Exchanges and Medicaid Under the Affordable Care Act

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Outline

- Exchanges 101 part 2: Essential Health Benefits
- Essential Health Benefits and Preventive Services in Exchanges and Medicaid
- Coordinated Enrollment
- Churning
  - Churning and Benefits
  - Churning and Providers
  - Basic Health Plans
  - Other solutions
- Considerations for family planning providers

Essential Health Benefit Coverage

- All new individual and small group health plans (including health plans offered through the Exchange) must include the "Essential Health Benefit" package (EHB)
- Coverage under the Medicaid Expansion will also include the EHB (more on that later…)

Essential Health Benefit Coverage

10 broad categories of coverage in ACA:

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

Essential Health Benefits in the Exchange

- HHS is taking a state-level "benchmark approach"
- States can choose a "base-benchmark" plan from among four options:
  - **the largest plan by enrollment in any of the three largest small group insurance products in the State's small group market (*this will be the default if the state doesn't choose);**
  - any of the largest three State employee health benefit plans by enrollment;
  - any of the largest three national FEHBP plan options by enrollment; or
  - the largest insured commercial non-Medicaid Health Maintenance Organization (HMO) operating in the State.

Essential Health Benefits in Medicaid

- Still a benchmark approach, but… different benchmarks! For Medicaid, states can choose from:
  - Standard Blue Cross/Blue Shield Federal Employee Health Benefit Plan (FEHBP);
  - State's employee health plans;
  - State's largest non-Medicaid HMO; or
  - Any other benefits approved by the Secretary of Health and Human Services (HHS) that provides appropriate coverage for the population to be served.

Coverage of Preventive Services

- Section 2713 of the Affordable Care Act requires new (non-grandfathered) health plans to cover *without cost-sharing*:
  - (1) Evidence-based items or services rated A or B by the USPSTF
  - (2) ACIP-recommended immunizations
  - (3) Preventive care for infants, children, and adolescents recommended by HRSA,
  - (4) Additional preventive care and screenings for women recommended by HRSA.

Preventive Services and the EHB

- HHS's proposed rule states that to cover EHB, plans *must* cover the section 2713 preventive services
- We *believe* the same will be true for Medicaid expansion plans, but HHS will be issuing further guidance

Preventive Services Under Traditional Medicaid

Additional 1% increase in FMAP percentage for any USPSTF A or B recommended preventive service provided, so long as the state does not impose any beneficiary cost-sharing

Enrollment: "No Wrong Door"

- Exchanges have to shuttle people to the right place depending what they're eligible for
- Can either
  - *Determine* eligibility for Medicaid (and CHIP) or
  - *Assess* eligibility but send info to Medicaid agency for final determination
- Need to communicate between systems, provide seamless experience for consumers

Churning

- Substantial instability expected for people whose income fluctuates near the eligibility thresholds between Medicaid and Exchange subsidies; or who experience changes (e.g. family size) that affect eligibility
- A 2011 analysis (Sommers and Rosenbaum) estimated that within 6 months of the 2014 Medicaid expansion and Exchange rollout, 35 percent of adults with family incomes below 200 percent of FPL would have a shift between Medicaid and Exchanges, and within a year this would reach 50% (28 million people).
- Churning threatens continuity of care

Churning and the landscape for benefits in 2014…

	Exchange plans	Medicaid expansion (in states that do expand…)	"Traditional Medicaid"
Essential health benefits package?	Required; based on state-selected benchmark (if state exchange)	Required; based on *different* state benchmark	N/A
Section 2713 preventive services?	Required, regardless of benchmark	Required, we think?	Optional; 1% FMAP bump as incentive

Churning and Providers

- Different reimbursement, different networks

One possible approach to churning: Basic Health Plans

• The Affordable Care Act allows states to establish "basic health plans" for people who:

- •Have incomes between 139%-200% FPL
- •Aren't eligible for Medicaid
- •Are under 65
- •Don't have access to employer or other coverage.
- •Also may include legal immigrants below 139% of FPL who are not eligible for Medicaid

Basic Health Plans must be at least as generous as the EHB offered through that state's Exchange

The potential effects of Basic Health Plans

- 2012 study by Hwang et al found that based on models of income fluctuation, basic health plans would reduce churning somewhat, but high rates would still exist
- Also, flexibility of basic health plans at the state level could mean higher out of pocket costs
- And, this only works if basic health plans are well integrated with Medicaid

What can states do to minimize effects of churning?

- Try to align benefits across Exchanges plans and Medicaid
- Try to align providers (e.g. states could consider incentivizing participation across both Medicaid and Exchange networks)
- Implement other approaches to create "smoother ride"

What can Family Planning Providers Do?

- Understand your state's Exchange
- Understand benefits in your Exchange, in "new" Medicaid, and in "old" Medicaid
- Weigh in with state on impact of churning and need to mitigate
- Increase network participation so that patients changing coverage are more likely to be able to continue care
- Act as a navigator (formally or not) for patients

Thank You.

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