NC Get Covered
POWERED BY THE BIG TENT COALITION

NC GET COVERED BRIEFING
January 21, 2016

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
- Filing for Taxes and ACA

Insurance Carriers and Agents
- Insurers Claim Rise in Costs
- Incorrect Provider Directories

Medicaid Coverage Gap
- President's Budget
- State Scorecard—AR, ID, KS, KY, LA, MI, MT, NH, SD, VA

Budget's Effect on ACA

CONSUMERS

Filing for Taxes and ACA

Last July, the IRS contacted some 1.6 million Federal Marketplace enrollees that had yet to resolve 2014 tax issues. At the time, the IRS stated that:
- 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 was that these 1.6 million enrollees would fail to file or reconcile their taxes for 2014, before the November start of Open Enrollment (OEP3). 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.

On January 8, the IRS announced that approximately 1.4 million households that received financial help for health insurance premiums under the ACA failed to properly account for it on their tax returns last year, putting their subsidies at risk if they want to keep coverage. A spokeswoman for the Department of Health and Human Services (DHHS) doubted there will be a major impact, because most of these people no longer have health law coverage.

The IRS said the more than 1.4 million households that have failed to properly account for their 2014 tax credits include:
- About 316,000 households that got tax credits paid to them in advance, but did not file a return at all last year. Before the health care law, many low-income people were not required to file

taxes. Now they must do so if they got a subsidy. But if taxpayers don't realize it, that can create mix-ups.
- Some 976,000 households that got tax credits and filed 2014 returns, but omitted the Form 8692 that is the key to accounting for their subsidies.
- About 147,000 households that had requested extensions to file their 2014 taxes, but never followed through.

CARRIERS & AGENTS

Insurers claim rise in costs due to SEP enrollees

DHHS requests information

Under the ACA's Special Enrollment Period (SEP), consumers may be eligible to enroll for health insurance under one of more than 30 special enrollment categories. Reportedly, DHHS sent emails to millions of consumers last year urging them to see if they might be able to sign up after the annual open enrollment deadline. But, insurers and state officials are now claiming that the federal government did little to verify whether the consumers were eligible under the SEP.

The concern being voiced by carriers is that DHHS' SEP policies allowed people to wait until they became ill or needed medical services to sign up, driving up costs. In a December 2, 2015 notice in the Federal Register, the administration said it had "heard concerns that these special enrollment periods may be subject to abuse," and asked for evidence. The insurance companies responded.

- "Individuals enrolled through special enrollment periods are utilizing up to 55 percent more services than their open enrollment counterparts" who sign up in the regular period, the Blue Cross and Blue Shield Association told the administration. Greg Thompson, a spokesman for Health Care Service Corporation, which runs Blue Cross Blue Shield plans in Illinois, Montana, New Mexico, Oklahoma and Texas, said one-fourth to one-third of its marketplace customers came in through special enrollment periods. And in their first month of coverage, he said, they were much more likely to generate large claims.

- "Many individuals have no incentive to enroll in coverage during open enrollment, but can wait until they are sick or need services before enrolling and drop coverage immediately after receiving services, making the annual open enrollment period meaningless," stated Steven B. Kelmar, an executive vice president of Aetna. A quarter of the applications that Aetna received in the health law's public insurance marketplace last year came through special enrollment periods, he said. Kelmar went on to state that: "On average, special enrollment period enrollees stay with us for less than four months, while enrollees who come to us during the annual open enrollment period maintain their coverage on average for eight to nine months."

- Daniel J. Schumacher, the chief financial officer of UnitedHealthcare, the insurance unit of UnitedHealth Group, said more than 20 percent of its marketplace customers signed up after open enrollment ended last year. And they used 20 percent more health care than people who signed up before the deadline, he said.

- The National Association of Insurance Commissioners, representing state officials, is troubled by the trend. "State regulators are concerned that consumers are not required to provide documentation to substantiate their eligibility for a special enrollment period," the association

> said in a letter to the federal Department of Health and Human Services. "We know of many cases where individuals with serious medical conditions purchased coverage midyear by simply checking the right box or using the right language, and their eligibility was not questioned."

Such concerns could portend higher insurance rates broadly. In setting current premiums, insurers say, they did not realize how many people would sign up after the deadline and how much care they would use. That information may affect future rates and benefits.

Consumer advocates said they had not seen evidence of abuse.
"Most consumers are confused by the rules on special enrollment periods and do not understand the system well enough to try to game it," said Christine Speidel, a lawyer at Vermont Legal Aid. On the other hand, she said, "many people feel that insurance is not affordable, even with subsidies, and they will call the marketplace to see if they qualify for insurance when they get sick."

Moreover, consumer advocates said, the government is partly responsible for the proliferation of special enrollment periods. In some cases, they said, consumers tried to sign up before the deadline, but were stymied by errors in government computer systems. In other cases, they said, people needed a special enrollment period because they had been improperly dropped from the rolls or left in limbo while trying to resolve questions about their citizenship.

Enroll America said the government "should not tighten eligibility or verification standards in ways that could place an undue burden on consumers."

DHHS Moves Forward
DHHS has announced it will tighten the rules for people who enroll during the SEP by eliminating some criteria for late sign-ups and making other criteria language clearer. The steps are necessary, said a DHHS official, because "bad actors" had taken advantage of the existing rules and tightening them would ensure that the SEP served its original purpose.

Incorrect Provider Directories

As of January 1, new regulations allow the Centers for Medicare and Medicaid Services (CMS) to fine insurers up to $100 per beneficiary for errors in plans sold on the federally-run insurance exchanges in 37 states, and up to $25,000 per beneficiary for errors in Medicare Advantage plan directories.

States also are imposing their own rules and sanctions. In November, California fined Anthem Blue Cross $250,000 and Blue Shield of California $350,000, after a survey found that more than 25% of doctors listed in their 2014 state directories weren't at the given location or denied accepting those plans.

Getting it Right
Healthcare advocates have complained that health-plan provider directories are riddled with names of doctors who have died, moved, retired, changed affiliations, don't accept that insurance or aren't seeing new patients. Insurers say it is up to providers to inform them of changes. They advise plan members to ask their doctors if they are in network, rather than relying on the directories. Still, with penalties looming, many carriers are placing increased emphasis on updating their listings.

A recent survey by LexisNexis found that doctors' contact information and affiliations can change frequently, often resulting in errors in insurers' directories.

- 2.4% of all providers change addresses or other contact information every month
- 30% change their hospital or practice-group affiliations every year
- 5% change their license status every year
- 35% of provider listings contain errors
- 32% of listings are duplicates

Thomas Suk, senior director for health care at LexisNexis, one of several data companies that offer to "cleanse" directories for insurers, said, "Directory management, which sounds so simple, is an absolute nightmare for payers."

The new CMS rules originally called for insurers to contact all network providers every month to verify listings. The agency revised that to quarterly, after opposition from insurers and doctors.

"The last thing physicians want is for hundreds of health plans to call them every month," said Anders Gilberg, senior vice president of government affairs for the Medical Group Management Association. One alternative is to have a central database where doctors can update their information, giving insurers a single source to check.

The Council for Affordable Quality Healthcare (CAQH), a nonprofit alliance, maintains a database for credentialing information on about 1.3 million U.S. doctors and other providers. Eight major insurers, including Aetna, CareFirst Blue Cross Blue Shield and UnitedHealth, launched a pilot program using that data to update directories last summer. The alliance plans to offer the service to all health plans in 2016.

MEDIGAP

President's budget extends full funding for Expansion

President Obama, in an attempt to entice states that have been reluctant to expand Medicaid, is proposing in his 2017 budget to allow any state that decides to expand Medicaid eligibility under the law to get three years of full federal funding, no matter when the expansion starts.

The ACA calls for the 100% matching funds to decline gradually after 2016 to 90% in 2020. The burden of that remaining 10% has been a primary argument in the holdout states agreeing to Medicaid expansion. The White House says President Barack Obama's fiscal 2017 budget proposal will include a legislative proposal to cover 100% of costs for three years no matter when a state gets on board.

The proposal is unlikely to win approval in the Republican-controlled House and Senate, where House Speaker Paul Ryan has consistently proposed budgets that would block-grant Medicaid to states. But it highlights Obama's willingness to make concessions to persuade states to expand. It also might establish a dialogue between the Congress and Republican governors, many of whom have accepted or are seeking to pursue Medicaid expansion. CMS has granted several sweeping Medicaid waivers sought by Republican governors that include unprecedented levels of cost-sharing and conditions of coverage, such as participation in wellness programs.

Arkansas

Arkansas Governor Asa Hutchinson has notified DHHS that the state will submit an application in the spring of 2016 to amend the existing private option (Medicaid expansion) program under a section 1115 waiver. The current Medicaid expansion (waiver) expires at the end of 2016. The governor was required to continue or seek changes to the waiver, or deviation from traditional Medicaid, a year in advance.

Potential changes listed under the waiver application from the Arkansas Department of Human Services reflect what the governor and a legislative Health Care Task Force agreed to in December. The Legislature will convene in a special session in April on Medicaid expansion. The potential changes include:

- Requiring premium payments for individuals in the new adult group with incomes above 100% of the federal poverty level (FPL)
- Supporting employer-sponsored health insurance, when offered
- Promoting work through work training referral requirement
- Offering access to additional benefits (such as dental coverage) to enrollees who demonstrate certain healthy behaviors or comply with other program requirements
- Requesting additional flexibility with respect to Demonstration termination
- Strengthening program integrity

Idaho

Idaho Governor C. L. "Butch" Otter announced that a new $30 million program would provide coverage for basic medical care to nearly 78,000 Idahoans caught in a gap where they neither qualify for health insurance subsidies or Medicaid. The plan is a state-funded alternative to choosing to expand Medicaid under the Affordable Care Act.

According to the proposal, qualifying participants would be adults who currently have no access to affordable coverage and who fall below 100 percent of the federal poverty level. They would be eligible to receive preventive primary medical care services, such as acute care for illnesses, chronic condition management and limited in-office behavioral health services. The program will not cover hospital stays, emergency room visits or specialty care.

Kansas

Six Kansas health foundations commissioned Manatt Health Solutions to study the financial impact of Medicaid expansion in Kansas. The Kansas Division of the Budget previously estimated raw costs of expansion but did not factor in any savings or revenue from expansion in other areas of the budget.

The Manatt study shows Medicaid expansion could not only be budget neutral but could potentially turn into a moneymaker for the state. It is contrary to popular belief by some Kansas policymakers who say expansion is too expensive and therefore not possible given the state's budget problems. The study laid out benefits of Medicaid expansion savings in three broad categories: 1) savings from state fund dollars that would be replaced with federal funds, 2) savings from higher federal matches, and 3) potential new revenue from fees associated with higher enrollment. It includes analysis of public data and experiences of expansion states around the country and applied it to areas of the Kansas budget through 2020.

Gov. Sam Brownback's office previously said he would consider only those expansion proposals that are budget neutral with sustainable funding, have a workforce component for recipients, and include a way to lower the state's waiting list for disability services.

Kentucky

Republican leaders in Kentucky's state Senate recently announced they will not block the $250 million in state spending needed to pay for the health insurance of more than 400,000 people enrolled in the state's expanded Medicaid program.

Kentucky, as well as other expansion states, will begin to assume a small percentage of the cost beginning in January 2017. Republican Senate President Robert Stivers said it will cost Kentucky about $250 million over the next two budget years—July 2016 through June 2018.

Meanwhile, newly-elected Gov. Matt Bevin, plans to overhaul the state's expanded Medicaid program with an ACA-based waiver. He cited Indiana's cost-sharing model as one to possibly replicate. Instead of the traditional 1115 Medicaid waiver, Bevin's administration will pursue a 1332 waiver, which actually is a component of the ACA that allows states to craft their own healthcare programs as long as the number of covered people remains the same or greater. States can apply for a 1332 waiver starting January 1, 2017.

In announcing the initiative, Gov. Bevin didn't directly answer whether the changes to the state's current program would force Medicaid beneficiaries to lose their insurance, but he emphasized that "it's important to empower people." He mentioned the new Medicaid program would focus on "better health outcomes," but there were no details about how that would be accomplished, or if it would change the reimbursement structure for hospitals and doctors. It's also unknown how the managed-care companies that administer Kentucky's Medicaid program—Aetna, Anthem, Humana, Passport Health Plan and WellCare Health Plans—would be affected.

Louisiana

Gov. John Bel Edwards signed an executive order expanding Medicaid coverage under the Affordable Care Act, fulfilling a campaign promise to expand health coverage to people in the state. Approximately 298,000 uninsured adults will be eligible for Medicaid under the expansion, according to an analysis by the state's Legislative Fiscal Office.

There are at least two challenges Edwards' new administration could face as the expanded program takes off.

- **Hiring new staff:** Most states that expanded Medicaid experienced a rapid buildup in the number of people signing up for health insurance. The Department of Health and Hospitals will need to hire new staff to ensure new enrollees are eligible and enter them into the system.
- **How to pay for the 10 percent match:** Starting in 2017, Louisiana and other Medicaid expansion states will begin covering a portion of the program's cost. Louisiana will do it through a combination of health insurance tax premiums and an assessment on hospitals, something hospitals have already agreed to. But the Louisiana Legislative Fiscal Office has expressed concern about legislation that was set up as a mechanism for creating the assessment that will provide the funding to cover the federal match.

Michigan

CMS denied a request to allow Michigan to increase cost-sharing for Medicaid beneficiaries, but granted other provisions sought by the state. A spokesman for Michigan House Speaker Kevin Cotter said that the state's health department told lawmakers it believes the waiver is sufficient to avoid triggering a sunset provision included in the state legislation that expanded eligibility under the Affordable Care Act.

Michigan had proposed that residents above the federal poverty level who have been enrolled in Medicaid for 48 months would be required to buy a private plan through HealthCare.gov or see their cost-sharing obligations rise to 7% of their income. Currently, beneficiaries with incomes between 100% and 138% of the federal poverty level pay 3% to 5% of their income for premiums and cost-sharing.

Instead of targeting those who had been on Medicaid for 48 months, the CMS went a step further and dictated that starting January 1, 2018, everyone enrolled in coverage who falls between 100% and 138% of the federal poverty level within that year, must complete a list of healthy behaviors like wellness visits and preventive screenings, or else be forced to leave the program and get a private plan through HealthCare.gov.

By July 1, 2017, Michigan must submit a letter for approval to the CMS that describes the list of healthy behaviors with which beneficiaries will be required to comply. The agency further required that the list cannot be more restrictive than what is already in place for Healthy Michigan.

"The Healthy Michigan Plan has provided Michiganders with the opportunity to improve their health and wellness by enrolling in health care coverage," said Gov. Rick Snyder in a statement. "I'm proud of this program, our residents, and Michigan's continued leadership in health care innovation. I appreciate the work of the CMS and thank it for its partnership and approval of our unique approach to keep Michigan moving forward."

Montana

Montana health officials have signed a two-year contract worth more than $16 million making Blue Cross and Blue Shield of Montana the first commercial insurance provider to administer a state's Medicaid expansion program under the Affordable Care Act.

Blue Cross will handle the enrollment, claims and grievances of most people who sign up through the program. However, the federal waiver requires Native Americans, people with exceptional medical needs, the medically frail, and people who earn less than 50 percent of the federal poverty level to be served directly by the state's Medicaid program.

New Hampshire

The prospect of a Republican-controlled House reauthorizing the state's expanded Medicaid has seemed dim over the last year. But heading into January, support for the health care program is growing among GOP representatives. The push is coming from an unlikely source. Rep. Joe Lachance, a first-term Republican with one of the most fiscally conservative voting records, is the prime sponsor of the legislation that would keep Medicaid expansion alive.

"My political career is on the line, and I am okay with that," said Lachance, whose bill has five Republican co-sponsors in the House. "We have an obligation to take care of our poor people."

House Speaker Shawn Jasper stated he won't back a Medicaid expansion plan unless a majority of members from his own party support it. "If we can find a way to show that every town, county, state budget is being positively impacted, and there is a way to pay for it, I would suspect there would be sufficient Republican support to say, 'Let's continue it,' " he said.

The Republican-controlled Senate, meanwhile, has a clearer path to reauthorization. Three Republican senators, including Majority Leader Jeb Bradley, have signed onto Lachance's bill, enough to join with all 10 Senate Democrats to form a majority in the 24-member chamber.

South Dakota

Gov. Dennis Daugaard has taken his plan for Medicaid expansion on the road in meetings with legislators and business leaders to convince a majority Republican Legislature to approve Medicaid expansion. In a recent interview he stated: "There may be some who are ideologically opposed, but most of them are fiscally conservative and this plan has the potential to not only cover expansion, but to do better than that," Daugaard said.

The governor's proposal to expand Medicaid is part of his $4.8 billion budget plan and is linked to a separate proposal to shift 100 percent of costs for providing Medicaid-eligible Native Americans' health care services to the Indian Health Service (IHS) or tribes. Currently, Medicaid-eligible American Indians can choose to receive covered services from any provider that participates in a state's Medicaid program. Where those patients seek services can affect the rates the state and federal government have to pay.

Daugaard said expanding the program could extend eligibility to 55,000 additional South Dakota residents. South Dakota'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.

Virginia

Gov. Terry McAuliffe's proposed budget calls for expanding Medicaid in Virginia. This year, McAuliffe is trying a new strategy that would expand the federal health-care program for the poor and disabled without state dollars and instead charge hospitals a fee, known as a "provider assessment," equal to 3 percent of their revenue. The cash is an untapped resource that McAuliffe said puts expansion within reach.

In an effort to gain Republican support, his budget ties those projected Medicaid savings to some of their favorite initiatives. He argues that the state could afford everything from tax cuts to grants for small towns if they would only agree to extend coverage to 400,000 Virginians through the Affordable Care Act.

Budget Agreements Effect on the ACA

Just before the Christmas Holiday, Congress enacted the $1.1 trillion Consolidated Appropriations Act for 2016 and a $650 billion tax extenders package.

<u>Effects on the ACA</u>

The legislation delays taxes enacted to fund the Affordable Care Act (ACA) and limits the effectiveness of some of the ACA's operational provisions. The bills do not, however, fundamentally change the ACA,

although some healthcare analysts believe a continued restriction on risk corridor funding could reduce insurer participation in the marketplaces and raise prices for consumers.

'Cadillac' Tax Delayed

The Appropriation Act delays for two years, from 2017 to 2019, the effective date of the excise tax on high-cost employer-sponsored coverage (the "Cadillac plan tax"). Members of Congress and their supporters have been concerned about the effect of the tax on employee benefits, particularly benefits provided to employee unions that have bargained for more generous health benefits in lieu of other forms of compensation. The excise tax was intended to be a significant source of revenue for funding the ACA, and delaying it for two years reduces the amount of revenue raised by the ACA. The excise tax is also a significant element of the ACA's cost control strategy, as it is believed that the tax imposed on employee benefits will in turn reduce those benefits and thus expenditures on health care.

Moratorium on Health Insurance Provider Fee

A second provision imposes a moratorium for one year, 2017, on the collection of the ACA's annual health insurance provider fee. This tax on health insurers has been in effect since 2013 and will go back into effect for 2018. The moratorium will result in a loss in revenue to the federal government of about $12 billion. Health insurers claim that the tax increases premiums by $170 per individual and $530 per family. If state regulators or competitive conditions compel insurers to reduce their rates for 2017 by these amounts, health policy analysts believe this provision could be a real gain for consumers. However, these analysts quickly add that it is possible that this provision will simply increase insurer profits as it decreases federal government revenues.

Moratorium on Medical Device Tax

The tax extender legislation eliminates the medical device tax for 2016 and 2017. This tax was imposed on medical device manufacturers by the ACA, as they were expected to see increased revenue because of expanded coverage under the ACA. A recent GAO report found that profits and sales of medical device manufacturers have in fact continued to increase after the imposition of the tax. The moratorium will reduce federal revenues by about $2 billion a year for two years.

Although the tax delays are being billed as legislative defeats for the ACA, it is important to note that they do not delay or undermine any of the substantive benefits of the ACA. The ACA's Medicaid expansions and tax subsidies are supported by permanent appropriations (although the question of whether or not the cost-sharing reduction payments are appropriated permanently is now being litigated in *House v. Burwell*). The tax delays do not affect these benefits; they simply increase the federal budget deficit.

Risk Corridor Funding Remains Limited

There are provisions of the appropriations act that do affect the implementation of the ACA. The provisions once again limit funding of the risk corridor program to the fees that the ACA collects from insurers that have excess profits. To the extent that the cuts in the risk corridor program reduce competition in health insurance markets or increase the risks born by insurers, this provision will increase the cost of health insurance. The risk corridor program has become an election-year political issue, however, and limitations on the program were inevitable.

Sources:

The information for this January 18, 2016 NC Get Covered Briefing was drawn from multiple sources, including:

- Associated Press
- Employee Benefit News
- Kaiser Health News
- The Hill
- Politico
- Associated Press
- Health Affairs
- Commonwealth Fund
- Thomson-Reuters
- Wichita-Eagle
- The Times-Picayune
- Modern Health Care
- Concord Political Monitor
- Argus-Leader
- South Dakota Public Radio
- Washington Post
- USA Today
- Great Falls Tribune
- Montana News
- New York Times
- Pittsburgh Post-Gazette
- Lexington Herald Leader

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