NC Get Covered
POWERED BY THE BIG TENT COALITION

NC GET COVERED BRIEFING
November 19, 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:

Consumers
- Provider Networks Model Law
- High Deductibles
- Balance Billing and Family Glitch

Insurance Carriers and Agents
- UHC may leave Marketplace in 2017
- DHHS hotline for agents

Medicaid Coverage Gap
- Alabama
- Kansas
- Kentucky
- Louisiana
- Nebraska
- New Mexico
- South Dakota

CONSUMERS

Model Law Addresses Provider Networks and Out-of-Network Costs

The National Association of Insurance Commissioners (NAIC) is recommending new standards to address concerns about limited access to doctors and hospitals in health plans. The recommendations were developed over an 18-month period of meetings that involved insurers, consumer advocates, and State insurance commissioners and are the basis for a model state law that is designed to update current state statutes in the 50 states.

If adopted by a state, the model law would require that insurers have enough doctors and hospitals in their networks to provide all covered services to consumers "without unreasonable travel or delay." Limited networks of health care providers are a feature of many insurance policies now being offered on the Federal Marketplaces. Low income consumers can often obtain subsidies that reduce their monthly premiums to $100 or less for such health plans. But the "narrow networks," consumers say, often do not include the doctors they need for specialized care for themselves or their children.

In determining whether a network of providers is sufficient, state insurance commissioners would consider factors like the ratio of people enrolled in a health plan to the number of doctors in each specialty, the geographic accessibility of providers, waiting times for appointments, and the ability of health plans to meet the needs of low-income people and "children and adults with serious, chronic or complex health conditions or physical or mental disabilities."

Insurers defend the offering of smaller networks as a way to hold down costs and improve care by steering patients to selected high-performing doctors and hospitals. Moreover, they say most consumers seeking insurance on the exchanges focus on price more than any other factor and are willing to accept limits on their choice of doctors and hospitals in return for lower premiums.

The NAIC's model law also seeks to protect consumers against excessive costs if, for some reason, they receive care from doctors or hospitals that are not in the insurer's network. Patients are typically required to pay more of the bill if they receive care outside their network – Out of Network (OON) costs. Under the model state law, insurers and hospitals would be required to inform patients of any possibility that they may be charged extra by a health care professional, such as an anesthesiologist, pathologist or radiologist, who does not participate in the insurer's network.

In such situations, the model law provides that patients should not be forced to pay more than their usual share of the bill for services provided by doctors affiliated with their health plan. Doctors who object to the amount of the payment could negotiate with the insurer in a mediation process, but the patient would be held harmless.

Consumers Frustrated by High Deductibles Need to Shop

For many Federal Marketplace consumers, sticker shock is coming not when they purchase the health insurance, but when they get sick. Reportedly, high deductibles are leaving some newly insured feeling nearly as vulnerable as they were before they had coverage. According to a New York Times survey, more than half the plans offered through HealthCare.gov have a deductible of $3,000 or more.

Recently, DHHS Secretary Sylvia Burwell issued a report analyzing premiums in the 38 states that use HealthCare.gov. "Eight out of 10 returning consumers will be able to buy a plan with premiums less than $100 a month after tax credits," she said. People with particularly low incomes can obtain discounts known as cost-sharing reductions, which lower their deductibles and other out-of-pocket costs, if they choose mid-level silver plans.

But in interviews conducted by the New York Times, a number of consumers made it clear that premiums were only one side of the affordability equation. Interviewers were told:

- "The deductible, $3,000 a year, makes it impossible to actually go to the doctor."
- "We have insurance, but can't afford to use it."
- "Basically I was paying for insurance I could not afford to use."
- "Our deductible is so high, we practically pay for all of our medical expenses out of pocket."
- "So our policy is really there for emergencies only, and basic wellness appointments."

The following is a sample of median deductibles, according to Healthcare.gov:

- Miami, FL $5,000
- Jackson, MS $5,500
- Chicago, IL $3,400
- Phoenix, AZ $4,000
- Houston, TX $3,000
- Des Moines, IA $3,000
- Newark, NJ $2,000, but some plans have no deductible

The Internal Revenue Service defines a high-deductible health plan as one with an annual deductible of at least $1,300 for individual coverage or $2,600 for family coverage.

"Everyone needs to come back to the marketplace and shop. You may get a better deal."

For those consumers worried about increased premiums and out-of-pocket costs this critical message has been extolled multiple times in emails and alerts from Enroll America, DHHS, insurance carriers, national consumer and enrollment assister organizations, and local enrollment assister organizations.

Florida Board Addresses Balance-billing and Family Glitch

The Florida Health Insurance Advisory Board is calling for state lawmakers to enact more protections for health-insurance consumers and families of workers in small businesses. The Board's legislative recommendations include two proposals aimed at fixing problems that currently confront consumers, providers, and insurers: "balance-billing" and the "family glitch."

The Board's first recommendation would protect members of preferred provider organizations (PPOs) and certain other network plans from being billed by a hospital or doctor outside their network for charges that occurred through no fault of their own. Sometimes this occurs because the PPO member suffers an emergency illness or injury and is taken by ambulance to a hospital. The ambulance, hospital and doctors may lack contracts with the PPO. Surprise out-of-network bills are being sent to patients who planned ahead and went to a hospital in their network. They may unwittingly be treated and billed by a doctor who is not in the plan network.

The board's other recommendation is for state lawmakers to amend current state law and clarify that a small business can indeed buy health policies that cover just the workers, not their family members. Consumer advocates admit this doesn't sound like a consumer-protection measure; it is because it would free the spouses and children to be eligible for and seek low-cost coverage through the federal Marketplace.

Small employers – those with two to 50 workers – are exempt from the Affordable Care Act's mandate to provide coverage that applies to larger companies. But many small employers want to provide some coverage for their workers, and do.

The problem is that many cannot afford to pay anything toward coverage of the family members. As a result, often the worker can afford to insure only himself. Because family members technically have access to employer coverage under the ACA, even though it's unaffordable, they don't qualify for the tax credits that make the Federal Marketplace plans affordable. This has left many spouses and children uninsured by what has come to be called the "family glitch."

Members of the advisory board say a way around the problem is for employers to buy policies that cover only the workers, not family members. But many employers -- and even agents -- don't know that they can legally do this, according to board members. A change in the wording of state law on small-business coverage would make clear that such policies are acceptable. That is the change recommended by the advisory board.

CARRIERS and AGENTS

UnitedHealth Group May Leave Obamacare Exchanges By 2017

UnitedHealth Group, in a surprising announcement, has revised its profit expectations for the rest of the year due to what it called a "deterioration" of its individual commercial insurance offerings on

government-run exchanges under the Affordable Care Act, and offered no commitment it would stay in the business beyond next year.

The nation's largest health insurer said it was "evaluating the viability of the insurance exchange product segment," pulling back on its marketing efforts for individual exchange products for next year and "will determine during the first half of 2016 to what extent it can continue to serve the public exchange markets in 2017." The insurer sells individual plans on public exchanges in 24 states and covers more than a half million Americans in these plans.

UnitedHealth had been among the more cautious in offering coverage to individuals on the exchanges, entering only a handful of markets in 2014, the first year such coverage became available. The company expanded for this year and only recently said it would expand its offerings in nearly a dozen more states for 2016.

CMS Public Exchange Agent Hotline Falling Short of Expectations

A hotline set up by DHHS to assist brokers with the Federal Marketplace will only assist agents with questions involving an agent's user ID, site registration and training questions, and not client issues as promised. Reportedly, DHHS' promise was to launch a direct hotline for brokers to answer general agent questions and issues related to consumers seeking coverage through the federally-facilitated marketplace.

The National Association of Health Underwriters is now being told there will be no further upgrades to the hotline for the 2016 plan year open enrollment. DHHS has plans in the future to increase support, but it will not be until 2017 open enrollment. NAHU's desire to have such a hotline comes from the fact that agents and brokers have clients with complex situations and they need assistance beyond the current capability of marketplace representatives.

MEDIGAP

Alabama

The Alabama Health Care Improvement Task Force, appointed by Gov. Robert Bentley, has recommended that the governor and the Legislature find a way to provide health insurance for Alabamians without coverage.

The Task Force report states that the biggest obstacle in improving health is the "coverage gap that makes health insurance inaccessible to hundreds of thousands of Alabamians." The majority of that group are working people who earn too much to qualify for Medicaid but don't have private insurance, according to the Task Force statement. It said expansion could provide coverage to about 290,000 Alabamians, including 185,000 who are working.

The Task Force recommended that the governor and the Legislature "move forward at the earliest opportunity to close Alabama's health coverage gap with an Alabama-driven solution."

Recently, Gov. Robert Bentley has stated that he and his staff are in the exploratory stages of considering Medicaid Expansion. He added that funding the state's share of costs could be a major stumbling block. But his recent comments were the strongest to date about the possible acceptance of expansion dollars.

His comments came during a speech about his concern for the "… plight of the working poor ... If doctors are not paid for seeing those patients, doctors will not go to rural Alabama because you can't expect a doctor to go to rural Alabama and lose money," Bentley said. Funding the state's share of costs, which would eventually rise to 10 percent in 2020, could pose a challenge. The Alabama Legislature this year largely rejected Bentley's call for tax increases. However, the governor said he expects a lottery to be proposed in the Legislature and said that might be something in his long-term plans.

Kansas

Three moderate state legislators who support Medicaid expansion have been removed from a House committee that oversees health care issues. Advocates for the Affordable Care Act state that the move is the latest in the fight over whether the state should expand Medicaid for those with low incomes under the Affordable Care Act.

House Speaker Ray Merrick, who makes House committee assignments, also moved moderates off key committees dealing with the budget and education. The lawmakers removed from the Health and Human Services Committee were Rep. Barbara Bollier of Mission Hills, a retired physician; Rep. Susan Concannon, R-Beloit, the vice chair who has a background in rural health; and Rep. Don Hill, R-Emporia, a pharmacist.

Opponents of expansion, including Gov. Sam Brownback, cite concern over costs and skepticism about a federal pledge to pay for most of any expansion. Supporters, including the Kansas Hospital Association, say the state is losing hundreds of millions of dollars in federal funding.

Kentucky

Kentucky's Governor-elect Matt Bevin campaigned hard against the Affordable Care Act. However, since being elected he has begun to send mixed signals about whether he would seek a full repeal that would affect the health care of 400,000 Kentuckians. Bevin has suggested he might pursue replacing the current program with a less generous model, as six other states have done — with the federal government's consent — to assuage conservative concerns.

Political analysts say his recent comments show how difficult it is to fully repeal Medicaid expansion once it's in place. At the start of the year he favored immediate, full repeal of Medicaid expansion. By summer, he appeared to have softened his position. By the end of the campaign, the governor-elect's website still called for repealing the expansion. But in public statements, he suggested instead he would merely replace it with a more market-friendly model similar to Indiana's.

Louisiana

Republican David Vitter and Democrat John Bel Edwards will face off Saturday, November 21st in Louisiana's gubernatorial runoff election. Both have addressed the issue of Medicaid expansion in the past with the following statements:

Edwards: "We should stop sending our federal tax dollars to Washington, D.C., so they can send it to the 30 states that have expanded the Medicaid program. I'm not going to back down; I do support the Medicaid expansion because it's the right thing to do."

Vitter: "We need to have a realistic plan to procure the match we need for those federal dollars because it's not all free money from Washington. If we don't have a realistic plan for that, and Baton Rouge has not come up with one yet, then we're going to be digging the hole deeper. I want to reform Medicaid, not expand a broken Medicaid system through a coverage system that emphasizes preventative and primary care."

There is pressure to expand Medicaid sooner rather than later because of an April 1 deadline the state's Legislature adopted during the 2015 session. If Louisiana expands Medicaid by April 1, 2016, the Louisiana Hospital Association's members have agreed to cover the state's matching funds starting in 2017 using a fee charged through hospitals.

Paul Salles, the president of the hospital association, said he is concerned that if the next governor pursues a waiver, as opposed to simple Medicaid expansion, it could mean less money for the state. "To me it's pretty straightforward: The more federal funding you can attract to solve the issues, the better. But the longer it takes, the less advantageous it is," Salles said.

Montana

Immediately following the federal government's approval on November 2nd of the state's Medicaid expansion waiver, the state announced that people could sign up for the program immediately through www.healthcare.gov. Approximately 5,500 did so in the first week.

Blue Cross and Blue Shield of Montana won the contract to manage the expansion and will collect premiums, process claims, and manage the network of health-care providers. Currently, it is building an automated system to collect premiums, track co-payments, and process claims. The state and Blue Cross and Blue Shield of Montana are working diligently to have that system in place by its planned coverage date of January 1.

Nebraska

Sen. Kathy Campbell of Lincoln recently urged the Lincoln and State Chambers of Commerce audience to carefully consider the economic advantages that Medicaid expansion would bring to the state. At stake, she said, is $2.3 billion in federal funding over the next five years and 10,000 potential new jobs.

Campbell and legislative colleagues—Sens. John McCollister and Heath Mello, both of Omaha—are crafting a new Medicaid expansion proposal. They plan to meet with the Greater Omaha Chamber of Commerce to discuss the outline of their plan.

The three state senators have teamed up to see if the Legislature can agree on a plan tailored to Nebraska that would provide health care insurance for about 77,000 Nebraskans who fell through the cracks of national health care reform. About 73 percent of those Nebraskans are workers who are primarily engaged in food service, construction, sales, janitorial and office support. They slipped through the coverage gap in the Affordable Care Act because they were ineligible for traditional Medicaid and ineligible for health insurance subsidies.

New Mexico

For several years, hospital executives in New Mexico have stated their number one concern has been the cost of providing care to patients who showed up at the emergency room without insurance. But a new report by the New Mexico Legislative Finance Committee shows that, for the first time, hospitals are spending less money on indigent care. The reason is because more and more patients have some type of private insurance or government-issued Medicaid coverage.

The report, "Uncompensated Care in New Mexico after the Affordable Care Act," states that as the rate of uninsured adults declined — from 18 percent in 2013 to 13 percent in 2015 — "uncompensated care has diminished significantly."

"All indications are that uncompensated care costs will continue to decline, but they will not disappear altogether," according to the LFC analysis. Since the health care reforms were put in place, uncompensated care costs dropped 26 percent in states such as New Mexico that expanded Medicaid coverage, the report states.

In addition, requests from hospitals for reimbursement dollars from a state fund called the "Safety Net Care Pool" for indigent expenses "dropped by more than a 30 percent," according to the LFC analysis.

South Dakota

Gov. Dennis Daugaard plans to focus on Medicaid expansion in his budget address to the legislature on December 8. The governor's office said expanding the program could extend eligibility to 55,000 additional South Dakota residents.

Concurrently, the state's Health Care Solutions Coalition continues to meet to discuss logistics of expanding the jointly-funded federal and state health insurance program for needy people. The main concerns with the expansion are keeping costs to the state low and ensuring that Native Americans in the state receive good care.

Though the plan for expanding the program in the state is not final, it is said to rely on ongoing efforts by The Centers for Medicare & Medicaid Services (CMS) to update a policy on funding 100 percent of the care for Medicaid-eligible American Indians through the Indian Health Service or tribes.

CMS drafted a white paper last month in which it considered allowing IHS and tribal facilities to provide services through contracts with outside providers, which would allow the state to get a 100 percent federal funding match. The proposed changes would also allow increased flexibility of both the IHS and tribal providers as well as the state's Medicaid programs.

Sources:
The information for this October 15, 2015 NC Get Covered Briefing was drawn from multiple sources, including:

- Associated Press
- Employee Benefit News
- Fiscal Times
- Health Care Daily
- Kaiser Health News
- The Times-Picayune
- Santa Fe/New Mexican
- New Mexico Legislative Finance Ctme.
- Lincoln Star Journal
- CQ Roll Call
- Health Access California
- Marketplace Morning Report
- Forbes
- Families USA
- Fierce Health Finance
- Money Watch
- Modern Health Care
- Montana News
- New York Times
- Salt Lake Tribune
- The Hill
- USA Today
- Wall Street Journal
- Washington Post

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