



American Hospital
Association®

Coverage

Background

For the millions of individuals without health insurance, the Affordable Care Act (ACA) holds the promise of broader access to the U.S. health care system, through either commercial insurance or expanded Medicaid. On Jan. 1, the ACA provided a gateway to coverage for many unable to afford it. The ACA includes a combination of expanded public programs and private-sector health insurance expansions, and the creation of new health insurance marketplaces, to make affordable coverage available.

Though the ACA has been through a myriad of legal, legislative, regulatory and operational challenges since it was signed into law in 2010, roughly 8 million Americans have signed up for coverage effective in 2014 through the federal and state-based marketplaces. We do not know the total number of individuals who will gain coverage through the marketplaces and Medicaid this year, but that number would likely have been higher before the 2012 Supreme Court decision that allowed each state to decide whether to expand their Medicaid programs. Hospitals play an instrumental role on the front lines of the enrollment effort. They also have implemented programs and strategies to ensure that the newly insured are able to access care when it is needed. Hospitals remain committed to providing access to health services and to connecting patients and families with available coverage options.

AHA View

Universal health care coverage is key to achieving the AHA's vision of healthy communities, where all individuals reach their highest potential for health. The AHA continues to work closely with the federal government, state hospital associations and hospitals to provide resources and tools that will help connect patients and their families with affordable coverage and access to quality care. The following are descriptions of the key components of the ACA, followed by their implications for hospitals.

KEY COMPONENTS OF THE ACA

Health Insurance Marketplaces. The ACA has changed how private insurance is bought and sold in the U.S. The most significant changes began Jan. 1, when coverage purchased on the new health insurance marketplaces became effective. All insurers must comply with reforms, such as bans on pre-existing condition exclusions and lifetime limits. For individuals who do not have an offer of qualifying and affordable coverage from their employers, the new marketplaces offer the opportunity to purchase private coverage. Individuals who purchase coverage through a federal or state-run insurance marketplace may be eligible to receive federal subsidies that make the insurance premiums and share of costs more affordable. However, many newly insured consumers, especially those that purchase low-cost plans, are anticipated to have significant cost-sharing obligations when they access care. For some hospitals, medical bad debt exposure will increase with the implementation of the ACA, but may be offset by a decline in uncompensated care and reduced cost sharing for low-income enrollees. Data on

utilization, cost share collection rates, low-income subsidy levels and Medicare and Medicaid disproportionate share hospital payment (DSH) reductions will ultimately determine the amount of increased financial risk for hospitals.

Insurance Market Reforms. The ACA requires significant insurance market reforms that are applicable to all plans, whether they are offered inside or outside the new health insurance marketplaces. These reforms include:

- *Guaranteed Issue* – Health insurers will be required to accept everyone who applies for coverage.
- *Renewability* – Health insurers will be required to guarantee the renewability of coverage regardless of health status or utilization of services.
- *Elimination of Lifetime Limits* – Insurers can no longer set lifetime or annual benefit limits on the dollar value of benefits.

For hospitals, this means that care, which was previously uncompensated because the patient was denied insurance due to a pre-existing condition or “dropped” by his or her plan upon becoming ill, will be covered. This should significantly reduce the financial burden on patients and their families, regardless of their income level.

Affordable and Comprehensive Insurance Products. The ACA requires every health plan, known as Qualified Health Plans (QHPs), to offer on the federal or state marketplaces a robust set of essential health benefits (EHBs) that cover 10 general categories. The EHBs are determined by the Health and Human Services (HHS) secretary and will be updated periodically. The QHPs are categorized based on their actuarial value into four benefit levels – bronze, silver, gold and platinum – that can be offered in the individual and group markets.

In addition to the four levels, catastrophic plans must be available to the following: 1) those aged 30 or younger; 2) those who cannot find coverage (net subsidies) for less than 8 percent of their adjusted gross income; and 3) those who meet one of the 12 hardship exemptions currently defined by the Internal Revenue Service (IRS) Code. All QHPs sold through the new marketplaces have enrollee out-of-pocket expenses capped at the level of a qualified High Deductible Health Plan as defined by the IRS. These are indexed by the IRS annually for inflation. For 2014, this limit is set at \$6,350 for individual coverage and \$12,700 for families. As a result, once the individual has paid this amount, the insurer will pay 100 percent of contracted amounts for covered services, thus capping bad debt exposure, except for uncovered services. Balance-billing for out-of-network services, the amount between the insurer’s contracted rate and the provider’s charge, paid by the enrollee do not count toward the out-of-pocket maximum.

Financial Assistance for Low-income Enrollees. There are two categories of financial assistance available under the ACA to low-income enrollees who purchase products through the marketplaces – premium credits and cost-sharing reductions that include assistance at the point of service and with total out-of-pocket costs. Premium credits reduce the monthly premium amount and are determined based on a sliding scale between 100 percent and 400 percent of the federal poverty level (FPL). Credits also are scaled by family size.

Cost-sharing reductions lower the amount that an enrollee must pay at the point of service. Cost-sharing reductions are available only to enrollees in silver plans. Individuals who select bronze plans are subject to higher cost sharing and do not benefit from the cost-sharing reductions. Cost-sharing reductions are paid directly to the QHP issuer by the government to make the issuer whole for the full cost-sharing amount under the plan. This means that the subsidized portion of cost sharing should be included in the plan's payment to providers. Providers are encouraged to review payments in light of these rules.

Individuals earning below 250 percent of the FPL and who enroll in a silver plan, are also eligible for financial assistance that lowers their out-of-pocket maximum, the amount at which they no longer owe cost sharing. Lowering out-of-pocket obligations for enrollees improves their ability to afford needed care and reduces the risk of unpaid obligations to providers.

IMPLICATIONS FOR HOSPITALS

Getting People Enrolled. Since the ACA became law in 2010, hospitals have marshaled resources and worked with community stakeholders to make available information on the coverage options and financial assistance to low-income individuals and families in their communities. To assist hospitals, the AHA has created tools and resources that can be found at www.aha.org/getenrolled. The website features resources on how to connect patients and families with coverage opportunities, including private options available through the marketplaces as well as public options available through Medicaid and the Children's Health Insurance Program (CHIP). There also is information on ACA consumer assistance programs, such as certified application counselors (CACs), that are intended to provide unbiased information to consumers about their coverage options. Hospitals and health systems can seek designation to serve as CACs once they meet certain criteria and complete training. In addition, hospitals can temporarily enroll patients in Medicaid coverage at the point of service with a few basic pieces of information such as income and household size. Known as Medicaid presumptive eligibility, this ACA provision not only aids patients in obtaining needed health coverage, but also helps hospitals receive payment for services provided before a full Medicaid determination is made.

The AHA also is collaborating with key stakeholders on the national level. 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 exchanges and Medicaid. Visit www.enrollamerica.org to learn more.

Narrow Networks. For products on the new marketplaces, many health plans have elected to offer narrow and tiered provider networks as a means of controlling medical costs. Narrow networks limit access to preferred providers, while tiered networks separate providers into preferred and non-preferred tiers (often based on cost) with different cost sharing for each tier.

Reduced Provider Payments. To address affordability issues in the new marketplaces, some health plans are negotiating with providers to accept lower payment rates. In some cases these are similar to Medicare rates. Others, in response to the administrative cost limitations of the medical loss ratio requirements, are moving more providers toward capitated payment arrangements where they shift the risk and a portion of administrative expense to the provider.

Administrative Simplification. There are administrative simplification requirements 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 standardized and coordinated process for helping low-income, uninsured patients obtain coverage will reduce administrative and uncompensated care costs for providers.

Premium Subsidies and Third-party Payment. Recognizing that an individual's share of the cost of a premium or for services received may be prohibitive, even with a federal premium subsidy, hospitals and health systems have expressed interest in providing subsidies for the purchase of premiums and cost sharing and have inquired whether there are any legal barriers to providing assistance if they wish to do so. The Centers for Medicare & Medicaid Services (CMS) recently released an interim final rule requiring issuers of QHPs "to accept premium and cost-sharing payments made on behalf of enrollees by the Ryan White HIV/AIDS Program, other Federal and State government programs that provide premium and cost-sharing support for specific individuals, and Indian tribes, tribal organizations, and urban Indian Organizations." However, the rule does not prevent QHPs from having "contractual provisions" prohibiting the acceptance of premiums and cost-sharing from third-party payers other than those specified in the regulation, and CMS continues to discourage third-party payments by hospitals, other health care providers, and other commercial entities, and encourages QHPs to reject such payments.

The AHA is extremely disappointed that CMS has failed to prohibit issuers of QHPs from rejecting premium or cost-sharing payments from hospitals or affiliated foundations on behalf of needy enrollees. The AHA is pressing for a confirming public statement from HHS officials that it is not discouraging hospital-affiliated and other charitable foundations from subsidizing premiums or cost sharing. Refer to the April 8 AHA Legal Advisory for more details on premium subsidies.

Streamline Quality Reporting and Metrics. The establishment of quality reporting requirements for health plans provides an opportunity to streamline the quality metrics and quality reporting requirements applied across health plans. The AHA, in its advocacy with CMS, has pushed for provisions to reduce the administrative burden associated with the inconsistencies across plans and programs. (Refer to the AHA issue paper, “Quality Reporting and Pay-for-Performance” for more details.)

Bad Debt Mitigation. Hospitals are encouraged to engage in coverage outreach and enrollment assistance to ensure that individuals – especially those with low incomes – are able to optimize the financial assistance programs available under the ACA. Additionally, hospitals should review the impact of the ACA’s policies on their hospital’s charity care policies so that patients and their families can understand the financial assistance programs available to them.