State ACA Implementation: Health Insurance Exchange and Medicaid Expansion Toolkit

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Abstract

Elements of the Patient Protection and Affordable Care Act (ACA) [PL No. 111-148] concerning the development and implementation of health insurance exchanges (HIEs) and Medicaid expansion were analyzed for accordance with the American Osteopathic Association’s (AOA’s) guidelines for state and federal health policy. The AOA is in support of state-based HIEs and full Medicaid expansion in all states. Educational materials were created for AOA state affiliate chapters to use in advocacy campaigns. The most effective tool was a PowerPoint presentation produced as part of this project.
# Table of Contents

Statement of the Problem .......................................................................................................................... 5
Objectives .................................................................................................................................................. 6
Review of Policy and Literature .................................................................................................................. 7
  H208-A/08 Centers for Medicare and Medicaid Services Policies ....................................................... 7
  H637-A/11 Health Insurance Exchanges ................................................................................................. 8
  H301-A/05 American Osteopathic Association Health Policy Statement ........................................... 9
Patient Protection and Affordable Care Act ............................................................................................... 9
Health Insurance Exchanges ..................................................................................................................... 10
  State Exchanges .................................................................................................................................... 11
  Federally Facilitated Exchanges .............................................................................................................. 13
  Partnership Federally Facilitated Exchanges ......................................................................................... 13
Federal Funding for Health Insurance Exchanges .................................................................................. 14
Coverage Choices Offered in Health Insurance Exchanges ..................................................................... 15
Essential Health Benefits .......................................................................................................................... 16
State Benchmark Health Insurance Plans ............................................................................................... 16
Multi-State Plan Programs ....................................................................................................................... 17
Medicaid Expansion Under the ACA ....................................................................................................... 17
  Federal Funding for State Medicaid Expansion .................................................................................... 19
Methods ................................................................................................................................................... 21
  Purpose .................................................................................................................................................. 21
  Audience ............................................................................................................................................... 22
Health Policy Analysis and Development of Educational and Advocacy Tools ....................................... 22
  Communication of Health Policy Analysis ............................................................................................... 24
Results ...................................................................................................................................................... 24
  Health Insurance Exchange Analysis ..................................................................................................... 24
  Analysis of Medicaid Expansion ............................................................................................................ 27
  Summary ............................................................................................................................................... 29
Conclusions ............................................................................................................................................. 30
  Recommendations ................................................................................................................................. 31
References ................................................................................................................................................ 32
List of Figures

Figure 1. Timeline of Important Health Exchange and Medicaid Expansion Dates 8

Figure 2. State Health Exchange Decisions 12

Figure 3. State Medicaid Expansion Status 20

Figure 4. Percentage of Federal versus State Funding for Medicaid Expansion (2014-2020) 21
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**Statement of the Problem**

Osteopathic physicians occupy the frontlines of health care. Their knowledge and advice concerning health care policy, its foibles and strengths, is an asset that should be used by policymakers when discussing future health care policies. Osteopathic physician, for their part, should stay informed on health policy issues and approaching policy decisions so that they may urge their communities and their local policymakers to make the most informed health policy decisions. Having a voice in political discussions empowers osteopathic physicians to drive the evolution of the health care system, protect their practice and ensure optimal health coverage and care is provided to their patients and the greater populations they serve.

The American Osteopathic Association (AOA) represents osteopathic physicians and may act as a lobbying body on behalf of osteopathic physicians. The AOA promotes the osteopathic philosophy, protects practicing osteopaths and promotes overall public health initiatives. As the AOA has direct relationships with physicians, it is well placed to deliver important information to physicians in regards to current and future health care policies.

Since the Patient Protection and Affordable Care Act (ACA) [PL No. 111-148] was upheld by the United States Supreme Court in June 2012, state policymakers have been pressured to respond to the evolving health care system. States must choose whether to implement and operate a state-based health insurance exchange (HIE) or defer to federal administration. States must also decide to expand Medicaid to ACA suggested levels or turn down significant federal funding and maintain current eligibility levels. The ACA has potential for comprehensive health policy reform; however, action from each state is needed to address health care issues that affect the whole country. Because osteopathic physicians primarily
practice in primary care settings, they can provide valuable insight to state policymakers on policy issues that affect access and quality of health care.

Although ACA deadlines are approaching (see Figure 1), thousands of pages of policy legislations can be a barrier to understanding and staying current on health policy decisions that states will face in the coming months and years. While AOA state affiliate organizations are ideally placed to communicate with policymakers on these issues, many state affiliate organizations lack the resources necessary to develop educational materials for their members and staff on health insurance exchanges and Medicaid expansion. As a result, many members of the osteopathic profession are not optimally equipped to become policy advocates and opportunities to share valuable insight on health care reform are missed.

Objectives

To better equip osteopathic physicians to respond to health care reform, health policy analysis based on the values of the osteopathic profession is needed. Health policy initiatives such as the development and implementation of HIEs and Medicaid expansion need to be researched and explained in a format accessible to osteopathic physicians. Additionally, state specific policy decisions, applicable funding mechanisms and essential health benefits packages need to be researched and compiled in accessible formats. Factors such as state autonomy, state versus federal spending and changes in state uninsured populations will be considered along with published AOA health policy to recommend the best course of action for states in regard to HIE development and implementation and optional Medicaid Expansion.

An analysis was prepared in various formats and presented to AOA state affiliate organizations and AOA members. Materials were prepared for members of the osteopathic profession and were comprehensive, yet easily understood. The prepared educational advocacy
materials will likely promote advocacy among AOA members facilitate informed health policy discussions between AOA affiliate organizations and state governments and policymakers.

![Timeline of Important Health Exchange and Medicaid Expansion Dates](image)

**Figure 1. Timeline of Important Health Exchange and Medicaid Expansion Dates**

**Review of Policy and Literature**

The AOA (2012) is committed to increasing access to primary care and has created policies that promise to promote initiatives that will increase the number of osteopathic medical students who will enter osteopathic primary care residencies.

**H208-A/08 Centers for Medicare and Medicaid Services Policies**

The AOA (2012) is committed to keeping state associations and members informed on policies and rules being considered by the Centers for Medicare and Medicaid Services (CMS) and other federal agencies on patient/physician issues. Additionally, the AOA encourages its state associations to provide members with information so that they may take an active role responding to CMS on policies that will potentially affect its members, practices and patients.
H637-A/11 Health Insurance Exchanges

The AOA (2012) has created initial guiding principles to assist states in the formation of HIEs. These include:

- HIEs should include all qualified health plans, employers should be able to select a plan to offer coverage to employees, exchange coverage should remain a choice, and state regulators should oversee insurance premiums.

- The governing body of the HIE should represent all parties including consumers and physicians and should not be dominated by one stakeholder.

- The HIE should promote enhanced access and quality primary care through including patient centered medical homes and compensating physicians fairly for care coordination and other non-traditional services.

- The HIE should develop uniform administrative functions that would ensure accessible applications, provisional enrollment, consumer assistance, uniform standards for enrollment and subsidy determinations and enable market choice.

- The HIE should provide standardized contracting for both physicians and insurance plans across states, if applicable.

- HIE benefit design should cover all services including osteopathic manipulative medicine and should promote continuous and comprehensive primary care.

- The HIE should be committed to quality improvement and reporting, enforce uniform quality measures across all participating plans and participate in patient registry programs.
H301-A/05 American Osteopathic Association Health Policy Statement

The AOA is committed to improving the quality and accessibility of healthcare services. The AOA (2012):

- Supports universal health care coverage and limited expansion of existing federal and/or state programs such as Medicaid.
- Opposes establishing a single payer healthcare system and government mandated healthcare coverage through a defined benefit or contribution program.
- Commits to ensuring affordable and quality medical care to uninsured and vulnerable populations.
- Believes the Medicaid program is underfunded.

Patient Protection and Affordable Care Act

The U.S. Department of Health and Human Services (DHHS, 2012a) reports that “the number of uninsured Americans is rising due to lack of affordable insurance, barriers to insurance for people with pre-existing conditions and high prices due to limited competition and market failures” (p. 3). The ACA was signed into law by President Barack Obama March 23, 2010 to battle already persistent rising health care costs and protect the health of a growing uninsured population.

As a requirement of the ACA, each state will establish a health insurance exchange (HIE) by January 1, 2014. HIEs will be online marketplaces for individuals and small-scale employers to compare and purchase health insurance plans. The law also encourages states to expand their Medicaid programs. States that choose to fully expand their Medicaid program under the ACA will cover all non-Medicare eligible individuals under age 65 and, at or below, 138% of the federal poverty level (FPL). In conjunction with other provisions that will come into effect in
January 2014 (such as long-term care insurance, health insurance regulations, multi-state insurance options, tax credits and cost-sharing, individual responsibility and ensuring coverage for individuals participating in clinical trials), this legislation aims to guarantee access to health care for all Americans.

**Health Insurance Exchanges**

The ACA provides a variety of funding sources to assist states with the development and implementation of HIEs. States will have the option of operating a state-based exchange, participating in a federally facilitated exchange (FFE) or partnering with the HHS to co-operate a partnership FFE (see Figure 2).

HIEs will offer eligible employers and individuals the opportunity to compare and buy qualified health plans (QHPs) in online marketplaces. All plans health insurers want to offer in the exchanges must be certified as QHPs. Enrollment in exchange coverage is voluntary and health plans will still be available outside of the HIEs. Individuals whose income is less than 400% of the FPL will qualify for federal subsidies when they purchase health insurance in an exchange. Federal subsidies will come in two forms: premium assistance tax credit and cost-sharing assistance. Small employers who want to obtain health coverage for employees may access the Small Business Health Options Program (SHOP). The SHOP marketplace, one element of the state’s HIE, will offer QHPs to eligible small employers. Until 2016, states are allowed to define small employers as those with either 100 or fewer, or 50 or fewer employees. After 2016, small employers will be defined as those with 100 or fewer employees (Fernandez & Mach, 2012).

HIEs will be responsible for three primary functions: (a) enrollment and consumer assistance functions, (b) exchange administration and (c) QHP administration. The exchange will
develop an internet website, establish a toll-free hotline for consumers, provide a way to calculate an individual’s cost of coverage and screen individuals for public programs and subsidies such as Medicaid and the Children’s Health Insurance Program (CHIP).

Figure 2. State Health Exchange Decisions

**State Exchanges**

The ACA encourages states to design and operate HIEs. States operating HIEs must determine the administration system and composition of exchanges, eligibility, certification of QHPs, risk adjustment, enrollment and surcharges. States can also determine if they want to employ outside contractors to carry out exchange functions. State-based exchanges can range in design from free-market, passive purchasers to active purchaser arrangements (Patient Centered Primary Care Collaborative [PCPCC], 2012). For example, Utah’s HIE will be a free-market while Massachusetts’s HIE will utilize an active purchaser mechanism (Fernandez & Mach, 2012).
States that opt for state-based exchanges are given some flexibility in the design of their HIE. States can choose to operate their exchanges through a government agency, quasi-governmental agency or non-profit organization. States that choose to run their exchanges through quasi-governmental or non-profit organizations must have a governing board in place. States maintain autonomy in the design of board membership. Some states attempt to limit conflicts of interest by prohibiting insurers, agents or brokers from participating in governing boards, while other states reserve board positions for insurers or other potentially conflicted parties (Center on Budget and Policy Priorities, 2011).

State-based exchanges are responsible for all exchange activities; however, the state may choose to use federal services to determine any or all of the following:

- advance premium tax credit (APTC),
- cost-sharing reduction (CSR),
- individual responsibility requirement and payment exemption,
- reinsurance, and
- risk adjustment.

Declaration letters and exchange blueprints for state-based exchanges were due on December 14, 2012 (Secretary of Health and Human Services, 2012a). Before states implement state-based exchanges or partnership FFES, they must submit a blueprint to DHHS and await its approval and certification. Blueprints for state-based exchanges were also due to DHHS by December 14, 2012, with approval or conditional approval by January 2013 (Center on Budget and Policy Priorities, 2011). As of January 2013, 18 states and the District of Columbia have declared they will operate a state-based exchange. As of January 2013, 17 states and the District of Columbia were conditionally approved for state-based HIEs by the DHHS. States that decide
to operate a state-based exchange after 2013 may submit their declaration letter and blueprint at any time for HHS review. State-based exchanges must be self-sustaining by January 1, 2015.

**Federally Facilitated Exchanges**

In states that will not have a certified and operable state-based exchange by the January 2014 deadline, or choose not to establish an exchange, the Secretary of HHS will establish a FFE.

In a FFE, HHS will operate the exchange; however, states may choose to manage a reinsurance program, Medicaid eligibility, or CHIP eligibility.

**Partnership Federally Facilitated Exchanges**

States will also have the option of engaging in a state partnership exchange in which states elect to assume partial responsibility for exchange oversight and administration. States that choose the state partnership model will be responsible for plan management functions, customer assistance functions or both.

Plan management partnership functions include:

- QHP analysis, review and certification
- QHP data reporting
- Management of certified QHPs

Consumer-assistance partnership functions include in-person assistance for:

- Application
- Eligibility determination
- Reporting status changes
- Coverage choice comparison
- Selection and enrollment in a QHP
In addition to partnership responsibilities, the state may choose to perform or use federal services to perform the following activities:

- Reinsurance
- Medicaid eligibility
- CHIP eligibility

The deadline for declaration letters and Exchange Blueprint applications for states pursuing partnership FFEs was extended to February 15, 2013. Approval for state partnership exchanges will be made on a rolling basis (The Secretary of Health and Human Services, 2012a).

**Federal Funding for Health Insurance Exchanges**

Exchange planning grants have awarded $45 million to 48 states, the District of Columbia and four territories to be used to conduct research on the development and establishment of an exchange in their area. States that make progress under the planning grants are eligible to apply for exchange establishment grants.

Early innovator grants were provided to states for the development of technologies to be used in exchanges. Over $126 million have been provided to Maryland, New York, Oregon and a multi-state consortium led by Massachusetts Medical School. Kansas, Oklahoma, and Wisconsin initially received innovator grants, but later returned the funds to the federal government.

States that have made progress in exchange related activities may apply for Level 1 establishment grants. Level 1 grants provide one year of funding for gathering background research, consulting with stakeholders, making legislative and regulatory changes, governing the exchange, establishing information technology systems, conducting financial management, performing oversight, ensuring program integrity and funding the first year of operations (Henry J. Kaiser Family Foundation [KFF], 2012). As of December 2012, over $1.2 billion have been
awarded in Level 1 establishment grants. States may reapply for additional Level 1 establishment grant funding for subsequent years.

Level 2 establishment grants provide long-term funding for state HIEs through 2014, as HIEs must be self-sustaining by January 1, 2015. As of December 2012, over $643 million have been awarded in Level 2 establishment grants.

To qualify for Level 2 establishment grant funding, a state must have:

- legal authority to establish state-based exchange that complies with current federal requirements,
- a defined governance structure,
- a budget and plan for financial sustainability by 2015.
- a fraud, waste and abuse plan, and
- a customer assistance plan (KFF, 2012).

**Coverage Choices Offered in Health Insurance Exchanges**

All health plans offered in HIEs must meet federal, state and HIE guidelines. Each health plan offered in a HIE must provide a minimum health benefits package coined *essential health benefits* (EHBs), be licensed by a state’s health insurance market and be certified by a state’s HIE. When a health plan has met these requirements, it is referred to as a quality health plan (QHP). Therefore, while all QHPs will provide the minimum EHBs, states and HIEs may impose additional benefit requirements for state licensure and ultimately will control the selection of plans offered in HIEs. Additionally, insurers will be required to further simplify benefits and coverage by offering health plans at defined coverage levels. Insurers will pay for a percentage of service costs as defined by the coverage level of the health plan: bronze – 60%, silver – 70%, gold – 80% and platinum – 90% (DHHS, 2012b).
Essential Health Benefits

Starting in 2014, the ACA mandates that all health plans offered in the individual and small group markets offer a package of essential health benefits (EHBs). EHBs are intended to cover a finite spectrum of essential health services.

EHBs must include services in 10 categories:

- ambulatory services,
- emergency services,
- hospitalization,
- maternity and newborn care,
- mental health and substance abuse services (including behavioral health treatment),
- prescription drug coverage,
- habilitative and rehabilitative services and devices,
- laboratory services,
- preventive and wellness services, and chronic disease management, and
- pediatric services including oral and vision care (DHHS, 2012b).

State Benchmark Health Insurance Plans

Each state is required to select a benchmark health insurance plan to be offered in the exchange. The benchmark plan will serve as a reference plan and will be chosen to reflect a typical employer health plan in the state. However, the benchmark plan must meet all federal, state and exchange requirements. As each state has a unique population, a state’s benchmark plan should be selected to meet the unique needs of its population. If the state does not designate a benchmark plan, the default benchmark plan is the small group health plan with the largest
enrollment in the state, as designated by DHHS. Enrollment data from www.HealthCare.gov can be used to determine states’ potential benchmark plans.

The following plans are potential benchmark plans as approved in the ACA:

- the largest non-Medicaid HMO in the state,
- one of a state’s three largest small group plans by enrollment,
- one of the three largest state employee health benefit plans by enrollment, and
- one of the three largest national federal employee health benefits plans by enrollment (DHHS, 2012b).

**Multi-State Plan Programs**

The ACA will create at least two multi-state plan programs (MSPPs), often referred to as *national* health insurance plans, to be offered in HIEs. Each federally contracted MSPP must comply with federal regulations, be licensed by each state it offers coverage in and must abide by state-specific HIE regulations. The ACA mandates at least one of the MSPPs be run as a non-profit organization.

**Medicaid Expansion under the ACA**

Medicaid and the Children’s Health Insurance Program (CHIP) are joint federal-state programs that have helped many low-income families and individuals achieve health care coverage. While these programs bring health care coverage to millions of low-income Americans, in many states coverage is only available for families with incomes far below the FPL. Additionally, only nine states have any level of coverage available for non-elderly, non-disabled adults without children (Center on Budget and Policy Analysis, 2012). Medicaid expansion is intended to increase access to health insurance coverage by simplifying eligibility policies for Medicaid and CHIP. Expanding Medicaid will decrease the uninsured population,
reduce enrollment and renewal barriers that result in discontinuous care and harmful health consequences and reduce states’ administrative costs that result from complex rules and procedures (DHHS, 2012a).

The ACA, as enacted, would have required all states to expand their Medicaid programs to cover all non-Medicare eligible individuals under the age of 65 and at or below 138% of the FPL by 2014 or lose all Medicaid funding. The Congressional Budget Office (CBO) estimates that 17 million uninsured Americans could be expected to newly enroll in an expanded Medicaid program by 2022. Holahan, Buettgens, Carroll, and Dorn (2012) of the Urban Institute, in a publication for the Kaiser Commission on Medicaid and the Uninsured, assert that if all states adopted Medicaid expansion alone, the uninsured population would decline by 10.3 million people.

On June 28, 2012, the United States Supreme Court’s decision in National Federation of Independent Business v. Sebelius changed mandatory Medicaid expansion to voluntary. More recently, the DHHS announced partial Medicaid expansions are not eligible for federal funding under the ACA (The Secretary of Health and Human Services, 2012b). A state will only receive federal funding if its Medicaid program expands to all provisions stated in the ACA.

Currently, states are deciding whether or not to expand Medicaid coverage to include people under age 65 and, at or below, 138% of the FPL (see Figure 3 for state Medicaid expansion decisions as of January 2013). The DHHS has not set a deadline for Medicaid expansion; therefore, states may choose to expand Medicaid as advised by the ACA when they see fit. Additionally, the ACA holds states that choose to expand Medicaid maintain the right to cut back on benefits in the future. While states are not beholden to Medicaid expansion, federal funding provides incentive for states that do adopt Medicaid expansion by 2014.
Figure 3. State Medicaid Expansion Status

Federal Funding for State Medicaid Expansion

Both federal and state governments are jointly responsible for financing the Medicaid program. Under the ACA, federal and state governments will continue to share the responsibility of financing Medicaid, however the federal government will finance most of the cost attributed to Medicaid expansion. Under the ACA, the federal government will pay all costs for newly eligible beneficiaries from 2014 to 2016. In subsequent years, the federal share of funding will remain high: 95% in 2017, 94% in 2018, 93% in 2019 and 90% in 2020 (Angeles, 2012). The tapered federal coverage encourages states to expand their Medicaid programs sooner rather than later to take advantage of federal dollars (see Figure 4 for ACA funding for Medicaid expansion).
In December 2012, DHHS (2012b) denied governors’ requests for more modest Medicaid expansions. The Secretary of HHS reaffirmed that in order for a state to become eligible for expansion funds under the ACA, the state must fully expand its Medicaid.

*Figure 4. Percentage of Federal versus State Funding for Medicaid Expansion (2014-2020)*
Methods

Purpose

The AOA desires to educate affiliates and members about controversial health policies and better equip them to advocate for the best health policy choices for their practice and their communities. The main purpose of this research is to determine the type of HIE (state-based, federally facilitated, or partnership federally facilitated) the osteopathic community should encourage state policymakers to pursue and if the osteopathic community should encourage state policymakers to expand their Medicaid programs to meet optional ACA guidelines. Secondly, this project entails creating effective communication tools to educate osteopathic physicians on elements of the ACA and corresponding AOA stance on the health policies at stake.

Due to complicated and lengthy ACA legislation, and varying state Medicaid policies, osteopathic physicians may find it difficult to fully engage in important health policy decision-making in which their input would be highly regarded. If physicians are better informed of their state’s status on health insurance exchanges, potential Medicaid expansion, EHB packages, the designation of benchmark plans and other changing health benefits, they can better anticipate the health consequences of their respective populations. Educating physicians will result in a stronger advocacy voice from physicians and will strengthen health policy decisions.

By using AOA policies as guiding principles, the author set out to conduct a policy analysis to better understand the impact of health insurance exchanges and Medicaid expansion. The results of this policy analysis were published and made available to AOA members, osteopathic physicians.
Audience

ACA health care analysis was conducted on behalf of osteopathic physicians and the communities they live and work in. AOA affiliate organizations are present in each state and they have the ability to influence state-level policymakers. AOA affiliate members are thus ideally placed to influence state health policy decisions such as the development and implementation of HIEs and the potential expansion of state Medicaid programs. Analysis was conducted using state-specific data for the benefit of AOA affiliate organizations so that they may familiarize themselves with their state’s stance on controversial ACA health policy, participate in discussions with state policymakers and prepare for the decisions their state policymakers make as important ACA deadlines approach. Health policy analysis and resulting educational and advocacy materials have been made available to all AOA members via links on the AOA member website. AOA affiliate organizations attended a Webinar presentation at which they were shown a PowerPoint presentation and participated in discussion afterwards. Additionally, the materials were presented to the AOA Board of Trustees during a meeting at the AOA headquarters in Chicago. The educational and advocacy materials will continue to be presented by AOA state affiliate organizations until they are obsolete.

While the target audience for this analysis was osteopathic physicians, similar population health ideals and increased collaboration among allopathic and osteopathic physicians potentially renders this analysis relevant to all physicians practicing in the United States.

Health Policy Analysis and Development of Educational and Advocacy Tools

In frequent contact with the AOA Director of State Government Affairs, the author gathered background research on AOA and ACA policies regarding HIEs and Medicaid expansion, daily updated data regarding state actions and proposed actions in regards to related
ACA policy decisions and created communication and advocacy materials. During the time the author prepared these materials, HHS released hundreds of pages of ACA policy, state elections resulted in leadership turnover and many policymakers failed – and then scrambled– to take steps to implement ACA policy due to the unfulfilled hope that the November 2012 presidential election would result in an abandonment of the ACA. Tumultuous politics led to extended deadlines for states to submit HIE declaration letters and blueprints. The author found it challenging, but crucial, to continuously update state HIE status to use as a reference in the analysis process. Additionally, state-specific data were periodically requested by policy advocates in Washington, DC and discussed in department meetings.

The author researched the three main types of HIE structures, state funding available for the development and implementation of HIEs and the types of coverage to be offered in exchanges. Next, the author researched Medicaid expansion policy, federal funding available and potential effects of expanded Medicaid such as projected state and federal spending and projected enrollment. The author was then able to analyze the health policy from the AOA policy perspective and was able to make policy recommendations for states.

A toolkit of educational materials was created that included:

- An ACA policy review on HIEs, Medicaid Expansion and applicable federal funding.
- State initiatives and progress related to HIEs and Medicaid Expansion.
- A PowerPoint presentation with summary data.
- Talking points in support of related AOA policies.
- Sample advocacy letters.
Communication of Health Policy Analysis

The method used to educate AOA members and physicians about ACA legislation and their state’s stance and progress was to provide concise and comprehensive educational material in various formats. Because AOA state affiliates organizations are located all across the country, it was determined that an online Webinar PowerPoint presentation on January 9th, 2013 would allow for the greatest number of participants. All AOA affiliates members were invited to attend the Webinar. Additionally, all resources created have been made accessible online to AOA members and can be uploaded or requested from AOA staff at any time. Draft advocacy letters were provided to encourage osteopathic physicians to write local policy makers to voice their opinions on state HIE and Medicaid expansion policies.

Results

Health Insurance Exchange Analysis

The AOA supports increased access to primary care and universal health care coverage, provided by government and/or private programs. HIEs give states the opportunity to offer health coverage to millions of Americans. HIEs stand to improve population health as a result of improved access to care, including preventive services and earlier treatment by health care providers. The AOA (2012) supports using tax credits and deductions, new purchasing agreements and the limited expansion of existing federal and/or state programs to achieve universal health care coverage. Subsidies available to consumers who live between 100% and 400% of the FPL will help offset the cost of health insurance for needy individuals and families. The AOA supports increasing access to health care coverage, especially to underserved populations.
By offering a variety of QHPs in an online marketplace, HIEs will increase choice and competition among health insurance plans. Requiring insurers to offer plans at defined coverage levels will allow consumers to choose a level of coverage right for them. Individuals and small employers will enjoy accessible, affordable insurance. Furthermore, HIEs will facilitate competition among private insurers that should result in improved benefit packages and lower costs. When private insurers offer health insurance plans through HIEs, they will be forced to compete with other insurers in the same market.

As a result of competition between plans, health insurers that offer attractive benefit packages and lower costs will fare better than those that fail to retain costs and offer desirable benefits. The AOA, through the Choice and Competition Coalition (CCC, 2011), supports the establishment of HIEs that promote competition and preserve consumer choice. To allow market competition forces to work to their fullest capacity, the CCC recommends that HIEs allow all qualified plans to offer coverage in exchanges.

HIE certification functions allow states to control the selection of plans offered to the public. A state’s HIE must grant QHP certification to plans before they are offered in the online HIE marketplace. Some states, like Colorado, may allow all plans that meet minimum QHP requirements to participate in its HIE (CCC, 2011). Offering a broad range of health plans preserves consumer choice and encourages competition (CCC, 2011). On the other hand, some states may choose to limit the number of QHPs it will offer in its HIE. For example, California will limit the number of QHPs offered in its HIE by using a competitive process that selects plans that provide choice, value, quality and service to California consumers (California Covered, 2012). The AOA recommends states to permit all QHPs to offer coverage in exchanges to allow for optimum choice for consumers (AOA, 2012).
The AOA believes states have the best ability to protect consumers, monitor quality and control health related costs for their populations. States have the ability to improve access to valuable health benefits by regulating health benefit packages. Proposed EHBs, to be required of all QHPs, will lower barriers to accessing primary care and will promote continuous and comprehensive primary care services (AOA, 2012). While the minimum EHBs are determined by federal regulations, benefit requirements for insurers offering coverage in HIEs can be further maintained by the state’s health insurer licensing process and again through state HIE regulations. This layering of regulation offers states the flexibility to determine which health benefits are essential for their specific population needs. In this system, physicians and patients can advocate for services they deem essential at a state level. For example, the AOA is advising states to ensure that their EHB packages cover Osteopathic Manipulative Medicine (OMM) (AOA, 2012).

The AOA encourages states to create state-based exchanges as states are the traditional regulators of the health insurance market and know their unique marketplace. States are able to retain maximum flexibility and autonomy if they choose to develop and implement state-based HIEs. As each state has its own cultural, economic and political conditions, each state should also have a unique HIE. State-based HIEs choose unique administration and governing laws and modulate how patients and providers interact with insurers and their products within an exchange. The AOA recommends that states represent all parties in governing boards by including consumers and physicians and by preventing board domination by one stakeholder, such as insurance companies (AOA, 2012). Additionally, the AOA recommends that state regulators remain responsible for overseeing health insurance premiums (CCC, 2011).
State-based HIEs enhance states’ abilities to drive health care reform and meet the health care needs of their populations. Innovative health care delivery models, such as the patient-centered medical home (PCMH), can be incorporated into HIEs to improve population health and save states money (PCPCC 2012). As an executive board member of the PCPCC, the AOA supports the incorporation of PCMH principles into state-based HIEs. With PCMH principles in mind, states can require HIE governance boards to include consumers, promote increased access to primary care, require that health plans implement a quality improvement strategy and encourage patient-centered payment models (PCPCC, 2012). Giving states the flexibility to incorporate innovative health delivery models will enhance the practice and delivery of cost-effective, patient-centered health care.

**Analysis of Medicaid Expansion**

The AOA supports universal health care coverage in which all Americans have access to health care coverage provided by federal, state and/or private programs. Medicaid expansion as directed by the ACA could provide coverage to 17 million Americans and cost states less than 2.8% more than Medicaid would have cost without health care reform (Angeles, 2012). The AOA believes Medicaid is underfunded and supports increased Medicaid funding to ensure high quality, accessible care is available to all Medicaid patients (AOA, 2012). Thus, the AOA supports the full expansion of Medicaid under the ACA because it will enable states to improve access to high quality health care.

If no states expand Medicaid, combined new federal and state spending on Medicaid from 2013 to 2022 may still be large due to increased enrollment resulting from the *individual responsibility* provision of the ACA. The individual responsibility provision mandates that all individuals maintain health insurance by 2015. Currently, many individuals eligible for Medicaid
are not enrolled in the program. As a result, Medicaid enrollment stands to increase regardless of a state’s participation in Medicaid expansion. Increased enrollment will increase financial burden on states. Increased enrollment and rising costs of health care is projected to cost $220.5 billion from 2013 to 2022 (Holahan et al., 2012). Of that, new federal spending would total $152.2 billion and state spending would account for $68.2 billion (Holahan et al., 2012). States would essentially be paying close to a third of new spending.

However, if all states participated in ACA Medicaid expansion, health care coverage would be provided to millions of low-income Americans at a relatively low cost to the state. If all states adopted Medicaid expansion as advised by the ACA, new federal spending would fund 93% of costs from 2013 to 2022 (Angeles, 2012). If all states expand Medicaid, combined federal and state spending on Medicaid would total $1.29 trillion from 2013 to 2022, and new federal spending during this time would account for $952.5 billion; however, total state contribution would only account for $76.5 billion in new spending (Holahan et al., 2012).

While expanding Medicaid to ACA levels will come at an initial high cost, long-term payback of improved population health may save states money even in the short-term. Additionally, the uninsured population places a significant financial burden on state and federal governments. In 2008, hospital care for the uninsured population cost state and federal governments $10.6 billion (The Henry J. Kaiser Family Foundation [KKF], 2008). With a higher portion of the uninsured population covered by Medicaid, the federal government, rather than states, will cover a significant portion of these costs. If all states expand Medicaid, states, as a whole, have the potential to save $10 billion from 2013 to 2022 that would have otherwise been spent on uncompensated care (Holahan et al., 2012). Furthermore, some states will actually see a net decrease in the state budget as a result of Medicaid expansion alone (Center on Budget and
Policy Analysis, 2012). Higher enrollment will increase costs for states, yet these costs are relatively low compared to financial savings and innumerable benefits that result from improved population health.

The AOA supports efforts by the federal government to work with the states to increase funding for Medicaid and ensure that a standard of high quality, accessible care is available to all Medicaid patients. Medicaid expansion will also improve the overall health of the population by increasing access to health insurance, especially among low-income families. Families with incomes between 100% and 400% will be granted premium and cost-sharing subsidies through health insurance exchanges. However, without Medicaid expansion, there will be a coverage gap that will exist between state Medicaid eligibility (which on average cover individuals below 63% of the FPL) and subsidies available in the health insurance exchange markets (Angeles, 2012).

**Summary**

Medicaid expansion and the development of state-based HIEs will be primarily federally funded and will improve health care access at a relatively low cost to states. Medicaid expansion would cost states a mere 2.8% or $76.5 billion more than the expected new state spending on Medicaid over the first six years and even less if the burden of uncompensated care is removed from state budgets (Holahan et al., 2012). Federal grants are available to states for the development of state-based HIEs, with current funding totaling close to $2 billion.

Medicaid expansion combined with efficient enrollment and subsidies provided through HIEs could reduce the uninsured population by 25.3 million people, representing nearly half of the current uninsured population (Holahan et al., 2012). Members and advocates of the osteopathic profession have a vested interest in reducing the medically uninsured population, granting consumers improved access to and choice among health care providers, generating
competition between health insurers, ensuring coverage of essential health benefits such as OMM and providing health care reform solutions that result in better, more cost-effective health care that results in a healthier population. Members of the osteopathic medical family should encourage state policymakers to develop and operate state-based HIEs and participate in Medicaid expansion as encouraged by the ACA.

The AOA believes it important to promote access to continuous and comprehensive primary care services and is dedicated to assisting states as they develop and implement HIEs and consider Medicaid expansion. Medicaid expansion and HIEs will have profound health and financial effects within states and within the country as a whole. The AOA encourages the involvement of state osteopathic organizations and members in responding to federal and state policy pertinent to their members, practices and patients (AOA, 2012). It is the hope of the AOA that the educational and advocacy materials created will be used to inform AOA members and state osteopathic organizations about two important implications of recent health care reform: HIEs and Medicaid expansion.

**Conclusion**

The goal of this project was to educate AOA members on health policy and to provide AOA affiliate organization members with educational and advocacy materials. The overall feedback from the project was positive, with many AOA state affiliate organizations requesting to use the PowerPoint presentation for use in local educational purposes and advocacy. The main concern with the toolkit is that it is rapidly falling out of use due to volatile political circumstance.

Although, charts displaying state-specific information were particularly useful for AOA leadership, there is no evidence that this particular form of information was useful to AOA
affiliate organizations. These charts were intended as points of reference for AOA state affiliate organizations; however, many states have since changed their stance on HIEs and Medicaid expansion and others remain undecided.

AOA affiliate organizations have given positive feedback in response to the presentation materials, in particular, observed in the Webinar. This suggests that visual tools such as posters, flyers and pamphlets may have been more accessible and beneficial to the target population.

**Recommendations**

While informational materials are available online to AOA members, many of them now contain out of date information as a result of ever changing policy decisions. Out of date information may mislead AOA members looking for the most current policy data. A solution to this problem may be to allow AOA members to access a live database where state-specific data could be maintained by both AOA members and the AOA Division of State Government Affairs.

The full effects of the ACA have yet to be understood, therefore the AOA must continue to conduct policy analysis for its members and affiliate organizations. This analysis and collection of informational and advocacy materials fails to address specific questions osteopathic physicians may have on how the ACA policies will affect their daily practice of medicine. The author has suggested that additional resources be created for practicing osteopathic physicians that address specific policy questions surrounding patient/physician interactions.
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