Health Reform Update –Week of August 11, 2014

CONGRESS

Federal court allows another challenge to ACA tax credits to proceed

A federal judge refused this week to dismiss all of a lawsuit filed by the state of Indiana and school districts acting as employers who claim that the Affordable Care Act (ACA) does not allow premium tax credits to be offered within the federally-facilitated Marketplace (FFM).

Judge William Lawrence with the U.S. District Court for the Southern District of Indiana did reject many of Indiana's claims, including challenges to the ACA's employer and individual mandates, noting that the latter was already upheld by the U.S. Supreme Court (see Update for Week of June 25, 2012). However, he concluded that the plaintiffs had standing to challenge the tax credits, as Indiana is one of 36 states that initially defaulted to the FFM.

The Indiana case, and a related challenge in Oklahoma, will continue to proceed despite conflicting appellate decisions in two other districts (see Update for Week of July 21st). A three-judge panel for the Fourth Circuit U.S. Court of Appeals appointed by Democratic presidents unanimously upheld the tax credits within the FFM, while two judges on the District of Columbia U.S. Court of Appeals declared them invalid. As with Judge Lawrence, both of those judges were Republican appointees.

Oral arguments in the Indiana case are set for October, and a final decision could be appealed to the Seventh Circuit U.S. Court of Appeals in Chicago.

Conservative groups that brought the Fourth Circuit case have already petitioned the U.S. Supreme Court for an expedited review due to the conflict in decisions. However, the high court has typically elected to wait for cases to run their course through the appellate courts before intervening (see Update for Week of July 28th).

FEDERAL AGENCIES

CMS seeks citizenship verification from federal Marketplace consumers

The Centers for Medicare and Medicaid Services (CMS) disclosed this week that it has sent letters to roughly 310,000 consumers in the federally-facilitated Marketplace (FFM) demanding they provide documentation of their citizenship or lawful immigration status by September 5th or lose coverage.

The agency notes that each of these consumers had already received 5-7 warning notices from CMS via e-mail, phone, or mail, as well as related communications from their insurer. CMS plans to follow-up with two additional calls and one e-mail before terminating any coverage on September 30th.

The notices are in response to Office of Inspector General (OIG) and Government Accountability Office (GAO) reports finding up to 2.9 million discrepancies between income and immigration data submitted by applicants and those on file in federal databases (see Update for Week of July 21st). The watchdogs both concluded that less than one percent of the 330,000 inconsistences that CMS could address had been actually resolved.

CMS now claims that it has resolved roughly 450,000 of the 970,000 outstanding cases last May that involved immigration status and are moving towards completion on another 210,000. Agency officials stressed that discrepancies are often a result of a technological or human error, such as a digit

inaccurately entered or left off an applicant's Social Security number, and are not automatically indicative of an applicant's ineligibility.

Rep. Diane Black (R-TN), sponsor of legislation to suspend any ACA subsidies until income and citizenship verification is complete (H.R. 1145), sent a letter this week to the Health and Human Services (HHS) Secretary demanding additional details about the documentation required by CMS.

Advocates urge CMS to create special enrollment window for those auto-enrolled in FFM

Consumer advocacy groups have submitted regulatory comments urging the Centers for Medicare and Medicaid Services (CMS) to give individuals auto-enrolled in 2015 coverage under the federally-facilitated Marketplace (FFM) an additional 90 days to switch plans without penalty. Enroll America, Families USA, and other groups argue that such a special enrollment period should apply whether or not the qualified health plan (QHP) in which an individual was automatically re-enrolled differs from their 2014 plan.

Proposed rules from CMS established the auto-enrollment feature, which would start December 15th and apply to 95 percent of FFM enrollees (see Update for Week of June 23rd). Under the rules, those earning less than 500 percent of the federal poverty line (FPL) will receive notices from the FFM informing them that to change plans or update their income levels and subsidy amounts, they will need to take the step of notifying federal and plan officials. If tax returns show that a consumer's income has risen above that amount, the FFM will stop providing subsidies at the end of 2014 and renew the person's coverage. Consumers who believe that they still qualify for subsidies will have to send documentation to the FFM.

State-based Marketplaces can voluntarily follow this approach. To date, only Covered California has indicated that it will not.

CMS insists that this process will make it easier for consumers to continue plan coverage and ACA subsidies without interruption. However, consumer groups want the agency to notify enrollees that simply continuing in their same plan may not always be in their best financial interests and facilitate their enrollment into more cost-effective alternatives. They note that consumers whose income has fallen below 250 percent of the federal poverty level would lose eligibility for cost-sharing subsidies if not automatically enrolled into silver-level coverage.

Consumer groups also warn that CMS should not base the auto-enroll decision solely on premiums, without factoring in the out-of-pocket costs that consumers will incur for plans that require higher deductibles or coinsurance.

Comments received from the insurance industry urge CMS to let consumers directly renew plans with insurers or through www.healthcare.gov. America's Health Insurance Plans (AHIP) also argued that insurers and not the FFM or state-based Marketplaces should be the ones deciding what plan to enroll consumers whose existing plans are being discontinued next year. CMS had sought comments on whether consumers should be automatically re-enrolled in plans at the same metal tier or simply in a plan with a comparable premium.

AHIP discouraged moving consumers with terminated plans to a new metal tier and insisted that the insurer would be in the best position to evaluate which plan has the "most similar premium, out-of-pocket costs or networks." However, for consumers receiving ACA cost-sharing subsidies, AHIP recommended that consumers be placed in a plan at the same assistance level, even if that requires changing metal tiers.

CMS clarifies how Medicare and Marketplace plans can overlap

The Centers for Medicare and Medicaid Services (CMS) released a frequently asked questions (FAQ) document this week clarifying the limited cases in which Medicare coverage overlaps with plans offered in the new health insurance Marketplaces.

The Affordable Care Act (ACA) exempts those enrolled in Medicare Parts A and B from the mandate that everyone must buy minimum essential coverage they can afford. In addition, the Social Security Act Amendments of 1994 prohibit any entity from selling coverage to Medicare enrollees that knowingly duplicates Medicare benefits.

As a result, Medicare enrollees are typically ineligible for Marketplace coverage. However, the guidance document identifies the rare instances in which Medicare enrollees could purchase a Marketplace plan.

These examples include individuals that were required to buy into Medicare Part A because they did not pay Medicare taxes while working. These individuals could drop their $426 per month Part A coverage to instead purchase qualified health plan (QHP) coverage through a Marketplace.

Those eligible for Medicare could also purchase QHP coverage if they have not enrolled in Medicare coverage or if they only have Medicare Part B (and thus are subject to the individual mandate since Part B is not comprehensive enough to be considered minimum essential coverage).

CMS also clarifies that those with Marketplace coverage do not have to automatically drop their plan when they become eligible for Medicare. However, if they are eligible for Part A without paying premiums (as are most Americans) and elect to opt-out of Part A, they cannot then claim any premium or cost-sharing subsidies for Marketplace coverage unless they at least enroll in Part B.

CMS restores Open Payments website, affirms September 30th public launch

The Centers for Medicare and Medicaid (CMS) reopened the Open Payments website this week, after taking it offline for ten days due to physician complaints of inaccurate data (see Update for Week of August 4th).

Drug and device manufacturers were required to report payments to physicians to CMS, pursuant to the physician payment "sunshine" provisions of the Affordable Care Act (ACA). CMS has continually needed to adjust the deadlines for reporting and public disclosure, the latter of which was most recently set for September 30th. Physicians were to have access to the website until August 27th in order to review and challenge data previously reported by manufacturers.

CMS has agreed extend the physician review period until September 8th and a corrections period will run from September 9th–23rd. However, CMS remains committed to the September 30th launch date.

The American Medical Association and roughly 100 physician groups have urged CMS to delay the public launch by at least six months (see Update for Week of July 28th).

RAND says 340B drug discount program needs clearer directives

A new report from the RAND Corporation concludes that federal regulators need to provide clearer directives governing the federal 340B drug discount program for safety net providers.

The study comes as the Health Resources and Services Administration (HRSA) prepares to issue a long-awaited "mega rule" clarifying vague eligibility and transparency rules that the agency acknowledges have created uncertainty. The "mega-rule" follows the interpretive rule issued last month

that extends mandatory 340B discounts to orphan drugs used for non-orphan indications, pursuant to the Affordable Care Act (see Update for Week of July 21st).

The RAND report notes that "there are increasingly divergent views on the program's purpose and the role it should play in supporting safety net providers." This is similar to the conclusion of the Government Accountability Office that previously urged greater HRSA oversight of the 340B program to ensure safety net providers are not reaping improper windfalls from the discounts (see Update for Weeks of July 1 and 8, 2013).

HEALTH CARE COSTS

Large employer costs to rise by 6.5 percent next year

A new report from the National Business Group on Health revealed this week that large employers expect their health benefit costs to rise by 6.5 percent next year.

The survey of 136 companies, most of whom have at least 10,000 employees, showed that the 6.5 percent could actually fall to around five percent if employers implement a number of planned initiatives to control costs and shift more responsibility to workers. Nearly three-fourths of respondents are taking measures to make employees better health care consumers while nearly one-third are set to offer only a consumer-directed health plan in 2015, as well as add or expand wellness programs. Roughly the same percentage plan to narrow their provider networks and increase plan cost-sharing.

At least 16 percent of respondents reported that they would offer at least one so-called "skinny" or "junk" plan to employees that fail to comply with the consumer protections in the Affordable Care Act (ACA). The Obama Administration gave states the discretion to allow these limited-benefit plans through 2016, and about 35 insurance commissioners have done so at least through next year (see Update for Week of March 3rd).

Some generic drug prices are skyrocketing

A new analysis from Pembroke Consulting determined that half of all generic drugs sold through retailers have risen in cost expensive over the past 12 months, with prices paid by pharmacies doubling for one out of 11 generics.

The study documented that in select cases for antibiotics and blood pressure medications, the cost increase reaching a staggering 17,000 percent over the last year. However, researchers stressed that prices for the other half of available generic drugs did fall

STATES

Arkansas reduced its uninsured more than any other state

The latest Gallup survey released this week shows that the rate of uninsured has dropped precipitously in ten states that both expanded Medicaid and created a state-based or state partnership Marketplace pursuant to the Affordable Care Act (ACA).

The results show that as of July 2014, no state experienced a greater decline than Arkansas, whose uninsured rate among adults now stands at 12.4 percent compared to 22.5 percent when Marketplace enrollment started last October. Prior to the ACA, Arkansas' population of uninsured adults was exceeded only by Texas, which resisted all ACA implementation and consequently still leads the nation in the rate of uninsured.

The 10.1 percentage point drop in Arkansas was rivaled only by the 8.5 percent decline in Kentucky. Delaware, Washington, Colorado, West Virginia, Oregon, California, New Mexico and Connecticut follow with uninsured rates that fell by roughly 5-7 percent. The survey found that nearly 97 percent of all working age adults in Delaware are now insured—the best rate in the nation.

All ten of these states expanded Medicaid and created their own Marketplace. Overall, Medicaid expansion and Marketplace states show their uninsured rate among adults fall by four percentage points to 12.1 percent, compared to only a 2.2 percent drop for non-expansion states (whose adult uninsured rate stands at 16.5 percent).

Gallup surveys previously found that the national rate of uninsured stood at 13.4 percent by mid-year, the lowest reported percentage since 2008 (see Update for Week of June 30th and July 7th). The findings were roughly consistent with those reported by The Commonwealth Fund, The Urban Institute, and Harvard University (see Update for Week of July 21st).

California

Kaiser lowers Covered California premiums in effort to improve market share

A private sector analysis of approved premiums for Covered California shows that Kaiser Permanente is the only participating insurer that will lower monthly premiums for 2015.

Covered California officials announced late last month that premiums would rise next year by only a modest average of 4.2 percent (see Update for Week of July 28th). However, Citigroup provided details this week showing that rates for most large insurers are above that average, including the six percent increase for Blue Shield of California and 4.9 percent hike for Health Net.

However, Kaiser Permanente, which garnered only the fourth-largest market share in Covered California, has elected to reduce its premiums by 1.4 percent in an effort to be more competitive. Kaiser's had the highest average premiums in the Marketplace for 2014, while the insurer with the lowest premiums (Health Net) beat out all other rivals with a 33 percent market share.

Citigroup points out that Kaiser's 2015 premiums are still the second highest in Covered California, on average. The cost of their silver-level plan for a 40-year old in the Los Angeles area would fall from only $297 to $297 per month, leading analysts to question whether the slight reduction will have much impact on Kaiser's market share. For example, Health Net's silver-level HMO option for the same 40-year old costs only $231 per month, still the lowest in the Los Angeles area.

The highest increase for any Covered California insurer is the 11.3 percent jump for HMO plans offered by L.A. Care.

Several health reform bills to receive floor votes this month

Several health reform measures were cleared by their respective Appropriations committees this week and will head to final floor votes before the legislative session closes at the end of August.

The Assembly Appropriations Committee passed S.B. 964, which would require the Department of Managed Health Care to annually review the network adequacy and timely access to care for Medi-Cal managed care plans, as well as separate reviews for Covered California and non-Marketplace plans. The measure already passed the Senate.

The Assembly Appropriations committee also passed S.B. 1176, which would make health plans responsible for tracking out-of-pocket (OOP) costs for in-network providers, and reimbursing consumers if the OOP is exceeded. A separate measure (S.B. 1182) would extend rate review to large group plans. Both already passed the Senate.

The Senate Appropriations Committee passed a complementary measure to S.B. 964 (A.B. 2533) that would ensure timely access to care at in-network cost sharing. The measure already passed the Assembly. It also cleared A.B. 2088, which makes limited-benefit or “junk” insurance (with actuarial values of less than 60 percent) supplemental to comprehensive coverage, without banning them entirely. Both measures already passed the Assembly.

A measure that would prohibit group health plans from imposing any waiting period on coverage (S.B. 1034) was sent to Governor Jerry Brown (D) last week. The 60-day period under current state law would be removed. The ACA allows up to a 90-day waiting period (excluding orientation periods) (see Update for Week of June 23rd).

A.B.1917, which would limit annual out-of-pocket costs for prescription drugs, is still awaiting a Senate floor vote (see Update for Week of August 4th).

Measures passed by the legislature before the end of session must be signed or vetoed by Governor Brown by the end of September.

Idaho

Legislative work group recommends Medicaid expansion, again

A 15-member panel of physicians, providers, and lawmakers commissioned by Governor Butch Otter (R) has recommended for a second time that Idaho participate in the Medicaid expansion under the Affordable Care Act (ACA).

As in 2012, the working group insisted that the case for expansion was “overwhelmingly compelling”, citing studies by the Idaho Hospital Association and University of Idaho concluding that ACA matching funds would result in more than $400 million in tax savings over the next 10.5 years (see Update for Week of November 12, 2012). Participation would also negate the need for local property taxes to be increased in order to fund the 10.6 percent increase in Idaho’s purely state-funded Catastrophic Health Care Cost Program (see Update for Week of January 13, 2014).

House Majority Leader Mike Moyle (R) was among the three panelists voting against the recommendation, insisting that expansion is “not going to go anywhere in this political climate.” Rep. Tom Loertscher (R), the original sponsor of legislation creating the state’s catastrophic program, also voted against the recommendation, claiming more data on long-term expansion trends was needed before he could support accepting the ACA matching funds.

Although Governor Otter has indicated some support for the concept, he has refused to consider any expansion proposals until conservative lawmakers are satisfied that the promised federal funding will materialize and prevention and wellness measures will be added (see Update for Week of January 6th).

Currently, at least 70,000 Idahoans fall into the coverage gap where they make too much for Medicaid but too little to receive ACA subsides to purchase Marketplace coverage.

New Hampshire

Medicaid expansion alternative enrolled one-sixth of eligible population during first month

In only its first month, New Hampshire’s expanded Medicaid program has enrolled roughly one-sixth of the newly-eligible population according to the state Department of Health and Human Services.

Enrollment in the Health Protection Program started on July 1st and now covers 8,207 people, with an additional 361 referred to New Hampshire’s existing Health Insurance Premium Payment program that assists with premiums for those also eligible for employer-sponsored coverage. Coverage starts

August 15th in the federally-approved alternative to the standard expansion under the Affordable Care Act and will enroll applicants in either Medicaid managed care plans or (when cost effective) in private plans offered by the state partnership Marketplace (see Update for Week of June 23rd).

State officials expect "several thousand" more enrollees in the coming months before hitting their ultimate goal of 50,000. They plan to reach out to roughly 40,000 that already "sought Medicaid assistance through the federal application process."

Ohio

HHS disputes insurance department claim of double-digit rate hikes

The Department of Insurance (DOI) announced late last week that premiums are likely to increase in 2015 by an average of 12 percent in both the individual and small group Marketplace operated pursuant to the Affordable Care Act (ACA).

States like Ohio that defaulted to the federally-facilitated Marketplace had to send premium data and recommendations to the federal Centers for Medicare and Medicaid Services (CMS) by August 8th. States will be notified of any needed technical corrections by August 26th though CMS lacks the authority under the ACA to modify or reject any double-digit rate hikes that it deems "excessive" (see Update for Week of August 29, 2011).

As it did last week for Florida (see Update for Week of August 4th), CMS promptly disputed DOI's average rate hike calculation, insisting that premiums for most of the state's largest and most popular insurers will rise "by only single digits." CMS noted that Medical Mutual consumers will see only a 7.7 percent increase on average, compared to double-digit rate hikes in the years preceding the ACA.

A recent study by Pricewaterhouse Coopers found that the average increase among 27 states releasing premium data will be around 7.5 percent for 2015 (see Update for Week of August 4th).

According to DOI, the average monthly pre-subsidy premium among the 16 participating Marketplace plans will be $372.86, compared to $332.58 in 2014. Individual consumers will have 290 plan options while small group plans will offer 185 options.