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**IN THE NEWS**

**Dear Employer, You Could Owe the IRS Millions of Dollars**

The first batch of employers are getting estimates from the IRS of penalties they owe for not providing health coverage to employees in 2015. Some of the estimates are in the millions. But that’s not the end of the matter. The penalties are just estimates and they might not be the actual amounts employers end up paying. Part of this is because the Internal Revenue Service will show some leniency given that both the agency and employers are still getting used to the new record-keeping requirements that might have some glitches.

The letters aren’t a “notice and demand for payment,” attorney Joanna C. Kerpen told Bloomberg Law. Employers that receive them must respond in 30 days, even if just to ask for an extension. “The IRS is giving employers the opportunity to challenge these and disagree,” said Kerpen, a partner with Winston & Strawn LLP in Washington. Her practice focuses on employee benefits tax and law issues. 2015 was the first year employers had to report to the IRS about coverage under the Affordable Care Act. Companies with 100 or more employees were required to tell the IRS in the spring of 2016 whether they had offered minimum essential coverage to full-time workers in 2015. The IRS is just now getting around to sending out the letters estimating penalties for 2015.

The IRS wouldn’t say how many “226-J” letters have gone out or who’s getting them, when contacted by Bloomberg Law. But some practitioners expect Industries like trucking, restaurant, and staffing to see a high proportion of them. That’s because there is a high turnover rate inherent in those industries, which makes it challenging to keep track of workers, Alden J. Bianchi, a member at Mintz, Levin, Cohn, Ferris, Glovsky & Popeo PC in Boston, told Bloomberg Law. Bianchi said about three-fourths of the letters he’s seen are for employers in these areas. These industries often didn't offer “broad-based coverage” before the ACA became law and struggled to secure coverage for employees after it went into effect. Some employers also “didn't get the memo, or didn't comply” with ACA requirements, which is why they’re seeing letters with large assessments now, he said.

For 2015, employers with at least 100 full-time employees were required to offer affordable minimum essential coverage to at least 70 percent of full-time employees. If that didn't happen, employers could face a penalty of $2,080 for every full-time employee. Penalties for failing to provide minimum essential coverage to full-time employees can be pretty steep, sometimes going to $10 million, Bianchi said. The amounts can be “eye-popping,” Nicole M. Elliott, partner with Holland & Knight LLP in Washington, told Bloomberg Law. Elliott previously served as senior director of operations for the ACA with the IRS. In some cases, “if these penalties stick, they are an existential threat to the companies,” Bianchi said. The IRS has been fair and responsive to employers seeking to correct their forms and possibly reduce their penalties, several practitioners told Bloomberg Law.

Many of the high assessments are a result of filing errors, something that employers expressed concerns about in the years leading up to 2015. “It may be that a number of employers misunderstood the filing requirements, but they still needed to get reports in,” resulting in errors, Edward I. Leeds, counsel with Ballard Spahr LLP in Philadelphia, told Bloomberg Law. Leeds’ practice focuses on health and welfare plans. And the IRS may have made some errors, as well, given this is the first year its ACA filing system was up and running, Rachel Lesier Levy, a principal at Groom Law Group, told Bloomberg Law. Levy served as associate
benefits tax counsel in the Treasury Department's Office of Tax Policy with a focus on Obamacare implementation.

Some employers are seeing high penalties because they incorrectly filed their forms detailing an employer's health insurance offer of coverage, Ryan Moulder, partner at Health Care Attorneys P.C. in Los Angeles. These employers either forgot to check the box asking if they provided minimum essential coverage, or they accidentally checked “no,” he said. Since the letters are for three years ago, employers need to be sure they're keeping all of their records to ensure their reporting was accurate.

After receiving a letter, an employer needs to go back and check its records to see if the employee it didn't offer coverage to was actually a full-time employee and also to make sure the codes reported to the IRS on the forms were accurate, Elliott said. Employers that discover errors need to tell the IRS about the problems they had and get the penalties corrected.

The initial letters can be jarring. But most employers could see their penalties go down after correspondence with the IRS. Moulder said he has a “high confidence level” in all penalty appeals he's sent to IRS. Levy agreed that penalty assessments are likely to be lowered. “I have yet to hear from any employer whose assessment has not been lowered,” she said.

**Health Policy Propels Dozens of Doctors in Bids for Congress**

The last straw for Kim Schrier was the bill to overhaul Obamacare that passed the House but failed in the Senate last year. Schrier, a pediatrician working in Issaquah, Wash., saw it as another threat to the health law's protections for people with serious medical conditions coming from a Republican-controlled Congress and warned her congressman, Rep. Dave Reichert (R-Wash.), about it.

When it passed the House, even though Reichert voted against it, Schrier felt she needed to take action. She spoke with her managers at Virginia Mason Medical Center, where she has worked for the past 17 years, about taking a leave of absence and reached out to progressive groups about her chances of swelling the relatively paltry ranks of liberal health-care providers in the House. “There were a few months of soul searching,” Schrier told Bloomberg Law. “It's not easy to take a year off. If I were in private practice, that practice would fall apart.” She is hoping to replace Reichert, who plans to retire after seven terms in office.

Schrier's story is similar to many of the 28 other doctors vying to join Congress in 2018, most of them Democrats. They're hoping health care remains a main issue for voters this year because they're selling themselves as experts in health policy.

There's slated to be at least 45 doctors with their names on congressional ballots this year, 15 of them Republican incumbents seeking re-election and 19 of them Democratic challengers. The exact number is unclear as no association or group keeps a record of health-care providers seeking office. They all face similar obstacles: lucrative careers that must be put on hold and a health-care industry that heavily favors incumbents. However, they're being propelled by groups on both sides of the aisle injecting hundreds of thousands of dollars into House and Senate races across the country hoping to get more doctors into office.

Several of those seeking to trade their white coats for suit coats in November, both Republican and Democrat, told Bloomberg Law they want to shake up health policy in Washington, namely how federal
lawmakers treat the Affordable Care Act, and have found it a potent message for voters. “I don’t see anyone, Republicans or Democrats, offering meaningful solutions,” Christopher Peters, a Republican surgeon trying for the second time to unseat Rep. Dave Loebsack (D-Iowa), told Bloomberg Law. “There's nothing in the center.”

Peters said he wants to give younger, healthy Americans the option to take advantage of tax credits to buy high-deductible insurance plans and to encourage them to set aside money for health-care emergencies. He said Congress isn't properly addressing the rising cost of health care. Health care has been top of mind for Congress since 2016 as Republicans attempted to repeal and replace the ACA in 2017 and lawmakers now try to come to grips with the opioid crisis. Many of the doctors running for Congress expect it to be top of mind for voters too. “Health care is the No. 1 issue on people's minds,” Christine Mann told Bloomberg Law. Mann is a family physician seeking to defeat Rep. John Carter (R-Texas), who has held his seat for 16 years.

Doctors generally see themselves as scientists and well equipped by their profession to tackle policy issues, Jason Westin, an oncologist trying to unseat Rep. John Culberson (R-Texas), told Bloomberg Law. However, most are reluctant to leave their practices to run for Congress when they understand how much work goes into campaigning. “Most aren't well-versed in what it takes to run for office, the fundraising and the campaigning,” Westin said.

There have been 49 doctors elected to Congress since 1960, nearly all of them Republican men, according to a 2004 study and an analysis by Bloomberg Law. There are 15 members of the GOP Doctors Caucus, which represents Republican health-care providers in the House, and three Republican senators who are doctors. There are only two Democratic doctors in Congress, Reps. Ami Bera (D-Calif.) and Raul Ruiz (D-Calif.). The underrepresentation of doctors in recent years compared with other professions doesn't appear to be caused by a lack of effort by the industry. Several medical societies, like the American Medical Association and the American College of Emergency Physicians, run workshops and training programs for health-care providers interested in running for office. These groups also help fund the campaigns of some doctors, although they’re far more generous to incumbents.

Two progressive groups have stepped in to push liberal doctors into office. A group called 314 Action has funneled $70,000 into campaigns across the country to support candidates with science backgrounds and has another $119,961 on hand to boost campaign coffers, according to Federal Election Commission data. Another, the Physician Women for Democratic Principles, has raised nearly $100,000. Rep. Michael Burgess (R-Texas), an obstetrician who heads an influential House health panel, founded an organization called the STAT Initiative to elect conservative doctors to Congress. His group is supported by his Lone Star Leadership PAC, which has funneled $240,000 to various other political committees and has more than $111,000 cash on hand to support more campaigns. Burgess told Bloomberg Law he gives advice to people who contact him about running for Congress, regardless of their background, and funnels funds to doctors he thinks can win.

INSIDE CMS

Gauging Effectiveness of Medicaid Waivers in Spotlight's Glare
Medicaid waivers are in the hot seat as congressional pressure mounts to ensure more transparency on how well they actually work. The state Section 1115 demonstrations make up about one-third of the $550 billion safety-net health insurance program's spending, according to the Government Accountability Office. And the Trump administration has placed a premium on the tool, promising a streamlined approval process for states and increased flexibility, as well as approving first-ever requirements in Indiana and Kentucky to tie Medicaid eligibility to work and community engagement.

The hotly contested waivers have sparked a National Health Law Program lawsuit and an intense debate over whether the changes move Medicaid beneficiaries toward self-sufficiency and better health outcomes or simply increase barriers to care that jeopardize the most vulnerable. That effectiveness may be difficult to gauge though, if current measurement standards continue. The GAO found that a lack of thorough, timely, and public waiver evaluations means government officials “don't fully know” if the state research programs are having the intended effects of curbing spending or boosting care. The government watchdog is pressing for more transparency. “We're just not gaining the knowledge from the research that is the justification for the exercise of 1115 power,” Sara Rosenbaum, a health policy and law professor at George Washington University, told Bloomberg Law. Rosenbaum formerly chaired the congressional advisory Medicaid and CHIP Payment and Access Commission.

The waivers are used to test theories about the benefits of forgoing normal Medicaid regulations. If successful, health officials can then take the changes to Congress to become law, Rosenbaum said. For example, state Medicaid waivers were used over the past two decades to implement family planning services but the services have since largely been deemed viable and no longer require a Centers for Medicare & Medicaid Services waiver. Rosenbaum doesn't expect Congress to act on the GAO's push for clearer and public Section 1115 evaluations. But she does believe the nonpartisan advice could sway Trump administration officials. “I certainly think we may find more attention paid by the administration to evaluation and to ensuring that evaluation is an integral part of the demonstration—before it ever gets underway and results are published,” she said.

“Timely, independent, and transparent Medicaid waiver evaluations are key” to making sure Medicaid is meeting its goals for its millions of patients, the Senate Finance Committee's ranking Democrat, Ron Wyden (D-Ore.), told Bloomberg Law in a statement. “In light of recent steps by the Trump Administration to promote and approve harmful waivers that violate the letter and intent of Medicaid, it's even more important to gather and release data on the negative impact these types of policies have on vulnerable families,” he said.

Wyden and the House Energy and Commerce Committee's ranking Democrat, Rep. Frank Pallone Jr. (D-N.J.), asked the watchdog in January to review the “public transparency of major changes” the CMS had approved, noting the program's role in covering more than 74 million people. The lawmakers pushed for details on the CMS's policies and procedures for evaluating the waivers throughout the demonstration projects, sharing of state data on the effects of proposed changes, state and federal documentation for evaluation and incorporating public feedback into a waiver's approval, and transparency of all waiver and waiver amendment approvals. A House committee aide told Bloomberg Law that stronger, data-driven waiver assessments would home in on effective state Medicaid practices and boost accountability over Medicaid spending for beneficiaries, and taxpayers.
Many states also used Medicaid waivers to expand their Medicaid programs under Obamacare. This watchdog review came in response to a request from Senate Finance Chairman Orrin Hatch (R-Utah), separate from the Pallone-Wyden request, and is based on 2015 data, according to a Finance Committee staff member. “While states need flexibility to administer their Medicaid programs, taxpayers should have the confidence that their federal dollars are spent on programs that work—especially since nearly one-third of Medicaid operates through waivers,” Hatch told Bloomberg Law in a statement. The GAO findings “illustrates the need for robust Medicaid data and improved evaluations that focus on outcomes and provide lessons for future spending,” he said.

The GAO in its report noted gaps in waiver evaluations from Arizona, Arkansas, and Massachusetts that included leaving out some measures of access and quality in a managed long-term care demonstration, not deciding whether quality incentive payments had affected care or cost, and not looking at a “key” idea that using Medicaid dollars to buy private insurance would boost continuity of coverage. The watchdog partially blamed the CMS for requiring evaluation reports only after the demonstrations had expired, instead of at the end of each three- to five-year waiver. The report also found the agency had “taken a number of steps... to improve the quality,” including proposing in 2017 to change that due date to the end of each demonstration cycle for all waivers. The Trump administration hasn’t finalized those changes. The CMS also has said it will allow more limited evaluations in certain cases, like a “longstanding or noncomplex waiver.”

The government watchdog wants the agency to produce new written rules for implementing agency policy on state final evaluation reports, written criteria for when CMS will allow the looser evaluation standards, and public release of findings from demonstration evaluations (both interim and final) with standards for “timely release.” Without that public release, they're “missing opportunities” to inform larger Medicaid policy discussions, the report said.

A Medicaid agency spokesman told Bloomberg Law the CMS had improved monitoring of the demonstrations and that the agency is working on processes and procedures to implement the changes consistently and strictly define longstanding waivers that the agency would deem successful. Rosenbaum said the pressure could extend to the types of designs a state uses to test Medicaid waivers’ effectiveness going forward. The demonstrations should take into consideration whether a mandate can actually be implemented, if counties are being exempted, or whether a third party is often paying a Medicaid beneficiary's required premiums to decide the effects of imposing them, she said. Indiana's waiver, for example, requires cost sharing. Twenty-four Medicaid waivers are pending across 23 states, according to the Kaiser Family Foundation. Many of them contain politically conservative elements such as cost sharing, work requirements, and lockout periods.

**Will End of Popular Medigap Plan Spur Managed Care Growth?**

Change is on the horizon for the Medicare supplemental insurance market that could spell opportunity for Medicare managed care organizations. The most popular Medigap plan type will be discontinued, and Medicare Advantage is waiting for those who might have joined the plan type with open arms. Medigap or Medicare supplemental insurance helps pay for health costs that traditional Medicare doesn't cover.
The potential enrollment shift comes at a time when thousands of baby boomers are becoming Medicare eligible daily. It could result in significant disruption in the Medigap market and a spike in Medicare Advantage preferred provider organization enrollment, John Gorman, founder and executive chairman of consulting company Gorman Health Group in Washington, told Bloomberg Law. Medicare Advantage competes directly against Medigap, he said. Carriers that sponsor the most Medigap plans include UnitedHealth Care, Mutual of Omaha, Aetna, and Anthem.

Congress instructed that policies offering beneficiaries “first dollar coverage” be closed to new enrollment as of 2020. Plans will be outlawed from paying the Part B deductible that covers doctor visits and various outpatient items and services. The decree in particular affects the high enrollment Medigap Plan F, which pays nearly all costs that traditional Medicare doesn’t, including deductibles.

Congress put the kibosh on first dollar coverage as a money saving attempt. “Scads of research” showed that beneficiaries without out-of-pocket costs because of their generous coverage were the highest utilizers of services, Gorman said. The Medigap coverage directive is in the Medicare Access and CHIP Reauthorization Act of 2015, a law best known for changing Medicare’s formula for paying doctors. In addition to Medigap Plan F, MACRA also discontinued the smaller enrollment Medigap Plan C that also pays the Part B deductible. MACRA allows current Plan F and C enrollees to stay put and those who turn 65 before Jan. 1, 2020, can still join the two plans. But the policies can’t be sold after that and will eventually wither away.

Although the change is 22 months away, preparation is afoot to fill the gap for new beneficiaries. “Many beneficiaries who can’t get Medigap F or C are going to be astute insurance shoppers” and will also look Medicare Advantage PPOs, Gorman said. Preferred provider organizations offer wide networks and ancillary services. Unlike Medigap plans, they also offer a drug benefit. PPOs should be the “Cadillac” product to compete against Plans F and C, Gorman said. Further, the baby boomers who will be shut out of Medigap Plans F and C are more comfortable enrolling in a managed care plan, like a PPO, than the previous generation, Gorman said. His consulting company staff is working with MA organizations to help beef up networks of PPOs that will be sold in time for 2020, he said.

However, not everyone is certain that MA will blossom as a result of the change in 2020. “I don’t see people limiting their options with a health plan that dictates where and when to get medical care,” Jesse Slome, founder and director of the American Association for Medicare Supplement Insurance, told Bloomberg Law.

Those who would have bought Plan F will get Plan G, which covers everything that F does except for paying the Part B deductible, he said. Another Medicare marketing executive also doesn’t see the discontinuation of the Medigap plans as industry transforming. “I don’t see a dramatic altering of the environment,” Dwane McFerrin, chairman of the National Association of Health Underwriters’ Medicare Working Group, told Bloomberg Law. Although MA won’t be slowing down, the termination of the Medigap plans “will not tilt the scale” in favor of MA, he said. McFerrin is vice president of Medicare at Senior Market Sales Inc., an insurance marketing organization in Omaha, Neb.

One reason is that many beneficiaries in rural areas lack access to an MA plan and only have the Medigap option, McFerrin said. Justin Bever, director of marketing at RB Insurance Group LLC in Chandler, Ariz., also said geography is a determinant. In urban areas, Medicare Advantage is “king,” especially among low-
income beneficiaries, Bever said. For city-dwellers in higher income groups, discontinuation of the Medigap plans “might be the push off the cliff to switch” to an MA PPO, he told Bloomberg Law.

MA plans have lower premiums than Medigap, but beneficiaries pay more when they get care. So if a beneficiary is healthy, why would he or she want to throw money away on premiums, Bever asked. Major carriers are bringing more local and regional PPOs to the table as 2020 approaches, Bever said. The available PPOs in each U.S. county increased by 13 percent between 2017 to 2018, he said. A PPO is the product most like a supplement because it offers both in- and out-of-network coverage, Bever said. PPOs have also become more competitive by offering benefits like dental, hearing, and vision, he said. There will always a place for Medigap, especially with the affluent, he said. But beneficiaries will continue to move toward an MA model as more options become available, he said.

**Some Coordinated Medicare Networks Skittish About Financial Risk**

Doctors and hospitals that coordinate care for certain Medicare patients aren't likely to see a reprieve from taking on financial risks next year, industry sources told Bloomberg Law. Industry groups say that forcing some health-care providers to repay Medicare for certain losses starting in 2019 in the accountable care organization program will likely shrink the program's participation and hurt the move from fee-for-service care to a value-based care system. Accountable care organizations (ACOs) are groups of doctors, hospitals, and other health-care providers who come together voluntarily to give coordinated high-quality care to their Medicare patients. If they save Medicare money, these groups can reap financial rewards.

Right now, 82 percent of the Medicare ACOs are Track 1, meaning they share in savings generated but they don't have to pay back money if they fail to meet program goals, according to the Medicare agency. That will change in 2019 as some of these ACOs will move out of Track 1, unless the Centers for Medicare & Medicaid Services agrees to revise program rules and let them stay in Track 1, which is what doctors and other health groups want. Overall, about 10.5 million Medicare beneficiaries are served by 561 ACOs, which is a jump from 9 million beneficiaries and 480 ACOs in 2017.

Allison Brennan, vice president of policy at the National Association of Accountable Care Organizations (NAACOs), told Bloomberg Law Feb. 28 that while she supports transitioning ACOs to risked-based models, some organizations are not prepared yet, and could end up quitting the program if forced into them too early. “If ACOs quit the program, it will hurt the transition to value-based care, counter to the program's intent,” she said. NAACOS, along with five other groups including the American Medical Association and Association of American Medical Colleges, recently requested that the CMS give some ACOs more time before they face risk. The groups said many ACOs are still in Track 1 “because they are unprepared to assume risk requiring them to potentially pay millions of dollars to Medicare.” Brennan added that CMS needs to act early this year to give ACOs time to make strategic decisions.

Track 1 is the only nonrisk-bearing model for ACOs in the Medicare Shared Savings Program. The risk-bearing tracks are Track 1+, which involves limited risk of losses, known as downside risk, for health-care providers, as well as Tracks 2 and 3, with Track 3 having the greatest risk and savings potential. Other types of ACOs are the ACO Investment Model, which is aimed at rural and underserved areas, and Next Generation program, for organizations with more experience in coordinating care. Tracks 2 and 3 account for 1 percent and 7 percent, respectively, of all ACOs in Medicare. The most recent cost savings data for
ACOs operating in the Medicare Shared Savings Program showed overall gross savings for Medicare in 2016 of $652 million, a CMS spokesperson told Bloomberg Law Feb. 28.

**Accountable Care Organization (ACO) Models (2018)**

The industry groups proposed that the CMS allow certain ACOs to continue in Track 1 if they generate net savings for four years or do well in quality improvements. Overall, quality scores for ACOs have been improving, according to the CMS.

A health-care consultant and a former White House health-care policy adviser said the administration is unlikely to act. “The CMS has signaled it's moving away from nonrisk-based ACOs as the agency is still losing money from them,” Chris Dawe, a former policy advisory for health care at the National Economic Council under the Obama administration, told Bloomberg Law Feb. 27. Dawe currently serves as senior vice president of Medicare partnerships at Evolent Health, a population health services firm specializing in value-based care. David Muhlestein, chief research officer at Leavitt Partners LLC, a consulting firm in Salt Lake City, said few ACOs will take on more risk without a push, due to the potential of losing money. He said that because only those ACOs that started in Track 1 in 2012 will be affected by this change next year, he doesn't expect a large drop-off in participation in the program. “We see a natural turnover every year,” he told Bloomberg Law Feb. 27. “Last year alone 50 organizations didn't renew their contracts.” He added that Alex Azar, secretary of the Department of Health and Human Services, has indicated financial risk needs to be taken by these organizations in order to bring down health-care spending.

Despite Azar's stance on risk, industry is hopeful the White House's position on providing flexibility and choice in the health market is a good sign. “This administration has taken steps to alleviate regulatory burden and our request is in line with that,” Brennan said. “The government is taking a real step backwards by forcing ACOs to take on risk before they are ready.” Seth Edwards, principal of population at Premier
Inc., another health-care industry organization that signed the recent letter to the CMS, said that smaller ACOs, like those in rural areas, are more likely to struggle to improve their savings. “If these smaller ACOs have even one patient who becomes very costly to treat, it can be difficult to keep their overall costs down,” he told Bloomberg Law Feb. 27. “A lot of these organizations are doing the right thing and trying to improve quality of care and generate savings, and that’s being overlooked.” While rural states feature fewer ACOs compared to urban centers, such areas are home to the largest organizations including Advocate Physician Partners Accountable Care Inc. in Rolling Meadows, Ill. which has 6,300 physicians and UnityPoint Health in West Des Moines, Iowa, with more than 900 physicians.

LEGISLATIVE/REGULATORY

**Governors Push for Action on Bipartisan Health-Care Fixes**

Governors from both sides of the aisle and across the country are pressing for action to fix health care. And while federal lawmakers’ attempts to overhaul health care faltered last year, the state officials are offering up their solutions in hopes of creating a lower cost, higher quality system. Govs. John Hickenlooper (D-Colo.), John Kasich (R-Ohio), Bill Walker (I-Alaska), Tom Wolf (D-Pa.), and Brian Sandoval (R-Nev.) called for stabilizing the health insurance market and prioritizing value-based care in a Feb. 23 blueprint. That includes steps like bringing back cost-sharing reduction payments to insurers, working social determinants of health (such as education and socioeconomic status) into the Medicaid program, and focusing on paying for quality of care, not the service, in Medicaid and state employee benefits. Those steps will allow states to “lead by example” and drive a larger shift toward a value-driven health-care system.

Incentives for healthier lifestyles and behaviors could also prop up the marketplace, the governors suggested.

The plan largely relies on encouraging private sector competition and addressing underlying cost drivers to bring down spending, with “targeted” government action when necessary. For example, governors warn of the impact of provider system consolidation and want to “combat anti-competitive behavior” in local hospitals, pharmacy benefits managers, and pharmaceutical companies, including a review of regulations that might be doing more harm than good.

The GOP pushed a slew of Obamacare repeal bills in 2017 but failed to pass anything except ending the requirement to carry health insurance—a plan governors opposed. A bipartisan plan from Sens. Patty Murray (D-Wash.) and Lamar Alexander (R-Tenn.) to decrease rising health insurance costs hasn’t gone anywhere. Meanwhile, the governors, who laid out similar plans to improve the health-care system last year, are adamant that more needs to be done and in a way that reaches across party lines.

The blueprint “hopefully will be the catalyst to get new conversations going and new approaches so that we stop getting bogged down in the partisan” fighting, Hickenlooper told reporters. “It’s so frustrating to see the same old discussions coming back already.” To be successful, health-care overhauls need to overcome that political bickering and to tackle those with money on the line like the nursing home industry, the governors said. But implementing the blueprint could save the federal government $1 trillion in the safety-net program alone, Kasich told reporters Feb. 23.
The state leaders also called for passage of the Alexander-Murray health-care bill as a step toward stabilizing the health insurance market and more broadly for the federal government to spearhead a larger move toward prioritizing health-care quality. And they want health insurers to be exempted from the health insurance tax in underserved areas to encourage coverage in those places. Will Congress actually take up the governors’ ideas? Walker is “optimistic” and said lawmakers want to move on health care. Others weren’t so sure. “I don’t want talk—I want action,” Kasich said.

The blueprint also pushes changes to the regulatory climate like cutting excessive red tape and the federal government taking the lead on drug industry regulation. “The pendulum swinging back and forth between administrations on health care: that's what's got to stop because the ones getting hurt in that swing of the pendulum are those that need health care and need coverage,” Walker said.

The governors want more leeway at the state level too to make changes to health care starting with a streamlined, quicker federal waiver request process. Walker told reporters Feb. 23 the governors have an “opportunity” to improve the American health-care system. “As governors, these costs roll downhill; they'll come to us ultimately so we need to be part of that solution,” he said. State Medicaid programs are already moving away from fee-for-service, according to the blueprint. But they’re also a “giant driver” of debt, Kasich said. Investing in those efforts by growing “proven” state innovations would reduce spending in the $550 billion program over the long term, they said. They want Medicaid to place a priority on models that build toward that goal like integrating physical and mental health care.

Kasich suggested giving states more control over Medicaid's prescription drug benefit, like being able to exclude a drugmaker who won't enter into price negotiation with a program. Massachusetts recently asked in a Section 1115 waiver to operate a closed drug formulary that would allow the state's Medicaid program to pick and choose which medicines to cover based on cost and effectiveness. Medicaid programs currently have to cover all FDA-approved drugs made by manufacturers who partake in the Drug Rebate Program.

States should also be allowed more flexibility in setting plan essential health benefits, the blueprint said. State-driven changes like Alaska's reinsurance program, which Hickenlooper called a “model for all of us,” will take working outside of silos and working together, the governors stressed.

Andy Slavitt, who ran Medicare and Medicaid for the Obama administration and is now a board chair of the United States of Care, tweeted Feb. 23 that the governors’ proposal highlights cost, not health coverage expansion. The USofCare, a group focused on health-care access, “will work with states on expanding coverage and capitalizing on leading ideas here,” he said.

**Trump's Obamacare Changes to Push Up Premiums, Report Projects**

The Trump administration's efforts to loosen health insurance rules will increase premiums for Obamacare plans by double-digit percentages in most states next year, according to a new analysis by the Urban Institute.

Monthly payments for a traditional health insurance plan sold through Obamacare will go up by 18 percent, on average, in 43 states where there aren’t limits on less-comprehensive but less-expensive coverage the administration is calling for, according to the Washington-based policy group.
Expanding access to short-term health policies, which can place limits on benefits and charge higher rates to sick people, draws healthy people out of the insurance pool. The tax law signed in December eliminated the requirement that all Americans have coverage or pay a fine. Combined, the result is higher premiums for those who continue to buy under the Affordable Care Act.

About 2.5 million people would drop out of the market for comprehensive health coverage under the plan the administration announced last week, according to the Urban Institute. The Trump administration projected that the drain from expanded short-term plans would be smaller, shifting only 100,000 to 200,000 people out of Obamacare in 2019.

Consumers will start shopping for 2019 coverage during the run-up to the 2018 mid-term elections on Nov. 6. Many Republicans favor expanding the market for low-cost policies that offer consumers fewer protections, while Democrats argue that such health plans undermine the market for comprehensive coverage.

The premium increases the Urban Institute researchers modeled don't reflect other factors such as the rising cost of health care, so the actual prices could go up or down more than projected.

States that don't allow short-term policies, including New York, New Jersey, Oregon, Vermont and Washington, would see more limited increases, according to the projections. Massachusetts, which bans short-term plans and has its own individual mandate, would not be affected by either policy change at the federal level.

**Lawmakers Keep Up the Pressure on Tax-Exempt Hospitals**

Amped up Republican lawmaker pressure on nonprofit hospitals and how they are monitored by the IRS is expected to stop short of leading to legislative changes for the near future. Nonprofit hospitals have faced scrutiny in recent years, including allegations of cherry-picking insured patients over other patients and not meeting certain community benefit standards, including providing charity care, which are required to maintain tax-exempt status. These concerns have led to numerous inquiries by lawmakers who question whether the hospitals are doing enough to maintain their tax-exempt status. Also, under the microscope is the IRS and how it's watching the hospitals to ensure they provide sufficient benefits to their communities.
Lindsay Bealor Greenleaf, director at the health reimbursement and policy consulting firm ADVI, said the tax exemption status for nonprofit hospitals might be ripe for changes. “These tax exemptions are under constant scrutiny because billions are spent every year on these tax breaks,” she told Bloomberg Law. “There is a sense among some that that bar is set pretty low for these hospitals to qualify for these tax exemptions.” Any changes to tax status for nonprofit hospitals could have a large impact across the U.S. health-care system, in terms of cutting benefits to communities and raising tax revenues. Nearly 60 percent of the 4,840 community hospitals in the U.S. are nonprofit, according to the American Hospital Association. For-profit hospitals make up another 20 percent of U.S. hospitals, and state or local government-owned hospitals make up the remainder.

The exact amount of tax dollars forgone as a result of hospital tax exemptions has been hard to pin down, but available data seems to support the conclusion that exempt hospitals give back more than they receive. An analysis by Ernst and Young, released by the American Hospital Association in October 2017, pinned the amount at about $6 billion in 2013. Sara Rosenbaum, a health policy and law professor at George Washington University, looking at 2011 data, put the number closer to $25 billion. Estimates of the value of nonprofit hospitals’ contributions to their communities came in closer, with Ernst and Young calculating a $67.4 billion benefit for 2013 and Rosenbaum estimating it at $62.4 billion in 2011.

The latest salvo from lawmakers over hospitals’ tax-exempt status came in a letter to the Internal Revenue Service by Sens. Orrin Hatch (R-Utah) chairman of the Senate Finance Committee, and Sen. Charles Grassley (R-Iowa). The senators asked Acting IRS Commissioner David Kautter Feb. 15 for details regarding the agency’s monitoring and of nonprofit hospitals and enforcement efforts involving them. “Given the importance of these institutions to their communities, and the forgone federal revenue associated with their tax-exempt status, it is important that both Congress and the IRS conduct oversight to ensure their
activities are in line with the benefits they enjoy under the Internal Revenue Code,” the senators said in the letter.

The senators noted that, for a hospital to qualify for charitable organization status with the IRS, it must meet a community benefit standard that mandates the hospital make contributions to their community. Among the requests from Hatch and Grassley: updates on the number of charitable hospitals reviewed by the IRS, and whether the agency has given guidance to hospitals on meeting the standard of aiding their community. The GOP senators requested an IRS response by March 26. The senators’ offices didn’t respond to Bloomberg Law's request for comment about the request and any future plans affecting hospitals. The letter is not the first from Grassley regarding nonprofit’s tax exemptions. In 2016, the Iowa Republican asked the IRS about its oversight of nonprofit hospitals in the wake of an investigation the lawmaker conducted into aggressive collection practices by a Missouri hospital. In 2015, Grassley expressed disappointment that a long-awaited IRS report on charity care spending by U.S. hospitals contained no qualitative analysis that would allow comparisons between the charitable contributions of the taxable and tax-exempt sectors.

“What has sometimes come out of these investigations is that the federal government believes it is overpaying hospitals either through reimbursements or programs like the 340B drug discount program,” Dan Mendelson, president of Washington-based consultant Avalere Health, told Bloomberg Law. The 340B drug pricing program allows certain health-care providers, including many safety-net hospitals that are exempt organizations, to receive discounted pharmaceuticals. The program, however, has been under heavy scrutiny by congressional Republicans and the pharmaceutical industry.

Julius Hobson Jr., a senior policy adviser for Polsinelli PC in Washington, told Bloomberg Law he doubts that anything will be done legislatively this year affecting the exempt hospital sector. If Republicans lose one or both houses of Congress in the November elections, they could try to push hospital legislation in a lame-duck session, Hobson said Feb. 23. “If they hold onto both Houses, I would not rule out a run at this next year.” He added that Democrats don't seem interested in the Republicans’ probe. Democratic staff on the Senate Finance Committee didn’t respond to Bloomberg Law's request for comment.

Hospitals defend nonprofits’ tax exemptions as well-earned in the face of new technology and staffing requirements. The Affordable Care Act also added requirements for hospitals to maintain their tax-exempt status, including conducting community health needs assessments, reigning in aggressive billing and collection practices, and revising financial assistance policies to ensure those entitled to charity care are able to obtain it. “Nonprofit hospitals are struggling in a marketplace that has been greatly disruptive” since the 2010 enactment of the ACA, C. Timothy Gary, a Nashville-based health-care attorney at Dickinson Wright and CEO of of Crux Strategies, a global strategy firm, told Bloomberg Law. He added that hospitals are facing uncertainly around potential declines in Medicaid coverage of their patients, constantly changing reimbursement schedules, and demands for hospitals to take on more risk of financial loss under bundled payment models. “When hospitals see falling revenues, the tendency is to be more cautious with spending, and charity care is going to be part of that,” he said.

Some nonprofits would be hit harder than others if tax exemptions were scaled back. Gary said that smaller nonprofit hospitals would fare poorly if they lost their tax exemptions. “Every nonprofit is different,” he said. “Here in Tennessee we have everything from the massive Vanderbilt University Medical Center to Houston County Community Center, which has gone bankrupt several times. It’s smaller, vulnerable
hospitals like this that would be hurt by this.” He added that eliminating tax exemptions is not going to give Congress what it wants: more community benefits. “If Congress revokes this status, both charity care and the number of hospitals beds will decrease,” Gary said. “That's the logical conclusion, and that's not going to give Congress what they want.” Fred Bentley, vice president at Avalere said because of the letter, the IRS “might be looking at this more than before because now they're under scrutiny from powerful senators.” He added that hospitals might also scale back their use of collection agencies and invest more in community programs because they're now in the spotlight.

While lawmakers haven't explicitly said they're considering changes to the tax exemptions, hospitals are already pushing back. Erin O'Malley, director of policy for America's Essential Hospitals, said hospitals already incur significant uncompensated costs related to charity care. “The savings our hospitals achieve through tax-exempt status is a crucial part of the support they need to remain viable,” she told Bloomberg Law. “We understand and share the senators’ concern for transparency and accountability for tax-exempt organizations [but] we urge policymakers to guard against unintended consequences to the safety net as they examine the oversight of tax-exempt entities.” AEH describes itself as an industry group of hospitals dedicated to high-quality care for all, including the most vulnerable. Rick Pollack, president and CEO of the American Hospital Association, said nonprofit hospitals are already accountable to their communities and report annually to the IRS the benefits they provide. “For every dollar invested in hospitals and health systems by means of their federal tax exemption [nonprofit hospitals] deliver $11 in benefits back to their communities,” he told Bloomberg Law. “No other health care sector can claim anything close in terms of providing such value for the public benefit it receives.” Selected nonprofit health systems, including Trinity Health in Livonia, Mich., and Ascension, based in St. Louis, contacted by Bloomberg Law for comments on community health benefits didn’t respond to a request for comments on the senators’ inquiry to IRS.

**HHS Hints at Letting ‘Skinny’ Health Plans Be Sold Even Longer**

The Trump administration is looking at allowing sales of “skinny” health plans to be sold for a year or longer, which could further divide the individual market into healthy people and those with medical conditions. The proposed rule, which would return sales of the non-Obamacare-compliant plans to up to a year in duration, includes a request for comments on allowing health insurers to continue sales of the plans for 12 months or longer. The plans don’t meet Affordable Care Act requirements that people with pre-existing conditions be sold coverage at the same price as healthy people, nor do they typically cover a comprehensive range of essential health benefits.

ACA supporters argue the proposal would push the individual market market back to the pre-2014 days before the ACA requirements took effect, and allowing the plans to be renewed for longer periods could make them even more attractive for healthy people at the expense of sicker ones. The Department of Health and Human Services argues the change is necessary because many people who aren't eligible for ACA premium subsidies have been harmed by escalating premiums. The plans are billed as covering health insurance gaps between jobs. In 2016 the Obama administration shortened the duration of short-term plans to less than three months, in part to try to prevent healthy people from leaving the ACA-compliant market. For nearly 20 years previous to that, the plans were sold for up to 12 months.

Short-term plans represent a small fraction of the health insurance market, the proposed rule said. In 2016, before the Obama administration rule took effect, about 160,000 people were in the short-term market paying about $146 million in premiums, it said. That same year 13.6 million people had
comprehensive major medical plans in the individual market, paying a total of $63.25 billion in premiums, it said. Sales of the plans were increasing before the 2016 Obama administration rule took effect, it said. The HHS estimated that in 2019, after the ACA penalty for not having health insurance is reduced to zero, between 100,000 and 200,000 individuals previous enrolled in ACA exchange coverage would buy the short-term plans. When the proposal was announced Feb. 20, Centers for Medicare & Medicaid Services Administrator Seema Verma said that it would have “virtually no impact on the individual market premiums.” UnitedHealth Group Inc. was the one of the largest sellers of the plans in 2016, according to a report from the National Association of Insurance Commissioners.

In the short term, the proposed rule would likely accomplish its goal of providing more choices, Chris Sloan, senior manager with Washington-based health policy consulting firm Avalere Health, told Bloomberg Law Feb. 26. However, “over the long term these could start to be pitched more like individual market policies” prior to the 2014 implementation of ACA rules, he said. “As we see how plans and states react to this, you could potentially see the growth of the short-term policy market.” Further, “Removing the requirement to reapply or buy a different plan could boost re-enrollment in these short-term plans over the long term,” Sloan said. But, Sloan added, “There's an upper bound of how many people want to go into these. They're just not that attractive as a policy.”

The HHS says short-term plans could cover some people who are currently uninsured. CMS data on exchange plans show that for the first quarters of 2016 and 2017, the number of off-exchange and unsubsidized enrollees with individual market coverage fell by nearly 2 million, an almost 25 percent decrease, the proposed rule said. Most people who switch from individual market plans to short-term plans could be young, healthy people who make too much money to receive ACA subsidies, the HHS said in the proposal. As a result, individual market issuers could experience higher costs and suffer financial losses, which might prompt more of them to leave the market and further reduce choices, it said. How much more risk the individual markets would bear if the rule is finalized, and if consumers could re-enroll more easily, is an open question. Even under current rules, “The ACA individual market will remain a marketplace for individuals that receive a subsidy as well as those that have higher morbidity,” Deep Banerjee, director of health insurance ratings for S&P Global Ratings, New York, told Bloomberg Law in an email Feb. 26.

The possible increased availability of short-term plans and the repeal of the mandate penalty mean “the risk profile of the ACA individual pool will not improve in the future,” Banerjee said. Premiums, before taking subsidies into account, will likely not decline as well, he said. “To the extent that short-term plans are attractive to lower-cost individuals, they could contribute to a deterioration of the ACA individual market and lead to higher ACA premiums,” Cori Uccello, senior health fellow with the American Academy of Actuaries, Washington, told Bloomberg Law in an email Feb. 26.

A report released Feb. 26 by the Urban Institute, which has been supportive of the ACA, found that expanding short-term policies as proposed by the HHS would increase the number of people without minimum essential coverage by 2.5 million in 2019. But it also found if the rules on short-term plans are loosened, 1.7 million of the people buying short-term policies would have been uninsured. In addition to health status, subsidies are a primary driver for ACA enrollment. “If you’re eligible for a generous subsidy the ACA premium is going to be more attractive because the government's paying the majority of the premium,” Greg Fann, a senior consulting actuary with Axene Health Partners LLC based in Murrieta, Calif., told Bloomberg Law Feb. 26. “Not having renewability is a small barrier, but I don't think that's the key
focus.” Fann is a fellow with the Society of Actuaries. If the proposed rule is finalized, and if people can re-enroll without reapplying or going through other steps, the ACA-compliant market will be smaller, Fann said. The short-term market is “going to be attractive to high-income people who are in good health.”

But Joel White, president of the Washington-based Council for Affordable Health Coverage, told Bloomberg Law Feb. 26 that even if more healthy people leave the ACA market, ACA plans will continue to be available for people who need them. The proposed rule is likely to “have an initial small impact,” White said. To a great extent, the ACA market already functions much like a high-risk pool market, he said. “That's a function of Obamacare. It's not a function of short-term medical,” he said. To stabilize the ACA markets, Congress needs to enact legislation that would enhance reinsurance funding to health insurers, White said. Republican and Democratic governors called for stabilizing the health insurance market and prioritizing value-based care in a Feb. 23 blueprint. But a bipartisan plan from Sens. Lamar Alexander (R-Tenn.) and Patty Murray (D-Wash.) hasn't gone anywhere.

LEGAL

Red States Take On Obamacare Following Tax Reform

A group of red states is claiming the tax reform law killed the Affordable Care Act, something neither Congress nor the Trump administration has been able to do through other means. Texas Attorney General Ken Paxton (R) Feb. 26 led a 20-state coalition in arguing that the Tax Cuts and Jobs Act, signed by President Donald Trump in December 2017, eliminated the rationale used by the U.S. Supreme Court when it declared the ACA valid in 2012. That is, when Congress repealed the tax penalty payable by people who fail to obtain health insurance, it did away with the legal basis for the Supreme Court's ruling that the ACA was valid because it was a revenue-raising provision passed pursuant to Congress's taxing power.

The lawsuit, filed in the conservative U.S. District Court for the Northern District of Texas, could accomplish something Republicans have tried and failed to do—repeal the ACA. As Paxton said in a press release announcing the suit, this would “give President Trump and Congress an opportunity to replace that failed experiment with a plan that ensures Texans and all Americans have better choices for health coverage at more affordable prices.” The other states joining the complaint are Alabama, Arkansas, Arizona, Florida, Georgia, Indiana, Kansas, Louisiana, Maine, Mississippi, Missouri, Nebraska, North Dakota, South Carolina, South Dakota, Tennessee, Utah, West Virginia, and Wisconsin.

This is a “nuisance suit,” according to Timothy S. Jost, a former professor at Washington & Lee University Law School in Lexington, Va., and a nationally recognized health policy expert. Many states, including Texas, already sued the federal government seeking a declaration that the ACA is unconstitutional. They lost in the U.S. Supreme Court, which overturned the U.S. Court of Appeals for the Eleventh Circuit's ruling holding the individual mandate unconstitutional. The Eleventh Circuit said the mandate was invalid, but nevertheless upheld the rest of the ACA. The states’ argument here is basically the same as the one they made and lost in the Eleventh Circuit, Jost said. Joshua Blackman, however, told Bloomberg Law the states “have a solid legal argument.” Blackman, an ACA critic, is an associate professor at South Texas College of Law in Houston and an adjunct scholar at the libertarian Cato Institute in Washington.

This was an “obvious lawsuit to bring,” Blackman said. Four justices said in Nat’l Fed’n of Indep. Bus. v. Sebelius that Congress doesn't have the power under the commerce clause to force citizens to buy health
insurance. But Chief Justice John G. Roberts Jr., joined by four other justices, concluded the penalty imposed for noncompliance with the insurance mandate was revenue-raising and, therefore, Congress had the power to enact the ACA under the Constitution's Taxing and Spending Clause.

The ACA's individual mandate is now a “zombie law,” Blackman said. That is, the mandate still exists, but the penalty's repeal means the government has no way to enforce it because noncompliance no longer triggers the penalty. Roberts’ opinion required the revenue-raising provision to be read as part of the ACA as a whole, Blackman said. Congress took that provision out, so now there is no basis on which Congress could require everyone to have health insurance, he said. Katie Keith, a health-policy expert who teaches at Georgetown University Law Center, disagreed. She told Bloomberg Law that Congress decided as part of the tax reform law that the penalty provision was severable. That is, the tax penalty could be removed without having any effect on the rest of the ACA. She said, “there isn't any ‘there’ there” in the states’ complaint. Moreover, the complaint isn't a model of clarity. It generally asks the court to enjoin enforcement of the ACA, but it primarily focuses on the individual mandate.

The ACA is a massive statute, however, that covers everything from discrimination to black lung benefits. Do the states want the court to block enforcement of every ACA provision, she asked. Keith said the lawsuit is a “big stretch,” but cautioned that other lawsuits involving the ACA that people didn't think would get far became highly contested fights that went all the way to the Supreme Court.

The “million-dollar question,” Blackman said, is: What will the Department of Justice do? The DOJ is charged with defending U.S. laws, but Blackman questioned whether Attorney General Jeff Sessions will defend the ACA. Jost said Sessions doesn't have a choice. The Trump administration is legally obligated to defend the law of the land, and Health and Human Services Secretary Alex Azar has vowed to do so. Keith said it can be assumed the DOJ will defend the case unless and until the agency indicates otherwise. Regardless, Keith expects to see Democratic state attorneys general ask the court for permission to join the case to defend the law.

This is where the Republican states’ choice of the court in which they filed the complaint is likely to come into play, Keith said. Judge Reed O'Connor, of the Northern District of Texas, has been criticized for denying or refusing to rule on intervention motions filed by interested parties in a lawsuit that challenged the regulations implementing the ACA's antidiscrimination provision. If the present case is assigned to him, will he likewise deny or refuse to act on attempts to join the suit made by other parties interested in the ACA's continuance, she asked. Both Jost and Blackman said the states may have to overcome an argument that they don't have standing, that is, they aren't in a proper position legally to seek an order barring the federal government from enforcing the ACA. Blackman, however doesn't see that as an insurmountable barrier. Courts have been more permissive lately when it comes to issues of state standing, Blackman said, referring to state lawsuits challenging Trump administration immigration policies. Jost thinks the entire argument is “ridiculous.” “Congress had the chance to repeal the ACA and didn't,” he told Bloomberg Law. Lawmakers already have spoken on this issue, and “it isn't permissible for one federal trial court judge to second-guess Congress,” he said.

HHS Told to Revisit Formula for Obamacare Insurer Payments
A New Mexico nonprofit health insurer appears to have become the first to successfully challenge part of an Obamacare program designed to level the health insurance playing field. The U.S. District Court for the District of New Mexico Feb. 28 ordered the Health and Human Services Department to rework part of its methodology for determining payments due from profitable health plans under the Affordable Care Act's risk adjustment program. That program requires successful insurers to pay an amount calculated using the methodology to the HHS, which then redistributes it to insurers that were less successful at setting premiums to cover the cost of care for their newly insured members.

At least three insurers have sued the federal government, claiming the risk adjustment program has made it difficult, if not impossible, for them to remain in business. They, along with about two dozen other insurers, are seeking billions of dollars in recompense for losses they suffered as the result of this and two other ACA creations, known as the risk corridors and reinsurance programs. Massachusetts's Minuteman Health Inc. recently lost its challenge, and Maryland's Evergreen Health Cooperative Inc. ended its lawsuit after converting to a for-profit insurer.

New Mexico Health Connections, the insurer that brought this case, is one of only four remaining ACA consumer-operated and oriented nonprofit health plans. It said the HHS's then-existing formula led it to be overcharged for the 2014 and 2015 plan years. In those years, it paid the HHS over $6.6 million and $14.5 million, or 21.5 percent and 14.7 percent of the premiums it took in during those years, respectively. The figures are comparable to insurers in similar positions. NMHC challenged multiple components of the HHS's risk adjustment methodology, but succeeded on only the state average premium piece.

Under the risk adjustment programs, the HHS assesses a charge against insurers whose members’ actuarial risk for one year is less than the average actuarial risk of all plan members in a state. The HHS uses those funds to pay insurers whose members’ actuarial risk is greater than the average actuarial risk of all plan members in the state. Actuarial risks are meant to make up for wrong assumptions made by actuaries when they calculate plan premiums, like the number and frequency of claims.

The HHS's formula first calculates the plan's average risk score by averaging its members’ risk scores, which are based on members’ age, sex, and diagnoses. It then multiplies the plan's average risk score by the average state premium. This shows how a plan's premium would differ from the state average premium. The amount the plan must transfer to the HHS is then calculated based on that amount. NMHC argued that the transfer amount can't be based on anything other than the actuarial risk. The court disagreed with that assessment, but still found the use of the average state premium to be arbitrary. The government had told the court that its decision to use the state average premium was based on its assumption that the risk adjustment program is budget neutral. That is, that the program can pay out only as much money as it takes in.

The ACA, however, doesn't require budget neutrality for the program, and the HHS cited no policy reasons for adopting neutrality, the court said. Budget neutrality “might be a reasonable policy choice,” but there was no evidence that choice was ever made, it said. “Because risk adjustment does not need to be budget neutral, HHS’ risk adjustment methodology could use a plan's own premium instead of a state's average premium” without imposing an adjustment to counter any “unintended distortions,” the court said. The court vacated the HHS's action regarding the use of a statewide average premium for the risk adjustment program and remanded the case to the agency for further proceedings. It dismissed NMHC's other claims. The court didn't say what will happen once the HHS reworks the formula. A new formula that doesn't
include the state-wide average premium might mean insurers like NMHC are entitled to an adjustment. That could cost the government, or insurers, millions of dollars.

The insurer’s former and current chief executive officers, Martin Hickey and Marlene Baca, called the ruling “a victory for New Mexicans insured under” ACA exchange health plans. “The risk adjustment formula unfairly penalized health plans that effectively managed care and therefore lowered costs, as New Mexico Health Connections consistently has,” the company leaders said in a statement provided to Bloomberg Law.

“The federal judicial finding that the use of the statewide average premium in the risk adjustment formula violates the Administrative Procedure Act because it was arbitrary and capricious” is “an important step towards stopping the unfair penalties that have been leveled against New Mexico Health Connections for offering lower premiums to New Mexicans,” they said. The ruling “validates” NMHC’s “history of effective medical management for our members,” which “helps keep premiums competitive,” Hickey and Baca said.

The Department of Justice represented the HHS. Pepper Hamilton LLP and Long Komer & Associates PA represented NMHC.

AROUND THE STATES

IDAHO

Idaho Tables Health Care Bill to Cover More Poor
A plan by Idaho’s Republican governor to provide health care for some of the 78,000 people living under the poverty line who don’t qualify for coverage under Medicaid or premium subsidies on the exchange has been sent back to a House committee in the overwhelmingly Republican Legislature where it will likely die.

The failure to enact a Republican politician’s plan for covering Idahoans in the so-called gap that the Legislature would embrace is an Idaho saga replete with years of work groups and proposals stretching back to the seminal years of Obamacare and the state’s decision not to expand Medicaid to include many of the people now living in the gap. And despite lame-duck Gov. Butch Otter’s (R) plan being well received just a few days ago by the Trump administration—which would have to approve it—Republican legislative leadership said Feb. 27 that there were not enough votes to pass the plan as laid out in HB 464.

The heart of the plan was a pair of waivers. The first was a Section 1332 state innovation waiver under the Affordable Care Act that would allow some 35,000 people with incomes below 100 percent of the poverty line to qualify for premium subsidies on the exchange. The second was a Section 1115 Medicaid waiver that would allow somewhere between 2,500 and 3,500 sick people on the private insurance market with certain complex conditions to be moved to Medicaid in a plan that would act like a reinsurance program. House Speaker Scott Bedke (R), House Health and Welfare Committee Chairman Fred Wood (R), the governor’s office, and his insurance department director Dean Cameron have not provided comments as requested by Bloomberg Law on the failure of HB 464. But Democratic lawmakers believe their politically
conservative colleagues fear primary challenges from the right from candidates charging Otter’s plan is tantamount to “Obamacare Light.”

Republican leaders “thought why take a chance and make people go on the record in an election year with votes that could be used against them in their primaries,” Assistant Minority Leader Ilana Rubel (D) told Bloomberg Law Feb. 28. “All of the behind-the-scenes reporting was that it was a dead heat and possibly could have passed,” said Rubel, who is also a member of the Health and Welfare Committee. Otter’s Idaho Health Care Plan with its dual-waiver approach, along with the state’s decision announced in January to allow health insurance plans on the individual market that don’t comply with the ACA, has attracted a lot of attention in the Trump administration as potentially innovative solutions to addressing both escalating premiums and the uninsured gap population. Otter and Cameron met in Washington on the weekend of Feb. 24 with Health and Human Services Secretary Alex Azar and Centers for Medicare & Medicaid Services Administrator Seema Verma, who reportedly received the plan warmly. “The feedback we were getting based on the conversations they had so far was that this was promising,” Rubel said.

HHS spokesperson Caitlin Oakley told Bloomberg Law in a March 1 email: “Secretary Azar and Administrator Verma met with the Idaho Governor this past weekend, as well as 16 other Governors from both sides of the aisle. They expressed empathy with the challenges that states such as Idaho face with Obamacare and highlighted the importance of the recently announced HHS proposed regulation that seeks to provide more choice and competition through short-term, limited duration plans. “HHS is committed to working with Idaho and all states to give them the flexibility, will enforce the law as needed, and looks forward to receiving comments from all states on the recently announced proposed regulation.”

Close the Gap Idaho is a coalition dedicated to finding a solution for the 78,000 uninsured Idahoans and composed of groups like the Idaho Medical Association, the Idaho Hospital Association, and the Idaho Association of Counties. Close the Gap steering committee member Lauren Necochea told Bloomberg Law in a Feb. 28 interview that HB 464 failed because “the politics of it are messy because pragmatic solutions driven by Idahoans, which is what the Idaho Health Care Plan is, can still get tagged with political rhetoric that links it to the Affordable Care Act.” While the Legislature could theoretically revive HB 464, with a March 5 deadline for passing bills in the originating chamber and March 9 being the end of the filing period for election candidates, Rubel doesn't think it's likely to happen. “I don't see any great acts of political bravery happening during that time for sure that could trigger someone to run against them,” she said. What’s next? Necochea points to a “grass roots effort to close the coverage gap through a ballot measure in Idaho. I would expect that effort to become much more energized.”

Luke Mayville, the founder of the Expand Medicaid in Idaho campaign, agrees with Necochea's assessment. “The failure of the governor's health-care plan raises the stakes of our ballot-initiative campaign. We know now that the 78,000 Idahoans in the Medicaid Gap are counting on us, and we are determined not to let them down,” he said in an email to Bloomberg Law.

**ILLINOIS**

**Illinois Seeks Quick Federal Decision on $3.5B Medicaid Plan**

Illinois officials are hoping for quick approval by a federal agency of a $3.5 billion Medicaid funding plan that ensures no interruption in critical payments to the state's safety-net hospitals. Illinois House members
Feb. 28 voted 107-7 to approve SB 1773, which redesigns the state's current multibillion-dollar hospital assessment program. Less than two hours later, state senators voted 53-3 to approve the legislation. Once Gov. Bruce Rauner (R) signs the legislation—which is expected—the federal Centers for Medicare & Medicaid Services must provide final approval to the assessment program.

The program is essential to inner-city safety-net hospitals and rural “critical access” facilities in part because the cost of providing health services has outpaced Medicaid reimbursement rates. The current program, which has existed for more than a decade, expires June 30 and legislators and others are pushing to complete the approval process quickly to ensure a smooth transition to the new program July 1.

The program collects fees from virtually all nonpublic state hospitals and pools that money to qualify for matching federal funds to support the state's Medicaid program. The resulting funds are then allocated back to the hospitals. The program was supplemented for the past four years with Affordable Care Act funds.

In 2017, hospital assessment program funds totaled $3.14 billion, and the approved legislation renewing the program would increase spending in 2018 to about $3.5 billion in Medicaid funding for hospitals and other health-care services. Generally, fees the hospitals pay will increase about 12 percent statewide in the program's first two years. The program will be effective for six years, with reviews of its operations conducted every two years.

The legislation approved Feb. 28 was needed for two reasons. The hospital assessment program, state rate reform transition payments, and Affordable Care Act access payments package expire on June 30. Second, the algorithms used to calculate hospital fees and disbursements, which use data sets from 2005 and 2009, have been criticized as being deficient. The CMS will not approve a new Illinois hospital assessment program using the current outdated funding formulas, so the Illinois program must change, state Rep. Greg Harris (D), the legislation's sponsor, said during floor debate Feb 28.

About 10 percent of the state's hospitals are safety-net hospitals, defined as hospitals with Medicaid inpatient populations exceeding 50 percent, and the hospital assessment program is vital to their survival because the amount they receive under the program can total one-third or more of their total annual revenue.

Legislators also approved affiliated legislation, SB 1573, which aims to enhance Medicaid managed care performance transparency, payment performance, and oversight.

The bill may also lead to additional legislation. Hospitals are either financial winners—their disbursement is bigger than the fee they pay out—or financial losers under the program, and those losing out on bigger disbursements may introduce legislation to try and boost their disbursements. Bill language also creates a “bridge” that temporarily extends current funding past the June 30 deadline to safeguard against any delays in a federal CMS decision, but that bridge component too must receive separate CMS approval to be effective. The law will use updated information and modern processes to improve the fees and disbursement regime. About $600 million, or 18 percent of the total disbursements, will be freed up and used to replace static, fixed payment schedules with dynamic claim-based payments and rates, allowing money to follow patients as they move among different health facilities.

Importantly, the bill contains about $262 million in innovation or transformation funding that can be used to help comparatively resource-starved hospitals develop modern health-care delivery models and
practices. The innovation funds can also be used to attract medical specialists to work at safety-net hospitals.

A government technical analysis of the legislation stated hospital assessments in 2018 totaling $1.47 billion will be leveraged to pull in an additional $2.03 billion in federal funds for the program.

WISCONSIN

Wisconsin Seeks Waiver for Obamacare Reinsurance Plan

Wisconsin is one step closer to introducing a $200 million reinsurance program that could help lower Affordable Care Act health insurance premiums for hundreds of thousands of state residents expected to buy the plans for 2019.

Gov. Scott Walker (R) Feb. 27 signed legislation (SB 770/Act 138) into law triggering a Section 1332 innovation waiver application to the federal Centers for Medicare & Medicaid Services that will add a reinsurance element to the state's Affordable Care Act marketplace. Wisconsin would join Alaska, Minnesota, and Oregon as states adopting reinsurance plans for their Obamacare individual marketplaces if the CMS approves its application. Walker Feb. 27 sent a letter to federal congressional leaders seeking support in securing the waiver.

Section 1332 of the Affordable Care Act creates state innovation waivers allowing states to tailor Obamacare insurance plans to the contours of a state's insurance market without abandoning the chief principles of the law's intent.

The state expects to submit the waiver application in mid-April to affect the 2019 plan year, Elizabeth Hizmi, Wisconsin Office of the Commissioner of Insurance spokeswoman, told Bloomberg Law in a Feb. 28 email. Once submitted, the CMS has 45 days to review the application for completeness and then up to 180 days for a determination, she said.

The Wisconsin Healthcare Stability Plan, if approved, will create a reinsurance program that will pay insurers up to 80 percent of that part of claims totaling more than $50,000 but less than $250,000 using public money. Insurers get no help on claim portions exceeding $250,000. The program's stated aims are to reduce premium increases, keep more individuals insured, and entice insurers to offer insurance plans in the state. The state will pay about $50 million of the $200 million annual cost of the program, with the rest coming from the federal government in pass-through funds.

A total of 225,435 individuals signed up for health insurance coverage on the ACA individual marketplace in Wisconsin for 2018, a 7.2 percent decrease compared with 2017, according to Kaiser Family Foundation data.