Health Law and Policy Update: February 24, 2012

This week's updates

Headlines of the week

Amended Hospital Payment Assistance Act passes unanimously out of committee
An amended version of Senate Bill 12-134, the Hospital Payment Assistance Act, passed unanimously out of the Senate Health and Human Services Committee on Thursday. The measure, sponsored by Sen. Irene Aguilar and actively supported by the Colorado Center on Law and Policy, gives working families important information about hospital discount policies and charity care, and a chance to responsibly pay their medical bills. Details are in a revised fact sheet. The Colorado Hospital Association (CHA) announced support of the bill in a statement released Thursday.

"As presented today by Sen. Aguilar, the proposed amendments to Senate Bill 134 recognize that hospitals should be permitted to maintain charity care policies that reflect the unique needs of the communities they serve and the financial realities of health care reform. As previously stated, CHA and its members believe the bill language governing hospital charity care policies should directly align with current and expected federal requirements. Sen. Aguilar has shown exemplary leadership in working with CHA to address and mitigate related concerns," the statement said.

The bill as amended, increases transparency about hospital charity care and discount policies, offers patients with incomes of less than 250 percent of the federal poverty level a discount on hospital bills equivalent to the lowest negotiated rate paid by a private insurance company, and requires hospitals to offer people reasonable payment plans before initiating collections actions.

The bill will be heard in the Senate Appropriations Committee on March 2. The bill as introduced had a fiscal impact, but that impact is expected to have been eliminated by the amendment adopted Thursday. Following the Senate Appropriations Committee hearing, the bill will move to the Senate floor.

Follow developments with the bill between editions of Health Law and Policy Update at CCLP's Hospital Payment Assistance Program action center.

Colorado exchange awarded $17.9 million federal grant
Colorado is among 10 states to receive new grant funding to support the development and implementation of state health care exchanges, the U.S. Department of Health and Human

Services announced Wednesday. The Colorado Health Benefit Exchange received $17.9 million to continue its work toward building a competitive health insurance marketplace for individuals and small businesses.

"This grant allows us to continue the hard work that is necessary to launch an Exchange in late 2013 for individuals and small employers looking to purchase health insurance," Executive Director Patty Fontneau said in a news release.

Proposal would require hospitals to notify patients of services withheld for religious or moral reasons

A measure requiring any hospital eliminating services for religious or moral reasons to give notice to patients and the Colorado Department of Public Health and Environment passed the state Senate on second reading Friday. Senate Bill 12-93 is sponsored by Sen. Morgan Carroll, D-Aurora, and endorsed by the Colorado Center on Law and Policy. The measure is likely to gain final passage in the Senate and begin working through the House next week.

CMS issues final regulations on Medicaid Section 1115 waivers

The Centers for Medicaid and Medicare Services (CMS) issued final regulations on Medicaid Section 1115 waivers Thursday. The Patient Protection and Affordable Care Act requires new regulations because of concerns raised about a lack of transparency in the waiver process. Section 1115 waivers offer states flexibility to test new approaches to delivering and financing Medicaid and CHIP.

A key element of the new rule is a 30-day public comment process at both the federal and state levels on a state's application for a new waiver request or extension of an existing demonstration project, the Georgetown University Center for Children and Families reported in a blog post. In addition, materials must be publicly available on state websites, and the state must hold at least two public hearings where there is an opportunity to give comment. A state must show how it has considered the public comments it has received upon submission of the final application.

What's new

HCPF seeks feedback on health reform implementation

Stakeholders can stay up to date on how the Colorado Department of Health Care Policy and Financing (HCPF) is planning for health care reform by following a new page on the department's website. The page solicits ideas from the public and offers opportunities for public comment.

HCPF is soliciting feedback on client correspondence, communications plans and a document-management system. Stakeholders will have one week from the date of posting to provide feedback. Forms related to each issue are available on the page. The first comment period began today.

Changes to Medicaid under federal health reform set to take effect on Jan. 1, 2014, include: new definitions of income eligibility and an increase in income eligibility to 133 percent of the federal poverty level for non-disabled Coloradans age 64 and younger. New processes will need to be established to facilitate a relationship between public health benefits (Medicaid and Child Health Plan Plus) and the Colorado Health Benefit Exchange. The processes will need to sure a seamless eligibility and enrollment experience for clients, regardless of whether they are enrolling in private or public insurance.

Colorado Health Benefit Exchange to make key recommendations next week
Members of the Colorado Health Benefit Exchange Board of Directors met Wednesday with the Legislative Implementation Review Committee to provide an update on the board's activities and answer legislators' questions. Exchange Executive Director Patty Fontneau described the Service and Technology RFP process, essential health benefit design (see below), and the ongoing policy decision-making process the board recently began. The consensus among board members and legislators was that while much has been accomplished, the lion's share of work has yet to come.

The board will be facing key decisions at its Feb. 27 meeting on issues related to risk pool integration and interoperability between the exchange and state health programs. Specifically, the board will make recommendations on the following issues:

- Whether the exchange should operate as one or two entities (split between the individual and small-group markets)
- Whether the exchange should have separate or combined risk pools for the individual and small-group markets
- Whether the small-group markets should remain limited to 50 employees or expand to 100 employees as the Patient Protection and Affordable Care Act will require in 2016

There will be an opportunity for public comment at the board meeting. Find an agenda on the exchange website.

Advancing the debate

Essential Health Benefits: HHS provides additional guidance, but questions remain
This is the third in a series of pieces regarding the development of the Essential Health Benefits Package in Colorado. Previous pieces were published Feb. 10 and Feb. 3.

The U.S. Department of Health and Human Services (HHS) issued a bulletin in December that proposed a process for states to establish an essential health benefits (EHB) package as part of implementing the Patient Protection and Affordable Care Act (ACA). The bulletin suggests that instead of a single uniform standard for defining the EHB, the department will allow states to benchmark to a "reference plan" based on a currently available health plan in the state, modified as needed to meet the EHB requirements found in the ACA.

The bulletin has prompted questions from health advocates, policymakers, and the insurance industry, many of which HHS addresses in a new document answering frequently asked questions. A summary of the major issues raised in the FAQ document:

One benchmark plan: The FAQ clarifies that states may select only one benchmark to apply across the individual and small group markets, both inside and outside of the exchange. States must choose the benchmark plan during the third quarter of 2012, and the benchmark would apply to plans through 2015. However, the FAQ also indicates HHS intends to provide flexibility to insurance issuers by permitting substitutions of benefits, an approach the Colorado Center on Law and Policy opposes as it has the

potential to result in a cost-driven calculation by the insurer resulting in restrictive benefit design features that limit services.

State mandates: Several questions in the FAQ address state benefit mandates and what costs would be the state's responsibility under the proposed approach. Under the ACA, states must defray the cost of state mandates that are in excess of the selected EHB plan. As an example, if a state has a mandate that provides services to treat autism but selects a benchmark plan as its EHB that does not cover autism services, the state will be responsible for defraying all costs of providing services under the autism mandate. The FAQ indicates if states select a benchmark plan that covers mandated benefits as its EHB, those services would be part of the EHB package at no cost to the state at least until 2016. In comments to HHS, CCLP raised a concern that failure to include state mandates in the EHB definition will mean states will have an incentive to drop mandates. CCLP recommends that mandates should be included in the EHB package permanently and not just during what is now a two year grace period for 2014 and 2015.

Missing coverage in benchmark plan: If the benchmark plan a state selects is missing coverage in one or more of the 10 mandatory categories under the ACA, HHS proposes the state must supplement the benchmark by reference to another benchmark plan that includes coverage of that service. The FAQ gives the following example:

If a benchmark plan covers newborn care but not maternity services, the State must supplement the benchmark to ensure coverage for maternity services. The default benchmark plan would be supplemented by looking first to the second largest small group market benchmark plan, then to the third, and then, if neither of those alternative small group market benchmark plans offers benefits in a missing category, to the FEHBP benchmark plan with the highest enrollment.

The FAQ indicates three of the 10 mandatory categories of services - pediatric oral services, pediatric dental services, and habilitative services - are not included in many health insurance plans and will be the subject of special rules for determining adequate coverage in the EHB. CCLP continues to have reservations about the process of ensuring adequate coverage of the 10 mandatory categories of services. CCLP previously recommended that HHS precisely define the scope of the 10 mandatory categories in the ACA to ensure comprehensive coverage.

Scope and duration limitations: HHS proposes benefits in the EHB can be subject to scope and duration limitations (i.e., limits on the quantity of covered services) so long as the plans subject to the limitations are substantially equal to the benchmark plan and do not discriminate on the basis of disability or health status. The FAQ also states that the ACA's prohibition of annual and lifetime dollar limits extends to the EHB. That prohibition also pertains to state-mandated benefits that may currently have annual or lifetime dollar limits.

Employer-specific EHB requirements: The FAQ indicates that self-insured group plans, large group plans, and grandfathered health plans do not need to cover the EHB. However, these groups may not impose annual or lifetime limits on benefits that are determined to be part of the EHB package. Further, small employers who operate in multiple states must comply with the EHB in the state where the employer's primary place of business is.

EHB applicability to Medicaid: In 2006, the Deficit Reduction Act gave states the option to provide certain

groups of Medicaid enrollees an alternative benefit package known as the "benchmark" or "benchmark-equivalent" coverage to customize health benefits to specific populations. Benchmark or benchmark-equivalent coverage options include one of three commercial insurance products (the state's largest non-Medicaid HMO, the state's employee health plan, and the federal employee health plan under Blue Cross Blue Shield) or a "Secretary-approved" coverage option. The FAQ indicates coverage of the expanded Medicaid population under the ACA may be based on the Medicaid benchmark or the state's traditional Medicaid benefit package. As of Jan. 1, 2014, Medicaid benchmark and benchmark-equivalent plans (which may include the state's traditional Medicaid benefit package) must include the 10 mandatory categories of services also required in the EHBs.

Due to the fact that the Medicaid benchmark options differ from the EHB benchmark options, states may select a different benchmark for Medicaid than for commercial plans. It is CCLP's position that the Medicaid benefit package should provide comprehensive coverage while ensuring continuity of care for individuals that move between Medicaid and qualified health plans in the exchange. CCLP recommends Colorado's current Medicaid benefit package as the basis of the Medicaid benchmark for the newly eligible Medicaid population.

The FAQ document gives states more guidance to continue with the proposed EHB design scheme. CCLP continues to have concerns with HHS's proposed approach, as clear federal minimum EHB requirements and standards are necessary to ensure all populations can access comprehensive care that consistently meets their needs across all states.

While CCLP appreciates HHS's efforts to provide guidance to states, crucial questions remain unanswered. Examples:

- Given the flexibility given insurers under the proposed plan, what kind of oversight and enforcement procedures will be required to ensure adequate benefit design?
- What evidence-based criteria or standards will insurers be required to meet to set cost-sharing or utilization management techniques?
- What definitions will be provided regarding the precise scope of the 10 mandatory categories of services under the ACA?
- What procedures will be implemented to ensure valuable state benefit mandates are included in the EHB package?

As Colorado moves forward with the process of defining the EHB, there will be opportunity for public engagement. This update will continue to brief the development of this process on both the state and federal level in the coming weeks. The next piece in this series will examine how excessive benefit design flexibility could weaken the EHB package.

Tool maps effects of insurance coverage expansions under the Affordable Care Act

The Kaiser Family Foundation recently developed a mapping tool that estimates the share of the population in geographic areas across the U.S. that will benefit from the insurance coverage expansions under the Patient Protection and Affordable Care Act (ACA).

Under the ACA, individuals with incomes of up to 133 percent of the federal poverty level will be eligible for Medicaid starting on Jan. 1, 2014. Additionally, individuals who purchase private insurance through

the newly-created health insurance exchanges will be eligible for premium tax credits to help reduce the cost of insurance. Those tax credits will be available on a sliding scale for people with incomes of up to 400 percent of the federal poverty level.

The mapping tool shows an estimated 17 percent of the nonelderly population will benefit from the Medicaid expansion and tax credits nationally. However, large areas of Colorado will benefit from the ACA at a much higher rate. For example, in areas of central and western Colorado, including Lake, Pitkin, and Gunnison counties, among many others, 30 percent to 40 percent of the population could benefit.

The information revealed in the mapping tool provides further support that the ACA will provide quality, affordable health coverage to countless Coloradans who are currently uninsured or underinsured.