NC Get Covered
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NC GET COVERED BRIEFING
August 17, 2015

NC Get Covered is continuing its monthly briefings with the goal of bringing to its coalition partners state-specific information on the ACA, as well as national policies and trends that may have an impact on the following topics:

Medicaid Coverage Gap
- State Scorecard

Insurance Carriers
- Premiums
- Competition

Consumers
- Tax Issues
- Network Adequacy

State & Federal Marketplaces
- Agents & Brokers

Employers
- ACA's impact on Employers

MEDICAID COVERAGE GAP

Republican governors continue to press forward to expand Medicaid even after being blocked by lawmakers in their own party.

Alaska will become the 30th state to expand Medicaid. Gov. Bill Walker, a first-term independent, used his authority under state law to accept the expansion. "I did it unilaterally because it was the right thing to do," Walker said in an interview.

Utah's Gary Herbert plans to meet with legislative leaders and hopes to call a special session in September to pass what he's calling an alternative to Medicaid expansion. Herbert's proposal requires a Medicaid waiver from CMS officials for elements designed to appeal to Republicans, such as having applicants get job training. "I'm optimistic," Herbert said in an interview. "I think our approach is better than traditional government-assistance Medicaid."

Last year **Georgia** lawmakers blocked the governor from expanding Medicaid without their approval. A provision tucked into this year's budget, though, allows the state to pursue a waiver. Georgia Gov. Nathan Deal, who declined to act so far, may seek a federal waiver to make insurance available to more residents.

Wyoming Gov. Matthew Mead called his expansion effort "a colossal failure." Still, he hopes to bring it back in February's budget session or in 2017. "It's going to take some time and continued work by all of us to eventually get to that point," Mead said.

Louisiana Gov. Bobby Jindal has been an adamant opponent of the ACA, but he leaves office at year-end. Republicans running to replace him have all expressed support for expansion in some form. Louisiana's Republican legislature also opened a legal door when it passed a provision requiring hospitals to pay the state's share of expansion.

Kentucky's Gov. Steve Beshear, spoke at the recent National Governors' Association meeting and urged his colleagues to consider expansion, citing the "boon" it has been for his state. "I know a lot of legislatures have trouble just because of the name of the act," Beshear said. "If you can get past that kind of politics, this is a win-win for both your people and your economy."

Arizona Gov. Doug Ducey plans to ask the federal government to approve major changes to the state's Medicaid insurance plan, for those who gained coverage through the state's expansion of Medicaid.

The Governor is proposing to:

1. Charge what are being called "strategic co-pays" on services that are considered a poor use of the system, like unneeded emergency room visits, missed medical appointments, or seeing a specialist without a referral. The total cost of the copays will be capped at 3 percent of household income and collected by the state Medicaid office, not healthcare providers.

2. Require Medicaid recipients to pay 2 percent of their income into a health savings account (HSA), which could only be tapped for non-covered services like eyeglasses or dental work if the individual meets at least one "wellness incentive" (See below). The HSA reverts to the individual once they leave the Medicaid program, so as to initially help the individual pay for premiums, deductibles and co-pays in the private insurance market.

   The goal of the HSA is to encourage, as opposed to discourage, people to get better jobs with higher wages. While they may lose their Medicaid eligibility, the HSA will transition the person to pay the subsidized insurance on the Marketplace.

   Should a person not pay into the HSA, one of two things may occur. For those persons with incomes above 100% FPL, they would be dropped from the program for six months. For those persons with incomes below 100% FPL, the money owed would be considered a debt to the state and potentially collected through the Department of Revenue.

3. Establish wellness incentives that are similar to those offered by employer-provided health plans and may include smoking cessation programs, annual checkups, annual flu shots, or other markers set individually or by private Medicaid plan providers.

4. Have recipients participate in a work search program or attend school, if unemployed; be actively looking for work; and use programs designed to help people find jobs, such as resume writing. An able-bodied adult could no longer use the AHCCCS program after a total of five years of coverage.

HEALTH INSURANCE CARRIERS

Premiums

Some health policy analysts, who have looked at health insurers' proposed premiums for next year, predict major increases for policies sold on state and federal health exchanges. Others say it's too soon to tell. One thing is clear: There's a battle brewing behind the scenes to keep plans affordable for consumers.

In a letter sent to insurance commissioners in every state, Kevin Counihan, the director of the federal health exchange, urged states to take a closer look at rate requests before granting them and consider a range of factors before making their decisions. In the letter he states:

- Recent claims data is showing that Marketplace enrollees are healthier;
- The federal tax penalty for going without insurance will increase in 2016 and should motivate a new segment of the uninsured to enroll, e.g. those who may not have a high need for immediate healthcare services;
- Much of the pent-up demand for health care has been met because consumers who enrolled last year have received treatments they could not obtain when they were uninsured; and
- Health care costs are not growing as fast as some had predicted, "even accounting for rapid growth in pharmaceutical costs."

Several recent studies bolster Counihan's case. An analysis of proposed rates by the consulting firm Avalere Health found that for a 50-year old non-smoker, premiums for the lowest-cost silver plan will rise by an average of 4.5 percent in the eight states they studied. Average premiums for the second-lowest silver plan will rise by only 1 percent. A separate analysis by the Kaiser Family Foundation found similar results: Increases should average about 4.4 percent for the two least expensive silver plans in the 10 major cities it studied.

Both analyses, however, warn that consumers may only be able to avoid increases by changing insurers. "In these markets, consumers will need to balance continuity of care with lower monthly premiums when comparing their health insurance options," said Avalere Senior Vice President Caroline Pearson.

Challenging the premise of these two studies is the fact that in approving final 2016 rates, the **Oregon** Insurance Division required some of the state's carriers to increase their rates. **Tennessee**'s state insurance commissioner also suggested that a requested average increase of 32.6 percent by Community Health Alliance might not be sufficient to make the nonprofit co-op financially sustainable.

Competition

A recently published DHHS report based on findings from a study of 35 states with a Federally-Facilitated Marketplace (FFM) indicates that most people who bought insurance through the FFM had a greater choice of health plans in 2015 than in 2014, and that premiums rose less in counties where more insurers were competing for business.

The report also states that 86 percent of eligible consumers had a choice of at least three insurers in the marketplace in 2015, up from 70 percent in 2014. In addition, benchmark premiums in 2015 were 9 percent lower in counties with three or more insurers than in places with just one or two. Fifty-nine percent of counties had an increase in the number of insurers offering health plans through the

marketplace this year, and 8 percent had a decrease. In the remaining counties, the number of insurers did not change.

For North Carolina:

- 63% of the state's population lived in a county where there were 3 carriers
- 8.8% of the population lived in a county where there was only 1 carrier
- 77 of the state's 100 counties had a net increase of 1 insurer offering plans on the FFM; those counties that did not experience a net increase were mainly in eastern North Carolina

FEDERAL and STATE MARKETPLACES

Role of Agents

According to the 2015 Kaiser Foundation Survey of Health Insurance Marketplace Assister Programs and Brokers, 60% of brokers helped up to 50 marketplace consumers during the 2015 ACA open enrollment period, while 20% of brokers helped more than 100. Brokers also reported a high degree of client continuity from the first year of open enrollment compared to assister programs, indicating they may be establishing more ongoing relationships with their clients than assister programs have been able to do so far. The survey also noted that brokers may be privy to information from insurance carriers outside of open enrollment that navigators and assisters may not. This provides brokers the opportunity to help clients prepare for changes to open enrollment before it even begins.

But, compared to assister programs, brokers were less likely to engage in outreach and public education activities (33% vs 80%) and less likely to help consumers appeal marketplace eligibility decisions (39% vs 58%), the survey found.

Both assister programs and brokers stated they would like to receive additional training on a range of topics, including tax-related issues, marketplace appeals, renewal procedures, Medicare, and Medicaid. And, similar to assister programs, brokers reported that the technical assistance from marketplace call centers was often inconsistent or ineffective.

CONSUMERS

Tax Issues

According to the IRS, about 7.5 million Americans paid an average penalty of $200 for not having health insurance in 2014. Unfortunately, approximately 300,000 of these taxpayers were eligible for, and should have claimed, an exemption. The IRS is sending letters to these taxpayers telling them they have three years to file an amended tax return.

For the 2015 tax year, the penalty increases to $325 per individual, with a maximum of $975 per household. The percentage-of-income penalty doubles to 2%, up to a maximum of about $12,850 per household. The Tax Policy Center has posted an ACA penalty calculator on its website.

Perhaps of more immediate concern is that in mid-July, the IRS began contacting some 1.6 million Federal Marketplace enrollees that had yet to resolve 2014 tax issues. According to the IRS:

- 710,000 Marketplace enrollees had not filed their tax return for 2014, as of May 31.
- 360,000 Marketplace enrollees have asked for an extension, so as to file their taxes by October 15, which is the final deadline for all 2014 tax filers—ACA or not.

- 760,000 Marketplace enrollees did not reconcile their APTC by filing form 8692 with their tax return.

The concern is that these 1.6 million enrollees may fail to file or reconcile their taxes for 2014, before the Marketplace Exchanges determine their eligibility for 2016 subsidies. If that were to occur, these 2015 enrollees may be automatically re-enrolled for coverage in 2016, but without premium subsidies or cost sharing reductions.

The Department of Health and Human Services plans an outreach campaign in the fall, coordinated with the start of the 2016 sign-up season on Nov. 1. However, that will be two weeks past the October 15, 2015 deadline to file tax returns for 2014.

Network Adequacy

Earlier this year, the Centers for Medicare & Medicaid Services (CMS) issued a letter to carriers establishing requirements for 2016 plans sold on the federal marketplaces this November. One of the requirements concerns “reasonable access” standards for provider network adequacy and the submission of detailed network provider data, including information on physicians, facilities and pharmacies.

As the start of OEP3 approaches, policy analysts are anticipating CMS will be reviewing network-adequacy and focusing on hospital systems, mental health providers, oncology providers, and primary care providers; and expecting that CMS will notify insurers when it sees problems with networks during the review process.

At the same time, CMS said it planned to evaluate recommendations from the National Association of Insurance Commissioners (NAIC) on network adequacy as the basis for future requirements for marketplace insurers. Over the past 10 months, the NAIC has been working on a draft model law to update its Network Adequacy Model Act that serves as a template to assist federal and state lawmakers and regulators in drafting insurance laws and regulations. The current version was adopted in 1996 and needs to be updated to address recent changes in the insurance marketplace, such as the extensive use of narrow networks by ACA marketplace plans.

As of early August, several NAIC committees were continuing to work on adopting the new model law. The goal is to review and adopt the model law during the NAIC’s December meetings, which would allow states to review and potentially adopt it in 2016, for implementation during the 2017 plan year.

EMPLOYERS

ACA, No Effect on Full Time Employment

The Affordable Care Act hasn't meant less time on the job for American workers, according to three recently published studies that challenge one of the main arguments raised by critics of the ACA.

The employer mandate took effect this year and requires businesses with more than 50 employees to offer health insurance to those working at least 30 hours a week. Various policymakers worried that employers would look for ways to get around the mandate, either by giving their employees fewer than 30 hours or by hiring fewer people.

So far, researchers say employers have not changed how they hire and schedule their workers in response to the law.

Analysts at ADP studied the payrolls of the firms' clients, about 75,000 U.S. firms and organizations. They expected that as businesses prepared for the mandate to take effect, they would adjust their employees' schedules, limiting them to no more than 30 hours a week. Yet ADP found no overall change in employees' weekly schedules between 2013 and last year. According to ADP's analysis, shifts in scheduling were trivial in every sector of the economy, even in industries that rely heavily on part-time work, such as leisure and hospitality.

ADP's findings were confirmed in another study by Aparna Mathur and Sita Nataraj Slavov of George Mason University and Michael Strain of the conservative American Enterprise Institute. Their paper, published this month in the journal Applied Economics Letters, uses data from the federal Current Population Survey and finds no statistically significant change in the proportion of part-time workers in the sectors most likely to be affected by Obamacare, such as janitorial and restaurant work.

The study, like ADP's analysis, only uses data from before the mandate took effect, on the assumption that employers would begin adjusting their workers' schedules beforehand. Yet Strain said that firms might still reduce their employees' hours in the future once they discover the cost of providing health care.

"There's still a big open question about whether the employer mandate will increase part-time work," said Strain, an opponent of the ACA. "That question has not been settled. Our paper provides evidence that that shift hasn't happened yet."

Bowen Garrett, an economist at the Urban Institute, disagreed. "It's reasonable to think that if there was going to be a large effect, some of it would have happened in 2014," he said. That was when the main provisions of the law went into effect, and around 15 million people gained health insurance.

Garrett and his colleague Robert Kaestner found that circumstances for workers last year were what you would predict based on overall economic conditions in 2013. In other words, the economy has recovered steadily, and if the ACA has had an effect, it has been too small to measure.

Sources:
The information for this August 17, 2015 NC Get Covered Briefing was drawn from multiple sources, Including:

- Wall Street Journal
- Employee Benefit News
- Modern Health Care
- New York Times
- Washington Post
- Associated Press
- Stateline
- Internal Revenue Service
- Politico
- Internal Revenue Service
- Kaiser Health News
- Utah Health Policy Project
- Los Angeles Times
- Chicago Sun Times
- CMS News
- Bloomberg News
- USA Today
- Healthcare Financial Management Association

Considerable background information was also gathered for this briefing document. For more information, please contact Lee Dixon at LDixon@caresharehealth.org.