

Health Care in Motion

Timely, Substantive Updates on Policy Shifts · Actionable Advocacy to Protect Health Care

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Regulatory Déjà Vu

Today's *Health Care in Motion* is a round-up of recent developments in health care policy that may invoke a general sense of [déjà vu](#)—that sense that we've been here before. The updates in this issue touch on topics that will be familiar to readers who have been along for the long, strange trip that has been health policy in 2018: (1) the opening of a new comment period regarding Kentucky's Medicaid program waiver; (2) the revival of Affordable Care Act (ACA) risk adjustment payments; (3) the Trump Administration's next wave of roll backs to critical consumer protections established by the ACA; and (4) a quick update on what's happening in the courts.

Medicaid Waiver Update: If the Public Record Does Not Serve You, Reinvent the Record?

In the wake of [Stewart v. Azar](#), the June 2018 ruling vacating approval of the waiver request that would have introduced work-related and other restrictive requirements into Kentucky's Medicaid program, the Department of Health and Human Services (HHS) has opened a new comment period to solicit feedback on the demonstration project in a kind of second round consideration of the state's application.

While the stated purpose of this new round of comment gathering is "to ensure that interested stakeholders have an opportunity to comment on the issues raised in the litigation and in the court's decision," HHS may be seeking to develop a different public record than that considered in *Stewart v. Azar*. After all, as explored in greater detail by *Health Care in Motion* [here](#), the court's decision is a testament to the importance of such submissions. Judge James E. Boasberg of the United States District Court for the District of Columbia found that HHS failed to analyze adequately the effects of the demonstration on a central objective of the Medicaid program: to provide insurance coverage.

More specifically, HHS failed to assess whether and to what extent the demonstration would cause recipients to lose coverage. As observed by Judge Boasberg, a significant body of comments submitted by the public in advance of HHS' first approval established concerns regarding the demonstration's impact on Medicaid coverage, access, and utilization; HHS failed to address these concerns and did not otherwise offer evidence to the contrary.

Although HHS may still appeal the decision in *Stewart v. Azar*, it more immediately has the opportunity to re-review—and re-issue a determination as to—Kentucky's demonstration project. It is therefore critical that we once again ensure a record replete with evidence illustrating the harm that work-related and other restrictive features of Kentucky's waiver can have on Medicaid enrollees, undermining the program's objective to provide coverage.

Health Care in Motion

Key logistical points for comments include:

- The scope of [material subject to public comment](#) spans: (1) Kentucky’s original demonstration proposal dated August 24, 2016, (2) Kentucky’s revised proposal dated July 3, 2017, and (3) the special terms and conditions that HHS approved on January 12, 2018.
- Following Judge Boasberg’s recognition that access to health insurance is the purpose of the Medicaid program, consider explaining your view as to how work requirements will result in decreased access to coverage for eligible, vulnerable individuals. An additional focus may be the development of evidence concerning HHS’s view that the proposal promotes health and well-being. For more information, please read our previous Health Care in Motion article, “[Working Mythology: A Deeper Dive on the Folly of Work Requirements in Medicaid.](#)”
- Comments are due by August 18, 2018 (11:00 pm EST), and can be submitted [here](#).

Risk Adjustment Do-over

Risk adjustment is back in the news again. One of the ACA’s [three programs](#) that were designed to help insurers cover members who need high-cost medical care, risk adjustment lessens the financial disincentive of enrolling members with chronic conditions. Each year, the Center for Medicare & Medicaid Services (CMS) transfers payments from insurers who cover people with lower expected medical costs, to insurers who cover people with higher expected medical costs.

CMS uses a formula to calculate the actuarial risk of an insurer’s members and uses the statewide average premium to determine how much money should be “adjusted” for the added risk of enrolling members who will likely need more expensive medical care. The problem was that some smaller insurers thought that this method put them at a competitive disadvantage. In February 2018, a federal district court in New Mexico ruled on the challenge brought by one of these small insurers, and [vacated](#) the formula. The court held that the government failed to provide proper reasoning for use of the statewide average premium measure. More specifically, the judge ruled that the measure was selected in order to keep the program [budget neutral](#)—a requirement the court said did not exist and was not adequately reasoned in the rulemaking process. In response, the government requested a rehearing in light of an opposite [ruling](#) from the district court in Massachusetts. Unfortunately, the New Mexico judge would not have been able to release a final decision until after August 2018, when CMS was scheduled to collect and administer the vacated 2017 risk adjustment payments. CMS thus issued a [statement](#) stopping the risk adjustment program in its entirety across the country—a move the agency [did not have to take](#)—and instead caused uncertainty among insurers setting prices for the 2019 plan year.

Last week, CMS [tried again](#) and issued an [interim final rule](#) reinstating the 2017 risk adjustment program. CMS explicitly included a comprehensive discussion of its reasoning behind the formula, including a justification for the program to remain budget neutral. With the interim final rule re-adopting the 2017 methodology, CMS [announced](#) that it would proceed to collect and administer the 2017 risk adjustment payments.

Ultimately, the twists and turns around risk adjustment may amount to much ado about nothing. With that being said, one key takeaway from these events is just how little regard the Trump Administration has for promoting market stability and certainty as insurers plan for their involvement in the ACA marketplaces in the years ahead.

Expanding “Junk Insurance”

In a move that is likely to have significant political implications, CMS has published its [final rule](#) loosening the restrictions on

Health Care in Motion

[short term limited duration plans](#). Expanded access to “[junk insurance](#)” will roll back many of the protections established by the ACA. Short term limited duration plans are temporary options to cover gaps in health insurance, and are not required to provide [essential health benefits](#). These plans can [exclude](#) necessary medical benefits, like prescription drugs or maternity care, and are able to deny coverage to people with pre-existing conditions, often openly excluding [people living with HIV](#) or other chronic illnesses.

To ensure these plans were not being substituted for legitimate health insurance, the Obama Administration set forth rules limiting the duration of these plans to three months (inclusive of renewal periods) and required plans to include a distinct warning that the plan did not meet minimum essential coverage standards.

Now, the Trump Administration has extended the maximum term of a short term limited duration plan to less than 12 months, with the ability to renew the same plan for no more than 36 months. This final rule also allows plans to use an alternatively-worded notice that is long and less prominent than the notice previously required under federal rules.

Navigators (funded by the federal government to help connect individuals and families to appropriate health care coverage) will be [expected](#) to present junk plans as a viable option for people seeking coverage in the 2019 enrollment period. Unfortunately, because coverage restrictions are often [buried in the fine print](#), many consumers will find a false sense of security in these plans, only to find out later that their plans don’t actually cover the care they need.

While this final rule loosens federal standards for short term limited duration plans, states still have the jurisdiction to enforce more restrictive requirements. Advocates and state officials in [Illinois](#), [California](#), and [Washington](#) are pursuing legislative and regulatory measures that would protect their state’s consumers from discriminatory, bare-bones coverage. It is likely that the battle to define what constitutes legitimate health insurance is far from over, with CMS’s [strained interpretation of the law](#) destined to end up in the courts.

Another Courtroom Fight to Protect Health Care

In June, Health Care in Motion published an [update](#) on how advocates were taking the health care fight to the courts. This month, we report another litigation effort to protect consumers from policy changes in the health care arena. New York, Massachusetts, and ten other states have [filed](#) a lawsuit against the United States Department of Labor to stop the recently [finalized rule](#) which rolled back protections against association health plans.

Small employers have traditionally been able to offer health insurance plans through organizations referred to as “associations.” Associations allow similar small businesses to band together and achieve common business purposes, such as organizing benefits for their employees. Associations who meet certain criteria under the Employment Retirement Income Security Act (ERISA) can exempt themselves from mandated consumer protections required by the ACA and certain state regulations. The Trump Administration’s final rule [relaxed](#) the exemption requirements, making it easier for associations to exempt themselves and offer plans that do not provide essential health benefits or plans that underwrite based on gender.

In the lawsuit, the state attorneys general claim that the Administration’s final rule is contrary to law, arbitrary and capricious, and promulgated in excess of the Department of Labor’s statutory authority. They argue that the Department of Labor’s expansion of exempt associations runs counter to both the ACA and ERISA, and “drastically departs from nearly four decades of settled law.”

Health Care in Motion

States are also pursuing protections on the home front that will temper the effects of the final rule. Association health plans have a history of [fraud and insolvency](#) and [efforts](#) to understand how the Department of Labor has factored this history into its finalized rule [remain unsuccessful](#). Thus, states such as [Vermont](#) and [Pennsylvania](#) are relying on state-specific solutions that will protect residents from both the erosion of consumer protections and the mismanagement of insurance benefits. As these cases develop, we will keep you updated on the ongoing battle to define what constitutes health insurance.

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In light of these developments, many advocates—at federal and state levels—may feel like they’ve been here before. Perhaps there is a silver lining? As [Crosby, Stills, Nash & Young](#) would have us believe:

*If I had ever been here before
I would probably know just what to do . . .*

*If I had ever been here before on another time around the wheel
I would probably know just how to deal.*

As we go around the wheel again, readers can rest assured that Health Care in Motion will continue to keep you up to date with information aimed at helping advocates navigate these trying times and figuring out together just how to deal.

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