Covered Clips

A Weekly Summary of News and Activities for the Cover Arizona Coalition

January 1 – February 3rd 2015

**171,051 Arizonans Signed up for Marketplace Coverage**

Individual plan selections for the states using the HealthCare.gov platform through mid- January were as follows:

|  |  |
| --- | --- |
| **HealthCare.gov States**  | **Cumulative Plan Selections** |
| **Nov 15 – Jan 16** |
| Alabama | 137,941 |
| Alaska | 17,051 |
| Arizona | 171,723 |
| Arkansas | 55,853 |
| Delaware | 20,776 |
| Florida | 1,301,745 |
| Georgia | 435,523 |
| Illinois | 290,791 |
| Indiana | 189,220 |
| Iowa | 37,338 |
| Kansas | 81,205 |
| Louisiana | 142,192 |
| Maine | 62,983 |
| Michigan | 301,646 |
| Mississippi | 84,101 |
| Missouri | 213,514 |
| Montana | 47,701 |
| Nebraska | 62,458 |
| Nevada | 54,101 |
| New Hampshire | 47,042 |
| New Jersey | 213,573 |
| New Mexico | 43,651 |
| North Carolina | 467,560 |
| North Dakota | 15,756 |
| Ohio | 198,608 |
| Oklahoma | 103,001 |
| Oregon | 92,059 |
| Pennsylvania | 425,854 |
| South Carolina | 166,159 |
| South Dakota | 18,248 |
| Tennessee | 188,276 |
| Texas | 940,707 |
| Utah | 118,064 |
| Virginia | 321,982 |
| West Virginia | 27,849 |
| Wisconsin | 179,626 |
| Wyoming | 18,112 |

Source: <http://www.hhs.gov/healthcare/facts/blog/2015/01/open-enrollment-week-ten.html>

 **AHCCCS Enrollment Declines Slightly**

The February 1 AHCCCS Population Statistics Report shows a slight decline in overall AHCCCS enrollment from the previous month (1%). The report shows that 275,743 have been added to the restoration category, and 37,369 have been added to the expansion category since December 2013. In January, there were 279,097 listed in the expansion category and 36,373 in the expansion category.

Source: <http://www.azahcccs.gov/reporting/Downloads/PopulationStatistics/2015/Feb/AHCCCS_Population_by_Category.pdf>

**U.S. Uninsured Rate Sinks to 12.9%**



**CMS Joins the Budget Fray to Push for Marketplace Transition Funds**

Inside Health Policy

The Obama administration is requesting $380 million for health insurance exchange grants in its fiscal 2016 budget and signals it may allocate that money to states moving from one type of marketplace to another while being unclear about how exactly those funds may be used. ‘CMS will continue to support transitions that may occur over the next year and the support needed thereafter’ in changing from a state partnership marketplace to a state-based exchange, or from using the federally-operated marketplace to a partnership, according to the CMS budget justification released Monday night (Feb. 2). The funds would come at a crucial time for states that may need to scramble to create their own marketplace if the U.S. Supreme Court rules against the administration in King v. Burwell, effectively disallowing premium tax credits from being distributed to low-income Americans in states that offer health care plans through the federal exchange. Though the justification adds that grants will not be awarded after Dec. 31, 2014, the document adds that CMS requires ‘administrative resources for continued activities’ in fiscal 2016. Some states will still be in the development stage of establishment and will need further technical assistance, the document says, as well as improving functions of renewals, privacy and security, and calculating and reporting advance payments for premium tax credits. ‘Funding will also be used for contracts to provide States with instruction on establishment of Marketplace business functions (e.g., eligibility, plan management) and to help States use their grant funding to implement programmatic components that are in line with Federal policy,’  the budget justification says. The ACA appropriated funding as needed to help states stand up their exchanges, but required the marketplaces to be self-sustaining as of Jan.1, 2015. However, CMS has said states can continue using the grant money for certain functions. ‘States may use Establishment grants to fund their start-up costs, whether for State-based or State Partnership Marketplace function, or to support the Federally-facilitated Marketplaces, but ongoing operations are self-funded through user fees or other funding,’ the HHS budget brief said. It is unclear whether the description referred to those grants paid out before the end of 2014 or the money that may be available in fiscal 2016. The money will also support an estimated 66 full-time equivalent staff members who work as project officers, grants management staff, technical help teams and managers to oversee state progress in their cooperative agreements.

**Losing KidsCare Hurt Arizona Families, Reports Suggest**

Arizona Daily Star

Arizona is the only state without an active federal Children’s Health Insurance Program, and the impact has been negative for low-income families, two new studies suggest.

Fourteen thousand children in Arizona lost their health insurance at the end of January 2014 when the state ended its KidsCare program for low-income children, becoming the only state in the country without an active CHIP program, Georgetown researchers found.

The reports, released Friday by the Georgetown University Center for Children and Families, found that Arizona families experienced chaos, confusion and disruptions in care for their children after the program ended.

Some children went without needed care or had to stop taking prescribed medications because their families could no longer afford them, the reports said.

The reports are timely because federal money for CHIP runs out in September and Congress must decide whether to renew it.

“Arizona’s experience suggests that if CHIP funding is not extended or the program itself is fundamentally changed, our nation’s historic gains in covering children could unravel, making many children worse off than they are today,” Georgetown University Center for Children and Families senior program director Elisabeth Wright Burak wrote in “Children’s Coverage in Arizona: A Cautionary Tale for the Future of the Children’s Health Insurance Program.”

The report noted that Arizona ranks 49th nationwide for percentage of uninsured children, a ranking likely tied to its rejection of CHIP.

In Arizona, the Children’s Health Insurance Program is called KidsCare. At one time it enrolled nearly 50,000 children from low-income families whose parents earned slightly more than the cutoff for Medicaid, a government health insurance program for extremely low-income people.

Another program also covered the parents of children on KidsCare. But in a series of budget-cutting decisions, the Arizona Legislature decided to end coverage for KidsCare parents in 2009 and the following year froze enrollment in KidsCare. By July 2011 the KidsCare waiting list had grown to more than 100,000 children.

A temporary KidsCare program, KidsCare II, was created in 2013, but expired when most provisions of the federal Affordable Care Act took effect at the end of January 2014. Enrollment in KidsCare remained frozen and is expected to dwindle to zero. KidsCare now enrolls fewer than 2,000 children, state data show.

The program is expected to stop operating altogether once the current enrollees either age out of the program or give up coverage because their family income changes or for other reasons.

The Phoenix-based Children’s Action Alliance would like to see the program restored.

Arizona’s Medicaid program is called AHCCCS, the Arizona Health Care Cost Containment System. AHCCCS spokeswoman Monica Coury had not yet seen the reports when contacted Friday afternoon and declined comment.

In 2013, Coury told the Star that families no longer able to get KidsCare could go to the federal marketplace where they would be able to buy private health insurance and possibly qualify for federal subsidies to help pay for it.

Also, since the state expanded AHCCCS eligibility to 138 percent of the federal poverty level, some KidsCare children were able to qualify for AHCCCS. Indeed, that’s what happened with about 23,000 children who transferred from KidsCare II and KidsCare to AHCCCS.

But the new reports say the insurance status of the 14,000 children who lost coverage and did not qualify for AHCCCS is unclear.

The second report, “Living Without KidsCare: Insights From Parents of Children Who Lost Their Health Coverage When Arizona Scaled Back Its Children’s Health Insurance Program,” is based on focus group research and interviews conducted by PerryUndem Research and Communication.

Joseph Fu, director of health policy at the Children’s Action Alliance in Phoenix, helped identify and recruit families who had lost coverage.

The families interviewed said they liked KidsCare, were not prepared when it ended and wanted it to be restored.

Families whose incomes were too high for AHCCCS struggled the most as they found the alternatives costly. Some children went without health insurance, without medication and without medical treatment, the report says.

http://tucson.com/news/local/article\_56f94216-da59-54c5-b447-fb0123c3dc9a.html

See the original reports at : <http://ccf.georgetown.edu/wp-content/uploads/2015/01/Living-Without-KidsCare.pdf> and <http://ccf.georgetown.edu/wp-content/uploads/2015/01/Childrens-Coverage-in-Arizona-A-Cautionary-Tale-for-the-Future-of-Childrens-Health-Insurance-Program.pdf>

**Consumers Who Need to Repay Excess Tax Credits Won’t Have to Meet April 14 Deadline**

Bloomberg View

If you got health insurance subsidies last year, and you're worried that you got too much in federal tax credits and will be faced with a huge tax bill for repayment, then you can worry a little less: The IRS says that people who are liable for repayment ("clawback") of excess subsidies won't have to pay by April 15. It's not relieving you of the obligation to repay; it's just saying that you won't be liable for a penalty if you don't repay by the deadline. Interest will continue to accrue, but the interest rates that the IRS charges are actually pretty reasonable (and probably much better than what your credit card company charges). It's the failure-to-pay penalties it layers on top -- half a percentage point a month, with even stiffer penalties for failing to file -- that really make your tax bill add up fast. The IRS emphasizes that this is a one-time-only deal, just for 2014. But I'm not sure if you should believe that. This emphasizes one of the problems we've spoken about a lot in this space: The political will to impose the costs of the Affordable Care Act is a lot less strong than the will to distribute the benefits. At every turn, when it has come time to actually make people bear the price, the government has blinked. The employer mandate was delayed, cuts to Medicare Advantage were delayed, deadlines to purchase insurance were pushed back, and now the need to repay excess subsidies has been eased. Remember, these payments were increased just a few years back in order to pay for the repeal of a different, unworkable part of the bill: the provision that would have required people to issue 1099s to anyone who sold them more than $600 worth of stuff.

<http://www.bloombergview.com/articles/2015-02-02/government-blinks-again-on-obamacare>

See specific guidance on the penalty relief here: <http://www.irs.gov/pub/irs-drop/n-15-09.pdf>

**The Implications of a Supreme Court Finding for the Plaintiff in King vs. Burwell: 8.2 Million More Uninsured and 25% Higher Premiums**

Robert Wood Johnson and the Urban Institute

The Supreme Court will hear the King v. Burwell case in early 2015, in which the plaintiff argues that the Affordable Care Act (ACA) prohibits the payment of premium tax credits and cost sharing reductions to people in states that have not set up state-managed marketplaces. We estimate that a victory for the plaintiff would increase the number of uninsured in 34 states by 8.2 million people (a 44 percent increase in the uninsured relative to the number uninsured under the law as currently implemented) and eliminate $28.8 billion in tax credits and cost-sharing reductions in 2016 ($340 billion over 10 years) for 9.3 million people. In addition, the number of people obtaining insurance through the private nongroup markets in these states would fall by 69 percent, from 14.2 million to 4.5 million, with only 3.4 million of these remaining in the ACA’s marketplaces. If tax credits and cost-sharing reductions are eliminated, there will also be indirect effects. The mix of individuals enrolling in nongroup insurance would be older and less healthy, on average. The lack of tax credits would make coverage unaffordable for many. As a result, fewer people would be required to obtain coverage or pay a penalty because the cost of insurance would exceed 8 percent of income, the affordability threshold set under the law. With lower cost individuals and families leaving the market, average premiums in the nongroup insurance market would increase by an estimated 35 percent, affecting not just marketplace enrollees but those purchasing outside the marketplaces as well. For example, virtually all of the 4.9 million people (mostly with incomes over 400 percent of the FPL) who are estimated to buy nongroup insurance without financial assistance in 2016—under the law as currently implemented—would also face these large premium increases.

http://www.rwjf.org/en/research-publications/find-rwjf-research/2015/01/the-implications-of-a-supreme-court-finding-for-the-plaintiff-in.html

**The Effect of Eliminating the Affordable Care Act’s Tax Credits in Federally Facilitated Marketplaces**

In this research report, RAND Corporation researchers assess the expected change in enrollment and premiums in the Patient Protection and Affordable Care Act (ACA)–compliant individual market in federally facilitated marketplace (FFM) states if the U.S. Supreme Court decides to eliminate subsidies in FFM states. The analysis used the Comprehensive Assessment of Reform Efforts (COMPARE) microsimulation model, an economic model developed by RAND researchers, to assess the impact of proposed health reforms. The authors found that enrollment in the ACA–compliant individual market, including plans sold in the marketplaces and those sold outside of the marketplaces that comply with ACA regulations, would decline by 9.6 million, or 70 percent, in FFM states if subsidies were eliminated. They also found that unsubsidized premiums in the ACA–compliant individual market would increase 47 percent in FFM states. This corresponds to a $1,610 annual increase for a 40-year-old nonsmoker purchasing a silver plan.

Source: <http://www.rand.org/pubs/research_reports/RR980.html>

**Obama Confident on King Subsidies Case**

Politico Pro

President Barack Obama told congressional leaders Tuesday that he doesn’t expect the Supreme Court to rule that Obamacare’s tax subsidies can only go to residents of states running their own health exchanges, according to one of the law’s biggest critics. Sen. John Barrasso (R-Wyo.) asked Obama during a roundtable discussion with congressional leaders why the administration hasn’t notified the public that premium subsidies could be eliminated and whether contingency planning is under way in case the court rules against the White House in King v. Burwell. He said he interpreted Obama’s public confidence as a sign that no contingency plans are in development. ‘I said to the president that there is a fair chance they may [rule] against the administration,’ Barrasso said. ‘He gave one of the longer answers of the day with a defense of the health care law and not a direct answer. … He said they are not anticipating a need for a contingency plan.’ A White House representative declined to comment on the president’s private conversation with the lawmakers. The Supreme Court has scheduled King arguments for March 4. The plaintiffs contend that the Affordable Care Act’s subsidies cannot go to residents of the 37 states without their own exchanges. Republicans are strongly backing the challenge with hopes that a ruling against the White House would reopen negotiations on Obamacare. A group of GOP lawmakers — Sens. John Cornyn, Ted Cruz, Orrin Hatch, Mike Lee, Rob Portman and Marco Rubio and Reps. Marsha Blackburn, Dave Camp, Randy Hultgren, Darrell Issa, Pete Olson, Joe Pitts, Peter Roskam, Paul Ryan and Fred Upton — told the court in an amicus brief that the subsidies were a lure that Congress provided to encourage states to set up exchanges. They called that a ‘compromise’ between moderate and liberal Democrats. Obama’s refusal to acknowledge any contingency planning is no surprise. Last month, Health and Human Services Secretary Sylvia Mathews Burwell declined to respond to several questions on whether the administration is working on a Plan B.

**Red States Are Reinventing Medicaid to Make It More Expensive and Bureaucratic**

New Republic

Since the implementation of the Affordable Care Act’s Medicaid expansion in 2014, 23 states have refused the federal money to offer health insurance to their low-income residents, depriving almost 4 million people of coverage. Slowly, some of the holdout red states are finding a way to say yes, but only if they can claim a conservative twist on expanding coverage. Tennessee last week became the latest state to release details on a proposal for its own unique version of Medicaid expansion via a waiver of Medicaid rules (known as an 1115 waiver). ‘We made the decision in Tennessee nearly two years ago not to expand traditional Medicaid,’ Gov. Bill Haslam, a Republican, has said. ‘This is an alternative approach that forges a different path and is a unique Tennessee solution.’ Versions of Haslam’s statement are common among Republican lawmakers who have negotiated with the Obama administration to pursue this path: They’re willing to accept Obamacare money so long as they can plausibly sell it as not Obamacare, and they want to use their leverage to attach conservative reform ideas to Medicaid. At the Washington Post, Sarah Kliff has called these measures ‘making Medicaid more Republican.’ Arkansas, Iowa, Michigan and Pennsylvania have already advanced unique versions of Medicaid expansion thanks to waivers that feature GOP-backed wrinkles to the program; Indiana has submitted a waiver pending approval from the federal Department of Health and Human Services, while Tennessee, Wyoming and Utah have developed proposals after active negotiations with the feds; and lots of other states are taking a look, including North Carolina, Georgia, and even Texas. That’s good news for those states' poorer residents, who have been left to fend for themselves while state legislatures offer massive resistance to Obamacare. In practice, however, crafting plans that are ostensibly more conservative has tended to add layers of bureaucracy and administrative complexity. The Republicanized versions of Medicaid thus far have ended up more complicated, confusing, and possibly costlier than the program Republicans refused to expand in the first place. Take, for example, Arkansas—the state that got the ball rolling for red states seeking GOP twists on Medicaid expansion with its privatized version known as the ‘private option.’ Last month the state got approval for a byzantine new program, called Health Independence Accounts, that imposes co-pays on some beneficiaries unless they pay a small monthly fee. Those who have paid their fees are eligible, under certain conditions, for up to $200 to pay for the costs of private health insurance if their income goes up and they transition off of Medicaid. To run the program, the state will pay a third-party administrator about $15 million annually (covered by the feds as part of the cost of expansion).

<http://www.newrepublic.com/article/120781/republican-governors-accept-medicaid-expansion-make-it-costlier>

**New Privacy Concerns over Government’s Health Care Website**

New York Times

A little-known side to the government's health insurance website is prompting renewed concerns about privacy, just as the White House is calling for stronger cybersecurity protections for consumers. It works like this: When you apply for coverage on HealthCare.gov, dozens of data companies may be able to tell that you are on the site. Some can even glean details such as your age, income, ZIP code, whether you smoke or if you are pregnant. The data firms have embedded connections on the government site. Ever-evolving technology allows for individual Internet users to be tracked, building profiles that are a vital tool for advertisers. Connections to multiple third-party tech firms were documented by technology experts who analyzed HealthCare.gov, and confirmed by The Associated Press. There is no evidence that personal information from HealthCare.gov has been misused, but the number of outside connections is raising questions. ‘As I look at vendors on a website...they could be another potential point of failure,’ said corporate cybersecurity consultant Theresa Payton. ‘Vendor management can often be the weakest link in your privacy and security chain.’ A former White House chief information officer under President George W. Bush, she said the large number of outside connections on HealthCare.gov seems like ‘overkill’ and makes it ‘kind of an outlier’ among government websites. The privacy concerns come against the backdrop of President Barack Obama's new initiative to protect personal data online, a highlight of his State of the Union message scheduled for Tuesday night. The administration is getting the health care website ready for the final enrollment drive of 2015, aiming to have more than 9 million people signed up by Feb. 15 for subsidized private coverage. Medicare spokesman Aaron Albright said outside vendors ‘are prohibited from using information from these tools on HealthCare.gov for their companies' purposes.’ The government uses them to measure the performance of HealthCare.gov so consumers get ‘a simpler, more streamlined and intuitive experience,’ he added. The administration did not explain how it ensures that privacy and security policies are being followed. Third-party outfits that track website performance are a standard part of e-commerce. HealthCare.gov's privacy policy says in boldface that ‘no personally identifiable information is collected’ by these web measurement tools.

<http://www.nytimes.com/aponline/2015/01/20/us/politics/ap-us-health-overhaul-privacy.html?utm_campaign=KHN%3A+First+Edition&utm_source=hs_email&utm_medium=email&utm_content=15655515&_hsenc=p2ANqtz-88PoYGuX2x-zhZjk8KLpAy95DWFPP07hX5FuEez_qbcgvmcnNy23EOKSdz>

**Spread the Word: Consumers Will Receive Subsidies Documentation in the Mail**

Charlotte Observer

If you're among the millions of consumers who got financial help for health insurance last year under President Barack Obama's law, better keep an eye on your mailbox. The administration said Monday it has started sending out tax reporting forms that you'll need to fill out your 2014 return. Like W-2s for health care, they're for people who got health insurance tax credits provided under the law. Because this is the first time Americans will experience the complex connections between the health care law and taxes, there's concern that some people may not realize the new forms are important, and that they do need to open that envelope. Some consumers may not know what to do with the paperwork. Called 1095-A, the forms come filled out with information from HealthCare.gov or your state's insurance exchange. They list who in each household got subsidized coverage, and how much the government paid each month to help with premiums. You don't actually file the form with your tax return, but you can't complete your return without the information it contains. Taxpayers, or their tax preparers, will use the financial details to fill out yet another form — 8962. That one is used to determine whether people received the right amount of assistance that they were legally entitled to. The amount of the tax credit is based on a formula that takes into account income, household size, and health insurance costs in your community. Those who got too much of a subsidy will get their tax refunds reduced by the IRS. For example, you can get dinged if your income went up during the year, and you didn't realize you had to report that to HealthCare.gov or your state insurance exchange. If you received less of a subsidy than you were entitled to, the IRS will owe you instead.

<http://www.charlotteobserver.com/2015/01/12/5442247/got-help-paying-for-health-care.html?utm_campaign=KHN:+First+Edition&utm_source=hs_email&utm_medium=email&utm_content=15562094&_hsenc=p2ANqtz--tbXyGRIXxSjkbJLoWYbi-46bFRQ1jBvOUfBcB8TPOsAyuWDlcPBfE#.VL8BmqR0y1s>

**Supreme Court Battle Brewing Over Medicaid Fees**

Kaiser Health News

Rita Gorenflo’s 7-year-old son Nathaniel was in severe pain from a sinus infection.

But since the boy was covered by Medicaid, she couldn’t immediately find a specialist willing to see him.  After days of calling, she was finally able to get Nathaniel an appointment nearly a week later near their South Florida home. That was in 2005.

Last month, [ruling](http://www.pilcop.org/wp-content/uploads/2012/01/1294-14-12-31-Findings-of-Fact-and-Conclusions-of-Law.pdf) in a lawsuit brought by the state’s pediatricians and patient advocacy groups, a federal district judge in Miami determined Nathaniel’s wait was “unreasonable” and that Florida’s Medicaid program was failing him and nearly 2 million other children by not paying enough money to doctors and dentists to ensure the kids have adequate access to care.

The Florida case is the latest effort to get federal judges to force states to increase Medicaid provider payment rates for the state and federal program that covers about 70 million low-income Americans. In the past two decades, similar cases have been filed in numerous states, including California, Illinois, Massachusetts, Oklahoma, Texas and the District of Columbia– with many resulting in higher pay.

But while providers and patient advocates nationwide hailed the Florida decision, they are deeply worried about a U.S. Supreme Court case  that they say could restrict their ability across the country to seek judicial relief from low Medicaid reimbursement rates.

The high court on Jan. 20 will hear a [case from Idaho](http://www.scotusblog.com/case-files/cases/armstrong-v-exceptional-child-center-inc/) seeking to overturn a 2011 lower court order to increase payments to providers serving Medicaid enrollees with development disabilities. In the original case, five centers serving developmentally disabled adults and children argued that Idaho was unfairly keeping Medicaid reimbursement rates at 2006 levels despite studies showing that the cost of providing care had risen.

[Idaho officials](http://www.ag.idaho.gov/media/newsReleases/2014/nr_07022014.html) argue only the state and federal government should be able to set provider fees in Medicaid  and all other “private parties,” including patients and providers, should not be able to use the court system to gain higher rates. Twenty-seven states and [the Obama administration](http://www.justice.gov/sites/default/files/osg/briefs/2014/12/10/14-15tsunitedstates.pdf) are supporting Idaho’s appeal, along with the National Governors Association.

But providers and patient advocacy groups say they need to use the courts because states too often put their overall budgetary needs over the need of Medicaid patients to have adequate access to doctors and hospitals. Low rates inhibit doctors, dentists and other providers from participating in Medicaid, they say.

“Without recourse to the courts… hospitals and other providers will continue to bear losses that, for some, are unsustainable,” the American Hospital Association said in a brief filed in the Supreme Court case.

This KHN story can be republished for free ([details](http://www.kaiserhealthnews.org/Syndication.aspx)).

Although federal law says provider payments should be sufficient for Medicaid recipients to have the same access to services as those with private insurance, advocates say in court papers that the federal government is “a paper tiger”  when it comes to enforcement.

Battles over rates paid by Medicaid, the nation’s largest single health program, are nothing new. Access issues have gained more attention recently, however, because 27 states have expanded eligibility under the Affordable Care Act, resulting in enrollment of millions more people.

Matt Salo, executive director of the National Association of Medicaid Directors, said patients and providers already have the ability to lobby state and federal governments to raise reimbursement rates.

“These lawsuits result in a massive expenditure of states’ limited resources,” he said. “There are more appropriate avenues for them to get their concerns across than dragging state Medicaid agencies to court.”

If Idaho wins its appeal to the Supreme Court,  the decision could severely limit such suits, legal experts say.

“It would be beyond just a chilling effect,” said Sarah Somers, managing attorney for the National Health Law Program, a patient advocacy group.

The lawsuits are not frivolous, she said — they are an important tool. “The record of success in lawsuits …shows that courts found that Medicaid laws were being violated. If it costs money to enforce the law and to comply with it, that’s not a waste**.”**

Other lawyers for providers and patients agreed.

“These cases can be very effective in terms of increasing rates,” said Zenia Sanchez Fuentes, an attorney in Washington, D.C. Her firm helped argue a case that in 2006 led the District to increase fees to dentists, which led to more dentists seeing Medicaid patients. That lawsuit was initially filed in 1993.

“It can take a while, but it’s well worth taking on,” she said.

Somers pointed to the Florida case as one example of why providers and patients groups need the courts.

For years, Florida has been one of the lowest-paying states in reimbursing physicians, court documents show. The low pay has led many physicians either to not participate in Medicaid or severely limit how many recipients they are willing to see, the court ruled.

Florida’s own reports showed that in 2007 more than 380,000 children on Medicaid who should have received at least one checkup did not receive any preventive care. In the same year, the study showed just one in five children on Medicaid saw a dentist, the lowest rate in the country.

Such access problems are not unique to Florida.

A federal study in November found millions of low-income children were failing to get the free preventive exams and screenings guaranteed by Medicaid and the Obama administration is not doing enough to fix the problem.

The report, by the Department of Health and Human Services’ Office of Inspector General, found 63 percent of children on Medicaid received at least one medical screening in 2013, up from 56 percent in 2006, but the figure was still far below the department’s goal of 80 percent. Florida’s rate in 2013 was 57 percent.

Tommy Schechtman is a president of the Florida chapter of the American Academy of Pediatrics and a Palm Beach Gardens pediatrician who testified in the Florida case.

He said the pediatricians did not want to file the lawsuit, but the state gave them no other option.

“We were not making any progress in Florida in improving access and we had seen some success in other states with litigation,” he said**.**

U.S. District Judge Adalberto Jordan, ruling on a 10-year old case on New Year’s Eve, found Florida was violating federal Medicaid law by not ensuring that children have adequate access to providers.

Florida officials could appeal the decision, and plaintiffs’ attorney Stuart Singer said the Supreme Court decision in the Idaho case could complicate matters.

The Florida Medicaid agency harshly criticized the ruling.  “The Judge’s outdated observations pertain to a Medicaid program that no longer exists,” said a statement from the Florida Agency for Health Care Administration.

“Florida’s new statewide Medicaid managed care program is cost-effective and a working success.”

In Medicaid managed care, the state pays private health plans a monthly rate per member to coordinate coverage. Until last year, managed care was optional for most Florida Medicaid recipients.

For years, Florida health officials have said managed care companies help patients because the state can hold such plans accountable if they deliver poor care — a point often disputed by providers. Health plans often limit the number of providers to steer patients to those in their networks.

In his ruling, Judge Jordan said the care and access the Medicaid plans provided was no better than the state’s traditional system  in which it pays providers directly for each service provided.

“Children enrolled in Medicaid HMOs suffer from the same lack of access as children in …fee-for-service Medicaid,” his ruling said.

Jordan will hold a hearing later in January to determine a penalty and how the state should fix the problem.

For Rita Gorenflo, whose son Nathaniel is now 16, the Florida ruling is good news, though it’s uncertain what it will mean for her family because the case took so long to wind its way through the courts.

“I am thrilled that all of the kids on Medicaid will be able to access better care,” said Gorenflo,  an emergency room nurse for 18 years. “I can advocate for my kids fairly well, but there are some parents that can’t, and their kids deserve care.”

<http://kaiserhealthnews.org/news/supreme-court-battle-brewing-over-medicaid-fees/?utm_campaign=KHN:+First+Edition&utm_source=hs_email&utm_medium=email&utm_content=15543103&_hsenc=p2ANqtz-9IWHYNTDsoCWyPPsdYoMK8TRLMOrTvy29D-ApHF5QCIujDzzL9uurNSihT2rT>

**Feds to Investigate Insurance Companies for Discriminatory Benefit Designs**

The New York Times

The Obama administration said Monday that it would investigate prescription drug coverage and other benefits offered by health insurance companies to see if they discriminated against people with AIDS, mental illness, diabetes or other costly chronic conditions. The administration said it had become aware of ‘discriminatory benefit designs’ that discouraged people from enrolling because of age or medical condition. In a letter to insurers, administration officials said that a health plan could be engaging in unlawful discrimination if its list of approved drugs excluded all medicines needed to treat a particular condition, or if it restricted access to such drugs by charging large co-payments or requiring prior authorization. The Centers for Medicare and Medicaid Services said it would focus on companies in the federal insurance marketplace. For each health plan, it said, it will try to determine the ‘estimated out-of-pocket costs associated with standard treatment protocols for specific medical conditions using nationally recognized clinical guidelines.’ The conditions, it said, are likely to include bipolar disorder, diabetes, H.I.V., rheumatoid arthritis and schizophrenia. The Affordable Care Act says that insurers must accept all applicants for coverage and cannot charge higher premiums because of a person’s pre-existing conditions or disabilities. Advocates for people with H.I.V./AIDS and certain other illnesses have complained that insurers were unduly limiting access to benefits.

<http://www.nytimes.com/2014/12/23/us/politics/obama-administration-to-investigate-insurers-for-bias-against-costly-conditions.html?utm_campaign=KHN:+First+Edition&utm_source=hs_email&utm_medium=email&utm_content=15389489&_hsenc=p2ANqtz-8jGhwvgV2t6p>

**New Health Literacy Resources**

Surveys show that many adults struggle to define important health insurance terms such as deductible or coinsurance. Many adults also struggle with understanding and processing basic health information. [**A new toolkit**](http://statereforum.us7.list-manage1.com/track/click?u=f5b50110fdd7921c0139473f9&id=d1020695be&e=a054486174) from the Alliance for Health Reform on the topic of health and health insurance literacy includes analysis of these surveys, as well as resources and experts that can offer in-depth information on this topic. Health literacy improvement efforts in [**New York**](http://statereforum.us7.list-manage.com/track/click?u=f5b50110fdd7921c0139473f9&id=1ea54b08d9&e=a054486174), [**Minnesota**](http://statereforum.us7.list-manage.com/track/click?u=f5b50110fdd7921c0139473f9&id=388ad9d2cc&e=a054486174), [**Kentucky**](http://statereforum.us7.list-manage.com/track/click?u=f5b50110fdd7921c0139473f9&id=f2d3d5f9be&e=a054486174) and [**Pennsylvania**](http://statereforum.us7.list-manage1.com/track/click?u=f5b50110fdd7921c0139473f9&id=417120877c&e=a054486174) are also mentioned.

Among the findings:

Only 12 percent of adults had proficient health literacy, 53 percent had intermediate, 22 percent had basic and 14 percent had below basic health literacy, a landmark Department of Education study concluded.

See <http://www.allhealth.org/publications/Private_health_insurance/Health-Literacy-Toolkit_163.pdf?utm_source=Email+news+subscribers&utm_campaign=61df4c3992-Newsletter_1621_30_2015&utm_medium=email&utm_term=0_b9f62f37ab-61df4c3992-89820469> for the toolkit.

**Changes in Federal Poverty Level**

For the federal Marketplace, as it pertains to tax credits and cost sharing reductions, the 2014 FPL guidelines will be used for all of 2015. The HC.gov website will use the 2015 FPL guidelines for Medicaid eligibility determinations only.

AHCCCS reports that the 2015 guidelines are being used as of February 1.

The 2015 Federal Poverty Level Guidelines can be found here: <http://aspe.hhs.gov/poverty/15poverty.cfm>.

**CMS Resources for Assisters**

CMS

* Common Complex Scenarios: Eligibility and Household Complications- <https://marketplace.cms.gov/technical-assistance-resources/eligibility-and-household-complications.pdf>
* Healthcare.gov FAQ for consumers who were automatically enrolled- <https://www.healthcare.gov/help/automatic-enrollment/>

**Tax Information and the ACA**

Sources include CMS, Families USA

Consumers should begin receiving the 1095-A in early February. A sample can be found here: [Sample 1095-A](http://cts.vresp.com/c/?FamiliesUSAFoundatio/c290c47050/35135f202b/ff34c6c699)

The information on the 1095-A is used by the consumer to complete the tax [Form 8962](http://cts.vresp.com/c/?FamiliesUSAFoundatio/c290c47050/35135f202b/5c05ead56f), Premium Tax Credit. This form should be completed to reconcile advance payments of the premium tax credit, and to claim this credit on the tax return. Instructions for the form are available [here](http://links.govdelivery.com:80/track?type=click&enid=ZWFzPTEmbWFpbGluZ2lkPTIwMTUwMTI3LjQwODEyNzUxJm1lc3NhZ2VpZD1NREItUFJELUJVTC0yMDE1MDEyNy40MDgxMjc1MSZkYXRhYmFzZWlkPTEwMDEmc2VyaWFsPTE3MzY3ODEyJmVtYWlsaWQ9bWVyeWxkQGFhY2hjLm9yZyZ1c2VyaWQ9bWVyeWxkQGFhY2hjLm9yZyZmbD0mZXh0cmE9TXVsdGl2YXJpYXRlSWQ9JiYm&&&122&&&http://www.irs.gov/pub/irs-pdf/i8962.pdf).

Tax [Form 8965](http://cts.vresp.com/c/?FamiliesUSAFoundatio/c290c47050/35135f202b/4689076322) is used to report a Marketplace-granted coverage exemption or claim an IRS-granted coverage exemption on the return.

Tax reminder: Marketplace call center vs. the IRS—where do people go for questions?

* The IRS handles questions about filing taxes, paying taxes, delaying paying taxes, and on how to complete tax related forms 8962 and 8965 (think how to complete it NOT why are the numbers the way they are)
* The Marketplace answers questions how to handle incorrect information on the forms, what the different tax credits are, who is exempt, penalties for not having coverage.

Here are some tips for completing tax returns as it related to premium tax credits:

Changes to Existing Forms

[Form 1040](http://links.govdelivery.com:80/track?type=click&enid=ZWFzPTEmbWFpbGluZ2lkPTIwMTUwMTI3LjQwODEyNzUxJm1lc3NhZ2VpZD1NREItUFJELUJVTC0yMDE1MDEyNy40MDgxMjc1MSZkYXRhYmFzZWlkPTEwMDEmc2VyaWFsPTE3MzY3ODEyJmVtYWlsaWQ9bWVyeWxkQGFhY2hjLm9yZyZ1c2VyaWQ9bWVyeWxkQGFhY2hjLm9yZyZmbD0mZXh0cmE9TXVsdGl2YXJpYXRlSWQ9JiYm&&&124&&&http://www.irs.gov/file_source/pub/irs-access/f1040_accessible.pdf), U.S. Individual Income Tax Return

* Line 46: Enter advance payments of the premium tax credit that must be repaid
* Line 61: Report health coverage and enter individual shared responsibility payment
* Line 69: If eligible, claim net premium tax credit, which is the excess of allowed premium tax credit over advance credit payments

[Form 1040A](http://links.govdelivery.com:80/track?type=click&enid=ZWFzPTEmbWFpbGluZ2lkPTIwMTUwMTI3LjQwODEyNzUxJm1lc3NhZ2VpZD1NREItUFJELUJVTC0yMDE1MDEyNy40MDgxMjc1MSZkYXRhYmFzZWlkPTEwMDEmc2VyaWFsPTE3MzY3ODEyJmVtYWlsaWQ9bWVyeWxkQGFhY2hjLm9yZyZ1c2VyaWQ9bWVyeWxkQGFhY2hjLm9yZyZmbD0mZXh0cmE9TXVsdGl2YXJpYXRlSWQ9JiYm&&&125&&&http://www.irs.gov/file_source/pub/irs-prior/f1040a--2014.pdf), U.S. Individual Income Tax Return

* Line 29: Enter advance payments of the premium tax credit that must be repaid
* Line 38: Report health coverage and enter individual shared responsibility payment
* Line 45: If eligible, claim net premium tax credit, which is the excess of allowed premium tax credit over advance credit payments

[Form 1040-EZ](http://links.govdelivery.com:80/track?type=click&enid=ZWFzPTEmbWFpbGluZ2lkPTIwMTUwMTI3LjQwODEyNzUxJm1lc3NhZ2VpZD1NREItUFJELUJVTC0yMDE1MDEyNy40MDgxMjc1MSZkYXRhYmFzZWlkPTEwMDEmc2VyaWFsPTE3MzY3ODEyJmVtYWlsaWQ9bWVyeWxkQGFhY2hjLm9yZyZ1c2VyaWQ9bWVyeWxkQGFhY2hjLm9yZyZmbD0mZXh0cmE9TXVsdGl2YXJpYXRlSWQ9JiYm&&&126&&&http://www.irs.gov/file_source/pub/irs-access/f1040ez_accessible.pdf), U.S. Individual Income Tax Return

* Line 11: Report health coverage and enter individual shared responsibility payment
* Form 1040EZ cannot be used to report advance payments or to claim the premium tax credit

**Tax Info for Consumers from Consumers Union**

Health Insurance & Tax Credits: What to Do at Tax Time – This fact sheet uses consumer–friendly language to explain what consumers need to know about the tax filing process if they purchased Marketplace coverage and provides basic definitions for concepts including “tax credit reconciliation.”

* To view this fact sheet in English, [click here](http://links.govdelivery.com:80/track?type=click&enid=ZWFzPTEmbWFpbGluZ2lkPTIwMTUwMTI3LjQwODEyNzUxJm1lc3NhZ2VpZD1NREItUFJELUJVTC0yMDE1MDEyNy40MDgxMjc1MSZkYXRhYmFzZWlkPTEwMDEmc2VyaWFsPTE3MzY3ODEyJmVtYWlsaWQ9bWVyeWxkQGFhY2hjLm9yZyZ1c2VyaWQ9bWVyeWxkQGFhY2hjLm9yZyZmbD0mZXh0cmE9TXVsdGl2YXJpYXRlSWQ9JiYm&&&151&&&http://consumersunion.org/wp-content/uploads/2014/11/Health_Ins_tax_credits.pdf).
* To view this fact sheet in Spanish, [click here](http://links.govdelivery.com:80/track?type=click&enid=ZWFzPTEmbWFpbGluZ2lkPTIwMTUwMTI3LjQwODEyNzUxJm1lc3NhZ2VpZD1NREItUFJELUJVTC0yMDE1MDEyNy40MDgxMjc1MSZkYXRhYmFzZWlkPTEwMDEmc2VyaWFsPTE3MzY3ODEyJmVtYWlsaWQ9bWVyeWxkQGFhY2hjLm9yZyZ1c2VyaWQ9bWVyeWxkQGFhY2hjLm9yZyZmbD0mZXh0cmE9TXVsdGl2YXJpYXRlSWQ9JiYm&&&152&&&http://consumersunion.org/wp-content/uploads/2014/11/Seguros_medicos_creditos.pdf).

Premium Tax Credits and “Tax Reconciliation” – This fact sheet includes commonly asked questions about the premium tax credit reconciliation process using a Q&A format and consumer –friendly language.

* To view this fact sheet in English, [click here](http://links.govdelivery.com:80/track?type=click&enid=ZWFzPTEmbWFpbGluZ2lkPTIwMTUwMTI3LjQwODEyNzUxJm1lc3NhZ2VpZD1NREItUFJELUJVTC0yMDE1MDEyNy40MDgxMjc1MSZkYXRhYmFzZWlkPTEwMDEmc2VyaWFsPTE3MzY3ODEyJmVtYWlsaWQ9bWVyeWxkQGFhY2hjLm9yZyZ1c2VyaWQ9bWVyeWxkQGFhY2hjLm9yZyZmbD0mZXh0cmE9TXVsdGl2YXJpYXRlSWQ9JiYm&&&153&&&https://consumersunion.org/wp-content/uploads/2014/11/Tax_reconciliation_FAQ.pdf).
* To view this fact sheet in Spanish, [click here](http://links.govdelivery.com:80/track?type=click&enid=ZWFzPTEmbWFpbGluZ2lkPTIwMTUwMTI3LjQwODEyNzUxJm1lc3NhZ2VpZD1NREItUFJELUJVTC0yMDE1MDEyNy40MDgxMjc1MSZkYXRhYmFzZWlkPTEwMDEmc2VyaWFsPTE3MzY3ODEyJmVtYWlsaWQ9bWVyeWxkQGFhY2hjLm9yZyZ1c2VyaWQ9bWVyeWxkQGFhY2hjLm9yZyZmbD0mZXh0cmE9TXVsdGl2YXJpYXRlSWQ9JiYm&&&154&&&http://consumersunion.org/wp-content/uploads/2014/11/Reconciliacion_de_impuestos.pdf).

**More Information on Taxes and Form 1095-A**

CMS

* Updated tax content and two tax tools (LCBP and SLCSP):  [www.healthcare.gov/taxes](http://www.healthcare.gov/taxes)
	+ <https://www.healthcare.gov/taxes/tools/#bronzeplan>
	+ <https://www.healthcare.gov/taxes/tools/#silverplan>
* Under the “Taxes” heading at the “Already enrolled” link, you will find fact sheets, checklist, drop in articles, and infographics:  <https://marketplace.cms.gov/outreach-and-education/already-enrolled.html>
* A recent blog post called “Things to know about health insurance and your taxes” can be found on HC.gov: <https://www.healthcare.gov/blog/things-to-know-about-health-insurance-and-your-taxes/>
* The “3 Tips about Marketplace Coverage and Your Taxes” video can be found on YouTube: <http://youtu.be/MFb3YX_p-Ow>

Here are some tips about IRS Free File (<http://www.irs.gov/uac/Do-Your-Taxes-for-Free-Use-IRS-Free-File>):

1. **Go to** [www.IRS.gov/FreeFile](http://www.IRS.gov/FreeFile) **.** The only way to use IRS Free File is through the IRS website. Once you choose a Free File company, you’ll go to their website to prepare and e-file your federal tax return.
2. **Find tax breaks.**  The question and answer format of tax software will help you find tax breaks. This could include tax credits, such as the Earned Income Tax Credit. The software selects the appropriate tax forms and does the calculations for you. Free File can help with the new health care law tax provisions as well.
3. **Free for all.**  If you made $60,000 or less you can use brand-name software. If you earned more, you can use Free File Fillable Forms. This option uses electronic versions of IRS paper forms. It is best for people who are used to doing their own taxes.
4. **Easy online extensions.** If you can’t finish your tax return by the April 15 deadline, it’s easy to use Free File to ask for a six-month extension. An extension of time to file is not an extension of time to pay. If you owe federal taxes, you need to estimate the amount and pay it with your request to avoid penalties and interest.

The IRS partners with 14 leading tax software companies, the Free File Alliance, to make this service available. Some companies offer free federal and free state returns. Choose your option on [IRS.gov/freefile](http://links.govdelivery.com:80/track?type=click&enid=ZWFzPTEmbWFpbGluZ2lkPTIwMTUwMTIxLjQwNTM0NTExJm1lc3NhZ2VpZD1NREItUFJELUJVTC0yMDE1MDEyMS40MDUzNDUxMSZkYXRhYmFzZWlkPTEwMDEmc2VyaWFsPTE2OTYyMzQyJmVtYWlsaWQ9dGFuY2hpY2EudGVycnlAY21zLmhocy5nb3YmdXNlcmlkPXRhbmNoaWNhLnRlcnJ5QGNtcy5oaHMuZ292JmZsPSZleHRyYT1NdWx0aXZhcmlhdGVJZD0mJiY=&&&131&&&http://www.irs.gov/uac/Free-File:-Do-Your-Federal-Taxes-for-Free). If you found this Tax Tip helpful, please share it through your social media platforms. A great way to get tax information is to use [IRS Social Media](http://links.govdelivery.com:80/track?type=click&enid=ZWFzPTEmbWFpbGluZ2lkPTIwMTUwMTIxLjQwNTM0NTExJm1lc3NhZ2VpZD1NREItUFJELUJVTC0yMDE1MDEyMS40MDUzNDUxMSZkYXRhYmFzZWlkPTEwMDEmc2VyaWFsPTE2OTYyMzQyJmVtYWlsaWQ9dGFuY2hpY2EudGVycnlAY21zLmhocy5nb3YmdXNlcmlkPXRhbmNoaWNhLnRlcnJ5QGNtcy5oaHMuZ292JmZsPSZleHRyYT1NdWx0aXZhcmlhdGVJZD0mJiY=&&&132&&&http://www.irs.gov/uac/IRS-New-Media-1). You can also subscribe to [IRS Tax Tips](http://links.govdelivery.com:80/track?type=click&enid=ZWFzPTEmbWFpbGluZ2lkPTIwMTUwMTIxLjQwNTM0NTExJm1lc3NhZ2VpZD1NREItUFJELUJVTC0yMDE1MDEyMS40MDUzNDUxMSZkYXRhYmFzZWlkPTEwMDEmc2VyaWFsPTE2OTYyMzQyJmVtYWlsaWQ9dGFuY2hpY2EudGVycnlAY21zLmhocy5nb3YmdXNlcmlkPXRhbmNoaWNhLnRlcnJ5QGNtcy5oaHMuZ292JmZsPSZleHRyYT1NdWx0aXZhcmlhdGVJZD0mJiY=&&&133&&&http://www.irs.gov/uac/Subscribe-to-IRS-Tax-Tips) or any of our [e-news subscriptions](http://links.govdelivery.com:80/track?type=click&enid=ZWFzPTEmbWFpbGluZ2lkPTIwMTUwMTIxLjQwNTM0NTExJm1lc3NhZ2VpZD1NREItUFJELUJVTC0yMDE1MDEyMS40MDUzNDUxMSZkYXRhYmFzZWlkPTEwMDEmc2VyaWFsPTE2OTYyMzQyJmVtYWlsaWQ9dGFuY2hpY2EudGVycnlAY21zLmhocy5nb3YmdXNlcmlkPXRhbmNoaWNhLnRlcnJ5QGNtcy5oaHMuZ292JmZsPSZleHRyYT1NdWx0aXZhcmlhdGVJZD0mJiY=&&&134&&&http://www.irs.gov/uac/e-News-Subscriptions-2).

Here are additional tools and resources related to taxes:

* Claim affordability exemption & calculate PTC- <https://www.healthcare.gov/taxes/tools/>
* Tax Policy Center’s ACA (Estimated) Tax Penalty Calculator- <http://taxpolicycenter.org/taxfacts/acacalculator.cfm>
* Turbo Tax’s ACA (Estimated) Tax Penalty Calculator- <https://turbotax.intuit.com/health-care/>
* ACA training course for VITA volunteers (free)- <https://cbpp.eleapcourses.com/>
* Health coverage and federal income taxes fact sheet- <https://marketplace.cms.gov/technical-assistance-resources/health-coverage-and-federal-taxes.pdf>
* Exemption 101 explainer- <https://marketplace.cms.gov/technical-assistance-resources/exemption-101-explainer.pdf>
* Corporation for Enterprise Development’s Weekly newsletter- <http://cfed.org/programs/taxpayer_opportunity_network/quality_weekly/>
* HHS to work with non-profit organizations and tax preparers to help consumers understand the intersection of taxes and healthcare (has list of organizations sharing tax info with consumers)- <http://www.hhs.gov/news/press/2015pres/01/20150128a.html>
* HHS tax fact sheet- <http://www.hhs.gov/healthcare/facts/factsheets/2015/01/health-coverage-federal-income-taxes.html>

**Where to Refer Consumers with Tax-Related Questions (Marketplace Call Center vs. IRS)**

CMS

This chart provides a reference on when consumers should contact the Marketplace Call Center or the IRS if they have questions about how their coverage status and/or Marketplace financial assistance will affect the tax filing process. As mentioned above, the Marketplace generates Form 1095-A, which is a summary statement for a consumer or anyone in his or her household enrolled in a health plan through the Marketplace. **The Call Center will explain the importance of Form 1095-A, how it will be used, who receives it, where to find it, and whether consumers can file taxes early before receiving it.**  The IRS generates Form 8962: “Premium Tax Credit”, and Form 8965, “Health Coverage Exemptions”. Consumers will use Form 8962 to claim premium tax credits by completing it with information from Form 1095-A, and consumers will use Form 8965 to file for exemptions from the individual shared responsibility payment.



**FAQs: Shared Responsibility Payments**

CMS

Q: For consumers who are applying for an affordability exemption, how does a consumer calculate or find out what the lowest cost bronze plan is in order to claim the exemption?

A: Consumers can access the lowest cost bronze plan finder tool on [https://www.healthcare.gov/taxes/](http://links.govdelivery.com:80/track?type=click&enid=ZWFzPTEmbWFpbGluZ2lkPTIwMTUwMTI3LjQwODEyNzUxJm1lc3NhZ2VpZD1NREItUFJELUJVTC0yMDE1MDEyNy40MDgxMjc1MSZkYXRhYmFzZWlkPTEwMDEmc2VyaWFsPTE3MzY3ODEyJmVtYWlsaWQ9bWVyeWxkQGFhY2hjLm9yZyZ1c2VyaWQ9bWVyeWxkQGFhY2hjLm9yZyZmbD0mZXh0cmE9TXVsdGl2YXJpYXRlSWQ9JiYm&&&136&&&https://www.healthcare.gov/taxes/). Consumers may need the premium for the lowest cost Bronze plan that was available to them for 2014 when they fill out Form 8965 to claim the exemption for coverage being unaffordable and you can find more information on this tool [here](http://links.govdelivery.com:80/track?type=click&enid=ZWFzPTEmbWFpbGluZ2lkPTIwMTUwMTI3LjQwODEyNzUxJm1lc3NhZ2VpZD1NREItUFJELUJVTC0yMDE1MDEyNy40MDgxMjc1MSZkYXRhYmFzZWlkPTEwMDEmc2VyaWFsPTE3MzY3ODEyJmVtYWlsaWQ9bWVyeWxkQGFhY2hjLm9yZyZ1c2VyaWQ9bWVyeWxkQGFhY2hjLm9yZyZmbD0mZXh0cmE9TXVsdGl2YXJpYXRlSWQ9JiYm&&&137&&&https://www.healthcare.gov/taxes/tools/#bronzeplan). Remember consumers won’t need to use this tool if they already have an Exemption Certificate Number (ECN) for this exemption. Consumers will just enter their ECN on Part 1 of Form 8965.

To claim the affordability exemption, consumers will also need to know how much financial assistance they were eligible for by looking up the premium for the second lowest cost Silver plan (SLCSP) available to them for 2014. This information is also available on [https://www.healthcare.gov/taxes/](http://links.govdelivery.com:80/track?type=click&enid=ZWFzPTEmbWFpbGluZ2lkPTIwMTUwMTI3LjQwODEyNzUxJm1lc3NhZ2VpZD1NREItUFJELUJVTC0yMDE1MDEyNy40MDgxMjc1MSZkYXRhYmFzZWlkPTEwMDEmc2VyaWFsPTE3MzY3ODEyJmVtYWlsaWQ9bWVyeWxkQGFhY2hjLm9yZyZ1c2VyaWQ9bWVyeWxkQGFhY2hjLm9yZyZmbD0mZXh0cmE9TXVsdGl2YXJpYXRlSWQ9JiYm&&&138&&&https://www.healthcare.gov/taxes/).

Q: What if a consumer could afford a bronze plan, but the silver plans were above 8% of their income, do they qualify for an affordability exemption?

A: No, the affordability exemption is based on a consumer’s ability to pay for the lowest cost bronze plan (or employer sponsored coverage, if offered). To qualify for an affordability exemption the lowest cost bronze plan available to the consumer (or employer sponsored coverage if offered) in 2014 would have to cost more than 8% of their household income.

**Helping Consumers with Data Matching Issues**

CMS

Background Information on Data Matching Issues

For most consumers, the information submitted on their Marketplace application is immediately verified by the Marketplace. But in some cases, the information the applicant provides does not match up with existing records or the applicant does not provide enough information to match with existing records. These types of situations are called data matching issues or inconsistencies. For consumers with data matching issues, the Marketplace uses the information the consumer provides to determine their eligibility, and if eligible, the consumers are able to continue to plan selection and enrollment. The consumer’s eligibility notice informs them of their eligibility determination and that more information is needed.

In most cases, these consumers are still able to enroll in Marketplace coverage, but they need to follow up with the Marketplace as soon as possible and provide additional documentation to ensure the Marketplace has the correct information. Under the law, consumers are given 90-95 days in which to submit additional documentation to verify their application information. Consumers who are newly-enrolled during 2015 open enrollment are still within that 90-95 day window. It is important to remember that while the Marketplace is working to review a consumer’s documentation, the consumer will be able to keep his or her Marketplace coverage.

As assisters, many of you helped consumers resolve data matching issues during the last plan year. This section provides an update for assisters on next steps for consumers who have 2014 data matching issues and/or 2015 data matching issues. Assisters can help consumers review their notices from the Marketplace to identify what documents the Marketplace needs and help determine whether or not consumers have submitted the required information. If a consumer has not submitted the required documents, assisters can help consumers upload or mail documents to the Marketplace. When possible, we suggest that consumers upload their documents to expedite the matching process. The Marketplace will continue to work with consumers to get the information needed to resolve data matching issues.

Reminder Notices to Consumers with Unresolved 2014 and 2015 Data Matching Issues

Beginning the first week of February, the Marketplace will begin terminating 2015 coverage for consumers with *unresolved 2014 citizenship and immigration data matching issues* who are also enrolled in coverage for 2015. Likewise, consumers with *unresolved 2014 income data matching issues* who are also enrolled in coverage for 2015 will have their APTC/CSRs re-determined based on available tax data. These consumers received 60-day and 30-day reminder notices and calls in 2014 to resolve their data matching issues. Consumers that were enrolled in the latter half of 2014 recently were sent a separate reminder notice. The title of the notice is, “Important: Respond by January 31, 2015 to keep your Marketplace health coverage.” These notices are being sent in English or Spanish, and mailed and/or emailed based on the consumer’s language and notification preferences. These consumers already received their Eligibility Determination Notice and recently got a call from the Marketplace to inform them that they still have not resolved their citizenship/immigration and/or annual income data matching issues.

Consumers who received 2014 and 2015 Eligibility Determination Notices, follow-up reminder notices, and phone calls from the Marketplace, but did not resolve their data matching issue will be subject to expiration. That is, the Marketplace will update their coverage status based on the information received by the Marketplace. For example, if a consumer with an outstanding income data matching issue did not submit documentation by January 31, 2015 to resolve their data matching issue, expiration will mean that the Marketplace will re-determine the consumer’s advance premium tax credit (APTC) and cost-sharing reductions (CSRs) based on available tax data. In this case, a consumer with an unresolved income data matching issue may have to pay a higher monthly premium, deductible, copayments and/or coinsurance through the Marketplace. Consumers with a citizenship/immigration data matching issue will be terminated from coverage if they do not resolve their data matching issue by January 31, 2015. CMS will be taking action on consumers with annual income and citizenship/immigration data matching issues and notifying them of the changes and next steps available to them. Consumers with a citizenship/immigration data matching issue that are terminated from coverage can submit documentation to the Marketplace to resolve their data matching issue and regain coverage through a Special Enrollment Period.

Expiration Plan for Unresolved 2015 Data Matching Issues

Starting in February, consumers with unresolved data matching issues that were newly generated upon 2015 application submission will be resolved based on when the consumer received their eligibility determination notice. For example, if a consumer received their eligibility determination on November 15th and has a data matching issue they would be expired 90-95 days following receipt of their eligibility determination.

Additionally, similar to 2014, consumers with data matching issues in 2015 will receive a 60-day notice, a 30-day notice, and a reminder phone call 60 days and 14 days before they are set to expire. Unlike in 2014, consumers must be able to resolve their data matching issue; simply submitting documentation to the Marketplace will not be enough to prevent expiration. More details on the expiration plan for unresolved 2015 data matching issues will be coming soon.

Resources:

We have several resources to help assisters assist consumers in resolving data matching or inconsistency issues:

* [How do I resolve an inconsistency?](http://links.govdelivery.com:80/track?type=click&enid=ZWFzPTEmbWFpbGluZ2lkPTIwMTUwMTI3LjQwODEyNzUxJm1lc3NhZ2VpZD1NREItUFJELUJVTC0yMDE1MDEyNy40MDgxMjc1MSZkYXRhYmFzZWlkPTEwMDEmc2VyaWFsPTE3MzY3ODEyJmVtYWlsaWQ9bWVyeWxkQGFhY2hjLm9yZyZ1c2VyaWQ9bWVyeWxkQGFhY2hjLm9yZyZmbD0mZXh0cmE9TXVsdGl2YXJpYXRlSWQ9JiYm&&&108&&&https://www.healthcare.gov/help/how-do-i-resolve-an-inconsistency/)
* [The Marketplace might need more information from you](http://links.govdelivery.com:80/track?type=click&enid=ZWFzPTEmbWFpbGluZ2lkPTIwMTUwMTI3LjQwODEyNzUxJm1lc3NhZ2VpZD1NREItUFJELUJVTC0yMDE1MDEyNy40MDgxMjc1MSZkYXRhYmFzZWlkPTEwMDEmc2VyaWFsPTE3MzY3ODEyJmVtYWlsaWQ9bWVyeWxkQGFhY2hjLm9yZyZ1c2VyaWQ9bWVyeWxkQGFhY2hjLm9yZyZmbD0mZXh0cmE9TXVsdGl2YXJpYXRlSWQ9JiYm&&&109&&&https://www.healthcare.gov/blog/the-marketplace-might-need-more-information-from-you/)
* [Tips to Resolve Outstanding Data Matching Issues (or Inconsistencies) – August 15, 2014 (slides)](http://links.govdelivery.com:80/track?type=click&enid=ZWFzPTEmbWFpbGluZ2lkPTIwMTUwMTI3LjQwODEyNzUxJm1lc3NhZ2VpZD1NREItUFJELUJVTC0yMDE1MDEyNy40MDgxMjc1MSZkYXRhYmFzZWlkPTEwMDEmc2VyaWFsPTE3MzY3ODEyJmVtYWlsaWQ9bWVyeWxkQGFhY2hjLm9yZyZ1c2VyaWQ9bWVyeWxkQGFhY2hjLm9yZyZmbD0mZXh0cmE9TXVsdGl2YXJpYXRlSWQ9JiYm&&&110&&&http://marketplace.cms.gov/technical-assistance-resources/resolve-data-match-issues.pdf)
* [5 Things Assisters Should know about Data Matching Terminations](http://links.govdelivery.com:80/track?type=click&enid=ZWFzPTEmbWFpbGluZ2lkPTIwMTUwMTI3LjQwODEyNzUxJm1lc3NhZ2VpZD1NREItUFJELUJVTC0yMDE1MDEyNy40MDgxMjc1MSZkYXRhYmFzZWlkPTEwMDEmc2VyaWFsPTE3MzY3ODEyJmVtYWlsaWQ9bWVyeWxkQGFhY2hjLm9yZyZ1c2VyaWQ9bWVyeWxkQGFhY2hjLm9yZyZmbD0mZXh0cmE9TXVsdGl2YXJpYXRlSWQ9JiYm&&&111&&&http://marketplace.cms.gov/technical-assistance-resources/data-matching-terminations.pdf)
* [How do I upload documents?](http://links.govdelivery.com:80/track?type=click&enid=ZWFzPTEmbWFpbGluZ2lkPTIwMTUwMTI3LjQwODEyNzUxJm1lc3NhZ2VpZD1NREItUFJELUJVTC0yMDE1MDEyNy40MDgxMjc1MSZkYXRhYmFzZWlkPTEwMDEmc2VyaWFsPTE3MzY3ODEyJmVtYWlsaWQ9bWVyeWxkQGFhY2hjLm9yZyZ1c2VyaWQ9bWVyeWxkQGFhY2hjLm9yZyZmbD0mZXh0cmE9TXVsdGl2YXJpYXRlSWQ9JiYm&&&112&&&https://www.healthcare.gov/help/how-to-upload-documents/)

**“Medicaid Block” Application Question**

CMS

CMS has made updates to an application question, referred to as the “Medicaid Block” question. Updates were made such that consumers with denials from Medicaid or CHIP based on immigration status do not need to have received these denials since November 15, 2014 to answer the Medicaid Block question correctly.

The purpose of this question is to prevent “loopers” (applicants looping between the FFM and the state Medicaid/CHIP agencies regarding Medicaid/CHIP eligibility).  Since consumers who select their name under this question will not be evaluated for Medicaid or CHIP eligibility, the date parameter sought to ensure that the Medicaid/CHIP denial was recent, thereby decreasing the likelihood that the applicant’s income or household size had changed since the denial.  This question allows these consumers who attest to being denied Medicaid and CHIP recently to continue with their application and enroll in a Marketplace plan with APTC and CSRs, if they are otherwise eligible.

Answering the Medicaid Block question also helps HealthCare.gov properly determine eligibility for low-income, immigrant applicants, including those with income under 100% of the Federal Poverty Level (FPL) who are ineligible for Medicaid or CHIP due to immigration status, but who may be eligible for APTC and CSRs on the Marketplace.

Update to the text for the Medicaid Block question

The updated Medicaid Block question asks, “Were any of these people found not eligible for Medicaid or the Children’s Health Insurance Program (CHIP) in the past 90 days? Or, were any of them found not eligible for Medicaid or CHIP due to their immigration status since October 1, 2013? (Check the box only if a person was found not eligible for this coverage by their state, not by the Marketplace.).”  The two updates to the question include:

1. Change to the date parameter for having received Medicaid and CHIP denials from **“since November 15, 2014”** to **“in the past 90 days.”** This change is designed to help ensure that consumers only attest to the question when they have had a recent Medicaid and CHIP denial, decreasing the likelihood that the applicant’s income or household size had changed since the denial.
2. Clarification that consumers with denials from Medicaid or CHIP **based on immigration status** **do not need to have received these denials since November 15, 2014**. Instead, consumers will be able to indicate if they have been found not eligible for Medicaid or CHIP due to their immigration status since October 1, 2013.  For immigrant consumers, answering yes to this question will display a second question which asks whether the consumer was denied Medicaid and CHIP eligibility based on immigration status.

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Have something you want us to possibly add to next week’s newsletter? Email Kim VanPelt at kim.vanpelt@slhi.org.