WELLNESS AND PREVENTION:

Impacts of the Affordable Care Act on Small Business Coverage Options

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Healthier Workforce Center for Excellence
University of Iowa College of Public Health

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INTRODUCTION

This report provides an overview of key provisions of the Patient Protection and Affordable Care Act (ACA), signed into law on March 23, 2010, that impact prevention and wellness. The law is being phased in over eight years, with implementation of various elements spanning the time frame. Of course, there has been much uncertainty and many questions about some of the key provisions as they are implemented. Many aspects of the ACA remain fluid. To date, there has been little attention given to individual and employer mandates or options to provide wellness and prevention services or programs.

In a review of Iowa and other states' initiatives for implementing the ACA, the focus for this report was on the fundamentals of individual and employer-offered coverage, the current situation in Iowa, and the implications for small businesses. Finally, a policy strategy is outlined to address the current and anticipated challenges to improved wellness and prevention efforts.

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KEY ELEMENTS OF THE ACA

Health Insurance Exchanges

Under the Patient Protection and Affordable Care Act (ACA) it is required for each state to house an insurance marketplace/exchange. States have the flexibility to choose how the exchange will be operated and its structural foundation. Each state was required to choose among three options on how the exchange will be operated in that state. The three operational structures are a state exchange, a state-federal partnership exchange, and federal exchange. All exchanges, no matter the type, are required to meet the minimum guidelines provided by the ACA and the Department of Health and Human Services (HHS) and offer an individual and a small-group employer exchange.

An exchange is a competitive marketplace for consumers (individuals and small businesses) to shop for health insurance coverage. The marketplace serves as a "one-stop shop" for health insurance, offering consumers multiple affordable options to choose from. All plans offered in the exchange will be certified as qualified health plans (QHP). Enrollment in the exchange is not compulsory – it is voluntary for consumers. The terms "Exchange" and "Marketplace" may be used interchangeably – they both refer to the health insurance exchanges established by the ACA.

Individuals are also assisted through an exchange to acquire federally subsidized premium and cost-sharing assistance available to low- and middle-income individuals to help them afford the costs associated with purchasing and using health insurance.

Exchange Functions

The Affordable Care Act defines minimum and additional exchange functions that are to be provided regardless of the type of exchange.[1]

Minimum Functions Defined in Section 1311(d)(4)

1. Certification, recertification and decertification of plans
2. Operation of a toll-free hotline
3. Maintenance of a website for providing information on plans to current and prospective enrollees
4. Assignment of a price and quality rating to plans
5. Presentation of plan benefit options in a standardized format
6. Provision of information on Medicaid and Children's Health Insurance Program (CHIP) eligibility and determination of eligibility for individuals in these programs
7. Provision of an electronic calculator to determine the actual cost of coverage, taking into account eligibility for premium tax credits and cost-sharing reductions
8. Certification of individuals exempt from the individual responsibility requirement
9. Provision of information on certain individuals identified in Section 1311 (d)(4)(I) to the Treasury Department and to employers
10. Establishment of a Navigator program that provides grants to entities assisting consumers as described in Section 1311(i)

Additional Exchange Functions

1. Presentation of enrollee satisfaction survey results under Section 1311(c)(4)
2. Provision for open enrollment periods under Section 1311(c)(6)
3. Consultation with stakeholders, including tribes, under Section 1311(d)(6)
4. Publication of data on the exchange's administrative costs under Section 1311(d)(7)

Types of Exchanges

State Exchange – States opting for a state-based exchange are responsible for planning and executing all exchange-related activities. State exchanges allow the greatest flexibility for states under the ACA.

State-Federal (Partnership) Exchange – This model allows states to customize the exchange to meet local demands and needs but still receive operational assistance from HHS. States will establish and administer plan management, in-person consumer outreach/assistance, or both of these functions. The federal system will operate all remaining marketplace functions.

Federal Exchange – States may choose or default into an exchange where HHS assumes the role as primary operator and assumes all functions of the marketplace.

Individual Exchange

Individual consumers wanting to purchase health insurance through the individual exchange or apply for public programs will fill out one application that collects information to be used to determine eligibility and show available coverage options and financial assistance. Specific programs the applicant will be screened for are: general qualified health plans (QHPs), Medicaid, State Children's Health Insurance Program, the Basic Health Program, advanced payment of premium tax credits, and cost-sharing reductions.[2] Only eligible consumers will be allowed to purchase in the exchange. To be eligible a consumer:

- Must be a citizen, national, or noncitizen that is lawfully present in the U.S.;
- Must not be incarcerated, other than pending the disposition of charges; and
- Must meet applicable state residency standards.

Essential Health Benefits

The ACA lists 10 categories of services that are required to be covered by insurance plans offered in the individual and small-group markets, both inside and out of the exchanges. These services are known as the essential health benefits (EHBs).

The essential health benefits are:[3]

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

States have flexibility in how coverage plans will address the EHBs. Each state is free to choose a benchmark plan that will serve as guidelines for other plans to follow in regards to covering the EHBs. All plans are required to offer benefits substantially equal to the benefits offered by the benchmark plan. Iowa's benchmark plan is a Wellmark (Blue Cross /Blue Shield) Alliance Select PPO plan.

Benefit Tiers and Cost-Sharing

The ACA requires that all health care insurance plans offered and taking effect on January 1, 2014, must include the essential health benefits. However, there is variation in the level of additional benefits and the cost-share to be paid by the consumer. To aid consumers in understanding and comparing health care coverage, the ACA established four benefit tiers, known generally as "metal" levels of plans: bronze, silver, gold, and platinum. These plans will be offered through the exchange and in the individual and small group markets.

Comparisons of the levels of coverage and cost are found in the following table. All of the four plans provide the essential health benefits.

Benefit Tier	Percent Coverage of the Benefit Costs of the Plan	Out-of Pocket-Limits
Bronze (minimum coverage)	60%	Health Savings Account (HSA) current limits
Silver	70%	HSA current limits
Gold	80%	HSA current limits
Platinum (maximum coverage)	90%	HSA current limits

Co-payments and deductibles are common forms of cost-sharing. Limits on cost-sharing prohibit:[4]

- Any deductible applicable to preventive health services
- Deductibles, in small group plans, that are greater than $2,000 for self-only coverage, or $4,000 for any other coverage in 2014 (annually adjusted thereafter)
- Annual cost-sharing limits that exceed limits specified in the tax code, relating to certain high deductible health plans

Out-of-pocket limits are reduced for those with incomes up to 400% of the federal poverty level (FPL).

Income as Percent of Federal Poverty Level	Out-of-Pocket Limits
100-200%	One-third of the current HSA limits
200-300%	One-half of the current HSA limits
300-400%	Two-thirds of the current HSA limits

The ACA also created a separate catastrophic plan that is required to be offered only in the individual market. Eligibility is limited to people up to age 30 or who are exempt from the mandate to purchase insurance for another reason. Various requirements and limitations apply to this special plan.

If an issuer would like to offer health coverage in a state it must be licensed and in good standing with that state. Issuers of qualified health plans (QHP) must offer at least one QHP in the silver and gold levels of coverage.

ACA IMPACTS ON SMALL BUSINESSES

Changes in policy of any type are often felt more acutely by small businesses than by larger corporations. "Small business" is defined differently by government agencies, researchers, or public understanding. The U.S. Small Business Administration defines manufacturers with between 500 and 1,500 employees as small businesses. The Affordable Care Act definitions of small business are much different as they apply to various requirements of the ACA; careful study of provisions is recommended to determine whether and how certain provisions apply to any particular business.

The Small Business Health Options Program (SHOP) Exchange or SHOP Marketplace provides similar plan comparison options for businesses that employ 50 or fewer full-time equivalent (FTE) employees, including part-time employees. Other FTE requirements apply to other elements of the ACA.

Grandfathered Plans

Employer-sponsored health plans that were in place before March 23, 2010, can be grandfathered plans. This applies to employers of all sizes, including small businesses. It means that any employer that wants to continue its current, non-ACA compliant health insurance plan has the ability to do so for the time that the insurer continues to offer that plan. These grandfathered plans are subject to fewer requirements and may not cover services such as:

1. Preventive services without cost-sharing
2. Essential Health Benefits
3. Internal and external appeals process for contesting coverage decisions
4. Allow direct access to an OB/GYN without referral

Grandfathered plans are required to comply with a number of requirements of the ACA, and these changes do not disqualify a plan from its grandfathered status. Many of these provisions of the ACA took effect or are being phased in prior to January 1, 2014, when ACA-compliant plans will be offered on the exchanges and in the private market. Some of those key requirements include:

1. Provide policyholders with a uniform explanation of coverage.
2. Report medical loss ratios and provide premium rebates if medical loss ratios are not met.
3. Prohibit lifetime and annual limits on Essential Health Benefits.
4. Extend dependent coverage to age 26.
5. Prohibit health plan rescissions.
6. Prohibit waiting periods greater than 90 days.
7. Prohibit coverage exclusions for pre-existing health conditions.

Grandfathered plans that undergo significant changes, such as changes in level of employee premium cost-sharing and reducing level of benefits, will no longer be considered a grandfathered plan and will be required to abide by the non-grandfathered plan standards set by the ACA.[5]

Broad Changes to Health Insurance Purchased by Small Businesses

A number of changes are taking place for the small business that offers new ACA-compliant (non-grandfathered) health care coverage for its employees.

1. Costs – In 2014, premium rating based on health status is prohibited for non-grandfathered plans. The only reasons premiums can differ in new plans are based on age, tobacco use, policy type (individual or family) and geographic location.
2. Coverage – Non-grandfathered plans are required to include Essential Health Benefits beginning in 2014. No plan, whether grandfathered or not, can impose pre-existing conditions exclusions.
3. Value – Insurance companies offering all plans (non-grandfathered and grandfathered) will be required to report the portion of their income premiums that are used on medical care and quality improvement. If this amount, called the Medical Loss Ratio (MLR), is less than 80%, small businesses and individuals enrolled in the plan will receive a rebate.
4. Comparison – New plans will receive labels (bronze, silver, gold and platinum) which will allow consumers to easily understand the value of the plan.

Small Business Health Options Program (SHOP)

Small employers typically pay more for health insurance than large employers, and businesses with fewer employees are less likely to offer health insurance coverage at all. In Iowa, about 77% of businesses of all sizes offer health insurance. Among businesses with 2-9 employees, about 50% offered insurance to their employees. Cost of coverage is also higher for Iowa small businesses with 2-9 employees, and they experience higher annual premium rate increases than businesses with 50 or more employees.[6] These are among the reasons that the SHOP exchange was developed. The SHOP creates a larger risk pool, creates competition, and increases purchasing power for small employers seeking to provide health insurance coverage for their employees.

Similar to the individual exchange, the Small Business Health Options Program (SHOP) is a new market, where small businesses can purchase health coverage. Generally, beginning January 1, 2014, small employers with 50 or fewer employees can use the SHOP to compare and purchase plans. Most employers with more than 50 FTEs will not be eligible to purchase health coverage through the SHOP exchange in the first two years.

Eligibility for small businesses to use the SHOP exchange will expand gradually. Starting in 2016, employers with 100 or fewer FTE employees will be able to purchase insurance through the SHOP. Beginning in 2017, employers with over 100 employees will be able to purchase coverage in the SHOP.

The insurance plans available for purchase in SHOP will be run by private health insurance companies. Plans offered in the SHOP will present the benefits and costs in plain language, making it easier for employers and their employees to compare plans. It is not required of small businesses to purchase plans through SHOP; they can still purchase plans that are not included in the exchange.[7] Also, it is not mandatory for employers to offer all available plans in the SHOP to their employees. The SHOP must allow employers to limit the selection of plans available to their employees.

To purchase health insurance through a SHOP, employers must submit an application to the SHOP about the company and all employees seeking coverage in a process to determine eligibility, similar to the application process in individual exchanges. A qualified employer meets the state's definition of a small business, and chooses to make, at minimum, all full-time employees eligible for at least one qualified health plan.[8] For this purpose, Iowa defines a small business as 1-50 employees, effective January 1, 2014. [9]

For answers to many questions about details of the SHOP Exchange, see *Key Facts About the Small Business Health Options Program (SHOP) Marketplace* on the Centers for Medicare and Medicaid Services website.[10] Employers with 50 or more employees may find the U.S. Small Business Administration website helpful.[11]

Tax Credits for Small Businesses

Small businesses with fewer than 25 FTE employees may be eligible for tax credits to assist in the cost of health insurance, a provision of the ACA that is particularly aimed at employers with low- and moderate-income workers. To qualify, such businesses must have average annual wages below $50,000 and must pay at least half of the cost of their employees' health insurance. There are two phases to the tax credit.

Phase 1 *(2010-2013)*: Eligible employers receive a tax credit of up to 35% of the employer's contribution toward insurance premiums, calculated on a sliding scale basis tied to average wages and number of employees. Small businesses with tax-exempt status meeting the requirements above may receive 25% of the employer's contribution in the form of tax credits.

Phase 2 *(2014 and onward)*: Eligible employers that purchase insurance through the SHOP may receive a tax credit of up to 50% of the employer's contribution toward insurance premiums. Beginning in 2014, these employers may take the tax credit for up to two consecutive tax years. Tax-exempt small businesses meeting the requirements above may receive 35% of their contribution in the form of tax credits. The exact amount each small business receives in tax credits will depend on the number of employees and average wages.[12]

Grants for Wellness Programs

Small businesses with fewer than 100 employees who work 25 or more hours per week on average and that did not have a workplace wellness program in effect as of March 2010 are eligible for grants to start such programs. The program is under development and information is not expected to be released until 2014.[13]

To qualify for a grant, a business must:

1. Have no more than 100 employees who work 25 hours or more per week,
2. Not have a wellness program, and
3. Use the grant for a comprehensive wellness program.

A comprehensive wellness program:

1. Helps individuals learn more about their health and how to stay healthy.
2. Encourages individuals to participate.
3. Helps individuals change their behavior through counseling, seminars, online programs, and helpful materials.
4. Encourages individuals to eat healthy, get more exercise, and improve their mental health.

Prevention and Wellness Provisions of the ACA

Provisions of the ACA directly related to prevention and wellness have taken a back seat to other discussions and concerns in the media, public, and employers' minds. Yet many expect prevention and wellness initiatives to be significant contributors to improving the health of individuals and the population in aggregate.

Four types of provisions are included as part of the prevention and wellness focus.

1. National strategy to improve the nation's health
2. Coverage of preventive services in health plans
3. Wellness programs
4. Nutrition information provided for vending machine and chain restaurant food

Participatory Wellness Programs

Participatory wellness programs do not require individuals to meet a health factor standard in order to obtain a reward or they do not offer a reward at all. An example of this is a fitness center membership.

Health-Contingent Wellness Programs

Health-contingent wellness programs are nondiscriminatory programs that require individuals to meet a specific standard related to their health to obtain a reward. An example of a health-contingent wellness program is a program that rewards individuals who don't use or decrease their use of tobacco.[14]

Health-contingent wellness programs must be reasonably designed. This means programs cannot be overly burdensome and individuals must have a reasonable chance at achieving better health. Alternative means of achieving the reward must be available to individuals who do not meet the standard based on measurement, test or screening. Reasonable alternative methods to achieve the award must also be available for individuals whose medical condition makes it unreasonably difficult to achieve. Notice of alternative methods to achieving the award must be given to individuals, and the notice must be written in plain language.

The maximum reward an individual can receive in a health-contingent program was increased from 20% to 30% of the cost of health coverage. Programs designed to prevent or reduce tobacco use are allowed to issue at maximum a 50% reward.[15]

Penalties for Large Businesses Not Providing Affordable Coverage

Businesses with more than 50 employees will face penalties if they fail to offer affordable coverage. Businesses with 50 or fewer FTE employees are exempt from these penalties. Penalties will begin in 2015, a year later than originally planned.

Businesses with 51 or more FTE employees will be fined $2,000 per employee (excluding the first 30 employees) if they do not offer coverage for employees who average 30 or more hours per week. There is no penalty for part-time employees not offered coverage.

To avoid penalties, employers must offer insurance that covers at least 60% of the actuarial value (or the bronze level) of the cost of benefits. The coverage must also be affordable to employees, meaning an individual employee's premium cannot exceed 9.5% of their household income.

If coverage offered does not meet the affordability standard, employees may receive tax credits to purchase insurance on their own through the exchange. If this is the case, employers will have to pay $3,000 per employee receiving the tax credit, or pay $2,000 per employee excluding the first 30 workers – whichever amount is less.

The guidance to determine compliance or if penalties will be applicable is somewhat complex, and various resources are available that define "affordable," calculate FTEs, and guide one through other steps to determine a company's status and obligation.

STATUS IN OCTOBER 2013

One Year Extension on Employer Mandate

Businesses with more than 50 employees will now have an additional year to begin providing health insurance to their workers. The mandate requiring large employers to provide insurance has been delayed one year; the mandate will now go into effect January 2015. The Obama administration cited complaints from business groups that additional time was necessary to allow employers to fully understand the complexity of the law, implement the reporting system, and make sure their health insurance meets the new standards.[16]

Final Rules for the ACA

The Centers for Medicare & Medicaid Services (CMS) released its final rules report on July 5, 2013.[17] The report clarifies several provisions in the Affordable Care Act, most of which relate to the Medicaid and CHIP programs. Among many topics the report addresses are:

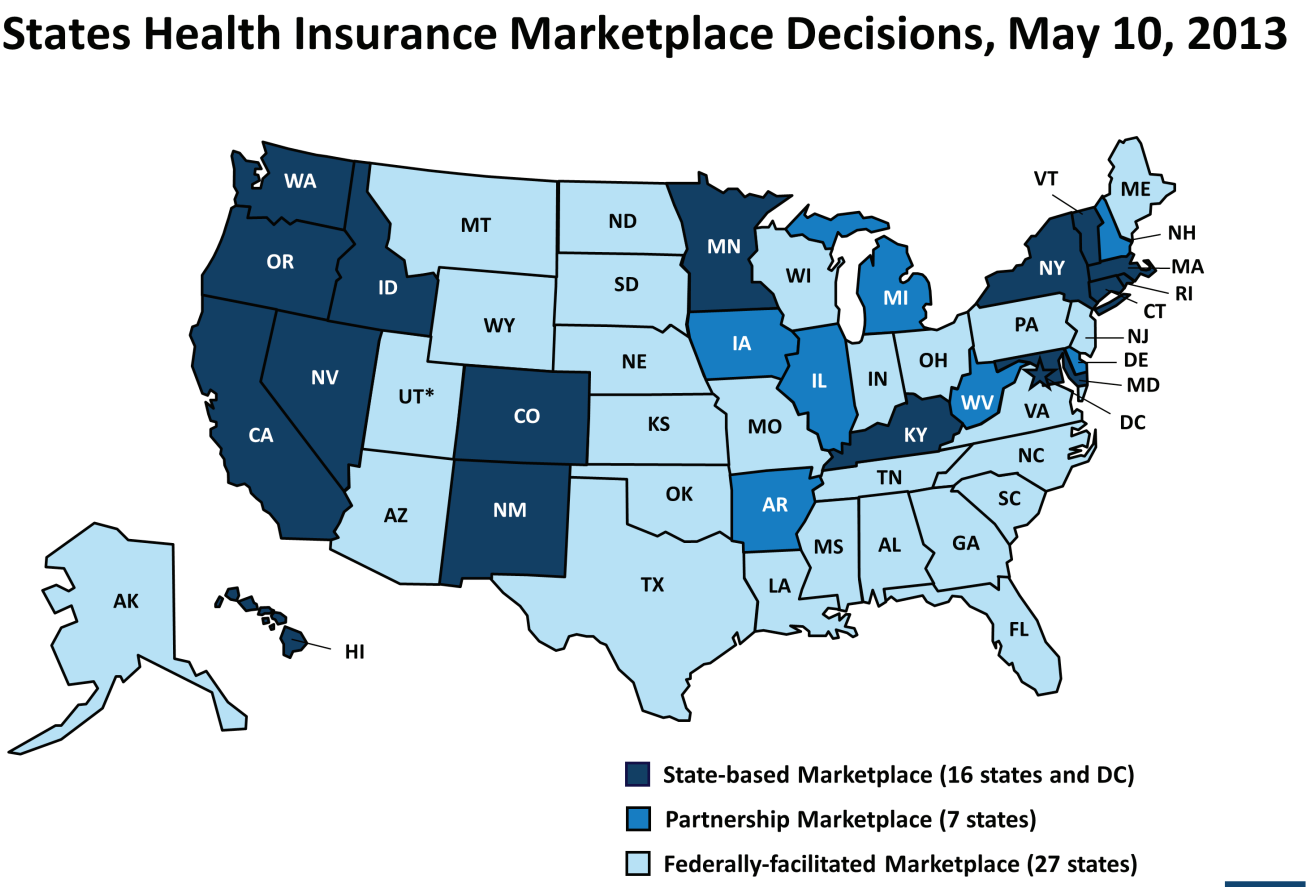
- Authorized representatives
- Notice requirements for state exchanges
- Eligibility redetermination
- Special enrollment periods
- Changes to cost-sharing amount

The final rules released in November 2012 can be found at: http://www.gpo.gov/.

State Decisions on Exchanges: Federal, State-Federal Partnership, or State-Based

Each state was required to choose whether to create their own state exchange, leave the exchange functions to the federal level, or participate in a state-federal partnership. It was expected that most states would choose to establish their own state-based exchange. However, only 18 did so. Seven states are involved in a state-federal partnership, and 26 states chose to participate in the federal exchange. This total includes the District of Columbia.

This map of state decisions is provided by the Henry J. Kaiser Family Foundation and can be found online at http://kff.org/health-reform/slide/state-decisions-for-creating-health-insurance-exchanges/.



* In Utah, the federal government will run the marketplace for individuals while the state will run the small business, or SHOP, marketplace.

State-By-State Status

The Patient Protection and Affordable Care Act is designed to ensure health care is available to all citizens across the country. Though key policy elements are enacted at the federal level, the ACA intentionally provides flexibility to states to develop systems that work best for their populations. In this section, a table is provided with an overview of several key factors indicating a state's approach to implementation of the ACA:

- State's decision on exchange structure: Federal, Federal-State Partnership, or State-based
- Status of U.S. Health and Human Services (HHS) approval of the state's Blueprint Plan

- Identification of a CO-OP Awardee in the state, if any
- State decision on expansion of Medicaid, as of October 22, 2013. Twenty-six states (including the District of Columbia) are moving forward; 25 states are not.
- Number of insurance companies active in the state with 5% or more market share

Note: Highlighted states are states contiguous to Iowa

State	Exchange Decision[i]	HHS Federal Approval Status[ii]	CO-OP Loan Awardee[iii]	Medicaid Expansion[iv]	Number of Insurers with More than 5% Market Share[v]
Alabama	Federal	NA	NA	Not Moving Forward	2
Alaska	Federal	NA	NA	Not Moving Forward	5
Arizona	Federal	NA	Compass Cooperative Health Network	Moving Forward	5
Arkansas	Partnership	Conditional Approval	NA	Moving Forward	3
California	State-based	Conditional Approval	NA	Moving Forward	4
Colorado	State-based	Conditional Approval	Colorado Health Insurance Cooperative, Inc.	Moving Forward	7
Connecticut	State-based	Conditional Approval	HealthyCT	Moving Forward	4
Delaware	Partnership	Conditional Approval	NA	Moving Forward	4
D.C.	State-based	Conditional Approval	NA	Moving Forward	4
Florida	Federal	NA	NA	Not Moving Forward	4
Georgia	Federal	NA	NA	Not Moving Forward	7
Hawaii	State-based	Conditional Approval	NA	Moving Forward	2
Idaho	State-based	Conditional Approval	NA	Not Moving Forward	4

State	Exchange Decision[i]	HHS Federal Approval Status[ii]	CO-OP Loan Awardee[iii]	Medicaid Expansion[iv]	Number of Insurers with More than 5% Market Share[v]
Illinois	Partnership	Conditional Approval	Land of Lincoln Health	Moving Forward	4
Indiana	Federal	NA	NA	Not Moving Forward	3
Iowa	Partnership	Conditional Approval	CoOportunity Health	Moving Forward	2
Kansas	Federal	NA	NA	Not Moving Forward	6
Kentucky	State-based	Conditional Approval	Kentucky Health Care Cooperative	Moving Forward	2
Louisiana	Federal	NA	Louisiana Health Cooperative, INC.	Not Moving Forward	3
Maine	Federal	NA	Maine Community Health Options	Not Moving Forward	3
Maryland	State-based	Conditional Approval	Evergreen Health Cooperative, Inc	Moving Forward	2
Massachusetts	State-based	Conditional Approval	Minuteman Health, Inc	Moving Forward	4
Michigan	Partnership	Conditional Approval	Michigan Consumer's Healthcare CO-OP	Moving Forward	4
Minnesota	State-based	Conditional Approval	NA	Moving Forward	4
Mississippi	Federal	NA	NA	Not Moving Forward	4
Missouri	Federal	NA	NA	Not Moving Forward	5
Montana	Federal	NA	Montana Health Cooperative	Not Moving Forward	3
Nebraska	Federal	NA	CoOportunity Health	Not Moving Forward	3

State	Exchange Decision[i]	HHS Federal Approval Status[ii]	CO-OP Loan Awardee[iii]	Medicaid Expansion[iv]	Number of Insurers with More than 5% Market Share[v]
Nevada	State-based	Conditional Approval	Hospitality Health CO-OP	Moving Forward	4
New Hampshire	Partnership	Conditional Approval	NA	Not Moving Forward	3
New Jersey	Federal	NA	Freelancers CO-OP of New Jersey	Moving Forward	2
New Mexico	State-based	Conditional Approval	New Mexico Health Connections	Moving Forward	2
New York	State-based	Conditional Approval	Freelancers Health Service Corporation	Moving Forward	5
North Carolina	Federal	NA	NA	Not Moving Forward	1
North Dakota	Federal	NA	NA	Moving Forward	2
Ohio	Federal	NA	Coordinated Health Plans of Ohio, Inc	Moving Forward	4
Oklahoma	Federal	NA	NA	Not Moving Forward	3
Oregon	State-based	Conditional Approval	Oregon's Health CO-OP; Freelancers CO-OP of Oregon	Moving Forward	7
Pennsylvania	Federal	NA	NA	Not Moving Forward	5
Rhode Island	State-based	Conditional Approval	NA	Moving Forward	2
South Carolina	Federal	NA	Consumer's Choice Health Insurance Company (CCHIC)	Not Moving Forward	3

State	Exchange Decision[i]	HHS Federal Approval Status[ii]	CO-OP Loan Awardee[iii]	Medicaid Expansion[iv]	Number of Insurers with More than 5% Market Share[v]
South Dakota	Federal	NA	NA	Not Moving Forward	3
Tennessee	Federal	NA	Community Health Alliance Mutual Insurance Company	Not Moving Forward	5
Texas	Federal	NA	NA	Not Moving Forward	5
Utah	State-based	Conditional Approval	Arches Community Health Care	Not Moving Forward	5
Vermont	State-based	Conditional Approval	The Vermont Health CO-OP	Moving Forward	2
Virginia	Federal	NA	NA	Not Moving Forward	2
Washington	State-based	Conditional Approval	NA	Moving Forward	4
West Virginia	Partnership	Conditional Approval	NA	Moving Forward	4
Wisconsin	Federal	NA	Common Ground Healthcare Cooperative	Not Moving Forward	6
Wyoming	Federal	NA	NA	Not Moving Forward	4

[i] http://kff.org/health-reform/state-indicator/state-decisions-for-creating-health-insurance-exchanges-and-expanding-medicaid/

[ii] http://kff.org/health-reform/state-indicator/health-insurance-exchanges/

[iii] http://kff.org/health-reform/state-indicator/co-op-loans/

[iv] http://kff.org/medicaid/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/

[v] http://www.kff.org/healthreform/upload/8242.pdf

A Look at Iowa

According to Iowa Insurance Division, there are more than 244,000 Iowans without insurance. Because about 90% of Iowa's uninsured have incomes below 400% of the federal poverty level, many could receive either Medicaid coverage or some type of subsidized coverage under the Affordable Care Act.

Many who are uninsured and eligible for programs do not enroll because they do not know they are eligible or do not know how to navigate the system. Medicaid and ***hawk-i*** (Iowa's children's health insurance program) will continue, but another program, IowaCare, will end on December 31, 2013.

Iowa chose to deliver individual and SHOP marketplace plans through a state-federal partnership. This means the state will conduct the outreach and assistance function and received a federal grant to establish Navigators to assist Iowans. The state will also accept the responsibility for plan management. Iowa officials chose to participate in the federal exchange, meaning that Iowans have been among those experiencing problems accessing the website to shop for individual or small business plans.

Each state was required to select a benchmark plan. The U.S. Department of Health and Human Services (HHS) determines essential health benefits (EHB) based on state-specific EHB-benchmark plans. Iowa's benchmark plan is a Wellmark PPO Alliance Select plan. A summary of Iowa's benchmark plan can be found at http://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/iowa-ehb-benchmark-plan.pdf.

Only two health insurance companies have more than five percent of the individual insurance market in Iowa, Wellmark and United Health Care. In 2010, Wellmark had 84% of Iowa's individual market and 63% of the small business market share.[18]

Wellmark Not Participating in Iowa's Exchange During 2014

Wellmark Blue Cross and Blue Shield announced it will not participate in the state's health insurance exchange for the first year. The state's main health insurance provider cited concerns over the efficiency of the exchange's implementation and the requirement of offering small business insurance plans in addition to plans for individuals. Wellmark has also announced it will not raise premiums in 2014 for individual and small group plans. However, it has said there may be some increased cost that is attributed to new fees associated with requirements of the ACA that will be passed on to customers, whether individuals or small businesses.

Consumer Oriented and Operated Plan in Iowa

The ACA provides for creation of a Consumer Oriented and Operated Plan (CO-OP) program to help foster competition in the individual and small business marketplace. Plans developed in this new model are nonprofit insurers where profits are used to benefit customers. The CO-OP insurers are directed by the customers. CO-OPs may operate in one or more states and are licensed and regulated like other health insurers. CO-OPs may operate within and outside of the exchange structure. The CO-OP program offered low-interest loans to eligible nonprofits for development of CO-OP plans.

CoOportunity Health received one of the low-interest loans to develop competitive health insurance plans on the individual and SHOP exchanges. The company offers plans in Iowa and Nebraska. CoOportunity Health is participating in the exchange/marketplace in both states.

For more information about Iowa's CO-OP model, see http://www.cooportunityhealth.com/.

Trinity Pioneer ACO

Early in 2012, the Centers for Medicare and Medicaid Services (CMS) awarded one of 32 grants nationwide to Trinity Medical Center in Fort Dodge to undertake development of an Accountable Care Organization (ACO) for its Medicare patients. The partnership includes CMS, Trinity Medical Center, UnityPoint Clinic, Berryhill Center, and UnityPoint at Home. The partnership is known as Trinity Pioneer ACO. Serving an eight-county area, Trinity is the most rural of the 32 Pioneer grants awarded nationwide.

An Accountable Care Organization brings health care providers, clinics, hospitals, and other health care-related services into a voluntary organization to identify ways to provide quality care and utilize practices that improve care and reduce costs.

Pioneer ACOs are tracking their results and will be part of regular reporting. The two-year testing period began January 1, 2012, so there are no findings available yet.

For more about Trinity Pioneer ACO, see https://www.unitypoint.org/fortdodge/aco.aspx.

Iowa Health and Wellness Plan

The Iowa Senate, House of Representatives, and Governor each saw the option for expansion of Medicaid to cover people up to 138% of FPL differently. After prolonged debate, a compromise was reached. A proposal, called the Iowa Health and Wellness Plan, was submitted to the U.S. Department of Health and Human Services for approval.[19] As of October 15, 2013, there have been negotiations but no federal approval of the plan described in this report.

The 2013 Iowa Health and Human Services Appropriations Bill (Senate File 446) expands Iowa's Medicaid program to cover an additional 150,000 Iowans by replacing the IowaCare program with the Iowa Health and Wellness Plan. The federal government will cover 100% of the costs in the first three years, and then gradually reduce its share by 10% over the next decade.

The new Iowa Health and Wellness Plan is a hybrid plan of Governor Branstad's "Healthy Iowa" plan and Medicaid expansion called for in the Affordable Care Act. Under this plan, Iowans living at or below the federal poverty level (currently $11,500 for individuals) will qualify to receive the same health benefits as state employees. These benefits will be paid for by federal Medicaid funds. These benefits represent a change in the benefits provided through Medicaid. By changing to the State Employee Health Benefit Package as a benchmark, Medicaid enrollees will receive a less robust benefit package than in the past.

Iowans living between 100% and 138% of FPL will be able to buy insurance in the state exchange using Medicaid funds to cover premium costs. This Premium Assistance program will also use the State Employee Health Benefit Package as a benchmark. This funding is not guaranteed; to continue receiving benefits, individuals must comply with a list of requirements including wellness check-ups and other preventive measures. Administrators have said they hope the new plan will put the focus on achieving better health outcomes in addition to extending coverage.

Elements consistent across Medicaid and the Iowa Health and Wellness Plan:

- No co-payments, except for $10 for using the emergency room when it is not a medical emergency
- No monthly contributions or premiums in the first year

- No contributions after the first year if the member completes preventive services and/or wellness activities
- Monthly contributions only for adults with incomes greater than 50% of FPL if preventive services/ wellness activities are not completed
- Out-of-pocket costs can never exceed 5% of income

In addition to extending care, the Iowa Health and Wellness Plan also provides structures for creating Accountable Care Organizations and Health Homes.

Massachusetts Health Care Reform and the Small Business Wellness Track

Massachusetts is often mentioned in discussion of the ACA for a very important reason: The statewide health care reform bill that Massachusetts passed in 2006 was the first effort in the nation to require all persons to have health insurance.[20] The law was called *An Act Providing Access to Affordable, Quality, Accountable Health Care*. It mandated individual coverage, established the Massachusetts Health Connector, implemented a tax penalty on individuals for not having health insurance, and implemented tax penalties on employers with more than 10 FTEs for not offering health compliant coverage. The law was amended several times, and many of its requirements have been taken over with enactment and implementation of the federal ACA.

Because Massachusetts provides some experience, it may be useful in predicting the direction of prevention and wellness priorities under the Affordable Care Act. There has been little attention given to prevention and wellness initiatives in implementation of the ACA outside of the provision of preventive health care services without cost to the individual, which is expected to serve as an incentive to receive preventive care. Massachusetts has undertaken a greater focus on prevention and wellness as the initial features of the system were in place.

The Massachusetts Health Connector is operated by the Commonwealth of Massachusetts. Its role is similar to that of the exchange or marketplace under the ACA. The Massachusetts Health Connector offers employers that are members of "Business Express" (a small business group health plan) an option to participate in the Wellness Track.[21] The Wellness Track is a free program that provides tools to promote a healthier workplace, including health trackers and exercise videos. Employers that participate may qualify for a maximum rebate of 15% on their group health insurance premium contribution for coverage purchased in the Connector.

The Health Connector was established in 2007, though the wellness program was not implemented until June 6, 2011. This illustrates the pattern seen in implementation of the ACA, that is, that attention is given to the basics of implementation of systems and services before taking up features focused on prevention and wellness.

Requirements to participate in the Wellness Track as of February 1, 2013, include that a small business:

- Is currently enrolled or is enrolling in a small business group health plan through the Health Connector,
- Purchase health insurance coverage for up to 25 employees, and
- Pay at least 50% of the premium for an individual employee's health plan and at least 33% of the premium toward an employee plan that includes dependents.

To qualify for the maximum rebate of 15% on its group health insurance premium contribution under the Wellness Track, a small business must:[22]

1. Demonstrate an effort to create a healthier work environment.
    a. Employers must implement one of three wellness toolkits: nutrition, physical activity, or stress management.
    b. Distribute toolkit materials to employees. Materials include nutrition programs, walking schedules, tobacco cessation resources, time management worksheets, and more.
2. Promote employee engagement in Wellness Track by incentivizing employees.
    a. Employers must choose between rewarding participating employees by giving them a day off or a health and wellness-related gift card. The cost of gift cards comes out of the employer rebate. A paid day off must be granted prior to the employer receiving the rebate.
    b. Employers must submit information on the Wellness Track website.
3. Show employee participation; at least 33% of employees are required to:
    a. Schedule a preventive care visit and submit a standard encounter form or complete a confidential online health risk assessment.
    b. As an option, an employee may earn an employer-sponsored reward (such as a gift certificate) by completing a preselected activity from a toolkit of activities determined by the employer.

POLICY IMPLICATIONS AND RECOMMENDED STRATEGIES

It is sometimes difficult and daunting to identify reasonable strategies that can impact a policy and program as large and complex as the Patient Protection and Affordable Care Act. It seems as if the "Patient Protection" element of the act is subsumed by the vast scope and span of the law and the shortcuts we use to refer to the law. Yet, with focus, it is possible to define and suggest strategies to improve certain elements of the law's positive impact on individuals – and help achieve the greater goal of a healthier population.

There is much to be learned from the information in this report. First is that much continues to change as time passes, and this may be the most important lesson. The lag in attention to prevention and wellness is a second key factor.

In considering implications and recommendations, several premises – fundamental assumptions – emerge that are relevant to the discussion.

- States have a good deal of flexibility within the parameters of the ACA.
- The complexity of the law results in stakeholder confusion.
- The politicized nature of discussions compounds existing confusion.
- It is inevitable that changes to the ACA will be made over time.
- Stakeholders will address the most pressing issues first, and these issues differ between stakeholders.

Within this set of premises, identifying the desired outcomes is critical. Then stakeholders and their interests must be analyzed. Finally, recommendations can be developed.

Desired Outcomes

Not surprisingly, the outcomes sought concerning small employers will support overall goals of the Patient Protection and Affordable Care Act. For purposes of the Iowa focus on prevention and wellness, small employer options, and improved individual health, the following outcomes are desired.

1. Prevention and wellness programs are commonly offered as part of health insurance plans for small employers.
2. Employees participate voluntarily in prevention and wellness programs.
3. Individuals, regardless of source of health care coverage, demonstrate improved prevention and wellness behaviors.

Stakeholder Analysis

Stakeholders with interests in prevention and wellness associated with the ACA are numerous. For purposes of this discussion and recommended strategies, stakeholders will be addressed in like-minded groups.

Stakeholder groups include:

- Employers with fewer than 100 employees and employer associations
- Individuals and families
- Elected officials and public agency officials
- Private and nonprofit insurers, public insurers, providers, provider groups and systems, and provider associations

Employers with fewer than 100 employees and employer associations are critical stakeholders. Employers of all sizes will be looking for ways to contain or trim their health care costs, and prevention and wellness programs hold promise for cost containment, if not reduction. Employers are the primary focus of prevention and wellness features in the ACA outside those included in the essential health benefits. Employers with fewer than 100 employees are those who are eligible for the wellness grants that will be further outlined in 2014.

Small employers may be particularly interested in prevention and wellness if it is available without requiring additional staff to handle a program or management of an initiative. It will also be more attractive if there is little cost associated with the program.

The SHOP marketplace is available to employers with 50 or fewer employees for two years before that limit increases to 100 for a year, and then opens to all employers. Employers with more than 50 employees are required to offer health insurance coverage and will be penalized if they do not. All employers have a stake in prevention and wellness.

Employer associations, such as trade or professional associations, are natural conduits to employers. Many associations, particularly those directly connected to businesses, have been providing information and advice to their members. The profile of prevention and wellness is very low at this stage of ACA implementation as employers see greater challenges and logistics at the outset. Introducing prevention and

wellness program options to employer associations could be effective as they may provide both education and advice to members.

Individuals and families are certainly the stakeholders where the path ends. They are impacted directly by their health care coverage and employer support for better or worse. Individuals and families are also in control in the one area that is of utmost importance in wellness and prevention efforts – they make the choices about healthy behaviors and follow through for the longer term.

Common chronic diseases such as heart disease, high blood pressure, diabetes, and obesity are often primary areas of focus for prevention and wellness programs. Programs within the workplace can also include injury prevention and safety programs. While focus remains on these types of programs, attention is increasingly deserved on the population that seems "healthy" in comparison to the others. Keeping people healthy and finding those with less-serious conditions means programs must address their interests and abilities to maintain or improve their health.

Requirements under the ACA for Medicare shared savings reimbursement structures, accountable care organizations (ACO), and transformation to a patient-centered medical home model will add impetus toward prevention and wellness efforts before too many more years pass. Patients will soon be directly impacted by practice and payment changes of their providers; they will likely be brought into prevention and wellness programs as part of health care soon after.

Regardless of the systems around individuals and families, personal choice and ability to follow through are fundamental drivers of the success of prevention and wellness initiatives in the workplace or the health care system.

Elected officials and public agency officials establish policy priorities through legislation and regulation, and they oversee program compliance. Local, state, and federal officials are all stakeholders with responsibilities related to their positions within the policy system. In short, these stakeholders make it possible, or not possible, for other stakeholders to impact choice of healthy behaviors through prevention and wellness programs. Within the current implementation of the ACA, prevention and wellness has not yet been elevated to a high priority.

Private and nonprofit insurers, public insurers, providers, provider groups and systems, and provider associations control the health care coverage and services the customers – employers, individuals, and families – receive. Insurers include private and public insurers. Medicare and Medicaid provide a large percentage of Iowans with publicly funded health care coverage.

Medicare provisions impact providers and their organizations and call for shared savings and delivery of services through ACOs. There is little attention paid to prevention and wellness for Medicare beneficiaries other than the preventive services provided at no out-of-pocket cost to the individual.

Medicaid, as a state-run and funded program with significant federal cost-share, is not subject to the same kind of shared-savings provisions as Medicare, but there are common-sense reasons to align some of the service delivery approaches with those of Medicare the sake of efficiency. Iowa is working through a process to develop a Medicaid ACO structure.

Private insurers are making decisions about participating in the ACA exchanges, participation outside the exchange, and their approach to maximizing corporate advantage through this transition period. Most of

the larger insurers are working with health systems and provider networks to develop ACOs as well.

By definition, these activities by public and private insurers bring providers and health systems directly into the position of determining how to manage all of the change in the systems and payers while seeking to maximize their success in the new system. Most share the goals of improving health outcomes for their patients. They see the value in transformation to patient-centered medical home models, and many see the importance of patient compliance with prevention and wellness measures. Providers have the relationships with individuals and are best positioned to ensure continuity of care. Providers are also seeking to align the payment and practice models with those required for Medicare patients and are moving quickly to become part of ACOs.

Provider systems and professional associations, like those in the employer group, are in an excellent position to address the opportunities for improved health outcomes through prevention and wellness programs.

Clearly, nearly every individual and health care-related organization is involved and is a stakeholder in supporting improved healthy behaviors through prevention and wellness programs. Within the complexities of the ACA, focusing on prevention and wellness touches the span of stakeholders, though in a targeted set of strategies.

Recommended Strategies

Recognizing the diversity and sheer numbers of stakeholders, recommended strategies are outlined to make progress toward the outcomes stated above and reiterated here:

1. Prevention and wellness programs are commonly offered as part of health insurance plans for small employers.
2. Employees participate voluntarily in prevention and wellness programs.
3. Individuals, regardless of source of health care coverage, demonstrate improved prevention and wellness behaviors.

The strategies recommended in this section reflect realistic opportunities for the Healthier Workforce Center for Excellence at the University of Iowa College of Public Health in its efforts to support broad implementation of prevention and wellness programs in Iowa. The newly formed Stakeholder Advisory Committee, developed in conjunction with the Center's Total Worker Health initiative, will play a significant role in reviewing and advising around the implementation of recommended strategies.

1. Engage broadly with employer associations, employers, individuals, and the public in practical outreach for information, networking, and planning for employer-based prevention and wellness programs.
2. Establish or partner with other stakeholders to establish a small employer-focused resource to aid small employers in understanding, accessing, and implementing employer-based prevention and wellness programs.
3. Work closely with and engage insurers, health care systems, provider organizations, and provider stakeholders at all levels to ensure policy and practice are supportive of employer-based and other prevention and wellness programs.

4. Work closely with and engage policy and regulatory stakeholders at all levels to ensure policy and practice are supportive of employer-based and other prevention and wellness programs.

The four strategies presented provide a broad approach to bringing prevention and wellness programs to a higher level of awareness, engagement, commitment, and utilization. They encompass all stakeholders at appropriate levels. They bridge interests of different stakeholders around common strategies. Most important, these strategies maintain the individual at the center, with all efforts focused on improved healthy behavior choices for the long term.

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