



Health Reform Update – Week of April 21, 2014

By Mark Hobraczek

CONGRESS

Lawsuit to block Congressional health insurance subsidies receives some Republican support

A group of 38 Senate and House Republicans signed on to a brief this week backing the federal lawsuit filed by Senator Ron Johnson (R-WI) that seeks to block final Office of Personnel Management rules extending federal subsidies for health insurance to members of Congress and their staff.

Senators John McCain (R-AZ), David Vitter (R-LA), and Ted Cruz (R-TX) were among the Republicans backing the lawsuit, even though it would leave them and their staff on the hook for the full cost of their coverage. The final rules allow members and staff to receive a subsidy of up to \$5,000 a year for individual coverage and \$11,000 for families in place of the 75 percent subsidy they currently receive through the Federal Employees Health Benefit Program (see Update for Week of September 30th). The subsidy will be provided so long as they purchase gold-level coverage in the small business Marketplace that the District of Columbia created pursuant to the Affordable Care Act (ACA).

Senator Johnson acknowledges that the lawsuit is not supported by many Republican lawmakers, including his home state colleague Rep. Jim Sensenbrenner (R-WI) (see Update for Week of January 6th).

CBO lowers state cost of Medicaid expansion

The Center for Budget and Policy Priorities (CBPP) issued a new report this week concluding that last week's cost estimates from the Congressional Budget Office (CBO) show that the federal government will assume more of the costs of expanding Medicaid under the Affordable Care Act (ACA) than initially anticipated (see Update for Week of April 14th).

The ACA specified that the federal government will cover 100 percent of expansion costs through 2016, which phases down to 90 percent in 2020 and subsequent years. However, for states that elect to participate, the federal share will effectively be more than 95 percent of the total expansion costs for the first ten years, because CBO has quietly reduced its estimate of the number of previously qualified individuals that will now enroll in Medicaid.

Groups like Kaiser Family Foundation had estimated that such a “woodwork effect” would increase Medicaid enrollment by seven percent in non-expansion states (see Update for Week of October 7th). However, CBPP contends that the CBO figures now show this “woodwork effect” will only increase state spending on Medicaid by 1.6 percent, regardless of whether they opt-in to the expansion. CBO had predicted this cost would be a third higher as it also anticipated a far higher number of people who already qualified for Medicaid but failed to enroll would suddenly sign-up because of simplified application procedures under the ACA, as well as the law's individual mandate. However, such a mass number of enrollees has yet to materialize.

FEDERAL AGENCIES

CMS creates special enrollment period for PCIP enrollees



The Centers for Medicare and Medicaid Services (CMS) have granted the fourth extension of coverage in the temporary federal high-risk pools created by the Affordable Care Act (ACA).

The Pre-Existing Condition Insurance Plans (PCIPs) were slated to close December 31st, before several extensions set their termination to April 30th (see Update for Week of March 10th). However, CMS issued a bulletin this week now giving existing PCIP enrollees until June 30th to purchase Marketplace coverage through www.healthcare.gov or the respective web portal for their state-based Marketplace.

Harvard study says plan cancellations were part of “normal churn” in individual market

A researcher at Harvard University concluded this week that the Obama Administration was correct in claiming that the mass cancellation of individual health plans in the weeks before full implementation of the Affordable Care Act (ACA) was part of the “normal churn” in the market (see Update for Week of November 11th).

Over five million consumers had their individual coverage canceled before the Administration agreed to allow plans that do not comply with the ACA’s new consumer protections to continue for three years (see Update for Week of March 3rd). While these cancellations may have been motivated fully or partly by the ACA, the analysis by Professor Benjamin Sommers of the non-group market from 2008-2011 found it was “characterized by frequent disruptions in coverage before the ACA and that the effects of the recent cancellations are not necessarily out of the norm.”

Relying on U.S. Census Bureau data, Sommers sampled 4,199 respondents under 65 years old with non-group coverage in their first month. He found that more than one-third of those respondents no longer had non-group insurance coverage after just four months and just 42 percent had stable non-group coverage after one year. This figure fell to only 27 percent after two years.

Given that there were an estimated 10.8 million people in the non-group market in 2012, Sommers concludes that as many as 6.2 million people could leave the market in any given year, with or without the ACA. Furthermore, Sommers found that most people leaving the market found coverage elsewhere, including 50 percent that obtained employer-based insurance in the study’s first year, another 20 percent that regained non-group coverage, and six percent that enrolled in Medicare or Medicaid.

Aetna blames ACA-deficient plans for expected increases in Marketplace premiums

The chief executive officer for Aetna announced this week that the nation’s third largest health insurer will likely continue to participate in only 17 of the health insurance Marketplaces created by the Affordable Care Act (ACA), despite higher than anticipated enrollment and profit during 2014.

While Mark Bertolini also acknowledged that premiums for Aetna’s Marketplace plans will rise in 2015, he acknowledged that such increases will range widely from only nominal rate hikes in some states to double-digit jumps in others. Bertolini blamed last-minute regulatory changes by the Obama Administration for at least half of the upcoming premium increases. He singled out the decision to extend ACA-deficient plans until 2017 as a primary cause (see Update for Week of March 3rd), even though he had stated in January that the early mix of healthier and sicker populations among its Marketplace plans had been better than Aetna initially anticipated.

Aetna withdrew last year from several of the 23 Marketplaces where it would have to compete with non-profit insurance cooperatives created by the ACA (see Update for Week of September 23rd). According to the National Alliance of State Health Co-Ops (NASHCO), more than 400,000 Marketplace enrollees chose Co-Ops as their premiums were about nine percent lower on average than competitors. Co-Ops also offered 37 percent of the lowest priced-plans and drew 15-20 percent of the market share in the states in which they participated and were the most likely of all insurers to have plans within ten percent of the lowest-priced option (see Update for Week of February 24th).



Co-Ops were not more prevalent in 2014 because Congress eliminated the remaining ACA funding for Co-Ops loans are part of the bipartisan compromise to avert the “fiscal cliff” (see Update for Weeks of December 24 and 31, 2012).

RAND recommends that Medicare consider drug costs when determining coverage

A report released this week by the RAND Corporation recommends that the Centers for Medicare and Medicaid Services (CMS) explicitly consider the cost effectiveness of prescription drugs when making Medicare coverage determinations.

RAND acknowledges that such authority could only be granted by Congressional action that is highly unlikely given fears of “rationing”. However, it comes at a time when Medicaid Health Plans of America is pressuring CMS and lawmakers to compensate Medicaid managed care plans for unanticipated losses incurred by costly prescription drugs, such as a recently-approved “cure” for Hepatitis C that costs \$1,000 per pill (or \$84,000 per course of treatment). UnitedHealth Group announced this week that this Sovaldi drug has resulted in more than \$100 million in costs for Hepatitis C drugs, far more than it anticipated or than Medicaid managed care plans could forecast when it set its capitated rates for 2014.

RAND likewise recommended that CMS create an approval process for price determinations that runs concurrent with FDA marketing approvals in order to more quickly get new drugs to market and maximize CMS’ bargaining clout to lower drug prices.

Other recommendations included raising out-of-pocket costs on beneficiaries for low-value services and quickly transitioning away from all fee-for-service reimbursement and towards the accountable care organization (ACO) model tested under the Affordable Care Act (ACA) where physicians and providers received a set amount for each episode of care or set time period.

STATES

Arizona

Legal challenge to Medicaid expansion receives new life

The state Court of Appeals resurrected a legal challenge this week brought by Republican lawmakers seeking to block Arizona’s participation in the Medicaid expansion under the Affordable Care Act (ACA).

Three dozen Republicans joined with the conservative Goldwater Institute to file suit last year after the legislature narrowly approved expansion legislation sought by Governor Jan Brewer (R). They argued that because the state’s share of the expansion will be funded through a hospital assessment, it was a new tax that can only be enacted with a two-thirds majority vote (see Update for Week of June 10th). However, Maricopa County Superior court Judge Katherine Cooper rejected that claim, holding that the plaintiffs lacking standing to sue since losing a legislative battle does not show a concrete injury to them as individuals (see Update for Week of February 10th).

The three-judge panel of the Court of Appeals remanded the case back to the lower court, which insisted the court and not the legislature should have been the final arbiter of the issue. State officials stated that they would first appeal the procedural decision to the Arizona Supreme Court.

Arkansas

Medicaid expansion alternative enrolls nearly 70 percent of those eligible



The Department of Human Services (DHS) announced this week that more than 155,500 Arkansans have applied and been determined to be eligible for the state's "private option" to the Medicaid expansion under the Affordable Care Act (ACA).

The Republican-controlled legislature narrowly reauthorized the program last month (see Update for Week of March 3rd), which uses federal expansion funds under the ACA to instead cover those made newly-eligible for Medicaid under qualified health plans offered through the state partnership Marketplace. Arkansas was the first state to receive federal approval for this alternative model, so long as they provide certain wrap-around services and limited cost-sharing (see Update for Week of September 23rd).

The 155,567 people already enrolled represent nearly 70 percent of the 225,000 that DHS estimated are eligible when the alternative was first proposed by Governor Mike Beebe (D). According to DHS, roughly 64 percent of those enrolled are age 19-44.

California

Senate panel rejects bill to add IT representatives to Covered California board

The Senate Health Committee voted down a proposal this week to add two seats to the Covered California board for information technology (IT) experts.

Senator Norma Torres (D) introduced the bill (S.B. 972), which was intended to avert some of the technological glitches with the web portal that initially hampered Covered California enrollment. Despite its success in enrolling more than 1.4 million consumers in private Marketplace plans (see Update for Week of April 14th), Covered California was frequently plagued with errors that prevent even more enrollees, such as slow loadings times, repeated error messages, and inaccurate provider directories (see Update for Week of February 10th).

Committee chairman Ed Hernandez (D) and other bill opponents insisted that Covered California's nation-leading performance showed that most of these problems had been resolved.

Researchers insist that Covered California increased competition in individual market

Researchers at the UCLA Center for Health Policy Research determined this week that Covered California has increased competition in individual market for health insurance after only its first year.

Even though only four insurers accounted for 95 percent of all enrollees in qualified health plans offered by the Affordable Care Act (ACA) Marketplace (see Update for Week of April 14th), the researchers found that many of the new entrants to the market succeeded by offering plans only in specific regions of the state. For example, the Chinese Community Health Plan was marketed exclusively in the San Francisco area and enrolled roughly 13,000 consumers. The Center thus concluded that Covered California gave smaller insurers the opportunity "to jump into the market [previously dominated by Anthem and Kaiser] and see what they could do."

According to Covered California officials, all 11 insurers participating in 2014 have announced plans to return for 2015, another sign of market competitiveness. They insisted that they do not anticipate any more premiums increases for next year.

Roughly 62 percent of the 1.4 million QHP enrollees for 2014 selected silver-level plans with \$2,000 deductibles (since ACA subsidies were tied to this level). Another 26 percent selected the cheaper bronze-level plans that come with a \$5,000 deductible.

Colorado

Kaiser dominates Marketplace enrollment despite high premiums, limited participation



According to Connect for Health Colorado (C4HC), nearly three out of every four enrollees in the state-based Marketplace created pursuant to the Affordable Care Act (ACA) selected plans from one of three non-profit carriers (Kaiser Permanente, Rocky Mountain Health Plans and the newly-created Colorado HealthOP cooperative). However, some of the traditionally big players in Colorado's individual health insurance market such as Anthem Blue Cross and CIGNA have yet to release enrollment data.

Roughly 46 percent of the 127,233 Coloradans that selected the private Marketplace plans chose Kaiser. Rocky Mountain Health Plans signed up only 13 percent and Colorado HealthOP enrolled 12 percent. Both Kaiser and HealthOP said that final enrollment figures beat their initial expectations.

Rocky Mountain Health Plans was the only Marketplace carrier that sold plans in every county for 2014. It is not yet clear if Kaiser will expand its participation, as it already incurred Congressional criticism for charging subscribers in ski resort communities the highest Marketplace premiums in the nation (see Update for Week of October 21st).

C4HC did disclose that only about 26 percent of enrollees were young adults age 18-34, slightly below the 28 percent that enrolled nationwide and well-below the 39-40 percent that the insurance industry had sought (see Update for Week of April 14th). However, the Colorado HealthOP cooperative created with ACA loans attracted a much higher percentage of young adults (34 percent overall, and 44 percent during the last month of open enrollment).

Florida

Florida Blue says ACA enrollment exceeded expectations, but 2015 premiums may still rise

Florida Blue announced this week that enrollment in the plans it offered in the federally-facilitated Marketplace (FFM) operated in Florida pursuant to the Affordable Care Act (ACA) "exceeded expectations" for 2014 (although it refused to release a final tally). However, the insurer's Marketplace premiums for 2015 are likely to rise.

Florida Blue was the only Florida insurer to offer Marketplace coverage statewide and its premiums were already markedly higher in those counties where it had no competition (see Update for Week of September 30th). However, Florida Blue's CEO and former Congressman Jason Altmire (D-PA) explained that the insurer may have no choice but to increase premiums next year because most 2014 enrollees were previously insured and likely to "cost more...because of deferred health needs." He acknowledged that despite a late uptick in young adult enrollments, Florida Blue did not sign-up as many of this lower cost population as it initially anticipated.

As with Aetna (see above), Altmire also blamed President Obama's decision to extend ACA-deficient plans until 2017 for putting upward pressure on premiums (see Update for Week of March 3rd).

CMS attempts to force Medicaid expansion by limiting Florida's low-income pool

The federal Centers for Medicare and Medicaid Services (CMS) approved a three-year extension this week for Florida's Statewide Medicaid Managed Care program that allows the state to move nearly all Medicaid enrollees into capitated plans (see Update for Weeks of January 28 and February 4, 2013).

However, the agency granted Florida only a one-year extension of the state's Low Income Pool (LIP) that provides the state with additional federal Medicaid funding for the uncompensated care incurred by safety net hospitals serving uninsured patients.

U.S. Senator Bill Nelson (D-FL) acknowledged that the one-year limit was an explicit attempt to nudge Republican lawmakers in Florida to participate in the Medicaid expansion under the Affordable Care Act (ACA). Despite the support of Governor Rick Scott (R) and the Republican-controlled Senate,



House Republicans have steadfastly rejected any federal expansion funds and refused to even raise the issue of expansion this session (see Update for Week of March 31st).

Florida would receive more than \$51 billion in federal funds over the next decade if it participated in the ACA expansion. However, opting-out will force safety net providers to incur higher uncompensated care costs in the absence of the LIP, since the ACA will ultimately phase-down federal disproportionate share payments for indigent care (see Update for Week of December 9th).

Kansas

Governor signs bill requiring legislative approval for Medicaid expansion

Governor Sam Brownback (R) signed H.B. 2552 this week, seeking to thwart any possibility of Kansas expanding Medicaid under the Affordable Care Act (ACA) should he lose his re-election bid.

The Governor is widely expected to win re-election. However, his opponent House Minority Leader Paul Davis (D) is performing better than anticipated and supports the Medicaid expansion, leading Republican lawmakers to pass the legislation that would prevent any governor from expanding Medicaid without legislative approval.

A similar measure was recently signed into law by Tennessee Governor Bill Haslam (R) (see Update for Week of April 14th) and Georgia Governor Nathan Deal (R) is expected to shortly do so (see Update for Week of March 3rd). Like Governor Brownback, Deal is fending off a stronger than expected challenge from former President Carter's grandson.

Brownback has steadfastly opposed the expansion, even though it has the backing of the Kansas Hospital Association and several business and consumer groups in the state. A new report this week by the Kansas Center for Economic Growth (funded by the Kansas Health Foundation) insisted that the expansion would be a boon to the state's economy, particular in the most rural areas of Kansas where most workers in farming and agricultural industries lack health insurance.

Governor makes Kansas ninth state to join compact hoping to opt-out of ACA

Governor Sam Brownback (R) signed H.B. 2553 this week over the objections of his Republican Insurance Commissioner. The measure makes Kansas the ninth state to join an "interstate health care compact" that could opt-out of the Affordable Care Act (ACA) and run Medicare and Medicaid as they choose.

The bill is based on model legislation promoted by the conservative American Legislative Exchange Council in the months after enactment of the ACA. Similar legislation died in the Kansas Senate during the 2012 session.

The nine conservative-leaning states (which include Alabama, Georgia, Indiana, Missouri, Oklahoma, South Carolina, Texas and Utah) would require the approval of Congress to create the compact, which presumably could only occur if they assume control of the Senate as well as retain the House after the mid-term elections this fall.

Louisiana

Full Senate to vote next week on specialty tier legislation

The Senate Insurance Committee passed S.B. 165 this week, which would limit coinsurance or copayments applied to drugs on a specialty tier to not more than \$150 per month for each specialty drug or up to a 30-day supply of any single drug.

The measure was amended by the Insurance Committee to remove prohibitions on specialty tier coinsurance and out-of-pocket limits for prescription drugs that were in the original version (see Update for Week of February 24th).



The full Senate is expected to vote on S.B. 165 on April 28th.

Senate passes legislation requiring insurers accept third-party premium assistance

The Senate unanimously approved legislation this week that prohibits health plans 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 initial refusal by three insurers in the federally-facilitated Marketplace (FFM) to accept such payments, before a preliminary injunction and new federal rules forced them to reverse course (see Update for Weeks of March 17th and 24th). However, S.B. 403 goes beyond the new federal rules by mandating that all insurers operating in Louisiana also accept premium assistance payments made by publicly-supported 501(c)(3) charitable groups like PSI (see Update for Week of April 14th).

Senate committee rejects Medicaid expansion bill

Legislation that would let voters decide whether Louisiana should participate in the Medicaid expansion under the Affordable Care Act (ACA) received only two votes this week in the Senate Health and Welfare Committee this week, effectively halting any chance of the state expanding until 2015.

S.B. 96 sponsored by Senator Ben Nevers (D) sought a constitutional amendment for voter-approved mandate requiring the state's participation. It sought to circumvent the opposition of Governor Bobby Jindal (R) via a two-thirds majority. However, it received no Republican support in committee after two Republicans that had back Medicaid expansion legislation last session changed their minds.

Maine

Democrats make last-ditch effort to expand Medicaid, despite previous vetoes

Despite three earlier vetoes by Governor Paul LePage (R), the Democratically-controlled legislature is making one last attempt at the close of the session to expand Medicaid under the Affordable Care Act (ACA).

The latest version introduced by House Speaker Mark Eves (D) would expand Medicaid for only one year while seeking a federal waiver to use ACA expansion funds to purchase private Marketplace coverage for 55,000 of the 70,000 that will be made newly-eligible, similarly to the models federally-approved for Arkansas, Iowa, and Michigan (see Update for Week of January 6th).

Speaker Eves noted that his measure (L.D. 1578) is "dramatically different" from L.D. 1487, the compromise measure pushed by Republican lawmakers that would have covered the newly-eligible in expanded Medicaid managed care plans. However, despite the changes Governor LePage has still promised to veto it.

L.D. 1487 fell two votes shy of the two-thirds majority needed to override the Governor's veto earlier this month (see Update for Week of March 31st), and L.D. 1578 is currently three votes short. The legislature will return in May to consider the Governor's vetoes of both bills.

Nebraska

Study says opting-out of Medicaid expansion has increased premiums for most Nebraskans

According to a study released this week by the Center for Rural Affairs, the decision by Governor Dave Heinemann (R) to opt-out of the Medicaid expansion under the Affordable Care Act (ACA) has "changed [Nebraska's] health insurance marketplace pool...and resulted in higher health insurance premiums for most Nebraskans."

The study notes that those Nebraskans earning below 100 percent of the federal poverty level but above the very limited Medicaid eligibility thresholds in Nebraska have been relegated to a "coverage



gap” because they are ineligible for ACA subsidies to help purchase coverage in the state’s federally-facilitated Marketplace (FFM). Researchers note that for the lowest three plan levels in the FFM (bronze, silver, and gold), premiums in Nebraska’s FFM are higher than for the same level plans in the FFM for neighboring Iowa. For example, a 60-year old Nebraska couple would pay nearly \$500 more per year for a bronze plan in Nebraska as compared to Iowa.

New York

Marketplace nearly hits 2016 enrollment target during first open enrollment period

NY State of Health announced this week that nearly 435,500 consumers have selected qualified health plans (QHP) offered by one of 16 private insurers while another 525,200 used the Affordable Care Act (ACA) Marketplace to enroll in Medicaid.

The final tally leaves the Marketplace only 140,000 shy of its initial goal of enrolling 1.1 million consumers by 2016. New York trailed only California and Washington (see below) in overall Marketplace enrollment, signing-up roughly one-eighth of the eight million private plan enrollees nationwide (see Update for Week of April 14th).

State officials credited the broad competition among Marketplace insurers for the affordable premiums that brought “tremendous interest”. They noted that those purchasing Marketplace coverage directly from insurers paid an average of 53 percent more in premiums than those going through the Marketplace.

More than 70 percent of New Yorkers who enrolled in NY State of Health reported being uninsured at the time.

Oregon

Covered Oregon becomes first state-based Marketplace to revert to federal model

Oregon became the first state this week to move back to the federally-facilitated Marketplace (FFM), after its effort to create its own state-based model failed to enroll a single individual online.

The non-functionality of the Covered Oregon website became an embarrassment for a state that considers itself a pioneer in health reform and resulted in the removal of Marketplace directors and two separate federal audits (see Update for Weeks of March 17th and 24th). However, the interim chief information officer informed the board this week that fixing the problems that continue to plague the website would cost \$78 million and still not be completed by the November 15th start of the next open enrollment period.

The Covered Oregon board had contemplated following the lead of Maryland and replacing its failed technology with the model used for Connecticut’s successful state-based Marketplace (see Update for Weeks of March 17th and 24th). However, that option cost Maryland an estimated \$40-50 million, compared to the \$4-6 million cost of transitioning back to the FFM over the next 5-7 months, which the board decided instead to pursue.

Despite the website failure, Covered Oregon was still able to manually enroll roughly 63,000 consumers in qualified health plans and nearly 154,000 in Medicaid.

Washington

Nearly one million consumers enrolled through Washington Healthplanfinder

Officials with the Washington Healthplanfinder announced this week that the state’s Affordable Care Act (ACA) Marketplace enrolled nearly one million consumers during the inaugural open enrollment



period, trailing only the much larger states of California and New York (see above) for the highest number of enrollees nationwide.

However, the roughly 164,000 consumers that purchased private Marketplace plans were actually slightly below the state's initial target. Its greatest success was in enrolling more than 423,000 in Medicaid, while another 416,000 used the portal to renew or adjust existing Medicaid coverage. These figures were more than double early projections.

The Healthplanfinder also lagged behind the national average in the number of young adult enrollees (25 percent compared to 28 percent nationwide). Critics pointed out that most of the enrollees came from the easiest-to-reach consumers as one-third were adults age 55-64 but only nine percent of all enrollees were Latino.

Roughly 78 percent of all qualified health plan (QHP) enrollees received ACA subsidies to help purchase coverage. More than half of QHP enrollees selected the silver-level coverage to which the ACA subsidies are tied. Another 37 percent purchased the lowest-level bronze coverage.

State officials credited the roughly 200 navigators and other consumer assisters for the overall success of the Healthplanfinder, noting that 89 percent of those signing-up for the state's expanded Medicaid program were helped by assisters.

The state's dominant insurer, Premera Blue Cross, controlled roughly 60 percent of the Marketplace. It is not yet clear if 2015 will bring additional competition as insurers seeking to participate have until May 1st to submit proposed plan offerings and premiums.