NC Get Covered
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NC GET COVERED BRIEFING
September 10, 2015

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

Medicaid Coverage Gap
- State Scorecard
- Additional ACA funding for SCHIP

Insurance Carriers
- Transparency Guidelines
- Narrow Networks
- Premiums

Consumers
- Late Tax Filers

State & Federal Marketplaces
- Maryland Exchange and Agents

MEDICAID COVERAGE GAP

In late August, the Annenberg School of Journalism at the University of Southern California published a report on how the Miami Herald researched and reported on the **Florida** Medicaid Coverage Gap.

The following is an excerpt from the Annenberg report: "In some ways, it was easy to report our project, 'Falling into the Coverage Gap,' because Florida and the Affordable Care Act have a love-hate relationship. Though an estimated 1.4 million Floridians signed up for a subsidized health plan through the ACA's Health Insurance Marketplace for 2015 – more than any other state – most of them are represented in the state Legislature and in the U.S. House of Representatives by Republicans who want to repeal the health law. But lost in the media reports — about the economic benefits that Florida was passing up by not expanding Medicaid, about the distrust state legislators have for the federal government— were the voices of the low-income adults, many of them unable to work, who believed their lives would improve greatly with Medicaid."

Republican leaders in the legislature voted to go to court to stop Gov. Bill Walker from accepting federal funds to expand Medicaid in **Alaska.** Walker planned to begin implementing the expanded program on Sept. 1, but lawmakers have asked a judge to put a temporary halt in place until the courts can decide a bigger question — whether the governor has the authority to accept federal funds for the expansion without a vote of the Legislature. On August 28, a Superior Court Judge turned down the lawmakers' request. The legislature's appeal to the state's Supreme Court was also turned down. On September 1, Alaska began to enroll eligible persons into its expanded Medicaid program.

Utah Democrats held a news conference in mid-August to prod Gov. Gary Herbert and Republicans in the Legislature to reach a resolution before the next legislative session in January 2016. They stated the governor, Lt. Gov. Spencer Cox, and key lawmakers failed to reach a deal to expand Medicaid by their self-imposed July 31 deadline. The Governor replied that they are actively working on a compromise, including meeting with U.S. Health and Human Services Secretary Sylvia Burwell when she was in Salt Lake City in mid-August.

During the news conference, stories of Utahns caught in the coverage gap were featured in a documentary film, "The Donut Hole." It was made by two University of Utah medical students and tells the stories of what being in the coverage gap means to a person's health, happiness, and ability to work.

State Representative Art Wittich expressed his concern that **Montana**'s draft waiver application appears to omit provisions requiring some recipients to work or look for work to continue receiving benefits. A spokesperson for Governor Bullock assured Wittich the employment requirements will be part of Montana's waiver application, which it plans to submit to DHHS in mid-September. The requirement to work to receive benefits only kicks in if recipients of expanded Medicaid benefits fail to pay premiums. The state is taking public comments on its Medicaid expansion waiver through the first week of September.

Arkansas Gov. Asa Hutchinson recently indicated he wants to keep the state's alternative Medicaid expansion, but only if the federal government grants changes that conservative state legislators are seeking. Arkansas is among the states that had the largest reductions in its uninsured rates under the ACA, according to the recent Gallup national survey. Under its private option for expansion, the state used federal money to buy private insurance for more than 200,000 low-income individuals. However, the private option has been unpopular amongst Arkansas lawmakers, even as several other states, including Indiana and Iowa, have adopted versions of it.

The Governor's recommended changes include:

- Requiring enrollees whose income is above the federal poverty level to pay premiums equaling 2% of their household income;
- Shifting people below 100% FPL to traditional Medicaid, which may well prove less expensive, instead of giving them private insurance; and
- Requiring people with access to employer-sponsored insurance that meets the standards of the ACA to sign up for that coverage instead of falling back on Medicaid. The state would cover their deductibles and co-payments, he said.

<u>ACA increases SCHIP Federal Matching Funds; States shift dollars</u>

Beginning October 1, the Federal government will assume a larger share of the funding for every state's Children's Health Insurance Program (SCHIP), including North Carolina's Health Choice program and children in Medicaid funded by Title XXI.

The two-year increase is a little known provision in the ACA and was made possible when Congress approved a two-year funding package for CHIP earlier this year as part of the bipartisan Medicare's "doc fix" and reauthorization of CHIP. The extra funding amounts to a 23 percentage point increase in federal match rates for CHIP. The provision was written into the ACA to keep states from curtailing their CHIP program in favor of insurance plans on the ACA Marketplace exchanges. In 2010, during the ACA debate, the increase in federal CHIP dollars was hailed as a victory for children's health programs.

During the next two fiscal years, the increase in federal funding will free up as much as $6 billion in state budgets. Child Advocacy programs are concerned that this money is now being used to backfill state budget holes, build roads, or fund tax cuts, instead of expanding the kid's health programs. States, like Kansas, Indiana, and California are shifting dollars they once spent on children's health to such activities.

These state budget actions are raising fears amongst advocates that important children's healthcare programs could lose their funding in the future. Shannon Cotsoradis, who leads Kansas Action for Children, said she's afraid states that divert their current CHIP funds elsewhere in the budget will face an uphill battle to add the funds back in two years from now. "It's hard to get that money back… what it might mean is a reduction in children's health coveragetwo years from now", she said.

In North Carolina

- The Health Choice (CHIP) Federal matching rate will increase on October 1, 2015 from 76.12% to 99.37% through September 30, 2017.
    - This increase in federal funding offsets state dollars that were funding the Health Choice and Medicaid programs.
- As of mid-August the House and Senate versions of the SFY 2015-16 contained a gain in both Medicaid and Health Choice. This is because there also are CHIP-eligible children in the state's Medicaid program.
    - The total in Medicaid was $38.7M in SFY 2015-16 and $54.3M in SFY 2016-17.
    - The total in Health Choice was $34.8M in SFY 2015-16 and $47.4M in SFY 2016-17.
    - The $73.5 million in "savings" to the state budget in SFY 2015-16 and $101.7 million in SFY 2016-17. Those funds have been used, in both the House and Senate versions of the budget, as reductions in appropriation needed for Division of Medical Assistance.

INSURANCE CARRIERS

Federal Agencies Take Steps on ACA's Sunshine Rules

In mid-August, the Departments of Labor, Treasury, and Health and Human Services published guidelines on two key provisions of the ACA designed to improve health plan transparency and regulatory oversight.

The so-called transparency provisions require insurers and group health plans to begin reporting to the federal government, state departments of insurance, the health insurance marketplaces and the public a range of data. That data includes information about insurers' practices for setting premium rates, paying or denying claims, enrollment and disenrollment of members, cost-sharing and out-of-network costs. The goal of the ACA provisions is to provide policymakers and the public access to information on:

- How insurance is working (or not working) for consumers, and
- How insurers are designing plans and paying for care in both employer-sponsored and marketplace coverage.

However, the new guidelines only pertain to the Federal Marketplace and not employer-sponsored plans where most people obtain their health insurance.

The Center for Health Insurance Reform (CHIR) at Georgetown University stated that excluding employer-sponsored plans from the guideline was an unfortunate omission since insurers and employers were supposed to start reporting on such activities in 2010.

CHIR went on to state that the only new information insurers are being asked to provide is a link to a web page with information on the companies' claims payment policies, including policies related to:

- The use of out-of-network services,
- Balance billing,

- Grace periods for failure to pay premiums,
- Retroactive claim denials,
- Timeframes for gaining medical necessity determinations or prior authorization,
- Information about Explanation of Benefit (EOB) forms, and
- Insurer contact information.

CHIR also noted that insurers will not be required to report on two statutorily required categories – dis-enrollments and denied claims. CHIR believes this is a "missed opportunity" to "implement the ACA provisions that were written to help policymakers at the state and federal levels better understand and monitor how health insurance is actually working for people."

Narrow Networks on the ACA Marketplaces

Narrow provider networks have emerged as one of the primary ways insurers are pursuing cost-containment. This is the conclusion drawn by a recent 50-state study: "State Variation in Narrow Networks on the ACA Marketplaces," published by the Leonard Davis Institute of Health Economics at University of Pennsylvania.

Dan Polsky, executive director of the Institute and lead researcher, stated in the report that narrow networks can be an effective way to control medical costs, but added that consumers still don't have an easy way to tell whether a health plan is narrow or not before enrolling.

The study points out Insurers use narrow networks to lower premium costs in various ways. They can:

- Directly exclude high-cost providers from the network;
- Offer a fixed lower reimbursement level to all providers, resulting in some providers opting out of the insurer's network; or
- Segment their network into tiers, with higher cost-sharing for the higher tiers, resulting in a de facto narrowing of the network for price-conscious consumers.

All of these strategies are being used to control the costs of individual plans offered on the ACA marketplaces.

Polsky and co-researcher Janet Weiner state that it is difficult for a consumer to assess network size, even as a broad concept. As a result, the trade-off between network size and premium cost is not clear to the consumer. It is even hard to gauge which providers are in the network as this involves checking the provider directories on the issuer's website for a particular provider for a particular plan. In the past, these provider directories often have been out-of-date. New federal rules for 2016 will require plans to publish up-to-date, accurate, and complete provider directories, including information on which providers are accepting new patients, the provider's location, contact information, specialty medical group, and institutional affiliation.

> [Note: See the August 17 NCGC Briefing Report on CMS rules and National Association of Insurance Commissioners' efforts to develop model state regulations for states to consider on Network Adequacy.]

Because of the new federal and anticipated NAIC model state regulations for states to consider, there is an opportunity for future provider directories to be more accessible, clear, accurate, and include up-to-date network characteristics, so that consumers know their choices and the trade-offs in selecting a marketplace plan. Polsky believes that ultimately, these steps will improve the implementation of narrow networks as a strategy for offering lower-cost plans on the marketplaces. Well-functioning

narrow networks will survive only if they are made more transparent to consumers and are regulated to ensure sufficient network adequacy.

Nationwide, the study found 41% of the marketplace networks were labeled narrow, meaning they included 25% or less of the physicians in a rating area. Network size varied across type of plans, with health maintenance organizations (HMOs) more narrow than Preferred Provider Organizations (PPOs). Network size also differed by specialty.

Polsky recommends a labeling system for networks that is akin to T-shirt sizes, going from extra small to extra large. Extra small and small are narrow networks under the researchers' 25% definition.
"We need a good way to communicate this information to consumers so they can make an informed decision at the point of purchase for a health plan," Polsky said. "Narrow networks in my opinion aren't necessarily bad things, but they are being poorly implemented."

Insurers Win Big Health-Rate Increases

An increasing number of health Insurers appear to be successfully demonstrating to state insurance commissions that hefty increases for 2016 are needed to cover the costs of acutely- and chronically-ill people who signed up for individual policies in the first two years of the Affordable Care Act.

Many of the most popular plans in the country offered low rates for the first and second year of the law's rollout, unsure what to expect but eager to snap up the new business. That was especially true in Tennessee, which had some of the lowest premiums in the U.S. initially.

Now insurers have found that business has been more costly than expected. They've incurred steep losses, the American Academy of Actuaries said in a recent paper, and some ACA programs designed to cushion them against high-risk enrollees are ending.

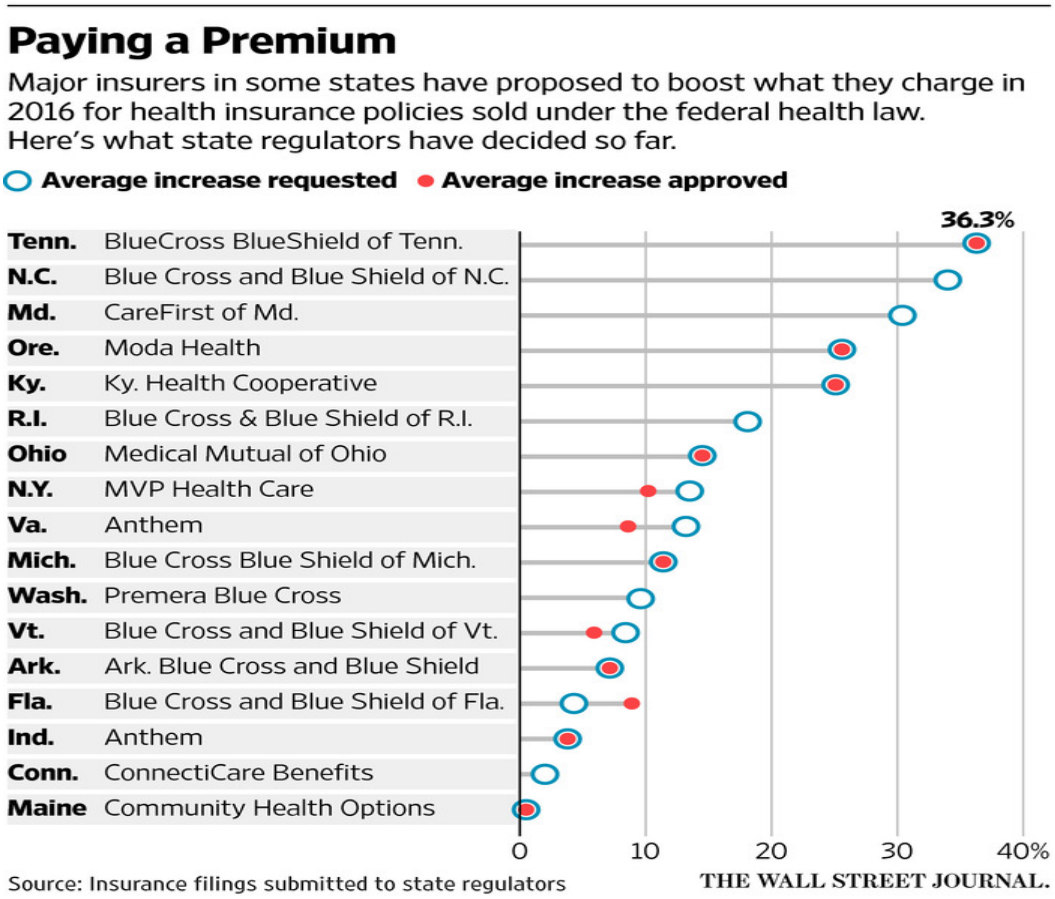
Tennessee's insurance commissioner approved the full 36.3% increase sought by BlueCross BlueShield of Tennessee, stating the insurer had demonstrated that the increase for 2016 was needed to cover higher-than-expected claims from sick people who signed up for individual policies in the first two years of the Affordable Care Act. The Commission is required to protect state residents by blocking unjustified increases, but also guaranteeing that health plans stay financially sound.

In **Florida**, monthly premiums for many of the plans sold on the federal health insurance marketplace will be increasing in 2016, according to the Florida Office of Insurance Regulation (OIR). A table from OIR shows the average approved rate changes for plans available on HealthCare.gov range from a decrease of 9.7 percent to an increase of 16.4 percent. It also notes that "this information has not been reviewed or finalized by the Department of Health & Human Services; therefore, it is subject to change."

As of early September, not all states have made their rate decisions, and some have approved relatively modest increases. Analysts point out that states with lower average increases this year previously had higher rates or increases.

A key point to keep in mind is that the ACA premium subsidies will blunt the impact of price increases for individuals, but the cost is assumed by federal government. In addition, Healthcare.gov has been striving to make it easier for customers to switch to a new insurer and find a more economical, yet comprehensive policy. Last year, more than half of re-enrolling customers on HealthCare.gov actively

shopped and selected a new plan. Navigators, agents, brokers, and other in-person assisters will again mount a stepped-up campaign this fall to persuade people to return to HealthCare.gov and shop around in the coming open enrollment season.



CONSUMERS

Tardy Tax Filers Risk Loss of Health Care Subsidies

The waning days of summer were crucial for hundreds of thousands of Healthcare.gov consumers who are at risk of losing financial aid when they renew coverage for 2016.

As of mid-July, an estimated 1.8 million households got subsidies for their premiums last year but failed to file a 2014 tax return as required by the law, or left out key IRS paperwork.

Because of coordination issues between the IRS and marketplaces like HealthCare.gov, consumers who continued to procrastinate into the fall months are taking chances with their financial aid, according to insurers and the IRS. That means, for example, that someone who's been paying a monthly premium of $90 could suddenly get hit with a bill for $360.

Government officials say they have a backstop planned that should help many procrastinators. Nonetheless, insurers and advocacy groups were told the best way returning customers can avoid hassles was to have filed their taxes corrected by August 31. How many of the 1.8 million did so is unknown.

Many of the low-income Healthcare.gov consumers previously were not required to file tax returns because their annual income was so low. But they must do so now if they received health care tax credits, which means dealing with complex new forms.

The issue and concern is complicated by the fact that Federal law imposes strict privacy safeguards for tax returns, and there are limits to information the IRS can provide to other agencies. Tax returns take time to process, and HealthCare.gov can't get real-time updates. So even if a procrastinator realizes his mistake and files a tax return in October, HealthCare.gov might not reflect that information until much later.

The government's planned backstop for those consumers who filed late is for them to attest that they filed their tax returns and continue to receive their subsidies in 2016. HealthCare.gov will also recheck IRS data in late December. But the backstop only works if the customer actually filed. If they did not, the system will catch up to them eventually. Those who lie about having filed a tax return would violate perjury laws.

STATE & FEDERAL MARKETPLACES

Maryland to transfer state-run exchange calls to brokers

Maryland's state-run ACA exchange will implement a pilot program November 1, during this year's open enrollment, that will transfer consumers' calls from a call center directly to a broker, who will then enroll the consumer. The exchange's customer service representatives will undertake the eligibility application as usual, then offer to transfer the call to a broker. After the transfer takes place, the call center representative will hang up and the broker will complete the enrollment.

"The program was designed to utilize the broker community to provide expert advice on plan selection while allowing the [call center] to shorten call times to maximize the number of consumers assisted and shorten wait times," said Michele Eberle, chief operating officer of the Maryland Health Benefit Exchange. Twenty-five brokers are expected to take part in the pilot. The state plans a full rollout in 2016 and beyond to brokers statewide, based on the pilot's outcome. Specifics on how the 25 brokers will be selected are being developed, but the producers selected must have experience selling policies through Maryland Health Connection and commit to availability during defined hours, including nights and weekends.

Sources:

The information for this September 11, 2015 NC Get Covered Briefing was drawn from multiple sources, Including:

- Wall Street Journal
- Employee Benefit News
- The Baltimore Sun
- New York Times
- Washington Post
- Associated Press
- Center for Health Insurance Reforms
- Internal Revenue Service
- Politico
- Boston Globe
- The Hill
- Kaiser Health News
- Salt Lake Tribune
- Desert News
- Los Angeles Times
- The Alaska Dispatch
- Idaho Statesman
- Bloomberg News
- Miami Herald
- Healthcare Financial Management Association
- Leonard Davis Institute of Health Economics

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