Health Reform Update – Week of July 18, 2016

CONGRESS

Bipartisan bill would reduce exclusivity for biologic drugs to seven years

Senators Sherrod Brown (D-OH) and John McCain (R-AZ) introduced legislation on June 23rd that would to reduce the period of exclusivity provided for biologic medicines approved by the Food and Drug Administration (FDA) from 12 years to seven years.

The Price Relief, Innovation and Competition for Essential Drugs (PRICED) Act (S.3094) would bring the exclusivity period back in line with the 7-year period initially sought by President Obama and many Democratic lawmakers during the drafting of the Affordable Care Act (ACA) (see Update for Week of March 3, 2014) and currently proposed by Democratic presidential candidate Hillary Clinton. The Department of Health and Human Services (HHS) has estimated that such a reduction would save consumers $6.9 billion over the first decade.

A House companion bill introduced by Rep. Jan Schakowsky (D-IL) has six Democratic cosponsors.

Both bills have the support of consumer groups like AARP and Families USA but are opposed by the Biotechnology Innovation Organization, which insists that "data exclusivity of 12 years is an essential incentive for the huge risks associated with biotechnology investment." Although the Senate measure has a Republican sponsor in Senator McCain, it is opposed by Republican leaders like Senator Orrin Hatch (R), who refuse to support reducing the exclusivity period below nine years.

MedPAC targets Medicare drug costs in annual report to Congress

The Medicare Payment Advisory Commission used its June report to Congress to recommend legislation that will stem that rising cost of prescription drugs for Medicare Part D, which the influential panel warns has risen nearly 60 percent from 2007 to 2014.

Their proposals would save Part D at least $10 billion over five years through greater use of generic drugs and incentives for insurers to negotiate better prices from drug manufacturers. These include a recommendation that Congress dramatically reduce or even eliminate copayments on generic drugs for lower-income Part D enrollees and create an annual out-of-pocket spending cap for higher-income enrollees similar to the cap already in place for lower-income enrollees. However, drug discounts given by manufacturers also would not count towards the out-of-pocket cap, making it harder to reach.

MedPAC estimates that the changes will result in about half of Part D enrollees remaining longer in the coverage gap or "doughnut hole", causing them to pay roughly $1,000 more per year in drug costs. The proposal would also increase costs on Part D insurers by requiring them to pay 80 percent of drug costs after enrollees hit their out-of-pocket maximum, compared to only 20 percent now.

Congress is not likely to consider the MedPAC proposals during an election year, but they are expected to be debated in 2017.

Tax credits under ACA are making Marketplace premiums comparable to employer coverage

The premium tax credits offered under the Affordable Care Act (ACA) has made premium costs for Marketplace enrollees comparable to premiums paid by individuals with employer-sponsored insurance (ESI), according to a survey released last week by The Commonwealth Fund.

Researchers found that 66 percent of Marketplace enrollees earning below 250 percent of the federal poverty level (FPL) currently spend less than $125 per month on premiums, compared to 60 percent of ESI enrollees. Lower-income enrollees in Marketplace and ESI coverage were also less likely to have deductibles greater than $1,000.

By contrast, the survey revealed that for those with higher incomes that are ineligible for subsidies, Marketplace enrollees were significantly more likely than ESI enrollees have a high-deductible plan (68 percent to 42 percent). Researchers also found that 49 percent of these Marketplace enrollees report that it was easy or somewhat easy to afford coverage compared to 75 percent for ESI enrollees.

FEDERAL AGENCIES

Two-thirds of Marketplace insurers lost money in 2014

Only about one-third of all insurers profited from Marketplace business during the first year of operations, according to a new study released this week by The Commonwealth Fund.

The analysis of all 144 Marketplace insurers that served at least 1,000 subscribers found that overall they underestimated their total medical costs by about 5.7 percent in 2014, causing profits to diminish despite higher premium revenues. However, because of reinsurance payments that the Affordable Care Act (ACA) provided to those insurers with an exceptional number of high-cost claims, total medical costs turned out to be only about two percent higher than insurers had predicted.

Despite the protection of the reinsurance program (which ends after 2016), a fraction of insurers "fared especially poorly" because they underestimated their claims by an average of 35 percent. The insurers incurred steep losses (nearly 22 percent on average) while those that performed the best had average profits of around 8.5 percent.

Researchers predict that Marketplace insurers will be more conservative in setting their premiums for future years to avoid these losses. The lack of ACA reinsurance payments for 2017 has already resulted in double-digit rate hikes for the largest state Marketplace in California (see below).

Marketplace enrollment experiences predictable drop due to premium nonpayment

The latest figures released by the Centers for Medicare and Medicaid Services (CMS) reveal that enrollment in health insurance Marketplaces created pursuant to the Affordable Care Act (ACA) fell from 12.7 million at the January 31st close of open enrollment to 11.1 million by March 31st.

The attrition was due to nonpayment of first month premiums and comparable to the rate experienced during prior years. CMS officials stressed that 87 percent of enrollees did pay their premiums and remained in their plans during the first two months after open enrollment.

The agency expects ten million people to remain enrolled at year end or about the same as the 10.2 million that were enrolled by March 31st of last year. It notes that 85 percent fewer consumers are losing coverage due to an inability to prove their legal immigration status.

CMS predicts per capita healthcare spending will surpass $10,000 for first time

Health care spending is expected to exceed $10,000 per person for the first time this year, according to new national health expenditure projections released last week by the Centers for Medicare and Medicaid Services (CMS).

The study predicts that the cost of health care will rise to $10,346 per person this year, up from $9,960 in 2015. Researchers attributed to climb to increasing costs for prescription drugs, hospital care, and insurance administrative costs.

However, the study did credit cost-control efforts including those within the Affordable Care Act (ACA) for stabilizing the growth of national health expenditures, at least in the short term. The rate of growth in total health spending increased by 5.5 percent last year, only a slight uptick from the 5.3 percent rate in 2014. The rate of growth in national health spending had reached nearly eight percent per year in the decade prior to the 2007-2009 recession.

New verification requirements for special enrollment periods may further deter enrollment

New requirements to verify eligibility for special enrollment periods (SEPs) may actually deter SEP enrollment by healthy individuals according to a new analysis released last month by the Urban Institute.

The verification measures were put in place earlier this year by the Centers for Medicare and Medicaid Services (CMS) in response to insurer concerns about healthier individuals abusing the SEPs to enroll only when they required medical care (see Update for Weeks of February 22nd and 29th). Consumers must now submit documentation attesting to their eligibility for a SEP, which include major life changes such as marriage, divorce, childbirth, adoption, or losing minimum essential coverage (MEC).

Researchers with the Urban Institute found that only five percent of the 33.5 million individuals who become SEP-eligible each year actually enrolled in 2015. They conclude that the low utilization of SEPs means that individuals are not applying until they are most in need of coverage and that additional barriers to enrollment will only further encourage healthy individuals to forgo them.

Instead of requiring documentation, the researchers instead recommend that CMS use a data-based, electronic verification system that only requires documentation if electronic verification fails. They note that more than 94 percent of SEP enrollees apply due to loss of MEC, which can be verified through data-matching with the previous insurer for the consumer.

STATES

Seven remaining CO-OPs under ACA are struggling to remain viable

The closure of four additional Consumer Operated and Oriented Plans (CO-OPs) over the past month means that only seven of the original 23 non-profit insurance cooperatives remain in operation nationwide.

The CO-OPs were created with Affordable Care Act (ACA) start-up loans and intended to offer lower-cost competition in all of the Marketplaces created by the ACA. However, Congress rescinded funding after CO-OPs were created in only 23 states and a subsequent shortfall in ACA reinsurance payments forced a dozen to be liquidated last fall after low premiums attracted more consumers and costly claims than the CO-OPs could afford to pay without additional federal funding (see Update for Week of November 30th).

While both Congress and CMS have refused to provide additional funding, CMS did issue new regulations last spring that allowed for outside investment that would help the remaining CO-OPs remain financially viable (see Update for Week of May 16th). These regulations also allowed CO-OPs to expand their plan offerings beyond just the individual and small group markets.

However, the relaxed requirements were not enough to spare CO-OPs in Connecticut, Illinois, Ohio, and Oregon from failing this month. Furthermore, they appear unlikely to help all but one of the remaining seven CO-OPs who owe substantial payments to the federal government under the ACA's risk adjustment program. This temporary program (that expires after 2016) was meant to help insurers with that incur an exceptional amount of high-cost claims by providing additional reinsurance payments. However, funding for these payments came partly from other insurers who case-mix was healthier than anticipated.

Since the low premiums offered by CO-OPs typically attracted a healthier case-mix, all but Community Health Options in Maine and New Hampshire will have to pay into the ACA reinsurance program for the 2015 plan year. Some of these payments are substantial, including the $31.2 million that caused Land of Lincoln in Illinois to be closed on July 12th and the $13.4 million that previously caused Healthy CT in Connecticut to close. Additional liquidations are likely as Health Republic in New Jersey has to pay more than $46 million and Evergreen Health in Maryland must pay $24.2 million, most of which will go to dominant carrier CareFirst Blue Cross and Blue Shield. Evergreen filed a federal lawsuit last month seeking to block the payment, which constitutes more than 28 percent of their premium revenue (see Update for Week of June 20th).

UnitedHealth Group may exit remaining three Marketplaces for 2017

The nation's largest UnitedHealth Group announced this week that it may withdraw from the Affordable Care Act (ACA) Marketplaces in Nevada, New York, and Virginia next year after its latest financial statements revealed that it lost more than $605 million in Marketplace business for 2016.

UnitedHealth Group had already pulled out of 31 of the 34 Marketplaces in which it participated in 2015, including the largest state of California, after incurring more than $720 million in losses for 2015 (see Update for Week of April 18th). Its 2016 losses were more than third higher than the insurer anticipated and blamed largely on a "higher consumption" of services due to a sicker case-mix than projected.

Despite its size, UnitedHealth Group had attracted only about 820,000 Marketplace consumers nationwide after sitting out the first year of Marketplace enrollment in 2014. However, its departure could have a significant upward impact on premiums in the 29 percent of counties in which it was one of only two insurers offering coverage. Its exit is already expected to cause premium spikes in states like Arizona, Iowa, Nebraska, and North Carolina (see Update for Week of April 18th).

The Marketplace losses did little to dent UnitedHealth Group's bottom line, as the insurer posted an 11 percent increase in profit last quarter to stronger than expected revenues from their Medicare Advantage and Medigap offerings.

Critics contends that UnitedHealth Group's own pricing decisions are to blame for their Marketplace losses, noting that they charged the highest premiums in most of the Marketplaces in which they participated. These high premiums effectively chased healthier, less costly, and more price sensitive consumers into competing plans. They note that other large insurers like Aetna and Anthem have elected to remain in all of their Marketplaces next year (see Update for Week of May 16th).

Humana to exit eight Marketplaces for 2017

Humana announced this week that it will dramatically scale back its offerings in the health insurance Marketplaces created by the Affordable Care Act (ACA).

For 2017, Humana will now offer individual market plans in only 156 counties across 11 states, down from 1,351 counties and 19 states in 2016. In addition, the insurer will withdraw "substantially all" of its individual market offerings that it offers outside the Marketplaces.

Humana attributes the withdrawals to higher than anticipated claims costs, as well as having to make higher payments than expected through the ACA premium stabilization program, where insurers with a healthier case-mix help to offset the costs of insurers with a sicker case-mix.

Alaska

Legislative council drops legal challenge to Medicaid expansion

The Alaska Legislative Council voted last week to drop its lawsuit challenging the state's expansion of Medicaid pursuant to the Affordable Care Act (ACA).

The decision follows the dismissal of the lawsuit by a lower court, which held that absent a state law prohibiting the expansion, Governor Bill Walker (I) was required by the federal Social Security Act to provide Medicaid services to the population made newly-eligible by the ACA (see Update for Weeks of February 22nd and 29th). The Alaska Supreme Court refused to allow an appeal to be pursued by only by the House of Representatives after the Senate elected not to proceed (see Update for Week of May 16th).

The suit had attempted to invalidate the Governor's rarely-used fiscal maneuver last summer that expanded Medicaid while the legislature was out of session (see Update for Weeks of August 31st and September 7th). The Council authorized the lawsuit in an effort to block the expansion from starting on September 1st. However, support for the costly legal action has waned among Senate Republicans with council chair Senator Gary Stevens (R) ultimately conceding that "the governor did the right thing in moving ahead with Medicaid expansion," as it had brought coverage to more than 17,700 Alaskans by May.

Only five lawmakers on the 14-member council voted in favor of proceeding, which would now require the filing of a separate lawsuit.

New law creates reinsurance program for high-cost enrollees in individual market

Governor Bill Walker signed H.B. 374 into law last week, which seeks to stabilize health insurance premiums in the individual market through a reinsurance program for high-cost enrollees funded by an existing tax on all health insurers (see Update for Week of June 20th).

The measure was prompted by Moda Health Plan's decision to exit the individual market for 2017, leaving Premera Blue Cross Blue Shield as the only remaining insurer and raising concerns of dramatic premium spikes (see Update for Week of January 25th and February 1st). It will still require federal approval of a waiver under Section 1332 of the Affordable Care Act.

California

Marketplace consumers to receive double-digit premium increases

Covered California officials disclosed this week that premiums will jump by an average of 13.2 percent for 2017.

The double-digit increase came as a surprise to many analysts as Covered California had used its authority as an "active purchaser" (one of only three nationwide) to negotiate average rate hikes of only four percent over the past two years (see Update for Weeks of July 27th and August 3rd). However, the expiration of the temporary reinsurance and risk adjustment payment under the Affordable Care Act (ACA) forced state officials to accept higher premiums in the Marketplace in order to account for higher than expected medical costs.

The Covered California director stressed that the rate hikes were not going towards insurer profits or administration, which the Marketplace limited to only 1.5 percent across all participating plans.

The rate hikes in California are consistent with the 11 percent average premium increase for benchmark silver tier plans that the consulting firm Avalere Health tallied last week for 14 states. The benchmark silver plans are the one to which the ACA premium tax credits are tied but Avalere noted that the lowest-cost silver plan in the 14 states would see smaller rate hikes (only eight percent on average).

Connecticut

CO-OP shutdown causes Marketplace to lose half of participating insurers

The Department of Insurance shutdown of Healthy CT earlier this month will leave the Marketplace created pursuant to the Affordable Care Act (ACA) with only two participating insurers for 2017.

UnitedHealth Group had already pulled out of AccessHealth CT and 30 other Marketplaces earlier this year, citing more than $720 million in losses on Marketplace business during 2015 (see above). However, UnitedHealth's high premiums had attracted only about 1,500 AccessHealth CT consumers compared to nearly 11,300 for the lower cost plans offered by Healthy CT.

Healthy CT was barred from selling any new plans after learning on June 30th that it would be required to pay more than $13.4 million in ACA risk adjustment payments. It was one of 23 Consumer Owned and Operated Plans created with ACA loans and the fourth to be shut down this month due to the risk adjustment payments (see above).

Current Healthy CT consumers can stay in their plans until they expire at the end of the year.

AccessHealth CT officials acknowledge that the loss of competition from both carriers will likely increase premiums for 2017 (only Anthem and ConnectiCare remain). As a result, they will continue to put pressure on Harvard Pilgrim Healthcare to join the Marketplace.

Massachusetts

MassHealth creates rebate program for Hepatitis C drugs

Governor Charlie Baker (R) made Massachusetts the latest state earlier this month to ensure all Medicaid enrollees have access to medically necessary treatments for the Hepatitis C virus (HCV).

The Baker Administration has engaged in negotiations with two manufacturers (Gilead and Bristol Myers Squibb) to create a rebate program effective August 1st that will significantly lower the cost of their recently-approved HCV medications.

Gilead's Harvoni drug, with a retail price tag of nearly$95,000 for a cost of treatment, will be the exclusive therapy for the roughly 80 percent of all HCV-infected enrollees in MassHealth. Gilead's other HCV drug, Sovaldi, and Bristol-Meyers Squibb's drug, Daklinza, together will be indicated for approximately 20 percent.

Since December 2013, Mass Health has spent more than $318 million for HCV medications, an amount that the Administration insists was unsustainable. At least 34 states had responded to these staggering costs by limiting HCV coverage only to those most severely ill. However, at least four states have already extended HCV coverage to all Medicaid enrollees following a federal court ruling that such rationing violated federal Medicaid law (see Update for Week of June 20th).

Missouri

New law gives regulators limited authority to review "unreasonable" premium increases

Governor Jay Nixon (D) signed S.B. 865 into law earlier this month authorizing the Department of Insurance (DOI) to conduct rate reviews of health plans offered on and off the federally-facilitated Marketplace operated pursuant to the Affordable Care Act (ACA).

Starting in 2018, DOI may determine that a rate is "unreasonable" and publicly disclose insurer justifications for the increase. However, the law does not give DOI the authority to block an "unreasonable" rate increase.

Oklahoma, Texas, and Wyoming are the only three states that lack any statutory authority to review health plan rate increases. In those states, the U.S. Department of Health and Human Services (HHS) will continue to require that insurers publicly disclose actuarial data for any double-digit rate hike that HHS deems "unreasonable" for failing to be reflective of increases in medical inflation (see Update for Week of August 29, 2011). However, the ACA does not give HHS the authority to block or modify "unreasonable" rate hikes.

Oregon

Regulators approve individual and small group premiums for 2017

The Division of Financial Regulation released final premiums last week for 2017 individual and small group plans sold on and off the Marketplace operated pursuant to the Affordable Care Act (ACA).

In the individual market, premium increases will range from 9.8 percent to 32 percent. The average monthly premium for a 40 year old non-smoker purchasing a standard silver plan in the largest city (Portland) will range from $312-442.

In the small group market, premium will range from a decrease of 8.9 percent to a 17 percent increase. The average monthly premium for a 40 year old non-smoker purchasing a standard silver plan in the largest city (Portland) will range from $255-362—lower than for the individual market.

The Division successfully persuaded Moda Health Plan to expand its health plan offerings to 13 additional counties, in order to restrain premium increases that were expected after Moda and three other carrier sought to limit the number of counties in which it would sell plans for 2017. One of those carriers (LifeWise Health Plan) has instead decided to leave the Oregon market altogether.

Rhode Island

Legislature approves bill to give consumers notice of cost-sharing changes for formulary drugs

The Senate and House both passed S.2294 last month, which would require individual or group health plans using a drug formulary to provide subscribers with a 30-day notice prior to removing any drug from the formulary or making a change in the preferred or tiered cost-sharing status.

South Dakota

Governor will not call special session on Medicaid expansion

Governor Dennis Daugaard (R) announced late last month that he will not call a special session to consider his alternative to the Medicaid expansion under the Affordable Care Act (ACA).

During the regular legislative session, the Governor had backed an expansion for roughly 55,000 state residents earning up to the eligibility threshold in the ACA (incomes under 138 percent of the federal poverty level). He sought to use ACA funds to purchase private Marketplace coverage for those made newly-eligible for Medicaid, similar to the model federally-approved for seven states, so long as it did not require the use of additional dollars from the state general fund and the federal government covered 100 percent of the costs for Medicaid-eligible Native Americans covered through the Indian Health Service (see Update for Week of December 7th).

Governor Daugaard's latter condition was approved by the Obama Administration, but he initially elected to delay debate on his proposal until the special session (see Update for Weeks of February 22nd and 29th). However, the Governor now insists that lawmakers need more time until the next regular session to fully evaluate his plan.

Tennessee

Task force proposes phased-in expansion of Medicaid under the ACA

The 3-Star Healthy Task Force commissioned by House Speaker Beth Harwell (R) released their proposed alternative late last month to the Medicaid expansion under the Affordable Care Act (ACA).

The plan would expand Medicaid in two steps. The first phase, scheduled to start in 2017, would expand Medicaid only to roughly 115,000 residents earning up to 138 percent of the federal poverty level (FPL) who also have a "qualifying diagnosis of a mental illness" or proof of honorable discharge from the United States military. The second phase would include all other residents earning up to 138 percent of FPL but would only commence 12-18 months following the first phase if the initial phase is deemed to be a "success" based upon factors such as costs per member, number of enrollees, health outcomes, and use of emergency rooms and primary care physicians.

Task force chairman Rep. Cameron Sexton (R) stated that the plan relies on Republican principles of "motivation and achievement". However, he acknowledged that it will likely require modifications in order to secure the needed federal approval, before being placed for an up or down vote in the legislature.

The Republican-controlled legislature previously rejected the Insure Tennessee plan proposed by Governor Bill Haslam (R), which would have made Tennessee one of eight states to use ACA funds to purchase private coverage for those made newly-eligible for Medicaid (see Update for Week of March 30, 2015). Lawmakers largely objected to provisions that would allow the Governor to modify his plan over time, causing the task force to prohibit any future changes in their proposal.

The Tennessee Hospital Association (THA) had agreed to a provider assessment that would have covered the state share of costs under Insure Tennessee (which phased-up to ten percent in 2020 and thereafter). However, it is not yet clear if THA will agree to a similar assessment to fund the task force's plan.