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 May 11th – June 8th

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**AHCCCS Provider Rate Increases Dropped**

AHCCCS

The Legislature enacted [Laws 2015, Chapter 14 (SB 1475)](http://www.azleg.gov/FormatDocument.asp?inDoc=/legtext/52leg/1r/laws/0014.htm&Session_ID=114) on March 12, 2015, which authorized AHCCCS to reduce rates for providers up to 5% in aggregate for dates of service [October 1, 2015 through September 30, 2016.](http://azahcccs.gov/AHCCCSProviderRateAnalysis.aspx) In this process, the Legislature also authorized the agency to account for changes in utilization that were less than the amounts appropriated, as long as the fiscal impact of final decisions on provider rates did not exceed the amount appropriated for capitation rates for fiscal year 2015-2016.

On April 1, the agency opened up a public comment period seeking feedback on the impact a potential 5% rate reduction could have on providers. The agency reviewed comments submitted from 145 different providers and associations representing thousands of providers statewide. Based on the data and information provided through these public comments, along with lower than forecasted utilization and other available funding, AHCCCS has, working with the Governor's Office, determined that no provider rate reductions are required at this time. The agency will continue to monitor access to care, as well as state budgetary issues and utilization trends. The agency appreciates the time and effort taken by the many providers and organizations that submitted comments. These comments were critical to informing the agency’s final decision.

**Arkansas Cancels Cost-Sharing for Poorest in Medicaid Expansion**

Modern Healthcare

Arkansas will not, for the time being, impose cost-sharing for Medicaid expansion beneficiaries below the federal poverty level.  
  
The state won a federal waiver in 2013 to use new funding available under the Patient Protection and Affordable Care Act that helps residents earning up to 138% of the poverty level buy private plans on the new insurance exchange rather than enroll in traditional Medicaid coverage.   
  
At the end of 2014, the Obama administration allowed Arkansas to mandate that all beneficiaries in these private-option plans make monthly contributions to health independence accounts, a version of health savings accounts.   
  
When the waiver was granted, Arkansas become the second state, behind Iowa, to gain the ability to impose cost-sharing below the federal poverty level. Those making between 50% and 100% of the federal poverty level ($11,925 to $23,850 for a family of four) were expected to pay $5 a month. Those between 100% to 138% were to pay between $10 to $25, depending on income. Of the roughly 190,000 people in the private option, 80% are below 100% below the federal poverty level.  
  
Making low-income adults pay part of the cost of their coverage and care helped sway Republican-elected officials in those states to approve the Medicaid expansion for adults with incomes up to 138% of the federal poverty level, which is optional under the Affordable Care Act.   
  
Indiana has since gotten permission to also impose cost-sharing on people under poverty, and Arizona and Montana also plan to seek the same permission.   
  
Initially, the plan was to conduct a six-month outreach campaign in Arkansas to enrollees under the poverty level in the private option, and then begin to start collections of the $5 contributions starting in July. Newly elected Republican Gov. Asa Hutchinson quietly altered the plan months ago, allowing cost-sharing for people above poverty to move forward, but canceling plans to impose it on the poorer enrollees.  
  
“We now know that the private option as it exists today will be replaced,” said Amy Webb, communications director for the Arkansas Department of Human Services. “We felt that it was not prudent to create this new piece for this population if we were just going to change it a year from now. We'd rather take a step back, look at all the scenarios and then move forward with a plan that the Legislature and governor believes is best.”  
  
There is now a healthcare task force of state lawmakers searching for alternatives to the private option, for which the waiver ends Dec. 31, 2016.  
  
Advocates in the state say in truth, the decision came down to administrative costs. “We're we going to spend more money to collect the cost-sharing than what we're going to receive?” Dr. Joe Thompson, a former surgeon general for the state and current director of the Arkansas Center for Health Improvement, a health policy center that focuses on health data and research, said of the state's decision making.   
  
Providers in the state say they support the decision to hold off on cost-sharing for some of the poorest in the state until the task force develops recommendations. “The original plan was to not only have copays, but healthcare independence accounts,” said Bo Ryall, president and CEO of the Arkansas Hospital Association.   
  
“This would be a big change and would require education for providers and cardholders that had not taken place earlier in the year.”  
  
David Wroten, executive vice president of the Arkansas Medical Society, agreed that “this decision makes perfectly good sense.”  
  
Iowa has no plans to change course in charging premiums to people under poverty, said Amy McCoy, a spokeswoman from the state's Department of Human Services.

http://www.modernhealthcare.com/article/20150608/NEWS/150609910?utm\_campaign=KHN:%20Daily%20Health%20Policy%20Report&utm\_source=hs\_email&utm\_medium=email&utm\_content=18203796&\_hsenc=p2ANqtz-8EsNq2ACZZZyF3Zg5hPJBH\_ERXwzZITMNiDJuPP0mEyonop-GPDYNgwJQmIDXVxfn2GKWp32Fjq9W3RPpb84Mvydd6OQ&\_hsmi=18203796

**Medicaid Cost-Sharing Demonstrations Have Netted Little Revenue So Far**

Modern Healthcare

Three states that require low-income adults to pay premiums or other cost-sharing to participate in their [Medicaid](http://www.modernhealthcare.com/section/articles?tagID=697) expansion programs have collected modest sums so far.  
  
As part of their Medicaid expansion programs Arkansas, Indiana, Iowa and Michigan each received time-limited Medicaid waivers from the Obama administration impose cost sharing in the form of premiums, copays, or both. Arizona and Ohio, which launched their Medicaid expansion programs without cost sharing, now plan to submit similar waiver requests to the [CMS](http://www.modernhealthcare.com/section/articles?tagID=973). Montana, which recently approved expansion, also is seeking such a waiver.  
  
Making low-income adults pay part of the cost of their coverage and care helped convince Republican elected officials in those states to approve the Medicaid expansion for adults with incomes up to 138% of the federal poverty level, which is optional under the [Affordable Care Act](http://www.modernhealthcare.com/section/articles?tagID=928).   
  
Supporters say making beneficiaries pay gives them more “skin in the game” and leads them to take better care of their health and use healthcare services more appropriately and thriftily. Politically, imposing cost-sharing helps counter arguments from conservative Republicans that able-bodied adults should not receive government-paid coverage and instead should find jobs that provide coverage. But studies show that most people who are eligible for expanded Medicaid coverage either are employed or are part of working households.  
  
Critics, backed by a number of studies, warn that imposing cost-sharing on Medicaid beneficiaries discourages people from signing up for coverage and from seeking needed care, which some proponents of cost-sharing have acknowledged. Other critics have predicted that states and healthcare providers would find it expensive and administratively cumbersome to extract premium and other cost-sharing payments from poor people.   
  
From a purely income-generating perspective, the cost-sharing policies have led to modest collections so far in Michigan, Iowa, and Arkansas. These states have the longest experience in using cost sharing in their expanded Medicaid programs.   
  
In Michigan, 600,000 people have gained access to coverage as part of the state's expansion, and the state collected $737,000 in monthly premiums from November 2014 to April 2015. The CMS gave Michigan permission to impose premiums only on beneficiaries with incomes between 100% and 138% of poverty, while most people who received coverage under the expansion have incomes below the poverty level. Under the state's Healthy Michigan program, beneficiaries pay up to 2% of their income for premiums.  
  
In Iowa, the state has collected in $142,000 from 15,000 beneficiaries to date. The rest of the people eligible to pay premiums completed the necessary healthy behaviors to avoid the premiums or else claimed financial hardship and didn't have to pay. The state's waiver allows it to charge a monthly premium of $10 a month for enrollees above 100% of poverty. For people with incomes from 50% to 100% of poverty, the state can charge them $5 a month after they've been in the program for one year.   
  
In Arkansas, 190,000 low-income adults have received coverage under the state's expansion. Starting in January, enrollees with incomes as low as 50% of poverty had to make monthly contributions to “independence accounts” from funds are drawn to cover premiums and copays. Monthly contributions range from $10 to $25 a month for people with incomes from 100% to 138% of poverty; for people under the poverty level, contributions are $5 a month. To date, $147,000 has been collected.  
  
Experts say the modest amounts collected aren't surprising. “Premiums from very low-income people are not a sound revenue-raising strategy for states,” said Joan Alker, executive director of the Georgetown Center for Children and Families, who has been critical of state efforts to impose cost sharing on Medicaid beneficiaries. “But I don't think that's why they do it anyway.”  
  
Katherine Hempstead, health insurance policy director at the Robert Wood Johnson Foundation, said requiring premium payments has allowed elected officials in conservative-leaning states to support Medicaid expansion. She said such cost-sharing requirements, however, are “highly symbolic” because “states do not really have a tremendous amount of leverage in terms of collections.”   
  
In Iowa and Michigan, the amount of required premiums is tied to beneficiaries' participation in healthy behaviors' programs. In Iowa, more than 18,000 people were exempt from paying premiums after completing healthy behaviors including getting an annual physical and completing a health risk assessment. In Michigan, 5,742 Medicaid beneficiaries completed the necessary healthy behaviors and got their monthly contributions reduced by 50%. If these Michigan beneficiaries again complete the health behaviors in the second year, they would get their contributions completely waived.  
  
MaryBeth Musumeci, associate director of the Kaiser Commission on Medicaid and the Uninsured, said the modest premium collections in Iowa and Michigan “could mean using cost sharing to incentivize healthy behaviors is working.”  
  
Tim Albrecht, an Iowa-based Republican strategist with Redwave Digital, said the health behaviors incentives are a good idea. “This saves taxpayers money because there isn't the cost associated with treating a chronic illness down the line," he said.  
  
There are no definitive data yet on what percentage of the Medicaid expansion population in Michigan, Iowa, and Arkansas who were supposed to be paying premiums are actually doing so, due to continuous enrollment and the phased-in launch of the cost-sharing requirements.  
  
There also are no data yet on how many beneficiaries have been kicked out of Medicaid for failure to pay premiums in states such as Indiana that received approval from the Obama administration for such lock-out provisions.  
  
Some healthcare provider groups say they have not seen patients skimping on needed care such as medications or medical visits due to cost sharing requirements, though no studies of this have been done so far.   
  
“Many of the patients have not had access to health coverage for years, so they are excited to finally have coverage and the ability to afford their medications,” said Katie Owens, communications program manager for the Iowa Primary Care Association, which represents the state's community health centers.   
  
If Iowa beneficiaries can't afford the premium contribution, they can claim financial hardship on their monthly premium statement and get the contribution waived. About 5,000 Medicaid beneficiaries in Iowa have been granted hardship exemptions, according to Amy McCoy, a spokeswoman from the Iowa Department of Human Services.  
  
Julie Tatko, enabling services director at the Michigan Primary Care Association, said her group also has not seen evidence that cost-sharing requirements have created barriers to care. She said that's mainly because co-pays and cost-sharing contributions are paid out of the beneficiary's health savings account after the services have been provided.

http://www.modernhealthcare.com/article/20150601/NEWS/150529869?tr=y&auid=15675051

**Some States Make Obamacare Backup Plans as Supreme Court Decision Looks**

Online health insurance marketplaces are central parts of the Affordable Care Act. And HealthCare.gov, the federally run exchange, is where 27-year-old Kathryn Ryan, a restaurant server in Philadelphia, turned for health coverage, as soon as the law took effect.

"I was excited because if it weren't for Obamacare, I wouldn't be insured at all," she says. "I wouldn't have the ability to go to the doctor."

She can afford health insurance thanks to a $200 a month subsidy that brings her premium down to $60 a month.

Ryan, who's also studying social work, is one of nearly [400,000 Pennsylvanians](http://aspe.hhs.gov/health/reports/2015/MarketPlaceEnrollment/APTC/ib_APTC.pdf) who have qualified for income-based financial assistance. But like [a lot of people](http://kff.org/health-reform/poll-finding/kaiser-health-tracking-poll-march-2015/), she had no idea that a case before the Supreme Court puts at risk the subsidies in states like Pennsylvania that rely on the federally run exchange.

"You telling me this is, like my heart has sank a bit to the bottom of my stomach, because I was planning on keeping this insurance until I am gainfully employed with an agency that offers benefits," she says.

The reasons Ryan's subsidy and those going to millions of other people nationwide are in jeopardy has to do with a lawsuit before the Supreme Court.

The plaintiffs in the case argue that only those with coverage in state-based marketplaces are eligible for subsidies. If the Supreme Court agrees, [Trish Riley](http://www.nashp.org/new-brief-outlines-state-options-pending-supreme-court-ruling/) with the National Academy for State Health Policy, says it could result in something insurance analysts refer to as a death spiral. "The whole individual market in states could collapse," she says.

Without subsidies, millions of people in the HealthCare.gov states would likely drop coverage. Those most likely to stay would be the really sick people who need expensive care. That change in customers would make insurance "premiums go through the roof," Riley says.

So how are the roughly three dozen states with federal marketplaces bracing for this? Not many states are officially declaring they have alternatives.

But Pennsylvania, for one, has a backup plan. "My biggest concern is, do we have a fallback if we need it?" asks Gov. Tom Wolf, a Democrat who took office in January after defeating an incumbent Republican. The state sent a blueprint of the contingency plan to the feds this month.

He stresses the plan is nonbinding and would only be set in motion if the court rules rules the subsidies for federally run marketplaces are illegal.

Teresa Miller, the state's insurance commissioner, says the potential legal setback is **"**forcing us to put together a plan that frankly most states spent years developing, and essentially we're having to do that in months," she says.

Under the plan Pennsylvania is considering, the state would transition to a model where HealthCare.gov would runs the technology but the state would oversee the funding, regulations and consumer assistance.

The steps Pennsylvania has taken aren't the norm. "Pennsylvania stands out," said [Joel Ario](https://www.manatt.com/Joel-Ario/), a consultant with Manatt Health Solutions.

He says many states may be exploring options behind the scenes. But supporting an actual plan at this point "is a political nonstarter" for at least a third of states with federal marketplaces, where the governors and state legislatures opposed the health overhaul.

That's because a backup plan means "standing up and saying, 'I want to work with this law in a public way in a state-based exchange,' " he says.

Arizona even enacted legislation prohibiting a state-based marketplace, with similar bills pending in several other states.

In New Jersey, a Department of Insurance spokesperson says it's too soon to talk about alternative plans.

But neighboring Delaware, like Pennsylvania, has submitted a contingency plan for a state-supported marketplace to the feds, says [Rita Landgraf](http://dhss.delaware.gov/dhss/admin/vpmbio.html), Delaware's health and social services director.

"Eighty-four percent of those who purchased plans on the marketplace received a financial subsidy, so that is critically important to our constituency that those subsidies are available to them," Landgraf says.

She says the federal marketplace won out over a state design due to the size of the state and the cost of running its own platform. Delaware officials considered a regional marketplace with other states, but it was too complicated.

A decision by the Supreme Court is expected by the end of this month.

http://knau.org/post/some-states-make-obamacare-backup-plans-supreme-court-decision-looms

**Pennsylvania Applies for State Health Insurance Exchange**

TribLive News

Thousands of Pennsylvanians who receive federal tax credits for health insurance could soon use a state-based marketplace to buy their coverage, Gov. Tom Wolf announced Tuesday.

The state Insurance Department filed a federal application this week to start an online exchange that could sell subsidized policies under the Affordable Care Act. Wolf said the move is part of a contingency plan to ensure more than 300,000 Pennsylvanians can keep the subsidies regardless of a pending U.S. Supreme Court decision.

“I don't think we've seen many other states step forward with a plan” in case the court overturns the subsidies, said Antoinette Kraus, director of the nonprofit Pennsylvania Health Action Network in Philadelphia.

The high court is expected to decide this month whether to uphold the credits that help 382,000 Pennsylvanians and 2.8 million more Americans afford health insurance.

“These actions do not mean that Pennsylvania must set up a state-based marketplace. However, the responsible thing to do is set a plan to protect hundreds of thousands of people, and I look forward to working with members of the Legislature to advance this plan if necessary,” Wolf said in a statement.

Court arguments hinge on a nuance of the Affordable Care Act, which says subsidies should be available through online marketplaces “established by the state.”

Pennsylvania and 33 other states rely on federal marketplaces at [HealthCare.gov](http://healthcare.gov/), throwing into question whether residents in those states should qualify for the assistance. Affected enrollees could lose their credits unless policymakers develop state-run exchanges.

Wolf, a Democrat, first said last month that his administration would craft a contingency to make sure credits continue flowing to Pennsylvanians no matter how the court rules. The approach would include outreach, education and a consumer call center to guide Pennsylvanians affected by the marketplace change.

At the House Republican Caucus, spokesman Stephen A. Miskin said the administration has not disclosed costs associated with the effort. Administration officials did not immediately share any cost estimates Tuesday with the Tribune-Review, although Wolf spokesman Jeff Sheridan has said expenses are expected to be “minimal.”

“They're not that transparent or open on everything,” said Miskin, who added that Republican leaders have few details about Wolf's plan. “The administration hasn't really shared fully what its intentions are, what it plans to do.”

The state Department of Human Services is finalizing costs for a state-based marketplace, spokeswoman Kait Gillis said. “Since Pennsylvania's contingency plan is to build on the department's existing IT infrastructure and the existing federal health exchange, the cost will be minimal,” she said.

Insurance Department spokesman Ron Ruman said a state-based marketplace could be up and running as early as Nov. 1 for open enrollment. A percentage fee levied on participating insurers would fund the effort, which would offer state-approved policies through a federal online platform, Ruman said.

About 81 percent of 471,930 Pennsylvanians who enrolled for insurance through HealthCare.gov by the end of open enrollment Feb. 15 qualified for a tax credit, according to the Department of Health and Human Services. It listed the average tax credit for enrolled Pennsylvanians at $230 a month.

The Kaiser Family Foundation found as many as 736,000 Pennsylvanians could receive subsidized coverage in 2016.

<http://triblive.com/news/adminpage/8485735-74/insurance-pennsylvania-health?tr=y&auid=15661391#axzz3c0OSomH3>

**White House Moves to Fix 2 Key Consumer Complaints about Health Care Law**

New York Times

The White House is moving to address two of the most common consumer complaints about the sale of [health insurance](http://topics.nytimes.com/top/news/health/diseasesconditionsandhealthtopics/health_insurance_and_managed_care/index.html?inline=nyt-classifier) under the Affordable Care Act: that [doctor directories are inaccurate](http://www.nytimes.com/2014/02/11/us/californias-health-exchange-removes-its-physician-directories-because-of-errors.html), and that patients are hit with unexpected bills for [costs not covered by insurance](http://www.nytimes.com/2015/02/08/sunday-review/insured-but-not-covered.html).

Federal health officials said this week that they would require insurers to update and correct “provider directories” at least once a month, with financial penalties for insurers that failed to do so. In addition, they hope to provide an “out-of-pocket cost calculator” to estimate the total annual cost under a given health insurance plan. The calculator would take account of premiums, subsidies, co-payments, deductibles and other out-of-pocket costs, as well as a person’s age and medical needs.

Since insurers began selling coverage through public marketplaces 19 months ago, many consumers and doctors have complained that the physician directories are full of inaccuracies. “These directories are almost out of date as soon as they are printed,” said Kevin J. Counihan, the chief executive of the federal insurance marketplace.

[Medicare](http://topics.nytimes.com/top/news/health/diseasesconditionsandhealthtopics/medicare/index.html?inline=nyt-classifier) and [Medicaid](http://topics.nytimes.com/top/news/health/diseasesconditionsandhealthtopics/medicaid/index.html?inline=nyt-classifier) officials have found similar problems in the directories of insurance companies that manage care for beneficiaries of those programs. In December, federal investigators said that more than a third of doctors listed as participating in Medicaid plans could not be found at the locations listed.

The Obama administration recently adopted stricter standards stating that each insurer in the federal marketplace “must publish an up-to-date, accurate and complete provider directory, including information on which providers are accepting new patients, the provider’s location, contact information, specialty, medical group and any institutional affiliations.”

In addition, Mr. Counihan said, the administration will require insurers to provide physician information in a format that software developers can use to create tools to help consumers find health plans in which their doctors participate. Consumer advocates like Robert M. Krughoff, the president of the Center for the Study of Services, also known as Consumers’ Checkbook, said such tools could be a boon to consumers.

The new standards significantly strengthen an earlier rule, which required insurers to publish directories online and to make paper copies available on request. In the federal exchange, violations are subject to civil penalties of up to $100 a day for each person adversely affected.

Federal officials said that inaccurate provider directories could be a sign of larger problems. If doctors listed in a directory are not available or are not taking new patients, consumers may not have access to covered services, and the insurers may not meet federal standards for “network adequacy,” the officials said. Consumers must often pay extra when they use doctors outside the network of their health plan, so an inaccurate directory could also lead to higher costs for patients.

Moreover, doctors said that they too need accurate directories so they can refer patients to physicians in the network when specialized treatment is required.

“The impact of inaccurate provider directories on consumers can be devastating, especially on those consumers who need to carefully examine networks for specific subspecialists, [cancer](http://health.nytimes.com/health/guides/disease/cancer/overview.html?inline=nyt-classifier) centers or children’s hospitals,” the American Medical Association told state insurance officials in a recent letter endorsed by dozens of health care provider and patient groups.

But insurers say that the problems might not be easy to fix, and that doctors are partly to blame for the directory errors. Insurers “are unable to guarantee the accuracy of the provider’s status” in a directory because doctors often “stop accepting particular health plans’ members off and on throughout the year and fail to notify the plan in a timely manner,” America’s Health Insurance Plans, the chief lobby for the industry, said in a letter to the Obama administration.

In its online doctor directory, Blue Cross and Blue Shield of Texas says that it makes every effort to provide correct information, but that it “cannot be responsible for omissions or errors in the provider details.” Aetna says that data in its directory is “subject to change at any time.” UnitedHealth tells Medicare beneficiaries, “A doctor listed in the directory when you enroll in a plan may not be available when your benefits become effective.”

The problems that consumers face with unexpected costs may result, in part, from the way plans are listed on HealthCare.gov, the website for the federal marketplace. More than 8.5 million people are in private health plans selected through the site, and the plans are listed in order of their premiums, from lowest to highest.

This encourages consumers to focus on premiums rather than total costs, said Mr. Krughoff, the Consumers’ Checkbook president, and they often spend hundreds or thousands of dollars more than they need to.

Mr. Krughoff’s group has been publishing a guide to health plans for federal employees for more than 30 years, and a version of its [online tool](http://www.healthplanratings.org/) for comparing health plans is available on the website of the federal marketplace in Illinois. “It’s been a great tool,” said Jose M. Muñoz, a spokesman for Get Covered Illinois, the state agency that promotes enrollment.

The tool can perform searches tailored to a person’s needs and priorities. It asks consumers to describe their health status, offering five levels from excellent to poor, and to list “expected medical procedures” like childbirth, [knee replacement](http://health.nytimes.com/health/guides/surgery/knee-joint-replacement/overview.html?inline=nyt-classifier) or [prostate removal](http://health.nytimes.com/health/guides/surgery/prostate-removal/overview.html?inline=nyt-classifier). It also provides an estimate of total yearly costs for the user.

Federal officials said that they might link HealthCare.gov to an out-of-pocket cost calculator later this year, and that they hoped to make such comparisons a standard part of the shopping experience at the site in later years.

“We know that we have work to do to make it easier for consumers to find plans that meet their needs,” said Lori Lodes, a spokeswoman at the Centers for Medicare and Medicaid Services, which runs the federal marketplace serving more than 30 states.

A few state-run exchanges are developing similar tools. Peter Nichol, the information technology director for the state insurance exchange in Connecticut, said it would add a “cost calculator” to its website this summer.

The Obama administration is also taking steps to increase the accuracy of doctor directories in Medicare. About 30 percent of the 55 million beneficiaries are in private Medicare Advantage plans that typically use networks of doctors to care for patients.

The Medicare agency said it had received complaints about insurance company directories that included doctors who “have retired from practice, have moved locations or are deceased.” New federal rules will require insurers to update their Medicare directories each month, “with specific notations to highlight those providers who are closed or not accepting new patients.”

http://www.nytimes.com/2015/05/09/us/politics/health-care-law-consumer-complaints-to-get-addressed-by-white-house.html?emc=edit\_th\_20150509&nl=todaysheadlines&nlid=31849406&\_r=1

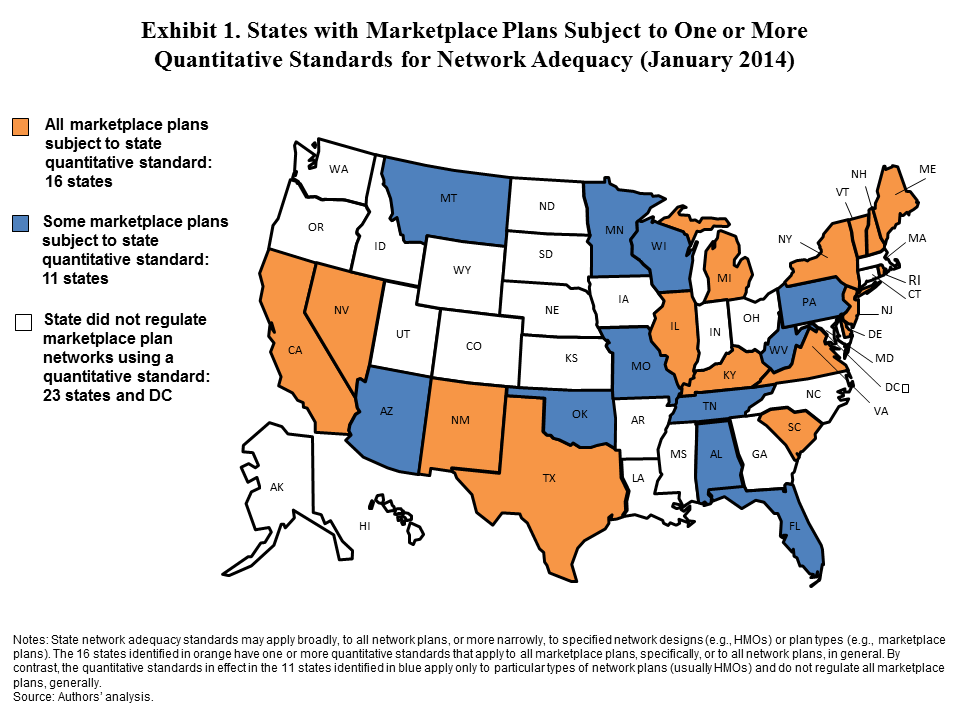
**Implementing the Affordable Care Act: State Regulation of Marketplace Plan Provider Networks**

“Narrow network plans”—which offer limited networks of health care providers as a way to constrain costs—are common in the new health insurance marketplaces, where plans compete on price. While narrow network plans existed before the Affordable Care Act (ACA), they have garnered attention recently because of concerns about whether they might jeopardize patients’ ability to get needed care or expose them to out-of-network costs.   
  
In a new issue brief, Justin Giovannelli and colleagues at Georgetown University explore how states are applying the ACA’s national standards for ensuring consumers have good access to providers. The law’s regulations give states leeway in determining if an insurer has complied with the rules and to enforce additional, state-specific network rules.

Find the brief here:

<http://www.commonwealthfund.org/publications/issue-briefs/2015/may/state-regulation-of-marketplace-plan-provider-networks?omnicid=EALERT777333&mid=kim.vanpelt@slhi.org>

And here is a visual on where Arizona stands:



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| --- |
| **In Arizona an Estimated 2,726,206 Individuals with Private Insurance are Guaranteed Access to Free Preventive services** |
| HHS  In Arizona an estimated 2,726,206 individuals, including 1,061,129 women and 598,585 children, have private health insurance that covers recommended preventive services without cost sharing, according to a new ASPE Data Point from the U.S. Department of Health and Human Services. Under the Affordable Care Act, most health plans are required to provide coverage for recommended preventive health care services without copays.  Nationwide, about 137 million individuals, including 55 million women and 28 million children, have private health insurance that covers recommended preventive services without cost sharing. Increased access to preventive services can reduce and prevent costly chronic diseases and help Arizonans live healthier lives. These services include but are not limited to:      \* Blood pressure screening                                \* Well-baby and well-child visits     \* Obesity screening and counseling                  \* Flu vaccination and other immunizations     \* Well-woman visits                                          \* Tobacco cessation interventions     \* Domestic violence screening/counseling  \* Vision screening (kids)     \* Breastfeeding support and supplies                \* HIV screening     \* FDA-approved contraceptive methods          \* Depression screening  “Thanks to the Affordable Care Act, more Arizonans have access to preventive services, including vaccinations, well-baby visits, and diabetes and blood pressure screenings," said Secretary Sylvia M. Burwell. “These services can substantially improve the health of families, and in some cases even save lives. We urge all individuals with health care coverage to take advantage of these services.  This can make a tremendous difference in the health of Americans.”  The data released today are broken down by age and gender.  Of the estimated 2,726,206 Arizonans with access to recommended preventive services without cost sharing:   * **598,585 are children,** who have access to free preventive service coverage for flu vaccinations and other immunizations, vision screening, and well-baby and well-child visits. * **1,061,129 are women,** who have access to free preventive services such as well-women visits, breastfeeding support and supplies, and recommended cancer screenings. * **1,066,492 are men,** who have access to annual wellness visits, blood pressure screening, and cancer screenings.   HHS previously estimated that approximately 76 million Americans – and 30 million women – received expanded coverage of one or more preventive services because of the Affordable Care Act nationwide.  In Arizona, approximately 1,486,000 Arizonans – and 557,000 women – received expanded coverage of one or more preventive services because of the Affordable Care Act. |
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**Federal Money for Charity Care at Risk in Several States**

Stateline Weekly

The federal government is quietly warning states that failure to expand Medicaid under the Affordable Care Act could imperil billions in federal subsidies for hospitals and doctors who care for the poor.

In an [April 14 letter](https://kaiserhealthnews.files.wordpress.com/2015/04/justin-senior_-fl_-041415.pdf) to Florida Medicaid director Justin Senior, Vikki Wachino, acting director of the U.S. Centers for Medicare and Medicaid Services (CMS) wrote: “Uncompensated care pool funding should not pay for costs that would be covered in a Medicaid expansion.”

Medicaid is the joint federal-state government health insurance program for the poor. Under the Affordable Care Act, states can choose to expand coverage to more people, with the federal government paying the entire costs of expansion through next year.

Florida has asked CMS to renew $1.3 billion in federal funding for its 2016 “low-income pool,” even though the state has rejected Medicaid expansion.  CMS maintains that any extension must take into account the more than 800,000 residents whose medical bills would be covered by Medicaid were the state to expand the program.

In addition to expanding Medicaid coverage to adults with incomes at or below 138 percent of the federal poverty level ($16,242 for an individual), CMS said Florida and other states should strive to pay safety-net providers fair market prices for their services, instead of using federal money to supplement inadequate state Medicaid payments.

For decades, states and the federal government have provided so-called “supplemental” payments to health care providers that serve large numbers of patients who are unable to pay their bills. Without that extra revenue, hospitals and doctors in low-income neighborhoods say they would be unable to keep their doors open.

“Hospitals are all for Medicaid expansion, but they still will need additional funding,” said Barbara Eyman, Washington counsel for [America’s Essential Hospitals](http://essentialhospitals.org/), which represents most of the nation’s safety-net hospitals. Hospitals that serve large Medicaid populations operate at negative profit margins, because Medicaid reimbursement rates are significantly lower than those of Medicare and private insurance, she said.

According to the independent [Medicaid and CHIP Payment and Access Commission](https://www.macpac.gov/wp-content/uploads/2015/01/MACFacts-UPL-Payments_2012-11.pdf), states and the federal government spent $43 billion on these extra payments in 2011, with wide variation among states. Of that, more than $17 billion came from “disproportionate share hospital” payments that all 50 states use to varying degrees under the Medicaid law. The rest are funding agreements negotiated between CMS and individual states under a waiver process.

With the Florida letter and subsequent phone calls to other states, CMS “is signaling it intends to restrict these funds, particularly in states that choose not to reduce uncompensated care by enrolling low-income adults in Medicaid,” said health care expert Deborah Bachrach of the law firm [Manatt, Phelps & Phillips](http://www.manatt.com/deborah-bachrach/).

Under the original assumption that all states would expand Medicaid (in 2012, the Supreme Court ruled that states could choose whether to expand or not) and uncompensated care would decline, the Affordable Care Act called for reductions in the federal share of supplemental funding starting in 2014. But Congress has repeatedly postponed those cuts, pushing any reductions to 2018 as part of a law passed in April that repealed the so-called “sustainable growth rate” formula for reducing Medicare spending.

U.S. hospitals provided more than $50 billion in uncompensated care in 2013. According to [U.S. Department of Health and Human Services estimates](http://aspe.hhs.gov/health/reports/2015/medicaidexpansion/ib_uncompensatedcare.pdf), that number dropped by $7.4 billion after more people became insured under the Affordable Care Act in 2014. Medicaid coverage in expansion states accounted for $5 billion of the decline.

Beyond Florida

Eight other states have supplemental funding agreements similar to Florida’s. Tennessee’s $500 million pool expires in June 2016, Texas’s $4 billion pool expires in September 2016 and Kansas’ $45 million pool in December 2017. All three states have chosen not to expand Medicaid and, therefore, may see future cuts to their supplemental funds.

Five states that have expanded Medicaid receive the supplemental funding. California’s expires in October, and Arizona’s expires in December. Hawaii’s funding expires in June 2016, New Mexico’s in December 2018 and Massachusetts’ in June 2019. In those states, actual reductions in uncompensated care will be taken into account when negotiating an extension of the funding.

The federal government will scrutinize states’ future supplemental funding requests, including a pending proposal from Alabama, in light of the state’s decision on Medicaid expansion.

In a [federal lawsuit](http://www.flgov.com/wp-content/uploads/2015/04/001-Complaint-Filed.pdf) filed last week, Florida’s Republican Gov. Rick Scott claimed the policy shift was an “attempt by the federal government to do precisely what the Supreme Court held just three years ago that the Constitution prohibits it from doing—namely, coerce states into dramatically expanding their Medicaid programs by threatening to cut off federal funding for unrelated programs unless they ‘agree’ to do so.” Scott [announced Monday](http://www.orlandosentinel.com/news/politics/political-pulse/os-kansas-texas-join-florida-medicaid-expansion-suit-20150504-post.html) that Texas and Kansas would file amicus briefs supporting Florida.

The same day Florida filed its lawsuit, the state’s Republican-led House of Representatives took the unprecedented step of closing its doors three days early after a row with the Senate over whether to expand Medicaid. (The Senate is for, the House against.) Scott, who once said he supported expansion, now opposes it.

The House’s abrupt exit left the state’s $77 billion budget and dozens of other bills up in the air. Leaders of both houses must now agree on a special session to resolve their differences over Medicaid expansion in time to pass a budget by the state’s June 30 deadline.

'Negotiated in the Dark'

For years, state Medicaid programs have drawn down billions in federal money for safety-net hospitals by taxing health care providers to create state matching funds. In a 2012 [report](http://www.gao.gov/products/GAO-13-48), the Government Accountability Office called for greater federal oversight of the funding program and more transparent accounting from state Medicaid agencies.

According to Georgetown University health policy expert Joan Alker, “supplemental funding waivers were negotiated in the dark.” In Florida’s case, “it was a special deal between then-President (George W.) Bush and Governor (Jeb) Bush,” she said. The new CMS policy should add more transparency and accountability to the process, she said.

<http://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2015/5/05/federal-money-for-charity-care-at-risk-in-several-states?utm_campaign=2015-05-11%20Stateline%20Weekly.html&utm_medium=email&utm_source=Eloqua>

**HHS to Health Insurers: Cover All Approved Contraception for Free**

Modern Healthcare

Women's health advocates cheered Monday after the Obama administration issued an unambiguous statement that said health insurers can't impose cost-sharing for approved birth control methods.  
  
“It's extremely helpful because there really was a problem that needed fixing,” said Susan Wood, the director of the Jacobs Institute of Women's Health at George Washington University.  
  
The business community also welcomed the clarification. Insurance companies said the guidance—which clarified other insurance issues such as testing for cancer—would help ensure their policies conform to Affordable Care Act standards.   
  
Under the ACA, preventive services such as contraception and wellness visits have to be covered by health insurance companies for free. However, studies from the [Kaiser Family Foundation](http://files.kff.org/attachment/report-coverage-of-contraceptive-services-a-review-of-health-insurance-plans-in-five-states) and the [National Women's Law Center](http://www.nwlc.org/stateofcoverage) last month found that many insurers were violating ACA policy by charging people co-payments and other out-of-pocket costs for contraceptive products and services.  
  
New [guidance issued by HHS, the departments of Labor and Treasury (PDF)](http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/aca_implementation_faqs26.pdf) said all health insurers must cover the 18 birth control methods approved by the Food and Drug Administration—including the vaginal ring, patch and intrauterine devices—with zero cost-sharing borne by the member.   
  
“These two studies that just came out made it crystal clear that it wasn't just a small problem or a very limited problem, but that it was widespread,” Wood said. Wood also served as the FDA's assistant commissioner for women's health from 2000-2005. She resigned from her position in 2005 after the FDA delayed approval of the contraceptive pill Part B for over-the-counter sales.   
  
The National Women's Law Center said in its April report that despite ACA rules, women in every state in the country reportedly had to pay for their birth control depending on their health plan and carrier. The not-for-profit group said the government's decision would keep business practices in line with the law.  
  
“It is past time for insurers to adhere to the law and stop telling women that their chosen method isn't covered or that they must pay for it,” Gretchen Borchelt, a vice president at the National Women's Law Center, [said in a statement](http://www.nwlc.org/press-release/insurers-must-cover-all-fda-approved-birth-control-methods-administration-says). “We welcome the administration's guidance and know it will go a long way to improve the health and economic well-being of women and their families.”  
  
Insurance companies have said their coverage of contraceptives is part of their “medical management” strategy, which pushes members to use the most cost-efficient and effective methods available. But the new guidance makes it clear that all health plans have to provide women with access to any approved birth control method that fits their needs.   
  
“Today's guidance takes important steps to support health plans' use of medical management in providing women with safe, affordable healthcare services,” America's Health Insurance Plans CEO Karen Ignagni said in a statement. AHIP is the primary lobbying group for private health insurers. “Health plans are committed to promoting evidence-based decision-making and to ensuring all consumers understand how their coverage works.”  
  
Although birth control headlined the federal government's announcement, other issues were made clearer. For instance, the feds said all health insurers must cover preventive screenings, genetic counseling and genetic testing for BRCA genes without cost-sharing, if women have an increased risk of harmful mutations. BRCA1 and BRCA2 mutations are associated with higher risks of breast and ovarian cancer.   
  
Insurers also cannot limit preventive services for transgender people, with the government saying insurers should defer to providers for medically appropriate coverage.

<http://www.modernhealthcare.com/article/20150511/NEWS/150519984?utm_source=modernhealthcare&utm_medium=email&utm_content=20150511-NEWS-150519984&utm_campaign=financedaily>

**ACA’s Medical Loss Ratio Not Hurting Insurers**

FierceHealthPayer

An examination of the medical loss ratio (MLR) in 2014 suggests that the financial performance of insurers has not changed substantially since the years before the Affordable Care Act, [according to](http://kff.org/private-insurance/perspective/how-have-insurers-fared-under-the-affordable-care-act/) the Kaiser Family Foundation.

The MLR has increased from 80 percent in 2010 to 85 percent in 2013, KFF said. This makes sense, as the ACA requires insurers to achieve an MLR of 80 percent for individual and small-group plans, and 85 percent for large-group plans; those who do not must pay a rebate to customers. [Insurers have been complying with the medical loss ratio](http://www.fiercehealthpayer.com/story/insurers-show-greater-compliance-medical-loss-ratio/2015-03-27), as customer rebates dropped from $1 billion in 2011 to $325 million in 2013.

The actual MLR for 2014 won't be known until the end of the month, when insurers are due to receive their reinsurance payments, but KFF estimates that it will range between 81 percent and 87 percent.

<http://www.fiercehealthpayer.com/story/acas-medical-loss-ratio-not-hurting-insurers/2015-06-02>

**Experts See Big Price Hikes for Obamacare**

Politico

The cost of Obamacare could rise for millions of Americans next year, with one insurer proposing a 50 percent hike in premiums, fueling the controversy about just how ‘affordable’ the Affordable Care Act really is. The eye-popping 50 percent hike by New Mexico insurer Blue Cross Blue Shield is an outlier, and state officials may not allow it to go through. But health insurance experts are predicting that premiums will rise more significantly in 2016 than in the first two years of Obamacare exchange coverage. In 2015, for example, premiums increased by an average of 5.4 percent, according to PwC’s Health Research Institute. The premium increases come at a tenuous time for Obamacare, which remains under fire from a Republican Congress that wants to repeal the law, while a Supreme Court ruling on federal subsidies for the health insurance looms in June as well. ‘Insurers seem to be reporting higher trend, which means they are seeing bigger increases in health care costs,’ said Larry Levitt, senior vice president for special initiatives at the Kaiser Family Foundation. ‘But really what’s going on here is they now have data showing what the risk pool looks like. Initially in 2014 they were completely guessing about who was going to enroll and how much health care they were going to use.’ Many plans haven’t yet made public their proposed rates; Monday is the deadline for publishing and providing an explanation for rate hikes of at least 10 percent. None announced so far is as dramatic as the New Mexico plan, although a few others are also quite sharp. The Blues in Maryland and Tennessee, both with the largest market share on the exchanges in their states, are seeking increases of more than 30 percent. In Oregon, Moda Health Plan — which attracted more than 40 percent of exchange customers in 2015, despite competing against a dozen other health plans — is seeking average rate increases of 25 percent. Other plans released to date — including some in these four states — are seeking far more modest increases. The reasons for the rising premiums are complex. Part of it, as Levitt noted, is simply that the carriers know a lot more about the health status and health care patterns of their new customers. Part of it’s rising drug prices. And the planned phasing out of certain ACA programs that were designed to reduce risk for insurers who entered the untested Obamacare marketplaces, are also causing carriers to price cautiously.

<http://www.politico.com/story/2015/05/how-affordable-is-the-affordable-care-act-118428.html?utm_campaign=KHN:+First+Edition&utm_source=hs_email&utm_medium=email&utm_content=18011918&_hsenc=p2ANqtz-8tNvge5eRNusWCHTFqjvV1wMsNA1zVU-yVMTUx5DLoU11NCfd-v&tr=y&auid=15650601>

**Talking Points on Insurance Rate Hikes**

* Open To Public Comment: Because of the Affordable Care Act and the state’s own rate review process, residents and small businesses will have an opportunity to weigh in on proposed increases of 10 percent or greater before the rates are finalized. While ADOI does not have authority to deny unreasonable rate increases (unlike many other states), ADOI’s process for rate review has resulted in more transparency, putting some pressure on insurers to keep rate hikes reasonable.
* Tax Credits Keep Premiums Affordable: 75 percent of Marketplace consumers in Arizona received a premium tax credit. As a result, the average premium paid by consumers was [$123](http://aspe.hhs.gov/health/reports/2015/MarketPlaceEnrollment/Mar2015/ib_2015mar_enrollment.pdf) in 2015, with a savings of [$155](http://aspe.hhs.gov/health/reports/2015/MarketPlaceEnrollment/Mar2015/ib_2015mar_enrollment.pdf) thanks to the premium tax credit.
* Competition is Strong:  In 2015, Arizona consumers could choose from an average of [71 plans per county and three more issuers than in 2014](http://aspe.hhs.gov/health/reports/2015/premiumReport/healthPremium2015.pdf).  Due in part to this competition, more than [86 percent](http://aspe.hhs.gov/health/reports/2015/MarketPlaceEnrollment/Mar2015/ib_2015mar_enrollment.pdf) of consumers who selected a plan with tax credits could have selected a plan with a premium under $100 per month and over [65 percent](http://aspe.hhs.gov/health/reports/2015/MarketPlaceEnrollment/Mar2015/ib_2015mar_enrollment.pdf) could have selected a plan with a premium of less than $50 per month.
* Strong Enrollment: Over [205,000 people](http://aspe.hhs.gov/health/reports/2015/MarketPlaceEnrollment/Mar2015/ib_2015mar_enrollment.pdf) signed up for coverage through the Marketplace during open enrollment in Arizona.

**Out of Pocket Cost Comparison Tool – Call for Comments**

CMS

The Centers for Medicare & Medicaid Services (CMS) is developing an Out-of-Pocket (OOP) Cost Comparison Tool to help consumers make more informed choices about their health insurance coverage and to help them pick a plan that will best meet their needs. The OOP Cost Tool will allow shoppers in the Federally-facilitated Marketplaces (FFMs) to see estimates of total spending (to include premiums and cost-sharing) across various health insurance plans. The purpose of this bulletin is to provide information and solicit comments on the proposed OOP Cost Comparison Tool, how the tool computes OOP Cost, and how it would be incorporated into the FFMs’ web sites. We anticipate this comparison tool would be available to consumers for the 2016 annual open enrollment period (for coverage effective starting as soon as January 1, 2016).

CMS requests comments on the proposed OOP cost methodology outlined in this bulletin and the incorporation into the Federally-facilitated Marketplaces’ (FFMs’) web sites. Specifically, we welcome public input on the three key areas of the proposed methodology including: (1) the utilization and cost data; (2) use of health plans’ cost sharing data; and (3) user input regarding consumer demographics, such as the number of family members, age, gender, and expected healthcare utilization. We also seek comments regarding whether it would be helpful to make the source code of an OOP Cost Comparison Tool available for use by State-based Marketplaces (SBMs) including the timing and preferred format for providing this information. Public input is

welcome by sending comments by June 29, 2015 to: OutofPocketCostEstimator@cms.hhs.gov.

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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).