Covered Clips

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

Week of February 15th and 22nd

**Arizonans Added to Medicaid and the Marketplace since January, 2014\***

St. Luke’s Health Initiatives

|  |  |  |
| --- | --- | --- |
| Medicaid | Marketplace | Total |
| 322,707 | 203,066 | 525,773 |

\* As of February 1, 2016

Sources: <https://www.azahcccs.gov/Resources/Downloads/PopulationStatistics/2016/Feb/AHCCCS_Population_by_Category.pdf>; <http://www.azcentral.com/story/money/business/consumers/2016/02/04/arizonas-affordable-care-act-health-insurance-signups-slow-third-year/79839048/>

**Proof Needed to Enroll in Health Plan Post-Deadline**

The New York Times

People who want to buy [health insurance](http://topics.nytimes.com/top/news/health/diseasesconditionsandhealthtopics/health_insurance_and_managed_care/index.html?inline=nyt-classifier) in the federal marketplace outside the annual open enrollment period will now have to provide documents to show they are eligible, the Obama administration announced on Wednesday.

In the last two years, insurers say, many people went without coverage and then signed up under the Affordable Care Act when they became sick and needed care. Insurers say that people who sign up after the deadline tend to generate more claims and more costs, raising premiums.

The National Association of Insurance Commissioners, representing state officials, complained recently that “consumers are not required to provide documentation to substantiate their eligibility for a special enrollment period.”

The new policy requires people to submit documents like a birth or marriage certificate if they want to sign up after the deadline using any of the most common special enrollment periods. These are available after a marriage or the birth or adoption of a child. They are also available when people move permanently to a new address or lose coverage provided by an employer, a government program or other source.

The administration has created more than 30 special enrollment categories and sent emails to millions of Americans last year urging them to see if they might be able to sign up after the open enrollment deadline.

It is unclear how rigorous the government will be in checking eligibility. Consumers who appear to qualify for a special enrollment period will be allowed to obtain insurance while the government tries to confirm eligibility based on the documents provided, federal officials said.

Kevin J. Counihan, the chief executive of the federal marketplace, said Wednesday that the new requirements would apply to people who want to enroll or change health plans midyear in the 38 states that use the federal website, [HealthCare.gov](http://healthcare.gov/).

“We are committed to making sure that special enrollment periods are available to those who are eligible,” Mr. Counihan said. “But it’s equally important to avoid misuse or abuse.”

If consumers do not provide the required documents, he said, “they could be found ineligible to enroll in marketplace coverage and could lose their insurance.”

Insurers welcomed the new policy. Clare Krusing, a spokeswoman for America’s Health Insurance Plans, a trade group, said the documentation requirements were “a much-needed step in the right direction.”

Justine G. Handelman, a vice president of the Blue Cross and Blue Shield Association, said the policy could help stabilize the federal insurance marketplace. The insurer Aetna said that, on average, people who signed up in a special enrollment period kept their coverage for about half of the time of regular enrollees.

Consumer advocates who usually support the White House denounced the administration’s action. Rachel Klein, the director of organizational strategy at Families USA, a consumer group, said, “We should be making it easier for people to sign up for [health insurance](http://topics.nytimes.com/top/news/health/diseasesconditionsandhealthtopics/health_insurance_and_managed_care/index.html?inline=nyt-classifier), not harder.”

Consumers, she said, are still learning how to navigate a complex enrollment process, so the administration should not be putting “bureaucratic roadblocks” in their path.

Judith Solomon, a vice president at the Center on Budget and Policy Priorities, a liberal-leaning research and advocacy group, said she was disappointed because the government was imposing the new requirements without clear evidence of abuse.

“There is evidence that special enrollment periods are underutilized,” Ms. Solomon said. “We fear that requiring more paperwork will exacerbate that trend and keep people out of coverage.”

The new policy was announced a few hours after the [Government Accountability Office](http://www.gao.gov/), an investigative arm of Congress, questioned another aspect of [HealthCare.gov](http://healthcare.gov/).

In a report to Congress, the investigators said that the Centers for Medicare and Medicaid Services “has assumed a passive approach to identifying and preventing fraud” by people who bought insurance and obtained subsidies through HealthCare.gov.

The Obama administration waived certain document filing requirements, did not always verify income and citizenship, and thus “allowed an unknown number of applicants to retain coverage, including subsidies, they might otherwise have lost,” the report said.

<http://www.nytimes.com/2016/02/25/us/politics/proof-needed-to-enroll-in-affordable-care-act-health-plan-post-deadline.html?_r=0>

**A Wrap up of 2015 Medicaid Expansion Waivers: Montana and Michigan**

Georgetown University Health Policy Institute Center for Children and Families Say AHHH Blog

Although we have been closely following Medicaid expansion waivers, we have neglected heretofore to blog about two “M” states that received waiver approval in the last few months of 2015. Montana [received approval](https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/mt/mt-HELP-program-ca.pdf) on November 2, 2015 to start its new coverage on January 1, 2016, and Michigan [received approval](https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/mi/mi-healthy-michigan-ca.pdf) of an amendment to its existing Section 1115 waiver on December 17, 2015.

Montana

CMS approved Montana’s [Section 1115 Medicaid demonstration called the Montana Health Economic Livelihood Partnership](http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/mt/mt-HELP-program-ca.pdf) (HELP) program which is slated to provide coverage to approximately 70,000 people. The state began providing this coverage to adults with incomes below 138% of the poverty line on January 1st, 2016.

The main issue under negotiation was the imposition of both premiums and cost-sharing for the newly eligible. As has been the case in other states, CMS approved premiums of 2% for those between 100-138% of the Federal Poverty Level (FPL) – analogous to premium levels in the Marketplace. As in Iowa, CMS allowed Montana to charge premiums starting at 50% of the federal poverty line. However, those beneficiaries living below the poverty level who are unable to pay their premiums will not be disenrolled, but this debt can become a lien on future state income tax returns. Those with incomes above the poverty line can lose coverage for nonpayment of premiums following a 90-day grace period. Ninety days is also the maximum amount of time that a beneficiary may be disenrolled for nonpayment, and they are permitted to reenroll once this period has passed and they have either paid past premiums or the state assesses the debt via income taxes. The enrollee does not have to reapply for coverage in this case.

The state will also charge maximum copayments permitted under regular Medicaid rules to those enrolled. It may come as a surprise to many, but Medicaid already permits states to charge copayments to adults unless they fall into certain exempt categories (i.e. pregnant women, American Indians, and dual eligibles to name a few). States do not need a waiver to do so. The new twist in the Montana agreement is that those who pay their 2% premium will see a credit towards copayment obligations. Some preventive services such as immunizations and medically necessary health screenings are exempt from copayments – one of the details to be worked out later was a more inclusive definition of preventive services.

On a positive note, CMS approved Montana’s request to provide twelve months of continuous eligibility to the new adults. This provision will reduce state administrative burdens and removes red-tape barriers for Medicaid beneficiaries whose income fluctuates frequently. Continuous eligibility also allows for states to do a better job in monitoring the quality of care. It was disappointing when Arkansas dropped this important provision from its waiver proposal, so it was good to see Montana become the second state after New York to receive waiver approval to do so.[[1]](http://ccf.georgetown.edu/all/wrap-2015-medicaid-expansion-waivers-montana-michigan/%22%20%5Cl%20%22_ftn1).

Michigan

Michigan, on the other hand, had already expanded Medicaid but has joined states such as [Arkansas and Arizona](http://ccf.georgetown.edu/all/arkansas-arizona-diverge-medicaid-transportation-benefit/) in [pursuing amendments to its existing Section 1115 waiver](https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/mi/mi-healthy-michigan-pa.pdf) to make changes in the coverage they provide to their expansion population. In Michigan’s case this waiver amendment was [foreshadowed in the initial state law](http://www.legislature.mi.gov/%28S%281iehfowp41msfc4cteihnthl%29%29/mileg.aspx?page=getObject&objectName=mcl-400-105d) authorizing expansion as a condition of continuing coverage. Michigan originally [expanded Medicaid via a waiver](http://ccf.georgetown.edu/all/michigan-medicaid-expansion-waiver-approved-cms-also-releases-new-medicaidchip-faqs/) that required beneficiaries between 100 and 133% FPL to pay 2 percent of their income in premiums. These payments go into a health savings account, and can be reduced if the beneficiary completes a ‘healthy behavior.’ Beneficiaries under the poverty line also have an account into which they contribute copays based on their usage of services for the previous six months. In terms of enrollment Michigan’s waiver has been very successful with over [600,000 individuals gaining coverage](http://www.michigan.gov/mdhhs/0%2C5885%2C7-339-71547_2943_66797-348791--%2C00.html).

The [agreement](https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/mi/mi-healthy-michigan-ca.pdf) that CMS came to with Michigan on December 17 follows the contours of the state law but includes some important consumer protections compatible with federal requirements. Beneficiaries between 100% and 138% FPL (who are not medically frail) will have the option of enrolling in one of two coverage options: 1) a Qualified Health Plan (QHP) through the state Marketplace, or 2) the Healthy Michigan Plan, the state’s current Medicaid managed care program through which those newly eligible under the current waiver have been receiving coverage. Those above the poverty level that enroll in the Healthy Michigan Plan will now be required to complete a ‘healthy behavior’ (a list of such behaviors remains to be determined) but will receive a cost-sharing reduction upon doing so. Those who do not complete a healthy behavior will be transferred to Marketplace coverage, though there is a one-year grace period.

Contrary to the state’s original proposal, out-of-pocket costs will not be allowed to exceed 5 percent of income and premiums will not exceed 2 percent. There are no enrollment implications for those that cannot pay premiums. Those that choose to enroll in a QHP through the Marketplace will receive wrap-around coverage for any services provided under the state’s Medicaid plan but not covered through a QHP – no benefits were waived.

Michigan’s waiver does not go into effect until April 2018 per state law (!), so there will be plenty of time to understand these new requirements. It also provides time to analyze further details as they emerge such as the list of healthy behaviors and more detailed protocols regarding switching between a QHP and the Healthy Michigan Plan.

[[1]](http://ccf.georgetown.edu/all/wrap-2015-medicaid-expansion-waivers-montana-michigan/%22%20%5Cl%20%22_ftnref1) *Note to devoted SayAhhh! readers – states can provide 12-month continuous eligibility to children without a waiver but not for adults. Readers also may remember that Arkansas said it would be too expensive to implement 12-month continuous eligibility for its expansion population because CMS required that a short period each year of coverage would have to be covered at a state’s regular match rate. Now we see in Montana that the match rate reduction is manageable – Montana will make a downward adjustment of 2.6 percent in claimed expenditures that will be reimbursed at regular match rate.*

**State and Local Health Spending Flat in First Year of Medicaid Expansion**

Governing

Health care spending by state and local governments changed by the second smallest rate on record in 2014, a year in which millions of Americans gained health insurance through the Affordable Care Act’s expansion of state Medicaid programs.

State and local health care spending rose by just 1.8 percent to $515 billion, according to the latest data from the Centers for Medicare & Medicaid Services (CMS), a unit of the U.S. Department of Health and Human Services. By comparison, the country’s total health bill—public and private—increased by 5.3 percent, breaking a five-year string of historically slow national growth of 4 percent or less.

The state and local deceleration, second only to a 1.4 percent drop in 2009, occurred across spending categories, but was principally driven by especially slow growth in the two largest: state Medicaid payments (0.9 percent) and public employee health insurance premiums (3.7 percent).

Nevertheless, health care spending remains a potential source of long-term fiscal pressure for states and localities.

Even with coverage expansion, state Medicaid spending levels off

One element that slowed the growth of state Medicaid expenditures was modest but steady economic recovery. The rolls of beneficiaries who were eligible prior to the ACA’s coverage changes expanded marginally, as all 50 states and the District of Columbia saw their annual average unemployment rate fall in 2014. (Analysis of state employment—not unemployment—trends can be found here). As a result, state Medicaid spending ticked up by just 0.9 percent, only the fourth time it has grown by less than 1 percent since 1987, the earliest year for which data are available.

The division of state and federal responsibility for financing the cost of newly eligible enrollees, as outlined in the ACA, also helped to contain state Medicaid spending growth. Beginning Jan. 1, 2014, the jointly funded federal-state health care program for low-income children, parents, people with disabilities, and the elderly became available to all individuals who earn up to 138 percent of the federal poverty level ($16,105 for a single adult in 2014). The federal government, which covered 58 percent of total Medicaid costs in 2013, committed to covering 100 percent of the bill for newly eligible enrollees (in those states that opted for expansion under the ACA) from 2014 to 2016, phasing down to 90 percent in 2020 and thereafter.

By the end of 2014, 26 states and the District of Columbia had elected to expand their programs in accordance with the law, bringing the country’s total annual enrollment to 66 million, a 13 percent increase from 2013. This represented the greatest year-over-year percentage increase since 1991. (As of January 2016, 31 states and the District of Columbia had expanded their Medicaid programs.)

The new CMS spending data show that the federal government shielded states from the costs of the ACA Medicaid expansion during the first year of implementation. In contrast to the unusually low spending growth at the state level, federal Medicaid expenditures rose by 18.4 percent, up from 6.1 percent in 2013.

Medicaid is states’ biggest expense after K-12 education. The share of states’ own money spent on Medicaid coverage grew from fiscal 2000 to 2012 but leveled off in 2013, according to an analysis by Pew’s Fiscal 50 resource. The latest CMS data point to a similar trend for 2014.

State and local employee health insurance holds stable

The 3.7 percent uptick in spending on health insurance premiums for state and local government employees was the fourth consecutive year of growth at or below 4 percent. By way of comparison, the constant annual growth rate from 2000 to 2010 was 9.8 percent. In the wake of the Great Recession, insurance costs have been held down as state and local governments reduced their workforces—and thus likely the numbers of those covered—and employer-sponsored insurance premiums rose moderately nationwide. (More information on state employee health plan spending can be found here.)

Long-term cost curve starts to bend

Despite the recent slowdown in spending growth, health care has long posed a fiscal challenge for states and localities that must balance competing priorities and align spending with revenue and reserves each year.

State and local government health care expenditures as a share of revenue totaled 30 percent in 2014, up from 16 percent in 1987, according to Pew’s analysis of data from CMS and the Bureau of Economic Analysis. But their fiscal footprint has remained stable since 2011 and actually fell slightly in 2013 and 2014, the first reductions since 2006.

Combined health care expenditures by state and local governments, in inflation-adjusted dollars, increased by 265 percent from 1987 to 2014, according to Pew’s calculations. The most significant elements of this expansion were state and local contributions to Medicaid and to public employee health insurance premiums, which experienced real increases of 367 percent and 495 percent, respectively. Over this period, the total number of Americans covered by Medicaid throughout the year rose by 46 million.

CMS projects that state and local government spending will rise by 56 percent in inflation-adjusted dollars from 2014 to 2024. However, if recent history is a guide, this may overstate future growth. For example, as recently as 2012, CMS projected that state and local spending would rise to $569 billion in 2014—10 percent higher than reality. CMS economists pin the overestimate on, among other factors, sluggish economic growth that lagged expectations and constrained spending, as well as lower-than-anticipated medical price inflation, which held costs down for payors across all sectors in recent years. The agency later adjusted its projections down in each of the three subsequent years.

Looking further ahead, the Government Accountability Office (GAO)—the nonpartisan investigative arm of Congress—warns that, based on current law, health care spending is a primary driver of the long-term fiscal challenges ahead for state and local governments. According to the agency’s simulation, state and local health-related expenditures are on track to nearly match all other program spending by the middle of this century. However, as with the CMS projections, GAO has recently made downward adjustments to its long-term projection of state and local health spending.

<http://www.governing.com/topics/health-human-services/sl-medicaid-expansion-spending-states.html?utm_medium=email&utm_source=Act-On+Software&utm_content=email&utm_campaign=While%20Homeless%20Veterans%20Get%20Housing%2C%20Rest%20Are%20Left%20in%20the%20Cold&utm_term=State%20and%20Local%20Health%20Spending%20Flat%20in%20First%20Year%20of%20Medicaid%20Expansion>

**Why Do States Have Such Varied Success Enrolling Consumers in the Marketplace?**

The Urban Institute

On November 1, consumers began enrolling in health insurance coverage for 2016. The launch of the third open enrollment period (OE3) in the marketplaces created by the Affordable Care Act (ACA) presents new challenges for consumers and officials alike.

To shed light on these challenges, the Urban Institute has published two studies: one analyzing factors that contributed to certain states’ [low enrollment rates in 2015](http://www.urban.org/node/72441) and another examining certain states’ [high enrollment rates in 2015](http://www.urban.org/node/72431). These studies offer insights into what worked well in those high enrollment states and where the greatest pitfalls were in those low enrollment states. They also identify some common challenges that are likely to continue in OE3.

We conducted these studies because states had such a [wide range of enrollment rates in 2015](http://www.urban.org/node/72436), based on a comparison of actual enrollment numbers to the Urban Institute’s projections of what 2015 enrollment should have been according to state population characteristics. Those varied enrollment results did not seem to follow any consistent patterns based on geography, population, political support for the ACA, or the type of marketplace. States that used the federal website HealthCare.gov to enroll consumers performed on average better than states that used their own web sites and information technology (IT) platforms in 2015.  But there were high-performing state-based marketplaces (SBMs) that used their own IT platforms and low-performing states that used HealthCare.gov. The Urban Institute selected five states with relatively low enrollment rates—Colorado, Iowa, Minnesota, Washington, and West Virginia—and five states with relatively high enrollment rates—Connecticut, Florida, New Hampshire, Pennsylvania, and Virginia—and interviewed diverse stakeholders in each state.



Our research found a few reasons for the dramatically different enrollment rates. Coordinated, collaborative grassroots outreach and enrollment systems were critical in high-enrollment states, while insufficient outreach and enrollment assistance resources prevailed in low-enrollment states. A few more of our key findings on low-enrollment states:

* All five low-enrollment states’ pre-ACA uninsurance rates were near or below the national average and thus their uninsured were likely harder to reach.
* In all five states, stakeholders reported that high premiums for higher wage groups made coverage unaffordable for many.
* The states that used their own IT platforms reported problems that created difficulties and negatively affected enrollment. Significant media attention to the IT problems exacerbated this effect.
* There was a shortage of navigators and assisters in all or parts of these states.

In the five high-enrollment states, we found:

* All five states had highly collaborative and coordinated outreach and enrollment assistance systems.
* All five states had pre-existing outreach and health enrollment networks and systems that had functioned successfully before the ACA. These networks and systems were leveraged in both 2014 and 2015 to enroll low-income consumers in the marketplace.
* In all five states, outreach and enrollment organizations emphasized grassroots, community-based outreach in places where people already tend to congregate and relied on trusted and familiar messengers to recruit and assist consumers.
* All five states had high enrollment rates in OE1 and some people reported that earlier success bred greater success in OE2.

As IT systems continue to improve and enrollment assisters throughout the country develop greater knowledge and experience, all states may see higher enrollment rates in OE3. But going forward, stakeholders in both sets of states identified several challenges:

* Shrinking resources for consumer outreach and enrollment assistance.
* Low rates of insurance literacy among the eligible population.
* Populations that remain uncovered are likely to be disproportionately comprised of harder-to-reach groups – e.g., the young and healthy, legal immigrants, rural populations, and those ideologically opposed to the law.

Over the next weeks and months, we will learn whether enrollment will continue to increase in all states despite these remaining challenges.

http://www.urban.org/urban-wire/why-do-states-have-such-varied-success-enrolling-consumers-marketplace

**The ACA and Its Employment Effects**

Health Affairs Blog

Two studies published in the most recent *Health Affairs* journal raise questions about the contention that the Affordable Care Act (ACA) will reduce employment, wages, and hours worked by employees.

The study by [Gooptu and colleagues](http://content.healthaffairs.org/content/35/1/111.abstract) examined the effects of the law’s Medicaid expansion on employment and found no statistically significant effect through March 2015. A related study by [Moriya and colleagues](http://content.healthaffairs.org/content/35/1/119.abstract) examined the subsidy structure provided to households getting health insurance through the ACA’s exchanges and similarly found no discernible effect on levels of part-time employment for employees eligible for these subsidies.

These studies provide useful new information, but they do not mean, [as some reporting on them seems to suggest](https://www.washingtonpost.com/news/wonk/wp/2016/01/06/one-of-the-biggest-fears-about-obamacare-never-happened/), that there is nothing to worry about with respect to the ACA’s effects on labor markets. Given the structure of the ACA, it would be hard to conclude the law would not eventually reduce hours worked or total compensation, although the magnitude of the resulting changes may be hard to detect in the U.S.’s large and complex labor markets.

Why CBO Concluded There Would Be an Effect On Employment

The Congressional Budget Office (CBO) [issued a comprehensive assessment](http://www.cbo.gov/sites/default/files/cbofiles/attachments/45010-breakout-AppendixC.pdf) of the law’s likely effects on labor markets in February 2014. The agency concluded that the ACA’s “largest impacts will probably occur after 2016, once its major provisions have taken full effect and overall economic output nears its maximum sustainable level.” Taking all of the ACA’s provisions into account, CBO concluded that the law would reduce overall hours worked in the U.S. economy by 1.5 to 2.0 percent over the period 2017 to 2024 and total compensation by 1.0 percent over the same period.

There are many ACA provisions affecting employment and wages (including many new explicit taxes and employer requirements), but CBO reached its conclusion based on the following effects:

* The ACA provides large subsidies through the exchanges to households with lower incomes to support enrollment in health insurance; those subsidies are provided independent of employment status and are reduced as incomes rise. The withdrawal of the subsidies as incomes rise represents an implicit tax on additional earned income, and therefore is likely to discourage some additional work effort in key income ranges.
* The ACA allowed states to expand Medicaid, making it possible for more people in expansion states to secure health insurance coverage without working. Prior to enactment of the ACA, it was most often the case that a low-income individual ineligible for Medicaid would need to work to secure stable health insurance.At the same time, some people on Medicaid may work more under the ACA because the higher income eligibility threshold will allow them to stay on the program with additional wages. In addition, some people with incomes below the poverty line in non-expansion states may work more to become eligible for subsidized exchange coverage. Overall, CBO estimated that the Medicaid expansion would reduce hours worked, but less so than the implicit tax of the exchange subsidy phase-out.
* Beginning in 2015, employers with more than 100 employees (falling to 50 this year) must pay penalties if they employ full-time workers and do not offer health insurance. Full-time work is defined as more than 29 hours per week, on average. This may encourage firms to move more workers into part-time status, although the effect of such an incentive on total hours of work is less clear.
* Requiring insurers to offer coverage to people with pre-existing conditions and limiting premium variability provides an incentive for some older workers to retire early.
* Providing subsidized health insurance irrespective of employment alleviates “job lock,” allowing workers to leave employment or switch to part-time jobs without fear of losing coverage. The prospect of being able to take a job without being concerned about insurance might encourage some workers to enter the workforce who would otherwise have kept their income low to qualify for Medicaid. The latter effect would not fully offset the others that would reduce hours worked.

Overall, CBO made it clear that its estimate of a reduction in total hours worked is based mainly on the law’s implicit tax on earned income for those eligible for exchange subsidies. The agency’s estimate of reduced compensation for workers is lower than the reduction of hours worked because it expects the contraction of labor supply to be concentrated among low-wage workers.

Analyzing the New Studies

The new *Health Affairs* studies do not find evidence that the ACA has caused a shift from full-time to part-time employment or major changes in the labor market behavior of low-income adults thus far. Those results would seem to contradict CBO’s forecast. But there are a number of reasons why this might not be so:

* CBO assumed the effects of the law on hours worked would take some time to become discernible because labor markets were expected to remain soft through 2016, with large numbers of Americans out of the workforce compared to earlier periods. By 2017, CBO assumed labor markets would be back to normal functioning, at which point the disincentive effects for additional labor income would become more relevant. In a soft labor market, where employees’ wages are rising more slowly than normal and job opportunities are sparse, employees will find it more difficult to reach what they consider to be their optimal level of work effort and compensation.
* The new studies examined the law’s effects in 2014 and 2015, but CBO made it clear it did not expect to see the full effects on hours worked until 2017, and then the effect would only be a reduction of 1.5 to 2 percent of total hours worked during the period 2017 to 2024. The labor market impact of the ACA in 2014 would be a fraction of that estimate. Can we reasonably expect to detect a change in hours worked that could be as low as 0.5 percent in 2014?
* The number of workers who could be affected by the definition of full-time work is relatively small. Even among the low-income, most have jobs that are close to 40 hours per week. A Department of Health and Human Services (HHS) [study](https://aspe.hhs.gov/basic-report/who-are-low-wage-workers) shows that 63.3 percent of low-wage workers usually worked 35 hours or more per week in 2001, while only 23.5 percent worked 20 to 34 hours. Those working within a few hours of 30 per week (and thus more likely to be subject to a reduction in work hours) represent an even smaller percentage of the total. By not being able to focus on the part of the market most affected, the new *Health Affairs* studies understate the response.
* The measure used by Moriya et al. to account for the impact of the ACA on hours of work differs from that used by CBO. The study estimates the change in the probability of part-time employment among employed people. CBO estimates the change in aggregate work hours. Workers who lose their jobs or leave the work force for any reason would not cause a reduction in the hours worked by those remaining employed but would reduce aggregate hours.
* Other market adjustments may have blunted the initial impact of the ACA on hours of work and employment levels. For instance, some employers may have delayed taking actions adverse to their current workers in the hope that future improvements in the economy would allow them to better accommodate the requirements of the ACA, or those requirements might be modified. The Administration’s delay in imposing the employer mandate penalties confirms that a go-slow approach was prudent for many employers. And employers might have made some adjustments that would not show up in the *Health Affairs* analyses. For example, employers may have delayed or cancelled expected pay raises or halted hiring they may have considered even in a weak economy.

Fighting a Tendency on Both Sides To Jump The Gun

Proponents and opponents of the ACA are susceptible to making the same mistakes. In recent years, opponents have often predicted the law’s imminent demise based on one or two data points. Those predictions have proven to be premature. At the same time, the law’s defenders are sometimes too quick to dismiss legitimate criticisms of the law based on partial or incomplete information.

The ACA is complex, with scores of provisions that impose major changes on health insurance, labor markets, and the national economy. It is going to take some time for a clear and fully accurate picture of all of these effects to emerge.

Placed in the appropriate context, research studies such as the two *Health Affairs* papers provide useful information. At a minimum, they make it clear that the forecasts from CBO and others which show the ACA will eventually reduce compensation and hours worked are far from certain. But it is also too early to conclude that those forecasts were wrong. That remains to be seen.

http://healthaffairs.org/blog/2016/02/03/the-aca-and-its-employment-effects/

**1095 B Forms May Cause Problems for Enrollees Who Transition from Marketplace to Medicaid Coverage**

Georgetown University Health Policy Institute Center for Children and Families

It’s tax time, and there is more to be said about the many issues that swirl around reconciliation of premium tax credits and accurate assessment of the penalty for going without health insurance. But there is one issue in particular that I am worried about for consumers who were enrolled in a Marketplace plan with financial assistance but then transitioned to Medicaid at some point during the calendar year.

Let’s start with some background. There are several types of 1095 forms, noted as A from the Marketplace and individual market issuers, B from Medicaid, and either B or C from employers. The purpose of all of these versions of the 1095 is to prove that an individual was enrolled in minimum essential coverage and is therefore not subject to a penalty for not having health insurance. This is the first year that Medicaid and CHIP agencies are required to send 1095B forms to enrollees showing which months they were enrolled in Medicaid or CHIP. Not all enrollees will have yet received these forms as the deadline for agencies for sending was extended for a month until February 28.

So here’s the problem. Consumers transitioning from the Marketplace to Medicaid will receive a 1095A from the Marketplace and a 1095B from Medicaid that may show overlapping coverage. The reason is because Medicaid coverage is effective as of the date of application or the account transfer date. Generally, speaking people are not eligible for premium tax credits when they have other minimum essential coverage. However, during the period of time it takes Medicaid to approve the application, the individual may continue to receive premium tax credits toward the cost of their Marketplace plan. This rule is clear in example six that the IRS provides in [26 CFR 1.36B-2](http://www.ecfr.gov/cgi-bin/retrieveECFR?gp=&SID=78c7f624c23525ff2a3eccdf343d78ea&mc=true&r=SECTION&n=se26.1.1_136b_62):

*Example 6. Mid-year Medicaid eligibility redetermination.* The facts are the same as in Example 5, except that G returns to the Exchange in July 2015 and the Exchange determines that G is eligible for Medicaid. Medicaid approves G for coverage and the Exchange discontinues G’s advance credit payments effective August 1. Under paragraphs (c)(2)(iv) and (c)(2)(v) of this section, G is treated as not eligible for Medicaid for the months when G is covered by a qualified health plan. G is eligible for government-sponsored minimum essential coverage for the months after G is approved *[emphasis added] for Medicaid and can receive benefits, August through December 2015.*

In essence, the rule protects consumers who were enrolled in Medicaid retroactively from having to pay back premium tax credits received until the month following the date Medicaid was *approved* – which is the actual date that eligibility was determined.

So what’s the problem if consumers are protected? The big problem is that tax filers and tax preparers are likely unaware of the rule. The fact that the rules protect consumers in this situation is not well known and there has not there been adequate public education or instructions so that assisters, tax filers’ and tax preparers know how to handle the overlap in coverage. When they go to complete Form 8962 to reconcile premium tax credits, they may incorrectly assume that premium tax credits received in any month they had Medicaid coverage will have to be paid back.

We are also worried about how this offers another opportunity for unscrupulous tax preparers to rip off consumers and line their pockets just as they did last year by not alerting tax filers about potential exemptions and telling tax filers to pay the individual penalty to them. The IRS cautions tax filers to [choose their tax preparer carefully](https://www.irs.gov/Affordable-Care-Act/Individuals-and-Families/ACA-Consumer-Alert-Choose-Your-Tax-Preparer-Wisely) to avoid such despicable practices.

We are already hearing reports from assisters that this is a real problem. And it will be worse in states with application backlogs that may have taken weeks or even months to process a new application or account transfer. It will also be a problem for CHIP programs in states that provide retroactive coverage in CHIP similar to Medicaid.

What can be done in the short run? Given no systemic solution at this point, it is really important that Medicaid agency staff, Marketplace call centers, assisters, tax preparers, and consumers have access to clear information describing how to deal with this issue. The simple solution is to ignore Medicaid coverage in the months before (and including) the month in which eligibility was approved. However, I suspect that not all consumers will know when their Medicaid was approved. While the date should be reflected on the eligibility notice from Medicaid, consumers may not have saved those notices. Even then, this could still present a problem when the IRS compares the various 1095 forms it receives and acts on the information at face value.

Another option is for Medicaid agencies to issue a corrected 1095B to reflect coverage starting the month after the determination date. But again, this would require enrollees and tax preparers knowing to ask for a corrected form.

What are the longer-term solutions? The most straightforward option is for the 1095B form from Medicaid or CHIP to be updated to reflect the determination date. But still, this would require that tax filers and tax preparers know whether the date is meaningful and why. Certainly, we don’t want to confuse tax filers who need to show retroactive Medicaid in order to avoid any penalty for not having insurance.

A more complicated solution would require system changes in both the Marketplace and Medicaid. The Marketplace could send an indicator reflecting whether the account transfer is for someone who is currently enrolled in a Marketplace plan. Medicaid could store that indicator and use a different process for creating 1095Bs for those individuals by showing coverage effective the month after the determination date. I can envision all those systems programmers rolling their eyes at this one, but it could help avoid consumer confusion.

Whatever the solution – CMS and the IRS need to take action now.

http://ccf.georgetown.edu/all/1095b-forms-may-cause-problems-enrollees-transition-marketplace-medicaid-coverage/

**Oregon Co-Op Files Class-Action Suit over Risk Corridor Payments**

A shuttered Oregon co-op health plan filed a class-action lawsuit against the federal government Wednesday, saying it and other insurers are owed as much as $5 billion in risk corridor payments.

[Health Republic Insurance Company of Oregon](http://oregon.healthrepublic.us/) alleges that the government had no right to reduce risk corridor payments to qualified health plans operating on the federal exchange. The money could have helped it and others stay open, said Stephen Swedlow, an attorney representing the insurer and a partner at Quinn Emanuel Urquhart & Sullivan.

So far, 12 of 23 co-ops created under the Affordable Care Act to offer affordable, high quality health plans have closed. A number of non-co-op insurers offering plans on the exchange have struggled as well.

Under the Affordable Care Act's risk corridor program, insurers offering plans on the federal exchange get money from the government if their losses exceed a certain amount, and they must make payments to the government if their profits exceed a certain amount. The program is designed to limit risks for insurers during these early years of the exchange.

But Congress passed spending bills in 2015 and 2016 that prevented CMS and HHS from paying plans their full risk corridor payments. For 2014, [plans requested $2.87 billion in payments but paid only $362 million](http://www.modernhealthcare.com/article/20151001/NEWS/151009996) into the program.

“Some companies were unable to remedy the cash flow and/or reserve shortfalls, and, as a consequence, went out of business,” the co-op says in the lawsuit. “This, in turn, forced hundreds of thousands of Americans to switch to other carriers, often with less attractive pricing and/or different provider networks.”

The Justice Department declined to comment on the lawsuit Thursday.

But the CMS released a [memo](https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-10-1.html) in November saying that it wants to make sure insurers get the money they're owed. According to the memo, HHS “will explore other sources of funding for risk corridors payments, subject to the availability of appropriations. This includes working with Congress on the necessary funding for outstanding risk corridors payments.”

The lawsuit is believed to be the first of its kind filed by an insurer seeking to get full risk corridor payments.

Swedlow hopes the lawsuit will allow co-ops to continue functioning.

He argues that the lack of large enough appropriations for the risk corridor program didn't change the fact that statute requires the government to make those payments.

“If the government takes on an obligation through a statute or contract, the government shouldn't then be able to pass a bill saying we don't have to pay our bill because then no one would enter into business with the government,” Swedlow said.

Those familiar with the risk corridor program say the money could have made a big difference to co-ops and other insurers.

“The federal government should be held responsible to make good on its promise, and there's also no question that the failure to pay the risk corridor money was a substantial factor in the closing of a number of co-ops,” said John Morrison, founder and past president of the [National Alliance of State Health CO-OPs](http://nashco.org/).

Morrison, who is now a partner at Morrison Sherwood Wilson Deola, said he hopes the case results in some of the closed co-ops being able to re-open.

Kelly Crowe, current CEO of the alliance, said in a statement that, “The marketplace was thrown into chaos when insurers received only 12.6% of expected risk corridor payments, with no clear understanding of how this promised money would be recouped in future years. We hope Health Republic Insurance of Oregon's lawsuit forces the federal government to address the concerns of all insurers—not just CO-OPs—about the efficacy and future of the marketplaces.”

Not everyone, however, is confident the insurer will prevail.

Cynthia Borrelli, a principal at Bressler Amery Ross who represents insurers, said the spending bills that led to the reduced payments effectively amended the law, and Congress can always amend laws.

“They cut the companies off at the knees by not appropriating, but I still think it was a lawful use of their appropriation authority,” Borrelli said.

She said the lawsuit may serve to further undercut Americans' confidence in the ACA. And if the insurer wins, that could make it more difficult for Congress to amend the ACA in the future, which could also lead to problems, she said.

“I think it's just another blow to the statute and another blow to the confidence the American people have in the government in terms of its ability to reform healthcare in the United States,” Borrelli said.

<http://www.modernhealthcare.com/article/20160225/NEWS/160229940?utm_source=modernhealthcare&utm_medium=email&utm_content=20160225-NEWS-160229940&utm_campaign=am>

**CMS Should Act to Strengthen Enrollment Controls and Manage Fraud Risk**

GAO

The Patient Protection and Affordable Care Act (PPACA) requires applicant information be verified to determine eligibility for enrollment or income-based subsidies. To implement this verification process, the Centers for Medicare & Medicaid Services (CMS) created an electronic system called the “data services hub” (data hub), which, among other things, provides a single link to federal sources, such as the Internal Revenue Service and the Social Security Administration, to verify consumer application information. Although the data hub plays a key role in the eligibility and enrollment process, CMS does not, according to agency officials, track or analyze aggregate outcomes of data hub queries—either the extent to which a responding agency delivers information responsive to a request, or whether an agency reports that information was not available. In not doing so, CMS foregoes information that could suggest potential program issues or potential vulnerabilities to fraud, as well as information that might be useful for enhancing program management. In addition, PPACA also establishes a process to resolve “inconsistencies”—instances where individual applicant information does not match information from marketplace data sources. GAO found CMS did not have an effective process for resolving inconsistencies for individual applicants for the federal Health Insurance Marketplace (Marketplace). For example, according to GAO analysis of CMS data, about 431,000 applications from the 2014 enrollment period, with about $1.7 billion in associated subsidies for 2014, still had unresolved inconsistencies as of April 2015—several months after close of the coverage year. In addition, CMS did not resolve Social Security number inconsistencies for about 35,000 applications (with about $154 million in associated subsidies) or incarceration inconsistencies for about 22,000 applications (with about $68 million in associated subsidies). With unresolved inconsistencies, CMS is at risk of granting eligibility to, and making subsidy payments on behalf of, individuals who are ineligible to enroll in qualified health plans. In addition, according to the Internal Revenue Service, accurate Social Security numbers are vital for income tax compliance and reconciliation of advance premium tax credits that can lower enrollee costs.

During undercover testing, the federal Marketplace approved subsidized coverage under the act for 11 of 12 fictitious GAO phone or online applicants for 2014. The GAO applicants obtained a total of about $30,000 in annual advance premium tax credits, plus eligibility for lower costs at time of service. The fictitious enrollees maintained subsidized coverage throughout 2014, even though GAO sent fictitious documents, or no documents, to resolve application inconsistencies. While the subsidies, including those granted to GAO's fictitious applicants, are paid to health-care insurers, and not directly to enrolled consumers, they nevertheless represent a benefit to consumers and a cost to the government. GAO found CMS relies upon a contractor charged with document processing to report possible instances of fraud, even though CMS does not require the contractor to have any fraud detection capabilities. CMS has not performed a comprehensive fraud risk assessment—a recommended best practice—of the PPACA enrollment and eligibility process. Until such an assessment is done, CMS is unlikely to know whether existing control activities are suitably designed and implemented to reduce inherent fraud risk to an acceptable level.

See the full report here: <http://www.gao.gov/assets/680/675340.pdf>

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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.