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 July 27th and August 3rd

**Governor Doug Ducey’s Medicaid Plan Calls for Lifetime Limits, Copays**

Gov. Doug Ducey’s plan to modernize Arizona’s Medicaid program has numerous details yet to be worked out. And much of it hinges on approval from the federal Centers for Medicare and Medicaid Services.

Its intent is clear: Require the estimated 350,000 able-bodied adults on AHCCCS to take more responsibility for their health coverage through copays and incentives to find work. The idea is to promote healthy, employable people and move them out of the Arizona Health Care Cost Containment System before a five-year lifetime limit would cut them off for good.

Critics say the governor is trying to fix something that isn’t broken. Sam Richard, executive director of Protecting Arizona’s Family Coalition, suggested the energy would be better spent reforming the state’s prison system, rather than making it harder for poor people to become independent.

On Monday, Ducey’s office held a briefing after formally unveiling the program. The following are questions and answers drawn from that briefing.

Why is the governor doing this?

With the state’s Medicaid program, AHCCCS, up for renewal next year, this is a good time to introduce changes.

What are the key changes that would affect the able-bodied adults the governor is targeting?

To qualify for what would be called the AHCCCS CARE program, these adults would have to:

1. Make copayments of up to 3 percent of their household income for certain services the state wants to discourage, such as an emergency-room visit when a doctor appointment would suffice.
2. Pay another 2 percent of their income into a health-savings account that could be tapped for health services AHCCCS doesn’t cover, such as dental or vision care.
3. Be actively looking for work and use programs designed to help people find jobs, such as resume writing.
4. Meet certain health goals, such as getting a wellness exam or an annual flu shot.

What if I don’t have the money to make the payments?

If your income is above the federal poverty limit ($11,770 for a single person; $24,250 for a family of four), you would be dropped from the program for six months.

If your income falls below that limit, the money would be considered a debt to the state, potentially collected through the Department of Revenue.

What if I find work, but my salary is low enough to still qualify for AHCCCS?

You could stay in the AHCCCS CARE program.

What if I can’t find work?

If you meet the able-bodied adult definition, you could no longer use the AHCCCS program after a total of five years of coverage.

What is this health-savings account all about?

It’s intended to help build a “personal safety net” that an person can use for services not covered by AHCCCS. If someone gets a job and moves off AHCCCS, the money in the account goes with the individual and can be used for other health-related expenses.

Who is NOT affected by this?

Children, the elderly, single parents caring for children age 6 or younger, the seriously mentally ill, those on disability and pregnant women. Of the 1.7 million Arizonans currently on AHCCCS, this would affect up to 350,000 people, or less than 25 percent.

Would doctors and hospitals have to collect the copays?

No. AHCCCS would be responsible for this. There should be no change to what health-care providers do.

How much money would this save the state?

Ducey’s staff says it has not calculated the amount yet.

What are the chances of this happening?

Much of it will depend on federal approval. The federal government has never approved a lifetime limit on health coverage. But Ducey’s staff say other elements of the plan, such as small copays, have been approved in other states’ plans.

Other aspects, such as development of a smartphone app to help AHCCCS clients stay on top of their health issues, will happen next year, regardless of what the federal government does.

How do I learn more?

There is a [fact sheet online here](http://www.azahcccs.gov/shared/Downloads/Modernizing_Medicaid.pdf).

AHCCCS will be hosting community forums, starting with two in Phoenix on Aug. 18. [Details are here](http://www.azahcccs.gov/publicnotices/Downloads/WaiverForumFlyer.pdf).

<http://www.azcentral.com/story/news/arizona/politics/2015/08/03/doug-ducey-arizona-medicaid-plan-lifetime-limits-copays/31088935/>

**Hospital Levy for Medicaid Expansion Now in Hands of Judge**

Capitol Media Services

An attorney for some state lawmakers warned a judge Thursday that a constitutional limit on tax hikes would be shredded if he allows a levy on hospitals to fund an expanded Medicaid program to stand.

"The voters added Proposition 108 to the Arizona Constitution on the constraint on the Legislature's power to collect money,'' said Christina Sandefur. It says that new taxes or tax increases need a two-thirds vote of both the House and Senate to take effect.

And Sandefur told Maricopa County Superior Court Judge Douglas Gerlach it was meant to be air tight, with the supermajority required even in cases of emergency. More to the point, she said it has to apply to a 2013 vote to let the head of the state's Medicaid program assess hospitals $270 million to pay for the state's share of expanding the program and adding 350,000 to the health care rolls.

"To exempt the provider tax here really creates a serious loophole,'' Sandefur said. And she said that loophole is not closed because lawmakers left it up to Tom Betlach, head of the state's Medicaid program, to determine how much to raise and who to exempt.

"It allows the Legislature to give ultimate discretion to an unelected, appointed administrator,'' she said.

But Douglas Northup, representing the Ducey administration, told Gerlach that the levy is not a tax but simply a fee. And he said the 1992 voter-approved constitutional amendment does not apply to fees.

What makes the difference, Northup said, is that a tax applies pretty much across the board. By contrast, he said, this levy is being imposed on just 97 hospitals.

And he said the levy has one other trait that makes it a fee: It benefits those who are paying it.

Northup acknowledged that the 350,000 Arizonans who are now getting care they did not have prior to expansion certainly are beneficiaries. About 1.7 million people are now enrolled in the Arizona Health Care Cost Containment System, the state's Medicaid program.

But he said the expansion was designed mainly to help the hospitals who said they were losing money because so many people were showing up at their doors without insurance or private funds to pay for their care. More people with insurance, Northup said, means more money for hospitals.

State officials pegged the benefit to hospitals at $407 million, far more than they are paying.

What Gerlach decides to call the levy will determine whether the state can continue to collect it.

The Ducey administration needs for the judge to call it a fee to uphold that 2013 vote enacting it. That's because it had the support of only a majority of lawmakers, short of the two-thirds vote the Arizona Constitution demands.

Lawmakers on the losing end of that vote -- enough of them to deny that two-thirds margin -- then filed suit, accusing their colleagues in the majority of ignoring the Constitution.

Last year, over Brewer's objections, the Arizona Supreme Court ruled that the dissident lawmakers do have a right to sue. Justice Rebecca White Berch, writing for the unanimous court, said if the levy is a tax, their votes -- and veto power -- were effectively and illegally nullified.

Gerlach said he could rule as early as this coming week whether he believes the levy is truly a tax. But even the judge acknowledged that whichever side loses is virtually certain to appeal.

The legal fight stems from a 2004 voter-approved law that requires AHCCCS to provide free care to virtually everyone below the federal poverty level.

But Gov. Jan Brewer and state lawmakers, facing a budget crunch, decided in 2011 to no longer provide coverage for single adults. Legal challenges to that decision went nowhere.

In 2013, however, Brewer figured out that Arizona could get money through the federal Affordable Care Act to restore coverage for the 60,000 single adults who had been cut.

But Arizona also had to expand the program to ensure everyone earning up to 138 percent of the federal poverty level, or about $27,000 for a family of three, could enroll, adding perhaps another 250,000.

Even with the federal dollars, though, there was still a cost to the state.

So Brewer crafted the law to let Betlach levy what she called an "assessment'' on hospitals to pay that share. That plan was approved with just the simple majority of Democrats and a few Republicans.

Most of the legislators voting against the plan, all Republicans, filed suit. They argued the assessment was a tax, making the simple majority vote unconstitutional.

Brewer first tried to kill the lawsuit by arguing that the only ones entitled to contest the legality of the assessment -- and the lack of a two-thirds vote -- were the hospitals themselves.

The hospitals, however, had no financial incentive to object. That's because Betlach designed the levy so that no hospital chain would pay more than what it would gain by more of its patients having health insurance. Put another way, every hospital chain would make money.

http://www.yourwestvalley.com/valleyandstate/article\_cb743a7c-3759-11e5-8189-6f98db292e1e.html

About 1.8 million households that got financial help for health insurance under President Barack Obama's law now have issues with their tax returns that could jeopardize their subsidies next year. Administration officials say those taxpayers will have to act quickly.

"There's still time, but people need to take action soon," said Lori Lodes, communications director for the Centers for Medicare and Medicaid Services, which runs [HealthCare.gov](http://healthcare.gov/).

The [health care law](http://topics.nytimes.com/top/news/health/diseasesconditionsandhealthtopics/health_insurance_and_managed_care/health_care_reform/index.html?inline=nyt-classifier) provides tax credits to help people afford private insurance. Nationally, that aid averages $272 a month, covering roughly three-fourths of the premium. By funneling the aid through the income tax system, Democrats were able to call the overhaul the largest middle-class tax cut for health care in history. But they also spliced together two really complicated areas for consumers: health insurance and taxes. Confusion has been the result for many.

Consumers who got health care tax credits are required to file tax returns that properly account for them, even if they are unaccustomed to filing because their incomes are low. Unless they follow through, "they will not be able to receive tax credits to help lower the cost of their health insurance for 2016," Lodes explained.

Treasury officials said 1.8 million households are at risk of losing subsidies for next year, and that number breaks down as follows:

—About 710,000 households that have not filed a 2014 tax return, although they were legally required to account for health insurance tax credits that they received.

—Some 360,000 households that got tax credits and requested an extension to file their returns. They have until Oct. 15.

—About 760,000 households that got tax credits and filed their tax returns omitted a new form that is the key to accounting for the subsidies. Called Form 8962, it was new for this year's tax filing season.

"I think it was definitely confusing for people," said Elizabeth Colvin of Foundation Communities, an Austin, Texas, nonprofit that helps low-income people with health insurance and taxes. "It could have been worse, quite honestly. I think a lot of tax preparers didn't know how to do these (forms) either."

The 1.8 million households with tax issues represent 40 percent of 4.5 million households that had tax credits provided on their behalf and must account for them. The rest had their returns successfully processed by the IRS as of the end of May.

Earlier this summer, a Supreme Court decision preserved health care tax credits for consumers in all 50 states, turning back a challenge from conservatives opposed to "Obamacare." Because of the law's built-in complexity, some of those consumers may now be at risk of losing their assistance.

Administration officials say they're working hard to prevent that. An estimated 16 million people have gained health insurance since HealthCare.gov opened for business in late 2013, and the White House does not want any slippage.

The IRS has started reaching out to consumers with tax issues. HealthCare.gov is reporting an increase in tax-related calls to its consumer assistance center. That telephone number is 1-800-318-2596. The Health and Human Services department plans another outreach campaign in the fall, coordinated with the start of the 2016 sign-up season on Nov. 1.

**Meritus Insurance Plan Enrollments Soar in 2015**

The Business Journal

Meritus has gone from a sizable failure to an insurance success, all in the matter of about eight months.

The nonprofit co-op health insurance plan was designed to provide competition for traditional plans under the Affordable Care Act. By the end of last year, it had 869 enrollees, according to KTAR.com

Enrollment, however, has spiked, and the provider now says it has 56,000 people on its rolls. That's a 28 percent share of plans purchased through the federal health insurance marketplace.

Company officials attribute the turnaround to overcoming some hurdles with the initial rollout of the ACA and a more knowledgeable public.

<http://www.bizjournals.com/phoenix/morning_call/2015/08/meritus-insurance-plan-sees-enrollments-soar-in.html?ana=e_phx_rdup&s=newsletter&ed=2015-08-04&u=R4NJyqTn50Qsr+EjOba3CQ0ad18c4b&t=1438706116>

**Tax Filing Problems Could Jeopardize Health Law Aid for 1.8 M**

The New York Times

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"What the IRS is doing here is sending these people a not-so-gentle reminder that they need to file or they will put their subsidy at risk," said Mark Ciaramitaro, vice president for tax and health care at H&R Block, the tax preparation company. He cautioned that many consumers will find the process cumbersome, so they should waste no time getting started.

Despite a thinning out of taxpayer services due to budget cuts, IRS Commissioner John Koskinen says the tax-filing season went relatively smoothly, even with the health care law added. Nonetheless, he acknowledged that there's a learning curve for everybody on health care.

"This is the first year for this new provision," Koskinen wrote in a letter to lawmakers last month. "We expect that taxpayers will continue to better understand this process as it becomes more routine."

The administration and the health law's supporters could be doing a better job educating consumers, said Judy Solomon of the Center on Budget and Policy Priorities, which advocates for low-income people.

"There is definitely room for improvement to make sure people understand how it works," she said. "They are getting an advance payment of a tax credit, and to finish the process they need to file a tax return. They have to look at it as a process that is a year long and has multiple steps."

<http://www.nytimes.com/aponline/2015/08/04/us/politics/ap-us-health-overhaul-tax-confusion.html?referrer&_r=1&tr=y&auid=15868037>

**Insurance Premiums Rose More Modestly in Rate-Review States**

Politico Pro

States that have a thorough insurance rate review process are more likely to see lower premium increases in the individual market than other states. A study published in Health Affairs examined states’ varying rate review processes between 2010 and 2013 — before the big ACA coverage expansion — and found that premiums purchased on the individual market in states with prior approval authority, as well as loss ratio requirements, were lower than premiums in states that had no rate review authority or had only file-and-use regulations, which allow insurers to use rates after they file without any review process. ‘Our study provides early evidence that stronger forms of rate review authority are associated with lower premiums,’ the researchers from the University of Minnesota’s School of Public Health said in the study. The time frame in this research precedes the big coverage expansion under the Affordable Care Act, which also includes rate review reform. The researchers said they wanted to get an early look at how those ACA rate review changes will impact premiums. The ACA’s federal rate review provisions require carriers to file and publicly justify the reasonableness of any rate increase exceeding 10 percent.

**Navigators Beat Agents in Fight for Young PPACA Exchange Plan Buyers**

Licensed insurance agents and brokers have had a hard time competing with official public exchange websites, call centers and nonprofit helpers, but they seem to be outselling the insurers' own websites and call centers.

Licensed producers also seem to be doing a better job of getting the attention of older Patient Protection and Affordable Care Act (PPACA) exchange plan buyers.

Analysts at [**Deloitte's health care unit**](http://www.lifehealthpro.com/2012/10/02/connecticut-hires-deloitte-to-build-its-exchange) have published data supporting those conclusions in a [summary of results](http://www2.deloitte.com/content/dam/Deloitte/us/Documents/life-sciences-health-care/us-lshc-hix-consumer-survey.pdf) from a recent consumer survey. The survey team asked the PPACA exchange plan enrollees in the sample about the channels they used to shop for qualified health plan (QHP) coverage.

PPACA has provided billions of dollars in funding to launch the public exchange enrollment systems, marketing operations and nonprofit consumer helper operations. The distribution picture could change in coming years, as PPACA exchange startup funding dries up.

But, for now, the official public exchange websites and call centers seem to be the big gorillas: 52 percent of the exchange QHP users in the sample said they shopped for their QHP coverage on an exchange website, and 21 percent said they got help from an exchange call center.

Navigators and producers were midsize players: 14 percent of the QHP users in the samples said they sought in-person help from a navigator, and 12 percent used agents or brokers.

Ten percent shopped for coverage through an insurance company website. Just 3 percent bought their coverage from an insurance company call center, and only 1 percent bought coverage from the new, much-publicized brick-and-mortar health insurance stores.

Agents and brokers may have sent the exchanges older applicants than the navigators did.

Agents and brokers brought in 87 percent as many QHP applicants as the navigators did for the 55-and-older age group; 80 percent as much for the 35-to-54 age group; and only about 68 percent as much in the 18-to-34 age group, according to the Deloitte survey data.

<http://www.lifehealthpro.com/2015/08/03/navigators-beat-agents-in-fight-for-young-ppaca-ex?eNL=55bfbafe160ba0127c77b007&utm_source=LHPro_HCRW&utm_medium=EMC-Email_editorial&utm_campaign=08032015&_LID=139512916>

**Poll: ObamaCare Enrollees Less Satisfied with Insurance Plan**

The Hill

ObamaCare enrollees are less satisfied with their plans than people with other types of health insurance, according to a new poll. The poll from the Deloitte Center for Health Solutions, the research arm of the consulting firm, finds that 30 percent of people with insurance through ObamaCare’s marketplaces are satisfied with their plans. That compares with 42 percent satisfaction from people with employer-sponsored plans, 48 percent with Medicaid and 58 percent with Medicare.  Cost is the most common reason cited for the dissatisfaction with ObamaCare. Republicans have attacked the high deductibles and other out-of-pocket expenses under the system.  An analysis from the consulting firm HealthPocket found that last year the average deductible for a silver-level ObamaCare plan was $2,907, more than twice as much as the average deductible in an employer-sponsored plan. Hillary Clinton has called for fixes to the law to ‘deal with the high cost of deductibles that put such a burden on so many working families.’ The poll finds that one in three ObamaCare enrollees had trouble paying their out of pocket expenses.  Twenty-four percent of ObamaCare enrollees are confident they can get affordable healthcare when they need it, compared to 27 percent in employer-sponsored plans and 38 percent in Medicare.  Still, 72 percent of ObamaCare enrollees who have used their benefits say they might not have been able to get the care without their coverage.  Other polls have also shown much higher level of satisfaction. A Commonwealth Fund survey in June found 81 percent of people were satisfied with ObamaCare coverage.

**Douglas Hospital to Shut Down Friday**

Cochise Regional Hospital in Douglas is expected to permanently close Friday, officials said.

On Thursday, U.S. District Judge Cindy K. Jorgenson denied the hospital’s request for a temporary restraining order on the federal government’s decision to terminate its Medicare contract. The U.S. Centers for Medicare & Medicaid Services stopped Medicare payments to the 25-bed acute care hospital near the U.S./Mexico border on July 10 because of patient safety concerns.

If the hospital closes, 70 employees will immediately lose their jobs, according to court documents.

The closure is “of great concern and utmost importance,” city of Douglas officials said in a news release issued Thursday afternoon. City officials say they are working with Cochise County to come up with both short- and long-term solutions for providing quality patient care to local residents.

During a court hearing July 22, hospital officials appealed to the government for a temporary restraining order on the contract termination, saying that ending the Medicare contract was going to in effect shut down the hospital. Officials said a closure would adversely affect the community of Douglas, which includes a population of about 20,000 people 118 miles southeast of Tucson.

Rural hospital closures are a “disturbing” national trend, said Dr. Daniel Derksen, director of the University of Arizona’s Center for Rural Health. He told a house subcommittee earlier this week that if Cochise Regional Hospital closes, it will be the 55th rural hospital in the U.S. to close since 2010.

In a July 27 letter to Sen. John McCain, Derksen said that when Medicare stopped paying Cochise Regional Hospital, so did other insurers.

“Cochise Regional Hospital serves 20,000 people living in Douglas, including Border Patrol personnel and the EMS/Ambulance system,” Derksen wrote. “The medical and economic impact to the community, and loss of access to health services are devastating.”

The nearest hospital to Cochise Regional is the Copper Queen Community Hospital in Bisbee, which is about 25 miles away. That hospital also operates a clinic in Douglas.

In her decision, Jorgenson noted that Cochise Regional Hospital never disputed the federal government’s findings that it was not in compliance with federal regulations during four surveys conducted between Feb. 19, 2014 and March 26 of this year.

Those surveys found, among many other issues, that there were continuing, serious problems with basic nursing care. During the fourth survey, completed on March 26, hospital nurses left a patient with congestive heart failure and renal disease unaccompanied and unmonitored, except for an admissions clerk, for 90 minutes while he waited for transportation to a dialysis center, according to a federal report.

The report says when the patient was transferred to the van, he was unresponsive and brought back to the emergency department without a pulse. He was placed on a ventilator, airlifted to Tucson and died, court documents show.

The federal surveys found numerous other problems, including that nurses failed to initiate oxygen for a patient with low oxygen saturation, failed to follow a physician order for another patient’s oxygen administration, and failed to ensure that nurses administering potentially dangerous drugs like Vecuronium and Etomidate and obtaining arterial blood gases were competent to do so.

The hospital has had prior problems with patient safety.

Last year, the hospital agreed to pay a civil fine of $4,250 to the Arizona Department of Health Services following an investigation that turned up numerous problems, including having no doctors credentialed to perform surgery and failing to keep the facility clean enough “to prevent the spread of infection.”

Jorgenson wrote that Cochise Regional Hospital did not meet “its heightened burden to establish that it is entitled to a TRO” (temporary restraining order).

Absent the reinstatement of Medicare coverage to the hospital by Friday, it is definitely closing permanently, Chicago-based attorney Harley Goldstein wrote in an email Thursday.

Goldstein is a partner at the law firm of Goldstein & McClintock, which is lead counsel to both Cochise Regional Hospital and People’s Choice Hospital. People’s Choice Hospital is a national company that specializes in saving financially distressed hospitals. People’s Choice Hospital commenced managing Cochise Regional Hospital after the hospital (previously known as Southeast Arizona Medical Center) filed for bankruptcy twice.

“We certainly hope that the U.S. Attorney or the politicians will intervene and convince the appropriate regulatory folks to change their minds so this community is not left deprived of critical-access medical services,” Goldstein wrote.

Officials with the office of U.S. Attorney for Arizona John S. Leonardo declined comment Thursday.

“My understanding is that the U.S. Attorney has not offered any solution which would permit continued Medicare coverage for Cochise Regional Hospital (even during the administrative appeal process), and thus the closing of Cochise Regional Hospital appears imminent,” Goldstein wrote.

The city and county are engaging all medical agencies from the area to arrive at the most effective solutions, the city of Douglas release says.

“Absolutely all options are being considered and both medical and allied health agencies are coming together positively and optimistically to offer solutions to include but not limited to: Copper Queen Community Hospital, Canyon Vista Medical Center, Tucson Medical Center, Chiricahua Community Health Centers, Arizona Ambulance and Lifeline.”

<http://tucson.com/news/state-and-regional/douglas-hospital-to-shut-down-friday/article_eaea84bb-cd98-590e-b6b9-e49e684ecd60.html>

**Understanding the Uninsured Now**

A new report by the Robert Wood Johnson Foundation, GMMB and Perry Undem provides findings from a survey of the remaining uninsured performed in May 2015. Key findings include:

* Most uninsured individuals think that having health insurance is important. More than four in ten have looked into getting insurance on their own in the last year and 56% say they are likely to go to the marketplace in the future.
* Cost remains the main barrier to insurance. Those who have looked made a calculated decision based on more than just the premium. They also consider out-of-pocket expenses, deductibles, co-pays and other factors in their decision.
* Many are struggling financially but are optimistic about the future. They believe their finances will improve soon and that they may get insurance then.
* There are other reasons uninsured individuals may be putting off insurance: the ability to still get care and pay for it out-of-pocket even without insurance and a perception of insurance as a “commitment” rather than something temporary to get in between jobs.
* Almost half (47%) have not gone to the health insurance marketplace and another 10% are unsure if they have. This means there is still a substantial number of uninsured to reach with information encouraging them to look into their options.
* There are substantial knowledge gaps around the tax credits and special enrollment periods that need to be filled. Education about the increasing fine amount could drive about one-quarter of the uninsured to enroll.

Read the full report at: <https://www.statereforum.org/sites/default/files/1814_giovannelli_implementing_aca_state_reg_provider_networks_rb_v2.pdf?utm_source=Email+news+subscribers&utm_campaign=1842893538-Newsletter_1867_31_2015&utm_medium=email&utm_term=0_b9f62f37ab-1842893538-89820469>

**AZ Insurers Receive Millions in Reinsurance Payments**

The Hertel Report

To help pay for high-cost patients and stabilize insurance premiums, the Affordable Care Act sent millions to Arizona health insurers, according to information released by the Centers for Medicare & Medicaid Services (CMS).

The money from the transitional reinsurance program is designed to reduce the uncertainty

of insurance risk by partially offsetting insurers’ claims associated with high-cost enrollees.

Under this temporary program, which expires in 2016, insurers are reimbursed if a person’s claims exceed $45,000 but are less than $250,000.

Under the risk adjustment program, money is transferred from plans with low-risk enrollees

to plans with high-risk enrollees, such as those with chronic conditions. Transfers are based on the actuarial risk of enrollees, the actuarial value of coverage, utilization and the cost of doing business in local rating areas, and the effect of different cost sharing levels on utilization.

Some experts argue the transitional reinsurance program allowed some health plans to artificially lower their premiums to gain market share. However, those premiums may increase once the program expires in 2016.

Blue Cross Blue Shield of Arizona had the largest reinsurance payment in the state,

$43.2 million. It also received more than $15 million in risk adjustments.

<http://www.thehertelreport.com/wp-content/uploads/2015/01/August-2015-THR-Newsletter-Final-Vision-Sponsor1.pdf>

**Healthcare Spending Expected to Grow Average of 5.8% through 2024**

The Hertel Report

The Centers for Medicare & Medicaid Services’ (CMS) Office of the Actuary (OACT) projects overall healthcare spending to rise to $5.4 trillion by 2024.

Expanded coverage due to the ACA, improved economic growth and the aging of the US populace cited as reasons for growth. The report projects that healthcare spending as a share of the economy will rise 2.2 percent from 17.4 percent in 2013 to 19.6 percent in 2024.

The Office of the Actuary annually produces projections of health care spending for categories within the National Health Expenditure Accounts, which track health spending by:

* Source of funds
  + Private health insurance, Medicare, Medicaid
* Type of service
  + Hospital, physician, prescription drugs, etc.
* Sponsor
  + Businesses, households, governments.

The latest projections begin after the latest historical year (2013) and go through 2024.

Read more about the 2014-2024 Projections of National Health Expenditures Data from [*CMS*](http://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2015-Press-releases-items/2015-07-28-2.html)

Read a summary of the projections from [*CMS*](http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/proj2014.pdf)

Read a robust article about the study and its projections at [*Health Affairs*](http://www.thehertelreport.com/wp-content/uploads/2015/07/Health-Aff-2015-Keehan-hlthaff.2015.0600.pdf)

**State Quantitative Standards for Network Adequacy Applicable to at Least Some Marketplace Plans, January 2014**

Commonwealth Fund

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| --- | --- |
| **Network standard** | **States** |
| Maximum travel time or distance | 23 states: AL\*, AZ\*, CA, DE, FL\*, IL, KY, MI, MN\*, MO\*, MT\*, NV, NH, NJ, NM, NY, OK\*, PA\*, SC, TN\*, TX, VT, WV\* |
| Provider-to-enrollee ratios | 10 states: CA, DE, IL, ME, MT\*, NV, NM, NY, SC, WV\* |
| Maximum appointment wait time | 11 states: AZ\*, CA\*, DE, FL\*, MO\*, MT\*, NH, NJ, NM, TX, VT |
| Extended hours of operation | 7 states: CA, IL, MN\*, MO\*, RI, VA, WI\* |

Notes: State network adequacy standards may apply broadly, to all network plans, or more narrowly, to specified network designs (e.g., HMOs) or plan types (e.g., marketplace plans). Standards identified in this exhibit and in the text are applicable to marketplace plans in either of two ways: 1) through state action that specifically identifies the requirements for such plans; or 2) to the extent a marketplace plan uses a network design (e.g., HMO) regulated by the state standard.

\* Standard applies only to specific types of network plans and does not regulate all marketplace plans, generally.

Source: Authors’ analysis.

<https://www.statereforum.org/sites/default/files/1814_giovannelli_implementing_aca_state_reg_provider_networks_rb_v2.pdf?utm_source=Email+news+subscribers&utm_campaign=1842893538-Newsletter_1867_31_2015&utm_medium=email&utm_term=0_b9f62f37ab-1842893538-89820469>

**IRS Needs to Strengthen Oversight of Tax Provisions of Individuals**

GAO

In January 2015, the Internal Revenue Service (IRS) began verifying taxpayers’ premium tax credit (PTC) claims using marketplace data on enrollments and advance payments of the PTC. IRS is using its standard examination processes to check the coverage, exemption, or shared responsibility payment (SRP) information taxpayers report. IRS’s overall goals are to efficiently and effectively enforce compliance with tax laws, reduce taxpayer burden, and encourage voluntary compliance.

Incomplete and delayed marketplace data limited IRS’s ability to match taxpayer PTC claims to marketplace data at the time of return filing. Complete marketplace data for the 2014 coverage year were due to IRS in January, but due to marketplace delays in transmitting the data and IRS technical difficulties with processing the data for matching, as of March 21, 2015, IRS had complete data available for verification of taxpayer PTC claims for 4 of the 51 marketplace states (i.e., the 50 states and the District of Columbia). IRS does not know whether these challenges are a single year or an ongoing problem. According to IRS officials, IRS checks the formatting, but not the accuracy of the data. Although IRS implemented contingency plans to compensate for missing and inaccurate data, those processes were more burdensome for taxpayers. Assessing whether the problems with the timeliness and reliability of the marketplace data are expected to be an ongoing challenge, rather than just a first-year problem, would help IRS understand how it can use the data effectively and better target contingency plans.

IRS does not know the total amount of advance PTC payments made to insurers for 2014 marketplace policies because marketplace data are incomplete. Without this information, IRS does not know the aggregate amount of advance PTC that taxpayers should have reported on 2014 tax returns. Thus, IRS does not know the size of the gap between advance PTC paid and reported or the extent of noncompliance with the requirement for recipients of advance PTC payments to accurately report those payments on their tax return, a measure that could help IRS assess the effectiveness of its education, outreach, and compliance efforts.

Successful implementation of the PTC and individual shared responsibility tax provisions requires IRS collaboration with the Centers for Medicare & Medicaid Services (CMS)—which is responsible for overseeing the marketplaces—and the marketplaces, and communication with other stakeholders, such as tax software companies, employers, and health insurers. IRS worked to collaborate and communicate with external stakeholders to implement PPACA requirements for tax year 2014. However, several external stakeholders GAO spoke with reported challenges with IRS collaboration efforts, such as not receiving certain IRS guidance in time for stakeholders to have complete information at the beginning of the filing season. IRS is evaluating opportunities for improving return processing and the taxpayer experience, but is not evaluating its collaboration efforts. Without an assessment of its efforts to collaborate and communicate with key external stakeholders, challenges in implementing the 2014 PPACA requirements that relied on these groups could also affect new requirements taking effect in 2015, including new information reporting requirements for the State-based Marketplaces, issuers of coverage, and applicable large employers.

<http://www.gao.gov/assets/680/671709.pdf>

**Special Enrollment for Victims of Domestic Violence and Spousal Abandonment**

CMS is committed to addressing the needs of victims of domestic abuse1 and spousal abandonment, including an increased need for health care and the ability to enroll in health coverage apart from their abuser or abandoner.

Special Enrollment Periods

45 CFR 155.420(d)(9) specifies that a special enrollment period will be available when “[t]he qualified individual or enrollee, or his or her dependent, demonstrates to the Exchange, in accordance with guidelines issued by HHS, that the individual meets other exceptional circumstances as the Exchange may provide.” In accordance with this provision, CMS has determined that in the Federally-facilitated Marketplaces, an eligible individual who is a victim of domestic abuse or spousal abandonment, and his or her dependents, as described in 45 CFR 155.420(a)(2), have met “exceptional circumstances” qualifying them for a special enrollment period under 45 CFR 155.420(d)(9).

In 2014, CMS provided a special enrollment period for spouses who were victims of domestic abuse and their dependents from March 31 to May 30 of that year. Beginning on the date of this guidance, CMS will provide this special enrollment period permanently and broaden its eligibility to include any member of a household who is a victim of domestic abuse, including unmarried and dependent victims within the household, as well as victims of spousal abandonment, including their dependents. Accordingly, the special enrollment period will be available for 60 days following the individual’s request, during which an eligible individual who is a victim of domestic abuse or spousal abandonment may apply for and enroll in current year coverage for him or herself and his or her dependents through the Federally-facilitated Marketplace. State-based Marketplaces similarly may determine such an individual and his or her dependents eligible for a 60-day special enrollment period.

Advance Payments of the Premium Tax Credit and Cost-Sharing Reductions

Victims of domestic abuse or spousal abandonment, who are married to their abuser or abandoner and are applying for coverage separately, may be determined eligible for advance payments of the premium tax credit (APTC) and cost-sharing reductions (CSRs).

Marketplaces can elect to permit victims of domestic abuse or spousal abandonment who are married to their abuser or abandoner to either attest to an expected filing status of Married Filing Separately or to indicate on the application that they are unmarried without fear of penalty for misreporting marital status, and be determined eligible for APTC and CSRs on that basis. The Federally-facilitated Marketplace will take the latter approach.

We note that to the extent that a consumer’s marital situation (including intent to file a joint return) changes after initial application, regulations at 45 CFR 155.330(b) requires him or her to report such changes to the Marketplace within 30 days.

Furthermore, the Internal Revenue Service has clarified that certain victims of domestic abuse and spousal abandonment can claim the premium tax credit on their federal income tax return using the Married Filing Separately filing status.

Because the number of qualifying insurer claims was lower than CMS anticipated, the agency increased from 80 percent to 100 percent the share of enrollees’ claims between $45,000 and $250,000 that it will reimburse.

“We are pretty happy with the way the results have turned out,” Jeff Grant, a deputy director in the Center for Consumer Information and Insurance Oversight at CMS, said during a conference call about the results. “The results look pretty reasonable, and it does look like the right issuers are receiving the right levels of compensation for the risk that they’ve taken on.”

That view was echoed by insurance industry watchers.

The report “indicates the permanent risk-adjustment and the temporary reinsurance programs are working as intended,” said Susan Horras, director, healthcare finance policy, health plan and population health initiatives at HFMA.

"These programs are critical to help consumers transition to the ACA market and to provide important stability in the early years of implementation," said Clare Krusing, a spokeswoman for America’s Health Insurance Programs.

The risk-adjustment and reinsurance programs are two of three programs created by the Affordable Care Act (ACA) to serve as a financial backstop for insurance plans offered in the new marketplaces. Information on the third program—the risk corridors program, which protects issuers against excessive losses—will be released later this year.

Grant said CMS expects the three-year reinsurance program to collect more funds than needed this year, and the agency will apply the surplus to the next two years.

Results from the Risk-Adjustment Program

Meanwhile, the permanent risk-adjustment program transferred about 10 percent of premiums among 468 individual marketplace insurers and about 21 percent of premiums among 291 catastrophic plan issuers, according to the report. The risk-adjustment data excluded Massachusetts because the state ran its own program.

The CMS report listed both the risk-adjustment transfers and the reinsurance amounts paid or received by each insurer in each state. Ten insurers failed to create an “EDGE server” or transfer the necessary data, which led to a default risk-adjustment charge.

The report noted that the risk-adjustment transfer amounts and reinsurance payment amounts listed did not reflect any payment or charge adjustments due to discrepancies, appeals, or the effects of sequestration.

“I would expect some issuers to exercise their appeal rights, so I wouldn’t view this report as the final amounts,” Horras said.

Self-Sustaining Programs?

The data indicated that the risk corridor program will not be affected by cost overruns. The program was originally expected to be budget-neutral, but some observers had raised concerns that insurers could incur greater 2014 losses than projected because higher-than-expected shares of sick people enrolled in the plans.

“We anticipate that over the life of the three-year program that risk corridors is going to be budget-neutral,” Grant said. “In any event, the administration is committed to seeking funding to the extent available through appropriations to pay for this.”

A federal funding package enacted in December for FY15 limited the use of new funding for the risk corridor program if it is not budget-neutral. At least one marketplace insurer cited that limitation as impacting its solvency. CoOpportunity Health, one of the co-op plans provided seed money under the ACA, was liquidated in February after its officials said it was at risk for losing $60 million under changes to the risk corridor program.

Key results described in the CMS report included the provision of risk-adjustment payments to many other co-op plans, while some co-ops paid into the risk-adjustment program, Tim Jost, a an expert on the ACA and supporter of the law, noted in a *Health Affairs*[blog post](http://healthaffairs.org/blog/2015/07/01/implementing-health-care-reform-first-year-results-from-reinsurance-and-risk-adjustment-programs/). Additionally, Blue Cross and Blue Shield plans, the largest insurers in many state marketplaces, generally received support under the reinsurance programs but had “mixed results” in the risk-adjustment program.

“But the big news is that two incredibly complex programs that play a key role in encouraging insurers to accept high-cost patients and to discourage insurers from risk selection seem to have come off without serious technical problems,” Jost wrote.

[Rich Daly](mailto:rdaly@hfma.org) is a senior writer/editor in HFMA’s Washington, D.C., office. Follow Rich on Twitter: @rdalyhealthcare.

Those payments to insurers with higher shares of sick enrollees are less than the $8.7 billion collected so far from insurers with less costly claims, according to a [report](https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/RI-RA-Report-Draft-6-30-15.pdf) from the Centers for Medicare & Medicaid Services (CMS). The agency had expected to collect $10 billion, but also had anticipated higher shares of costly claims. The agency expects to collect and pay out another $1 billion by Nov. 15 from the insurers, which covered a total of 6.3 million enrollees in 2014.

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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).