NC Get Covered
POWERED BY THE BIG TENT COALITION

NC GET COVERED BRIEFING
July 22, 2015

Previously, NC Get Covered/The Big Tent Coalition reported on actions, programs, policies, guidelines and regulations affecting the implementation of State and Federal Marketplaces and other Affordable Care Act (ACA) initiatives. The information in these reports was gathered from a variety of national and state resources. NC Get Covered is resuming these 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 groups:

Medicaid Coverage Gap
- Coverage Gap
- State Scorecard

Insurance Carriers
- Mergers
- Risk Adjustment
- Agents & Brokers

Consumers
- Narrow Networks
- Pre-Medicare Retirees

Employers
- "Cadillac Tax"
- IRS Webinar Series on ACA Provision

MEDICAID COVERAGE GAP

"With the King decision behind us, the drumbeats for Medicaid expansion are increasing," said Matt Salo, executive director of the National Association of Medicaid Directors. "There is movement in every state. They'll get there. Maybe not today and maybe not this year, but they'll get there soon."

However, states with the most to gain have proven to have the strongest objections to accepting federal funding to provide health care for their poorest residents.

Under the ACA, the federal government pays the full price for covering newly eligible Medigap adults with incomes up to 138 percent of the federal poverty level ($16,243 for an individual) through 2016 and then gradually lowers its share to 90 percent in 2020.

A recent report sponsored by the Robert Wood Johnson Foundation (RWJF), which advocates for health care, touted budget savings for eight regionally and demographically diverse expansion states—**Arkansas, Colorado, Kentucky, Michigan, New Mexico, Oregon, Washington** and **West Virginia**.

In general, GOP-led states—**Arkansas, Indiana** and **Iowa**—have sought federal approval for a combination of rule changes that allow Medicaid enrollees to purchase private policies on an exchange, while requiring them to engage in "personal responsibility," such as paying copayments and premiums, engaging in healthy behaviors, seeking employment.

For more information on the private option, see RWJF's report: ***Medicaid Expansion, the Private Option and Personal Responsibility Requirements: The use of Section 1115 Waivers to Implement Medicaid Expansion Under the ACA May 2015.***

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The Scorecard of State Activity

1. **Arkansas—**Implementing a Coverage Gap waiver with a private option to purchase insurance off the Marketplace.
2. **Iowa—**Implementing a Coverage Gap waiver with a private option purchase insurance off the Marketplace.
3. **Michigan**—Implementing a Coverage Gap waiver.
4. **New Hampshire**—Implementing a Coverage Gap waiver.
5. **Indiana**--Implementing a Coverage Gap waiver
    a. Instead of premiums, the Healthy Indiana Plan requires patients to contribute to a health savings account used for their medical expenses. Monthly contributions, based on income, range from $1 to $27.
    b. If patients make the contributions, medical care is essentially free. People can even lower their contributions by getting recommended preventive care, such as cancer screenings.
    c. If patients don't contribute, they lose dental and vision coverage and must pay up to $8 to see a doctor or fill a prescription.
6. **Pennsylvania—**Implementing expansion, after having adopted a Coverage Gap waiver.
7. **Alaska**—Governor to meet with HHS week of July 20 to discuss Alaska's Coverage Gap proposal for implementation this fall.
8. **Montana—**Proposed a Coverage Gap waiver. The 60-day public comment period began July 7. Scheduled submission to HHS in early September.
    a. According to Governor Bullock, The Health and Economic Livelihood Partnership (HELP) Act will create jobs by bringing our tax dollars back from the federal government to extend health coverage, allow Montanans to access health care coverage, while "throwing a lifeline to Montana's rural hospitals."
    b. Both of the following caveats came from Republican lawmakers who wanted the working poor to pay even a small amount so Medicaid wouldn't be a total freebie and that business, not government, would manage Medicaid's growth.
        - Low-income participants will pay premiums equal to 2 percent of their personal income.
        - In addition, Montana is requiring a third party contractor to administer the program.
9. **Utah**—Governor Gary Herbert and a working group of GOP legislative leaders hope to pitch a compromise plan when the 2016 Legislature opens in January.
10. **Tennessee**—Debate on a waiver has stalled.
11. **Louisiana**—The Legislature has enacted legislation giving the next Governor (January 2016) the ability to expand the Medicaid program. The Gubernatorial candidates in both parties have indicated their interest in doing so. State's hospitals have agreed to pay for the state's costs.
12. **Arizona**—Threat to the state's already implemented expansion. Republican legislators brought suit against the legislation, which passed on a simple majority. Basis for the suit is: The state's portion of the expansion is being funded by fees on hospitals. The suit claims these fees are really a tax on hospitals. Enacting a tax in Arizona requires a "super-majority" in the chamber of the legislature.

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INSURANCE CARRIERS

Mergers

Aetna Insurance's announcement to purchase Humana Insurance is said to mark the first round as the industry races to bulk up in a market reshaped by the ACA. The health law was "an action-forcing event that has catalyzed a lot of very important discussions," said Aetna CEO Mark Bertolini..

Humana CEO Bruce Broussard flagged changes in the health care system that are often tied to the law, including an increasing focus on selling to individuals rather than employers. The result is millions of potential new customers, though reaching them has required insurers to pivot by offering more choices and lower-cost plans. The law also helped prod a movement away from paying doctors and hospitals a fee for each service, and toward reimbursement methods meant to reward more efficient care.

One primary reason for the latest merger activity is the companies' need to have more clout in local markets so they can negotiate better deals with local hospitals and doctors. Across the bargaining table are increasingly powerful local health systems that have been consolidating to become more efficient and to gain more say about the price of care and the networks they will join. "What it all comes down to is the relative market share between plans and the hospitals," said Len Nichols, a health economist at George Mason University.

In eight states, the Aetna-Humana merger would remove a competitor from the exchanges where individuals can buy coverage under the Affordable Care Act, though insurers may not offer plans in every region of a state.

Risk Adjustment

As part of the ACA's plan to protect against adverse selection and protect insurers from excessive losses that could come from a disproportionate share of consumers with high medical costs, money is transferred between plans with relatively lower-risk enrollees to plans with relatively higher-risk enrollees.

An insurance carrier's claims are eligible for reinsurance funds if an enrollee buys an ACA-compliant plan and the person's costs exceed $45,000 but are less than $250,000. In this instance, the federal government pays a sizable portion of those costs back to the insurer. Previously, CMS was going to pay 80% of those costs. However, CMS announced in late June that it was increasing that payment to 100%, meaning insurers will be fully covered for any of those high-cost claims from 2014, the first year ACA plans went into effect.

"The early results for the risk adjustment and reinsurance premium stabilization programs demonstrate that these programs are working as intended, which will help keep premiums stable and encourage insurance companies to compete on quality and price, not who can attract the healthiest enrollees," said Kevin Counihan, CEO of the Health Insurance Marketplaces.

Agents and Brokers

CMS estimates that more than 77,000 brokers and agents assisted with enrollments on the federally-facilitated marketplace (FFM) during the second year of open enrollment, up 46% from the year prior.

In order to serve as facilitators to enrollment, CMS requires agents and brokers to register with the federally-facilitated marketplace, complete a training course covering eligibility and enrollment criteria for assisting with qualified health plan enrollment, and sign an agreement that formalizes the

agents/brokers understanding and commitment to adhere to the rules of the program. These rules apply to the FFM, which CMS oversees. State-based marketplaces follow their own set of rules.

In February, at a National Association of Health Underwriters conference, Kevin Counihan, CEO of the FFM, said that "the broker is integral … as integral as it can be in the sale and distribution of our product." But he added, "that does not mean the role of the broker doesn't evolve" and said the Department of Health and Human Services needs to provide more tools for brokers, such as a helpline during open enrollment. "That's something we're investigating right now." A change will also be made on Healthcare.gov to better connect consumers with local brokers. However, details are not yet available.

CONSUMERS

Narrow Networks

A recent report by Avalere Health indicates that Federal Marketplace had access to one-third fewer doctors and hospitals, on average, than people with traditional employer-provided coverage, according to an analysis released Wednesday.

The analysis is based on data from the largest rating region in each of the top five ACA Marketplace states—California, Florida, Georgia, North Carolina, and Texas. Avalere Health stated that the study provides a statistical basis for previously anecdotal reports from consumers and others about the more limited doctor and hospital choices in plans offered on marketplaces created by the ACA.

In these "narrow networks," health plans negotiate contracts with a select number of providers who agree to be reimbursed at lower rates. That means the insurers can set their premiums lower, at least theoretically. But, depending on the plan's design, consumers typically pay more, and sometimes much more, if they use a doctor or hospital outside the network.

The report underscores the importance of consumers knowing whether particular doctors or hospitals are included in their plans' networks. Some plans, such as HMOs, don't permit out-of-network coverage.

A poll last year by the Kaiser Family Foundation found that the people most likely to buy coverage on the insurance marketplaces were more willing than the public at large and people with employment-based coverage to accept a narrower network of doctors and hospitals in exchange for lower costs. In general, older people and those with higher incomes prefer broad networks, even if they cost more, while younger people and those with lower incomes are more evenly divided.

Health coverage changes for early pre-65 retirees

With the Supreme Court's ruling Thursday, "employers will be able to plan for their workforce," said Susan Feigin Harris, a partner at law firm Baker & Hostetler L.L.P. in Houston. For example, many employers have been mapping out strategies in which they would terminate the coverage they now provide to their pre-Medicare-eligible retirees. Instead, employers would make contributions to health reimbursement arrangements (HRA), which the retirees could use to purchase coverage in the exchanges. But lower-income retirees could turn down the HRA and instead opt for richer federal premium subsidies to buy coverage in the public exchanges, an option that would have ended for those living in states where the federal exchange provides coverage if the Supreme Court had overturned the IRS rules.

In a recent survey by Mercer, 45% of all respondents and 54% of respondents with 5,000 plus employees, reported they expect to steer pre-Medicare eligible retirees to the public exchanges. Since coverage for a retiree population traditionally costs more than an active population, this is a potential win-win for employers and their pre-65 retiree population, Mercer notes.

Similarly, data from Aon Hewitt shows that two-thirds of companies are considering altering their pre-65 retiree health strategies over the next few years, data from Aon Hewitt show. Of those, 35% favor sourcing health coverage through the public exchanges under a defined contribution approach. However, 28% are considering eliminating pre-65 retiree coverage and subsides altogether.

EMPLOYERS

Cadillac Tax

Again, following the Court's decision, employers are turning their attention to changing some of the elements they don't like. High on their priority list is the "Cadillac tax." The ACA's excise tax on high-cost health plans does not go into effect until January 1, 2018, but employers have already set their sights on changing it.

The 40% tax is assessed on employer-sponsored plans that exceed the ACA's set threshold of $10,200 for individual coverage and $27,500 for family coverage. The cost is the total amount both the employer and employee pay in premiums. Revenue from the tax is to be used to fund future premium tax credits.

To illustrate employers concerns, Verizon recently stated that its union health plans for a worker with one or more family members cost an average of $20,000 a year, well above the $16,800 national average. Fredrik Eliasson, CFO of Jacksonville, Fla.-based CSX, said his company will be subject to the Cadillac tax and has implemented consumer-driven plans and co-pays for prescription drugs to try to "ratchet back" costs.

IRS Webinar Series offered on ACA Provisions for Employers and Coverage Providers

The IRS designed an educational series of webinars to help business owners, tax managers, employee benefits managers and health coverage providers understand the ACAs employer provisions. The IRS is presenting three different webinars in July that will each be repeated in August and September.

Employer Shared Responsibility and Information Reporting

Learn about the ACA's employer shared responsibility provisions and information reporting requirements for employers and providers of minimum essential coverage.

- July 28, 11 a.m. – 12: 30 p.m. – Click here to register
- Aug. 20, 1 – 2:30 p.m. – Click here to register
- Sept. 16, 1:30 – 3 p.m. – Click here to register

Employer-Sponsored Health Coverage Information Reporting Requirements for Large Employers

Learn about employer-sponsored health coverage information reporting requirements for applicable large employers, including who is required to report, what information the law requires you to report, and how to complete the required forms.

- July 29, 1 – 2 p.m. – Click here to register
- Aug. 11, 1 – 2 p.m. – Click here to register
- Sept. 10, 11 a.m. – 12 p.m. – Click here to register

Information Reporting Requirements for Providers of Minimal Essential Coverage
Learn about the information reporting requirements for providers of minimum essential coverage, including employers that provide self-insured coverage. Learn who is required to report, what information the law requires you to report, and how to complete the required forms.

- July 30, 1 – 2 p.m. – Click here to register
- Aug. 26, 1 – 2 p.m. – Click here to register
- Sept. 22, 1 – 2 p.m. – Click here to register

For more information about the Affordable Care Act and tax provisions for employers and health coverage providers, visit IRS.gov/aca.

Sources:
The information for this July 22, 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
- The Missoulan
- Associated Press
- Stateline
- Politico
- Internal Revenue Service
- Kaiser Health News
- Utah Health Policy Project
- Los Angeles Times
- Chicago Sun Times
- Detroit News
- Georgetown University Center for Children & Families

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