



Health Reform Update – Week of April 14, 2014 By Mark Hobraczek

CONGRESS

Lower than expected premiums force CBO to downgrade ACA cost estimate

The Congressional Budget Office (CBO) downgraded its projection this week of the overall cost of the Affordable Care Act (ACA) due largely to lower than anticipated premiums for the health insurance Marketplaces created by the new law.

Previous CBO estimates predicted that Marketplace plans would resemble employer-sponsored coverage. However, the non-partisan scorekeeper found that the plans offered in 2014 typically relied on more narrow provider networks and tighter utilization controls to keep premiums and provider reimbursement lower than their employer-based offerings.

As a result, CBO now expects the coverage provisions of the ACA to cost \$5 billion less than the \$41 billion it projected earlier in the year. This translates to \$164 billion lower premium and cost-sharing subsidies over the next decade, and a \$104 billion drop in overall costs. The average expected subsidy in 2014 is about \$300 or six percent cheaper than initial projections and is expected to be \$1,200 or 14 percent less by 2024.

CBO acknowledges that costs may rise in subsequent years as the Department of Health and Human Services (HHS) has already taken steps to broaden provider networks under Marketplace plans for 2015 (see Update for Weeks of March 17th and 24th). Consequently, CBO predicts a small increase in 2015 premiums from an average of \$3,800 for a benchmark silver plan in 2014 to \$3,900. However, CBO emphasizes that this figure is still 15 percent below its initial projection in 2010.

Despite the downgrade in costs, CBO notably did not revise its projection that six million will enroll in Marketplace plans in 2014, even though more than eight million signed-up during the inaugural open enrollment period according to HHS (see below). CBO pointed out that its six million figure reflects an average of those enrolled throughout the year, so its final tally will not be determined until 2015.

CBO expects Medicare spending to decrease despite resurgence in health care spending

Along with its downgrade of Affordable Care Act (ACA) costs, the Congressional Budget Office (CBO) projected this week that Medicare spending over the next decade will be \$98 billion less than it estimated in February, although costs will rise in later years.

Departing Health and Human Services (HHS) Secretary Kathleen Sebelius had told Senate Finance committee members last week that Medicare trustees believe spending growth will be only 3.4 percent per capita in 2014, the lowest in the history of the program. This nearly half the six percent growth rate from 2001-2009.

CBO attributes the lower projections to reduced spending for Part D drugs as well as benefits under both Parts A and B. However, it also assumes that the annual Sustainable Growth Rate (SGR) cuts in Medicare physician payments will actually go into effect, even though Congress has postponed them every year since enactment and is currently debating a permanent fix (see Update for Week of March 10th).



Despite the modest growth expected in Medicare spending, the latest monthly estimates from the Bureau of Economic Analysis (BEA) shows that the lull in overall health care spending brought on by the 2007-2009 recession may be abating. According to the Altarum Institute, BEA numbers show a “steep upward trend in health spending growth over the past several months, culminating in February in a year-over-year growth rate of 6.7%, the highest observed since March 2007.” A related study by the IMS Institute for Healthcare Informatics confirmed that consumers have started increasing their utilization of health care services over the past three months, reversing the record-low spending growth that had occurred since the recession (see Update for Week of January 6th).

CBO forecasts a drop in federal deficit due to ACA and Medicare, but increases for following years

The Congressional Budget Office (CBO) predicted this week that the federal budget deficit will fall this year by more than it initially forecast in February, but will start rising steeply in subsequent years.

CBO’s latest estimate pegs the deficit at \$492 billion by 2015 or 2.6 percent of gross domestic product (GDP), down from 2.8 percent for 2014. That would make it the lowest since the 1.1 percent of GDP prior to the recession that started in late 2007 and a stark decline from the 9.8 percent prior to the federal stimulus package that was enacted in 2009.

CBO warned that without further legislative action projected deficits will expand again to four percent of GDP by 2022 due to the aging of the population, rising healthcare costs (see below), and increasing interest payments on the debt. The ten-year projection of \$7.6 trillion in cumulative deficits is still \$286 billion less than its February projection due to lower cost estimates for Medicare and the ACA (see above).

FEDERAL AGENCIES

Marketplace enrollment breaks eight million, but less than a third are young adults

President Obama announced this week that more than eight million consumers signed-up for private Marketplace coverage during the inaugural open enrollment period, with 3.8 million enrolling during the last month of open enrollment and another 900,000 signing-up during the “grace period” since the March 31st deadline (see Update for Week of March 31st).

Enrollment among adults age 18-34 ticked up slightly during the last several weeks and now represents more than 28 percent of all sign-ups—the same proportion that Massachusetts registered during the first open enrollment period for their new Marketplace in 2007. The insurance industry had insisted that 39-40 percent of enrollees needed to be from this younger and less costly population in order to ensure the financial viability of the Marketplaces, although Kaiser Family Foundation insisted that insurers could still make a small profit if the proportion were as low as 25 percent (see Update for Weeks of January 20th and 27th).

Pharmaceutical groups seek delay in ACA payment cut for generic drugs under Medicaid

A coalition of drug manufacturers and pharmacists are urging the Department of Health and Human Services (HHS) to delay or phase-in the implementation of an Affordable Care Act (ACA) provision that will reduce Medicaid reimbursement rates for generic drugs.

Medicaid bases generic drug reimbursement on the average wholesale price (AWP). After an unsuccessful attempt to move to an average manufacturer price (AMP) in 2005, Congress made it part of the ACA and HHS set July 2014 as the implementation date.



The HHS Office of Inspector General (OIG) determined last year that AMP limits under the ACA are an average of 22 percent lower than current state Medicaid generic drug reimbursement limits. OIG estimated that the difference could save Medicaid up to \$1.2 billion annually.

In a letter sent last week to HHS, the American Pharmacists Association, the Generic Pharmaceutical Association, and five other groups insisted that July 2014 was too short of a time frame for state implement the required legislative and regulatory changes, as well as develop new dispensing fees. Pharmacy groups also argue that the new rates would only allow them to break even on Medicaid generics, rather than turn a profit.

HEALTH CARE COSTS

Report shows soaring prices for specialty drugs

A new report released this week by the IMS Institute for Healthcare Informatics shows that Americans with costly conditions like cancer, hemophilia, hepatitis C, or rheumatoid arthritis are paying far more for prescription drugs even as overall drug spending declines.

According to IMS, consumers spent less than \$5 on average for more than half of the prescriptions they had filled in 2013, with generic drugs comprising 86 percent of all prescriptions. In addition, roughly 23 percent of prescriptions imposed no out-of-pocket cost at all, which researchers attributed to the Affordable Care Act's removal of cost-sharing for certain preventive services that went into effect for the 2011 plan year.

In stark contrast, IMS found that those purchasing costlier specialty drugs paid disproportionately more, as 30 percent of all out-of-pocket costs were attributed just to 2.3 percent of all prescriptions. The rising cost of these specialty drugs increased overall prescription drug spending by 3.2 percent in 2013, compared to a one percent drop in 2012.

IMS noted that drug manufacturers are increasingly investing in such high-cost drugs, bringing 17 orphan drugs to the market in 2013 out of 36 overall (the most in more than a decade). Because orphan drugs are tailored to small populations, they can be dramatically more expensive.

This has caused a surge in the use of specialty tiers by insurers, where subscribers are forced to pay a sizeable percentage of the cost for the highest-ticket drugs. IMS found that 23 percent of employer-sponsored health plans relied on specialty tiers in 2013, compared to only five percent in 2006. [Avalere Health previously found that 59 percent of all silver-level Marketplace plans were using specialty tier coinsurance for 2014 (see Update for Week of February 17th)].

IMS' findings mesh with the conclusions from two other studies by two pharmacy benefit managers. CVS-Caremark reported last week that specialty drug spending for their clients increased by 15.6 percent in 2013, compared to a mere 0.8 percent for other medications. Express Scripts found that while its growth in specialty drug spending was at its lowest point in six years (14.1 percent), it is expected to increase dramatically as nationwide specialty drug spending may spike by 63 percent from 2014-2016.

However, the IMS study noted that "2013 was striking for the increased use by patients of all parts of the U.S. health care system....following several years of decline", but stressed that the renewed consumer confidence and utilization occurred prior to the Affordable Care Act being fully implemented. Researchers attributed the improving economy to the fact that patient visits to costly specialists increased by nearly five percent last year while filled prescriptions increased by two percent.



Gallup confirms uninsured rate fell fastest in states that expanded Medicaid, created Marketplace

The latest survey released by Gallup this week affirms that states expanding Medicaid or creating their own health insurance Marketplace have reduced their uninsured rates by more than those states resisting these provisions of the Affordable Care Act (ACA).

The 21 states and the District of Columbia that have done both saw an average decline of 2.5 percent from their uninsured rate prior to the ACA. By contrast, the uninsured rate fell by less than one percent on average in the other 29 states.

The number of Americans reporting that they are uninsured also continued to drop to 15.6 percent, the lowest rate since 2008 and nearly 2.5 percent below the peak of 18 percent before the Marketplaces commenced open enrollment last October. The latest figure is lower than the 15.9 percent Gallup recorded through February (see Update for Week of March 10th).

Arizona

House and Senate pass navigator licensure bill that meets federal requirements

The legislature sent a measure to Governor Jan Brewer (R) this week that would make Arizona the latest state to require state licensure, fingerprinting, and background checks for those entities facilitating enrollment in the health insurance Marketplaces created by the Affordable Care Act (ACA).

H.B. 2508 applies to both navigators and certified application counselors (CACs) and supplements minimum federal standards. However, the additional measures in the bill are those that are permitted under recent regulations published by the Centers for Medicare and Medicaid Services (see Update for Weeks of March 17th and 24th).

By contrast, Health Care for America Now has identified at least 17 other states that have enacted laws or rules that impose such severe restrictions that they effectively prevent navigators or CACs from carrying their federally-required duties and constitute “navigator suppression.” This includes limitations imposed by four states (Georgia, Missouri, Ohio, and Tennessee) that go to the extreme of barring navigators from advising Marketplace applicants about the benefits, terms, and features of a particular health plan.

Governor Brewer has yet to indicate whether she will sign H.B. 2508. The measure has the backing of some consumer groups after lawmakers agreed to drop requirements for a licensure fee and examination. It also exempts navigators working on tribal lands from the additional state standards.

However, it remains to be seen whether the measure can still withstand a legal challenge as a federal court in Missouri has already thrown out Missouri’s restrictive navigator law on the grounds that states defaulting to the federally-facilitated Marketplace (FFM) cannot go beyond federal standards (see Update for Week of January 20th and 27th). Arizona and Missouri are both FFM states.

Similar legislation in Louisiana cleared its first House committee last week (H.B. 764) and also passed the Oklahoma Senate this week after already being approved by the House (H.B. 3286). Oklahoma lawmakers dropped a surety bond requirement that at least three other states have imposed (Iowa, Utah, and Wisconsin).

California

Final Marketplace enrollment surpasses targets for every demographic



Covered California officials announced this week that nearly 1.4 million consumers signed-up for private Marketplace coverage during the inaugural open enrollment period.

The final tally includes the 206,000 consumers that enrolled during the “grace period” from March 31st to April 15th when those that were unable to complete online applications due to technological issues were allowed to still enroll. More than 50,000 consumers signed-up on April 15th alone—the highest for any single day during open enrollment.

Despite initial glitches and early difficulties attracting Latinos, Covered California wound up exceeding its initial enrollment target by 570,000 and enrolling 17.5 percent of all Marketplace consumers nationwide (even though California represents only 12 percent of the United States population). Officials emphasized this week that the figures “surpassed base projections in every ethnic group and demographic in the state.” For example,

- About 29 percent of enrollees were aged 18-34, comparable to the national average of 28 percent (see above) and above their initial target (see Update for Week of March 31st).
- About 28 percent were Latino, even though initial Latino enrollment was in the single digits (see Update for Week of February 17th).
- About 88 percent qualified for premium tax credits or cost-sharing subsidies (above the 83 percent national average).
- About 41 percent signed-up for coverage through the online web portal while nine percent were assisted by a certified enrollment counselor.

The distribution among participating insurers largely resembled the individual market outside the Marketplace (see Update for Week of February 17th). Anthem Blue Cross accounted for 30 percent of qualified health plan (QHP) enrollment (gaining more than 425,000 new members), while Blue Shield of California represented 27 percent and Health net and Kaiser Permanente garnered 19 and 17 percent respectively.

An additional 1.9 million residents signed up for Medi-Cal coverage during the open enrollment period, with most qualifying due to the Medicaid expansion for everyone earning up to 138 percent of the federal poverty level.

Colorado

Connect for Health meets enrollment target, despite lag in young adults

Connect for Health Colorado announced this week that 124,000 consumers enrolled in private Marketplace plans during the inaugural open enrollment period, exceeding the 92,000 target initially set by the Centers for Medicare and Medicaid Services though below the board’s mid-range target of 133,000 (see Update for Week of March 10th).

Nearly 6,000 consumers enrolled after the March 31st deadline, as Colorado followed the lead of the federal Marketplaces and allowed those unable to enroll earlier due to technical issues to complete their applications by April 15th (see Update for Weeks of March 17th and 24th).

Young adults age 18-34, the population critical to the financial viability of Marketplace, made up only 26 percent of all enrollees. This is close to the same proportion as all Marketplaces nationwide (see above) but below the 39-40 percent figure that the insurance industry insists was needed to keep premiums affordable (see Update for Weeks of January 20th and 27th).

The largest number of enrollees (35 percent) came from the age 35-54 age bracket, while 27 percent were age 55-64. Children under 18 represented 12 percent of enrollees.



About 500 small employers participated in the small business Marketplace covering 1,860 employees and family members.

Despite meeting the minimum target, Connect for Health is seeking to raise fees on participating insurers in order to ensure it can be self-sustaining in 2015 as required by the ACA (see Update for Week of March 10th).

Delaware

Senate passes legislation that creates pathway for biosimilar substitution

The Biotechnology Industry Organization and the Delaware BioScience Association praised the Senate for passing industry-backed legislation this week that would create a pathway for the substitution of interchangeable biologic medicines with certain restrictions.

Senate Substitute 1 for S.B. 118 would require a pharmacist to record the name and manufacturer of a biologic product that the pharmacist dispensed and communicate which product was dispensed to the prescribing physician no later than ten days after dispensing. It also would require the Board of Pharmacy to maintain a link on the board's website to the current list of all biological products that are determined by the FDA to be interchangeable with a specific reference biologic.

Indiana was the sixth and latest state to set limits on when and how biosimilars can be substituted for the reference biologic (see Update for Weeks of March 17th and 24th). Ten states have already rejected industry-backed limits. However, Delaware's limits were not as restrictive as proposed in several of these states and passed the Senate unanimously.

The Affordable Care Act created a first-time regulatory pathway for the approval of generic biosimilars. However, biosimilars are not expected to be approved before 2015 as the Food and Drug Administration has yet to promulgate implementing regulations (see Update for Week of September 3rd).

Hawaii

Connector extends grace period until April 30th due to depressed enrollment

The Hawaii Health Connector announced this week that it was extending the grace period for the inaugural open enrollment period from April 15th to April 30th.

Hawaii is one of five state-based Marketplaces likely to be audited by the Government Accountability Office and Health and Human Services Office of Inspector General after website failures led to severely depressed enrollment (see Update for Week of March 10th). It had enrolled only 30 percent of all eligible consumers through February, well below the national average of 70 percent and only slightly above Massachusetts and the District of Columbia for the worst rate nationwide.

Connector officials initially followed the lead of the federal Marketplaces in giving individuals unable to complete applications due to website glitches until April 15th to enroll. However, only 8,132 individuals have signed-up for private Marketplace coverage, despite over 29,100 completed applications. As a result, the Connector will give applicants an additional 15 days while contacting those individuals that submitted the required "save my place in line" form to receive the initial extension.

The House and Senate are continuing to reconcile bills (S.B. 2470/H.B. 2530) seeking to rectify some of the initial Marketplace problems and ensure its viability despite lower than anticipated enrollment (see Update for Week of March 10th).

Louisiana

Senate to vote on bill requiring insurers accept third-party premium assistance



The full Senate is expected to hear and pass legislation next week that formally prohibits all health insurers from refusing to accept third-party premium assistance payments under the federal Ryan White HIV/AIDS Program.

The measure (S.B. 403) was in response to the refusal by three insurers in the federally-facilitated Marketplace to accept such payments. The insurers ultimately reversed course after a preliminary injunction was issued against them and the Obama Administration later issued rules clarifying that Marketplace insurers are required to accept Ryan White payments (see Update for Weeks of March 17th and 24th).

However, S.B. 403 goes beyond the federal rules by mandating that as of August 1, 2014 all insurers operating in Louisiana also accept premium assistance payments made by publicly-supported 501(c)(3) charitable groups like PSI, other state or federal government programs, or Native American tribes and organizations.

Minnesota

MNSure extends deadline until April 22nd in effort to boost depressed enrollment

MNSure officials announced this week that about 180,000 consumers have enrolled in coverage through the health insurance Marketplace created by the Affordable Care Act (ACA), with roughly 47,700 selecting qualified health plans (QHPs). Nearly 95 percent of those choosing QHPs have already paid their first premium.

The final tally for the inaugural open enrollment period could still rise by up to 23,600 consumers as MNSure will allow those unable to enroll before March 31st due to website glitches to complete their enrollment by April 22nd and pay the premiums by April 30th (so long as they filled out a prior attestation).

Minnesota is one of five state-based Marketplaces likely to be audited by the Government Accountability Office and Health and Human Services Office of Inspector General after website failures led to severely depressed enrollment (see Update for Week of March 10th). It had enrolled only 42 percent of all eligible consumers through February, well below the national average of 70 percent.

Nevada

Independent audit details flaws with Marketplace web portal

An independent audit of the Nevada Health Link Marketplace created pursuant to the Affordable Care Act (ACA) lays the blame for continued technological glitches on the state's lead contractor.

At least 40 consumers have already filed a class action lawsuit against Xerox, Nevada Health Link, and state officials after the flawed web portal left paying customers unenrolled and caused total qualified health plan (QHP) enrollment to be far below anticipated targets (see Update for Week of April 7th). Nevada has already needed to bring in a second contractor to fix many of the existing problems (see Update for Week of February 24th).

The report issued this week by Health Claim Auditors, Inc. confirmed that Xerox failed to achieve key performance benchmarks and designed the web portal so poorly that it continues to display inaccurate premium information, incorrectly calculate premium subsidies, and omit the subsidies entirely from invoices for more than 1,000 eligible consumers. Roughly 11 percent of claims sampled did not correctly reduce consumer out-of-pocket costs to reflect the subsidies.

Xerox also received a "fail" rating for call response and resolution times, specific benchmarks that could result in penalties being assessed against Xerox under its contract with the state.



In response to the continued problems, Nevada has already given consumers an additional 60 days past the March 31st deadline to complete applications, a much longer “grace period” than instituted by other states (see Update for Week of March 31st).

Oregon

Insurance division extends all open enrollment for one month, limits rates for transitional plans

The Insurance Division has filed two temporary rules this week governing health insurance plans outside of the crippled Affordable Care Act (ACA) Marketplace.

Because website flaws prevented online sign-ups for the duration of the inaugural open enrollment period (see Update for Week of March 10th), the Oregon Insurance Commissioner exercised the discretion granted by the Obama Administration to extend plans that do not comply with the ACA for at least one year. While these so-called “transitional” health plans remain exempt from most ACA standards, the temporary rules would require that these transitional plans keep premiums from varying by no more than 300 percent—consistent with the 3:1 age rating band imposed by the ACA.

The second set of temporary rules would formally extend the open enrollment period for Marketplace and non-Marketplace plans from the initial March 31st deadline until April 30th.

Tennessee

Governor signs legislation barring Medicaid expansion without legislative approval

Governor Bill Haslam (R) signed legislation this week that bars him or other state officials from participating in the Medicaid expansion under the Affordable Care Act (ACA) without legislative approval.

The Governor has supported a “private sector” alternative similar the model that was federally-approved for Arkansas, Iowa, and Michigan (see Update for Week of January 6th). However, his proposals have been stymied by conservative lawmakers that oppose accepting any federal funds.

H.B. 937/S.B. 804 was just one of several measures sought by conservative lawmakers to prohibit or hinder any implementation of the ACA (see Update for Week of February 24th). It prohibits any eligibility expansions without approval via a joint resolution of the General Assembly and denies lawmakers any compensation for a special session that may be required to approve such a resolution.

Governor Haslam repeatedly indicated that he does not object to the restrictions on his authority since he has no intention of pursuing any Medicaid expansion without legislative support (see Update for Week of March 3rd). Tennessee is one of only four states that have yet to decide on whether to expand.