

# **The Patient Protection and Affordable Care Act in Kentucky**

**A Report Prepared for the  
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### **Overview**

The following brief report discusses implications of the Patient Protection and Affordable Care Act for individuals with disabilities in Kentucky. The Survival Coalition of Wisconsin Disability Organizations created a comprehensive report titled “The Affordable Care Act in Wisconsin: Implications for People with Disabilities” which is a good summary of the effects the Affordable Care Act will have on people with disabilities in Wisconsin and elsewhere. This report is a more in-depth look at these changes and specifically how they will affect people in Kentucky, especially people with disabilities.

The most notable changes include the implementation of the Kentucky Health Benefit Exchange which will enable greater access to increased health care options, an end to pre-existing condition discrimination which will allow people with disabilities to receive health insurance through the private market rather than Medicaid, the support of long-term care programs such as the Money Follows the Person Program and the Community First Choice Option which aim to transition people with disabilities back into the community, and an end to annual or lifetime limits on health care coverage.

### **Analysis**

The Patient Protection and Affordable Care Act, generally referred to as the Affordable Care Act (ACA) has and will continue to make changes in Kentucky similar to those noted in the study by The Survival Coalition of Wisconsin Disability Organizations, titled “The Affordable Care Act in Wisconsin: Implications for People with Disabilities.” That study noted health insurance changes that have already gone into effect as a result of the law, including

- allowing children to remain on their parent’s health insurance plan until the age of 26,
- insuring people with pre-existing conditions through the state Risk-Sharing Plan,
- reducing the Medicare Part D donut hole,
- eliminating lifetime limits on coverage,
- prohibiting termination of health insurance because a person becomes sick,
- prohibiting pre-existing condition exclusions for children, and
- establishing rebates from health insurance plans that do not spend at least 80% of premium dollars on health care and quality improvements rather than overhead.

The report notes that the Supreme Court’s ruling to uphold the ACA in June of 2012 will keep these provisions in place and allow the upcoming changes to be implemented. Provisions which will take effect in 2014 include

- the operation of health insurance exchanges,
- elimination of pre-existing condition discrimination for adults,

- expansion of Medicaid to those with incomes below 133% of the Federal Poverty Level (FPL),
- subsidies for people with incomes below 400% FPL to purchase health insurance, and
- requiring most people to have health insurance or pay a penalty.

The study notes that some aspects of the ACA, such as expanded access to affordable, quality health care regardless of age, income, or pre-existing condition, an emphasis on prevention and near-universal coverage, the introduction of health care exchanges to help people find the coverage that is right for them, and the promotion of long-term care services such as the CLASS Act and the Money Follows the Person Program (MFP), will benefit people with disabilities. In addition, the Wisconsin study claims the ACA will further support employment of people with disabilities through greater access to insurance as well as expanded coverage (which will include specialty care) in the private market, enabling them to seek employment, increase work hours, or expand their businesses because they will no longer have to worry about meeting the poverty requirements of Medicaid.

In Kentucky to date, the ACA has made it illegal to limit or deny benefits to children under 19 due to a pre-existing condition. The ACA has also expanded health care for young adults, making it possible to stay covered through their parents' policies through the age of 26, insuring 48,000 more people in Kentucky.

Kentucky is one of only 15 states to have already established an insurance exchange, which every state will be required to have starting January 1, 2014. Governor Beshear signed an executive order on July 17, 2012 to establish the Kentucky Health Benefit Exchange which will be state-run within the Cabinet for Health and Family Services. It will be headed by an 11 member Exchange Advisory Board, to be announced in September. Kentucky has received \$66.5 million in grants from the federal government for planning and setting up IT systems for the exchange. A blueprint must be turned in to the Department of Health and Human Services (HHS) by November 16, 2012. This blueprint must demonstrate that the state exchange will meet all the legal and operational requirements as well as delegate which activities will be run by the state and which will be run by the federal government. In a state-based exchange like Kentucky's almost all activities are run by the state, with the option to allow the federal government to determine eligibility for exemptions and premium tax credits and cost sharing reduction, and to operate the risk adjustment and reinsurance programs. It is estimated that 1.0-2.4 million Kentucky residents will use this exchange.

Only Qualified Health Plans (QHP) will be offered by the Kentucky Health Benefit Exchange. These plans will be certified by the Exchange. Although full requirement details for the state of Kentucky have not yet been determined, by the end of September the state must select an existing health plan as a benchmark for the Exchange. All other health plans that wish to be included in the Exchange will have to provide similar or better coverage. In addition, the ACA indicates that the health provider must be licensed and in good standing by the state, pay user fees if applicable, and submit data annually to the Exchange and HHS regarding rates, coverage

benefits, and cost sharing requirements. There are four levels of coverage defined by HHS. They are Bronze, which covers 60% of the cost of the benefits provided under the plan, Silver, which covers 70% of the cost of the benefits, Gold, covering 80% of the cost of the benefits, and Platinum, covering 90% of the cost of the benefits. Each provider must offer at least Gold coverage, Silver coverage, and a child-only plan. In addition, each plan must offer Essential Health Benefits, including: (1) Ambulatory patient services, (2) Emergency services, (3) Hospitalization, (4) Maternity and newborn care, (5) Mental health and substance use disorder services, including behavioral health treatment, (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. Each plan must also offer preventive care at no cost to the patient.

The Pre-Existing Condition Insurance Plan (PCIP) was put in place by the Department of Health and Human Services on July 1, 2010 and will last until January 1, 2014 when pre-existing condition discrimination for adults is prohibited. The PCIP is a cheaper alternative to the already-existing state risk pool, Kentucky Access, however those covered by Kentucky Access cannot switch immediately to PCIP since one of the requirements is being uninsured for at least 6 months. As of June 30, 2012, 867 Kentucky residents have enrolled in this plan. In the long-run the plan to end pre-existing condition discrimination could help over 27.3% of the non-elderly population (about 980,000 people) in Kentucky who have been diagnosed with a pre-existing condition.

In Kentucky, 18% of the population is insured currently through Medicaid. Of those insured, 48% are children, 16% are adults, 26% are disabled, and 11% are elderly. Coverage is currently limited to individuals at or below the Federal Poverty Level (FPL). The ACA requires Medicaid to expand coverage to people at up to 133% of the Federal Poverty Level starting January 1, 2014, but this provision has been ruled unconstitutional by the U.S. Supreme Court, leaving the choice to adopt the provision to the states.. Five percent of an individual's income is disregarded, effectively raising this limit to 138% FPL. The Federal Poverty Level in 2012 is \$15,415 for an individual and \$26,344 for a family of three. According to a study by The Kaiser Commission on Medicaid and the Uninsured, titled "Medicaid Coverage and Spending in Health Reform: National and State-by-State Results for Adults at or Below 133% FPL," if implemented, this expansion will benefit Kentucky more than any other state, and is expected to reduce the rate of uninsured by 57.1% by 2019. However, the majority of the newly insured will be low-income non-disabled single adults, since Medicaid currently funds zero percent of this group.

Several changes have been implemented affecting the Medicare Part D coverage gap, popularly called the Donut Hole, since passage of the ACA. The coverage gap is a gap in prescription drug coverage for prescription drug expenses in the range of \$2840 and \$4550, at which point costs qualify as Catastrophic Coverage. All costs in this range were required to be paid out of pocket before 2010. Currently those who reach costs in the donut hole receive a 50% discount on the total cost of brand name drugs in the gap. By 2020 additional discounts on both brand name and generic drugs will effectively close the coverage gap so patients will pay only 25% of the cost.

The Community Living Assistance Services and Supports program (CLASS Act), created by Title VIII of the ACA, is a self-funded and voluntary long-term care insurance choice meant to help people with disabilities remain in their homes, communities, and jobs through cash benefits to pay for community support service. This program is expected to reduce Medicaid costs and the national deficit over 10 years. Enrollment is intended to begin at the end of 2012 but payouts will not begin until 2017, since benefit eligibility requires payment of monthly premiums for 5 years, with employment for at least 3 of those years. In order to receive the benefits, the participant must have a functional impairment expected to last more than 90 days and which requires substantial assistance with two or three Activities of Daily Living, or has substantial cognitive impairment. Benefits are intended to be \$50 to \$75 a day. There are many issues with this program that need to be addressed before it is implemented. A memorandum from the Centers for Medicare and Medicaid Services notes:

In general, voluntary, unsubsidized, and non-underwritten insurance programs such as CLASS face a significant risk of failure as a result of adverse selection by participants. Individuals with health problems or who anticipate a greater risk of functional limitation would be more likely to participate than those in better-than-average health. Setting the premium at a rate sufficient to cover the costs for such a group further discourages persons in better health from participating, thereby leading to additional premium increases. This effect has been termed the “classic assessment spiral” or “insurance death spiral.” The problem of adverse selection is intensified by requiring participants to subsidize the \$5 premiums for students and low-income enrollees. Although Title VIII includes modest work requirements in lieu of underwriting and specifies that the program is to be “actuarially sound” and based on “an actuarial analysis of the 75-year costs of the program that ensures solvency throughout such 75-year period,” there is a very serious risk that the problem of adverse selection will make the CLASS program unsustainable.

Due to the issues raised with this program, progress on implementing the CLASS Act has been indefinitely suspended since October of 2011.

The Money Follows the Person Program (MFP) was enacted into law in 2006 but has been strengthened and extended by the ACA until 2016. This is another long term care program designed to transition people with Medicaid from institutions to the community. The majority of MFP recipients have been seniors and individuals with physical disabilities, while individuals with mental illness and developmental disabilities are less likely to be candidates. The program is known in Kentucky as the Kentucky Transition Program. The Community First Choice (CFC) Option is another transitional program created by the ACA to give states more funding to provide attendant services and supports as well as moving costs for those with disabilities living in a community.

Additional changes by the ACA which will benefit the people of Kentucky include prohibiting insurance companies from rescinding coverage when a patient gets sick and eliminating annual and lifetime limits on essential benefits.

Of Kentucky's 120 counties, 85 are classified as rural, encompassing over 1.8 million people. The ACA also takes steps to make health care more accessible and affordable to people in rural areas. These changes include increasing the number of primary care workers, with increased payment as an incentive for those who work in rural areas, increasing funding for Community Health Centers, which are main providers for rural areas, and tax credits for small businesses of up to 35% of employer premium contributions to firms that choose to offer coverage, as well as a tax credit of up to 25% for small non-profit organizations in order to make it easier to cover employees.

The ACA aims to bring health care costs down by expanding the primary care work force through incentives such as loan forgiveness and scholarships, construction and expanding community health centers to serve new patients, and focusing on prevention instead of treatment. In order to bring down health care premiums the new law requires health insurance companies to spend at least 80-85% of all premium dollars collected on health care services and health care quality improvements rather than administrative costs. If they are unable to do so they will be required to provide rebates to their customers. The ACA also establishes the Center for Medicare & Medicaid Innovation which will look for new ways of delivering care to patients in order to improve the quality of care and reduce the rate of growth in costs for Medicare, Medicaid, and the Children's Health Insurance Program (CHIP). The Individual Mandate, requiring that all individuals obtain health insurance or pay a fee will also help lower health care costs. Exemptions are available for religious reasons as well as to those who cannot afford health care, including a tax credit for people with incomes between 100% and 400% FPL who are not eligible for other coverage.