Health Benefit Exchanges and PKU

Coverage for PKU Medical Foods: How?

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Bruce Merlin Fried
Partner
T +1 202 408 9159
bruce.fried@dentons.com

Thomas E. Hutchinson
Managing Director, Health Care
T +1 202 408 9190
thomas.hutchinson@dentons.com

The Affordable Care Act, Exchanges and PKU

- Obamacare: The Basics of Exchanges and What's Covered
  - Insurance Exchanges
    - Purpose
    - Eligibility
    - Subsidies
    - State or Federally Operated
  - Coverage
    - The Metal Levels
  - Essential Benefits
    - Minimum Benefits
    - Chronic Disease Management
- Essential Health Benefits
  - The Details
  - Variation by State
- Coverage of PKU medical foods

Purpose of Exchanges

- One of the centerpieces of the Affordable Care Act (ACA) was to create health insurance exchanges effective January 1, 2014.
- Exchanges are a competitive market where individuals and small businesses can choose from various health insurance plans.
- Basic goal: make high quality, comprehensive coverage more accessible/affordable through:
  - Increased competition
  - More standardization of benefit offerings
  - Increased focus on quality measures
  - More information for consumers
  - Federal subsidies for lower income purchasers
  - Individual mandate on consumers, and certain other reforms, to limit adverse selection and premium costs
- All states will have an exchange. States will sponsor. If states refuse, exchange will be federally operated.

Goals of Exchange

- Exchanges are intended to address gaps/problems in the current system. They are not a wholesale replacement for how health services are paid for in the U.S.
- The law intends for workers to remain covered through employer sponsored plans.
  - Excise tax imposed on larger employers to discourage dropping coverage
- Large parts of the population will still be covered by government payers — Medicare, Medicaid, VA, etc.

Eligibility

- Initially, exchanges will be open to individuals buying their own coverage and employees of firms with 100 or fewer workers (50 or fewer in some states).
- Most will be people who are eligible for subsidies, which will average an estimated $4,600 per person in 2014.
- Undocumented immigrants will be barred from buying insurance on the exchanges.

Coverage: The Metals

- Insurance sold through exchange must be at one of four actuarial value levels (measures costs covered by policy):
  - Bronze: 60%
  - Silver: 70%
  - Gold: 80%
  - Platinum: 90%
- Federal rules require insurer in exchange offer at least silver and gold policies
- Insurers may also sell a lower actuarial value Catastrophic Plan in the non-group market to individuals who: (1) are under the age of 30; or (2) would otherwise be exempt from the requirement to have coverage because available coverage is unaffordable or enrollment in available coverage would be a hardship
- Plans must have maximum cap on out-of-pocket costs based on the maximum out-of-pocket limits in Health Savings Account qualified plans (if law applied in 2013, those amounts would be $6,250 for self-only, $12,500 for family coverage)
- No cost for preventative services

Federal Subsidies

- Tax credits for person based on income (see below)
- Not available for person eligible for public coverage, or for employer coverage that is minimum essential coverage (unless employer plan does not have an actuarial value of at least 60% or the premium cost for the employer coverage exceeds 9.5% of individual's income)
- Credits based on second cheapest silver plan in state
- Individuals contribute to premium costs based on the following sliding scale:

Income Level	Premiums as a Percent of Income
100-133% FPL	2% of income
133-150% FPL	3-4% of income
150-200% FPL	4-6.3% of income
200-250% FPL	6.3-8.05% of income
250-300% FPL	8.05-9.5% of income
300-400% FPL	9.5% of income

Federal Subsidies

- Individuals and families with incomes up to 250% of FPL also eligible for enhanced “silver” policies with higher actuarial values/lower cost sharing:

Income Level	Actuarial Value
100-150% FPL	94%
150-200% FPL	87%
200-250% FPL	73%

- OOP liability further reduced for these individuals.
- Income Levels Covered by Subsidy Provisions
  - 100% of FPL for household of 1: $11,170
  - 100% of FPL for household of 4: $23,050

Other Federal Provisions Aimed at Costs

- Beginning in 2014, premium rates:
  - Can vary in individual products based on age (max 3:1 ratio)
  - Can vary in the individual market by tobacco usage (max 1.5:1 ratio)
  - Cannot vary by gender
  - Cannot vary by health status
- Risk adjustment provisions transfer funds from plans with healthier populations to plans with sicker populations

Exchange Options for States

- HHS offers multiple Exchange models as well as a number of design alternatives within each model

State or Federally Operated

Location	Exchange Decision	Federal Approval Status	Structure of Exchange	Type of Exchange
United States	**17 Declared State-based Exchange; 7 Planning for Partnership Exchange; 27 Default to Federal Exchange**	**NA**	**NA**	**NA**
Alabama	Default to Federal Exchange	NA	NA	NA
Alaska	Default to Federal Exchange	NA	NA	NA
Arizona	Default to Federal Exchange	NA	NA	NA
Arkansas	Planning for Partnership Exchange	Conditional approval	NA	NA
California	Declared State-based Exchange	Conditional approval	Quasi-governmental	Active purchaser
Colorado	Declared State-based Exchange	Conditional approval	Quasi-governmental	Clearinghouse
Connecticut	Declared State-based Exchange	Conditional approval	Quasi-governmental	Clearinghouse
Delaware	Planning for Partnership Exchange	Conditional approval	NA	NA
District of Columbia	Declared State-based Exchange	Conditional approval	Quasi-governmental	Clearinghouse
Florida	Default to Federal Exchange	NA	NA	NA
Georgia	Default to Federal Exchange	NA	NA	NA
Hawaii	Declared State-based Exchange	Conditional approval	Non-profit	Clearinghouse
Idaho	Declared State-based Exchange	Conditional approval	Quasi-governmental	Clearinghouse
Illinois	Planning for Partnership Exchange	Conditional approval	NA	NA
Indiana	Default to Federal Exchange	NA	NA	NA
Iowa	Planning for Partnership Exchange	Conditional approval	NA	NA
Kansas	Default to Federal Exchange	NA	NA	NA
Kentucky	Declared State-based Exchange	Conditional approval	Operated by State	Not yet addressed
Louisiana	Default to Federal Exchange	NA	NA	NA
Maine	Default to Federal Exchange	NA	NA	NA
Maryland	Declared State-based Exchange	Conditional approval	Quasi-governmental	Clearinghouse
Massachusetts	Declared State-based Exchange	Conditional approval	Quasi-governmental	Active purchaser
Michigan	Planning for Partnership Exchange	Conditional approval	NA	NA
Minnesota	Declared State-based Exchange	Conditional approval	Quasi-governmental	Clearinghouse

Data as of May, 28, 2013
Accessed http://kff.org/health-reform/state-indicator/health-insurance-exchanges/

State or Federally Operated

Location	Exchange Decision	Federal Approval Status	Structure of Exchange	Type of Exchange
United States	**17 Declared State-based Exchange; 7 Planning for Partnership Exchange; 27 Default to Federal Exchange**	**NA**	**NA**	**NA**
Mississippi	Default to Federal Exchange	State-based blueprint rejected	NA	NA
Missouri	Default to Federal Exchange	NA	NA	NA
Montana	Default to Federal Exchange	NA	NA	NA
Nebraska	Default to Federal Exchange	NA	NA	NA
Nevada	Declared State-based Exchange	Conditional approval	Quasi-governmental	Clearinghouse
New Hampshire	Planning for Partnership Exchange	Conditional approval	NA	NA
New Jersey	Default to Federal Exchange	NA	NA	NA
New Mexico	Declared State-based Exchange	Conditional approval	Quasi-governmental	Not yet addressed
New York	Declared State-based Exchange	Conditional approval	Operated by State	Active purchaser
North Carolina	Default to Federal Exchange	NA	NA	NA
North Dakota	Default to Federal Exchange	NA	NA	NA
Ohio	Default to Federal Exchange	NA	NA	NA
Oklahoma	Default to Federal Exchange	NA	NA	NA
Oregon	Declared State-based Exchange	Conditional approval	Quasi-governmental	Active purchaser
Pennsylvania	Default to Federal Exchange	NA	NA	NA
Rhode Island	Declared State-based Exchange	Conditional approval	Operated by State	Active purchaser
South Carolina	Default to Federal Exchange	NA	NA	NA
South Dakota	Default to Federal Exchange	NA	NA	NA
Tennessee	Default to Federal Exchange	NA	NA	NA
Texas	Default to Federal Exchange	NA	NA	NA
Utah	Default to Federal Exchange	NA	NA	NA
Vermont	Declared State-based Exchange	Conditional approval	Operated by State	Active purchaser
Virginia	Default to Federal Exchange	NA	NA	NA
Washington	Declared State-based Exchange	Conditional approval	Quasi-governmental	Clearinghouse
West Virginia	Planning for Partnership Exchange	Conditional approval	NA	NA
Wisconsin	Default to Federal Exchange	NA	NA	NA
Wyoming	Default to Federal Exchange	NA	NA	NA

Data as of May, 28, 2013
Accessed http://kff.org/health-reform/state-indicator/health-insurance-exchanges/

Minimum Covered Benefits

- Beginning in 2014, health plans offered in the individual and small group markets, both inside and outside of Exchanges, must offer a comprehensive package of items and services, known as “essential health benefits”
  - Essential benefits requirements do not apply to self-funded employer plans, plans in the large group market, or so-called “grandfathered” employer plans
- Must include items and services within at least 10 categories:

1. Ambulatory patient services
2. Emergency services
3. Hospitalization
4. Maternity and newborn care
5. Mental health/substance use
6. Prescription drugs
7. Rehabilitative and habilitative services and devices
8. Laboratory services
9. Preventive and wellness services and chronic disease management
10. Pediatric services, including oral and vision care

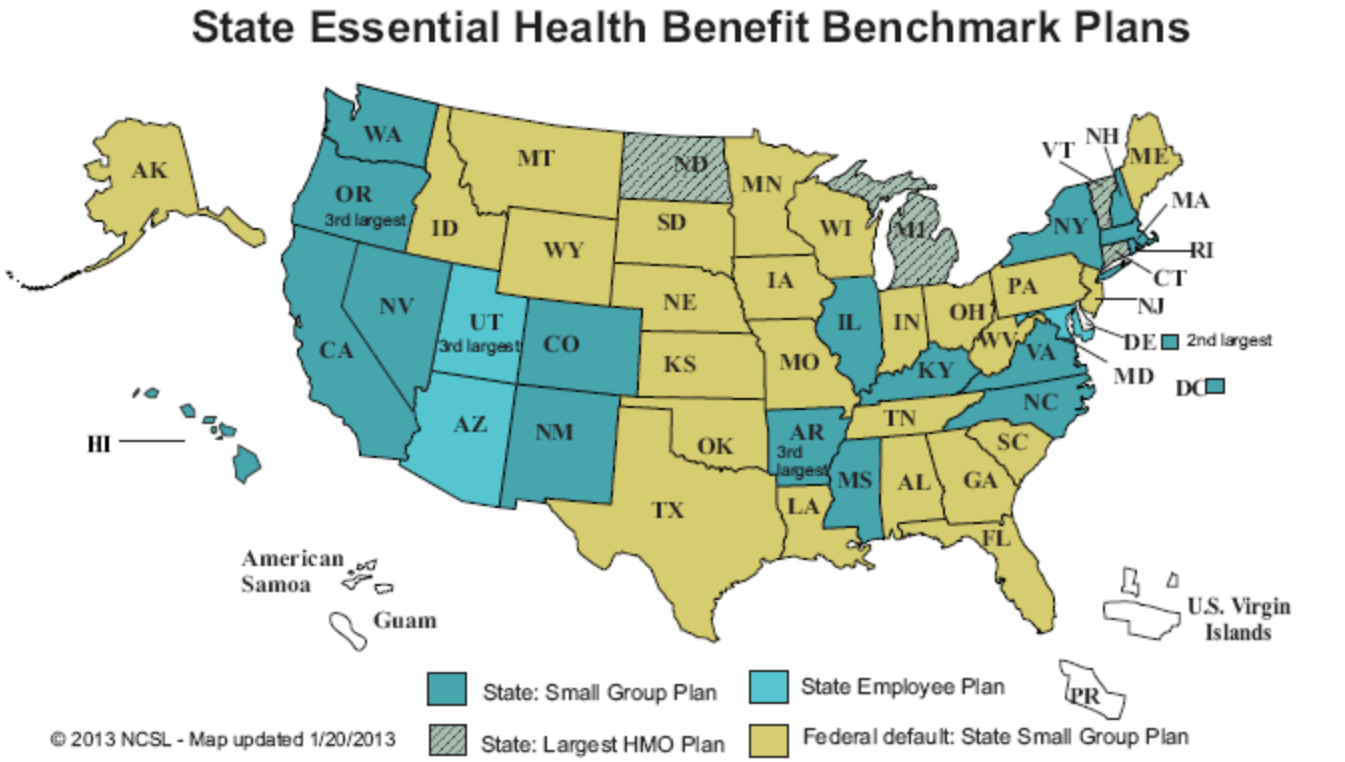
Minimum Covered Benefits, continued

- The states must define a minimum essential benefits package for 2014 and 2015 by choosing a benchmark plan from among the following:
  - one of the three largest small-group plans in the state by enrollment,
  - one of the three largest state employee health plans by enrollment,
  - one of the three largest federal employee health plans by enrollment, or
  - the largest health maintenance organization (HMO) plan offered in the state's commercial market by enrollment. (This is the default if a state does not choose.)
- Insurers are not required to replicate the benefits of the benchmark plan, but the benefits offered must be "actuarially equivalent."

Minimum Covered Benefits, continued

- State mandated benefits that exceed the essential benefit package must be paid for by the state.
- Exchanges will determine what, if any, state mandated benefits exceed the essential benefit package.
- However, most benefit mandates are included in the plans from which each state selected its benchmark plan.
  - HHS has clarified that benefits required by the states prior to December 2011 are considered to be included in the essential health benefits.

State Essential Health Benefit Benchmark Plans



Essential Health Benefit (EHB) selections were submitted to HHS by 25 states and DC by December 10, 2012.
The other 25 states did not make a selection; this allowed HHS to assign those state's "largest small-group plan" as the benchmark.

Minimum Covered Benefits

- The following states with federally facilitated exchanges - AK, AL, FL, GA, IA , ID, IN, KS, LA, ME, MN, MO, MT, NE, NJ, OH, OK, PA, SC, SD, TN, TX, WI, WV, WY - have benefits set at the level of the state small group plan.
- The following states - AZ, MD, UT - have benefits set at the level of the state employee plan.
- The following states - AR, CA, CO, DC, DE, HI, IL, KY, MA, MS, NC, NH, NM, NV, NY, OR, RI, VA, WA - have benefits set at the level of the small group plan.
- The following states - CT, MI, VT - have benefits set at the level of the largest HMO plan.

NPKUA's Website Provides State Level PKU Coverage Data

The Affordable Care Act

Medical Foods Equity Act

Newborn Screening Saves Lives Act

State Coverage for PKU

The Economic Impact of PKU

GINA and ERISA Summary

Your Legislators

Join

Connect

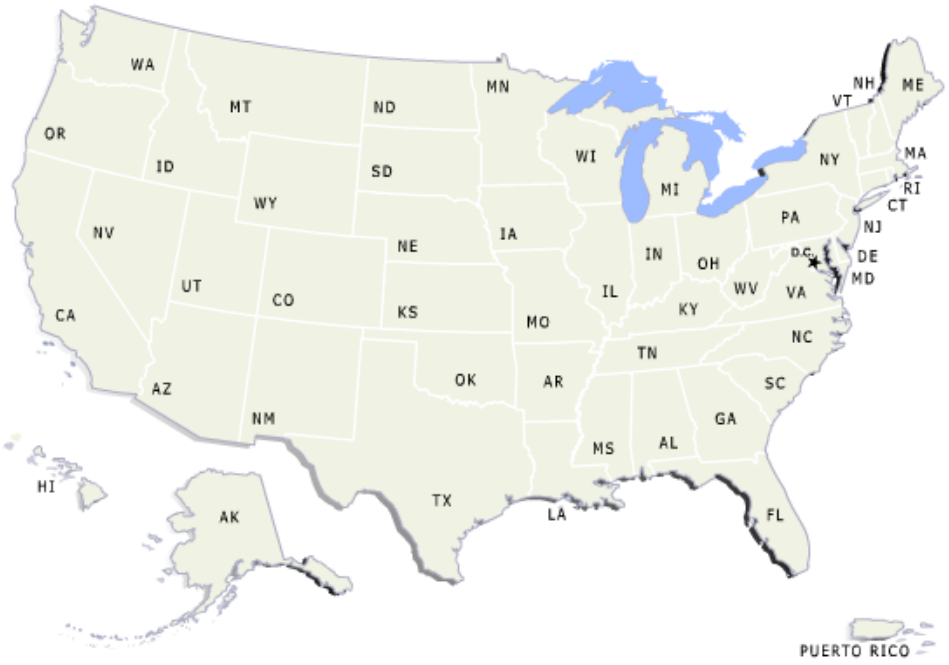
Find A Clinic

Donate

STATE COVERAGE FOR PKU

Coverage for PKU varies from state to state, although 38 states have passed legislation that requires at least some coverage of medical foods. Some states have passed legislation to mandate insurance coverage for PKU, while others provide medical foods directly to PKU patients through newborn screening or state health department programs. Click on a state below to view its legislation.

State Level PKU Coverage Interactive Map



Even with state mandates, the Employee Retirement Income Security Act (ERISA) prevents many families with self-insured health care plans to actually get coverage for medical foods despite recognized standards for PKU treatment. For a summary of ERISA in relation to PKU, please click here...>

Appeals - Internal

- An initial internal appeal asks the plan to reconsider an adverse benefit determination.
- Plans are required to give consumers detailed information about the grounds for the denial of claims or coverage.
- Consumers are entitled to a full and fair review of the denial.
- Plans must provide consumers with an expedited appeals process in urgent cases.

Appeals - External

- If a patient's internal appeal is denied, patients have the right to appeal all denied claims to an independent reviewer not employed by their health plan.
- Patients are entitled to expedited access to external review in some cases – including emergency situations, or cases where their health plan did not follow the rules in the internal appeal.
- Health plans must pay the cost of the external appeal and cannot require consumers to pay more than a nominal fee.
- Final appeal decisions are binding - if the consumer wins, the health plan must pay for the previously denied benefit.

Thank you

Dentons US LLP
1301 K Street, NW
Suite 600, East Tower
Washington, DC 20005-3364 USA