Covered Clips

A Weekly Summary of News and Activities for the Cover Arizona Coalition[](http://stylegirlfriend.com/wp-content/uploads/2012/04/paper-clips-style-girlfriend.jpg)

Weeks of April 13th and April 20th

**Will Ducey Let 200K Arizonans Lose Health Insurance?**

Arizona Republic

While Gov. Doug Ducey hops aboard his "Opportunity Express" bus today to celebrate 100 days in office, close to 200,000 Arizonans might be wondering about their opportunity to get decent health care soon.

Ducey on Friday quietly signed House Bill 2643, barring the state from spending any public money to run a health insurance exchange under the Affordable Care Act.

Arizona is one of 34 states that declined to set up a state-run exchange, forcing the feds to step in.

But the U.S. Supreme Court could soon bar federal exchanges from offering subsidized coverage.

Opponents of the ACA sued, contending that the law doesn't allow subsidies for insurance purchased through the federally run exchanges – only insurance purchased through state-run exchanges. The ACA says subsidies can be offered "through an exchange established by a state" but says nothing about federally run exchanges.

The court is expected to decide the matter in June.

And if the high court rules that only state-run exchanges may offered subsidized policies?

Well then, it appears that close to 200,000 Arizonans may be out of luck – or, in the alternative, the state would presumably have to pick up the tab without the feds' help. (I'm quite sure the Arizona Legislature will be happy to help...)

Then again, I'm sure the hospitals will be quite happy to resume picking up the crushing tab for uncompensated care.

Won't they?

Ducey told reporters on Tuesday that he won't budge on Arizona running an exchange if the Supreme Court bars subsidies via a federally-run exchange.

"I'm not in favor of a state exchange. I've been outspoken on this issue and what my opinion is of Obamacare and that I'm no fan of it," he told reporters on Tuesday. "But let's see how the court rules. And then we will have a plan of action."

Sure. Like that plan of action for the $24 million Arizona Public School Achievement District – the one aimed at funneling money to charter schools?

Thus far, there isn't one, yet lawmakers funded the district anyway.

Not to worry, Ducey says. If the court tosses out the federally run exchanges, "I think we'll be prepared with some good ideas."

<http://www.azcentral.com/story/laurieroberts/2015/04/15/ducey-obamacare-health-exchanges/25824713/>

**3-Year Navigator Grants Will Provide Stability to Enrollment Assistance**

Georgetown University Health Policy Institute Center for Children and Families

A recent posting of a [Paperwork Reduction Act (PRA) notice](http://www.gpo.gov/fdsys/pkg/FR-2015-03-30/html/2015-07089.htm) in the federal register details plans by CMS to tweak navigator entity reporting requirements, which I’ll say more about in a few minutes.

But what really excited me about the notice – drumroll please – is that, in the [supporting statement](http://www.cms.gov/Regulations-and-Guidance/Legislation/PaperworkReductionActof1995/PRA-Listing-Items/CMS-10463.html), CMS signaled its intent to provide three years of funding in the next round of navigator grants. Extending the length of the funding period is important to build stability in enrollment assistance programs. No longer will individual navigators have to put their resume on the street at the end of the grant year, just in case. Three-year funding periods will enable navigator entities to recruit and retain permanent, professional consumer assisters and assure high quality assistance for consumers. If you like this change, I definitely recommend that you submit supporting comments.

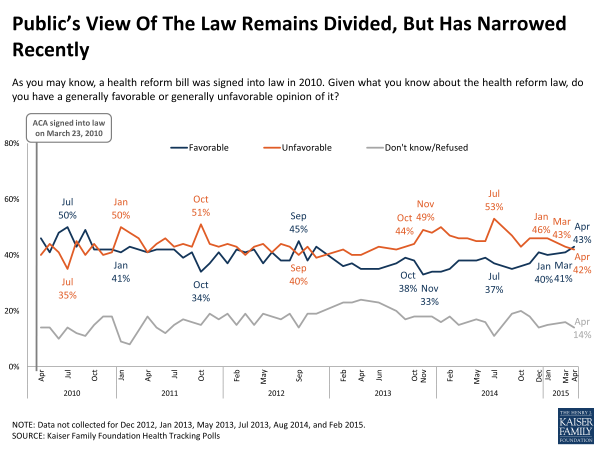
As to the reporting requirements, according to the supplemental information, CMS has reduced the weekly reporting requirements significantly. However, the monthly data collection has increased to account for more monitoring and oversight of grantee performance. Furthermore, the quarterly reporting requirements have been reduced substantially. In the end, it seems like the same amount of effort will be required to comply with the reporting requirements.

Here are some thoughts about the proposed reporting requirements:

* How do the navigator reporting requirements align with the reporting requirements for enrollment counselors in community health centers receiving HRSA outreach and enrollment grants? While I recognize there are some differences (but not many) in the expectations of the two different types of enrollment assistance, much of what these assisters do is the same. So why not align the data collection so we can get a big picture view of federally financed outreach and enrollment assistance?
* And what about transparency? Public reporting of these data could be very useful in a number of ways, from advocating for more adequate funding levels to demonstrating the value of consumer assistance.
* CMS could enhance its technology so that specific functionality enables the system to track and report on data from applications and accounts served by assisters. This would further reduce the time and expense of reporting so that more dollars could be dedicated to direct consumer assistance. Such system capacity could report even more robust data, while adding new capabilities for assisters to better serve consumers. For example, Kynect (Kentucky’s equivalent of Healthcare.gov) allows assisters to send emails to consumers and check the status of applications.

While we’re on the subject of consumer assistance, I want to commend CCIIO for boosting its training and technical assistance to navigators. A hotline was established this year that is dedicated to helping assisters with complex cases. And certainly the folks in the Consumer Support Group are working round the clock to open up the lines of communication between the group and assisters or the organizations that coordinate and support them. But there is more that can be done systemically to strengthen and improve our enrollment assistance programs, as we [recommended to Secretary Sebelius](http://ccf.georgetown.edu/all/recommendations-to-strengthen-navigator-and-assister-programs/) more than a year ago. We hope CMS will continue to chunk away at these strategies, which would allow Navigators to stretch their resources to reach the largest numbers of consumers.

Stakeholders are welcome to comment on any aspect of the PRA, just as they submit comments when CMS proposes new rules. Comments on this notice are due by May 29, 2015, and can be submitted electronically at [http://www.regulations.gov](http://www.regulations.gov/).

[](https://kaiserfamilyfoundation.files.wordpress.com/2015/04/apr-tracking-fig-1.png)

**68K Sign Up During ObamaCare’s Extra Period**

The Hill

More than 68,000 people have signed up for healthcare during ObamaCare’s extra enrollment period so far this year, the federal government announced Monday.

People who lack insurance have 10 more days to buy coverage through the federal marketplace to avoid next year’s penalty, which will rise to at least $325 a person.

The Obama administration announced in [February](http://thehill.com/policy/healthcare/233308-administration-gives-second-chance-to-sign-up-for-obamacare) that it would give people a second chance to buy coverage if they learned about the fee for the first time while paying their taxes.

While officials had not said how many people they expected to sign up during the special enrollment period, the current tally is a small fraction of the administration’s previous estimates that as many as [6 million](http://thehill.com/policy/healthcare/231018-feds-15-to-30-million-exempt-from-obamacare-penalty) people could pay the penalty.

The enrollment period runs from March 15 to April 30. About [36,000](http://thehill.com/policy/healthcare/237680-around-36k-sign-ups-so-far-in-extra-obamacare-enrollment-period) people had signed up during the first two weeks of the enrollment period.

“We hope uninsured tax filers take the next few days to learn about the options and financial assistance that is available and to enroll in a plan that meets their needs — rather than taking the risk of choosing to get by without insurance for another year,” HealthCare.gov CEO Kevin Counihan wrote in a statement.

This year is the first time that ObamaCare’s individual mandate penalty goes into effect. Critics had complained that ObamaCare’s original deadline was Feb. 15 — several weeks before the end of tax season on April 15, which meant some people may not have known about the 2015 tax until it was too late to sign up.

Lack of awareness about the ObamaCare penalty has been a major problem for the administration: A survey of uninsured people earlier this year found that [about half](http://thehill.com/policy/healthcare/233272-almost-half-of-uninsured-unaware-they-have-to-pay-penalty) of people knew nothing or little about ObamaCare's penalties.

The 2014 fee amounts to $95 a person or 1 percent of household income. Next year’s fee will rise to $325 per person or 2 percent of household income.

http://thehill.com/business-a-lobbying/239438-70k-sign-up-during-obamacares-extra-enrollment-period

**Budget Packs Wallop for Universities, Hospitals**

Arizona Republic

The loss of more than half a billion dollars in federal matching funds for Medicaid. Deep cuts at Arizona's three universities. Community colleges in the state's two largest counties losing all of their state funding. Counties and cities losing tax revenue.

The budget state lawmakers approved Saturday hits several Arizona constituencies hard, in ways that could have long-term implications for the state's economy. The authors of the $9.1 billion spending plan, however, say the plan is a tough but realistic solution to a $1.5 billion deficit. Plus, they say, it puts Arizona on track to have spending match the money the state takes in.

The move to dramatically reduce spending for higher education triggered protests and caused some Republican lawmakers to dig in their heels, slowing the march to passage. In the end, the Legislature agreed to a $99 million cut, down from an earlier $104 million proposal but still much higher than the $75 million Gov. Doug Ducey proposed in January.

Community colleges in Maricopa and Pima lose all state support, about a combined $15.6 million, but lawmakers opted to keep $2 million flowing to the Pinal County Community College system.

Medicaid-provider rates affecting hospitals and doctors are cut by up to 5 percent. Critics say this risks long-term damage to the health-care industry, one of the state's more vibrant economic sectors. Reducing the state investment also could have federal ramifications, including a much larger reduction to federal Medicaid matching funds. The cuts "total $127 million over two years which mean a loss of another $588 million in federal matching funds from Arizona's economy over that time," Assistant Senate Minority Leader Steve Farley, D-Tucson, wrote in a blog entry he posted to Facebook lastweek.

"It's just not a sustainable policy," said Greg Vigdor, the Arizona Hospital and Healthcare Association's president and CEO. "We've got to start looking for better options for how we do this, because cutting provider rates and cutting federal dollars out is just not an answer."

And cities and counties, reliable sources of cash for state budget-balancers, are seeing more costs shifted to their residents.

Austere "is a kind word" to describe Ducey and the GOP leaders' budget, said David Berman, an Arizona State University professor emeritus of political science and a senior research fellow at ASU's Morrison Institute for Public Policy.

"If you're not going to raise taxes, then you're really going to have to do something pretty drastic," he said. "So it's predestined that you are going to hear some really serious grievances about what's going on. It's a very bad political spot; I don't know how they're going to get out of it, other than that people have very short memories when the next election comes up."

However, the budget does have support among fiscal conservatives who like its lower cost to taxpayers and long-term impact on the state's financial standing.

The state is making permanent annual inflation adjustments to income-tax brackets, a move that will shield millions in income from being taxed at higher rates. It's expected to save $6 million in the coming fiscal year. The plan also would do away with the state's job-training tax credits, a lightly used giveaway to larger businesses, said Scot Mussi, president of the Arizona Free Enterprise Club.

The budget aims to bring the state's revenues and expenditures back in line within three years, something that hasn't happened since the onset of the Great Recession.

The perennial cash shortages have left lawmakers lurching from one stopgap measure to another — the three-year penny hike to the sales tax, repeated budget cuts to higher education and fund sweeps from every corner of state government.

"Something that's very important for the future of Arizona is to be able to have a budget that's actually balanced," Mussi said. "We're very pleased to see that lawmakers are willing to take on these tough decisions."

More at:

<http://www.azcentral.com/story/news/arizona/politics/2015/03/06/budget-packs-wallop-universities-hospitals/24540423/>

**15 States Extend Health Law’s Higher Medicaid Payment to Doctors**

Kaiser Health News

Fifteen states are betting they can convince more doctors to accept the growing number of patients covered by Medicaid with a simple incentive: more money.

The Affordable Care Act gave states federal dollars to raise Medicaid reimbursement rates for primary care services—but only temporarily. The federal spigot ran dry on Jan. 1. Fearing that lowering the rates would exacerbate the shortage of primary care doctors willing to accept patients on Medicaid, the 15 states are dipping into their own coffers to continue to pay the doctors more.

It seems to be working.

Indiana Gov. Mike Pence speaks during a press conference March 31, 2015 at the Indiana State Library in Indianapolis, Indiana. (Photo by Aaron P. Bernstein/Getty Images)

In Indiana, which is spending about $40 million a year in state dollars to keep the higher reimbursement rate, an additional 335 doctors have started accepting Medicaid patients since the beginning of this year. So have more than 600 other medical providers, such as nurse practitioners and physician assistants.

“We’ve seen good results,” said Joe Moser, the state’s Medicaid director. “We are interested in seeing if the results continue, and we have every reason to think that it will.”

Colorado has had a similar experience. There the number of new providers participating in Medicaid is increasing by about 100 each month, according to Marc Williams, spokesman for the Department of Health Care Policy and Financing.

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In addition to Indiana and Colorado, Alabama, Iowa, Maryland, Mississippi and New Mexico are keeping reimbursement rates where they were before the federal bump ended. Connecticut, Delaware, Hawaii and Maine, Michigan, Nebraska, Nevada, and South Carolina also are continuing to pay higher rates, though they aren’t as high as they were before the federal money disappeared, according to a March [report](https://www.macpac.gov/publication/march-2015-report-to-congress-on-medicaid-and-chip/) to Congress from the Medicaid and CHIP Payment and Access Commission (MACPAC).

In the 23 states that have indicated they won’t continue to make the higher payments, payments for primary care will fall 47 percent on average this year, an Urban Institute [analysis](http://www.urban.org/research/publication/reversing-medicaid-fee-bump-how-much-could-medicaid-physician-fees-primary-care-fall-2015)estimates.

David Schultz, a family physician who runs a clinic with a high percentage of Medicaid enrollees in southwestern Indiana, said low Medicaid reimbursement rates had made it increasingly difficult to maintain the practice.

“Frankly, we were losing money and losing personnel,” he said. “We had to increase the numbers of people we saw every day, stayed open much longer, worked through lunches, not taking half-days off.”

The higher rates haven’t changed his life enormously, he said, but the office has at least been able to cut back on the heavy scheduling.

Rejecting Medicaid

In 2012, a third of primary care doctors didn’t accept new patients with Medicaid coverage, according to a previous MACPAC [report](https://www.macpac.gov/wp-content/uploads/2015/01/2014-03-14_Macpac_Report.pdf) to Congress. Only 25 percent of patients covered by Medicare, the government health program for seniors, were turned away. And only 15 percent with private insurance were.

Before the federally subsidized higher reimbursements were paid, Medicaid paid only 59 percent of what Medicare did for primary care services, according to the Henry J. Kaiser Family Foundation.

When the federal subsidy ended, states had to decide whether to continue to pay higher rates with little hard data on whether doing so would persuade more doctors to accept Medicaid patients. Other factors, such as the relatively long time it takes doctors to receive their Medicaid payments, also may contribute to their reluctance to take on Medicaid patients.

A multistate [study](http://www.nejm.org/doi/full/10.1056/NEJMsa1413299) on the impact of the reimbursement increase published in the *New England Journal of Medicine* in February found that the availability of primary care appointments for Medicaid patients had increased 7.7 percent with the higher payments. But the study did not examine how many more doctors were accepting Medicaid patients.

There was, however, anecdotal evidence from individual states. Alaska, for example, has long paid Medicaid reimbursement rates that are higher than those for Medicare. Margaret Brodie, director of the Division of Health Care Services, said she believes that’s why the state hasn’t had a shortage of Medicaid providers.

And in Connecticut, the number of primary care doctors participating in Medicaid was 3,589 at the start of this year, up from 1,622 on Jan. 1, 2012, the year before the fee bump, according to David Dearborn, a spokesman for the Department of Social Services.

Paying for the Bump

The states that are continuing the higher payments are turning to a variety of sources to finance them.

Indiana will do it with an increase in the cigarette tax and an eventual increase in taxes on hospitals.

Nebraska is using state general funds for the $8.9 million it needs to pay the higher rate. Maine is redirecting $7.4 million in state tobacco settlement money to help pay the higher rates. To get the $18 million it will cost to fund the increase for six months, Colorado is relying on an advantageous recalibration of its federal-state Medicaid match.

Maia Crawford, a program officer at the Center for Health Care Strategies, a nonprofit that focuses on improvements in publicly financed health care, argues that maintaining the higher rates isn’t a heavy price for states to pay in return for “garnering good will among Medicaid providers and working to ensure that Medicaid stays well stocked with providers.”

http://kaiserhealthnews.org/news/15-states-extend-health-laws-higher-medicaid-payments-to-doctors/

**Potential Change in Defendant for Expansion Lawsuit**

The Yellow Sheet

The Arizona Center for Law in the Public Interest wants to intervene as a defendant in the lawsuit against Medicaid expansion, arguing that AHCCCS Director Tom Betlach does not necessarily represent the interests of its clients, four childless adults that are receiving Medicaid coverage as a result of the 2013 law. Hogan argued that the four would-be defendants meet all of the requirements needed to intervene under the Arizona Rules of Civil Procedure, and that they have an obvious and direct interest in the case’s outcome. But Betlach argued that one critical piece is missing: They can’t show that the existing defendants aren’t already adequately representing their interests. Attorney Douglas Northup, who represents Betlach, wrote in his reply to Hogan’s motion that the AHCCCS director and the four applicants share the same objective of defending the constitutionality of the disputed hospital assessment. “Director Betlach will vigorously defend the constitutionality of H.B. 2010, and Applicants’ interest in ensuring their continuing receipt of AHCCCS benefits will be more than adequately represented by Director Betlach,” Northup wrote. He added that he welcomes ACLPI’s participation in the case as an amicus, but that adding the four AHCCCS patients as defendants “will only serve to delay and complicate an otherwise straightforward proceeding with a single question to be resolved by the court.” Northup wrote that Hogan failed to demonstrate how Betlach would not adequately represent his clients. Hogan laid out his case in his response to Northrup’s points. Hogan argued that Betlach’s defense of his clients’ interests is questionable because of his boss, Ducey, who repeatedly voiced his opposition to Medicaid expansion on the campaign trail last year and has hired former Goldwater Institute analyst Christina Corieri, a vocal expansion critic, as an advisor. Hogan also noted that that Betlach serves at the pleasure of the governor. “Under the circumstances, the Applicants have ample reason to be concerned that the Governor’s position regarding Medicaid expansion could adversely impact the adequacy of the Director’s defense to the constitutional challenge,” Hogan wrote. He also said his concerns do not rest solely with Ducey, noting that Betlach implemented and defended the AHCCCS enrollment freeze approved by Brewer and the Legislature in 2011, which resulted in scores of thousands of childless adults losing health coverage. “Not only did Defendant Betlach capitulate to the Legislature’s plainly unlawful conduct, he defended the Legislature’s action in the resulting litigation and argued for an interpretation of Proposition 204 that would result in the continued denial of healthcare to childless adults,” Hogan wrote. “In light of these past actions, it should come as no surprise that Applicants are a bit leery of embracing Defendant Betlach as their sole advocate in this action.”

**Justices Drop Another Clue about Obamacare’s Future**

Bloomberg View

Is it better to follow the strict letter of the law or to adjust it where appropriate to produce a more equitable result? This is one of the oldest questions in legal thought, one that can be traced back at least to Aristotle -- and on Wednesday the U.S. Supreme Court weighed in, 5-4, on the side of equity, with Justice Anthony Kennedy providing the deciding vote. Ordinarily, a decision like this one, involving the interpretation of the Federal Tort Claims Act would be of interest only to practitioners who are specialists in statutory interpretation. But this isn’t an ordinary spring. In June, the Supreme Court will hand down its most important statutory interpretation case in a generation, essentially deciding whether the Affordable Care Act will survive or fall. The interpretation question before the court in that high profile case, King v. Burwell, bears a striking structural resemblance to the obscure one the court decided Wednesday. And, not for the first time, Kennedy is the justice whose intentions we can’t help trying to predict. The technical issue before the justices in federal courts case, U.S. v. Kwai Fun Wong, had to do with what happens when a plaintiff who alleges that he’s been injured by the government files suit after the statute of limitations has run its course. The law says, rather biblically, that a suit ‘shall be forever barred’ if the plaintiff misses one of the required deadlines. Sounds pretty clear, right? Well, yes -- except what should be done if the reason the plaintiff couldn’t file was that she was blocked from doing so by a court that didn’t do its job right or by the government that injured her failing to provide information necessary for her to file? Under those circumstances, courts have the established authority to engage in what’s called ‘equitable tolling of the statute of limitations.’ The ‘tolling’ part means that the statute of limitations will be frozen at the moment when the plaintiff was blocked from filing, thus allowing the suit to go forward later. The ‘equitable’ part means that the court is exercising the form of justice known as ‘equity.’ That’s the English translation of what Aristotle had in mind when he proposed that the strict letter of the law should be overridden when following it would produce an unjust result.

<http://www.bloombergview.com/articles/2015-04-22/justices-drop-another-clue-about-obamacare-s-future>

**GAO to Report on Security Incidents at HealthCare.gov**

Government investigators will release a report later this year about multiple cybersecurity “incidents” at HealthCare.gov, a GAO official told lawmakers Wednesday.   
  
Gregory Wilshusen, director of Information Security Issues for the Government Accountability Office (GAO), suggested there have been several cyber events at ObamaCare’s online exchange. He did not provide further details.

“We presently have work ongoing, looking at both the security and privacy of the state-based insurance marketplaces as well as looking at the incidents that have identified for HealthCare.gov by [the Centers for Medicare and Medicaid Services],” Wilshusen told members at a House Oversight Committee hearing.   
  
The GAO “just recently received a list of the incidents” from CMS and is now studying them, he said.   
  
The eventual GAO report is sure to stoke debate about the security of HealthCare.gov, the website where millions have purchased medical coverage since the site's rocky 2013 launch.   
  
To apply for health insurance, users must input a variety of personal details, including Social Security numbers and addresses. Security experts predicted the site was likely to be a hacking target as a result.   
  
It was unclear from Wilshusen’s comments whether hackers  successfully breached the website’s defenses more than once. In September, federal officials acknowledged that intruders gained access to an outer HealthCare.gov server, but said they neither viewed nor took any personal information.   
  
The GAO has been critical of HealthCare.gov’s security in the past. A 78-page report released in September described a series of technical steps investigators said CMS did not take while constructing and repairing the sprawling website.   
  
The agency did not require strong password controls for systems supporting the site, implement consistent security patches or properly configure the administrative network, for example, GAO [**said**](http://thehill.com/policy/healthcare/217948-gao-healthcaregov-still-not-fully-secure).   
  
The Department of Health and Human Services replied at the time that it had adopted many of GAO’s recommendations, and said the hackers’ intrusion was discovered quickly by industry standards.   
  
Wilshusen made his comments during an exchange with Del. Eleanor Holmes Norton (D-D.C.) during a hearing on third-party vendor security.

http://thehill.com/policy/cybersecurity/239747-gao-to-report-on-security-incidents-at-healthcaregov

**Medicaid Expansion Waivers**

Health Advocate (Newsletter of the National Health Law Program)

Although the Affordable Care Act (ACA) includes a provision making Medicaid expansion mandatory, the Supreme Court’s Medicaid expansion decision in 2012 resulted in effectively giving every state the choice of whether to expand. To date, 29 states (including DC) have expanded Medicaid. The first 23 states did so exactly as authorized by the law. However, the next 6 states expanded using the Social Security Act’s section 1115 demonstration authority – an authority to pilot innovative Medicaid experiments. The states proposed, and HHS approved, alternate versions of the Medicaid expansions, which include “waivers” of long-standing Medicaid protections – meaning that HHS has waived an otherwise mandatory Medicaid Act provision to allow the state to implement the experimental project.

While these approvals mean that benefits will be available to previously uninsured individuals, they could raise serious concerns for the integrity of the Medicaid program in the future.

The Waivers Begin

Arkansas was the first state to pursue Medicaid expansion through a section 1115 waiver, and was approved in September 2013 to conduct Medicaid expansion (starting January 2014) using premium assistance. Under the premium assistance demonstration, Arkansas uses Medicaid expansion money to pay the premiums for a Qualified Health Plan (QHP) for enrollees. QHPs are the plans sold on the Arkansas Marketplace.

Although these Medicaid enrollees are enrolled into a Marketplace product, they remain Medicaid enrollees, meaning they must receive the scope of benefits, affordability protections and all other applicable rights and protections that are contained in the Medicaid Act. Therefore, it is the state’s responsibility to provide for covered benefits if the QHP fails to provide them.

One potential advantage of premium assistance is that it will facilitate transitions between Medicaid and Marketplaces, since the same QHPs might be used for both. As of yet, there is no evidence confirming or disproving this hypothesis. One of the most important reasons Arkansas is committed to Medicaid premium assistance is the impact it has outside of Medicaid. The QHP enrollees covered through Medicaid premium assistance make up 80 percent of the *entire* QHP Marketplace. In other words, non-Medicaid enrollees make up only 20 percent of the Arkansas Marketplace, and as such, the Medicaid expansion is essentially stabilizing the state’s private insurance market.

To date, however, the Arkansas model has received mixed reviews. Serious questions have been raised about the model’s cost-effectiveness compared to normal Medicaid expansion. It has also been unclear whether the state has been ensuring coverage of benefits that are not covered by the QHP, particularly for 19- and 20-year-olds who should have important Medicaid Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefits. There have also been problems with the federal Marketplace conducting eligibility and enrollment for the Medicaid QHP population and challenges for consumer advocates getting information from the Medicaid agency about QHPs as compared to traditional Medicaid health plans.

Since Arkansas’ approval, two other states (Iowa and New Hampshire, discussed later), have also implemented premium assistance models. As mentioned above, there are concerns; however, the premium assistance model is relatively untested in this context and thus there are some experimental benefits. Therefore, it is reasonable to have a limited number of these section 1115 demonstrations to determine whether are not they are a viable means of providing health coverage to the Medicaid populations.

More Waivers

Subsequent to the Arkansas approval, various states became interested in pursuing Medicaid expansion through the section 1115 demonstration authority and began negotiations with HHS. States frequently made aggressive requests to waive numerous Medicaid Act provisions, testing the limits of how much HHS might concede in exchange for securing another Medicaid expansion state. The states ultimately approved so far include Iowa (December 2013), Michigan (December 2013), Pennsylvania (August 2014), Indiana (January 2015) and New Hampshire (March 2015).

The sheer number of waiver requests (*i.e.*, requests to ignore otherwise mandatory Medicaid Act provisions) from these states makes it impossible to list out all of their requests. However, there are some consistent themes of great concern. Most notably, all of these states received section 1115 waiver approvals that raise at least two broad issues.

First, many of the waivers serve only to *reduce* access to Medicaid coverage for vulnerable Medicaid enrollees as compared to what Congress intended with the Medicaid expansion. For example, despite Medicaid law’s common-sense prohibition of premiums on individuals below 150 percent of the Federal Poverty Level (FPL), HHS approved the use of mandatory premiums above 100 percent FPL (IA, PA, IN; optional in MI) and optional premiums below 100 percent FPL (AR, IA, IN). With mandatory premiums, an individual just above the poverty line who fails to pay is terminated from Medicaid. HHS also approved waivers allowing states to stop providing transportation assistance for low-income individuals to attend their medical appointments (IA, PA, IN). In the most extreme case, HHS also approved a state’s waiver requests to implement a waiting period delaying access to Medicaid coverage after application, and a lock-out barring individuals from re-applying for 6 months if they failed to make premium payments (IN). In each of these cases, Medicaid waivers were proposed by states and approved by HHS at the expense of access to care for impoverished and needy Medicaid enrollees.

Second, many of the waivers fail to comply with the legal requirements of section 1115 authority. Section 1115 requires demonstrations to actually demonstrate something. For example, with respect to the demonstrations allowing premiums, there is already ample evidence in research literature establishing that premiums sharply reduce coverage for low-income populations, meaning there is no valid experiment being tested in the waivers of the Medicaid Act’s premium protections. Section 1115 also requires demonstrations to “promote the objectives” of the Medicaid program, which is to “furnish medical assistance” to enrollees, yet HHS’s waivers of medical transportation and waivers to allow waiting periods and lock-outs clearly will not help furnish care to enrollees. These specific waivers not only fail to comply with the requirements of section 1115 demonstrations, they also create dangerous precedent for the section 1115 authority to be used without restraint to dismantle core Medicaid protections.

Back to the Future?

Another problematic consequence of these waiver approvals is that each new approval undercutting Medicaid’s legal requirements sets a new and lower baseline that the next state will use to start negotiations. For example, the most recent flexibilities granted in Indiana have become features of new proposals now being developed in other states (such as FL, MT, and TN). Moreover, these waivers can impact all states – even states that have *already* expanded may pursue these new flexibilities as a condition of preserving their *existing* Medicaid expansions. In fact, Arkansas, the first state to expand through section 1115, actually went back to HHS after their waiver had been approved, to request additional waivers (*e.g.,* premiums) that other states had subsequently received. The provision of these waivers, therefore, destabilizes the Medicaid expansion for all states, those that have expanded and those that have yet to expand.

The outlook is of concern for the Medicaid program. Medicaid’s careful design makes the coverage affordable and accessible for low-income enrollees who have special health care needs and who experience barriers to obtaining needed care. As these core Medicaid protections are traded away, enrollees risk being left with low-value health insurance that fails to provide real access to care.

This is additionally troubling because, given the extremely generous federal funding provided by the Medicaid expansion, it is only a matter of time until all states choose to participate. Twenty-nine states have already expanded. By comparison, when Medicaid was established in 1965, only 26 states chose to participate in the first year. Five years into Medicaid, 49 states were participating, and even the two holdouts had joined the program by 1982 (AK 1972, AZ 1982). The lesson from Medicaid’s history is clear: dismantling Medicaid’s core protections to entice states is unnecessary given the incredible value Medicaid provides states.

**Implementing Health Reform: As King Decision Looms, GOP Senators Introduce Transition Plans**

Health Affairs Blog

At some point between now and the beginning of July, 2015, the Supreme Court will decide *King v. Burwell*.  If the Court sides with the plaintiffs and invalidates the Internal Revenue Service (IRS) rule permitting federally facilitated exchanges to grant premium tax credits, the effects will be dramatic. Premium tax credits and cost-sharing reduction payments in the federally facilitated exchanges would probably cease at the end of July.

At that point, [approximately 8 million Federally Facilitated Marketplace (FFM) enrollees currently receiving subsidies would have to decide](http://www.urban.org/research/publication/implications-supreme-court-finding-plaintiff-king-vs-burwell-82-million-more-uninsured-and-35-higher-premiums) whether to continue to pay the premiums themselves. Without the subsidies, their premiums would increase 122 to 774 percent depending on the state, with a national average increase of 255 percent. Millions of individuals would likely be unable to afford these premium increases and would cease paying their premiums. Their coverage would probably end 30 days thereafter.

This would only be the beginning of the repercussions of a decision to invalidate the IRS rule, however. The taxes imposed on employers that fail to provide minimum essential coverage, or adequate and affordable coverage, for their employees only apply if one or more employees receive premium tax credits, so the employer mandate would cease to apply in states that do not have state-operated exchanges. Individuals who cannot afford health insurance are exempt from the individual responsibility requirement. Affordability is determined after taking into account available tax credits; thus if premium tax credits ceased to be available in FFM states, far more of the residents of those states could choose to remain uninsured and not be penalized.

A Supreme Court decision for the *King* plaintiffs would not affect the provisions of the ACA that prohibit insurers from considering an individual’s health status in offering coverage or setting premiums or from excluding coverage for pre-existing conditions. But without premium tax credits and with a weakened individual mandate, it is likely that many more healthy Americans would forego coverage. The entire nongroup market in each state is a single risk pool, so as low-risk individuals left the exchange market, premiums would increase across the entire nongroup market, now populated with higher-risk individuals with greater needs for coverage. Recent studies of the impact of a decision denying the FFM the authority to grant tax credits predict that the number of uninsured nonelderly adults in FFM states would increase by 44 percent to 26.6 million, the nongroup market (both in and out of the exchange) would shrink by 70 percent to about 4.5 million, while premiums in the nongroup market generally would increase 35 to 47 percent.

Repercussions of a decision invalidating the IRS rule would spread beyond adults in the nongroup market and FFM states. It is projected that [between 450,000 and 730,000 children would lose coverage](http://healthaffairs.org/blog/2015/04/23/implementing-health-reform-as-king-decision-looms-gop-senators-introduce-transition-plans/%20http:/healthaffairs.org/blog/2015/03/17/moving-in-reverse-potential-coverage-impacts-for-children-of-king-v-burwell-medicaid-and-chip-eligibility-changes/). Some of these would be children of higher income families insured through the exchange, while others would be from families in which the parents lost exchange coverage and did not keep their children enrolled in Medicaid or CHIP.

Health care providers in FFM states could see a dramatic drop in their income and increase in their uncompensated care burden. Particularly hard hit would be rural hospitals, community health centers, and other safety net facilities. Serious damage would spread throughout the health care system.

There seemed to be a general recognition during the oral argument in *King* that a ruling for the plaintiffs could have dramatic consequences. Justice Alito suggested, however, that if the Court found for the plaintiffs, Congress could adopt legislation addressing potential problems. Solicitor General Verrelli responded incredulously, “This Congress?” provoking laughter in the courtroom.

Transition Plans Introduced By GOP Senators

Two Republican senators have introduced separate pieces of legislation, each of which is apparently aimed at demonstrating to the Court that “this Congress” can solve the problems a ruling for the plaintiffs would cause. Another group of three Republican senators have sketched out another approach. These proposals seek neither to repeal nor to repeal and replace the ACA. Both would leave the vast majority of the provisions of the ACA in place. But each is intended to avoid a sudden end to premium tax credits for qualified health plan enrollees in federally facilitated exchange states and to make other immediate changes in the ACA.

The Johnson Bill

[Minnesota Senator Ron Johnson’s bill](https://www.congress.gov/bill/114th-congress/senate-bill/1016?q=%7b%22search%22%3A%5b%22\%22health+care\%22+%26+Johnson%22%5d%7d), introduced on April 21, with 29 cosponsors, makes more extensive changes in the ACA than the other bill, offered by [Nebraska Senator Ben Sasse](https://www.congress.gov/bill/114th-congress/senate-bill/673/text?q=%7b%22search%22%3A%5b%22\%22king+v.+burwell\%22%22%5d%7d). Johnson’s bill seems to be intended to allow individuals currently receiving premium tax credits through the FFM to continue to receive them through August 2017. It is not clear that it actually would accomplish this. It would amend the ACA provision that the *King* plaintiffs argue defines “premium assistance amount” in terms of premiums for qualified health plans purchased through an “Exchange established by the State” to also include premiums for qualified health plans in which an individual is enrolled through any exchange, including the FFM. The bill, however, fails to amend another subsection of the ACA that defines “coverage month” using the “Exchange established by the State” language. Since premium tax credits are only available for coverage months, the legislation could still be interpreted as barring federal exchange enrollees from receiving tax credits (and possibly cost-sharing reduction payments).

While it is questionable whether the Johnson bill would in fact fix the problem it is aimed at, it is clear that it is intended to make other dramatic changes in the ACA. First, it would end any tax credits for new enrollees in either the federal or state exchanges. Individuals currently receiving tax credits would be grandfathered in. But no new tax credits would be granted. Given the turnover that is natural in insurance markets as individuals move back and forth between exchange coverage, employer coverage, and Medicaid, the number of Americans receiving tax credits would diminish quickly.

Second, the Johnson bill would repeal the individual and employer mandates. The immediate effect of this would be a dramatic loss of tax revenue. Under the CBO’s most recent estimate, the employer mandate was supposed to result in $167 billion in revenue over the 2016-2025 period; the individual mandate $43 billion.  More importantly, however, the loss of the individual mandate would likely destabilize the nongroup market, leading to higher premiums and fewer enrollees.

The Johnson bill would further grandfather in all coverage in which an individual or group was enrolled prior to December 31, 2017. None of the ACA’s insurance reforms would apply to such plans. The effect of this provision would be to allow healthy individuals and groups with skinny coverage and favorable premiums to keep those plans, while older and sicker individuals and groups would remain in a separate risk pool, with much higher premiums.

Finally, the Johnson bill would allow each state to define its own essential health benefits package. This is to a considerable extent what happens now under current rules. It is likely, however, that some states would adopt a more limited benefits package while other states would impose new mandates. The former approach could leave benefits like mental health and maternity services uncovered while the latter approach would increase the cost of insurance.

The Sasse Bill

[Senator Ben Sasse’s bill](https://www.congress.gov/bill/114th-congress/senate-bill/673/text?q=%7b%22search%22%3A%5b%22\%22king+v.+burwell\%22%22%5d%7d), introduced on March 4, 2015, takes a very different and more limited approach. First, it would allow enrollees who lose coverage or tax credits because of a decision for the plaintiffs in *King v. Burwell* to elect to continue that coverage for 18 months from the date of the decision. During that period, insurers could not change that coverage (except insofar as they change the plan for all similarly situated enrollees) and could not raise premiums. The insurer could terminate coverage only if it terminated all qualified health plan coverage or if an enrollee ceased paying premiums. Insurers would have to inform enrollees of their right to continue coverage within 10 days of a decision and enrollees would have 45 days from the date of receiving the notice to notify their insurer of their election to continue coverage.

Although the Sasse bill refers to the transitional coverage as “COBRA-like,” there is an important distinction between the Sasse transitional coverage and group continuation coverage under the Consolidated Omnibus Budget Reconciliation Act. An employee or dependent qualifying for COBRA continuation coverage must pay the full cost. But premium tax credits would continue to be available to some extent to pay for transitional coverage.

The Sasse bill would offer individuals who opt for transitional coverage a flat tax credit of 65 percent of the cost of the premium for the first six months. After that the tax credit would be reduced by 5 percentage points per month and would end at the 18th month. The tax credit would only be available to individuals who did not otherwise have employer, Medicare, Medicaid, or Tricare coverage. The tax credits would be advanceable on a monthly basis. Taxpayers would not be permitted to claim a deduction for the cost of premiums for coverage paid for in part through these premium tax credits. Insurers who provide continuation coverage would have to file a return with the IRS and provide a statement to each covered individual as to the payments received for the individual.

Senator Sasse’s bill is more narrowly targeted than the Johnson bill. In addition to providing continuation coverage, it would also prohibit HHS from making available to states technology otherwise used for the federally facilitated exchanges for the operation of state exchanges, although it expressly allows states to establish their own exchanges. It also includes a provision that would require CMS to establish spending limits for Medicaid 1115 research and demonstration projects that would apply nationwide benchmark Medicaid enrollment and cost growth rates, as certified by independent actuaries.

Senator Sasse’s bill would be less disruptive than Senator Johnson’s as it would leave current coverage and tax credit arrangements in place for state-operated exchanges and would avoid changes in the ACA not immediately related to a *King v. Burwell* ruling for the plaintiffs. It would, however, have anomalous effects. In the short run, higher-income enrollees would see their tax credits increase while low-income enrollees would see their subsidies cut dramatically. In particular, older enrollees would see substantial increases in the cost of their coverage. As the size of the premium tax credits began to drop steadily after six months, coverage would become increasingly less affordable for currently subsidized enrollees. As more and more healthy individuals found their premiums unaffordable, the nongroup risk pool would steadily deteriorate. Millions of additional Americans would become uninsured.

Insurers in the nongroup market would in turn face a steadily deteriorating risk pool. The bill, however, prohibits them from raising premiums for 18 months after a *King v. Burwell* decision. Most insurers in the nongroup market would experience financial distress under this situation and some would likely become insolvent.

The Hatch-Alexander-Barasso Plan

Three Republican Senators, [Orin Hatch, Lamar Alexander, and John Barasso](http://www.washingtonpost.com/opinions/we-have-a-plan-for-fixing-health-care/2015/03/01/e0925502-becc-11e4-8668-4e7ba8439ca6_story.html), published an op-ed in the *Washington Post* on March 1, 2015, claiming to have a transition plan. Their proposal, not yet released in legislative form, would allow individuals now covered through the FFM to retain their coverage for a transition period while giving the states greater flexibility to govern their own insurance markets and exchanges. Without additional detail, it is impossible to evaluate the effects of such a proposal.

<http://healthaffairs.org/blog/2015/04/23/implementing-health-reform-as-king-decision-looms-gop-senators-introduce-transition-plans/>

**Study Finds Broad Rise in Medication Use by Those Newly Joining Medicaid**

New York Times

People newly covered by Medicaid drove a significant increase in prescription drug use in 2014, even as those with private commercial coverage filled fewer prescriptions and, over all, patients did not visit the doctor as often, according to a new report by the IMS Institute for Healthcare Informatics, which tracks the health industry. The report, released on Tuesday, offers a window into how consumers used their insurance in 2014, the first full year after millions of Americans gained coverage through the health care law, which expanded eligibility for Medicaid in many states and set up marketplaces where consumers could shop for insurance. Patients with Medicaid in states that expanded access to the program filled 25.4 percent more prescriptions than in the previous year, before the expansion. In states that opted not to expand the program, the increase was much smaller at 2.8 percent. Sabrina Corlette, a senior research fellow at the Center on Health Insurance Reforms at Georgetown University, described the difference as ‘stark,’ adding, ‘it suggests that in the Medicaid expansion states, people are accessing the health care system. They are seeing physicians and other prescribers and getting needed drugs.’ The report also provided some new details on the overall growth of spending on prescription drugs, which, it said, rose substantially in 2014 — by 13.1 percent, to $373.9 billion. The increase is the highest since 2001 — mainly because of the arrival of expensive new drugs for conditions like hepatitis C, cancer and multiple sclerosis, at the same time that sales eroded less for brand-name drugs because of new competition with generic drugs. Spending on so-called specialty drugs — high-priced treatments that typically treat serious chronic diseases — accounted for one-third of drug spending in 2014, up from 23 percent five years ago. Last year ‘was a remarkable year in terms of growth in spending on medicines,’ said Murray Aitken, executive director of the IMS Institute. But he added that while growth in specialty drug spending was expected to continue, the eye-popping increase in 2014 was unique and spending would most likely not rise as sharply in future years.

<http://www.nytimes.com/2015/04/14/business/study-finds-broad-rise-in-medication-use-by-those-newly-joining-medicaid.html?emc=edit_tnt_20150414&nlid=58462464&tntemail0=y&_r=2&utm_campaign=KHN%3A+First+Edition&utm_source=hs_email&utm_medium=email&utm_content=17064129&_hsenc=p2ANqtz-8JLx_R4kIYxR0B_BqMVAqKowTzdjtIPSDOTlRsbw13ZRWYznPL9xGxxDRxwBiX-pkmpWfSX6dkbPPihzaixtebYH9YRMzlIO-ftEnlE9uh9KsUrS0&_hsmi=17064129>

**Federal Marketplace More Adept than States at Enrolling Customers, Study Finds**

Kaiser Health News

Despite its rocky launch, the federal health insurance exchange did better than the exchanges run by individual states at both enrolling new people in Obamacare and hanging onto previous enrollees during the 2015 open enrollment period that ended in February, according to a recent analysis. Enrollment for 2015 on the federal exchange increased by 61 percent over 2014, to 8.8 million. On the state-based exchanges, enrollment increased 12 percent, to 2.8 million, according to the analysis by the consulting firm Avalere Health.  In addition, the federal exchange re-enrolled 78 percent of its enrollees from the previous year, while the state-based exchanges re-enrolled 69 percent. Several factors may have contributed to the disparities in enrollment and retention, says Elizabeth Carpenter, a director in the health reform practice at Avalere, which conducted the analysis based on federal enrollment data released in March for the federal and state-based exchanges. The many website and other glitches that bedeviled the 2014 launch of healthcare.gov, the federal portal for Obamacare coverage in about three dozen states, may have contributed to its stronger enrollment showing this year, Carpenter says. ‘Some folks have pointed to the technological problems with healthcare.gov, saying that there may have been people who didn’t get through the enrollment process last year’ because they couldn’t get the website to work, Carpenter says. In 2015, instead of error messages and frozen screens, healthcare.gov functioned smoothly for the most part, even during periods of heavy use. It may also be that the federal exchange covers more states that have a larger proportion of lower income people, Carpenter says. More than 85 percent of people who bought health insurance on the state and federal marketplaces were eligible for premium tax credits that were available to people with incomes up to 400 percent of the federal poverty level ($46,680 for an individual). As for retention differences, it’s possible that more people over-reported their income on state-based exchanges for 2014 coverage and were subsequently shifted to the Medicaid program this year. Twenty-eight states have expanded Medicaid to adults with incomes up to 138 percent of the federal poverty level (about $16,100). In those states, if someone applies for a marketplace plan, the exchange will move them into Medicaid if their income falls below that threshold. Such shifting could make it appear that some states had lost enrollees when instead they just moved to Medicaid. Avalere didn’t incorporate Medicaid eligibility shifts into its analysis.

<http://kaiserhealthnews.org/news/federal-marketplace-more-adept-than-states-at-enrolling-customers-study-finds/>

**Health Insurance Shoppers Look to Limited Networks to Save Money**

New York Times

In all the turmoil in health care, one surprising truth is emerging: Consumers seem increasingly comfortable trading a greater choice of hospitals or doctors for a health plan that costs significantly less money. ‘Are they willing to trade choice and access for price? There’s no question about that,’ said Mark Newton, the chief executive of Swedish Covenant Hospital, a Chicago hospital that recently teamed with an Illinois insurer, Land of Lincoln Health, to offer a health plan. This year, nearly half of the plans offered on public health care exchanges are so-called narrow network options, which sharply limit the medical providers whose services will be covered, new data shows. Furthermore, nearly a fifth are considered ‘ultranarrow networks,’ which offer even fewer choices. At the same time, more employers are also embracing the plans for their workers, largely as a way to lower health care costs. The data, gathered by the McKinsey Center for U.S. Health System Reform, is significant, given early criticism from some providers and patients who reacted to these plans last year by arguing they were like the overly restrictive health maintenance organizations, or H.M.O.s, of the 1990s, which were ultimately rejected by consumers. The financial strategy is relatively simple. Insurers say one way to lower the price of a plan is to limit the number of hospitals and doctors in their networks. They can then ask providers to discount their prices in return for a potentially higher volume of patients; some also say they are trying to pick a select group that provides better care. But consumers can find themselves responsible for high bills if they do not understand how the plans work or which providers are included in the network — as was often the case during the first year of the federal law. If they go to a specialist or hospital whose services are not covered by a narrow network plan, they face paying the full cost of the care.

<http://www.nytimes.com/2015/04/14/business/health-insurance-shoppers-look-to-limited-networks-to-save-money.html?emc=edit_tnt_20150413&nlid=58462464&tntemail0=y&utm_campaign=KHN%3A+First+Edition&utm_source=hs_email&utm_medium=email&utm_content=17064129&_hsenc=p2ANqtz--bAerYhBSsCmeJJegV5kfkaZ9n-qSavo76_U1jpa7H2zBXvCXtJrwxLcjdkrCh03s2qriC2vN9au0qx1MDa7q1ZB6XU8pYPxqtJw21D2tz1Hs-_Us&_hsmi=17064129&_r=0>

# **System Fix Affecting Certain Immigrants Below 100% FPL now allows for a Prospective and Retroactive SEP**

CMS

*KEY TAKEAWAY: As we shared in the March 17, 2015 Assister newsletter, we have resolved a system issue in which not all applicants who were eligible for APTC based on an income under 100% of the Federal Poverty Level and ineligibility for Medicaid due to immigration status received APTC.  Consumers affected by this issue can now change their applications to receive an updated APTC determination.* NEW: The consumers impacted by this system issue now can qualify for a prospective or retroactive special enrollment period (SEP).

Background:  The Marketplace application includes a question to help consumers who have been denied Medicaid and CHIP by the state because of their immigration status to be assessed for APTC and CSRs.  The question asks:

*“Was this person found not eligible [for Medicaid or CHIP] by their state because of their immigration status”?*

The question appears when: (1) an applicant attests to being denied eligibility for Medicaid or CHIP, and (2) the applicant attested earlier in the same application to having a QHP-eligible immigration status. Answering this question allows the Marketplace to properly evaluate individuals with income under 100% FPL for APTC and CSRs when they have an immigration status that makes them ineligible for Medicaid or CHIP.

System Issue: We have resolved a system issue that was affecting certain immigrants with incomes below 100% of FPL who applied for coverage with financial assistance between 11/15/14 and 3/13/15. Previously, when a household applied for Marketplace coverage and more than one applicant selected “yes” to the question below asking whether the applicant was denied Medicaid or CHIP eligibility based on his or her immigration status, the system issue was causing only the first person on the list of applicants to receive APTC. This issue has been resolved so that all applicants who select “yes” to the question described above can receive APTC, if otherwise eligible.

If a consumer meets the criteria above they may have been impacted by this system issue, and can confirm by looking at their Eligibility Determination Notice (EDN) which will display two distinct patterns listed below. Consumers can also contact the Marketplace Call Center to see if they were impacted by this system issue.

1.     The EDN will show that the first applicant was found eligible for APTC and CSRs, while the other applicants were not.

2.     Under the EDN section titled “Why Don’t I Qualify for Other Programs?” the applicants who are affected by this system issue and found not eligible for APTC or CSRs will have the message:  “Your household’s yearly income is too low for a tax credit. Generally, individuals and families whose household income for the year is between 100 percent and 400 percent of the federal poverty line for their family size may be eligible for the tax credit.”

*New Info for Impacted Communities:* Assisters can help consumers who were affected by this issue to see if they are eligible for a Special Enrollment Period (SEP) that can be prospective or retroactive with a coverage effective date of January 1, 2015. Assisters should help consumers follow the instructions below.

1.     Option 1: Visit Healthcare.gov to determine if consumer is eligible for an existing SEP (prospective coverage only). Visit Healthcare.gov, log into account, and select “Report a Life Change” to update application. Consumers who are already eligible for an SEP can choose a plan and enroll.  Consumers affected by the system issue are likely able to attest to the following question which grants an SEP:  *“Did any of these people apply for coverage between November 15, 2014 - February 15, 2015? (Select their names if they applied through their state or the Marketplace).”* If a consumer is able to enroll through this SEP and does not want retroactive coverage, they can enroll prospectively with no further action needed.  If a consumer is able to enroll through the SEP and would like to enroll retroactively, they can do so by calling the Marketplace Call Center as outlined below.

2.     Option 2: Contact Marketplace Call Center for an SEP (prospective and/or retroactive coverage). Consumers affected by the system issue can call the Marketplace Call Center at 1-800-318-2596 / TTY: 1-855-889-4325. Consumers should explain that they were affected by the “immigration block system issue” and that only some people in their household received APTC when they applied earlier. A Call Center Representative will help the consumer complete an application and grant a prospective SEP, if one is not unlocked by answering the question described above.

Consumers can also request a retroactive SEP with a coverage effective date of January 1, 2015. Note: consumers who request retroactive coverage will be responsible for premiums due back to the coverage start date and will be responsible for any deductibles, co-pays, and co-insurance for services received during those months.

# 2. UPDATE/NEW: System Issue-FFM Incorrectly Counting Income of Certain Tax Dependents with Social Security Benefits

*KEY TAKEAWAY: CMS has resolved a system issue where the FFM was incorrectly counting the income of certain tax dependents with Social Security income. Consumers who were impacted should report a life change to the Marketplace and complete the application to receive a new eligibility determination which will appropriately calculate their household income moving forward.*

Income from a tax dependent is only included in the household income if the tax dependent has income that requires them to file taxes. This is true of all tax dependents, regardless of age. If a tax dependent only has Social Security benefits, they do not meet the requirement to file taxes and therefore their income should not be counted toward the household income.

As we shared in the March 10, 2015 newsletter, the Federally-facilitated Marketplace (FFM) was experiencing a system issue causing income of certain tax dependents with only Social Security income to be incorrectly included in household income. This did not impact consumers who do not receive Social Security benefits, households that do not include tax dependents, or households where no tax dependent has Social Security benefits.

NEW: CMS did implement a system fix on April 17th for this issue, so consumers applying as of April 17th will no longer be affected by this defect.  Consumers who have households with tax dependents whose only income was Social Security benefits and do not meet the requirement to file taxes may have been impacted by this issue. Assisters who are helping consumers who were impacted should go back to their application and report a life change (even if they do not have a change to make), complete the application, and they will then receive a new eligibility determination based on the corrected household income. Assisters should NOT change their current approach, which is to help consumers enter all of their income and let the FFM calculate which income to include or exclude.

We will share more information soon about how consumers who were impacted by this issue can access a Special Enrollment period (SEP).

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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](mailto:kim.vanpelt@slhi.org).