CATALYST CENTER

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

The Affordable Care Act and Implications for Early Hearing Detection and Intervention: Changes, Challenges and Opportunities

13th Annual Early Hearing Detection & Intervention Meeting

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Presenter Disclosure

- Neither I nor any member of my immediate family has a financial relationship or interest (currently or within the past 12 months) with any entity producing, marketing, re-selling, or distributing health care goods or services consumed by, or used on, patients.

- I do not intend to discuss an unapproved/investigative use of a commercial product/device.

The Catalyst Center: Who are we?

- **Funded by** the Division of Services for Children with Special Health Needs, Maternal and Child Health Bureau
- **A project of** the Health and Disability Working Group at the Boston University School of Public Health
- **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 and financing".

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What do we do?

- Provide technical assistance on health insurance and financing policy to states and stakeholders
- Conduct policy research to identify and evaluate financing innovations
- Create educational resources (such as policy briefs, electronic newsletters and webinars)
- Connect those interested in working together to address complex financing issues

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Coverage and benefits that meet the needs of children with hearing loss must be:

- Universal and continuous
- Adequate
- Affordable

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, MOE, Marketplaces), paired with Individual Mandate (everyone has to have coverage)
- Cost and Quality Provisions

ACA Insurance Reform and Consumer Protection 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
- No **denial or charging higher premiums based on health status or gender** (only permitted based on age, tobacco use, family size, geography)

ACA Insurance Reform and Consumer Protection Provisions – Selected Examples

No more Annual and Lifetime Benefit Limits

- Effective Now
  - No annual benefit cap allowed
  - No more lifetime benefit caps for existing or new plans

- NOTE: benefits themselves can still be capped or excluded, e.g., limits on speech or communication therapy; hearing and communication devices

State mandated benefit laws (SMBLs)

- State mandated benefit laws require *some* private insurers to pay for specific health services. Examples of interest include cochlear implants, hearing aids, newborn hearing screening, etc.
- Self-funded (aka ERISA) plans are exempt
- The ACA does not change existing SMBLs – more detail on intersection with Marketplace plans to come

Resource for SMBLs on hearing aids: American Speech-Language-Hearing Association: http://www.asha.org/advocacy/state/issues/ha_reimbursement/

Resource for SMBLs on newborn hearing screening: National Council of State Legislatures: http://www.ncsl.org/research/health/newborn-hearing-screening-state-laws.aspx

ACA Insurance Reform and Consumer Protection Provisions – Selected Examples

- **Preventative Services** w/o cost-sharing (no co-pay, co-insurance or deductible charged – in network only)
  - Applies to all new (non-grandfathered) group health plans (fully insured and self-funded) and new individual policies issued or renewed on or after August 1, 2012

Recommendations of the United States Preventive Services Task Force (USPSTF)
http://www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm

Recommendations of the Advisory Committee on Immunization Practices (ACIP) adopted by CDC
http://www.cdc.gov/vaccines/acip/recs/index.html

Comprehensive Guidelines Supported by the Health Resources and Services Administration (HRSA)
Bright Futures Recommendations for Pediatric Preventative Health Care
http://brightfutures.aap.org/pdfs/AAP%20Bright%20Futures%20Periodicity%20Sched%20101107.pdf

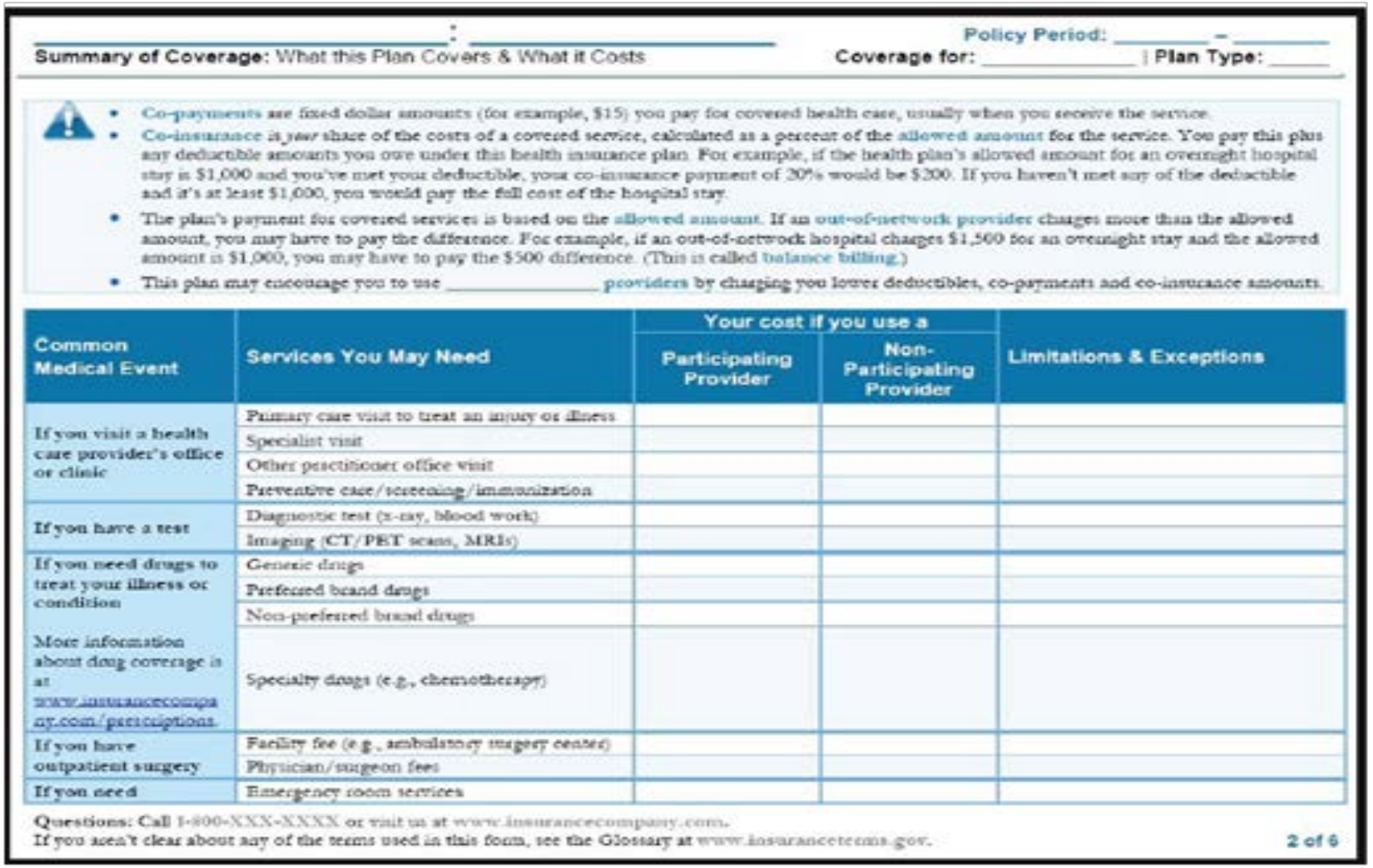
Implications for children with hearing loss:
•Verify the Newborn Hearing Screening (NBHS) results
Ensure a NBHS is conducted if child was not born in a participating hospital
•Ensure that follow-up screening or diagnostic evaluations are conducted, based on NBHS recommendations
•Based on a risk assessment, refer the child for diagnostic audiological assessment

HRSA's Women's Preventive Services: Required Health Plan Coverage Guidelines
http://www.hrsa.gov/womensguidelines/

Recommendations of the Secretary's Advisory Committee on Heritable Disorders in Newborns and Children (RUSP)
http://www.hrsa.gov/advisorycommittees/mchbadvisory/heritabledisorders/recommendedpanel/uniformscreeningpanel.pdf

Includes hearing screening

Uniform Coverage Summaries for Consumers



_____: _____ Policy Period: _____ – _____

Summary of Coverage: What this Plan Covers & What it Costs **Coverage for:** _____ | **Plan Type:** _____

- Co-payments are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- Co-insurance is your share of the costs of a covered service, calculated as a percent of the allowed amount for the service. You pay this plus any deductible amounts you owe under this health insurance plan. For example, if the health plan's allowed amount for an overnight hospital stay is $1,000 and you've met your deductible, your co-insurance payment of 20% would be $200. If you haven't met any of the deductible and it's at least $1,000, you would pay the full cost of the hospital stay.
- The plan's payment for covered services is based on the allowed amount. If an out-of-network provider charges more than the allowed amount, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the allowed amount is $1,000, you may have to pay the $500 difference. (This is called balance billing.)
- This plan may encourage you to use _____ providers by charging you lower deductibles, co-payments and co-insurance amounts.

Common Medical Event	Services You May Need	Your cost if you use a Participating Provider	Your cost if you use a Non-Participating Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness			
	Specialist visit			
	Other practitioner office visit			
	Preventive care/screening/immunization			
If you have a test	Diagnostic test (x-ray, blood work)			
	Imaging (CT/PET scans, MRIs)			
If you need drugs to treat your illness or condition More information about drug coverage is at www.insurancecompany.com/prescriptions.	Generic drugs			
	Preferred brand drugs			
	Non-preferred brand drugs			
	Specialty drugs (e.g., chemotherapy)			
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)			
	Physician/surgeon fees			
If you need	Emergency room services			

Questions: Call 1-800-XXX-XXXX or visit us at www.insurancecompany.com.
If you aren't clear about any of the terms used in this form, see the Glossary at www.insurancetems.gov. 2 of 6

http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8244.pdf

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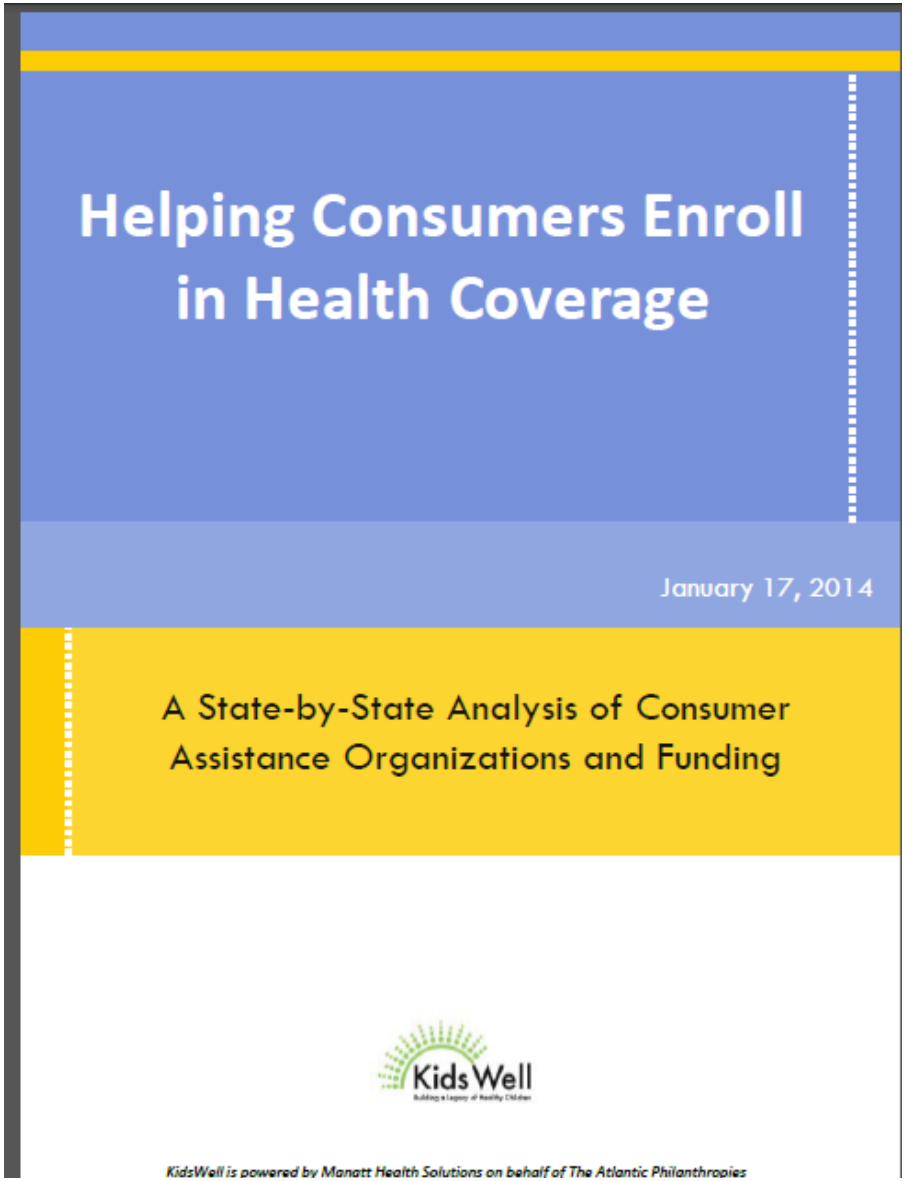
Coverage and benefit appeals

- The ACA requires insurers in both the individual and group markets to establish an independent appeals process for "coverage determination and claims" issues (Section 1001). (Grandfathered plans are exempt.) When a claim is denied, insurers must tell enrollees:
  - The reason the claim was denied
  - They have the right to file an internal appeal
  - They have the right to request an independent, external review if the internal appeal was unsuccessful
  - The availability of Consumer Assistance or Ombudsman Programs, (part of the state's Marketplace)

Coverage and benefit appeals

- For more information on appealing private insurance decisions, go to http://www.hhs.gov/healthcare/rights/appeal/appealing-health-plan-decisions.html

- If you think an insurance company is out of compliance with these rules, contact your state's insurance regulator: http://www.naic.org/state_web_map.htm



Finding Consumer Assistance Organizations

http://www.kidswellcampaign.org/

State Database of Consumer Assistance Organizations and Funding

State	Marketplace Website	Call Center	Total # of Consumer Assistance Entities	Consumer Assistance Entities (Navigators and In-Person Assisters)	Total Consumer Assistance (CA) Funding	Total # of Health Center Entities	Health Center Entities	Total Health Center Funding
Alabama	www.HealthCare.gov	1-800-318-2596 TTY: 1-855-889-4325	3	Ascension Health AIDS Alabama, Inc. Tombigbee Healthcare Authority	$1,443,985	13	Bayou La Batre Area Health Development Board, Inc. Birmingham Health Care, Inc. Cahaba Medical Care Foundation Capstone Rural Health Center, The Central North Alabama Health Services, Inc. Franklin Primary Health Center, Inc. Health Services, Inc. Mobile, County Of Northeast Alabama Health Services, Inc. Quality Of Life Health Services, Inc. Rural Health Medical Program, Inc. Southeast Alabama Rural Health Associates Whatley Health Services, Inc.	$3,789,241
Alaska	www.HealthCare.gov	1-800-318-2596 TTY: 1-855-889-4325	2	Alaska Native Tribal Health Consortium United Way of Anchorage	$599,918	24	Alaska Island Community Services Aleutian Pribilof Island Associations Anchorage Neighborhood Health Center Bethel Family Clinic Bristol Bay Area Health Corporation Bristol Bay, Borough Of Council Of Athabascan Tribal Government Cross Road Medical Center Dena' Nena' Henash Eastern Aleutian Tribes, Inc. Iliuliuk Family And Health Services, Inc. Interior Community Health Center Kodiak Island Health Care Foundation	$2,652,770

New and expanded coverage options and benefits under the ACA

- There is one new pathway to coverage under the ACA:
  - State Health Insurance Marketplaces (Exchanges)
- and two major expanded pathways to coverage:
  - Medicaid and the Children's Health Insurance Program (CHIP)
- Eligibility for coverage is based on a variety of factors: income, access to other coverage (Minimum Essential Coverage), state policy choices, etc.
- Benefits vary depending on the source of coverage

New: State Health Insurance Marketplaces 101

- Choice of different **individual** policies and **small group** plans (aka Qualified Health Plans - QHPs)
- Help for consumers in choosing a plan – comparison website, navigators, assisters
- Tax credits and subsidies for enrollees with income between 100%- 400% FPL

Eligibility for Marketplace coverage

- Individuals and employees of small businesses
  - Different levels of plans, with different cost-sharing obligations:
    - Bronze: plan covers 60% of eligible healthcare costs, insured pays 40%
    - Silver: plan covers 70% of eligible healthcare costs, insured pays 30%
    - Gold: plan covers 80% of eligible healthcare costs, insured pays 20%
    - Platinum: plan covers 90% of eligible healthcare costs, insured pays 10%

Eligibility, continued

- Individuals with **Minimum Essential Coverage** aka MEC (employer-sponsored insurance, large group, Medicaid, CHIP, etc.) are ineligible for tax credits and subsidies in the Marketplace
  - Children with dual coverage – okay to enroll in family Marketplace coverage and keep Medicaid. Premiums will be based on whole family, tax credits/subsidies on those without MEC

Essential Health Benefits (EHBs)

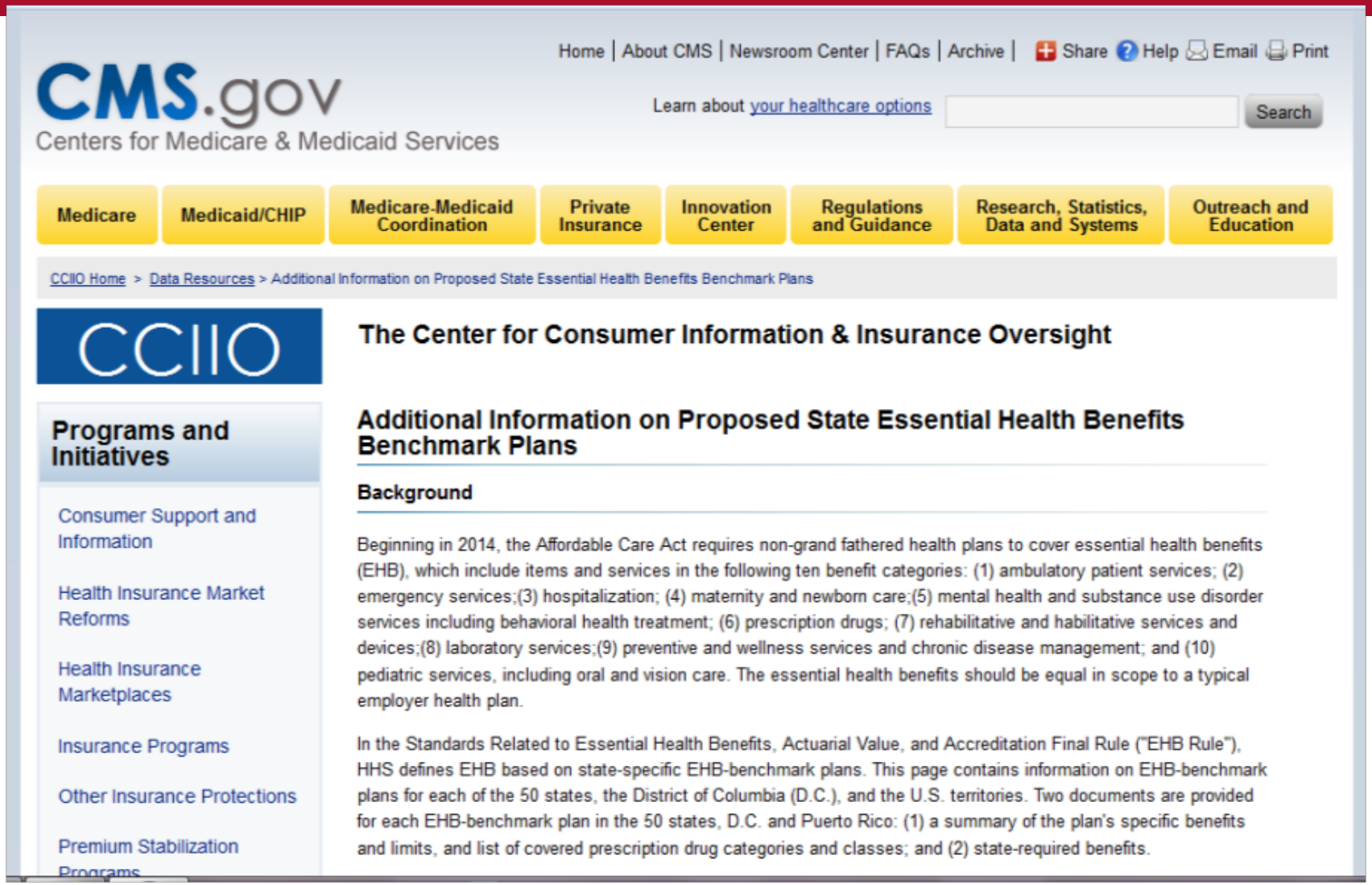
- Section 1302 of the ACA
- ACA requires that individual and small group plans include “essential health benefits”, including those offered through the Marketplace
- **Plans covering large groups and grandfathered plans are exempt, as are self-funded or ERISA plans**

The 10 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

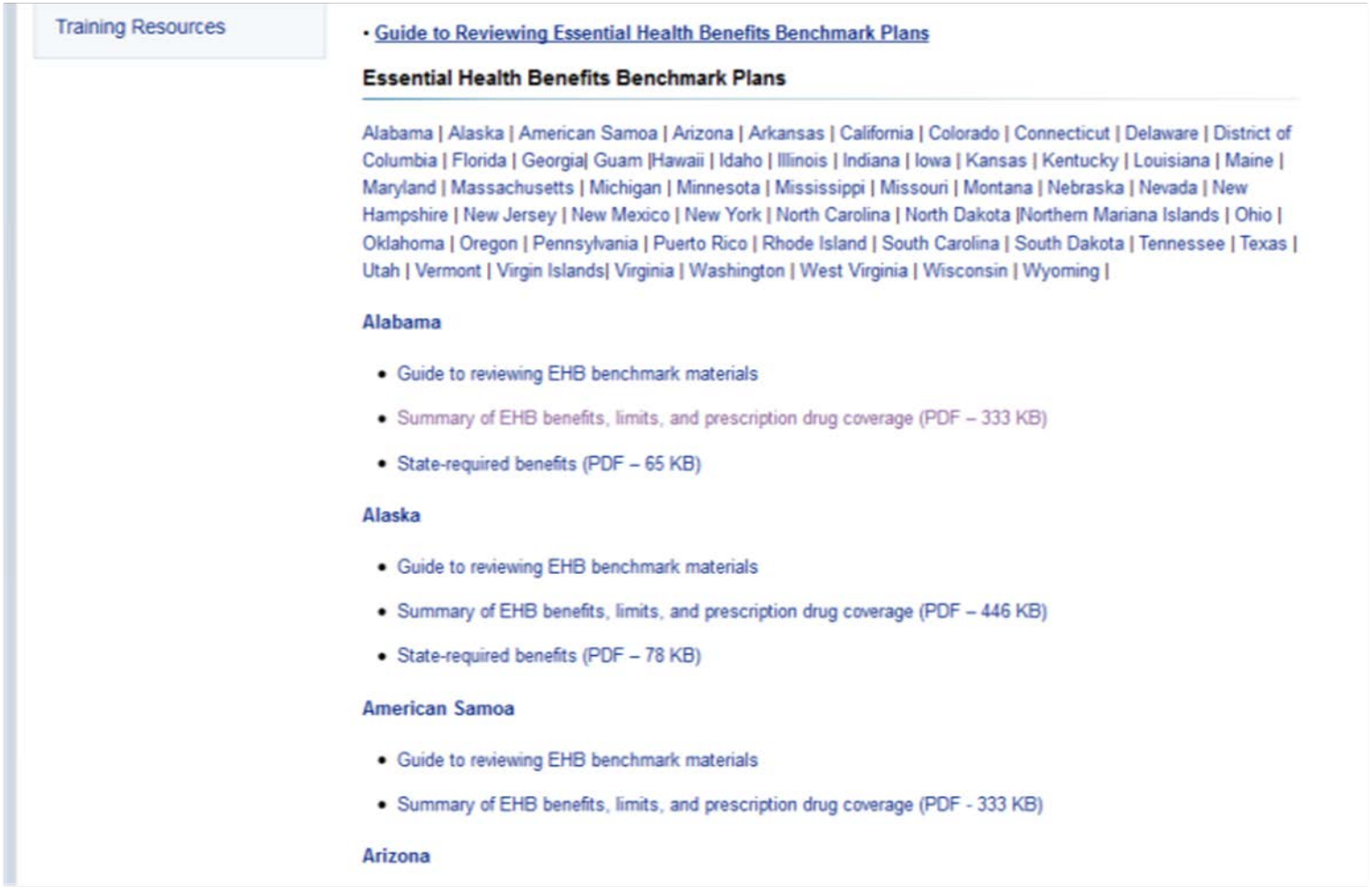
Scope, Duration and Definition of the EHBs

- ACA as passed directed the Secretary of HHS to determine the **scope, duration** and **definition** of benefits under the broad EHB service categories
- 12/16/11 EHB Benchmark Bulletin
  - Instead of one standard benefit package for all state Marketplace and individual/small group plans, HHS authorized states to choose one of four kinds of current (2012) plans to use as a model or **benchmark....**



http://www.cms.gov/CCIIO/Resources/Data-Resources/ehb.html

State-specific benchmark plan details



Training Resources

• Guide to Reviewing Essential Health Benefits Benchmark Plans

Essential Health Benefits Benchmark Plans

Alabama | Alaska | American Samoa | Arizona | Arkansas | California | Colorado | Connecticut | Delaware | District of Columbia | Florida | Georgia| Guam |Hawaii | Idaho | Illinois | Indiana | Iowa | Kansas | Kentucky | Louisiana | Maine | Maryland | Massachusetts | Michigan | Minnesota | Mississippi | Missouri | Montana | Nebraska | Nevada | New Hampshire | New Jersey | New Mexico | New York | North Carolina | North Dakota |Northern Mariana Islands | Ohio | Oklahoma | Oregon | Pennsylvania | Puerto Rico | Rhode Island | South Carolina | South Dakota | Tennessee | Texas | Utah | Vermont | Virgin Islands| Virginia | Washington | West Virginia | Wisconsin | Wyoming |

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

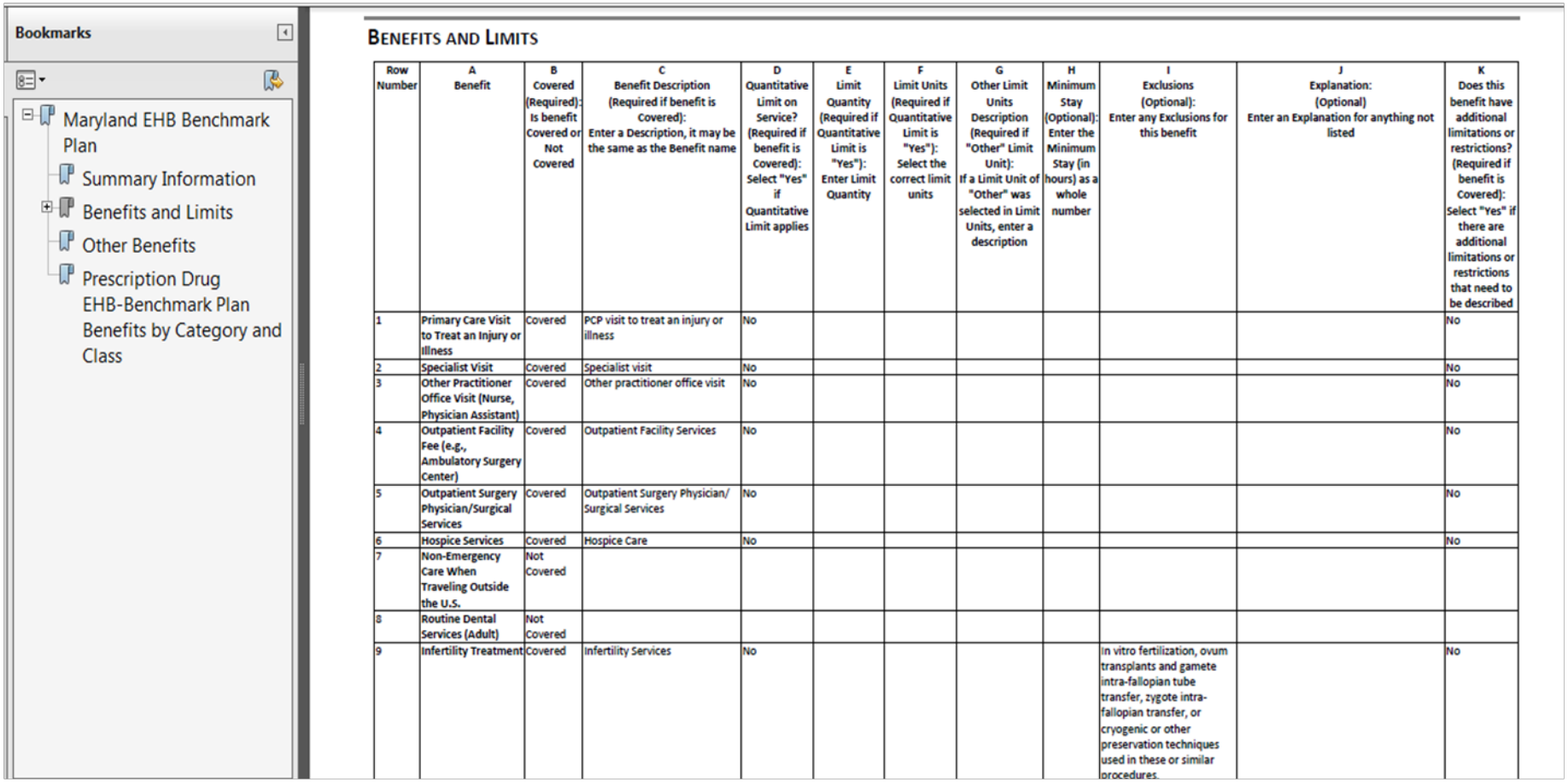
Summary of the benchmark plan

MARYLAND EHB BENCHMARK PLAN

SUMMARY INFORMATION

Plan Type	Plan from largest small group product, Health Maintenance Organization
Issuer Name	CareFirst BlueChoice, Inc.
Product Name	Blue Choice HMO HSA Open Access
Plan Name	Blue Choice HMO HSA Open Access
Supplemented Categories (Supplementary Plan Type)	• Pediatric Oral (State CHIP) • Pediatric Vision (FEDVIP)
Habilitative Services Included Benchmark (Yes/No)	Yes
Habilitative Services Defined by State (Yes/No)	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.

Specific Benefits and Limits



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 and the EHBs

- ACA: States must cover cost of SMB that go beyond EHBs
- Rule: SMB in place before 12/31/11 are considered EHBs, so no additional cost to states for them
- This only applies to SMB that impact care, treatment or services
- Any limits in original SMB law still applies; only individual plans, for example

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)

The Supreme Court decision on the ACA

- The individual mandate is a tax
- Congress has the power to levy taxes
- The law itself is constitutional and its provisions will go into effect as scheduled
- There is one exception…..

Medicaid Expansion under the ACA

- 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 was 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 previously ineligible adults
- Children are an existing Medicaid-eligible population; now, maximum family income has increased to 138% FPL in all states
- No change allowed in states with higher income eligibility levels till 2019 (MOE)
- Children in separate CHIP programs with family income <138% move to Medicaid

Selected resources for choosing a plan or policy

From the American Academy of Pediatrics (AAP)

www.healthychildren.org – Health Insurance pages

- *The Affordable Care Act: What your family needs to know*
- *Reviewing your family's health insurance: Questions to ask*
- *Exclusions and Limitations: Reading the fine print*
- *Understanding Cost-sharing: Deductibles, co-pays and co-insurance*

Other health care reform resources

- The State Family-to-Family Health Information Centers fv-ncfpp.org/
- The Catalyst Center (shameless plug)
  - hdwg.org/catalyst/resources
  - hdwg.org/catalyst/publications/aca
- Kaiser Family Foundation
  - http://kff.org/statedata/
  - http://kff.org/health-reform/

What can I do? Get involved!

- Sign up for *Catalyst Center Coverage*, e-newsletter, product/activity announcements (www.catalystctr.org)
- Read our policy briefs, participate in webinars, etc. Ask us TA questions!
- Partner with advocacy/consumer groups – lend your voice and expertise to theirs
- Comment on federal regulations as they come out

Summary

- ACA offers historic opportunities, for example:
  - Improved access to **universal, continuous, affordable coverage** through the consumer protections and new and expanded pathways to insurance

- ACA is predicted to have an impact on uninsurance; underinsurance remains a concern

- **Because the ACA doesn't do everything for everyone, work must continue on improving health care coverage and benefits for CSHCN**

Discussion and Questions

For more information, please contact us at:

The Catalyst Center
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