YEAR-END REPORT - 2023

Published 18-Dec-2023
HPTS Issue Brief 12-18-23.1

Health Policy Tracking Service - Issue Briefs
Access to Health Insurance
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This Issue Brief was written by a contributing writer.

12/18/2023

Introduction

The U.S. Department of Health & Human Services announced the release of the 2024 Notice of Benefit and Payment Parameters Proposed rule aimed at increasing access to health insurance coverage.

The $1.7 trillion omnibus spending bill that President Joe Biden signed into law on December 29, 2022 includes a provision that will require states to reevaluate their Medicaid and Children's Health Insurance Program (CHIP) beneficiaries for eligibility requirements and begin the reauthorization that was frozen due to the COVID-19 pandemic since March 2020.

Researchers at the Kaiser Family Foundation (KFF) recently published a study of noncitizens in the United States in relation to health insurance coverage.

Virginia residents saw the largest decrease in the cost of health insurance premiums in the country for the 2022 plan year.

In Austin Texas, the Central Health Board of Managers voted to increase funding by $1 million to an organization that will help an additional 500 local musicians gain health insurance coverage.

The California Department of Health Care Services announced that a deal had been reached with five commercial health plans to provide Medi-Cal services in 2024.

The American Hospital Association (AHA) sent a letter to the Centers for Medicare & Medicaid Services (CMS) commenting on proposed changes relating to health insurance.

Enrollment in Delaware's Health Insurance Marketplace for 2023 set a record high for 2023 at the close of the open enrollment period.

U.S. Senator Chris Van Hollen (D-Md.) recently reintroduced a bill aimed at simplifying enrollment in health insurance plans by allowing enrollment through federal tax returns.

NY State of Health, the state's official health plan Marketplace, announced that it will attend job fairs to educate New York residents about enrolling in health insurance coverage.

According to a new report, while Virginia residents spend less than the national average on health care, their out-of-pocket costs continue to increase.

The Centers for Medicare & Medicaid Services released a fact sheet outlining the unwinding of the federal Public Health Emergency for COVID-19 (PHE).

The Centers for Medicare and Medicaid Services has awarded a contract to Serco to continue supporting eligibility determinations for consumers who purchase health insurance plans through the federal marketplace.

Humana Inc. announced recently that it will exit the Employer Group Commercial Medical Products business.

An Oregon bill that would create a path for universal health care in the state is pending in the state.

A federal judge in Texas ruled that health insurance plans are not required to cover essential benefits, including preventive health care services.

The Texas Health and Human Services Commission announced that it is resuming eligibility redeterminations for Medicaid recipients.

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According to the American Hospital Association, health care providers including hospitals and hospital systems are working to help their patients maintain health insurance coverage during the Medicaid reenrollment campaign.

According to a new analysis by Kaiser Family Foundation, between 8 and 24 million people in the United States could lose health insurance coverage under Medicaid due to the unwinding of the continuous enrollment provision that was put in place at the start of the COVID-19 pandemic.

Illinois State Senator Karina Villa moved a bill out of the Senate Labor Committee that would provide access to health insurance for emergency workers injured on the job.

The Department of Health and Human Services (HHS), through the Centers for Medicare & Medicaid Services (CMS), released a proposal that would expand access to healthcare for

Deferred Action for Childhood Arrivals (DACA) recipients.

According to a recent study, the stability of coverage through Medicaid increased during the first year of the COVID-19 pandemic.

The Department of Health and Human Services (HHS) released a fact sheet outlining changes to health care that will result from the ending of the federal COVID-19 Public Health Emergency (PHE).

U.S. Representatives Pramila Jayapal (WA-07), Debbie Dingell (MI-06) and U.S. Senator Bernie Sanders (I-VT) introduced legislation that would expand access to health insurance coverage under Medicare.

The Congressional Budget Office (CBO) released updated projections for health insurance coverage for people under age 65.

United States Department of Health and Human Services (HHS) Secretary Becerra wrote a letter to the nation's governors announcing new flexibilities from HHS aimed at minimizing avoidable health insurance coverage losses for children and families.

House Republicans passed a bill that would increase options for employers, allowing tax advantages for reimbursing employees who purchase their own health insurance.

North Carolina Insurance Commissioner Mike Causey announced that Friday Health Plans of North Carolina Inc. (FHP-NC) consented to being placed into receivership.

A recent Kaiser Family Foundation Survey showed that most (58%) people with health insurance had at least one issue using their coverage in the past year.

Minnesota extended the deadline for renewing Medical Assistance, the state's Medicaid program, for 35,500 people who had overdue renewal paperwork for coverage continuing July 1.

Connecticut Governor Ned Lamont signed an amendment to the Connecticut General Statutes that creates a special enrollment period in state health insurance programs for employees whose health care coverage is terminated due to a labor dispute.

The Colorado Division of Insurance recently announced that it will liquidate Friday Health Plans, leading to a loss of health insurance coverage for consumers on August 31, 2023.

Senator Maggie Hassan (D-NH) expressed support for the Food and Drug Administration (FDA) approval of the first birth control pill available over the counter without a prescription.

The Biden-Harris Administration announced a proposed regulation aimed at improving parity for access to mental health care.

The U.S. Department of Health and Human Services (HHS) released a new report showing that the national uninsured rate reached an all-time low in 2023.

Kansas Governor Laura Kelly launched an effort to rally support for Medicaid expansion, a top priority for the upcoming legislative session.

The U.S. Department of Health and Human Services (HHS) announced that it helped nearly half a million children and families regain Medicaid and Children's Health Insurance (CHIP) coverage.

According to experts, people living in rural areas of the United States are at greater risk of losing health insurance coverage during the unwinding of COVID-era Medicaid enrollment protections.

The Departments of Health and Human Services, Labor, and the Treasury (the Departments) announced that they are seeking public comment on coverage and access to over-the-counter (OTC) preventive services.

According to the 2023 benchmark Kaiser Family Foundation (KFF) Employer Health Benefits Survey, annual family premiums for employer-sponsored health insurance increased an average of 7% to $23,968.

The Centers for Medicare and Medicaid (CMS) recently released a new batch of state-reported Medicaid unwinding data. The data release is through the Unwinding and Returning to Regular Operations after COVID-19 landing page.

Health insurance costs for employer-provided family plans increased an average of 7 percent in 2023 nationwide, while increases in Pennsylvania are almost twice as high as the national average.

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Michigan Governor Gretchen Whitmer signed legislation focused on decreasing healthcare costs for cancer patients by requiring health insurance coverage equity for orally administered chemotherapy medications and other forms of chemotherapy.

The Biden-Harris Administration (the Administration), through the Departments of Health and Human Services (HHS), Labor, and the Treasury (the Departments), along with the Office of Personnel Management (OPM), released a proposed rule on the No Surprises Act's Federal independent dispute resolution (IDR) process.

Study: Immigrants and Health Insurance Coverage

Researchers at the Kaiser Family Foundation (KFF) recently published a study of noncitizens in the United States in relation to health insurance coverage.

Researchers noted that noncitizens are significantly more likely to lack health insurance coverage than citizens in the United States.

In 2021, noncitizens made up approximately 6% of the United States population. Both lawfully present individuals and undocumented immigrants are considered noncitizens. Many families in the United States have mixed immigration status, with one or more members legally present immigrants, undocumented immigrant, and/or citizens.

Within the nonelderly population of noncitizens, 25% of lawfully present immigrants and 46% of undocumented immigrants lacked health insurance coverage. Approximately 8% of citizens are uninsured.

Eight percent of citizen children with at least one noncitizen parent were uninsured. Four percent of citizen children with both citizen parents were uninsured.

Noncitizens have less access to private health insurance coverage than citizens due to the type of jobs they work typically not offering health insurance coverage. They also face eligibility restrictions for government-sponsored programs. Medicaid, the Children's Health Insurance Program (CHIP) and Marketplace coverage restrict coverage eligibility based on immigration status.

Even noncitizens who are eligible for coverage face enrollment barriers such as confusion and fear about signing up and language and literacy barriers.

Noncitizen immigrants also are less likely to report having a usual source of care (33% vs. 20%), not seeing a doctor in the past 12 months (32% vs. 20%), and going without needed medical care in the past year due to cost (10% vs. 7%).

As a result of more limited access and use, expenditures for health care per person are lower for immigrants than for people born in the U.S.

Recently, some activity has been aimed at expanded access to health insurance coverage for immigrants. However, concrete action has not been taken. Proposed federal legislation would expand eligibility for health coverage for immigrants, but passage is unlikely in Congress.

Some states have expanded Medicaid and CHIP coverage for lawfully present immigrant children and pregnant people. A small number of states have expanded fully state-sponsored coverage to some low-income people without regard to immigration status. Many immigrants remain without access to coverage.

Efforts are underway to rebuild trust and reduce fears about accessing programs and services for immigrant families. The Biden Administration changed a Trump Administration policy for public charge restrictions, aiming to reduce fears about participating in non-cash assistance programs, including health insurance programs.

The Biden Administration also increased funding for Navigator programs designed to help people sign up for coverage.

Researchers noted, “However, even with these actions, it will likely take time and sustained community-led efforts to rebuild trust and reduce fears surrounding the use of services among immigrant families. Addressing the needs of immigrants is of growing importance as the pandemic has likely worsened the health and financial challenges faced by immigrants and there has been increasing immigration activity in the U.S.-Mexico border region.” [FN2]

Passage of Omnibus Spending Bill Includes April Restart of Medicaid Eligibility Verification Requirements

The $1.7 trillion omnibus spending bill that President Joe Biden signed into law on December 29, 2022 includes a provision that will require states to reevaluate their Medicaid and Children's Health Insurance Program (CHIP) beneficiaries for eligibility requirements and begin the reauthorization that was frozen due to the COVID-19 pandemic since March 2020.

The Medicaid redeterminations will begin in April 2023 regardless of the Public Health Emergency status.

According to the Robert Wood Johnson Foundation, up to 18 million Medicaid enrollees could lose health insurance coverage when redeterminations begin. Last August, the U.S. Department of Health & Human Services estimated that 15 million could lose coverage after redeterminations.

The law will also extend funding for the Medicare rural hospital program. Funds for the Small Rural Hospital Improvement Grant Program were included. Hospitals in many rural areas of the United States have faced challenges due to the COVID-19 pandemic. Many facilities faced long-term consequences, which would lead to a loss of access to care in many geographic areas.

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Telehealth flexibilities begun during the COVID-19 pandemic and hospital at home programs have also been extended for two years due to the passage of the bill.

Funding was included for mental health programs and to allow physicians to more easily prescribe medication to treat substance use disorders. [FN3]

HHS Releases Policies Aimed at Increasing Access to Coverage

The U.S. Department of Health & Human Services announced the release of the 2024 Notice of Benefit and Payment Parameters Proposed rule aimed at increasing access to health insurance coverage.

Under the proposed rule, access to health care services will be improved, the process to select a health plan will be simplified, and enrollment will be easier.

“The Biden-Harris Administration has taken historic action to expand access to health care, and the Affordable Care Act Marketplace provides millions of Americans vital coverage,” said HHS Secretary Xavier Becerra. “As we make a final push now during Open Enrollment, we are encouraged that so many people are signing up for Marketplace health plans. Already we are working to build on this success.”

“We know that access to affordable health care is a concern across the nation. During the first several weeks of Affordable Care Act Marketplace Open Enrollment, we have already seen 5.5 million people select a Marketplace health plan, an 18% increase compared to last year” said CMS Administrator Chiquita Brooks-LaSure. “Continuing to propose policies that help make it easier for consumers to choose and maintain the health coverage that best fits their needs is vital. If finalized, this proposed rule does just that.”

A top priority for the Biden-Harris Administration is expanding access to behavioral health care. The proposed rule creates two new major essential community provider (ECP) categories for delivering behavioral health care. The categories include Substance Use Disorder Treatment Centers and Mental Health Facilities.

In addition, the rule includes a proposal to extend the current overall 35% provider participation threshold to two major ECP categories, including Federally Qualified Health Centers and Family Planning Providers

Proposals to expand Network Adequacy requirements, along with these changes, will increase provider choice. The changes are focused on addressing health equity and expanding access to care for consumers with low incomes, complex conditions and chronic conditions. They are also aimed at people living in underserved areas.

The rule proposes changes that would simplify plan choices for consumers based on public feedback. It would update designs for standardized plan options and limit the number of non-standardized plans offered through the health insurance marketplace by issuers of qualified health plans.

The average number of plans available to a consumer through the Marketplace has increased to 113.6 in PY 2023 from 24.9 in PY2019. Too many plans limit the consumer's ability to make a meaningful choice of a health insurance plan. Streamlined plan availability is aimed at simplifying the selection process for consumers so they can more effectively choose the plan that fits their needs.

The rule would also allow for an enhanced special enrollment period for beneficiaries losing coverage under Medicaid or the Children's Health Insurance Program (CHIP). It would allow these consumers to select a Marketplace plan 60 days before losing coverage or up to 90 days after the loss of coverage. This proposal is aimed at decreasing coverage gaps when consumers lose government-sponsored coverage.

The rule will change current coverage effective date requirements to allow consumers to attest to a future coverage loss and receive coverage earlier by enrolling in a Marketplace plan. This change will provide an increased likelihood of a seamless transition between forms of health insurance coverage. [FN4]

Medi-Cal to Include More Insurance Providers

The California Department of Health Care Services announced that a deal had been reached with five commercial health plans to provide Medi-Cal services in 2024.

The original plan included awards of contracts to only three health plans. The expanded offerings will allow more Medi-Cal beneficiaries to keep their current insurer and health care providers.

The agreement will also avert a re-enrollment process for most members and prevent disruptions to care. It will also allow the state to avoid a long legal battle from insurers wanting to be included.

Blue Shield and Community Health Group initially lost bids for contracts but will now be included. Health Net will maintain some of its enrollees.

“To bring certainty for members, providers and plans, the State used its authority to work directly with the plans to re-chart our partnership and move with confidence and speed toward the implementation of the changes we want to see,” the department wrote in a statement.

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“At some level it makes the transition easier, but we want to do better than the status quo,” said Anthony Wright, executive director of Health Access, a consumer advocacy group. “Less disruption is good, but we don't want to lose the reason for the change, which is to have more accountability on these plans going forward.”

Over 14 million low-income California residents receive health insurance coverage through Medi-Cal. Over one third of the state's population is enrolled in the program.

The Department of Health Care Services, which oversees the Medi-Cal program, began a bidding process in 2021 that would re-negotiate contracts with commercial insurers. The state intended to reduce the current nine health insurance plans in Medi-Cal and include only the most qualified plans.

The goal was improvements to patient outcomes, wait times, and beneficiary satisfaction. The state also wanted to reduce health disparities.

Last summer, California announced that it intended to award $14 billion of Medi-Cal contracts to only three companies, Health Net, Molina and Anthem Blue Cross. The proposal would have required 2 million enrollees to change insurance companies and potentially find new health care providers.

Health care providers were critical of the decision, claiming that it would cause significant disruption to care.

Kaiser Permanente bypassed the bidding process early last year by negotiating a special contract with California. Most non-profit organizations for community-based health plans also did not have to compete for a contract.

After the state's announcement that it would limit the contracts to three insurers, the insurers that were left out appealed the decision and filed legal action.

Health advocates are concerned that the state's decision to fold to pressure from the insurance companies will affect the competitive contract process in the future. They argued that the competitive process is necessary for accountability.

Zara Marselian, CEO of La Maestra Community Health Centers in San Diego, was in favor of the decision for his organization. La Maestra's clinics serve low-income patients and have worked with Community Health Group for almost 30 years.

Twenty-six percent of its patients rely on Community Health Group for Medi-Cal. Without the agreement, Marselian would have needed to hire more staff to handle a transition to new provider.

“It's really better for the Medi-Cal recipients that will not now have to transfer to another health plan and have their whole continuity of care disrupted,” Marselian said. “I'm really grateful however this happened. I'm really grateful on behalf of our patients.” [FN5]

Texas Musicians Receive Health Insurance Coverage

In Austin Texas, the Central Health Board of Managers voted to increase funding by $1 million to an organization that will help an additional 500 local musicians gain health insurance coverage.

The Health Alliance for Austin Musicians (HAAM) will use the funds to help musicians enroll in coverage through Sendero Health Plans.

Low-income, working musicians in Greater Austin are eligible for the coverage though HAAM. The coverage focuses on prevention and wellness. Musicians in Austin are often self-employed with limited access to health insurance coverage or basic health services.

The deadline for enrolling in the coverage was January 15 for 2023 coverage through HAAM and Central Health.

“Thanks to Central Health's Premium Assistance Program, musicians pay nothing for their monthly health insurance premiums and have extremely limited out-of-pocket expenses,“ HAAM CEO Paul Scott said. “HAAM and Central Health are dedicated to providing affordable healthcare - and improving health outcomes - for musicians and their families.”

“This is just incredible news. We're so grateful to central health for this extra budget allocation because it means we can fund an additional five hundred musicians,” said HAAM's Rachel Blair.

Musicians eligible for the coverage from the additional funds must live in Travis County and have incomes between 100% and 200% of the Federal Poverty level.

Premium subsidies from Central Health average about 221 dollars a month.

'We never want a musician to have to stop playing music because they have to go make more money somewhere else to pay off medical bills. That would be an absolute tragedy,' said HAAM Chief Operating Officer, Rachel Blair. ‘We want to make sure that you're covered if something big happens. So sign up now and make sure that you're protected for the future.’

In 2022, HAAM and Foundation Communities helped almost 1,900 musicians enroll in 2022 insurance plans. The assistance saved musicians over $14 million in health insurance costs for the year.

The average savings on insurance costs per musician was $7,711 per year, or $643 per month. [FN6]

Virginians Saw Largest Decrease in Cost of Health Insurance

Virginia residents saw the largest decrease in the cost of health insurance premiums in the country for the 2022 plan year.

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The cost of plans available through the health insurance marketplace in the state decreased more than the cost of plans in any other state.

The decrease in price was due to the state's decision to begin covering some of the cost of insurers' largest claims to help lower costs overall for health insurance consumers. This reinsurance was funded in part by federal grants.

Virginia made the decision to cover the cost of the most expensive medical care for health insurance companies in 2021. The policy went into effect for the 2022 enrollment period that began November 1.

According to data analyzed by researchers at the Kaiser Family Foundation, Virginia previously had the 20th most expensive average health insurance premiums of all states for marketplace insurance plans. After implementing the reinsurance program, the cost of premiums decreased to the fifth lowest in the country.

An average monthly premium for a 40-year-old resident of Virginia seeking a plan through the health insurance marketplace decreased from $450 per month to $371 per month after the reinsurance policy.

The State Corporation Commission, which regulates the insurance industry in Virginia, reported that insurance companies in the state had planned on increasing rates for health insurance plans in the state by 2% before the implementation of the reinsurance funding program.

The overall reduction of average costs for premiums in Virginia was 17% for plan year 2022. During that same year, plans in other states increased, including in Georgia, where the cost of plans increased by 20%. [FN7]

Delaware Marketplace Insurance Enrollment at Record High

Enrollment in Delaware's Health Insurance Marketplace for 2023 set a record high for 2023 at the close of the open enrollment period.

The state credited increased choice in plans, enhanced federal subsidies, and Delaware's reinsurance program that kept the cost of monthly premiums relatively steady for the record enrollment numbers. Enrollment for open enrollment increased 8% over the enrollment numbers for 2022.

The open enrollment period began November 1, 2022, and ended January 15, 2023. A total of 34,742 Delaware residents enrolled in health insurance through HealthCare.gov, the federal health insurance marketplace. In 2022, open enrollment numbers were slightly lower at 32,113.

“All Delaware families need access to affordable, quality health care,” said Governor John Carney. “This year, we celebrated the 10th year of open enrollment on Delaware's Health Insurance Marketplace with more plans to choose from, helping to make coverage even more affordable. With record-breaking enrollment numbers, we know Delawareans are prioritizing their health. Thank you to all the community navigators and health advocates who helped us reach this milestone.”

“Marketplace plans play a crucial role in improving access to high-quality and affordable health care,” said Department of Health and Social Services Secretary Molly Magarik. “I am thrilled to see a record number of Delawareans taking advantage of the many affordable options offered through Delaware's Health Insurance Marketplace, and we are grateful to the community navigators and application counselors who worked hard during open enrollment to help individuals and families find the plan that was right for them.”

Delaware residents had the choice of three insurers for 2023, an increase from the single insurer available through the marketplace in 2022. They also had a choice of 30 plans, the highest ever in the ten years the marketplace has existed.

In June 2022, Insurance Commissioner Trinidad Navarro announced that AmeriHealth Caritas (four plans) and Aetna CVS Health (nine plans) would join Highmark Blue Cross Blue Shield Delaware (17 plan options) to offer Delaware residents health insurance through the marketplace.

All plans offered though the marketplace must cover pre-existing conditions, outpatient care, emergency services, hospitalization, prescription drugs, mental health and substance use disorder services, lab services, pediatric services, birth control and breastfeeding coverage, and COVID-19 vaccines, including the updated bivalent booster. Insurers cannot terminate coverage because of a change in health status.

“Judging from the final enrollment numbers, it is clear that Delaware consumers appreciate being able to choose from a variety of plans at prices that are affordable,” said Insurance Commissioner Trinidad Navarro. “Affordable, high quality health care is critical to Delaware consumers, and market stability and increased competition are key to helping provide consumer-friendly health insurance options in Delaware.”

The state credited the continued federal approval of Delaware's reinsurance program with the overall stability of the Delaware's Health Insurance Marketplace.

Reinsurance uses federal money and assessments collected by the Delaware Department of Insurance from health insurance carriers to pay insurers for part of the cost of their highest cost claims. The cost of covering health care services is lower for insurers, leading to lower costs of health insurance premiums.

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The recent federal law, the American Rescue Plan Act, temporarily increased tax credits and expanded subsidies for middle class Americans. The Inflation Reduction Act continued the enhanced benefits through 2025. The enhanced subsidies allow a family of four making $50,000 to qualify for a credit of about $16,000. Previously, the same family was eligible for about $14,300.

"Over a decade ago, when crafting the Affordable Care Act, we had one goal in mind: to make affordable, quality health care available to all Americans - and the marketplaces were vital to reaching that goal," said U.S. Senator Tom Carper. "Now, we are seeing enrollment numbers go up year after year, and more Delawareans are able to get preventative screenings at no cost and get access to health care services previously not afforded to them. I thank the hard-working navigators for their work enrolling uninsured Delawareans in plans that work best for their families, and I look forward to continuing our work to drive down health care costs for all Americans."

"Over the past decade, the Affordable Care Act has made affordable, quality health care coverage a reality for millions of Americans," said U.S. Senator Chris Coons. "I'm proud to have worked with President Biden and my colleagues to strengthen the ACA in the American Rescue Plan and Inflation Reduction Act, further driving down costs for families, and am excited to see record numbers of Delawareans benefitting from this landmark legislation this year."

"Ensuring that Delawareans have accessible, affordable, high-quality health care is critical to the health and well-being of communities across the First State," said U.S. Rep. Lisa Blunt Rochester. "I am encouraged to see that this year a record number of Delawareans signed up for health care coverage through Delaware's marketplace. This would not have been possible without the hard work of DHSS, Insurance Commissioner Navarro, and Community Navigators such as Westside Family Healthcare and Quality Insights that were on the ground guiding Delawareans and providing the resources they needed to find plans that fit them and their families best. I am grateful to be a partner in keeping Delaware healthy and remain as committed as ever in advocating for more affordable, accessible, high-quality health care for Delawareans in the 118th Congress." [FN8]

AHA Letter Includes Comments on Health Insurance Proposals

The American Hospital Association (AHA) sent a letter to the Centers for Medicare & Medicaid Services (CMS) commenting on proposed changes relating to health insurance.

The organization supported several proposals, stating, "We commend CMS for proposing steps that would enhance access to care for the individuals and families who rely on the Health Insurance Marketplaces (Marketplaces) for their coverage."

The group supported the following:

- Designating two critical behavioral health provider types as "essential community providers" (ECPs);

- Designating Rural Emergency Hospitals (REHs) as "Other ECP Providers;"

- Providing more opportunities for navigators and other assisters to enroll individuals in coverage, as well as other changes to ease enrollment, especially in the context of the winding down of the COVID-19 public health emergency (PHE);

- Modifying the requirements related to standardized health plans to support consumers' understanding of their coverage while still allowing plans the flexibility to test different benefit structures; and

- Restricting no-network plans on the Marketplaces.

The group strongly supported the designation of Rural Emergency Hospitals (REHs) as "Other ECP Providers." REHs provide critical services to their communities. Many rural communities rely on them as the only source of many higher acuity services. The organization supported finalizing the proposal while also recognizing that REHs may need their own ECP designation at some point.

The organization strongly supports proposals aimed at enrolling new consumers in health insurance coverage and continuing coverage for current enrollees, particularly considering the impending redetermination process for Medicaid and CHIP enrollees.

The group supports allowing navigators and other enrollment assisters to directly contact unsolicited potential consumers, including door-to-door visits. Proposed changes also allow for immediate enrollment, rather than requiring a follow-up appointment.

The organization also supports allowing increased flexibility for Marketplace auto reenrollment policies.

AHA noted, "Again, we believe this policy could prevent inadvertent loss of coverage if the individual or family is confused about the need to reenroll or assumes that they will be auto-reenrolled. We are particularly pleased to see CMS' recognition of provider networks as an important consideration when establishing auto-reenrollment policies."

The AHA supports permitting two years (rather than only one) for enrollees to file and reconcile their advance premium tax credits. This provision is aimed at helping consumers retain their subsidies and preventing unexpected tax burdens because of delayed IRS data or lower health coverage literacy.

The AHA is in favor of allowing earlier start dates of health insurance coverage for individuals and families who have lost minimum essential health coverage and allowing consumers up to 90 days after the loss of Medicaid or CHIP coverage to enroll in marketplace coverage. [FN9]

Virginia Out-of-Pocket Costs Increasing

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According to a new report, while Virginia residents spend less than the national average on health care, their out-of-pocket costs continue to increase.

Researchers from the Altarum Institute, a non-partisan, non-profit research and consulting organization, looked at data from the Centers for Medicare & Medicaid Services (CMS), Virginia's All-Payer Claims Database, and other public sources to study spending on health care. They found that the cost of a single health insurance premium averaged $7,300 the cost of an average family health insurance premium was $21,300 in the private sector employer-sponsored health insurance coverage.

These costs were almost the same as national averages even though Virginia's health care spending is lower than average per capita.

Increases in the cost of health insurance premiums in Virginia have risen from “22.5% and 21.5%, respectively, between 2015 and 2021, while combined premium and deductible totals have increased even faster (31.1% for single coverage and 27.7% for family coverage).”

Researchers found that the cost of single annual premiums have increased 74.3% since 2008. Family premiums have increased 78.9%. Adding together the cost of premiums and deductibles, costs have increased 89.1% for single coverage and 91.3% for family coverage.

The significant increases in the cost of premiums and out-of-pocket costs is “significantly greater than the underlying private per-enrollee health care spending trend, which has risen by 45.7% over the same period.”

During 2020 and 2021, health insurance premiums and cost-sharing expenses continued to increase despite decreases in health care utilization and spending at the beginning of the COVID-19 pandemic.

Researchers found that while health insurance costs trended upward in Virginia, the health spending growth rates in the state averaged 3.8% annually since 2015, which is lower than the national average of 4.7%.

In fact, researchers noted, “health spending per capita in 2021 was over $1,700 lower than the national average in Virginia, with all major spending categories lower than their national comparators.” In 2020, it was $1,400 per person lower than the national average.

Private health insurance is the largest payer for personal health care in Virginia, including both products and services. Spending was an estimated $28.0 billion in 2021. Medicare spent $17.9 billion in the state and Medicaid spent $13.3 billion.

The fastest growing payer in spending and enrollment in Virginia since 2015 has been Medicaid.

The state Gross Domestic Product (GDP) on total health spending in the state decreased to approximately 15.3% in the fourth quarter of 2021, which is the smallest share since 2015. The national average of GDP on health spending is 17.8%.

The difference in GDP represents about $15.8 billion. Even with a decrease in spending on health care in the state, the health care sector continues a significant employer in Virginia, with 370,000 employees in the fourth quarter of 2021. This number represents 11.3% of total private sector employed population. The overall sector employment was lower than the pre-pandemic peak of 381,000 health care workers.

In 2021, unemployment in the Virginia health care industry was 2.1%. [FN10]

NY Aims to Enroll Job Seekers in Health Insurance Plans

NY State of Health, the state's official health plan Marketplace, announced that it will attend job fairs to educate New York residents about enrolling in health insurance coverage.

Certified enrollment assistors will attend the fairs to help new and returning health insurance consumers compare health insurance options. They will assist in accessing federal financial assistance and enrolling in plans.

'Job seekers may be currently unemployed, without health insurance, and unaware of their options. It is our priority to make sure New Yorkers have access to health coverage, no matter where they are in their career search,' NY State of Health Executive Director Danielle Holahan said. ‘Assistors at these job fairs will help new consumers enroll and take advantage of possible financial assistance and prepare current enrollees who may need to renew their coverage this spring.’

New York residents might be eligible to receive enhanced federal subsidies through the Inflation Reduction Act to lower the cost of health insurance premiums. Higher-income consumers might qualify for the subsidies for the first time due to temporary changes under the law.

Over 9 million New York residents enrolled in Medicaid, Child Health Plus (CHP), and the Essential Plan (EP) during the COVID-19 pandemic. They had coverage automatically extended without eligibility reviews during the Public Health Emergency (PHE). Changes from the most recent Congress will require enrollees to complete eligibility reviews to keep their coverage in 2023.

The state will send renewal notices to public program enrollees in the spring. The notices will include the deadline to renew before coverage expires leading to an insurance gap. The deadlines will be based on enrollment end dates for specific enrollees. The end dates vary from June 30, 2023, through May 31, 2024.

Enrollment in a Marketplace plan will remain open through spring of 2024 for consumers who are no longer eligible for Medicaid, Child Health Plus or the Essential Plan.

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The state is encouraging enrollees to verify that their contact information is correct so they do not miss notifications and deadlines. Consumers can also sign up for text message notifications. Enrollment is available in person, by phone, or online. [FN11]

Bill Would Allow for Health Insurance Enrollment on Tax Returns

U.S. Senator Chris Van Hollen (D-Md.) recently reintroduced a bill aimed at simplifying enrollment in health insurance plans by allowing enrollment through federal tax returns.

The Easy Enrollment in Health Care Act is modelled after a program already implemented in Maryland. The legislation would allow consumers to receive health care plan information and enroll in coverage through their federal income tax returns.

“More Americans than ever can access free or low-cost health insurance through the Affordable Care Act, yet millions are still uninsured because of barriers they face in enrollment. Getting covered doesn't need to be this complicated - and that's why I'm introducing this bill to help Americans more easily find the health plans that work best for them by simply checking a box on their federal tax returns. Easy Enrollment is a simple, yet powerful approach that has already been proven in Maryland to boost participation in affordable health care plans, and it's time we make it available nationwide,” said Senator Van Hollen.

Congressman Ami Bera, M.D. (D-Calif.) will reintroduce companion legislation in the U.S. House.

“As a doctor who has cared for our nation's patients, I have seen first-hand how stressful and overwhelming it can be to sign up for health care coverage,” said Representative Ami Bera, M.D., who previously served as Chief Medical Officer for Sacramento County. “That's why I'm introducing the Easy Enrollment in Health Care Act with Senator Van Hollen to help millions of uninsured Americans automatically enroll in affordable health insurance at the same time they file their federal tax returns. It's critical that we cut burdensome red tape to make it easier for Americans to get insured.”

Senator Van Hollen joined Maryland Comptroller Brooke Lierman, Maryland Healthcare for All! Coalition President Vinny DeMarco, Maryland Health Benefit Exchange Executive Director Michele Eberle, and other state and local leaders and advocates at a press conference.

The leaders expressed support for the bill, and encouraged Maryland residents to sign up for coverage through their state tax returns. They pointed to the success of that program, Maryland's Easy Enrollment Program. It began in 2019 and has facilitated the enrollment of over 10,000 residents.

“I am grateful to Senator Van Hollen for championing the Easy Enrollment in Health Care Act, paving the way for the rest of the country to be afforded the same access to healthcare information Maryland residents can obtain when they file their annual state tax returns,” said Maryland Comptroller Brooke Lierman. “These types of tax reforms modernize our system and present a unique opportunity to help millions of uninsured Americans, many of whom may not be aware they are eligible for free coverage or have the time to navigate a complex enrollment system.” [FN12]

Humana to Exit Group Health Insurance Market

Humana Inc. announced recently that it will exit the Employer Group Commercial Medical Products business.

This move will include exiting all fully insured, self-funded and Federal Employee Health Benefit medical plans, as well as associated wellness and rewards programs.

The company indicated that no other Humana health plan offerings would be affected.

It a press release, Humana Inc. indicated, “The company remains committed to the long-term growth of its core Insurance lines of business, including Medicare Advantage, Group Medicare, Medicare Supplement, Medicare Prescription Drug Plans, Medicaid, Military and Specialty (Dental, Vision, Life, etc.), as well as its CenterWell healthcare services business.”

As a reason for exiting the group market, the company cited a strategic review and noted that it decided “that the Employer Group Commercial Medical Products business was no longer positioned to sustainably meet the needs of commercial members over the long term or support the company's long-term strategic plans.”

The company plans to exit from the group market gradually over the next 18 to 24 months. During that time, it will work toward a smooth transition of services for its current beneficiaries and commercial customers.

“This decision enables Humana to focus resources on our greatest opportunities for growth and where we can deliver industry leading value for our members and customers,” said Bruce D. Broussard, Humana's President and Chief Executive Officer. “It is in line with the company's strategy to focus our health plan offerings primarily on Government-funded programs (Medicare, Medicaid and Military) and Specialty businesses, while advancing our leadership position in integrated value-based care and expanding our CenterWell healthcare services capabilities. We are confident in Humana's continued success, and our commitment to improving the health of those we serve is unwavering.”

The company indicated that financial results for Employer Group Commercial Medical Products will be adjusted for non-GAAP purposes for the future. They do not expect the change to impact the company's full year 2023 Adjusted earnings per share (EPS) guidance.

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Due to the change and the seasonality of Employer Group Commercial Medical Products earnings, Humana Inc. predicts that first-quarter earnings for 2023 will represent about 33 percent of full-year 2023 Adjusted EPS.

The company also noted, “Further, due to this seasonality dynamic, the non-GAAP treatment of Employer Group Commercial Medical results is also anticipated to increase the first-quarter 2023 Insurance segment benefit ratio by approximately 30 basis points, with no impact expected on the full-year 2023 Insurance segment benefit ratio.” [FN13]

CMS Awards Contract for Servicing Federal Marketplace

The Centers for Medicare and Medicaid Services has awarded a contract to Serco to continue supporting eligibility determinations for consumers who purchase health insurance plans through the federal marketplace.

The contract will be worth $690 million if the company and CMS exercise all option periods. It will run for four years and seven months with a 1-year base period and four option periods.

The contract is set to begin July 1.

“We are grateful for the trust CMS has placed in us to continue to deliver these vital eligibility services building on the value-based relationship we have formed since commencing these services in 2013,” said Mark Irwin, Serco Group chief executive.

“During this time, we have assisted tens of millions of Americans on their health journey, and as an impact partner to CMS, we are fully committed to continuous improvement in citizen experience and delivering our case management expertise in support of the strategic goals of our customer.”

The company will assist Americans in obtaining health insurance coverage through the federal marketplace set up under the Affordable Care Act. The contract includes supporting operational services, customer support, data analytics and program management.

The company will focus on continuously improving service delivery and program integrity. [FN14]

CMS Fact Sheet: Transition from Public Health Emergency

The Centers for Medicare & Medicaid Services released a fact sheet outlining the unwinding of the federal Public Health Emergency for COVID-19 (PHE).

The PHE is set to expire at the end of the day on May 11, 2023.

According to CMS, “Thanks to the Administration's whole-of-government approach to combatting the virus, we are in a better place in our response than we were three years ago, and we can transition away from an emergency phase.”

The agency noted that there were many changes to healthcare delivery during the PHE due to the emergency declarations, legislative actions by Congress, and regulatory actions across government.

These changes included allowing health care providers maximum flexibility to streamline delivery of care and increase access to health care throughout the PHE. Some of the changes will be extended. Other changes will remain permanently because of Congressional action. However, many waivers and flexibilities will expire.

CMS indicated, “This fact sheet will help you know what to expect at the end of the PHE so that you can continue to feel confident in how you will receive your health care. Please note that this information is not intended to cover every possible scenario.”

The topic covered in the fact sheet include:

COVID-19 vaccines, testing, and treatments;

Telehealth services;

Health Care Access: Continuing flexibilities for health care professionals; and

Inpatient Hospital Care at Home: Expanded hospital capacity by providing inpatient care in a patient's home.

People accessing health insurance coverage through Medicare will continue to receive access to COVID-19 vaccinations without cost sharing after the PHE ends. People with traditional Medicare will continue to receive free COVID-10 PCR and antigen tests if the test is ordered by a physician or other health care provider, including physician assistants and some registered nurses. People with Medicare Advantage plans might have changes to cost-sharing for COVID-19 tests. Access to free over-the-counter tests will end for Medicare beneficiaries, although some Medicare Advantage plans may continue coverage as a supplemental benefit.

Medicare recipients will see no changes to the cost sharing and deductibles for COVID-19 treatments.

Many Medicaid and CHIP enrollees will continue to have coverage for COVID-19 vaccines until the ARPA coverage requirements expire on September 30, 2024. After that date, coverage for testing and treatment will vary by state.

Some states opted to provide Medicaid coverage for COVID-19 vaccines, testing, and treatment to uninsured individuals. That coverage will end with the end of the PHE.

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Most private health insurance will be required to cover COVID-19 vaccines given by in-network health care providers without cost sharing after the end of the PHE. Out-of-network providers might trigger cost sharing.

Mandatory coverage of over-the-counter testing for private insurers will end with the PHE. However, some insurers may choose to continue coverage with or without cost sharing, prior authorization, or other types of medical management.

People with private insurance will be subject to cost sharing and deductibles for the treatment of COVID-19 infection.

Medicaid continuous enrollment will end prior to the ending of the PHE, as it is no longer linked to the PHE. The Consolidated Appropriations Act included a provision that will end the continuous enrollment provision of the Families First Coronavirus Response Act on March 31, 2023.

The temporary Federal Medical Assistance Percentage (FMAP) will be gradually decreased beginning April 1 and will completely end December 31. [FN15]

Judge Rules to Strip Essential Benefits from ACA Plans

A federal judge in Texas ruled that health insurance plans are not required to cover essential benefits, including preventive health care services.

The 2010 Affordable Care Act required health insurance plans to include coverage without copays for preventive care services and other essential benefits, such as pregnancy-related care, cancer screenings, HIV prevention pharmaceuticals and more.

The Biden administration is expected to appeal the case. It is not clear when the decision will affect consumer health insurance plans.

U.S. Senate Majority Leader Chuck Schumer immediately called for a stay and appeal of the ruling. He also asked that insurance providers "publicly commit they will retain free preventive care."

"This ruling is not only misguided, it is outright dangerous and could cost lives," Schumer, a New York Democrat, said in a statement.

New Jersey Democratic Rep. Frank Pallone, ranking member on the U.S. House Energy and Commerce Committee, said in a written statement the judge's decision "imperils access to lifesaving care including mammograms, lung cancer and skin cancer screenings, screenings for pregnant women and newborns, and PrEP."

"It has no basis in the law, will unnecessarily cause confusion, and will put lives at risk if people are forced to forgo routine screenings and treatment," he indicated. "The Department of Justice should immediately move to appeal this reckless decision and have it stayed so that Americans do not lose access to care."

Neither the White House nor the U.S. Justice Department and the Department of Health and Human Services immediately commented on the case, Braidwood Management v. Becerra, or the ruling.

In the ruling, Judge Reed O'Connor, from the U.S. District Court in the Northern District of Texas, asserted that preventive services required by the U.S. Preventive Services Task Force to be covered are unlawful because they violate the Appointments Clause.

This clause requires presidents to nominate people to certain positions, also known as principal officers. The U.S. Senate must then confirm the appointment.

Often, the president, Cabinet secretaries, or others in the executive branch hire "inferior" positions without Senate confirmation.

The plaintiffs in the case, conservative Christian business owners, argued that the preventive care measure mandates are unconstitutional because of a lack of oversight on the process by which the U.S. Preventive Services Task Force makes the recommendations.

Plaintiffs argued that the ACA does not allow the secretary of HHS or other agency leaders to reject recommendations made by the committee. Therefore, the oversight of the committee is insufficient.

O'Connor was nominated to the federal judiciary by former president George W. Bush. He agreed with the plaintiffs in the case.

The plaintiffs brough the case because of they want to purchase health insurance plans that do not cover "PrEP drugs, the HPV vaccine, contraceptives, and screenings and behavioral counseling for STDs and drug use."

Plaintiffs also argued that the employees did not need this coverage. They also argued that the coverage violated their religious beliefs under the Religious Freedom Restoration Act.

PrEP, or pre-exposure prophylaxis, are medications that prevent HIV infection by 99%. All demographics of Americans use the medications; however, they are primarily used by men who have sex with men. According to CDC, the PrEP "played a part in recent decreases in new HIV infections."

The CDC estimates that 1.2 million Americans are eligible for a prescription for PrEP.

O'Connor wrote in the ruling that Braidwood Management Inc. and Kelley Orthodontics, as well as others "need not comply with the preventive care coverage recommendations of the U.S. Preventive Services Task Force issued on or after March 23, 2010, because the members of the Task Force have not been appointed in a manner consistent with Article II's Appointments Clause."

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Many medical groups filed a brief in November asking the court to keep mandatory coverage of preventive services. They included the American Medical Association, The American College of Obstetricians and Gynecologists, the Society for Maternal-Fetal Medicine, the American Academy of Pediatrics, the American Medical Women's Association, the American Academy of Family Physicians, the National Medical Association and the Infectious Diseases Society of America.

"Ultimately, if this Court invalidates the Task Force's recommendations nationwide, physicians and healthcare professionals will be left in an untenable situation," they wrote.

"Amici will struggle to encourage their patients to accept services that they know will save lives and to help their patients navigate a new and confusing insurance situation," they added. "Amici will see many of their patients, including some of their most vulnerable, turn down medically indicated services because of the very financial barriers that Congress sought to remove."

"The past ten years have shown the benefits of no-cost preventive coverage, and amici ask that the Court hesitate before ordering a remedy that could upset that substantial progress," they said.

Preventive care services include domestic violence counseling, postpartum depression counseling, breastfeeding support, and treatment for heart disease.

Cancer screenings include breast, colorectal, ovarian, lung and skin for patients as young as 6 months to 24-year-olds with fair skin.

According to estimates by HHS, almost 152 million people had access to preventive care services because of the law in 2020. That number includes about 58 million women, 57 million men, and 37 million children.

Experts at the Kaiser Family Foundation indicated that the effects of the ruling will likely not be immediate. Health insurance companies typically set plans for a year. The Biden administration will likely request a stay of the ruling and appeal it. If the case if appealed to the U.S. Supreme Court and the justices uphold the judge's ruling, health policy executive vice president Larry Levitt predicts that health insurance companies will likely keep coverage for prevention activities but that consumers will have to pay for some of the cost.

Costs will depend on the type of insurance, the amount of the deductible, and many other factors. [FN16]

Oregon Bill: Universal Health Insurance

An Oregon bill that would create a path for universal health care in the state is pending in the state.

The bill was scheduled for a committee vote in late March.

Labor unions and many members of the public support Democratic lawmakers' efforts toward universal coverage. However, many business groups oppose the plan.

Senate Bill 704 aims to lay the groundwork for universal coverage in Oregon. It would move the planning process to the next level by creating a new nine-member panel, the Universal Health Plan Governance Board. This panel would develop a plan for revamping health insurance in Oregon.

The currently proposed system would cover all residents by a generous statewide government-run comprehensive health insurance plan. Residents would not have to pay premiums, co-pays, office visit fees, deductibles and co-insurance. The system would be funded through federal revenue and a $21 billion annual tax on employers and individuals.

If it succeeds, Oregon would be the first state to offer universal health insurance coverage. Several other states, including Vermont, Colorado, Massachusetts and California, have all explored universal health care, but have not been able to implement a plan due to high cost and political opposition.

A 2019 task force, co-led by state Sen. James Manning, issued a report last fall. In November, voters approved a measure making access to affordable health care a right guaranteed by the Oregon Constitution.

A proposed governance board would have until the fall of 2025 to present lawmakers with a plan for implementing a universal health insurance system. [FN17]

Health Care Providers Work to Help People Maintain Coverage During Reenrollment Campaign

According to the American Hospital Association, health care providers including hospitals and hospital systems are working to help their patients maintain health insurance coverage during the Medicaid reenrollment campaign.

Due to the winding down of the COVID-19 public health emergency and the actions of Republican legislators to end the continuous enrollment policies early, people enrolled in Medicaid and the Children's Health Insurance Program are facing a significant coverage challenge. Beneficiaries must reenroll in the program to maintain coverage even if they remain technically eligible.

For the first time in almost three years, states are permitted to resume normal eligibility redetermination for Medicaid and CHIP beneficiaries. There are currently 90 million people enrolled in these programs.

Five states have already begun reenrollment procedures. Experts predict that up to 18 million people could lose coverage under the redetermination process. Half of those people are expected to be children.

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According to the AHA, it “is fully committed to ensuring all individuals and families are enrolled in health care coverage. We have been actively working with the Centers for Medicare & Medicaid Services, member hospitals and health systems, state, regional and metropolitan hospital associations, and other stakeholders to prepare for the Medicaid/CHIP redetermination process.”

The AHA indicated that it will share resources to help patients retain coverage. The tools include:

AHA Advocacy Checklist - This toolkit contains a checklist for engaging with Medicaid managed care plans to support the renewal process, partnering with community stakeholders to reach enrollees, and advocating for state policies to automate the eligibility redetermination process by leveraging data from other state and federal resources.

CMS Medicaid PHE Unwinding Resources - With AHA's input, the agency has developed extensive resources for state Medicaid agencies and community stakeholders.

Connecting to Coverage Coalition - AHA is a member of the Connecting to Coverage Coalition, which brings together more than 20 national organizations of providers, insurers, employers, and consumer and patient advocates to share information, best practices and solutions to ensure access to and enrollment in coverage for millions of individuals, including parents and children.

AHA indicated that many hospitals and health systems are working with state governments to help individuals and families retain coverage.

Healthcare providers are communicating directly with patients covered under Medicaid to help them reapply for coverage. They are also making information and resources available online and during appointments. They are creating education and training resources for staff such as community health workers and financial counselors.

The AHA emphasized the importance of health insurance coverage: “Coverage is central to achieving the goal of eliminating disparities and addressing health equity - a strategic priority for the AHA - by ensuring that individuals have access to comprehensive coverage. Studies confirm that coverage improves access to care; supports positive health outcomes, including an individual's sense of their own health and well-being; incentivizes appropriate use of health care resources; and reduces financial strain on individuals, families and communities.”

The organization pointed to the additional stress on health care providers and communities as well as the entire health care system that additional uninsured patients will create. The AHA noted that hospitals and health systems are already battling “unprecedented challenges”-workforce shortages, significant increases in costs, and underpayment by Medicare and Medicaid, to name a few.

The organization pledged, “The AHA will continue to work with all stakeholders to ensure that those who qualify for Medicaid/CHIP continue to receive coverage and those whose eligibility is no longer valid have affordable, accessible and comprehensive coverage options.” [FN18]

Redetermination Commences in Texas

The Texas Health and Human Services Commission announced that it is resuming eligibility redeterminations for Medicaid recipients.

About 5.9 million people in the state receive health insurance coverage under Medicaid.

The federal requirement for continuous enrollment in Medicaid ended March 31. Under federal guidance, states must conduct a renewal determination for all Medicaid recipients over the next 12 months.

HHSC indicated that it would most likely complete the redetermination process by May 2024.

Under HHSC estimates, the enrollment in Medicaid is expected to return to levels aligned with historic trends in the state within the next two years.

“We urge Medicaid recipients to update their information and to be on the lookout for renewal notices,” said HHS Executive Commissioner Cecile Erwin Young. “We are committed to redetermining eligibility for our clients as quickly as possible and to continue services to those who still qualify.”

HHSC expects an increase in workload for the agency. It responded by increasing its eligibility workforce using recruitment and retention efforts. It also hired temporary staff to assist with the workload. It also implemented merit pay and salary adjustments and promoted flexible work schedules and streamlined training requirements.

The agency has added 1,000 eligibility staff to its employees since April 2022.

The agency reminded Medicaid recipients to respond to renewal packets or requests for information in a timely manner. Responding appropriately will prevent potential gaps in coverage from the redetermination process.

The agency also encouraged recipients to update and verify that contact information is correct. Beneficiaries can access this information through the internet at Your Texas Benefits. Recipients must respond to renewal packets or requests for information within 30 days to maintain their current coverage.

The agency will then complete a redetermination to confirm continued eligibility for Medicaid benefits.

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Medicaid beneficiaries will receive notification of the end of the continuous coverage requirement through several methods. At the time renewal is necessary, HHSC will send out mail or electronic notifications. Mail notifications will be in yellow envelopes with the words “Action Required” in red.

HHSC will perform the Medicaid redeterminations over multiple months. They will prioritize redeterminations for people who are most likely to no longer qualify for Medicaid.

Beneficiaries with Your Texas Benefits accounts who opted to go paperless will receive notices electronically.

The agency will also utilize advertising methods such as social media posts, online banner messages, flyers, emails, and text messages to inform recipients that they must renew their benefits. HHSC provided outreach tools to partner organizations and ambassadors to facilitate educating the public about reenrollment.

The agency has encouraged recipients to sign up for online accounts and log into those accounts at YourTexasbenefits.com. They can opt-in to electronic notices through their online account or the Your Texas Benefits mobile app. Recipients can also view their account details, which will indicate if it is time to renew.

HHSC is also beginning to evaluate continued eligibility for other HHSC health care programs, including the Children's Health Insurance Program or Healthy Texas Women.

HHSC will notify recipients if they are determined to be ineligible for Medicaid and are moved to a different health care program. Recipients who no longer qualify for medical coverage through HHSC will have their applications automatically forwarded to the federal Health Insurance Marketplace. [FN19]

HHS Proposes Expanding Health Insurance Access to DACA Recipients

The Department of Health and Human Services (HHS), through the Centers for Medicare & Medicaid Services (CMS), released a proposal that would expand access to healthcare for

Deferred Action for Childhood Arrivals (DACA) recipients.

The notice of proposed rulemaking (NPRM) will expand access if finalized. HHS announced its intention to release the proposal earlier in April 2023.

The proposed change will affect the Health Insurance Marketplaces, the Basic Health Program, and some Medicaid and Children's Health Insurance Programs (CHIP).

“DACA recipients, like all Dreamers, are Americans, plain and simple. The United States is their home, and they should enjoy the same access to health care as their fellow Americans,” said HHS Secretary Xavier Becerra. “Every day, nearly 580,000 DACA recipients wake up and serve their communities, often working in essential roles and making tremendous contributions to our country. They deserve access to health care, which will provide them with peace of mind and security.”

“Young people who come to this country-in many cases, the only country they have ever known as home-work hard to build their lives here, and they should be able to keep themselves healthy,“ said CMS Administrator Chiquita Brooks-LaSure. “The Biden-Harris Administration is committed to ensuring affordable, quality health care for all, and to providing DACA recipients the opportunities and support they need to succeed.“

If finalized, the proposed rule would eliminate the exclusion that prevents DACA recipients from being eligible for health insurance under certain CMS programs.

Finalization of the rule in the proposal form could result in as many as 129,000 uninsured DACA recipients becoming covered by health insurance plans or programs. Over 800,000 people have received protection and work authorization through DACA over the last ten years.

Under the proposed rule, the definition of “lawfully present” would include DACA recipients for Medicaid and CHIP eligibility. Children and pregnant women in states that elected the “CHIPRA 214” option for children and/or pregnant individuals, the Basic Health Program, and Affordable Care Act Marketplace coverage would be eligible for Medicaid and CHIP coverage. DACA recipients would need to meet all other eligibility requirements to qualify for coverage under those programs.

The rule change would also open eligibility for financial assistance to DACA recipients purchasing health insurance through the Marketplace. They would become eligible for advance payments of the premium tax credit and cost-sharing reductions if they meet eligibility requirements.

Upon finalization of the rule as proposed, DACA recipients would receive a special enrollment period of 60 days to select and enroll in a qualified health plan through the Marketplace.

The NPRM has a proposed effective date for all provisions of November 1, 2023. The public can comment on proposed regulations. CMS requests comments, particularly about the feasibility of the effective date. [FN20]

Illinois Bill Would Provide Access to Health Insurance for Injured Emergency Workers

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Illinois State Senator Karina Villa moved a bill out of the Senate Labor Committee that would provide access to health insurance for emergency workers injured on the job.

Firefighters, police officers and probation officers injured while working would receive health insurance coverage through their employers.

“Law enforcement and firefighters risk their health for the safety of our communities every day,” said Villa (D-West Chicago). “This legislation will protect those who are gravely injured on the job by making sure their employers cover their health insurance.”

The legislation, House Bill 3249, would require public employers to pay the full premium of a health insurance plan for a current employee, their spouse or their dependents if the employee is a full-time law enforcement officer, correctional or correctional probation officer or firefighter who has suffered a catastrophic injury. It would also apply to the families of emergency workers killed in the line of duty.

Currently, under the Public Safety Employee Benefits Act, employers are only required to pay for a basic plan. Eligible individuals are not given a choice of health insurance plans if injured on the job.

The pending legislation would change requirements so that employers must cover the health insurance plans that an employee chooses in addition to the most basic plan.

“When the unthinkable happens while on the job, we need to make sure these firefighters, police officers and their families are taken care of, just as they take care of us,” Villa said.

House Bill 3249 passed the Senate Labor Committee. The Senate will take up the bill for further consideration. [FN21]

Analysis Predicts Millions to Lose Health Insurance from Medicaid Disenrollment

According to a new analysis by Kaiser Family Foundation, between 8 and 24 million people in the United States could lose health insurance coverage under Medicaid due to the unwinding of the continuous enrollment provision that was put in place at the start of the COVID-19 pandemic.

Researchers made estimates based on data collected through a recent KFF survey of state Medicaid and CHIP officials. The survey was conducted with the Georgetown University Center for Children and Families.

The survey collected data relating to states' eligibility and enrollment policies, and states' approaches to reenrollment policies. States were prevented from disenrolling people from Medicaid due to the pandemic public health crisis. Due to an act of Congress, those protections are now gone.

Researchers asked how many people states estimate will lose health insurance coverage under Medicaid in the months after the continuous enrollment protections ended in March 2023.

The midpoint estimate for states responding to the survey showed that 18 percent of Medicaid beneficiaries would be disenrolled. That rate translates into a loss of coverage for approximately 17 million people throughout the United States. Five million children and 12 million adults would lose coverage.

Researchers presented three scenarios for how Medicaid enrollment could decline at the state level between March 2023 and May 2024. Estimates range from 8 percent to 28 percent of total enrollees. This number represents plus or minus 10 percentage points from the midpoint.

Researchers found that states had similar projections of loss of coverage.

The range nationally is expected to be neither the lowest nor the highest of the expected rates of disenrollment. However, the range helps to illustrate potential variations across the states.

Researchers' findings were consistent with HHS estimates that up to 15 million people will be disenrolled from Medicaid in the next year. Of those disenrolled, 6.8 million will likely still be eligible for the program.

According to the KFF analysis, “The unwinding of the continuous enrollment provision will play out differently across the states based on policy choices states have made and variation in their administrative infrastructures. Some states have adopted multiple policies that are more likely to promote continued coverage among those who remain eligible. Other states have adopted fewer of these policies, which will likely lead to a larger number of people losing Medicaid coverage, including some who remain eligible.”

Another recent KFF analysis showed that eight states meet at least eight of the nine key metrics supporting continued Medicaid coverage for eligible beneficiaries. Seven states meet three or four of those metrics. Some of the metrics include taking 12-14 months to complete al renewals, following up with enrollees who fail to respond to a renewal request prior to terminating coverage, and completing 50 percent or more of renewals with an automated process.

It is uncertain how many of the 17 million children and adults who are likely to become disenrolled from Medicaid will remain uninsured. According to a recent KFF analysis, almost two-thirds of people became uninsured for a period after being disenrolled from Medicaid or CHIP.

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Researchers pointed to two recent analyses, “How Many People Might Lose Medicaid When States Unwind Continuous Enrollment?” and “State Policy Choices Are Likely to Affect the Extent of Medicaid Enrollment Declines During the Unwinding Period.” [FN22]

HHS Outlines Health Care Changes with End of COVID-19 Public Health Emergency

The Department of Health and Human Services (HHS) released a fact sheet outlining changes to health care that will result from the ending of the federal COVID-19 Public Health Emergency (PHE).

The PHE, which was declared under Section 319 of the Public Health Service (PHS) Act, expired on May 11, 2023.

HHS indicated that it has been working closely with partners such as Governors, state, local, Tribal, and territorial agencies, industry, and advocates, to facilitate a transition from the PHE.

The fact sheet includes flexibilities enabled by the COVID-19 emergency declaration and how the end of the PHE will affect those flexibilities.

According to HHS, “Still, we know so many people continue to be affected by COVID-19, particularly seniors, people who are immunocompromised, and people with disabilities. That is why our response to the spread of SARS-CoV-2, the virus that causes COVID-19, remains a public health priority. To ensure an orderly transition, we have been working for months so that we can continue to meet the needs of those affected by COVID-19.”

HHS asserted its commitment to keeping access to vaccines, tests, and treatment, “Even beyond the end of the COVID-19 PHE, we will continue to work to protect Americans from the virus and its worst impacts by supporting access to COVID-19 vaccines, treatments, and tests, including for people without health insurance. We will continue to advance research into new, innovative vaccines and treatments through an investment of $5 billion in Project NextGen, a dedicated program to accelerate and streamline the rapid development of the next generation of vaccines and treatments, including investments in research, development, and manufacturing capacity and advancing critical science. And we are continuing to invest in efforts to better understand and address Long COVID and to help mitigate the impacts.”

The end of the COVID-19 PHE will not completely end the Administration's response to the pandemic. Some flexibilities and actions will remain after May 11.

The COVID-19 vaccine and some treatments, including Paxlovid and Lagevrio, will be somewhat affected, despite efforts from HHS to remain “committed to maximizing continued access to COVID-19 vaccines and treatments.”

After May 11, Americans eligible to receive the COVID-19 vaccine will receive it at no cost until the federal government stops purchasing and distributing the COVID-19 vaccines according to the requirements of the CDC COVID-19 Vaccination Program Provider Agreement.

HHS indicated, “Once the federal government is no longer purchasing or distributing COVID-19 vaccines and treatments, payment, coverage, and access may change. In order to prepare for that transition, partners across the U.S. Government (USG) are planning for and have been developing plans to ensure a smooth transition for the provision of COVID-19 vaccines and certain treatments as part of the traditional health care market, which will occur in the coming months.”

After the access to the COVID-19 vaccine transitions to the traditional health care market, nearly all individuals will continue to receive the vaccine with no out-of-pocket costs, depending on health insurance status.

HHS also asserted that it “will continue to ensure that effective COVID-19 treatments, such as Paxlovid, are widely accessible.”

Under the “HHS Bridge Access Program For COVID-19 Vaccines and Treatments” (“Bridge” Program), uninsured Americans will receive access to vaccines and treatments. Most types of private health insurance plans will cover COVID-19 vaccines recommended by the Advisory Committee on Immunization Practices (ACIP) as a preventive health service without co-pay when provided by an in-network provider.

COVID-19 vaccinations will continue to be covered under Medicare Part B without cost sharing. Medicare Advantage plans will cover COVID-19 vaccinations in-network without cost sharing.

Medicaid will continue to cover COVID-19 vaccinations without a co-pay or cost sharing through September 30, 2024. Medicaid will generally cover ACIP-recommended vaccines for most beneficiaries after that date.

People with private traditional health insurance plans will most likely have to pay out-of-pocket expenses for treatments for COVID-19, including Paxlovid and Lagevrio after those treatments transition to the traditional health care market.

Under Medicaid, COVID-19 treatments will be covered without cost sharing through September 30, 2024, when coverage and cost for beneficiaries will vary depending on the state.

FDA's ability to authorize various products, including tests, treatments, or vaccines for emergency use will not be affected by the end of the COVID-19 PHE.

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Telehealth flexibilities under Medicare will not be immediately and significantly affected by the end of the PHE. People with Medicare, especially people living in rural areas or other people who struggle to access care, will still be able to access telehealth through December 2024.

States have been granted significant flexibility and waivers to allow for coverage of Medicaid services delivered through telehealth. This flexibility was in place prior to the COVID-19 PHE and will remain after it ends.

HHS indicated, “Our whole-of-government response to Long COVID will not change. The Department has and will continue to coordinate a whole-of-government response to the longer-term effects of COVID-19, including Long COVID and associated conditions.”

COVID-19 PHE flexibilities and policies that will expire after May 11:

Certain Medicare and Medicaid waivers and broad flexibilities for health care providers;

Coverage for COVID-19 testing will no longer be available for over-the-counter tests (PCR testing will be available with cost sharing under traditional insurance if ordered by a physician);

Certain COVID-19 data reporting and surveillance will be significantly reduced. [FN23]

Study: Health Coverage Stability Increased During COVID-19 Pandemic

According to a recent study, the stability of coverage through Medicaid increased during the first year of the COVID-19 pandemic.

Researchers noted, “The COVID-19 pandemic had the potential to alter patterns of health insurance coverage in the US. Using data from the Medical Expenditure Panel Survey, we found increased stability of Medicaid coverage for children and nonelderly adults during the first year of the pandemic. Fewer people who had Medicaid in 2019 became uninsured in 2020 (4.3 percent) than in 2018-19 (7.8 percent).”

In 2020, the COVID-19 pandemic and recession threatened to significantly disrupt health insurance coverage. The two-month period from February to April 2020 had a surging unemployment rate from 3.5 percent to 14.7 percent.

People with insurance coverage through employers were at risk of becoming uninsured because of the extensive layoffs and business closures as well as some employers ending health insurance benefits.

The Families First Coronavirus Response Act of 2020 increased federal funding to states if they did not disenroll Medicaid beneficiaries, regardless of changes in eligibility. Enrollees becoming ineligible for coverage under the program in 2020 may have retained coverage, potentially increasing the number of people continuously enrolled in Medicaid.

Researchers compared data from 2018-2019. It showed that people who had Medicaid in 2019 were more likely to keep the coverage and less likely to become uninsured the following year.

Researchers looked at data from prior periods showing that enrollment in employer-sponsored health insurance fluctuates with economic downturns. Medicaid traditionally partially offsets insurance losses during those times.

According to the results of the study, “Compared with the 2018-19 period, when 14.4 percent of people with Medicaid lost that coverage, only 10.7 percent of people who had Medicaid in 2019 lost that coverage in 2020. The higher proportion of people retaining Medicaid was a result of fewer people becoming uninsured in the second year (7.8 percent during 2018-19 compared with 4.3 percent during 2019-20.” [FN24]

CBO Releases Health Care Projections

The Congressional Budget Office (CBO) released updated projections for health insurance coverage for people under age 65.

The data was published in the journal Health Affairs. CBO's analysis showed the agency's May 2023 baseline projections for health insurance. Researchers used the CBO's health insurance simulation model, HISIM2. The agency updates the model annually to include the most recent data, recent legislation, and other policy changes.

The model also includes CBO's demographic and economic forecasts. Data comes from estimates under the HISIM2 and estimates from the staff of the Joint Committee on Taxation (JCT), and from CBO's Medicaid and Medicare models.

Health Affairs organized a press briefing where CBO's analysts presented an overview of projections. The agency presented updated baseline tables of federal subsidies for health insurance plans.

According to CBO, the share of people under age 65 who lack health insurance coverage is at an all-time low. Enrollment in Medicaid and enrollment in health insurance plans available through the marketplace reached the highest levels ever in 2023. The agency credited temporary policies that were put in place due to the COVID-19 pandemic with the increase in Medicaid and marketplace enrollment.

Only 8.3 percent of people under age 65 are uninsured, a number that CBO calls “unprecedented.” From 2019 to 2022, Medicaid enrollment increased from 60.5 million to 76.6 million. In 2023, 28.1 percent of the population in the United States was covered by Medicaid. About 5.2 percent of the population had subsidized plans through the health insurance marketplace.

Employment-based health insurance covered over half of the population at 57.3 percent.

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The demographic segment of the population with the largest gains in health insurance coverage was low-income people. That segment also saw the largest decrease in the share of people lacking health insurance coverage. The share of people lacking health insurance who had incomes below 150 percent of the federal poverty level decreased from 17 percent in 2019 to 10 percent in 2023.

According to CBO, "In the latest updates to its microsimulation model, CBO has expanded its capacity for distributional analyses by race and ethnicity. Many factors drive variation in coverage by race and ethnicity, but employment, income, and immigration status are especially important. By CBO's estimates, the share of the Hispanic population that is uninsured, at around 15 percent, is the highest among the shares for the groups examined."

CBO predicted that the share of uninsured people will increase over the next year and a half. There will most likely be significant declines in enrollment in Medicaid due to the end of continuous enrollment that was put in place early in the COVID-19 pandemic.

The enhanced federal subsidies for health insurance purchased through the state and federal marketplaces are set to expire in 2025. After that expiration, 4.9 fewer people are expected to enroll in health insurance through the marketplace. Those people are expected to either enroll in unsubsidized nongroup or employment-based coverage or become uninsured.

The share of people who are uninsured is projected to increase to 10.1 percent by 2033.

CBO also projected growth in private health insurance premiums, particularly in the near term. The agency noted, "Private health insurance premiums are an important component of the agency's coverage projections. CBO estimates higher short-term growth rates for premiums (6.5 percent in 2023 and an average of 5.9 percent in 2024 and 2025), partly reflecting a bouncing back of medical spending from the suppressed levels of utilization early in the pandemic. Then, CBO projects lower growth rates (an average of 5.7 percent during 2026 and 2027 and of 4.6 percent over the 2028-2033 period)."

CBO also projected the direction of federal subsidies for health insurance coverage for people under age 65. According to projections from CBO and JCT, net federal subsidies in 2023 for insured people under age 65 are $1 trillion. IN 2033, the amount is expected to reach $1.6 trillion per year or 4 percent of gross domestic product.

For the 2024-2033 period, federal subsidies are expected to reach $12.5 trillion total. Employment-based coverage will account for 40 percent; Medicaid and the Children's Health Insurance Program, 39 percent; Medicare, 13 percent; and subsidies for coverage obtained through the marketplaces or the Basic Health Program, 8 percent.

CBO announced that it will publish a report in the fall that will expand the analysis of health insurance. The report will include estimates of health insurance coverage and federal subsidies for people living throughout the United States and its territories. [FN25]

Legislation Introduced to Advance Medicare for All

U.S. Representatives Pramila Jayapal (WA-07), Debbie Dingell (MI-06) and U.S. Senator Bernie Sanders (I-VT) introduced legislation that would expand access to health insurance coverage under Medicare.

The House legislation is cosponsored by over half of the Democratic Caucus, including 13 committee ranking members.

"We live in a country where millions of people ration lifesaving medication or skip necessary trips to the doctor because of cost," said Jayapal. "Sadly, the number of people struggling to afford care continues to skyrocket as millions of people lose their current health insurance as pandemic-era programs end. Breaking a bone or getting sick shouldn't be a reason that people in the richest country in the world go broke. There is a solution to this health crisis - a popular one that guarantees health care to every person as a human right and finally puts people over profits and care over corporations. That solution is Medicare for All - everyone in, nobody out. I'm so proud to fight for this legislation to finally ensure that all people can get the care they need and the care they deserve."

"Every American has the right to health care, period. If you're sick, you should be able to go to the doctor without being worried about the cost of treatment or prescription medicine. The United States is the only industrialized nation in the world that doesn't guarantee all its citizens access to health care," said Dingell. "The COVID-19 pandemic didn't create the flaws in our health care system, but it brought to light many of the shortcomings that have caused unnecessary and preventable hardship for countless American families for decades. We've been fighting this fight since the 1940s, when my father-in-law helped author the first universal health care bill. It's time to get this done."

"The American people understand, as I do, that health care is a human right, not a privilege," said Sanders, Chairman of the Senate Health, Education, Labor, and Pensions Committee. "It is not acceptable to me, nor to the American people, that over 85 million people today are either uninsured or underinsured. As we speak, there are millions of people who would like to go to a doctor but cannot afford to do so. That is an outrage. In America, your health and your longevity should not be dependent on your bank account or your stock portfolio. After all the lives that we lost to this terrible pandemic, it is clearer now, perhaps more than it has ever been before that we must act to end the international embarrassment of the United States being the only major country on earth to not guarantee health care to all."

The legislation would expand Medicare access to every person in the United States. It would provide comprehensive health care benefits including primary care, vision, dental, prescription drugs, mental health, substance abuse, long-term services and supports, reproductive health care, and more.

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The bill would also include universal coverage of long-term care with no cost-sharing for older Americans and people with disabilities. It would prioritize home and community-based care over institutional care.

Beneficiaries would have the freedom to choose their doctors, hospitals, and other health care providers without limitations of a network for coverage. The legislation would streamline the health care system by allowing for the negotiation of medication prices. It also aims to reduce administrative waste.

The legislation is significant in a time when 85 million people in the United States are either uninsured or underinsured. Many people who have health insurance coverage cannot afford health care due to high costs of deductibles and other cost-sharing.

As protections put in place early in the COVID-19 pandemic have ended, an additional 15 million people are projected to lose health insurance coverage this year.

“Over the last few years, we have asked our members around the country to fill out a healthcare cost calculator to figure out how much they are already paying for healthcare,” said Carl Rosen, General President, United Electrical, Radio & Machine Workers of America (UE). “Not surprisingly, it turns out that a large majority of them are spending at least 15 to 25 percent of their income on healthcare costs, between premium shares, co-pays and deductibles. Medicare for All, under virtually any scenario, would save these members large sums of money. Furthermore, taking health care off of the bargaining table will allow all of our members to make much-needed improvements in wages and working conditions, and to catch up with the inflation that has seen the cost of basic necessities skyrocket over the past year.”

“Everyone should have health care when they need it. Sadly, our health care system allows greedy private health insurance companies to put profits over people,” said Sulma Arias, Director, People's Action. “These companies waste billions on executive pay while denying their members the care they need. We applaud Congresswomen Jayapal and Dingell and Senator Sanders for rejecting the corporate takeover of our health system and offering a vision in which health care is a human right. We won't stop organizing until we turn it into a reality.” [FN26]

HHS Offers Flexibilities to Minimize Coverage Losses

United States Department of Health and Human Services (HHS) Secretary Becerra wrote a letter to the nation's governors announcing new flexibilities from HHS aimed at minimizing avoidable health insurance coverage losses for children and families.

The effort supports the Biden-Harris Administration's commitment to expanding access to high-quality, affordable health care coverage. The flexibilities will help Americans keep health insurance coverage as states resume the renewal process for Medicaid and the Children's Health Insurance Program (CHIP).

Secretary Becerra urged all states to adopt the flexibilities to minimize avoidable coverage losses for children and families.

“Nobody who is eligible for Medicaid or the Children's Health Insurance Program should lose coverage simply because they changed addresses, didn't receive a form, or didn't have enough information about the renewal process,' said HHS Secretary Xavier Becerra. “We encourage states to utilize all available flexibilities to ensure children and families don't lose coverage. We also urge states to join us in partnering with local governments, community organizations, and schools to reach people eligible for Medicaid and CHIP where they are.”

“CMS is committed to making sure people have the affordable, high-quality health coverage they need,” said CMS Administrator Chiquita Brooks-LaSure. “I am deeply concerned about eligible losing coverage, and am urging states and partners to adopt the strategies we have outlined to help people renew their Medicaid and Children's Health Insurance Plan coverage if they are eligible or link them to new health coverage. We will continue to monitor and work collaboratively with states, advocates, the health care industry and others to keep people covered.”

HHS added to existing flexibilities. The changes include:

Allowing managed care plans to assist people with Medicaid with completing their renewal forms, including completing certain parts of the renewal forms on their behalf.

Allowing states to delay an administrative termination for one month while the state conducts additional targeted outreach. This will give people more time to be reminded to fill out and return their renewal forms.

Allowing pharmacies and community-based organizations to facilitate reinstatement of coverage for those who were recently disenrolled for procedural reasons based on presumptive eligibility criteria.

The number and type of flexibilities that states have adopted varies.

In the letter, Secretary Becerra emphasized the particular concern that children who remain eligible for Medicaid or CHIP are at risk of losing coverage. He encouraged states to work to prevent this loss by partnering with local governments, community-based organizations, schools, faith-based organizations and leaders, grocery stores, pharmacies, and other community members.

He noted the importance of educating people about the Medicaid and CHIP eligibility and renewal process, pointing to an example of a school district that began sending eligibility and renewal information home with students and hosting outreach events for the local community.

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The agency noted, “HHS, through the Centers for Medicare & Medicaid Services (CMS), has worked extensively with state Medicaid agencies to provide guidance on federal requirements, develop strategies to make Medicaid and CHIP renewals easier for people, and troubleshoot operational issues. This has included partnering with health plans, health care providers, federally-qualified health centers, home visiting programs, early childhood providers, advocates, and civil rights, faith-based, health industry, employers, and other community-organizations.” [FN27]

House Passes Bill Increasing Health Insurance Options for Employers

House Republicans passed a bill that would increase options for employers, allowing tax advantages for reimbursing employees who purchase their own health insurance.

The Custom Health Option and Individual Care Expenses Arrangement Act, or CHOICE Arrangement Act, would write into law the health reimbursement arrangements established by the Trump administration in 2019.

The legislation would permit employers to reimburse their employees for individual health insurance plans as well as provide tax-advantaged funds for qualified medical expenses. The bill is aimed at providing tax cuts to employers for health insurance costs other than employer-provided health plans, which are already tax-privileged.

“Washington should not stand in the way of workers getting the healthcare coverage that's best for them and their families. Just as important, workers should be able to take their insurance plan with them if they leave their current job,” said Chairman of the House Ways and Means Committee Jason Smith (R-MO).

“This bill gives small businesses the opportunity, if they so choose, to shed the administrative burden of managing traditional insurance coverage. At the same time, it gives workers more options for their own health care and makes that coverage portable,” said Smith.

Democrats opposed the bill, noting that it would bring back Trump-era rules that would undermine the Affordable Care Act (ACA).

“This is all Trump, Trump, Trump,” said Rep. Lloyd Doggett (D-TX), calling it “death by a thousand cuts” to Obamacare.

The legislation includes a provision drafted by Rep. Claudia Tenney (R-NY) that mandates that the Treasury Department clearly inform employers of the various tax advantages and programs related to healthcare benefits for employees.

“Small employers want to provide these benefits to their employees to not only retain them but to ensure they have a high quality of life,” said Tenney, who owns a small printing business in upstate New York. “It is time that we increase awareness of these programs and address any obstacles to their successful and effective implementation.”

H.R. 3799 also includes provisions that shield self-insurance, stop-loss insurance, and association health plans.

Rep. Robert Scott (D-VA) criticized the legislation as a “recycled futile attempt to circumvent the Affordable Care Act.”

Scott and Doggett warned that the bill would open the door for employers to discriminate against employees with pre-existing health conditions. They also expressed concern that the bill would allow employers to force employees into purchasing “junk” health insurance plans that offer limited coverage.

Small businesses have long held the cost of employee health insurance coverage as a top concern, as noted by the National Federation of Independent Businesses.

Approximately 39% of businesses that have up to nine employees offer health insurance benefits. Eighty-nine percent of businesses with 30 or more employees offer health insurance. Ninety-four percent of small businesses report that they have difficulty offering employer-sponsored health insurance.

Small businesses have consistently reported for 40 years that the cost of providing health insurance to their employees is their top concern, according to the National Federation of Independent Businesses. [FN28]

Friday Health Plans Placed into Receivership

North Carolina Insurance Commissioner Mike Causey announced that Friday Health Plans of North Carolina Inc. (FHP-NC) consented to being placed into receivership.

The decision was an effort to protect North Carolina policyholders as the company reported its insolvency and inability to raise additional funds from outside investors.

Policyholders with health insurance plans from the company through the federal health insurance exchange will receive coverage through August 31. The policyholders will then have a special enrollment period to obtain alternative health insurance coverage from another insurer on the exchange.

The special enrollment period will begin on July 2 and end on Oct. 30. In order to avoid a coverage gap, consumers must choose an alternative health insurance plan by August 31, 2023. [FN29]

Minnesota Extends Deadline for Medicaid Reenrollment

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Minnesota extended the deadline for renewing Medical Assistance, the state's Medicaid program, for 35,500 people who had overdue renewal paperwork for coverage continuing July 1.

The state urged residents to send in completed renewal paperwork and required documentation as soon as possible to prevent gaps in coverage.

Minnesota is working alongside the federal government to help prevent people who are eligible from losing coverage under Medical Assistance because of reenrollment issues like failing to receive renewal forms through the mail.

“We don't want anyone to lose their health insurance,” said Minnesota Human Services Commissioner Jodi Harpstead. “Our goal is for every eligible Minnesotan to keep their Medical Assistance.”

The federal government offered to extend the July 1 deadline to August 1. The first group of families and children renewing Medical Assistance coverage since the pause in reenrollment requirements implemented due to the COVID-19 pandemic will be eligible for the deadline extension.

The Minnesota Department of Human Services will use the extra time to attempt to locate people with overdue paperwork.

The August extension allowed eligible Minnesota residents to remain covered through Medical Assistance during the Independence Day weekend. According to the Department, “Having insurance makes it easier to get health care and supports the health and well-being of people and their families and communities.”

Minnesota residents who were already determined to be ineligible for Medical Assistance coverage will still lose the coverage July 1. Some of those residents qualify for coverage through MinnesotaCare. The state's health insurance marketplace, MNsure, is available to other residents. [FN30]

Survey: Consumers Experience Issues Using Health Insurance

A recent Kaiser Family Foundation Survey showed that most (58%) people with health insurance had at least one issue using their coverage in the past year.

Researchers found that an even larger share of people with the highest health care needs had issues using health insurance coverage.

Issues included denies claims for care consumers thought was covered, problems with finding in-network health care providers, and delays and denials of care for prior authorization.

At least half of health insurance beneficiaries from each major type of health insurance coverage experienced issues. They included beneficiaries of employer, Medicaid, the Affordable Care Act's marketplace, and Medicare coverage.

People with more need of health care services experienced more issues:

Two-thirds (67%) of consumers who rate their own health as “fair” or “poor” encountered a problem in the past year.

About three-quarters (74%) of those who received mental health treatment in the past year reported a problem.

More than three-quarters (78%) of those who received a lot of health care (more than 10 provider visits in the past year) reported a problem.

“The survey shows that the sheer complexity of insurance is as big a problem as affordability, particularly for those with the greatest needs,” KFF President and CEO Drew Altman said. “People report an obstacle course of claims denials, limited in-network providers, and a labyrinth of red tape, with many saying it prevented them from getting needed care.”

The survey included data from a nationally representative sample of 3,605 people with health insurance coverage from private, employer, and government-subsidized sources. Researchers plan on exploring this issue further, with a focus on people with different types of coverage and people with chronic conditions.

Researchers found variations in the issues beneficiaries encountered, particularly with different types of insurance coverage. People with employer and marketplace coverage experienced more denied claims than people with Medicare or Medicaid.

Medicaid beneficiaries and people with marketplace coverage more frequently encountered issues finding in-network healthcare providers.

The issues with insurance coverage led to increased costs for 28% of people who indicated they experienced problems with insurance coverage when seeking care. One third of people with marketplace or employer coverage who reported issues experienced increased costs as a result of the issues.

About half of the people who reported insurance problems indicated that the issue was eventually resolved. About half said that the problem either remained unresolved or was resolved unsatisfactorily.

Sixty percent of insured adults did not know that they have a right to appeal an insurance coverage decision by law. Over three quarters of those surveyed did not know which government agency could offer assistance.

The issues with insurance coverage led to an inability to receive recommended care (17%) or a significant delay in medical care (17%). Approximately 15% of people with insurance issues experienced a decline in health.

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Researchers found that over half (51%) of adults with insurance coverage did not understand at least one feature of their health insurance plans. Over a third did not know what their insurance covered. Thirty percent did not know what they would owe for out-of-pocket costs. Another 30% did not understand what their benefits statement meant.

Twenty-five percent of respondents found terms like "deductible" and "copay" confusing. A similar number of people found it difficult to find if healthcare providers were in-network for their coverage.

A particularly vulnerable group, according to researchers, was people with mental health challenges. People rating their mental health as fair or poor, including one in five people with health insurance, and one in three people with Medicaid coverage, rated the availability of mental health care providers at fair or poor (45%). They also rated the quality of those providers (37%) as fair or poor.

Forty-three percent of those people also indicated that there was a time during the past year when they were unable to obtain needed mental health services. Fifty-five percent of people under age 30 who had fair or poor mental health did not receive needed mental health services.

Various factors were barriers to mental health care. Insurance issues were a factor for over four in 10 who indicated that they could not afford the cost of care. Over one third indicated that their insurance would not cover the cost of mental health services.

Of all insured people, sixteen percent indicated that they experienced difficulty in paying for medical care in the past year. The rate was similar for all types of insurance coverage, employer, marketplace, Medicaid, and Medicare.

Survey respondents also cited the cost of premiums as an issue, especially beneficiaries of employer and marketplace plans. Half of people with employer coverage or marketplace coverage rated the affordability as low when considering the cost of premiums and the out-of-pocket costs.

A much lower number of people with Medicare or Medicaid rated affordability of premiums and out-of-pocket costs poorly.

Although many survey respondents had a number of issues with their insurance coverage, overall, a majority (81%) rated their coverage excellent or good.

According to researchers, "Large majorities of consumers with insurance say they would support requirements on insurers that could make it easier to avoid or resolve insurance problems. These include requirements to maintain accurate and up-to-date information about who is in their network (91%) and to provide simpler, easier-to read statements explaining coverage decisions and how to appeal if you disagree (94%), all of which have been enacted by Congress though not all have been implemented."

The study, the KFF Survey of Consumers Experiences with Health Insurance, was conducted from February 21-March 14, 2023, online and by telephone. Researchers sampled 3,605 adults in the U.S. with health insurance coverage, including 978 adults with employer-sponsored insurance, 815 adults with Medicaid coverage, 885 adults with Medicare, and 880 adults with marketplace insurance. [FN31]

Senator Calls for Coverage of Over-the-Counter Birth Control Pills

Senator Maggie Hassan (D-NH) expressed support for the Food and Drug Administration (FDA) approval of the first birth control pill available over the counter without a prescription.

She also called for insurance companies to fully cover the cost of the pills without fees or out-of-pocket costs for consumers.

"Expanding access to birth control is a key way to protect a woman's fundamental freedom and stand up to the attacks on women's reproductive rights that we've seen in New Hampshire and across the country," said Senator Hassan. "Allowing birth control to be sold over the counter will make it easier for women across the country to access contraception, and I urge insurance companies to fully cover this important form of reproductive health care."

Senator Hassan and colleagues introduced a bill last May that would require health insurance companies to fully cover over-the-counter birth control without any fees or out-of-pocket costs. She also called on the Biden administration to improve enforcement of the federal law that guarantees complete coverage of birth control medication for Affordable Care Act (ACA) health insurance plans.

Senator Hassan questioned insurance companies about reports of illegal delay and denial of coverage of birth control. [FN32]

Colorado to Liquidate Friday Health Plans, Consumers to Lose Coverage

The Colorado Division of Insurance recently announced that it will liquidate Friday Health Plans, leading to a loss of health insurance coverage for consumers on August 31, 2023.

Four other states have already liquidated Friday Health Plans.

Some advocates raised concerns that health care providers would stop seeing patients who have Friday Health Plans coverage prior to the closing of the company.

Approximately 30,000 Colorado residents are enrolled in Friday Health Plans. They will lose health insurance coverage sooner than expected. They will need to find another health insurance plan by the end of August.

Some health insurance consumers will also face having to restart paying deductibles and out-of-pocket maximums for the year.

Most Colorado residents who have Friday HMO coverage purchased their plans in the individual market.

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According to the insurance division, it requested the court to place Friday into liquidation with a plan termination date of August 31, 2023.

“Diving deeper into Friday's finances after putting the company into rehabilitation, the Division became concerned about its ability to make it through the rest of the year,” Commissioner of Insurance Michael Conway said. “As a result, I am taking this step to protect Coloradans and the people enrolled in Friday, and to protect the open enrollment process for 2024.”

Conway noted that he is ‘disappointed that some health care providers are refusing to see Friday members and provide treatment.’

He indicated, “It's especially concerning because of the Division's efforts to make sure Friday Health became a member of the Colorado Guaranty Association in order to, in part, protect providers.”

In late June, the agency placed Friday Plans of Colorado into rehabilitation, a type of receivership. The hope was that the company would be able to continue operating through the end of the 2023 plan year.

Enrollment in Friday plans in Colorado was halted in May. Gov. Jared Polis signed legislation that would give providers and consumers in HMOs, including Friday, protection up to a statutory cap of $500,000 per insured member.

The agency reviewed the financial projections of the company and came away with “significant concerns” about the accuracy of the projections. After the company was placed into rehabilitation, the projections worsened. The parent company decided to shut down operations on July 6 without winding down the business, increasing costs for the affiliate in the state.

“Friday's problems are national - the company's aggressive growth in other states around the country got ahead of their financing,” the division said last June.

The liquidation decision sparked action under HB 1303 that requires the Colorado Insurance Guaranty Association to pay claims from health care providers for services to Friday beneficiaries, under the terms of the company's contracts.

The association will cover up to the statutory limit, $500,000 for claims for each person covered by Friday.

Health insurance consumers with Friday plans will receive a special enrollment period through October 31 to choose a plan from another company. Enrollees prior to August 31 will have new health insurance coverage beginning September 1.

People who enroll after the end of August will receive coverage beginning the following month.

The division recommended that small businesses enrolled in Friday's group plans contact their insurance brokers about choosing a new plan for employees from another insurance company.

The division asked other Colorado insurance companies to honor the deductibles and out-of-pocket maximums that Friday customers have already paid this year.

Kaiser Permanente has agreed to that request. Eighty-five percent of Friday customers have access to a Kaiser Permanente plan.

Denver Health has not decided whether to honor the deductibles, while Anthem, Cigna, and Rocky Mountain Health Plans announced that they would not honor the deductibles.

Texas, Georgia, Oklahoma and North Carolina have decided to liquidate their Friday Health plan affiliates.

According to Saskia Young, executive director of the Colorado Association of Health Plans, “Carriers are working hard to create a seamless transition for Friday members to new health insurance plans so that their care is not interrupted.”

“We do, however, remain concerned about the long-term impacts to the Colorado health insurance market for consumers and the ability of carriers to meet premium reduction targets given this unfortunate occurrence,” Young said. “We appreciate the work of the Division of Insurance to navigate the situation and continue to reiterate the importance of ensuring that premium rates for 2024 are adequate given this latest upheaval in Colorado's insurance market.”

Three other companies announced in the last year that they would leave the Colorado market: Bright Health, Humana and Oscar Health. The four companies had approximately 219,000 Colorado customers. [FN33]

Connecticut Offers Health Insurance to Striking Employees

Connecticut Governor Ned Lamont signed an amendment to the Connecticut General Statutes that creates a special enrollment period in state health insurance programs for employees whose health care coverage is terminated due to a labor dispute.

The amendment had wide support of the legislature, with no representatives or senate members voting against it.

It will allow employees engaged in labor disputes to enroll in health insurance coverage through Access Health CT, the health insurance exchange in the state.

Prior to the amendment, employees who lost health insurance coverage due to participating in a strike did not have access to state health insurance programs. The change will give these employees a special enrollment period that was not provided under the federal regulations for the Affordable Care Act (ACA).

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Union advocates supported legislation that would force employers to allow striking employees to retain employer-provided health insurance coverage. Advocates on the state and national levels continue to push for that change. [FN34]

Uninsured Rate Fell to All-Time Low

The U.S. Department of Health and Human Services (HHS) released a new report showing that the national uninsured rate reached an all-time low in 2023.

The rate of uninsured people in the United States reached 7.7 percent early in 2023. Approximately 6.3 million people have gained health insurance coverage since 2020.

The Biden-Harris Administration credited the success of the open enrollment period which included a record-breaking 15 million enrollments through the federal and state ACA health insurance marketplaces.

Efforts from the federal government have turned to keeping people insured as Medicaid coverage renewals begin for the first time in three years. The renewal requirements were paused due to the COVID-19 pandemic.

The Administration has called on states and other stakeholders to help prevent loss of coverage.

“The Inflation Reduction Act has played a critical role in helping more Americans afford coverage through the Affordable Care Act. And this year, the nation's uninsured rate reached an all-time low, even breaking last year's record,' said HHS Secretary Xavier Becerra. ‘HHS will continue to do everything we can to help Americans keep or get coverage and have access to quality, affordable health care.”

The report includes data from the National Health Interview Survey and American Community Survey, showing that the Biden-Harris Administration's efforts to increase access to health care and lower costs has had a significant impact.

The Administration credited President Biden's American Rescue Plan's enhanced Affordable Care Act (ACA) subsidies and the Inflation Reduction Act's extension of the subsidies. Other important factors include the continuous enrollment of Medicaid, several recent expansions of Medicaid to additional states, and the enrollment outreach efforts of the federal government from 2021-2023.

HHS's Office of the Assistant Secretary for Planning and Evaluation (ASPE) published the report, which noted the following:

The nation's uninsured rate declined significantly in early 2023, relative to 2020, reaching an all-time low of 7.7 percent for U.S. residents of all ages in the first quarter (January-March) of 2023, based on new data from the National Health Interview Survey.

Approximately 6.3 million people - including 5.5 million adults ages 18-64 and 0.7 million children ages 0-17 - have gained health coverage since 2020. These gains in health insurance coverage are concurrent with the implementation of the American Rescue Plan's enhanced Marketplace subsidies, the Inflation Reduction Act's continuation of those subsidies, the continuous enrollment condition in Medicaid, recent state Medicaid expansions, and substantial Marketplace enrollment outreach by the Biden-Harris Administration in 2021-2023.

Uninsured rates among adults ages 18-64 declined from 14.5 percent in late 2020 to 11.0 percent in early 2023. The uninsured rate among children ages 0-17, which had increased during 2019 and 2020, fell from 6.4 percent in late 2020 to 4.2 percent in early 2023.

Approximately 5.8 percent of adults ages 18-64 reported having Marketplace coverage in early 2023 compared to 4.4 percent in 2020.

Changes in uninsured rates from 2020 to 2023 were largest among individuals with incomes below 100% of the Federal Poverty Level (FPL) and incomes between 200% and 400% FPL. These gains follow record breaking sign-ups for health coverage in the ACA Marketplaces during the 2022/2023 Open Enrollment Period, with the increased Marketplace enrollment contributing to the substantial growth of private coverage.

There were significant gains in health insurance coverage continually in 2021, 2022, and early 2023. The Administration credited policies to support health insurance expansion.

HHS noted, “These gains build on the large reductions in the uninsured rate that occurred after the implementation of the ACA in 2014, which research demonstrates produced improved health outcomes, access to care, and financial security for families.”

Changes in the uninsured rate are expected to continue throughout the year, with the first quarter traditionally marking the lowest uninsured rate while people transition to new coverage and lose coverage during the year. Additionally, the ending of the Medicaid continuous coverage condition is expected to affect the uninsured rate as people lose coverage due to re-enrollment requirements.

The Administration is focused on reducing the effect of Medicaid enrollment requirements: “The Biden-Harris Administration is taking a whole-of-government approach to ensure that those who are eligible for Medicaid remain covered by the program, and those who are not transition to other forms of coverage through HealthCare.gov, their employer, or other options. The Administration wants to make sure people stay covered whether that's through Medicaid, Medicare, the Marketplace, or employer-sponsored coverage.” [FN35]

Proposed Rule Aimed at Increasing Access to Mental Health Care

The Biden-Harris Administration announced a proposed regulation aimed at improving parity for access to mental health care.

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The 2008 Mental Health Parity and Addiction Equity Act (MHPAEA) marked the bipartisan priority of making access to mental health care equal to access to physical health care under health insurance coverage. These efforts were strengthened in 2020 on a bipartisan basis.

The Biden-Harris Administration pointed to a need to further improve access to mental health care: “Yet today, too many Americans still struggle to find and afford the care they need. Of the 21% of adults who had any mental illness in 2020, less than half received mental health care; fewer than one in ten with a substance use disorder received treatment. Research shows that people with private health coverage have a hard time finding a mental health provider in their health plan's network.”

The Administration pointed to issues with in-network coverage of mental health services. People in need of mental health care often face months-long waiting lists or find that in-network therapists are not accepting new clients.

The Administration stated that insurers too often make it difficult for beneficiaries to access mental health care services, forcing them to seek care out-of-network at significantly higher costs, either paying out of pocket or failing to find care at all.

According to one study, insured people are more than twice as likely to need to seek mental health care services out-of-network than they are for physical health care services.

This issue has been getting worse, as the gap between the use of out-of-network care for mental health and substance use disorders versus physical health care needs has increased by 85 percent.

The Administration noted, “President Biden believes mental health is health. As part of his Unity Agenda, he released a comprehensive national strategy to transform how mental health is understood, accessed, treated, and integrated in and out of health care settings. That's why, today, the President is announcing new actions that would improve and strengthen mental health parity requirements and ensure that more than 150 million Americans with private health insurance can better access mental health benefits under their insurance plan.”

The proposed rule will reinforce the goal of increasing access to mental health and substance use benefits to equal that of physical health care benefits. The rule aims to improve access to in-network mental health care and eliminate barriers to access that prevent people from receiving mental health care.

The rule would require health plans to provide adequate access to mental health care. The 2020 changes that Congress made to MHPAEA require health plans to perform comparative analyses that will help to ensure access to mental health and substance use benefits at the same availability of access to physical health services.

The proposed rule would require health plans to evaluate the outcomes of their coverage rules to ensure that people have access to mental health benefits. Insurers will have to evaluate the actual provider network, the level of payments for out-of-network providers, and how often prior authorization is required, as well as the rate that prior authorization is denied.

The evaluations are meant to show where plans are failing to meet requirements under the law. Insurers will need to make changes like including more mental health professionals in their networks.

The rule will clarify what health plans can and cannot do regarding mental health coverage. It will provide specific examples for health plans to follow to improve access to mental health services. [FN36]

HHS Helps Nearly 500,000 Regain Medicaid

The U.S. Department of Health and Human Services (HHS) announced that it helped nearly half a million children and families regain Medicaid and Children's Health Insurance (CHIP) coverage.

The Centers for Medicare & Medicaid Services (CMS) issued a call to action to states on August 30 to address potential state systems issues that resulted in inappropriate disenrollment of children and other enrollees in Medicaid and CHIP. The enrollees remained eligible for the programs.

CMS acted swiftly, helping almost 500,000 children and other enrollees to regain coverage. Many more people are expected to receive protection from improper disenrollments in the future.

On August 30, CMS sent a letter to all states, the District of Columbia, Puerto Rico, and the U.S. Virgin Islands requiring them to address potentially malfunctioning enrollment systems. The systems were inappropriately disenrolling children and families even when the state had proper enrollment information for eligibility requirements for Medicaid and CHIP.

At least 30 states to date had this systems issue. CMS required all 30 states to pause disenrollments for procedural issues of impacted people until they could ensure that all eligible people would not be disenrolled.

“Thanks to swift action by HHS, nearly half a million individuals, including children, will have their coverage reinstated, and many more will be protected going forward. HHS is committed to making sure people have access to affordable, quality health insurance - whether that's through Medicare, Medicaid, the Marketplace, or their employer,” said HHS Secretary Xavier Becerra. “We will continue to work with states for as long as needed to help prevent anyone eligible for Medicaid or CHIP coverage from being disenrolled.”

“Medicaid and CHIP are essential for millions of people and families across the country,” said CMS Administrator Chiquita Brooks-LaSure. “Addressing this issue with auto-renewals is a critical step to help eligible people keep their Medicaid and CHIP coverage

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during the renewals process, especially children. CMS will keep doing everything in our power to help people have the health coverage they need and deserve."

The August 30 letter notified the 30 states to potential eligibility systems issues related to automatic renewals for both Medicaid and CHIP. Auto-renewals, or "ex parte" renewals, are a powerful tool that states use to help eligible people retain enrollment in Medicaid and CHIP during the renewal process.

Under federal rules, states are required to use information already available to them through existing data sources such as state wage data to determine the eligibility of people for these healthcare programs. Auto renewals help people to renew their Medicaid and CHIP coverage more easily.

Auto-renewals also help ensure that eligible people do not lose coverage due to procedural error.

CMS is continuing to provide technical assistance to states for these system issues.

According to the agency, "Throughout the renewals process, CMS has offered states many strategies to assist them in making it easier for people to renew their coverage. Nearly all states have adopted at least some of these strategies, and CMS continues to urge states to adopt these strategies. Additionally, to help make transitions from Medicaid to other health coverage options more accessible in every state, CMS has launched national marketing campaigns and made available Special Enrollment Periods through HealthCare.gov, State-based Marketplaces, and Medicare. CMS' top priority remains making sure everyone has access to affordable, quality health coverage." [FN37]

Kansas Governor Rallies Support for Medicaid Expansion

Kansas Governor Laura Kelly launched an effort to rally support for Medicaid expansion, a top priority for the upcoming legislative session.

Medicaid expansion was first made available to states under the Affordable Care Act to allow more low-income people to become eligible for the program.

The "Healthy Workers, Healthy Economy" tour will bring Kelly statewide, travelling to share the benefits of expanding access to Medicaid, including reducing costs for Kansas residents, preserving and strengthening rural health care, and making Kansas more competitive economically.

Kelly has long supported the expansion of Medicaid in Kansas. This statewide tour to garner support for the expansion will be a first for the governor. She wishes to encourage the 78% of Kansas residents who support the expansion to pressure state legislators to bring the issue to a vote early next year.

"Expanding Medicaid and ensuring that every Kansan has access to affordable, high-quality health care is the smartest, sanest way to keep our state moving forward," Governor Laura Kelly said. "When the legislature reconvenes in January, I will propose Medicaid expansion for the sixth time so Kansas can achieve a healthier workforce and a healthier economy. I encourage every Kansan to call their legislator and tell them to demand that legislative leadership give them a chance to vote for Medicaid expansion."

Kansas has chosen not to expand Medicaid up to this point. Since the state had the option, seven rural hospitals in the state have closed. Sixty out of the remaining 104 rural hospitals are at risk of permanent closure, which is a higher percentage of at-risk rural hospitals than in any other state.

Kelly emphasized the risk to rural hospitals by starting the tour at Willam Newton Hospital in Winfield, a small rural hospital that would benefit from Medicaid expansion.

William Newton Hospital CEO Brian Barta joined her.

"Kansas is one of ten states that continues to lag behind the rest of our country to expand Medicaid and address healthcare inequity for many hardworking Kansans. We greatly appreciate Governor Kelly's persistence and dedication to move Kansas toward passing commonsense legislation to utilize federal funding that will cover 90% of the cost to expand Medicaid," said Brian Barta, CEO of William Newton Hospital. "It is estimated that Medicaid expansion will help over 150,000 Kansans and continued failure by the state legislature to support Medicaid expansion undermines the physical, emotional, and economic health for all of Kansas."

According to census data nearly 140,000 Kansas residents work but lack health insurance coverage. Kelly emphasized this point by introducing Chandra Dickson, a Kansas resident whose mother passed away in 2016 when she worked waitressing and several jobs, making slightly too much to qualify for KanCare, the Kansas Medicaid program.

She lacked health insurance coverage and delayed treatment for cancer, ultimately leading to her death. She would have been covered under Medicaid expansion if the state had chosen to expand eligibility.

"Watching my mother be unable to access health care and then ultimately die because of lack of access to lifesaving treatment was one of the most painful experiences of my life. It wasn't fair to her or my family," Chandra Dickson said. "I want to see Medicaid Expansion in Kansas because everyone should have access to health care no matter their life circumstances or ability to pay. Expanding Medicaid is the right thing to do for the state and its citizens."

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Estimates show a positive impact of Medicaid expansion on the Kansas economy. It would create approximately 23,000 new jobs. It would also likely create a healthier workforce.

A small business owner, Alex Gottlob, also joined Kelly to advocate for Medicaid expansion in Kansas.

Gottlob has several employees who fall into the current coverage gap for KanCare.

"As an employer of both full time and seasonal employees, my wife and I see first-hand the challenges related to health care that our employees face and how it oftentimes affects their performance at work," said Alex Gottlob, Owner of Gottlob Lawn & Landscape. "Insurance costs grow more and more out of reach for small companies such as ours. Medicaid Expansion would not only benefit individuals but has the ability to bridge the gap when small businesses are not able to provide insurance."

Under Medicaid expansion, the federal government would fund 90% of the cost to expand Medicaid in the state. Kansas would be required to provide 10% of the funds to match federal funding.

By not expanding Medicaid, the state has left over $6.5 billion in federal funding on the table for the years in which it could have chosen to the expansion.

The state has missed out on nearly $80 million already this year alone in federal funding by refusing to agree to expand Medicaid. [FN38]

HHS Request Comments on Access to Over-the-Counter Treatments

The Departments of Health and Human Services, Labor, and the Treasury (the Departments) announced that they are seeking public comment on coverage and access to over-the-counter (OTC) preventive services.

The change would require most health insurance plans to cover the services at no cost and without a prescription by a health care provider.

The new Request for Information (RFI) asks for comments on access to several OTC items for preventive care recommended by experts. The medication could be purchased without a prescription. Treatments include contraceptives, tobacco smoking cessation products, folic acid during pregnancy, and breastfeeding supplies.

The Affordable Care Act requires most plans and issuers to cover certain recommended preventive items and services at no cost. Currently, some of the recommended preventive items and services are available to consumers OTC without a prescription but can be subject to cost sharing unless a health care provider prescribes the item.

The RFI aims to address the potential challenges and benefits of interested parties, such as consumers, plans, issuers, pharmacies, and healthcare providers.

The OTC preventive products would be available without cost sharing without a prescription.

The Departments have an interest in ensuring universal access to affordable and critical preventive items and services, such as OTC preventive products.

"All Americans deserve access to quality health care. We know that making preventive care available over the counter can improve access - but there may still be cost barriers. That's why we are working with the Department of Labor and Department of the Treasury to better understand how a policy change that could further increase access to affordable, preventive care might affect consumers, pharmacies, and health insurance providers," said HHS Secretary Xavier Becerra. "I hope everyone who might be impacted will submit their comments and help us advance equity in access to high-quality preventive care like contraception and tobacco cessation."

"The Centers for Medicare & Medicaid Services (CMS) remains steadfast in its commitment to advancing health equity. Easing financial barriers to preventive health care items, without a prescription, is one way to help achieve this goal," said CMS Administrator Chiquita Brooks-LaSure. "Public input on this change to current policy is vital, and we look forward to hearing from consumers, plans, issuers, and providers about its potential impact."

In addition, "The Biden-Harris Administration is committed to ensuring access to health care and addressing health equity across its programs. Having access to affordable, evidence-based preventive items and services is key to promoting the health and well-being of all people. Issuing this RFI is consistent with President Biden's executive orders on Strengthening Access to Affordable, High-Quality Contraception and Family Planning Services (June 23, 2023), Strengthening Medicaid and the Affordable Care Act (January 28, 2021), and Continuing To Strengthen Americans' Access to Affordable, Quality Health Coverage (April 25, 2022)."

With the RFI, the Departments hope to receive comments that expand their understanding of the effect of coverage for OTC preventive products on health equity. Other related issues include systemic racism and historic inequity for women and LGBTQIA communities.

The comment period will be open for 60 days. The comments must be received 60 days after the date of publication in the Federal Register. [FN39]

Rural Americans at Higher Risk of Losing Health Insurance

According to experts, people living in rural areas of the United States are at greater risk of losing health insurance coverage during the unwinding of COVID-era Medicaid enrollment protections.

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Katie Charleson, communications officer for Nevada's state health marketplace, noted that it has traditionally been challenging reaching rural Americans. Some are concerned that limited resources for outreach will decrease access to health insurance for rural Americans during the Medicaid unwinding process.

Data from the Centers for Medicare & Medicaid Services shows that 72% of people who lost Medicaid coverage during the unwinding process started earlier in the year were disenrolled for procedural reasons, not because officials determined that they were ineligible for the program.

In August, federal officials required state Medicaid departments to pause some procedural disenrollments and reinstate coverage for eligible enrollees who had lost coverage.

The procedural disenrollments could affect rural people more, experts noted.

Researchers from the Georgetown University Center for Children and Families indicated that rural Medicaid recipients faced additional barriers to coverage renewal. Barriers such as longer distances to offices to reapply for coverage and less access to fast and reliable internet connections.

Medicaid and the Children's Health Insurance Program (CHIP) covered 47% of children and 18% of adults throughout the rural areas of the United States. In metropolitan areas, coverage by those programs is about 40% of children and 15% of adults.

“As is clear from our research, rural communities rely on Medicaid to form the backbone of their health care system for children and families,” said Joan Alker, who is one of the brief's co-authors, the executive director of the Center for Children and Families, and a research professor at Georgetown's McCourt School of Public Policy. “So if states bungle unwinding, this is going to impact rural communities, which are already struggling to keep enough providers around and keep their hospitals.”

Rural people lack access to navigators to help enrollees keep Medicaid coverage or find alternative health insurance coverage. This lack could make it more difficult for rural people to access health insurance.

Navigators assist people with determining eligibility for Medicaid and CHIP, and enrolling in ACA marketplace plans.

In Nevada, Navigators operate apart from over 200 call center staffers assisting residents with social service benefits.

The federal government requires Navigators to provide services at no cost to consumers and to provide unbiased guidance. In that way, they are unlike insurance broker agents, who earn commissions on some health plans.

Navigators are the only free service guiding consumers through obtaining health insurance coverage. They also provide education about health plan coverage, such as preventive care services.

In Nevada, about 30 to 40 certified enrollment counselors work at navigator organizations to help consumers enroll in plans through Nevad Health Link, the state health insurance marketplace. One group works in the small capital city of Carson City which has less than 60,000 residents.

The rest of the Nevada Navigators work in the urban centers of Reno and Las Vegas.

The availability of Navigators varies in each state.

For example, Montana, geographically larger than Nevada, has only a third of the population. Six Navigators serve the entire state. They assist people over the phone and in person traveling throughout the vast state.

Alker noted that the Medicaid unwinding has made it even more important that people have assistance with the complex process of obtaining and maintaining health insurance coverage.

A recent survey showed that consumers encounter significant difficulties in obtaining coverage when independently searching for health coverage via Google.

“The results are really concerning,” said survey co-author JoAnn Volk, a research professor and the founder and co-director of the Georgetown University Center on Health Insurance Reforms.

Medicaid enrollees searching for private health plans encountered aggressive misleading marketing for limited-benefit plans that do not cover important health care services and lack protections from high healthcare costs.

Over half of the sales representatives pushed the limited-benefit products and made false and misleading statements about the plans and lied about the availability or affordability of plans through the marketplace. [FN40]

CMS Releases Medicaid Unwinding Data

The Centers for Medicare and Medicaid (CMS) recently released a new batch of state-reported Medicaid unwinding data. The data release is through the Unwinding and Returning to Regular Operations after COVID-19 landing page.

The batch includes data from June and preliminary data for July. The data release includes new information about national and state-specific metrics for Medicaid and CHIP eligibility renewal outcomes as well as total enrollment numbers.

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CMS released more comprehensive data regarding Marketplace enrollment and coverage transitions. It included cumulative enrollment data between April and June from HealthCare.gov, State-Based Marketplaces (SBMs), and the Basic Health Programs. It also included separate CHIP enrollment data for April 2023.

CMS intends to release data about Medicaid unwinding monthly until all data is reported through June 2024.

The key findings from the data batch include the following.

Of the 6.6 million redeterminations in June, 51% of enrollees, or about 3.3 million individuals, received approval for renewals. About one-fourth of enrollees, or 1.6 million individuals, were terminated from Medicaid or CHIP. Approximately 24%, or 1.5 million individuals, had redetermination pending.

The following states held terminations of coverage for procedural reasons for June (such as failure to return paperwork): Arkansas, the District of Columbia, Delaware, Iowa, Illinois, Kansas, Kentucky, Maine, Michigan, Minnesota, Missouri, New Jersey, New York, Oklahoma, South Carolina, West Virginia and Wyoming.

Also, Oregon and Texas did not complete renewals for the paperwork due in June.

Idaho had the highest rate of procedural disenrollment with 67% or about 18,000 individuals. North Carolina had the highest rate of ex parte renewal at 74% or approximately 102,000 individuals.

HealthCare.gov data in the batch release revealed that over 267,000 individuals were transferred to HealthCare.gov after their Medicaid or CHIP coverage was terminated in April. About 22%, or 59,000 individuals, of those people were determined to be eligible for Qualified Health Plan (QHP) coverage. About 51,000 of those people were eligible for advance premium tax credits (APTCs). Of the people eligible for the tax credits, 46,000 enrolled in a QHP.

According to CMS, the cumulative number of individuals who had previous Medicaid or CHIP enrollment was over 436,000 between April and June. About 77% (337,000 individuals) were eligible for APTC and 67% (approximately 291,000 individuals) enrolled in Marketplace coverage.

In SBM states, over 593,000 individuals who were beneficiaries of Medicaid or CHIP submitted applications for Marketplace coverage between April and June. Almost 70% of them, or 415,000 individuals, were QHP-eligible. Only 11% of those people, or 63,000 people, enrolled in a QHP. Ten percent of the total applicants, or 60,000 individuals, were eligible for BHPs. About 56,000 of those people enrolled.

In April, over two million individuals were enrolled in a separate CHIP in April.

According to State Health & Value Strategies, a nonprofit program at Princeton University supported by the Robert Wood Johnson Foundation, "CMS' expanded data set, which will continue to be released until June 2024, provides helpful feedback for states and continues to indicate areas where course correction and technical assistance support may be necessary. It remains to be seen whether CMS will re-issue compliance letters based on states' May data. However, CMS is expected to issue an interim final rule; which may codify into regulation new penalties that Congress has authorized during the unwinding period for states that fail to comply with federal reporting and renewal requirements in the Consolidated Appropriations Act, 2023." [FN41]

Cost of Employer-Sponsored Coverage Increases

According to the 2023 benchmark Kaiser Family Foundation (KFF) Employer Health Benefits Survey, annual family premiums for employer-sponsored health insurance increased an average of 7% to $23,968.

This increase is a significant difference from last year, which had virtually no growth in premiums.

Workers contributed an average of $6,575 per year toward the cost of family health insurance premiums. The cost increased almost $500 from 2022. Employers covered the rest of the cost of the health insurance premiums.

With potential future increases in the cost of premiums, 23% of employers indicated that they will increase employee contributions to the cost of health care in the next two years.

People working for firms with fewer than 200 employees contributed an average of almost $2,500 more toward family premiums than workers at larger firms. The average cost of family coverage was $8,334 vs. $5,889.

About 25% of covered workers at small businesses paid at least $12,000 per year for health insurance premiums for family plans.

The 7% increase in average premiums was slightly higher than the yearly increase in workers' wages at 5.2%, and inflation at 5.8%.

Over the past five years, the cost of premiums increased by 22%. Wages increased by 27% and inflation rose 21%.

Workers facing an annual deductible for single coverage had an average deductible of $1,735, similar to last year. The average deductible amount increased 10% over the last five years. It increased 53% over the last ten years.

Workers at small businesses faced significantly larger deductibles than workers at larger firms: $2,434 vs. $1,478.

Employers perceived the burden of cost-sharing on their employees. Over half of employers (58%) indicated that their employees have at least a moderate level of concern about the affordability of the cost-sharing requirements of their plan.

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“Rising employer health care premiums have resumed their nasty ways, a reminder that while the nation has made great progress expanding coverage, people continue to struggle with medical bills, and overall the nation has no strategy on health costs,” KFF President and CEO Drew Altman said.

Nearly 153 million people in the United States access health insurance through employer-sponsored plans. Researchers conducted the 25th annual survey of over 2,100 small and large employers to collect data about costs and coverage.

Relating to coverage of abortion by employer-sponsored plans and considering the Supreme Court's decision that ended the federal constitutional right to abortion, states have adopted new laws prohibiting or restricting access to abortion. These laws created challenges for employers with workers in multiple states.

One in ten of all large firms indicated that their largest health insurance plan does not cover legal abortions under any circumstances. An additional 18% of employers indicated that their plans cover legal abortions under limited circumstances.

However, almost one third (32%) of large employers cover legal abortions in most or all circumstances. Forty percent of large employers were unsure of the coverage of abortion in their employee health insurance plans.

Seven percent of large employers said they would provide financial assistance for travel expenses for employees who had to travel out of state for a legal abortion. About 19% of very large employers (5,000 employees or more) provide travel reimbursements to employees seeking legal abortions.

Large employers also reported on adequacy of healthcare provider networks. Most (88%) employers indicated that their plan had adequate networks of primary care physicians for employees. However, only 59% reported the same for mental healthcare providers, and only 58% reported adequate access to substance use treatment.

Almost one in five large firms said they took steps to address the lack of adequate mental health providers in their plan's largest network. Of the largest employers with 5,000 employees or more, 44% took this action.

However, at the same time, one in five large employers indicated that their plan limits the number of covered mental health services, leading to restrictions on access to care for employees with long-term mental healthcare needs.

“For several years now, the survey has shown that many large employers do not believe that their networks have enough mental health providers to provide timely access to care. In 2023, many large employers, including nearly half of the largest employers, say that they are taking steps to better meet enrollees' needs,” said Gary Claxton, a KFF senior vice president and director of the Health Care Marketplace Project, the lead author of the study. [FN42]

No Surprises Act Proposed Rule

The Biden-Harris Administration (the Administration), through the Departments of Health and Human Services (HHS), Labor, and the Treasury (the Departments), along with the Office of Personnel Management (OPM), released a proposed rule on the No Surprises Act's Federal independent dispute resolution (IDR) process.

The Administration is committed to implementing the No Surprises Act (NSA) to prevent surprise medical billing. It is working toward improving the Federal IDR process, which providers, facilities, and health plans can use to resolve payment disputes for specific out-of-network charges.

The proposed rule is aimed at improving communications between payers, healthcare providers, and certified IDR entities who make payment determinations. The rule would also adjust Federal IDR timelines, create new batching criteria, create a more efficient Federal IDR process, and change the administrative fee structure to improve accessibility.

“The Biden-Harris Administration continues to take actions to protect patients from junk health insurance and unfair billing practices. This rule is the next step in ensuring we take patients out of the middle of billing disputes between insurers and health care providers,” said HHS Secretary Xavier Becerra. “Eliminating surprise medical bills, reducing the burden of medical debt, and curtailing junk insurance plans continue to be high priorities. HHS will continue to do everything in our power to protect patients.”

“The No Surprises Act continues to protect consumers from surprise medical bills,” said CMS Administrator Chiquita Brooks-LaSure. “The Biden-Harris Administration continues to demonstrate a commitment to implementing the law for the American people. Today's proposed rule will strengthen the communication between health care payers and providers and improve upon the independent dispute resolution process.”

The agency responded to feedback from stakeholders including payers and providers regarding the need to provide access to necessary information to all parties to determine if a payment dispute is eligible for the Federal IDR process. The rule will require payers to provide additional information at the time of the initial payment or notice of denial of payment.

The Departments proposed a requirement of the use of standardized codes to communicate whether a claim for an item or service by an out-of-network provider or facility is subject to the NSA's surprise billing provisions and the dispute resolution process.

The changes are focused on benefiting all disputing parties and reducing the number of ineligible disputes that are submitted to the Federal IDR process.

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The proposed changes to the open negotiation process are intended to encourage disputing parties to engage in meaningful negotiations prior to initiating the Federal IDR process. The Departments propose to centralize the open negotiating process with the Federal IDR portal.

The process would proceed as follows: “Under this proposed rule, a party choosing to initiate open negotiation must provide an open negotiation notice and a copy of the remittance advice or notice of denial of payment to the other party and the Departments through the Federal IDR portal. Under the current process, a party must contact the other party directly to initiate open negotiations, which has resulted in uncertainty as to whether open negotiation was ever properly initiated.”

The Departments also proposed a new content element in the open negotiation notice, including plan type, location of service, and claim number, to help the parties identify the service and properly match it to the dispute resolution process.

The proposed provisions are intended to promote open negotiations and engagement during the process.

The new process would also include new requirements for a notice of IDR initiation response from the non-initiating party.

Eligibility determinations for the Federal IDR process have been costly in terms of time and resources. Certified IDR entities are often uncompensated to the time spent on eligibility determinations. Delays in eligibility determinations have also delayed timely payment determinations.

The proposed rule would create a Departmental eligibility review process that could be called upon to address high dispute volume, leading to faster dispute resolution. [FN43]

Michigan Law to Lower Healthcare Costs for Cancer Patients

Michigan Governor Gretchen Whitmer signed legislation focused on decreasing healthcare costs for cancer patients by requiring health insurance coverage equity for orally administered chemotherapy medications and other forms of chemotherapy.

The new law also creates limits for co-pays.

“I'm proud to sign legislation that lowers health care costs for Michiganders and ensures they get the care they need,” said Governor Whitmer. “Since I took office, I have signed bipartisan legislation to hold pharmacy benefit managers accountable, increase price transparency, and protect Michiganders from surprise medical billing. Today's bills will ensure people who need certain chemotherapy medications are not charged more for it than other forms of this life-saving care. No one should have to worry about whether they can afford the treatment that works best for them. Let's keep working together to lower health care costs and make Michigan a safer, healthier place to live.”

House Bill 4071 requires health insurance coverage for orally administered chemotherapy medications to be equal to coverage of other forms of chemotherapy. The legislation also places ceilings on co-pays.

“As a cancer survivor, I know firsthand the toll that treatment takes on your body and your life. For some patients, intravenous chemotherapy might be the right choice, but for others, orally administered chemo is an excellent option for treatment,” said state Rep. Samantha Steckloff (D-Farmington Hills). “This legislation is simply about providing dignity for people fighting a terrible disease, and after more than 15 years of legislative sessions, I'm so excited to see this bipartisan bill finally signed into law.”

“The American Cancer Society Cancer Action Network (ACS CAN) was overjoyed to see the passage of oral chemotherapy fairness legislation after fifteen plus years. This legislation would give chronically ill patients more affordable access to the cancer treatment they need and ensure that the out-of-pocket costs to the patient for oral and intravenous (IV) chemotherapy are similar,” said Molly Medenblik, Government Relations Director, Michigan. “Currently, the out-of-pocket costs for some oral chemotherapy medications are higher than IV medications. This is an unnecessary barrier for some Michiganders.” [FN44]

Health Insurance Cost Increases in Pennsylvania More than Two Times the National Average

Health insurance costs for employer-provided family plans increased an average of 7 percent in 2023 nationwide, while increases in Pennsylvania are almost twice as high as the national average.

Average rate increases for policies renewing in December in Pennsylvania will be significant, noted brokers who placed the blame partly on labor shortages.

The annual KFF Employer Health Benefits Survey indicated that the average 2023 rate increase was the largest in the last decade. The cost of individual health plans through employers also increased about 7 percent to $8,435.

“Rising employer health care premiums have resumed their nasty ways, a reminder that while the nation has made great progress expanding coverage, people continue to struggle with medical bills,” KFF President and CEO Drew Altman stated.

In Pennsylvania, health insurance renewal rate increases for the 2024 plan year showed an average of 15 percent. This increase represents over twice the national average increase for plans, noted Steve Fisher, agent at Meadville-based DJB Group Inc., an independent insurance agency.

“It's still hard to find workers so some employers are paying 100 percent for employee benefits,” Fisher said. “We would absolutely love to have the 7 percent increase in northwest Pennsylvania.”

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Increases in the cost of health insurance premiums were associated with the history of costly medical claims increasing health insurance costs with the annual renewal of health insurance plans. [FN45]

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[FN2]

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