Covered Clips

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

Weeks of December 21st – January 11th

**Federal Marketplace Enrollment November 1 – January 2, 2016**

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| --- | --- |
| **Week 9** | **CumulativeNov 1 – Jan 2** |
| Alabama | 177,158 |
| Alaska | 21,645 |
| Arizona | 172,955 |
| Arkansas | 65,899 |
| Delaware | 26,528 |
| Florida | 1,569,551 |
| Georgia | 517,715 |
| Hawaii | 11,591 |
| Illinois | 348,346 |
| Indiana | 182,348 |
| Iowa | 49,595 |
| Kansas | 87,994 |
| Louisiana | 189,169 |
| Maine | 78,377 |
| Michigan | 324,359 |
| Mississippi | 95,399 |
| Missouri | 258,696 |
| Montana | 55,552 |
| Nebraska | 79,500 |
| Nevada | 76,368 |
| New Hampshire | 50,876 |
| New Jersey | 260,323 |
| New Mexico | 47,649 |
| North Carolina | 558,892 |
| North Dakota | 19,857 |
| Ohio | 225,207 |
| Oklahoma | 130,256 |
| Oregon | 133,776 |
| Pennsylvania | 412,914 |
| South Carolina | 199,385 |
| South Dakota | 22,967 |
| Tennessee | 236,021 |
| Texas | 1,108,935 |
| Utah | 151,058 |
| Virginia | 387,470 |
| West Virginia | 34,594 |
| Wisconsin | 218,394 |
| Wyoming | 20,913 |

<https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-01-06.html>

**Health Law Enrollment Periods to Be Tightened**

Wall Street Journal

The Obama administration will tighten the rules for people who enroll in insurance through HealthCare.gov outside of official enrollment periods, hoping to hold down costs that insurers blamed on late sign-ups.

A top federal health official said Monday that the administration will eliminate some criteria for late sign-ups and make other criteria language clearer. Andy Slavitt, acting administrator of the Centers for Medicare and Medicaid Services, who made his comments during a [J.P. Morgan](http://quotes.wsj.com/JPM)health-care conference, didn’t provide further details.

Insurers say that the rules are so broad that people can wait until they get ill to buy insurance. That raises health-care spending and overall premiums because people who are sicker generally cost more to cover.

The steps are necessary, Mr. Slavitt said, because “bad actors” had been taking advantage of the existing rules and tightening them would ensure that the special enrollment period served its original purpose.

“It’s critical to enforce the integrity of the open enrollment period,” he said. He described earlier approaches as part of the administration’s own learning curve in implementing the health law and aimed at helping people adjust to it, too. The changes, he said, will ensure so-called special enrollment periods serve their intended purpose.

He also said the agency has created an enforcement task force to ensure that people are being honest, and said the task force has terminated coverage for some consumers who didn’t have legitimate reasons for enrolling outside the deadline.

Under the Affordable Care Act, people can buy coverage beyond the enrollment deadline under special circumstances including a marriage, divorce, job change or new baby. Last year, federal officials granted an extension to uninsured people who wanted to get health coverage at the same time they filed their taxes. Exceptions have also been made for people who faced technical problems using the federal government’s insurance website, HealthCare.gov, which serves about three dozen states.

Consumer groups, however, have pressed for additional exceptions that could allow more people—such as pregnant women—to gain coverage.

UnitedHealth Group Chief Executive Officer [Stephen Hemsley](http://topics.wsj.com/person/H/Stephen-Hemsley/592) mentioned concerns over the special enrollment period when announcing in November that his company expected to take a big hit from its insurance sales under the Affordable Care Act.

The Blue Cross Blue Shield Association in December wrote to Mr. Slavitt, saying the administration should reduce the 33 categories that qualify people to sign up after the deadline, which is known as “special enrollment.” It said officials should allow fewer special circumstances and require verification.

A Medicare program and the private market already have greater limits on special enrollment.

Nearly 950,000 new consumers selected a plan through the federal exchange, HealthCare.gov, outside the open enrollment period between Feb. 23 and June 30, 2015, federal officials said in August. The Obama administration has stressed that the robust sign-ups were a sign that there is demand for coverage and was further evidence the health law is working. About half obtained coverage after the enrollment deadline because they lost their health insurance.

The Obama administration has also provided additional reasons people could sign up past the deadline. Last year, the Obama administration offered uninsured people a reprieve if they missed the sign-up deadline for 2015 coverage, originally set at Feb. 15.

People were given through April to sign up if they said they had learned about the penalty for going uninsured only when they filed their taxes. The idea was to help people avoid a situation in which they were fined for going uninsured in 2014 and then learned they would face another fine for 2015—with no opportunity to remedy it.

Federal officials have already ruled out a similar reprieve for this year.

Mr. Slavitt also said the administration is ending a program that provides financial incentives to get health providers to use electronic health records to improve patient care. Instead, it is being replaced with a program that will focus on patient outcome based on the use of that technology.

Also Monday, Kentucky Gov. Matt Bevin took steps to start the process of ending the state-run exchanges to move to the federal exchange. The Republican had vowed to do so when campaigning.

The Health and Human Services said Monday that it is committed to work with the state on a seamless transition. They said the announcement by the state will have no impact on the current open enrollment. As of Sept. 30, there were about 87,000 residents with health coverage through Kentucky’s state exchange.

http://www.wsj.com/articles/health-law-enrollment-periods-to-be-tightened-1452573856?tr=y&auid=16375351

**Advocates Push to Restore Health Insurance for Kids in Low-Income Families**

The Arizona Republic

A coalition of health and advocacy groups are spearheading an effort to restore a pre-Affordable Care Act program that provided health insurance for thousands of low-income Arizona children.

In 2010, Arizona froze enrollment in the KidsCare health-insurance program for low-income families amid budget cuts following the Great Recession. In 2014, Arizona ended KidsCare with the idea that children would instead be covered under the Affordable Care Act’s Medicaid expansion and federal marketplace.

More than 26,000 children obtained health insurance through the state's Medicaid expansion after KidsCare ended in 2014. But the families of about 14,000 KidsCare children were sent to the federal marketplace to buy subsidized plans that many can’t afford, family advocates say.

Arizona Rep. Regina Cobb, R-Kingman, said she will sponsor a bill to fully restore KidsCare, Arizona’s version of the federal-state Children’s Health Insurance Program (CHIP).

Cobb's bill would restore KidsCare eligibility for families earning between 138 and 200 percent of the federal poverty level, or $33,465 to $48,500 for a family of four. Eligible families that earned less would retain their Medicaid coverage.

Cobb and officials with Children’s Action Alliance said that restoring KidsCare would not cost the state money because Arizona is one of nine states eligible for 100 percent federal funding for the program beginning this fiscal year. The Arizona Legislature must pass legislation and Gov. Doug Ducey would need to sign a bill to direct the state's Medicaid program to seek the federal funding.

Ducey administration officials said the governor is open to proposals that make fiscal sense.

"The governor is receptive to ideas to improve coverage so long as the options are fiscally responsible and provide reliability and certainty in health-care matters," said Daniel Ruiz II, a Ducey spokesman.

Cobb said Arizona needs to restore KidsCare, in part, because many families can't afford subsidized "Obamacare" plans sold over the federal marketplace. Unlike KidsCare coverage, ACA plans require consumers to pay more for out-of-pocket costs such as copays, deductibles and co-insurance.

“We are the only state without a CHIP program now,” said Cobb, a dentist who said families with Obamacare coverage don't always access health care because of out-of-pocket costs. "It's not costing us anything and we will get (insurance coverage) for that bracket of the working poor."

It's not clear what kind of reception KidsCare restoration would get at the Arizona Legislature. During past sessions, health-care issues such as the Medicaid expansion have divided the Republican-controlled Legislature. A total of 36 current and former lawmakers are suing to overturn Arizona's Medicaid expansion, which was championed by GOP Gov. Jan Brewer during her time in office.

Dana Wolfe Naimark, president and CEO of Children's Action Alliance, said her group would make the argument that KidsCare expansion would provide both economic and educational opportunities for Arizona families.

"We can't afford to let this opportunity to go by," Naimark said. "It really fits the major goals that Gov. Ducey has set for us, one being opportunity for all kids no matter what ZIP code they come from, the other being educational success."

Census figures show that about 1 in 10 Arizona children did not have health insurance in 2013, the second-highest uninsured rate in the nation.

The uninsured rate was even higher, 16.5 percent, for families that earned between 138 and 200 percent of federal poverty level, the groups that a restored KidsCare program would provide coverage for, for those who are eligible.

Children's Action Alliance estimates 30,000 or more eligible children would be signed up for coverage. Undocumented children are not eligible for the program.

The Arizona Health Care Cost Containment System or AHCCCS, the state's Medicaid program, would need to request additional federal funding to pay for KidsCare. AHCCCS officials said that the funding would come as a block grant that could carry some financial risk for the state if enrollment surpassed expectations.

But Children's Action Alliance said the federal program has safeguards if more children signed up than expected. Also, a state law allows AHCCCS to immediately halt new applications if the agency determines that funding won't meet program costs.

About two dozen community, health and advocacy groups have formed a group called the Cover Kids Coalition to push for the restoration.

Dr. Elizabeth McKenna, an East Valley pediatrician and an American Academy of Pediatrics' Arizona chapter board member, said families formerly insured by KidsCare frequently delay needed care. That creates more acute and costlier medical conditions later.

McKenna said one family of five children can't afford private coverage because the father earns $20 too much per pay period to qualify for Medicaid. One child has development delays and another child is afflicted with a nervous-system disorder — conditions that can be managed with regular access to medical care.

"Then there are the kids who have a regular illness like a cold or bronchitis," McKenna said. "Those kids end up with a pneumonia in the emergency room because they don't have insurance."

http://www.azcentral.com/story/news/arizona/politics/2016/01/07/arizona-advocates-seek-restore-kidscare-health-insurance-low-income-families/78383858/#

**Modifying the ACA’s Family Subsidy Rules to Help Ensure Affordability**

The Commonwealth Fund Blog

The Affordable Care Act (ACA) aims to increase the number of Americans with health coverage by expanding access to Medicaid and establishing marketplaces where people can compare private plans and, if eligible, receive premium and cost-sharing subsidies. Partly to reduce the law’s fiscal impact, the ACA encourages workers with access to employer-provided coverage to retain that coverage by restricting their eligibility for marketplace subsidies. This “affordability firewall” means that all members of a family are ineligible for subsidies if at least one member has access to employer-provided insurance in which his or her contribution for a *single* premium is less than 9.56 percent of household income.

Because of the firewall, many families whose incomes would make them eligible for subsidies for marketplace plans are penalized for having access to employer coverage. Even though their required contribution for an employer family plan may be substantially higher than the contribution for a single plan, these families do not qualify for marketplace subsidies. In contrast, families that are eligible for subsidies in the marketplaces pay no more than 9.56 percent of their income for a *family* premium if they enroll in benchmark coverage, and many will pay considerably less, depending on their income. Figure 1 illustrates this difference by comparing premium contributions for two families of the same size and income.1

**Figure 1: Family Health Insurance Premium Contributions, Employer Coverage Compared with Marketplace Benchmark Plan**

*Based on a Family of Four Earning $48,500 per year (200% of the Federal Poverty Level)2*



Sen. Al Franken (D-Minn.) proposed a modification to the firewall that would allow dependents to receive subsidies—but not the worker—when the family employer premium contribution exceeds 9.56 percent of the worker’s household income.3  We estimated the changes this modification would bring about in coverage, federal spending, and family out-of-pocket spending. To conduct this analysis we used the COMPARE microsimulation, a health economic model developed by RAND.

If the Franken proposal were implemented, we estimate that 2.3 million individuals who are not currently eligible for subsidies because of the firewall would become eligible and enroll in subsidized coverage in the individual marketplaces (Figure 2). These newly subsidized enrollees would include three groups: 1) 700,000 individuals who would have been covered by an employer plan under current law;4  2) 900,000 individuals who would have purchased unsubsidized individual coverage under current law; and 3) 700,000 people who would have been uninsured under current law.5  We also estimate that, in addition to the 2.3 million newly subsidized enrollees, there would be 400,000 low-income children whose parents would enroll them in Medicaid or the Children’s Health Insurance Program when they moved from an employer to a marketplace plan.

**Figure 2. Projected Health Insurance Coverage Changes in 2017 Under the ACA and Under the Proposed Modification to the Affordability Firewall**

*(millions of individuals)*

We also considered the impact of this policy change on government spending and revenue, accounting for increases in marketplace subsidies and Medicaid spending, decreases in uncompensated care, decreases in individual mandate revenue from the uninsured, and increases in tax revenue due to increased wages that may occur if employers’ spending on health insurance declines. The net impact under the policy change is an increase of $3.9 billion in federal spending relative to what the government is expected to spend under current ACA policy.

Elimination of the firewall would significantly reduce financial burdens for individuals who become newly eligible for marketplace coverage. Table 1 shows the average out-of-pocket spending and average total health care spending that these individuals face under the ACA and under the modification.6  We find that the modification would reduce their out-of-pocket spending by $305 per year, and their total health care spending by $2,080 per year compared with their spending under current policy. Out-of-pocket spending falls because some individuals become eligible for cost-sharing reductions when they become newly subsidized; others use subsidies to enroll in more generous plans. The table also shows that their risk of spending more than 10 percent of income on health care would fall dramatically—from 87.3 percent to 57.6 percent. Their risk of spending more than 20 percent of income on health care would fall by more than two-thirds.

**Table 1. Annual Spending in 2017 for Previously Insured, Newly Subsidized Families**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Scenario | Average Out-of-Pocket Spending  | Average Total Health Care Spending  | Percent Spending More Than 10% of Income on Health Care | Percent Spending More Than 20% of Income on Health Care |
| ACA |  $977  |  $6,564  | 87.3% | 33.7% |
| Modification |  $672  |  $4,484  | 57.6% | 9.2% |

We project that by spending about $1,700 per newly subsidized individual the government would extend insurance to another 700,000 people and substantially reduce health care spending for 1.6 million individuals who are insured but face high health care costs under current ACA policy.

<http://www.commonwealthfund.org/publications/blog/2016/jan/the-impact-of-modifying-acas-family-subsidy?omnicid=EALERT966238&mid=kim.vanpelt@slhi.org>

**Blog: Liberal and Conservative Reformers Press Candidates on ACA Changes**

Modern Healthcare

Some liberal healthcare policy experts are urging an [ambitious, costly program](http://apps.tcf.org/key-proposals-to-strengthen-the-aca) to expand and improve the Affordable Care Act's coverage. Meanwhile, [conservative policy mavens are promoting an even more ambitious ACA replacement package](http://newsatjama.jama.com/2015/12/21/jama-forum-replacing-the-affordable-care-act-and-other-suggested-reforms/) they say would reduce the uninsured rate and lower healthcare spending with less government intervention.

Falling in between, the centrist Bipartisan Policy Center recommended last month that the Obama administration meet with governors to advance new health insurance approaches, including [flexible use of the ACA's Section 1332 state innovation waivers](http://bipartisanpolicy.org/wp-content/uploads/2015/11/BPC-Health-Improving-Expanding-Coverage.pdf) allowing implementation of alternative coverage models.

These proposals represent efforts from the left, right and center to frame the health policy options for the next president and Congress following the November elections. Indeed, Democratic presidential candidate [Hillary Clinton has proposed measures](http://www.modernhealthcare.com/article/20150925/blog/150929909) similar to those offered by the liberal reformers to make healthcare more affordable, while [Republican hopefuls Jeb Bush, Marco Rubio and Chris Christie](http://www.modernhealthcare.com/article/20151102/BLOG/311029999) have borrowed ideas from the conservative experts.

“The smart players realize this isn't a healthcare election,” said Lawrence Jacobs, a political science professor at the University of Minnesota who studies healthcare politics. “But that doesn't mean you're not active preparing the ground for post-election discussions.”

The competing proposals come as enrollment on the ACA exchanges appears on track to exceed the [Obama administration's cautious projection of 10 million](http://www.modernhealthcare.com/article/20141220/MAGAZINE/312209970), and the percentage of eagerly sought enrollees under age 35 has ticked up from the same period a year ago.

Nevertheless, both ACA supporters and opponents note that 10.5 million Americans who were eligible to buy subsidized coverage through the exchanges were still uninsured as of last fall, and that the law is moving much more slowly than predicted in achieving its goal of near-universal coverage. Last year there still were 29 million uninsured people, down from 45 million in 2013 before the ACA coverage expansion kicked in, according to the Centers for Disease Control and Prevention.

A big concern is high deductibles and other cost sharing that makes ACA individual-market plans unattractive, particularly for higher-income people who don't qualify for generous premium and cost-sharing subsidies. The [New York Times](http://www.nytimes.com/2016/01/04/us/many-see-irs-fines-as-more-affordable-than-insurance.html) reported that some people figure it's cheaper to pay the law's tax penalty for not buying coverage than buy a plan that doesn't offer any coverage until they hit the deductible that might be $3,000 or higher.

“It literally covered zero medical expenses,” said Tim Fescoe, an artist in Culver City, Calif. who last year dropped his and his wife's ACA plan that carried a $6,000 deductible.

Liberals who want to improve the ACA focus on reducing the cost-sharing burdens. A report published last month by Century Foundation, written by Tim Jost of Washington and Lee University and Harold Pollack of the University of Chicago, laid out a 19-point proposal for making the system better.

“People like me are very proud of the Affordable Care Act and see many things going well,” Pollack said in an interview. “But a lot of things aren't going well. What can we do to make sure the experience of using the marketplaces is more comprehensible and humane.”

His and Jost's proposal includes:

* Fixing the ACA's so-called family glitch so that working families qualify for exchange premium subsidies when an employer-based plan would be unaffordable.
* Increasing tax credits for moderate- to middle-income households that currently receive little financial aid in buying coverage.
* Reducing cost-sharing and out-of-pocket limits for moderate-income individuals and improving minimum coverage requirements in employer-based plans.
* Expanding the use of value-based insurance design to cover high-value services without cost-sharing.
* Strengthening state regulation and transparency of network and formulary adequacy.
* Beefing up consumer protection from balance billing.
* Standardizing insurance plans on the ACA exchanges.
* Having the federal government permanently assume the full cost of the ACA Medicaid expansion.
* Boosting Medicaid payment rates to ensure adequate patient access to care.
* Allowing exchange customers to buy into Medicare through the ACA exchanges, starting with people 60 and older

But many of these steps would require large new federal spending, and that would be a steep uphill battle even if the Democrats win the White House and the Senate because the Republicans are expected to hold control of the House. Jost and Pollack recognized this. “Yet an administration committed to improving access could take some of the actions we recommend without new legislation, while other proposals could be implemented by the states, marketplace, or simply by insurers,” the authors wrote.

Conservative policy experts last month laid out their own sweeping plan for replacing the ACA, relying on consumer incentives and market mechanisms. While they want to do away with Obamacare, [they write](http://healthaffairs.org/blog/2015/12/09/improving-health-and-health-care-an-agenda-for-reform/) that “unless a credible and practical alternative reform plan is presented to the public, and supported by policymakers, the long-term trend toward ever-increasing governmental control will continue unabated in the years ahead.”

Their complex proposal includes:

* Capping the tax exclusion for employer health plans at the 75th percentile of employer plan cost.
* Providing age-adjusted tax credits to households without access to employer coverage.
* Eliminating ACA benefit requirements and allowing states to decide whether to retain public exchanges and what health plans could be offered.
* Replacing the ACA's blanket ban on pre-existing condition coverage exclusions with a guarantee of coverage to those who have maintained near-continuous insurance over the preceding three years.
* Giving states fixed, per-capita payments for Medicaid beneficiaries, and creating separate programs and funding streams for able-bodied and disabled recipients.
* Giving Medicaid beneficiaries tax credits to buy coverage in the private insurance market.
* Converting Medicare into a defined-benefit “premium support” program featuring private plans competing with traditional Medicare, and combining Medicare Parts A and B into a single program with one premium, and requiring beneficiaries with Medigap plans to pay a deductible.
* Greatly expanding use of health savings accounts.
* Abolishing the CMS Innovation Center and the Independent Payment Advisory Board, while giving providers and health plans greater flexibility in conducting tests of new value-based models.
* Sharply reducing federal support for graduate medical education.
* Paring down the Veterans Health Administration to focus only on essential services that aren't offered elsewhere.

The authors, including Joseph Antos of the American Enterprise Institute, James Capretta of the Ethics and Public Policy Center, and Gail Wilensky of Project Hope, acknowledged the political and policy difficulties in implementing these changes. “The depth and breadth of the reforms listed here are not likely to be accomplished and perhaps not even attempted in a single presidential term,” [they wrote](http://newsatjama.jama.com/2015/12/21/jama-forum-replacing-the-affordable-care-act-and-other-suggested-reforms/).

House Speaker Paul Ryan (R-Wis.) recently [vowed to unveil a Republican plan to replace the ACA](http://www.modernhealthcare.com/article/20160106/NEWS/160109933) on the heels of congressional Republicans pushing through ACA repeal legislation which was promptly vetoed by the president.

Republicans have been sharply criticized for failing to present their own reform plan. They are hobbled by sharp differences between various factions of the party. Some favor a comprehensive plan with tax subsidies to help people afford coverage, similar to the conservative policy experts' proposal described above. Others prefer a much more limited approach featuring Republican standbys such as limits on medical malpractice lawsuits, allowing insurers to sell plans across state lines, letting employers band together to buy insurance, and greater reliance on health savings accounts.

Despite the prodding from liberal and conservative reformers, the University of Minnesota's Jacobs predicts that neither Republican nor Democratic candidates will offer detailed healthcare proposals during this year's election campaign. The Democrats will avoid it because they don't want to open themselves to criticism about more costs and regulation. Their message is “consolidation and bite-size improvements” in the ACA. Meanwhile, he said, Republicans don't want to discuss specific plans with features that may resemble Obamacare and would alienate their political base.

After the election, even if the Republicans win the White House, “reality is staring them in the face, the world has changed, and going back (to the pre-Obamacare system) is not an option,” Jacobs said. Depending on the size of their victory, they may ratchet down premium subsidies and convert Medicaid into a state block grant program. But given healthcare industry and public support for many key ACA features, he predicted Republicans largely would be “relabeling aspects of Obamacare.”

<http://www.modernhealthcare.com/article/20160113/BLOG/160119943?utm_source=modernhealthcare&utm_medium=email&utm_content=20160113-BLOG-160119943&utm_campaign=am>

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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.