum Level (90). Federal regulations gave states the ability to set their own EHB benchmarks within certain federal parameters.

Beginning in 2014, some health plans must meet the EHB requirements depending on whether they hold "grandfathered" status and whether they are fully insured or self-insured. The AHA March 21 *Regulatory Advisory* describes how grandfathering works and which ACA provisions apply to which employers and when. It will be difficult for health plans to maintain grandfathered status over time, so that all health plans, ultimately, will have to meet the EHB requirements.

Implications for Providers. With the many moving parts involved in implementing the health insurance exchanges and the amount of flexibility granted to states, there are likely to be a variety of implications for providers in terms of both state regulations and actions taken by health plans in response. Examples include:

- *Changes in Health Plan Network Contracting.* Several health plan strategies are already taking shape, including adopting more narrow or tiered provider networks where in-network providers are separated into preferred and non-preferred tiers (often based on cost) with different cost-sharing for each tier and for non-network providers. Part of this strategy involves a greater focus on the application of quality metrics and elements of a value-based purchasing approach.
- *Changes in Health Plan Payment Methods for Providers.* To address affordability issues, some health plans are asking providers to accept Medicare-like payment rates or other types of rate reductions for plans offered through the insurance exchanges. Others, in response to the administrative cost limitations

of the medical loss ratio requirements, are moving more providers toward capitated payment arrangements where certain administrative costs are embedded in the delivery of care, thereby removing them from the health plan. We also may see pressure on state governments to enact provider rate review/setting requirements as plans address the premium rate review and disclosure requirements of the ACA.

- *Administrative Simplification.* There are general administrative simplification requirements in the ACA being implemented separately, but others are central to the establishment and functioning of health insurance exchanges. Chief among them is how Medicaid programs will interact with the exchanges, especially on eligibility and enrollment processes. A more standardized and coordinated process for helping uninsured patients achieve coverage will reduce provider administrative and uncompensated care costs.
- *Covered Benefits.* The debate around the establishment of EHBs may have both positive and negative effects for coverage of specific services, and under what circumstances, depending on how individual states and the federal government define EHB benchmarks and the issuers' plan designs.