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Essential Health Benefits Under The Affordable Care Act

On March 23, 2010 the Patient Protection Affordable Care Act was signed into law by President Obama. The act is now known simply as the Affordable Care Act or ACA. One of the components of the ACA is what is known as "essential health benefits". Essential health benefits would apply to all plans that are offered by the state and federal exchanges as well as non-grandfathered individual plans and non-grandfathered, fully insured small group plans through private insurers. Large group fully insured plans, self-funded plans and grandfathered plans are not required to add essential health benefits.

Essential health benefits as defined by the law must include items and services within at least the following 10 categories: ambulatory patient services (services you receive without being admitted to a hospital); trips to the emergency room; maternity and newborn care; mental health and substance use disorder services (includes behavioral health treatment, counseling, and psychotherapy); prescription drugs; trips to the hospital for in-patient care; services and devices to help you recover if you are injured, or have a disability or chronic condition (includes occupational and physical therapy plus devices, speech-language pathology, psychiatric rehabilitation); laboratory services; preventive services including counseling, screenings, and vaccines to keep you healthy and care for managing a chronic disease; and pediatric services (includes dental care and vision care for kids).

States expanding their Medicaid programs must provide these benefits to people newly eligible for Medicaid.

Essential health benefits vary from state to state. There can also be differences within the state from insurance company to insurance company. The primary focus of essential health benefits was to regulate the individual and small group fully insured market. Under the ACA, a small group is defined as 49 employees or less. Individuals quite simply would mean a sole individual and his or her family. This marketplace is extremely volatile for insurance companies and in many cases insurance companies actually lose money from year to year.

During the debate on the ACA, insurance companies voiced strong opinions on how essential health benefits should be set up. The main concern of most insurance companies is "cherry picking" (as they like to call it), which is when an individual or small group is permitted to pick benefits that only suit their needs.

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At first glance, it appeared that the insurance companies were being selfish; however, their decision to do this was based upon their increased risk factors required under the ACA. This risk was the elimination of any pre-existing condition exclusions and medical underwriting. In essence, this would mean if a pregnant woman was uninsured at the time of her pregnancy she could go to the insurance company and obtain coverage for her and her baby even though she was already pregnant. Prior to the passing of the ACA, this would have not been possible nor would it have been possible if the person had cancer, diabetes or a heart condition. By eliminating the pre-existing condition clause, the additional financial risk to insurance companies is an additional 15%. In order to mitigate this increase, insurance companies lobbied that individual and small group plans sold in this market must include all of the items listed as essential health benefits. This would mean that an individual 62 years old of age would be required to have coverage for pregnancy when it would be very impractical due to the person's age. Prior to the ACA, states permitted employees to choose plans that best matched their individual needs. Now under the ACA, any fully insured plan in the individual and small group market must include these essential health benefits in order to reduce overall healthcare cost. The theory being the entire country's cost would be reduced by the spread of risk across the population of individual and small group markets. As an example, people who are beyond the childbearing age would not use pregnancy coverage; however, the premiums associated with that would offset the premiums for younger people who are still in their childbearing years. Conversely, coverage for arthritis and Alzheimer's would offset the cost to older individuals by what the younger groups would pay.

Even though the focus on essential health benefits was for individual and small employers, large employers (whether fully insured or self-funded) and grandfathered plans were exempt from essential health benefits. Large employers are considered 50 or more full-time employees (defined as working 30 or more hours per week). Even though large employers are exempt from essential health benefits, their plans must offer a minimum value of at least 60% of the value of the full array of essential health benefits. All essential health benefits that large employers do offer cannot have any lifetime limits. The 60% minimum value is derived by examining the program to see if it meets the safe harbors that are established under the law; if this is not the case the employer has an opportunity to use an actuarial valuation or mathematical formula established by the law to calculate the minimum value of the essential health benefits.

Another interesting aspect that large employers have is that if they choose to self-fund their program, they can choose essential health benefits from any state they wish even though they might not be situsted in that state. This aspect of the ACA is fluid to say the very least! As a matter of fact, large employers that are self-funded can actually draft their own essential health benefits in order to meet the minimum standard. Generally, a large employer will tend to choose essential health benefits from a state that they consider not to be that stringent. A good example of this would be in the state of New York where one of the essential health benefits is infertility coverage. Conversely, a state like Utah has the smallest number of essential health benefit requirements.

If a small employer decides to self-fund their program, then they would have the same options as a large employer. However, since small employers are 49 employees and under, self-funding could be a risky endeavor. Because the group is small, a high claims year could drastically increase their liability and potential cost in subsequent years. The one advantage of self-funding, whether the group is small or large, would be to eliminate the 2.3% premium tax required for fully insured plans under the ACA.

Since the passing of the ACA, many of its requirements have come into greater focus; some people have been critical of the duality of how individuals, small employers and large employers are affected. Advocates of the law wanted everyone to be treated equally for continuity purposes; however, through the debate and final product, reality set in that small groups and individuals would be treated differently than large groups. As we move forward with the ACA law, it is apparent that there will be numerous changes to address some of these issues. Whether it is uniform for all or still based upon size, the changes will come sooner than we all think.

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Health Care On Credit?

With the rising costs of medical and dental services, many patients are turning to health care credit cards to finance the work they have performed. At the forefront of these credit cards are CareCredit and AccessOne MedCard.

AccessOne MedCard has been around for nearly a decade and has continued gaining popularity with hospitals and patients alike. According to their mission, from a hospital perspective, AccessOne MedCard is appealing because they offer a medical card that is easy-to-administer, significantly cuts costs and minimizes recourse. From a patient perspective, it is appealing because they extend payment options to every individual regardless of circumstances. AccessOne has worked with more than 50 hospitals to manage nearly 400,000 client hospital accounts. According to their website, they offer patients a choice between 12 equal monthly payments with no interest, or an affordable low interest option.

CareCredit is part of GE Capital and has been around for over 25 years. According to CareCredit.com, they offer a healthcare credit card with more than 150,000 enrolled providers around the country participating. The credit card helps patients access the care they need and want. For patients with employer-provided benefits, CareCredit helps bridge the gap between what the patient's insurance covers and what the medical or dental bill amounts to. For patients with no insurance, CareCredit offer's them a way to finance the procedures they need and want. Providers can offer the CareCredit card right in their facilities. CareCredit will train the practice and provide them with informational materials. Once the program is integrated into the practice, the practice can present the CareCredit card as a payment option along with cash and checks. Once the patient is scheduled for treatment, CareCredit will pay for the patient's services and the patient will pay back CareCredit. CareCredit is ideal for dental care, eye care, hearing care, and cosmetic surgery. According to their website, CareCredit offers patients the option of no interest on their purchases if paid in full within the promotional periods of 6, 12, or 18 months or 14.90% APR and fixed monthly payments required until the balance is paid in full. If a provider chooses to offer CareCredit, a processing fee will be charged for each transaction. The fee varies by Plan. Patient education materials, presentation materials and team training are provided for the provider.

Benefits and Pitfalls for Providers Offering Health Care Credit Cards

The American Medical Association and the American Dental Association have no formal policy regarding the use of health care credit cards.

An advantage of offering medical and dental credit cards is that medical and dental providers receive payment upfront from self-pay patients which could result in a decrease in bad debt expenses. Oftentimes, these credit cards offer non-recourse programs so if the patient delays payment or defaults; it is not the provider's responsibility. There is also an incentive for doctors and dentists to offer the financing because it encourages patients to follow through with procedures they may have otherwise forgone because they could not afford them. This could result in an increase in revenues due to an increase in procedures and a shift in case mix (more acute procedures performed). Additionally, the card may reduce the expenses associated with the billing and collection process since little to no follow up will be needed from the providers billing and collection department because the medical credit card will handle those responsibilities. This could result in a decrease in compensation expense as fewer hours and staff may be required from the billing and collection departments.

A disadvantage of offering medical and dental credit cards is the possibility that it could jeopardize the relationships between providers and patients. Patients may not receive sufficient information in regards to the credit card terms or may not fully understand them and therefore blame the provider when they incur high interest rates or default penalties. Patients may not understand that the provider is unrelated to the credit card company (patient is responsible for paying credit card company, not the provider). This may cause patients to discontinue seeing the provider in the future thus decreasing visits and revenues.

Beginning in 2014, Americans who cannot afford private health insurance coverage will be permitted to shop around for less costly, government subsidized plans utilizing health insurance exchanges. As more Americans obtain health insurance, fewer out-of-pocket expenses will be incurred which may lead to a decreased need for these types of credit cards. However, plans provided through the health insurance exchange will boast significantly higher deductibles than employer-sponsored insurance and patients could benefit from the use of medical credit cards to finance the deductibles.

> "With the rising costs of medical and dental services, many patients are turning to health care credit cards to finance the work they have performed."

Article written by Karen Salvalzo, Manager
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PROVIDING VALUE TO THE HEALTH CARE INDUSTRY

Today's growing and advanced health care industry is a fast-paced environment where regulatory issues, competition, and rapidly changing consumer expectations converge. Managing risks and realizing opportunities becomes a more important focus as health care organizations decide how they will adapt and evolve their business models for long-term survival.

Ensuring today's actions will lead to achieving long-term goals can be a major challenge for anyone. Many health care organizations are unable to address the issues at hand and consider the "big picture" because they are overwhelmed with urgent matters and patient care. UHY LLP's National Health Care Practice brings an understanding of the industry together with innovative solutions that have a positive impact on bottom line. We understand the challenges facing health care providers and facilities.

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