Maximizing the Payment of Health-Related VR Services by Private Insurers and Medicaid: *The VR Program and the Affordable Care Act*

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Handout

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MEDICAID EXPANSION ACTIVITY

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The ACA expands Medicaid eligibility to all adults below 133 percent of the federal poverty line. Previously, Medicaid eligibility was reserved for children and individuals who met income and health status requirements – for example, individuals who are low income and also have a certain disability. The expansion population would include low income adults, regardless of their health status.

The federal government would fund the entire cost of the newly eligible population for three years, and this funding would remain at 90 percent in the future. The Supreme Court's ruling regarding the ACA has given states the option to opt out of the Medicaid expansion without losing the federal matching funding for serving the other Medicaid eligibility populations.

In our table, we have designated states in one of three categories: Supports, Opposes, and Weighing Options.

- *Supports* means the states' **Governors** support expanding Medicaid
- *Opposes* means the states' **Governors** oppose expanding Medicaid
- *Weighing Options* includes states where no official statement, either supporting or opposing the Medicaid expansion, has been made; if the budget did not include a decision on the Medicaid expansion; the Governor has indicated he/she is leaving the decision to the legislature; or the Governor has indicated he/she is awaiting additional analysis.

Medicaid Expansion

Supports		**Opposes**		**Weighing Options**
Arizona	Minnesota	Alabama	Nebraska	Kansas
Arkansas	Missouri	Alaska	North Carolina	South Dakota
California	Montana	Georgia	Oklahoma	Utah
Colorado	Nevada	Idaho	Pennsylvania	Virginia
Connecticut	New Hampshire	Iowa	South Carolina	
DC	New Jersey	Louisiana	Tennessee	
Delaware	New Mexico	Maine	Texas	
Florida	New York	Mississippi	Wisconsin	
Hawaii	North Dakota		Wyoming	
Illinois	Ohio			
Indiana	Oregon			
Kentucky	Rhode Island			
Maryland	Vermont			
Massachusetts	Washington			
Michigan	West Virginia			

STATE EXCHANGE ACTIVITY

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Open enrollment through health insurance Exchanges is scheduled to begin on October 1. Exchanges will provide standardized health care plans where individuals and small businesses can purchase health insurance. Each state can choose to create its own state-based exchange, default into a federally operated exchange or form a partnership exchange with the federal government.

- In a *State-Based Exchange*, the state performs all exchange functions, with HHS oversight, assistance and guidance.
- For states which choose not to run or are unprepared to operate a state-based exchange, the Department of Health and Human Services (HHS) is obligated to create a *federally facilitated exchange* (FFE). HHS will perform most or all exchange functions for FFEs, except where states opt to partner with HHS, as described in the next bullet.
- In the FFE "hybrid model," known as *State Partnership Exchanges*, the state may perform plan management functions, consumer assistance functions, or both, and HHS will perform the remaining functions. States essentially assume control over portions of a FFE that can transition into a state-based exchange over time.

Exchange Type

Declared State-based Exchange		Default to Federal Exchange		Planning for Partnership Exchange
California	Minnesota	Alabama	New Jersey	Arkansas
Colorado	Nevada	Alaska	North Carolina	Delaware
Connecticut	New Mexico	Arizona	North Dakota	Illinois
DC	New York	Florida	Ohio	Iowa
Hawaii	Oregon	Georgia	Oklahoma	Michigan
Idaho	Rhode Island	Indiana	Pennsylvania	New Hampshire
Kentucky	Utah	Kansas	South Carolina	West Virginia
Maryland	Vermont	Louisiana	South Dakota	
Massachusetts	Washington	Maine	Tennessee	
		Mississippi	Texas	
		Missouri	Virginia	
		Montana	Wisconsin	
		Nebraska	Wyoming	

ESSENTIAL HEALTH BENEFITS BENCHMARK PLANS

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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). There are ten categories of benefits that are considered EHBs. The ACA limits EHBs to those covered by a typical employer health plan.

States had until December 26, 2012 to select a benchmark plan. Each state could choose as its benchmark plan one of the three largest (by enrollment) small group health plan options, the three largest state employee health plan options, or the largest commercial HMO plan sold in the state. If states did not choose a plan they will default to the largest small group plan in the state.

The states or HHS have supplemented those benchmark plans, making those plans "EHB benchmark plan" which serves as reference plans for qualified health plans operating in the small group and individual markets. The EHB benchmark benefits include state-required benefits that were enacted prior to December 31, 2011.

Essential Health Benefits Benchmark Plan	
State	**Plan**
Alabama	320 Plan
Alaska	Heritage Select Envoy
Arizona	Arizona Benefit Options EPO Plan, administered by United Healthcare
Arkansas	HMO Partners, Inc. Open Access POS, 13262AR001
California	Kaiser Foundation Health Plan Small Group HMO 30 ID 40513CA035
Colorado	Ded HMO 1200D
Connecticut	Connecticare HMO
Delaware	Simply Blue EPO 100 500
DC	Blue Preferred PPO Option 1
Florida	BlueOptions 5462
Georgia	HMO Urgent Care 60 Copay
Hawaii	HMSA Preferred Provider Plan 2010
Idaho	Preferred Blue
Illinois	BlueCross Blue Shield of Illinois BlueAdvantage
Indiana	Blue 5 Blue Access PPO Medical Option 6 Rx Option G
Iowa	Alliance Select, Copayment Plus
Kansas	Comprehensive Major Medical Blue Choice GF 500 Deductible with Blue
Kentucky	Anthem PPO
Louisiana	GroupCare PPO

Maine	Blue Choice 20 with Rx 10 30 50 50
Maryland	BlueChoice HMO HSA Open Access
Massachusetts	HMO Blue 2000 Deductible
Michigan	100 Percent Hospital Services Plan
Minnesota	500 25 Open Access
Mississippi	Network Blue
Missouri	Blue 5 Blue Access Choice PPO Medical Option 4 Rx Option D
Montana	Blue Dimensions
Nebraska	Blue Pride
Nevada	HPN POS Group 1 C XV 500 HCR
New Hampshire	Matthew Thornton Blue Health Plan
New Jersey	Horizon HMO Access HSA Compatible
New Mexico	Lovelace Classic PPO
New York	Oxford EPO
North Carolina	Blue Options
North Dakota	Sanford Health Plan HMO
Ohio	Blue 6 Blue Access PPO Medical Option D4 Rx Option G
Oklahoma	BlueOptions PPO, RYB05
Oregon	Preferred Co Deduct Value 3000 35 70
Pennsylvania	PA POS Cost Sharing 34 1500 Ded
Rhode Island	Vantage Blue BCBSRI
South Carolina	Business Blue Complete
South Dakota	Blue Select
Tennessee	BC BST PPO
Texas	BestChoice PPO, RS 26
Utah	Utah Basic Plus
Vermont	BlueCare, The Vermont Health Plan, LLC, CDHP
Virginia	KeyCare 30 with KC30 Rx Plan 10 30 50 OR 20
Washington	Regence Innova; Regence Blue Shield non-grandfathered small group
West Virginia	Super Blue Plus 2000 1000 Ded
Wisconsin	Choice Plus Definity HSA Plan A92NS
Wyoming	Blue Choice Business 1000 80 20

CCIIO Final and Interim Final Rules Regarding ACA

Affordable Insurance Exchanges

CMS-9989-F: Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers

CMS-9989-CN: Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers; Correction

Plan Management

CMS-9965-F: Data Collection to Support Standards Related to Essential Health Benefits; Recognition of Entities for the Accreditation of Qualified Health Plans

CMS-9980-F: Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation

Additional Information on State EHB Benchmark Plans
Actuarial Value Calculator
Actuarial Value Calculator Methodology
Minimum Value Calculator
Minimum Value Calculator Methodology

Consumer Support and Information

External Appeals

OCIIO-9993-IFC: Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Internal Claims and Appeals and External Review Processes Under the Patient Protection and Affordable Care Act

CMS-9993-IFC2: Group Health Plans and Health Insurance Issuers: Rules Relating to Internal Claims and Appeals and External Review Processes

CMS-9993-CN: Group Health Plans and Health Insurance Issuers: Rules Relating to Internal Claims and Appeals and External Review Processes; Correction

Summary of Benefits and Coverage and Uniform Glossary

CMS-9982-F: Summary of Benefits and Coverage and Uniform Glossary

Consumer Operated and Oriented Plans Program

CMS-9983-F: Patient Protection and Affordable Care Act, Establishment of Consumer Operated and Oriented Plan (CO-OP) Program

Content Requirements for Healthcare.gov

Health Care Reform Insurance Web Portal Requirements

Early Retiree Reinsurance Program

Early Retiree Reinsurance Program

Health Market Reforms

CMS-9972-F:Patient Protection and Affordable Care Act: Health Insurance Market Rules; Rate Review

Annual Limits

OCIIO–9994–IFC: Patient Protection and Affordable Care Act: Preexisting Condition Exclusions, Lifetime and Annual Limits, Rescissions, and Patient Protections

Coverage for Young Adults

OCIIO – 4150 – IFC: Group Health Plans and Health Insurance Issuers Relating to Dependent Coverage of Children to Age 26 Under the Patient Protection and Affordable Care Act

Grandfathered Plans

OCIIO–9991–IFC: Interim Final Rules for Group Health Plans and Health Insurance Coverage Relating to Status as a Grandfathered Health Plan Under the Patient Protection and Affordable Care Act

> OCIIO–9991–IFC2: Amendment to the Interim Final Rules for Group Health Plans and Health Insurance Coverage Relating to Status as a Grandfathered Health Plan Under the Patient Protection and Affordable Care Act

Medical Loss Ratio

CMS-9998-IFC2: Medical Loss Ratio Rebate Requirements for Non-Federal Governmental Plans

CMS-9998-F: Medical Loss Ratio Requirements under the Patient Protection and Affordable Care Act

CMS-9998-IFC3: Medical Loss Ratio Requirements under the Patient Protection and Affordable Care Act; Correcting Amendment

CMS-9964-F: HHS Benefit and Payment Parameters for 2014

Patient's Bill of Rights

OCIIO–9994–IFC: Patient Protection and Affordable Care Act: Preexisting Condition Exclusions, Lifetime and Annual Limits, Rescissions, and Patient Protections

Prevention

CMS-9992-F: Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act

Review of Insurance Rates

CMS-9972-F:Patient Protection and Affordable Care Act: Health Insurance Market Rules; Rate Review

CMS-9999-F: Rate Increase Disclosure and Review: Definitions of Individual Market and Small Group Market

Student Health Plans

CMS-9981-F: Student Health Insurance Coverage

Pre-Existing Condition Insurance Plan

OCIIO–9995–IFC: Pre-Existing Condition Insurance Plan Program

CMS–9995–IFC2: Pre-Existing Condition Insurance Plan Program (Amendment)

Premium Stabilization Programs

CMS-9975-F: Standards Related to Reinsurance, Risks Corridors and Risk Adjustment

CMS-9964-F: HHS Benefit and Payment Parameters for 2014

CMS-9964-IFC: Amendments to the HHS Notice of Benefit and Payment Parameters for 2014

State Innovations

CMS-9987-F: Application, Review, and Reporting Process for Waivers for State Innovation