Health Law and Policy Update:
June 1, 2012

This week's updates

Headlines of the Week

IRS postpones decision on affordability of family coverage

The Internal Revenue Service (IRS) recently released the final rule on Health Insurance Premium Tax Credit regulations. The regulations indicated that future rulemaking will take into account concerns raised by advocates over the affordability of employer-sponsored health insurance for families. A provision in the previous draft rule would have determined whether employer-sponsored coverage was affordable for an entire family, based solely on the cost to the individual employee. CCLP had significant concerns with the original rule since employees are typically charged much higher premiums for family than for individual coverage. The original rule would have meant that many employees would be denied premium tax credits even though the premium they would have to pay to insure their family would far exceed the household income eligibility level to receive tax credits. The final rule indicated that the Treasury Department will postpone a final decision on the affordability of family coverage, as it continues to address the concerns raised by advocates. Until a decision is reached, an employee will be considered to have affordable coverage and not be eligible for premium tax credits, if his or her employer offers self-only coverage for 9.5% or less of household income.

The First Focus Campaign for Children sent a letter to the President and Congressional leadership in March, detailing the problems with the original draft rule.

Medical device tax repeal bill moves forward

A bill removing the excise tax on medical devices from the Patient Protection and Affordable Care Act (PPACA) was marked up in the House Ways and Means Committee this week. The excise tax, which helps to fund the coverage expansions in PPACA, imposes a 2.3% tax on sales of medical devices over $5 million. The bill is sponsored by Representative Erik Paulsen (R-MN) and has bipartisan sponsorship. The Joint Committee on Taxation estimates that repealing the excise tax would cost $29 billion from 2013-2022. Paulsen has not yet indicated how he would offset the cost of eliminating the excise tax.

The Center on Budget and Policy Priorities (CBPP) released a paperopposing the repeal of the tax. According to CBPP, Paulsen has overestimated the effect the tax will have on the medical device industry. The paper challenges the assumptions that the tax will cause manufacturers to shift jobs overseas and that the tax will limit innovation in the medical device industry. Additionally, CBPP raises the concern that the repeal of the tax will likely be offset by eliminating coverage expansion provisions from PPACA. This could encourage further cuts to the funding of PPACA, which would prevent the expansion of coverage to 33 million Americans, or significantly increase the deficit.

Coverage of the excise tax debate is available from the Washington Post.

Please contact your members of Congress, and ask them to keep all of the funding for the Patient Protection and Affordable Care Act in place, including the excise tax on medical devices. The tax is a key funding component to offer care to millions of uninsured Americans.

Call 888-876-6242 toll free, and tell your Representative to protect funding for the Patient Protection and Affordable Care Act.

Contact your representative.

What's New

Cost of healthcare services expected to rise 7.5% in 2013

According to a report by the Health Research Institute at PricewaterhouseCoopers, the cost of health care services in the United States is projected to rise 7.5% in 2013. This is significantly higher than the projected 2.4% increase in gross domestic product, a measurement of how the economy as a whole grows. Premiums for large employer-sponsored health plans are expected to grow slightly more slowly than the cost of all health care services, with a projected increase of 5.5%. The report attributes this difference to wellness programs and plans that impose higher insurance costs on workers.

While the cost of health care continues to grow faster than the economy as a whole, the report does note that 2013 will represent the fourth year in a row of relatively flat growth in health care costs. The Health Research Institute suggests that this represents a slowdown in health care inflation, compared to earlier decades when costs rose by double-digits annually.

Coverage of the report is available from Reuters.

Colorado submits proposal to coordinate care for dual eligibles
This week, the Department of Health Care Policy and Financing (HCPF) submitted a proposal for permission to operate a demonstration project designed to coordinate care for those Coloradans who are eligible for Medicare and Medicaid, so called "dual eligibles". The Department proposes to move most of Colorado's 70,000 duals into the Accountable Care Collaborative (ACC) program through the demonstration project.

The Centers for Medicare and Medicaid Services (CMS) are currently seeking comments on Colorado's proposal. Comments are due by June 30th and can be submitted to CMS.

Colorado Health Benefit Exchange (COHBE) Update

Exchange will develop technology platform to support supplemental and additional benefits

The COHBE Board of Directors voted at its last meeting to move forward with development and implementation of a technology platform that will allow the exchange to offer supplemental and additional benefits. Federal law requires that state exchanges allow stand-alone dental plans that offer at least a pediatric oral health services benefit, which will be defined in the fall of 2012. However, exchanges have the discretion to offer additional and supplemental benefits if they believe it to be in the best interest of the state. Supplemental and additional benefits may include adult and family dental plans, vision plans, Health Savings Accounts, life insurance, and coverage of chiropractic and acupuncture services. The scope of COHBE's decision was limited to the creation of a technology platform to support supplemental plans and benefits. The COHBE Board put on hold deciding the final scope and minimum number of supplemental plans and benefits until after engaging with stakeholders and presumably after defining the Essential Health Benefits (EHB) package.

Exchange board to make key decisions on appeals, billing procedures, and exemptions from the individual mandate
As part of its ongoing policy decision-making process, the COHBE Board introduced five policy decisions that it will take formal action on in the coming weeks. Among these decisions is whether

COHBE should use a federal service in 2014 and 2015 to certify exemptions from the individual mandate or develop its own state-run process to determine and report exemptions from the individual mandate. Under the Patient Protection and Affordable Care Act (PPACA), qualified individuals may be exempt from the individual mandate, which is the requirement that all Americans purchase health insurance. Exemptions may be based upon financial hardship, membership in Native American tribes, religious traditions, and undocumented status, among other bases. PPACA requires a certification process to ensure that individuals qualify for the exemption. Using the available federal process would likely reduce Colorado's administrative and workload expenses. CCLP supports the idea of using the federal system but urged the COHBE board at its last meeting to consider what impact using the federal system would have on appeals processes. The COHBE Board will vote on this issue at its June 11 board meeting.

The COHBE Board will also decide how the exchange should manage eligibility appeals for individual mandate exemptions, advanced premium tax credits, and purchasing coverage through the exchange. This will be an important and complex discussion since each appeals process must abide by a separate set of rules (IRS rules apply to tax credit appeals, HHS rules to individual mandate exemption appeals, and state insurance rules to enrollment appeals). CCLP will monitor this issue closely to ensure that all appeals processes ensure compliance with federal law and due process requirements. The COHBE Board plans to vote on this issue at its July 9 board meeting.

Other issues that the board will vote on over the coming weeks include approving a policy to protect against fraud, waste, and abuse (June 11), establishing a process to bill and reconcile payments between consumers and insurance carriers (June 11), determining how to administer premium tax credits (June 25), and deciding what information to display to consumers when they are comparing qualified health plans (June 25).

Exchange advisory groups begin regular meetings
In early May, the COHBE Board announced the formation of four new advisory groups: the SHOP (small business exchange) Advisory Group, the Individual Experience Advisory Group, the Health Plan Advisory Group, and the Communications and Outreach Advisory Group. These advisory groups begin meeting this week and will take up crucial issues that will define how the exchange operates. For example, the SHOP Advisory Group will make recommendations on the role of insurance agents and brokers in the exchange; the Health Plan Advisory Group will recommend certification requirements for health plans sold in the exchange; and the Individual Experience Advisory Group will recommend the role and compensation structure for navigators. All advisory group meetings are open to the public and we encourage your participation.

Upcoming advisory group meetings include:

SHOP Advisory Group Meeting
June 1, 2012 at 10:00 AM

Health Plan Advisory Group Meeting
June 5, 2012 at 1:00 PM

Individual Experience Advisory Group Meeting
June 5, 2012 at 2:30 PM

All meetings are located at 3773 Cherry Creek N. Dr. Suite 290. If you are unable to attend in person, you may participate via teleconference by dialing 319-279-1000, PIN: 8559663#.