

The Patient Protection and Affordable Care Act

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Maureen Greer, Executive Director
IDEA ITCA
Emerald Consulting LLC

Health Reform Implementation

- Signed into law on March 23, 2010
- Identified Outcomes:
 - Decreasing the number of uninsured Americans;
 - Reducing the overall costs of health care;
 - Improving healthcare outcomes ;and
 - Streamlining the delivery of health care.
- Supreme Court Decision declaring law constitutional on June 28, 2012

Key Provisions

- Guaranteed issue:
 - Regardless of Medical Condition
 - Community Rating
- Individual Mandate
- Health Insurance Exchanges
- Federal subsidies for families above 100% up to 400% of FPL
- Medicaid expansion
- Essential Benefits – Preventive Care

Benefits to Children

- Insurers cannot:
 - Drop coverage when a child becomes sick
 - Refuse to cover a child based on a pre-existing condition
 - Establish annual or lifetime caps on coverage
 - Require cost-sharing for preventive care
- Requires coverage of both habilitative and rehabilitative services

2013 Changes

- Enhanced Medicaid reimbursement for preventive care provided at little or no cost
- Bundled payments
- Increased provider payments
- CHIP reauthorization
- Enrollment begins in the Insurance Marketplace.

Definitions

- Premium: An insurance premium is the cost of an insurance plan.
- Deductible: A deductible is the amount that must be spent by the policy holder on covered health care services before insurance coverage begins.
- Co-insurance: The insurer covers a certain percentage of the costs of services and the insured pays the remaining percentage.

Definitions

- Co-payment: A set dollar amount that an insured individual must pay for stipulated health care services.
- Network Providers: the insurer has contracted with specific hospitals, pharmacies, physicians, and other providers.
- Out-of-Pocket Limit/Maximum: The out-of-pocket maximum is the most money the insured must pay during a policy before costs associated with covered health care services are covered in full by the insurer.

Essential Health Benefits:

- Ambulatory patient services;
- Emergency services;
- Hospitalization;
- Maternity and newborn care;
- Mental health and substance use disorder services, including behavioral health treatment;
- Prescription drugs;
- Rehabilitative and habilitative services and devices;
- Laboratory services;
- Preventative and wellness services and chronic disease management; and
- Pediatric services, including oral and vision care

Developmental Screening

- Since September 2010, ACA requires insurance plans to cover 26 preventive and primary care services to children at no cost to the family.
- Must follow periodicity schedule of the AAP *Bright Futures* recommendations for pediatric preventive health care
 - *Developmental Screenings at 9, 18 and 30 months*
 - *Autism Screening at 18 and 24 months*
- Screenings are covered in Medicaid under EPSDT benefit

Grandfathered Plans

- Grandfathered plans are those that were in existence on March 23, 2010 and have stayed basically the same.
- The plans can enroll people after that date and still maintain their grandfathered status.
- Health plans must disclose if they are grandfathered in all materials describing plan benefits.

What Grandfathered Plans must cover -

- All health plans must:
 - End lifetime limits on coverage;
 - End arbitrary cancellations of health coverage;
 - Cover adult children up to age 26;
 - Provide a Summary of Benefits and Coverage; and
 - Hold insurance companies accountable to the 80% threshold for medical expenses.

Grandfathered Plans (employer based) do not have to –

- Be held accountable through rate review for excessive premium increases;
- Cover preventive care for free;
- Guarantee your right to appeal; and
- Protect your choice of doctors and access to emergency care.

In addition, Grandfathered Plans (individually purchased) do not have to –

- End yearly limits on coverage; and
- Cover children under 19 years with pre-existing conditions.

Actuarial Value

- The ACA requires insurance plans on the Marketplace to be grouped by actuarial value.
 - Platinum plans must cover 90% of costs associated with covered essential health benefits;
 - Gold plans, 80%;
 - Silver plans, 70%; and
 - Bronze plans, 60%.
- Plans with higher actuarial value will typically carry higher premiums.

The Health Insurance Marketplace

- More commonly known as the health insurance “exchange”
- Review plans in the Marketplace to determine “best fit”;
- Single Application;
 - Qualification for lower out-of-pocket costs
 - Qualification for free or low cost coverage through Medicaid or CHIP
- Enrollment began October 1, 2013

Challenges

- Definition of Essential Benefits
- Expansion of Medicaid
- Insurance Exchanges
- Cost Curve

For More Information

- www.healthcare.gov
- <http://kff.org/health-reform/>