THE AFFORDABLE CARE ACT KEY PROVISIONS –THE AFFORDABLE CONSIDERATIONS FOR INDIAN HEALTH INSURANCE MARKET

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Footnote: The views presented in this paper are that of the Authors only and shall not be treated as that of the Employer.

1. INTRODUCTION

United States of America has been the World's largest spender in Healthcare. The National Center for Health Statistics 2014 publication cites the U.S per capita national health expenditures of $9,255 and Total national health expenditures as a percent of Gross Domestic Product of 17.4% in 2013. US had a long journey in achieving these results.

The important milestones in the journey of US Health Care are as follows:

Medicaid / State Health Insurance Assistance Program (SHIP) can be considered as a pioneering step in this journey. It was instituted for the very poor in 1965. Medicaid is a means tested, social welfare or social protection program rather than a social insurance program jointly funded by the states and federal government and managed by the states. The states have leeway to determine the enrolment eligibility.

The introduction of Medicare is another important milestone. Medicare is a national social insurance program, administered by the United States federal government since 1966, currently using about 30 private insurance companies across the U.S. It provides health insurance for aged 65 and above who have worked and paid into the system by paying Medicare taxes for at least 10 years and to people with disabilities, end stage renal disease and amyotrophic lateral sclerosis. Medicare covers approximately 13 percent of the US population. On average, Medicare covers about half (48 percent) of the health care charges for those enrolled in Medicare and enrollees must then cover the remaining approved charges either with supplemental insurance or with out-of-pocket coverage.
Medicare benefits have four parts, original plans being 'Part A: Hospital Insurance' and 'Part B: Medical Insurance'. 'Part C: Medicare Advantage Plans' and 'Part D: Prescription Drug Plans' were subsequently introduced.
People eligible for both Medicaid and Medicare and are known as Medicare dual eligibles.

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) is another milestone in the journey which enables certain individual to extend the coverage if certain "qualifying events" would otherwise cause them to lose it. Employers may require COBRA-qualified individuals to pay the full cost of coverage, and coverage cannot be extended indefinitely. It allows employees and their dependents to maintain coverage at their own expense by paying the full cost of the premium that the employer and the employee previously paid. COBRA allows for coverage for up to 18 months in most cases. If the individual is deemed disabled by the Social Security Administration, coverage may continue for up to 29 months. In the case of divorce from the former employee, the former spouse's coverage may continue for up to 36 months. In the case of death of the former employee, the widow's coverage may continue for up to 36 months.
The Act impose an excise tax upon qualifying employer, with 20 or more employees, whose health insurance plan fails to allow employees and their immediate family members to maintain their coverage in case of the "qualifying event".

The "qualifying events" includes (1) employee's death; (2) loss of eligibility for benefits due to voluntary or involuntary termination or a reduction in hours due to resignation, discharge (except for "gross misconduct) layoff, strike or lockout, medical leave, or slowdown in business operations; (3) termination of ex-spouse's eligibility due to divorce or legal separation; (4) dependent child crossing the eligible age for coverage.

Emergency Medical Treatment and Active Labor Act (EMTALA) passed in 1986 became part of the COBRA. It requires emergency department of hospitals that accept payments from Medicare to treat emergency conditions of all patients and is considered a critical element in the "safety net" for the uninsured. EMTALA's provisions apply to all patients and not just to Medicare patients seeking treatment for emergency medical condition, regardless of Citizenship in the United States, legal status, or ability to pay.

The Health Insurance Portability and Accountability Act (HIPAA) which was enacted in 1996 protects health insurance coverage through Group health plans and certain individual health insurance policies for workers and their families when they change or lose their jobs. The exempted plans are long-term health plans and limited-coverage standalone plans such as dental or vision plans unless they are part of a general health plan. In group health plans the coverage is extended to pre-existing conditions with limited restrictions. The pre-existing conditions coverage may be after a period of 12 months from enrolment or 18 months in the case of late enrolment. Same provision allowed individuals to reduce the exclusion period by the amount of time that they had "creditable coverage" prior to enrolling in the plan and after any "significant breaks" i.e. 63 day period without any creditable coverage. Creditable coverage nearly included all group and individual health plans. Also, the provisions under Title I required insurers to issue policies regardless of health conditions without exclusion to those leaving group health plans with “creditable coverage” exceeding 18 months, and renew individual policies or provide alternatives to discontinued plans without exclusion.

The ‘Administrative Simplification (AS) provisions’ of this act requires the establishment and maintenance of privacy and security for electronic health care transactions and national identifiers for providers, health insurance plans, and employers. It also outlined numerous offenses relating to health care and sets civil and criminal penalties for violations and created several programs to control fraud and abuse within the health care system. This Act promoted ‘Medical Savings Accounts’ (MSA), where an employee covered under an employer-sponsored high deductible plan of a small employer and self-employed individuals can contributes an amount that may be saved in a pre-tax medical savings account.

Medicare Prescription Drug, Improvement, and Modernization Act 2003 (MMA) created a new Health Savings Account (HSA) statute that replaced and expanded the previous Medical Savings Account law (MSA) by expanding allowable contributions and employer participation.
The most significant difference between HSAs and MSAs is that employers of all sizes can offer an HSA account and insurance plan to employees. MSAs were limited to the self-employed and employers of 50 or fewer people. HSA is a tax-advantaged account available to taxpayers in the US who are enrolled in a high-deductible health plan (HDHP) and fund contributed are not subject to federal income tax at the time of deposit. HSA funds may currently be used to pay for qualified routine, out-of-pocket medical expenses at any time without federal tax liability or penalty. HSA funds roll over annually & accumulate, even if an employee changes jobs. The accumulated funds can be removed for non-eligible expenses, subject to Federal Income Tax and 20% penalty. Once qualified for Medicare these accumulated funds can still be used tax free for medical expenses not covered by Medicare. In addition, if the high-deductible health plan is not pursued further then these funds can usually be rolled into the retirement account without facing taxes.

Thus the US market has witnessed many milestones before making a comprehensive law that aims for affordable, more accessible health care scheme for the country.
The following section discusses the Affordable Care Act in detail.

2. PATIENT PROTECTION AND AFFORDABLE CARE ACT 2010 (PPACA or ACA)

The Patient Protection and Affordable Care Act also known as **Affordable Care Act** (ACA) was enacted into law on March 23, 2010. It is one of the most significant reforms in the US Healthcare system since Medicare and Medicaid in 1965.The Act focuses on to lower the uninsured rate by expanding public and private insurance coverage, curb the growth in healthcare costs and improve health care delivery system through shared responsibility. The most significant changes, particularly affecting the availability and terms of insurance became effective since January 1, 2014.

The Act contains ten titles which covers various aspects ranging from quality, affordable health care to revenue provisions. Though the Act covers wide range of issues, this paper mainly aims at the provisions relating to health insurers, provisions related to government sponsored schemes, provisions related to motivating the public for accessing the health insurance and the initiatives to enhance the quality of health care.

2.1 RESTRICTIONS ON INSURERS- BASED ON DEMOGRAPHICS

Effective 2014 The Affordable Care Act mandates the Health Insurers to guarantee the issue and renewability of health plans and Health Insurers are prohibited from denying coverage or setting rates based on the following (Sec 2705):

- Health Status
- Medical condition (including both physical and mental illnesses)
- Claims Experience
- Receipt of health care
- Medical History
- Genetic Information
- Evidence Of Domestic Violence
- Disability
- Any other health status-related factor determined appropriate by the Secretary of Health and Human Services (HHS)

Prohibition of discrimination based on salary, Sec 2716: The ACA provisions prohibits the health insurance coverage eligibility rules which discriminates in favor of higher wage employees or are based on the total hourly/annual salary of the employees.

Premiums rates will vary only by:

- Family Structure
- Geography
- Actuarial Value
- Tobacco Use (limited to 1.5. to 1 ratio)
- Participation in a Health Promotion Program and
- Age (limited to 3 to 1 ratio)

The following paragraphs discuss about how the premium can vary based on the above factors.

- *Age*: The person's age for rating purposes is their age at the time of the policy's effective or renewal date. The rate must not vary by more than 3:1 for individuals of different age who are 21 years and older.

Therefore If a 21-year-old woman's premium is $200 a month for a particular health plan, a 64-year-old woman's premium for that same health plan cannot be more than $600 a month ($200 x 3 = $600).
The variation in rate must be actuarially justified for individuals under age 21, consistent with a uniform age rating curve. A state may use a narrower ratio with approval from CMS.

Uniform Age Bands:
Child age bands: A single age band for individuals' age 0 to 20 years
Adult age bands: One-year age bands starting at 21 years and ending at age 63
Older adult age bands: A single age band for individuals age 64 and older

- *Tobacco Use*: Rates based on tobacco use may not vary by more than 1.5:1 for similar individuals who vary in tobacco usage. A state may use a narrower ratio with approval from CMS.
  Rates for tobacco users can vary up to the 1.5:1 ratio means that younger smokers may have lower tobacco rating factors (e.g., 1.25) than older smokers (e.g., 1.5).

- *Gender*: The ACA's directive to insurance companies was to no longer charge members based on gender, burdening men with the health care costs of women. A study by the National Institutes of Health reported that Women health expenditure is approximately 20% more than Men (assuming men live as long as women).

- *Actuarial Value (AV)*: If the plan has Actuarial Value of 70% then for a standard population (and without regard to the population the plan may actually provide benefits to), the plans pays 70% of their health care expenses, and the enrollees pays 30% out-of-pocket through some combination of deductibles, coinsurance and copayments (or other required point-of-service charges). Higher is the AV, then on-average the plan will have less patient cost-sharing requirement.

  Because of the inherent uncertainty in actuarial analysis, driven by different assumptions and data, plans having same actuarial value may have different combinations of deductibles, copays, and coinsurance. The percentage a plan pays for any given enrollee will generally vary from the actuarial value. Thus the details of the patient cost-sharing will likely to vary from plan to plan having same AV, such that one plan may have a higher deductible than other and compensated by having a lower coinsurance percentage once the deductible is met.

Pre-existing conditions and Ill-Health**:** The insurance market reform will eliminate the discriminating practices by the Insurers such as pre-existing condition exclusion. The aim is to extend the health insurance coverage to most citizens and legal residents in American as being part of the healthcare system. The comfort of premium affordability is being derived from tax credits introduced for Individuals and families.

The transitional program created in the ACA is known as Pre-existing Condition Insurance Plan (PCIP) for eligible citizens who have been uninsured for the last 6 months and have a pre-existing condition or have been denied health coverage because of their health condition.

2.2 RESTRICTIONS ON INSURERS- BASED ON LOSS RATIOS:

MEDICAL LOSS RATIO AND PREMIUM RATE REVIEWS

The Affordable Care Act requires health plans to report the proportion of premium dollars spent on clinical services, quality, and other costs. It also mandates to provide rebates, effective January 1, 2011, to consumers for the amount of the premium spent on clinical services and quality that is less than 85% for plans in the large group market and 80% for plans in the individual and small group markets. There is requirement to report medical loss ratio.

The Act also established a process for reviewing increases in health plan premiums and requires plans to justify the increases. The states are required to report on trends in premium increases and recommend whether certain plan should be excluded from the Exchange based on unjustified premium increases. The ACA provides grants to States to support efforts to review and approve premium increases.

OTHER RESTRICTIONS ON INSURERS

- To provide dependent coverage for children up to age 26 for all individual and group policies
- Prohibit insurers from rescinding coverage except in cases of fraud
- Prohibit pre-existing condition exclusions for children
- Prohibit individual and group health plans from placing lifetime limits and/or annual limits on the dollar value of coverage. Prior to January 2014, plans may only impose annual limits on coverage as determined by the Secretary.
- Imposing the same insurance market regulations relating to guarantee issue, premium rating, and prohibitions on pre-existing condition exclusions in the individual market, in the Exchange, and in the small group market.
- Limiting deductibles for health plans in the small group market to $2,050 (in 2015) for individuals and $4,100 (in 2015) for families unless contributions are offered that offset deductible amounts above these limits. This deductible limit will not affect the actuarial value of any plans.
- Limiting any waiting periods for coverage to 90 days.

2.3 STANDARD HEALTH INSURANCE PLANS

ESSENTIAL HEALTH BENEFITS PACKAGE

The ACA mandates creation of an Essential Health Benefits Package that provides a comprehensive set of services, covers at least 60% of the actuarial value of the covered benefits, limits annual cost-sharing to the current law Health Savings Account limits ($6,600 for individuals and $13,200 for families in 2015), and is not more extensive than the typical employer plan.

Effective from January 1, 2014 the Secretary of Health and Human Services (HHS) is to define and annually update the benefit package through a transparent and public process. The ACA also requires all qualified health benefits plans, including those offered through the Exchanges and those offered in the individual and small group markets outside the Exchanges, to offer at least the essential health benefits package.

Essential Health Benefits shall include at least the following general categories and the items and services covered within the categories mentioned below without imposing any cost sharing requirements for preventive health services as recommended from time to time by United

States Preventive Services Task Force, Advisory Committee on Immunization Practices and Health Resources and Services Administration:
(A) Ambulatory patient services
(B) Emergency services
(C) Hospitalization
(D) Maternity and newborn care
(E) Mental health and substance use disorder services, including behavioural health treatment
(F) Prescription drugs
(G) Rehabilitative and habilitative services and devices
(H) Laboratory services
(I) Preventive and wellness services and chronic disease management, and
(J) Paediatric services, including oral and vision care

Effective since January 1, 2014 the ACA also prohibits the Abortion coverage beyond those for which federal funds are permitted (to save the life of the woman and in cases of rape or incest) from being part of the essential health benefits package.

BENEFITS TIERS

The Affordable Care Act has created four benefit categories of Qualified Health Insurance Plans in the individual and small group markets to be offered through the Exchange.

The level of coverage in ACA is not defined based on the co-payment, deductibles and co-insurances but is defined in terms of the Actuarial Value. It is mandatory that the Health Insurer participating in the Exchange must offer atleast one Silver and One Gold plan.

– Bronze plan represents minimum creditable coverage and provides the essential health benefits, cover 60% of full actuarial value of the benefits provided under the plan, with an out-of-pocket limit equal to the Health Savings Account (HSA) current law limit ($6,600 for individuals and $13,200 for families in 2015);
– Silver plan provides the essential health benefits, covers 70% full actuarial value of the benefits provided under the plan, with the HSA out-of-pocket limits;
– Gold plan provides the essential health benefits, covers 80% full actuarial value of the benefits provided under the plan, with the HSA out-of-pocket limits;
– Platinum plan provides the essential health benefits, covers 90% full actuarial value of the benefits provided under the plan, with the HSA out-of-pocket limits;
– Catastrophic plans are separate plans only available in the individual market for those up to age 30 years or to those who are exempted from the mandate to purchase coverage. The catastrophic plans generally have low premiums, high deductibles and high cost sharing amounts. It provides the minimum essential coverage level set at the HSA current law levels except that the prevention benefits and coverage for three primary care visits would be exempted from the deductible. There are no subsidies for these plans.

Most citizens are required to have insurance that is at least at the bronze level (a 60% actuarial value) or are subject to a federal tax penalty. The family with income up to 400% FPL seeking coverage through the Exchange may be eligible for premium and cost-sharing subsidies. The subsidies are applicable on the second lowest cost silver plan (70% actuarial value). The low and modest income group may be eligible for coverage with a higher actuarial value in Exchanges.

Therefore these requirements apply to all tiers of health insurance coverage, which means that differences in the levels of coverage will reflect variation in cost-sharing and not the differences in the underlying benefits.

2.4 MANDATES ON INDIVIDUALS, EMPLOYERS AND INSURERS

INDIVIDUAL MANDATE

The Affordable Care Act requires the U.S. citizens and legal residents to have qualifying health coverage else are subject to tax penalties. The Exemptions are granted for financial hardship, religious objections, American Indians, those without coverage for less than three months, undocumented immigrants, incarcerated individuals, those for whom the lowest cost health plan option's premium exceeds 8% of an individual's income, and those with incomes below the tax filing threshold (in 2009 the threshold for taxpayers under age 65 was $9,350 for singles and $18,700 for couples).

If appropriate Health Coverage is not procured by Individuals/families the tax penalties are imposed from 2014 in phased-schedule such as, $95 in 2014, $325 in 2015, and $695 in 2016 for the flat fee or 1.0% of taxable income in 2014, 2.0% of taxable income in 2015, and 2.5% of taxable income in 2016, whichever is greater respectively. Beginning after 2016, the penalty will be increased annually by the cost-of-living adjustment.

EMPLOYERS OBLIGATION

Employers with 50 or more full-time equivalent employees: Effective since January 1, 2014, if such employers do not offer health coverage and have at least one full-time equivalent employee (at least 30 working-hours per week) who receives a premium tax credit for health insurance through an Exchange, the employer is subject to a fee of $2,000 per full-time, excluding the first 30 employees.
Such employers who offer coverage which is deemed unaffordable (the federal government considers the insurance policy as "unaffordable" if the employee contribution exceeds 9.5% of the employee's household income,) or does not meet the standard for minimum essential coverage or that offer coverage but have at least one full-time employee receiving a premium tax credit, will pay the lesser of $3,000 for each employee receiving a premium credit or $2,000 for each full-time employee, excluding the first 30 employees.

Employers with up to 50 full-time equivalent employees are exempted from any of the above penalties.
The Act requires employers with more than 200 employees to automatically enroll new employees into health insurance plans offered by the employer. Employees may opt out of coverage.

QUALIFICATIONS OF PARTICIPATING HEALTH PLANS

Qualified Health Plans provides the essential health benefits package and is offered by a health insurance issuer that agrees to offer at least one qualified health plan in the silver level and at least one plan in the gold level in each such Exchange; The health insurance issuer must also agrees to charge the same premium rate for each qualified health plan of the issuer without regard to whether the plan is offered through an Exchange or whether the plan is offered directly from the issuer or through an agent; and complies with the regulations developed by the Secretary and such other requirements of the applicable Exchange.

The ACA mandates the Qualified Health Plans participating in the Exchange to meet marketing requirements, have adequate provider networks, contract with essential community providers, contract with navigators to conduct outreach and enrollment assistance, be accredited with

respect to performance on quality measures, use a uniform enrollment form and standard format to present plan information.

These qualified health plans are required to report information on claims payment policies, enrollment, disenrollment, number of claims denied, cost-sharing requirements, out-of-network policies, and enrollee rights in plain language.

2.5 Common and Reliable place for purchase of insurance schemes- INSURANCE EXCHANGES

The ACA imposes new regulations on health plans in the Exchanges for the individual /families and small group markets. These Exchanges are administered by a governmental agency or non-profit organization, through which individuals and small businesses with up to 100 employees can purchase qualified coverage. Access to Exchange is restricted to U.S. citizens and legal immigrants who are not incarcerated. The exchanges play the role in helping consumers understand their choices and also provide tools for estimating their out-of-pocket costs.

Individuals and Families: The ACA mandates the States to create the States based American Health-Benefit Exchange where individuals can purchase coverage, with premium and cost sharing credits available to individuals/families with income between 133-400% of the federal poverty level (the FPL level is $19,530 for a family of three in 2013). Individuals qualified to receive tax credits for Exchange coverage must be ineligible for affordable, employer-sponsored insurance or any form of public insurance coverage.

Small Businesses: The ACA also mandates creation of Separate Exchanges through which small businesses up to 100 employees can purchase coverage known as Small Business Health Options Program (SHOP) Exchanges.
ACA permits States to allow businesses with more than 100 employees to purchase coverage in the SHOP Exchange beginning 2017.
States may form regional Exchanges or allow more than one Exchange to operate in a state as long as each Exchange serves a distinct geographic area. Funding is available to states to establish Exchanges within one year of enactment until January 1, 2015
The States also have to provide oversight of health plans with regard to the new insurance market regulations, consumer protections, rate reviews, solvency, reserve fund requirements, premium taxes, and to define rating areas.

The Secretary of Health and Human Services (HHS) is to establish a national public option – the Community Health Insurance Option – and permit states to opt-out. Federal support will also be available for new non-profit, member run insurance cooperatives.

States will have flexibility to establish basic health plans for non-Medicaid, lower-income individuals; states may also seek waivers to explore other reform options; and states may form compacts with other states to permit cross-state sale of health insurance. No federal dollars may be used to pay for abortion services.
The Affordable Care Act defined the yardstick for the following Health Insurance plans as being part of the benefits provided by the State or available in Exchanges:

- Basic health plan: The ACA gives option to the states to create a Basic Health Plan for uninsured individuals with incomes between 133%-200% FPL who would otherwise be eligible to receive premium subsidies in the Exchange. To execute such plan the opting States are required to contract with one or more standard plans to provide at least the

essential health benefits. The premium of such plans should not be more than that paid in the Exchange. The cost-sharing requirements are not to exceed those of the platinum plan for enrollees with income less than 150% FPL or the gold plan for all other enrollees.
Individuals with incomes between 133-200% FPL in states creating Basic Health Plans will not be eligible for subsidies in the Exchanges.
States will receive 95% of the funds that would have been paid as federal premium and cost-sharing subsidies for eligible individuals to establish the Basic Health Plan.

- Multi-state plans: The ACA requires the Office of Personnel Management to contract with insurers to offer at least two multi-state plans in each Exchange. At least one plan must be offered by a non-profit entity and at least one plan must not provide coverage for abortions beyond those permitted by federal law. Each multi-state plan must be licensed in each state and must meet the qualifications of a qualified health plan. These multi-state plans will be offered separately from the Federal Employees Health Benefit Program and will have a separate risk pool.

- Consumer Operated and Oriented Plan (CO-OP): The ACA mandates creating the Consumer Operated and Oriented Plan (CO-OP) program to foster the creation of non-profit, member-run health insurance companies in all 50 states and District of Columbia to offer qualified health plans. For being eligible to receive funds, among other conditions, the organization:
  - Should not be an existing health insurer or sponsored by a state or local government,
  - Substantially all activities consist of the issuance of qualified health benefit plans in respective state, and
  - Profits to be used to lower premiums, improve benefits, or improve the quality of health care delivered.

Obligations of the Exchanges:
- The Exchanges are to maintain a call center for customer service
- Establish the procedures for enrolling individuals and businesses and for determining eligibility for tax credits
- Exchanges can contract with state Medicaid agencies to determine eligibility for tax credits in the Exchanges
- Require States to develop a single form for applying for state health subsidy programs that can be filed online, in person, by mail or by phone
- Exchanges to submit financial reports to the Secretary and comply with oversight investigations

CONSUMER PROTECTION – Obligations of Insurers:

- Establishing an internet website to help residents identify health coverage options
- Developing a standard format for presenting information on coverage options
- Developing standards for Insurers in providing information on benefits and coverage.

2.6 STATE INCENTIVES TO INCREASE INSURANCE NETWORK IN TERMS OF TAX BENEFITS AND SUBSIDIES

INDIVIDUALS

These provisions are effective from January 1, 2014. The employees who are offered coverage by an employer are not eligible for premium credits unless the employer plan does not have an actuarial value of at least 60% or if the employee's share of the premium exceeds 9.5% of income.
Premium tax credits are provided to eligible individuals and families with incomes between 100%-400% FPL. An explicit method of calculation of income is defined in the Act.
The limitation on premium contributions ranges from 2% to 9.5% of income levels ranging from 133% to 400% of FPL.
Cost sharing reductions limits the Out-of-pocket expenses for enrolees with income ranging from 100% to 250% of FPL, the maximum Out-of-pocket expenses ranges from 1/3 to 1/2 of HSA level.

EMPLOYERS

Small Business: Small employers, with not more than 25 employees and average annual wages of less than $50,000, who have purchased health insurance for its employees gets tax credit under ACA provisions.

For tax years 2014 and later, for eligible small businesses that purchase coverage through the state Exchange, provide a tax credit of up to 50% of the employer's contribution toward the employee's health insurance premium if the employer contributes at least 50% of the total premium cost. The credit will be available for two years.
The full credit will be available to employers with 10 or fewer employees and average annual wages of less than $25,000. The credit phases-out as firm size and average wage increases.
The tax-exempted small businesses which meet these requirements are eligible for tax credits of up to 35% of the employer's contribution toward the employee's health insurance premium.

2.7 RATIONALISATION OF STATE SPONSORED SCHEMES - MEDICARE AND MEDICAID

The Affordable Care Act has provided many provisions relating to Medicare and Medicaid. Some of them have been summarised below.

MEDICARE

- Donut Hole:
  The Affordable Care Act eliminates the "Donut Hole" in Medicare Part D in phased manner from 2013 to 2020. The gap for generic and brand-name drugs is closed by lowering the amount paid out-of-pocket in the coverage gap to 25% by 2020 which is the same percentage paid from the time the deductible is met until reaching the out-of-pocket spending limit (For 2013, the true out-of-pocket, TrOOP, spending was $4,750). In order to have their drugs covered under the Medicare Part D program, drug manufacturers will provide a 50% discount to Part D beneficiaries for brand-name drugs and biologics purchased during the coverage gap beginning July 1, 2010. The initial coverage limit in the standard Part D benefit is expanded by $500 for 2010.

MEDICAID

- The Affordable Care Act has expanded Medicaid to all non-Medicare eligible individuals under age 65 (children, pregnant women, parents, and adults without dependent children) with incomes up to 133% of FPL. Under the current law undocumented immigrants are not eligible for Medicaid.
  The Supreme Court ruling on the constitutionality of the ACA upheld the Medicaid expansion, but limited the ability of HHS to enforce it, thereby making the decision to expand Medicaid optional for states.

- With an effective date of January 1, 2014, to finance the coverage for the newly eligible, states will receive 100% federal funding for 2014 through 2016, 95% federal financing in 2017, 94% federal financing in 2018, 93% federal financing in 2019, and 90% federal financing for 2020 and subsequent years.
  States that have already expanded eligibility to adults with incomes up to 100% FPL will receive a phased-in increase in the federal medical assistance percentage (FMAP) for non-pregnant childless adults so that by 2019 they receive the same federal financing as other states (93% in 2019 and 90% in 2020 and later).

2.8 INITIATIVE ON IMPROVING THE QUALITY OF HEALTH CARE

The Hospital Value-Based Purchasing (VBP) Program is a 'Centers for Medicare & Medicaid Services' (CMS) initiative that rewards acute-care hospitals with incentive payments for the quality of care they provide to people with Medicare.

The measures for the purposes of the program should contain at least the following five conditions:
Acute myocardial infarction (AMI); Heart failure; Pneumonia; Surgeries, as measured by the Surgical Care Improvement Project; Healthcare-associated infections, as measured by the prevention metrics and targets established in the HHS.
In establishing the relevant measures, the criteria considered are:

- Practical experience with the measures involved
- Historical performance standards
- Improvement rates, and
- The opportunity for continued improvement

The method for assessing a hospital's score on a particular measure is based on where a hospital's results during a "performance" period fall between a "threshold" and a "benchmark" for both achievement and improvement. A hospital will be awarded the greater of its achievement points or improvement points on a measure.

Measurement of Level of Achievement: The achievement "**threshold**" is the median score on a measure of all participating hospitals nationally during the performance period. Hospitals that score below the threshold (i.e., score in the bottom half of hospitals nationally), receive no achievement points for that measure.

The achievement "**benchmark**" is the top half of the top decile score (i.e., 95%) of all participating hospitals nationally during the performance period. Hospitals that achieve that "benchmark" receive the maximum of 10 points for that measure. Hospitals scoring between the 50% threshold and 95% benchmark are allotted between 1-9 points depending on where its score falls between the threshold and benchmark.

Measurement of Level of Improvement: The number of "improvement" points earned by a hospital is determined on a particular measure by comparing the hospital's performance on

that measure during the performance period to the hospital's performance on that measure during a "base period." A hospital that falls below its base period score will get 0 improvement points (obviously) and a hospital that achieves the national benchmark will still receive the full 10 points for the measure.

Thus the value-based incentive payments to the Hospitals depend on its total performance score such that highest-scored hospital shall receive the largest incentive payments from the Medicare. As the VBP Program is budget neutral, the Medicare payments to all hospitals is reduced by a small percentage starting with 1% in 2013 which will be used for incentive payments to hospitals that perform well / show improvement. In other words, all the hospitals which do not perform well are automatically penalized.

Hospital Acquired Conditions Reduction Program: The Hospital-Acquired-Conditions Score (HAC score) is based on hospital's performance on 3 quality measures viz., patient safety indicator 90 composite, central-line associated bloodstream infection and catheter associated urinary tract infection. Medicare payments are reduced for hospitals belonging to the worst performing quartile of the HAC score i.e. hospitals with HAC score above the 75th percentile (or in top quartile) are subject to reduction in payment by 1%.

3. CONSIDERATIONS FOR INDIAN HEALTH INSURANCE INDUSTRY

It can be observed from the provisions of ACA, the citizen or the beneficiary is the central focus of the entire provisions. The insurance industry and health care industry were mandated to work in customer centric framework. US administration is trying to improve the health care results for each segment of their population by widening the insurance network through mandates and incentives in the form of tax concession. The Act also tried to rationalise the existing state sponsored schemes and tried to improve the quality of health care by assessing the health care providers.

The Health Care sector in India is at an infancy stage as compared to the World's biggest economies such as the USA. The IRDAI Annual Report 2013-14 shows the USA's insurance penetration as 7.5% (3.2% in Life and 4.3% in Non-Life Sector) and insurance density (in US $) is $3,979 ($1,684 in Life and $2,296 in Non-Life Sector). In contrast to above, the India's insurance penetration is 3.9% (3.1 % in Life and 0.8% in Non-Life Sector) and insurance density (in US $) is $52 ($41 in Life and $11 in Non-Life Sector), therefore reflecting the high side uninsured population in India or nascent health insurance penetration in India

Governments in India have also introduced various schemes to provide financial security for their population belonging to both organised sector and unorganised sector. In the organised sector the government employees are covered for health care expenditure through schemes such as Central Government Health Scheme (CGHS), Employees State Insurance Scheme (ESI), Railway Hospitals for Railway employees. Also, many employers (private, state/central government) offer group health insurance coverage to their employees and in most cases to their family members through group products in the insurance market.
For the unorganised and vulnerable segments various government schemes were floated.
Some of the examples of such Government Sponsored Health Insurance Schemes are 'Rashtriya Swasthya Bima Yojana (RSBY), Aam Aadmi Bima Yojana (AABY), Janashree Bima Yojana (JBY), Artisan Weaver, Swaayam Mahila Suraksha Yojana, Biju Krushak kalian Yojana, Sericulture Scheme, Ministry of Road Transport & Highways Scheme, Swarnajayanti Arogya Bima Yojana etc.

Among the schemes mentioned above, the ESI Scheme, a Social Security Schemes, is a self financing health insurance scheme. Contributions are raised from covered employees and their employers as a fixed percentage of wages. As of now, covered employees contribute 1.75% of the wages, whereas, the employers contribute 4.75% of the wages, payable to their employees. Employees earning upto Rs.100/- a day are exempted from payment of their share of contribution. The State Governments, as per provisions of the Act, contribute 1/8th of the expenditure of medical benefit within a per capita ceiling of Rs. 1500/- per Insured Person per annum. Any additional expenditure incurred by the State Governments, over and above the ceiling and not falling within the shareable pool, is borne by the State Governments concerned. The scheme covered 19.5 million families as on 31st March 2014 covering beneficiaries to the tune of 75 million population. Though the scheme is big in size in terms of number of beneficiaries, limited literature is available on the performance and initiatives to improve its network and coverage.

This paper mainly looks at the most popular and deeply studied RSBY scheme as the government, insurance companies and health care providers are major contributors for success of this scheme. Also the paper discusses the regulations applicable for health insurers, the mechanism of performance measurement and hospital accreditation of health care providers,

thus providing the scope for examining the application of some of the provisions of ACA to Indian environment.

3.1 Scope for a Standard Health Insurance Scheme:

The RSBY, attempts to empower the consumer, the BPL family, by giving them a choice. The beneficiary has an option to select from any of the networked hospitals, both in the private and public domain, anywhere in the country. The beneficiary is not tied down to a delivery point as in case of almost all the public sponsored social welfare scheme.

Key design features:

1. Public-Private Partnership (PPP): Public and private medical facilities, Third Party Administrators (TPA) and insurers partner with the State Nodal Agencies (SNAs) that set the guidelines, quality standards, and monitors programme implementation.
2. Central-State Government Collaborative Model: While the programme was designed by a department of the central government, the implementation and management is undertaken in collaboration with respective state governments. The premium subsidies are co-financed by the centre and the states, thus ensuring mutual ownership and control.
3. Leveraging of Technology: Since the scheme targeted Below Poverty Line (BPL) families with low literacy levels, paperwork was minimized by using biometric identification that enabled instant enrolment, and control over fraud.
4. Demand-side Financing: The scheme financially empowers the patient through the provision of a value-loaded smartcard that offers cashless access to medical facilities covering almost all procedures. The smartcard can be used at any empanelled hospital in the national network, allowing the convenience of flexibility to the considerable migratory population in the country.
5. Premium Subsidy: The premium is subsidised 100% from government funds, with only a nominal enrolment cost paid by the beneficiary.
6. Setting incentives, and encouraging and leveraging competition at two levels - among hospitals and among insurers- to improve quality of outcomes.
7. Collection, Storage and Maintenance of Data: Data collected from the administration of the scheme is stored and maintained by the Government agency, thereby facilitating future actuarial calculations and market development.

The RSBY prides itself in being built on a ‘Business Model’ which will sustain the scheme. There is an inbuilt financial incentive for the public and private players to do what they ought to do. The Insurance Companies have an incentive to issue as many smart cards as possible because the payment to them is as a multiple of the number of cards issued by them. Similarly, the hospitals are not chasing away the beneficiaries because they get compensated for the treatment given to the beneficiaries. It is indeed a win-win situation for all the players, including the respective Governments because if the Insurance Companies and the hospitals do what they ought to do, the objective of RSBY gets fulfilled.

The RSBY scheme faces some challenges encountered through fraudulent activities in enrolment process, hospitals practices etc. The onus of claims payment lies on the Insurers participating in the scheme and government does not compensate Insurers through any form of high-risk pooling. On the other hand such kinds of schemes in U.S. have scope of government participation in claims payment to hospitals thus leading to shared responsibility.

The RSBY scheme is subject to maximum sum insured in contrast to the actual incurred medical expenses. Similar to the provisions in ACA to promote extended coverage the RSBY

scheme can be extended in providing at least the 'Essential Benefits' with a pattern of regulated cost-sharing by the policyholders through deductibles, co-pays etc.

Like in ACA, this scheme can be expanded to have benefit tiers. Like in ACA, the current level of RSBY can be limited to below poverty population, a slightly better scheme for above poverty line population and a much better scheme for self-employed population. The existing organised workforce health care schemes can also be built into one of the benefit tiers of this proposed expanded scheme, through self-funding by the individual or through some sharing by the government.
The government may also extend the RSBY scheme to the children up to specified age, pregnant women and to all senior citizens without any restriction based on income level, with regulated cost-sharing by the policyholders through deductibles etc.

3.2 Regulations for Health Insurers:

It is observed in the earlier sections that the ACA has provided many restrictions on health insurers operating in US market. In India, the insurance regulator Insurance Regulatory and Development Authority of India (IRDAI) has brought in some mandates on health insurers in the form of "Health Insurance Regulations, 2013" and "Guidelines on Standardisation in Health Insurance".

The regulations mandate the Health Insurers on the following aspects:

- The maximum period of exclusion for pre-existing conditions is 48 months only.
- The period of exclusion for pre-existing condition is portable from one insurer to another insurer.
- Compulsory renewal upto 65yrs of age
- Premium revision can be done on the basis of performance of claims at portfolio level and not at individual policy level
- Restrictions on the method of cumulative bonus operation
- Restriction on the period of Group Health insurance covers
- Standard definitions of certain diseases, procedures and certain regular terms used in Health insurance

These provisions are similar in nature with provisions discussed under ACA. The scope for IRDAI is limited to Health insurance business only, some of the provisions can be considered with the help of government and other stakeholders.

Similar to the ACA, the Indian health insurance provisions may be extended to include 'Essential Benefits' to all health insurance plans, limiting the annual and/or lifetime limits on the coverage, eliminating pre-existing conditions exclusion. Also prohibiting the rating factors based on health status, medical conditions, disability etc. The Indian provisions may standardize the rating factors across the health insurance plans. Like ACA, such provisions are only achievable if the risk is spread over the mass and not just few insured group. Thus to achieve this the Indian Government may mandate a standardised health insurance coverage, with minimum essential benefits and combinations of deductible, co-pay etc, for all to whom any form of state/central sponsored health insurance coverage is not available.
The existence of individuals' 'Health Savings Account' in the US healthcare system and its integration with the health insurance benefits is an illuminating process to manage regulated out-of-pocket healthcare expenses which if implemented in Indian healthcare scenario will be quite feasible and achievable.

3.3 State Incentives to Widen the Health Insurance Umbrella:

In the Budget of 2015, keeping into account the rising costs of medical expenses and to encourage the public to enrol for insurance, the government has increased deductions allowable under Section 80D in respect of Health Insurance Premium for an Individual or HUF. It has been increased from ₹15,000/- to ₹25,000/-. for an Individual or HUF and for senior citizens the same has increased from ₹20,000/- to ₹30,000/-.
Also for senior citizens above 80 years of age will get upto ₹30,000/- deduction under Section 80D towards the aggregate of payment made on account of medical expenses and Health Insurance Premium paid (if any).

To achieve the mass health insurance coverage, the Indian taxation regime can be extended to provide incentives to those who are covered in appropriate health insurance. Further the regime may also levy fees to employers/individuals who can afford but do not take appropriate health insurance.

3.4 Initiatives towards Quality Care:

The **National Accreditation Board for Hospitals & Healthcare Providers (NABH), India** is a constituent board of Quality Council of India (QCI) and an institutional member of the International Society for Quality in Health Care (ISQua). ISQua is an international body which grants approval to Accreditation Bodies in the area of healthcare as mark of equivalence of accreditation program of member countries. India becomes the 12th country to join in this group.
The approval of ISQua authenticates that NABH standards are in consonance with the global benchmarks set by ISQua. Patients are the biggest beneficiary because accreditation results in high quality of care and patient safety. The patients are serviced by credential medical staff. Rights of patients are respected and protected. Patients satisfaction is regularly evaluated. NABH has a panel of trained and qualified assessors for assessment of hospitals.

NABH has 102 Standards, Patient Centered and Organization Centered and 636 objective elements.

- Patient Centered Standards are based on Access, Assessment and Continuity of Care (AAC); Care of Patient (COP); Management of Medication (MOM); Patient Right and Education (PRE) and Hospital Infection Control (HIC).
- Organization Centered Standards are based on Continuous Quality Improvement (CQI); Responsibility of Management (ROM); Facility Management and Safety (FMS); Human Resource Management (HRM) and Information Management System(IMS).

Hospitals willing to be accredited by NABH must ensure the implementation of NABH standards in its organization. The assessment team from NABH checks the implementation of NABH Standards in the organization and the accreditation is for a period of 3 years subject to terms and condition and renewal of accreditation will be provided on review.

The Indian structure of quality care does not extend any direct financial incentives to accredited hospitals. Like in ACA, the government may extend financial incentives to accredited hospitals which are paid through the charges levied on hospitals with below standard quality.

3.5 Initiatives on building up the data:

Electronic Health Records: The Government of India and MoHFW since September 2010 are working towards development of standards for Electronic Health Records. Electronic health

records are a summary of the various electronic medical records that get generated during any clinical encounter. These are pre-defined standards for information exchange that includes images, clinical codes and a minimum data set. Electronic health records can improve care by enabling functions that paper medical records cannot deliver. FICCI has been the nodal agency for coordination of this exercise nominated by the MoHFW.

It may be noted there is a long way to achieve the desired results in this direction.

4. Way Forward

As stated in the earlier paragraphs, the citizen or the customer is the focus of health care regulations or acts. The health insurance has been identified as a major tool in this endeavour. The health insurers are required to work within a framework centred on the customer. The same trend has been observed on examining the most advanced US market and a nascent Indian market.

In this background, it is quite a challenge for health insurance industry to meet the expectations of law makers, the general population and commercial needs. However, this challenge can be met by various measures from all the stakeholders involved in this endeavour as summarised below:

Initiatives required from the Government:

- Co-ordinating mechanism to bring consistency, coherence of various health insurance schemes like Employees' State Insurance Scheme, RSBY and others. This needs a deep study into each scheme and increasing the network base.

- Rationalizing Existing RSBY Scheme:
    - Government participation in claims payment to hospitals thus leading to shared responsibility,
    - Regulated cost-sharing by the policyholders through deductibles, co-pays etc,
    - Extending the scheme to the children up to specified age, pregnant women and to all senior citizens without any restriction based on income level,
    - Quality based payments to Hospitals,
    - Extending the scheme to higher income group in form of Benefit-tiers.
- Financial Planning for Out-Of-Pocket Healthcare Expenses:
    - The Government may develop, encourage and subsidize targeted savings for Health contingencies through regulated individual health savings accounts.
    - The insurance industry may develop innovative product structures integrated with such savings with foremost aim to benefit the Policyholders.
- Development of Healthcare infrastructure and workforce. Launching incentive based programs for hospitals for improving and maintaining international standards in quality of health care. Penalizing hospitals based on poor quality performance.
- Formulating mechanism of sharing the healthcare cost burden by subsidizing the needy through premium subsidies and levying fees on those who can afford but do not take health insurance by choice. Employers can also be given premium subsidies for providing appropriate health coverage to employees. And, developing taxation regime for employers who can afford but do not provide such coverage to employees.

Initiatives required from Insurance Regulator and Industry:

- Expanding the existing insurance market distribution structure by development of a fairly accessible platform for Insurance product comparisons and trade. The health insurance products sold through these markets are to be specially designed and regulated to achieve mass coverage. Tailor-made health insurance products or products for target market can be sold out of such platform thus maintaining the status quo.
- Minimum Essential Benefits and Standardization in Health Insurance Products for the mass coverage:
    - For orderly growth, fair treatment and transparency in the insurance market such health insurance products can be formulated based on minimum essential benefits, limiting annual /lifetime limits and standardised rating factors. Elimination of discrimination based on health/medical status.
- Development of effective ways to promote and regulate the healthcare providers and supervising the medical costs and growth therein.

BIBLOGRAPHY

- Patient Protection and Affordable Care Act
- U.S. Department of Health & Human Services, HHS.gov
- Focus on Health Reform, The Henry J. Kaiser Family Foundation
- The Affordable Care Act: Rating Factor Limitations, Coventry Health Care, Inc
- Patient Protection and Affordable Care Act, Responsible Reform for the Middle Class Democrats.Senate.Gov/Reforms
- Sub-Regulatory Guidance Regarding Age Curves, Geographical Rating Areas and State Reporting, Department Of Health & Human Services, February 25, 2013
- Health, United States, 2014 by U.S. Development of Health and Human Services, Centers for Disease Control and Prevention. National Center for Health Statistics.
- World Bank Indicators
- Medicare and Medicaid, Centers for Medicare & Medicaid Services
- IRDAI, Annual Report, 2013-14
- Rashtriya Swasthya Bima Yojana - Performance trends and Policy recommendations - Working paper
- Recommendations of EMR Standards Committee, constituted by an order of Ministry of Health & Family Welfare, Government of India and coordinated by FICCI on its behalf.