



Federal Health Reform Provisions Related to Diabetes

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Nearly 26 million Americans live with diabetes. That number more than doubled during the past two decades, and researchers expect diabetes to become even more prevalent in coming years. A recently published study, for example, forecasts that if current trends continue, by 2020 52 percent of American adults will have either diabetes or pre-diabetes.¹ People with chronic diseases, such as diabetes, often encounter uncoordinated care, inadequate information and high health care costs. Diabetes costs in the United States grew swiftly between 2002 and 2007 to more than \$174 billion. Of this amount, \$116 billion was for direct treatment costs, and an estimated \$58 billion was due to lost productivity.



The federal Affordable Care Act (ACA) of 2010 contains provisions that may be of particular interest to people with diabetes and to policymakers who are concerned with diabetes (and other chronic diseases). These provisions include insurance components, diabetes prevention, chronic disease management and standards. Some provisions, such as creating temporary high-risk pools, required immediate federal and state action; other provisions will become effective in 2014 and beyond.

Certain provisions in the law intend to improve the quality of care, increase and improve delivery of preventive services, and ensure that patients receive care that is more efficient. According to health care finance experts, people with diabetes should expect lower health care costs under health reform due to capped annual out-of-pocket spending, no discrimination for preexisting conditions and health status, health insurance exchanges where people select the most appropriate plans, coverage for preventive screenings, and better coordinated care and reduced health disparities.



The State Role: While provisions of the ACA are federal law, most sections described below include or even emphasize the role of state government. In the coming months and years, state legislatures and executive branch agencies can choose to administer or implement certain provisions themselves and apply for grants to fund designated new programs or activities. States also can decide to defer to the federal government to administer certain provisions.

Insurance Components

Preexisting Conditions: Preexisting health conditions are those for which an individual has been diagnosed, received treatment in the past or is currently receiving treatment. Insurance companies consider diabetes a preexisting condition. Each insurer has its own rules and regulations to determine criteria for covering services related to preexisting conditions. Some insurance plans and companies allow complete coverage after a waiting period, while others deny coverage outright. Those with diabetes and other chronic conditions who try to buy insurance in the individual market often are not able to obtain health coverage or are offered coverage at a high cost.



Preexisting condition denials change significantly under the Affordable Care Act. Beginning Sept. 23, 2010, provisions within the law restrict denying coverage to children with preexisting conditions such as diabetes. The act also created a federally funded Pre-Existing Condition Insurance Plan (PCIP). Adults can enroll in high-risk insurance pools that offer insurance to those who have been uninsured for at least the past six months and have had difficulty obtaining coverage because of a preexisting condition. These federally subsidized preexisting condition insurance plans provide an immediate, additional option for those with diagnosed diabetes if they have been refused coverage or cannot afford traditional individual (non-group) health coverage. Policies are sold at not more than 100 percent of standard market rates within each state. Effective Jan. 1, 2011, the federal Department of Health and Human Services (HHS) made available a new category within the federally administered Pre-Existing Condition Insurance Plans to allow families to enroll eligible children at a generally lower child-only premium rate for PCIP beneficiaries from birth to age 18.²

In 2014, insurance companies no longer will be able to deny coverage to adults because of preexisting conditions. People with diabetes will be able to obtain coverage through Health Benefit Exchanges. In addition, insurers cannot drop coverage for individuals who are diagnosed with a new condition or illness.

Lifetime Limits: As of Sept. 23, 2010, insurance plans no longer can set lifetime limits—a dollar limit on what health plans will spend for a person’s covered benefits during the entire time he or she is enrolled in that plan—on policy benefits. The law prohibits insurers in both the individual and group markets from setting lifetime limits and restricts annual limits on essential benefits.³ This provision may apply to some people with diabetes because the “average medical expenditures among people with diagnosed diabetes were 2.3 times higher than what expenditures would be in the absence of diabetes.”⁴

Annual Limits on Coverage: The average total annual health care costs for a person with diabetes as of 2007 were \$11,744,⁵ more than \$4,100 above a typical person’s costs.⁶

Under HHS regulations, plans offered between September 2010 and September 2011 may not limit annual coverage of essential benefits such as hospital, physician and pharmacy benefits to less than \$750,000. The restricted annual limit will be \$1.25 million for plan years starting on or after Sept. 23, 2011, and \$2 million for plan years starting between Sept. 23, 2012, and January 1, 2014.

In February, it was announced that Florida, Massachusetts, New Jersey, Ohio and Tennessee received waivers allowing health insurance companies to continue offering less generous annual limits on benefits. In these cases, existing state law already mandates that policies with lower annual limits on coverage be offered. The Center for Consumer Information and Insurance Oversight (CCIIO), explained that because “limited benefit plans, or mini-med plans, are often the only type of insurance offered to some workers,” the one-year waivers allow continuity.

Beginning Jan. 1, 2014, there no longer will be annual limits on standard health insurance coverage—a dollar limit health plans put on yearly spending for a person’s covered benefits. This will apply to the cost of what the law defines as “essential health benefits,” which include services that each health insurance plan must cover.

Rescission: Beginning Sept. 23, 2010, under the Affordable Care Act, insurers no longer can cancel medical coverage after a policyholder has become sick or injured.⁷ Therefore, coverage for people diagnosed with diabetes or who need treatment for a diabetes-related complication will not be cancelled because they have the disease or related complications.

Increased Costs Based on Health Status: Health insurance companies currently can charge higher premi-

ums for people who have a chronic condition such as diabetes. Under the ACA, beginning in 2014, insurance companies will not be able to charge higher premium rates for those who have diabetes or any other chronic condition.

Preventive Care: As of Sept. 23, 2010, private insurers must guarantee coverage, without requiring copayments or deductibles, for certain health screenings and immunizations. Group health plans and health insurance issuers in the group and individual markets specifically must provide coverage under new or renewed policies that are not grandfathered for preventive health services that are evidence-based items or services that have a rating of “A” or “B” from the U.S. Preventive Services Task Force (USPSTF).⁸ The USPSTF recommends screening for type 2 diabetes in certain circumstances.⁹ Starting Jan. 1, 2011, Medicare also must reimburse for some preventive coverage services. Diabetes screening tests and outpatient self-management training are specifically covered preventive services under Medicare.¹⁰ “This is expected to help curb the increase in type 2 diabetes (79 million Americans have pre-diabetes), thereby reducing health care costs. Currently, about \$116 billion a year is spent in the United States on diabetes treatment.”¹¹

The ACA covers preventive services based on ratings by the U.S. Preventive Services Task Force:

- Preventive services such as diabetes screening are covered only if they have an “A” or “B” recommendation from the USPSTF.
- The USPSTF currently recommends screening for type 2 diabetes only in asymptomatic adults with diagnosed high blood pressure.
- The ACA requirement does not apply to adults with other risk factors such as obesity or a family history of diabetes because USPSTF determined that current evidence is insufficient to recommend it. Medicare has covered this more broadly for the past five years.

Essential Health Benefits Package: Effective beginning in 2014, Qualified Health Plans will be required to cover “essential health benefits” specified by the secretary of HHS. Essential health benefits will include at least the following general categories:

- ambulatory patient services;
- emergency services;
- hospitalization;
- maternity and newborn care;
- mental health and substance use disorder services, including behavioral health treatment;
- prescription drugs;
- rehabilitative and habilitative services and devices;
- laboratory services;
- preventive and wellness and chronic disease management; and
- pediatric services, including oral and vision care.

A number of these general categories apply to diabetes coverage and treatment. The plans will offer essential health benefits packages at bronze, silver, gold or platinum coverage levels, which differ by cost-sharing requirements. Plans cannot impose annual cost-sharing limits that exceed the thresholds applicable to health savings account-qualified high deductible health plans. Small group health plans that provide the essential health benefits package will not be allowed to impose a deductible greater than \$2,000 for self-only coverage or \$4,000 for any other coverage in 2014 (adjusted annually thereafter). Plans that provide the essential health benefits package will not be allowed to apply a deductible to preventive health services, as described earlier.

The ACA requires the secretary of HHS to define and periodically update coverage that provides essential health benefits. The secretary will ensure that the scope of essential health benefits is equal to that of benefits under a typical employer-provided health plan (as certified by the chief actuary of the Centers for Medicare and Medicaid Services). A health plan can provide benefits beyond the essential health benefits defined by the secretary.

Existing State Law Coverage Mandates: As of 2010, laws in 42 states already required most state-regulated insurance to cover treatment for diabetes, including self-management training, supplies and equipment (such as insulin pumps, test strips and meters). Although federal law does not preempt these laws, a new provision—“standard benefit packages” that include policies sold through health benefit exchanges beginning in 2014—may lead to reexamination of or proposed changes in these laws, if any are determined to be beyond the standard package. The definitions have not yet been established by HHS.

Diabetes Prevention

Incentives for Prevention of Chronic Diseases in Medicaid: The secretary of HHS will award state grants for primary prevention activity initiatives to provide incentives to Medicaid beneficiaries who participate in tobacco cessation programs; control or reduce weight; lower cholesterol; lower blood pressure; avoid the onset of diabetes or, in the case of people with diabetes, improve disease management; and address co-morbidities.¹² The act allocated \$100 million to the program for a five-year period.

The secretary will award three-year grants to states beginning Aug. 1, 2011. States that receive grants must conduct outreach and education campaigns to make Medicaid beneficiaries and providers aware of state initiatives under the program. States that receive grants must meet a number of requirements, such as tracking beneficiary participation; evaluating changes in risks, results and overall effectiveness; and establishing standards and targets. To implement the program, states may create partnerships with Medicaid providers, community-based or faith-based organizations, Indian tribes or other entities.¹³

The Prevention and Public Health Fund: The ACA established the Prevention and Public Health Fund to provide \$15 billion to wellness initiatives over the next 10 years. The fund is designed to invest in proven strategies that prevent people from becoming sick, thereby

potentially reducing short- and long-term state budget pressures and costs. The fund will support community-based prevention programs, initiatives to reduce the effects of chronic diseases such as diabetes, and support screenings and other evidence-based health programs. It also will support state, local and community efforts to focus on preventive health initiatives.

Beginning in 2010, for example, states received money from the Prevention and Public Health Fund to support strategies that address current and projected workforce shortages. Twenty-six states received funding to begin comprehensive health care workforce planning or implementation. Six states received funding to develop and evaluate curriculum to train qualified personal and home care aides. Thirty-two entities in 23 states received Health Profession Opportunity Grants to train low-income people in a variety of health care professions.

The ACA also authorized the following initiatives but did not appropriate funding for them.

Healthy Aging, Living Well Grants: Healthy Aging, Living Well grants will be awarded to states, local health departments and Indian tribes to carry out pilot programs. Each five-year pilot program must provide public health community interventions. In addition to community-wide public health interventions, grantees must conduct ongoing health screening to identify risk factors for cardiovascular disease, cancer, stroke and diabetes among residents in both urban and rural areas who are between the ages of 55 and 64. Clinical referrals for individuals who are between the ages of 55 and 64 also are required.¹⁴ Funding amounts are not specified for fiscal years 2010-2014.

National Diabetes Prevention Program: The law also establishes a national diabetes prevention program for adults who are at high risk for diabetes. The secretary of HHS and the director of the Centers for Disease Control and Prevention are authorized to establish this program to help eliminate the preventable burden of diabetes. It would include grants to community or-

ganizations for lifestyle intervention programs to prevent type 2 diabetes. The community-based diabetes prevention program model sites, a program within the CDC, would determine applicant eligibility to deliver community-based diabetes prevention services; training and outreach programs; and evaluation, monitoring and technical assistance. Model site pilot programs have shown promising results, among them reducing the risk of diabetes by 58 percent.^{15, 16} The funding amount is not specified for fiscal years 2010-2014.

Chronic Disease Management

Health Homes for Enrollees with Chronic Conditions: Several diabetes studies focus on the need for coordinated care and care management. Most people with diabetes initially are able to manage their disease. As it progresses, however, they may develop other diseases or conditions, which increase the need for both coordinated care from several physicians and effective disease management. Many states are adopting the “patient-centered medical home” or “health home” model to help patients manage complications or multiple chronic diseases. The model includes a multidisciplinary team, coordinated by a primary care physician or specialist who coordinates and directs appropriate and timely services. The models attempt to reduce overuse and misuse of services so the patient receives better results at a reduced cost.¹⁷ The health reform law requires the secretary of HHS to establish standards that designate providers as eligible health homes.

Independence at Home Demonstration Program:

The ACA created a demonstration program to test a payment incentive and service model that uses physician- or nurse practitioner-directed home-based primary care teams to provide continuous, coordinated and accessible care to high-need groups. The design is expected to reduce expenditures and improve health results by reducing preventable hospitalizations, hospital readmissions and emergency room visits; providing more efficient care; reducing the cost of health care services; and satisfying beneficiaries and family caregivers. Diabetes is included as a chronic illness for which

applicable beneficiaries may receive treatment. These beneficiaries must be served through a qualifying independence at home medical practice, must be entitled to such benefits, must not be enrolled in Medicare Advantage Plan Part C or a PACE program, and must have two or more chronic illnesses. The act allocated \$5 million for each fiscal year from 2010 to 2015.

Standards and Reporting

Catalyst to Better Diabetes Care Act of 2009: The Catalyst to Better Diabetes Care Act of 2009, a section of the ACA, requires the secretary of HHS to prepare a biennial national diabetes report card for each state. The report cards must be publicly available on the Internet. States must include aggregate health results related to those diagnosed with diabetes and pre-diabetes, including preventive care practices and quality of care, risk factors and results. The federal government must conduct a national trend analysis to track progress, and inform policy and program development. “The secretary will promote education and training of physicians on the importance of birth and death certificate data, encourage state adoption of the latest standard revisions of birth and death certificates, and work with states to re-engineer their vital statistics systems.”¹⁸ Improved death certificate reporting could help track information about diabetes-related deaths.

The secretary also must consider the appropriate level of diabetes medical education. In collaboration with numerous organizations and federal agencies, the secretary will conduct a study of the effect of diabetes on the practice of medicine in the United States. The group also must study the appropriate level of diabetes medical education that should be required before licensure and board certification and recertification.

Ensuring Quality of Care: The ACA requires the secretary of HHS, in consultation with experts in health care quality, to develop national priorities on quality, standardize quality measurement and reporting, invest in patient safety, and reward providers for high-quality care. These provisions may help provide better infor-

mation to those with diabetes to support their health care choices and give physicians incentives to provide all patients with high-quality, effective and efficient care.

Notes

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3. Congressional Research Service, *Private Health Insurance Provisions in PPACA (P.L. 111-148)* (Washington, D.C.: CRS, Feb. 15, 2010); http://bingaman.senate.gov/policy/crs_privhins.pdf.

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9. The USPSTF recommends screening for type 2 diabetes in asymptomatic adults with sustained blood pressure (either treated or untreated) greater than 135/80 mm Hg. B.

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About This NCSL Project

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