Health Care Reform
And Health Insurance Coverage for Hearing Services

by Theresa Morgan

Key health care insurance reforms mandated by the Affordable Care Act (“ACA”), signed into law by President Obama on March 23, 2010, went into effect at the start of this year. These reforms enable individuals, including individuals who are deaf and hard of hearing, to compare and purchase state and federally regulated health insurance products which by law must meet a number of new requirements.

For example, issuers are no longer allowed to deny people with hearing loss or other pre-existing conditions coverage under most new health insurance plans; certified qualified health plans (QHPs) must cover a minimum benefits package (including an array of hearing services which vary by state); and coverage limits under these plans cannot include annual and lifetime monetary coverage caps on essential health benefits (EHBs).

On Tuesday, October 1, 2013, states and the U.S. Department of Health and Human Services (“HHS”) opened their health insurance exchanges, otherwise known as “marketplaces.” The marketplaces exist online and, when operating as intended, provide one-stop shops at which individuals and small groups can compare and purchase health insurance plans. Issuers display the various plans they are offering and consumers should be able to see what benefits are covered and at what cost, and choose the right plan for their circumstances.

Although all states have the authority to run their own marketplace, over 30 states have elected or defaulted to a federally-run or “partnership” exchange in which HHS will have significant operational and legal responsibility over the state activity. Only 18 states will run their own exchange in 2014.

In the first days and weeks of their debut, both HHS and state exchanges experienced significant technical difficulties, rendering the exchanges at least temporarily inaccessible.

To date, HHS is reporting that at least 2 million individuals have purchased private insurance through the federal exchange. States are reporting varied success with enrollment. Starting this year, non-exempt individuals must show consistent enrollment in health insurance coverage or pay a fine.

The ACA provides premium subsidies for individuals earning between 100 percent and 400 percent of the federal poverty level (“FPL”). These subsidies will vary in value depending on where the individual’s income falls within these limits. For those earning between 100 percent-250 percent of the FPL, subsidies for deductibles and copayments will also be available.

Coverage purchased on the exchanges by individuals and small groups before the December 2013 deadlines became effective on January 1, 2014. For each successive month, the deadline is the 15 in order to have coverage effective by the first of the next month. It is important for consumers to note that issuers only have to guarantee coverage during the initial enrollment period; after that initial deadline is passed, only consumers who have qualifying life events (i.e., marriage or having a baby), are guaranteed issue until the next open enrollment period.

Essential Health Benefits, the Benchmark Plan Process and Hearing Health

The ACA requires that all non-grandfathered individual and small
group health insurance plans, as well as Medicaid benchmark and benchmark-equivalent plans, cover essential health benefits (EHBs); most new small employer and individual plans must cover EHBs regardless of whether these plans are offered on an exchange.

By law, there are ten categories of EHBs, including ambulatory patient services, emergency services, hospitalization, prescription drugs, rehabilitation and habilitation services and devices, chronic care management and other categories of benefits.

Neither the law nor the federal EHB regulations stipulate the specific benefits within each category that plans must cover. Instead, federal guidance to the states has directed state officials to select an existing typical small group plan to become that state’s benchmark plan for health care reform. When a benchmark plan within a state fails to cover one of the EHB categories (for example, habilitation services), the state and the issuer are required to ensure that the category is sufficiently covered moving forward. In addition, if a benchmark did not cover a state benefit mandate (such as hearing aids) in the past, the benchmark must include the benefit mandate as an EHB moving forward. However, this requirement only exists for mandates passed before January 1, 2012.

All “qualified health plans” or “QHPs” in a state must cover substantially equal benefits to the benchmark plan in that state. Many states allow plans to substitute actuarially equivalent benefits within EHB categories. When they compare and purchase plan coverage, it is important for consumers to look carefully at the types of benefits covered within the EHB categories, as there will be some variation between plans even within the same state. Individuals who are deaf and hard of hearing should review plan documents which detail specific service coverage, including coverage for rehabilitative and habilitative services and devices.

States and the federally facilitated exchanges have identified “navigators” in the community who can assist consumers with comparing and purchasing plans. These navigators are independent of insurance plans, and are not allowed to accept payment from consumers or insurance plans. In addition, many states have officials within the Department of Insurance who can answer consumer questions.

Health Care Reform and Fluctuation in Medicaid Covered Services

As of January 1, states have the option of expanding Medicaid eligibility to all adults below 133 percent of the FPL. In states which expand Medicaid, newly eligible individuals will have access to Alternative Benefit Plans (“ABPs”) which must cover EHBs, including rehabilitative and habilitative services and devices. Individuals who are medically frail (i.e. have serious disabilities or chronic conditions) will have a choice of the standard Medicaid plan in their state or an ABP. Some ABPs might cover EHBs that would be considered “optional” for adults under the state plan (cochlear implantation, for example).

States can use existing benchmark and benchmark equivalent plan authority to develop ABPs to target a specific population. Just over half of the states are expanding their eligible Medicaid population this year. But even those states which are not expanding can build ABPs which must cover EHBs. States will remain extremely busy this year as they regulate - and legislate - differences into their Medicaid plans.

Marketplace Tiered Coverage and Small Employer Exchanges

The marketplaces will offer five different categories of insurance plans: catastrophic, bronze, silver, gold, and platinum. Catastrophic plans have low premiums, high cost-sharing, and are available to individuals under the age of 30 who cannot find affordable insurance coverage elsewhere. Bronze, silver, gold, and platinum plans cover 60 percent, 70 percent, 80 percent, and 90 percent of the cost of care, respectively. Bronze tier coverage will have the lowest premiums and platinum tier coverage will have the highest premiums. All of the plans cover the ten essential health benefits required by the ACA.

The ACA provides for the creation of health insurance marketplaces exclusively for small businesses, known as the Small Business Health Options Program (“SHOP”). For most states operating their individual market exchanges through the federally facilitated exchange, HHS will run both a SHOP and an individual marketplace. Premium subsidies will be available for some employers on the SHOP marketplace. The subsidies scale with the size of the employer and the annual wages of their employees.
Useful Links

Information on the health insurance exchanges


Centers for Medicare and Medicaid Services (CMS) Frequently Asked Questions


HHS ACA information

http://www.hhs.gov/healthcare/rights/index.html

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