Health Reform Update – Week of July 25, 2016

CONGRESS

Senate oversight committee targets ACA reinsurance payments

The chairman of the Senate Homeland Security and Governmental Affairs Committee sent a letter this week to the Department of Health and Human Services (HHS) demanding that the agency respond to repeated requests about how it intends to continue funding reinsurance payments to insurers through 2016.

The temporary reinsurance and risk corridors program created by the Affordable Care Act (ACA) is set to expire after 2016. It is intended to stabilize premiums in the individual market during the period in which many high-cost and previously uninsured patients move into insurer risk pools. However, Republican lawmakers have increasingly stepped up attacks on the program, which they consider a "slush fund" for insurers (see Update for Weeks of January 20 and 27, 2014).

The risk corridors portion protects against pricing uncertainty by sharing gains and losses between plans and the federal government. Insurers share part of their annual profits with HHS, who uses the funds to cover part of the losses for other insurers.

Senator Marco Rubio (R-FL) led the effort to pass a budget provision that has already dramatically reduced the funding available to help insurers through the risk corridor program. However, the most recent letter from chairman Ron Johnson (R-WI) and committee member Ben Sasse (R-NE) targets the reinsurance payments that redistribute funds from plans with relative few high-cost enrollees to those that served an exceptional number.

Under the ACA, HHS was supposed to collect enough money from insurers to redistribute the reinsurance funds while also sending $5 billion to the Department of Treasury as a deficit reduction measure. However, after failing to collect sufficient funds to do so, HHS issued recent rulemaking prioritizing payments to insurers in favor of those due to Treasury.

The letter from Senators Johnson and Sasse demands details and meeting logs regarding this decision from HHS, as well as more information on how HHS is calculating that rate for insurers paying into the reinsurance program. The Senators want the agency to justify leaving a $3.5 billion shortfall in funds due to the Treasury.

Senator Sasse has already sponsored a bill that would slash the entire HHS budget in half if the agency does not deposit at least $4 billion of the required $5 billion into the Department of Treasury fund. The measure (S.2803) recently gained a House counterpart (H.R. 5904) from Rep. Mark Walker (R-NC) and is backed by several conservative groups although it will not move forward during an election year.

FEDERAL AGENCIES

Medicare Part D premiums to remain stable for 2017

The Centers for Medicare and Medicaid Services (CMS) actuary announced this week that the average basic premiums for Medicare Part D prescription drug plans are expected to remain relatively stable for the coming year.

The agency estimates that Part D enrollees will pay an average of $34 per month in premiums or roughly $1.50 over the actual average premium of $32.56 in 2016. The projection comes as somewhat of a surprise given that the Medicare trustees recently reported that the growth rate in Part D drug costs exceeds the growth in all other Medicare costs and overall health expenditures. Their report predicted that Part D expenditures would increase by 5.8 percent through 2025, far more than the four percent estimated per enrollee growth rate for Medicare Parts A and B combined.

The CMS actuary noted that Part D enrollees are continuing to benefit from out-of-pocket savings in Part D costs due to the narrowing of the coverage gap required by the Affordable Care Act. Since the law was enacted in 2010, more than 10.7 million enrollees have received over $20.8 billion in discounts on their prescription drugs (for an average of $1,945 per enrollee).

STATES

CIGNA to expand Marketplace presence for 2017

Health insurer CIGNA announced this week that it has filed for approval to participate in the Marketplaces for Illinois, North Carolina, and Virginia in 2017.

While CIGNA is seeking to add the three Marketplaces, it will limit its plan offerings only to the major metropolitan areas of Chicago, Raleigh-Durham, Richmond, and northern Virginia.

The move comes amid the departures of insurance giants UnitedHealth Group and Humana from all or most of the Marketplaces in which they offered plans last year (see Update for Week of July 18th). CIGNA joins with Aetna and Anthem, who both have also sought to expand their participation in the Marketplaces created pursuant to the Affordable Care Act (ACA) but are experiencing single-digit losses.

Despite the Marketplace losses, the expansion of Medicaid under the ACA has proven to be a financial boon for insurers participating in Medicaid managed care. Anthem report higher-than-expected profits this week due to Medicaid managed care enrollment that has risen substantially in expansion states. UnitedHealth Group is even seeking to expand its Medicaid managed care presence in states like California where it pulled out the ACA Marketplace.

Individual market premiums have dropped post-ACA

A new study released this week by the Kaiser Family Foundation concludes that average premiums in the individual market have fallen since the implementation of the Affordable Care Act (ACA).

Proposed premiums have garnered significant media attention this year has the expiration of the ACA's temporary premium stabilization programs have caused several insurers to seek staggering rate hikes, including the 60 percent jump sought by Blue Cross and Blue Shield of Texas and the 40 percent increase filed by Geisinger Health Plan in Pennsylvania.

However, the Kaiser study focused on the benchmark silver-tier plans in 14 markets and found that average premiums for 2017 are likely to increase by about ten percent. Benchmark plans are the second-lowest cost silver plan to which the ACA's premium and cost-sharing subsidies are tied. They are thus by far the most popular choice among consumers in ACA Marketplaces.

Kaiser researchers did acknowledge that there was great variation in average benchmark premiums nationwide. For example, they will increase by more than 15 percent in states like Connecticut and Oregon (as well as Washington, DC), while actually declining in states like Rhode Island and Washington.

The study emphasized that despite outliers that far exceed the ten percent average, overall premium increases in the individual market were far greater prior to the ACA being fully implemented in 2014. They cite data from the Brookings Institute showing the benchmark premiums are "between 10 and 21 percent lower than average individual market premiums in 2013, before the ACA" while 2016 premiums are twenty percent below the original projections issued by the Congressional Budget Office.

In addition, the authors emphasize that silver-tier plans give consumers more value for their money, as they cover 17 percent more health expenses than the average individual market plan before the ACA.

Kaiser credits several factors for moderating premium increases in the individual market. These include greater competition from an individual market that expanded by millions of consumers following the ACA, as well as the medical loss ratios and greater rate review authority provided by the law.

However, Kaiser singled out the ACA's temporary premium stabilization as the most important factor, as it insulated many insurers with an exceptional number of high-cost claims from incurring substantial losses (see Update for Week of July 18th). Researchers note that the Commonwealth Fund previously estimated that the premium stabilization programs reduced average premiums by as much as 14 percent of the three years that it remains in place.

Most states receiving failing grade for consumer price transparency

The annual report card on state price transparency laws released by independent health policy organizations finds that only three states are excelling at making usable pricing information available to health care consumers.

The Health Care Incentives Improvement Institute and Catalyst for Payment Reform flunked 43 of 50 states for failing to make any pricing data accessible to online consumers, despite state laws in many of those states that sought to make health care pricing more transparent. Roughly a dozen states that are collecting pricing data received failing grades because they have yet to publicly share that data.

Colorado and Maine joined New Hampshire this year as the top-performing states due to "the increased quality of their reporting and transparency websites." However, Oregon made the most progress, jumping all the way from an "F" to a "B" grade. Arkansas, Vermont, and Virginia where the only other states to received passing grades.

Arizona

Arizona receives federal approval to unfreeze SCHIP enrollment

Arizona this week became the last state to provide coverage for children from low and middle-income families after receiving federal approval to unfreeze its enrollment in the State Children's Health Insurance Program (SCHIP).

Roughly 30,000-40,000 children from families earning up to 200 percent of the federal poverty level will become newly-eligible for SCHIP services starting September 1st. Enrollment in KidsCare was frozen in 2010 (see Update for Week of April 9. 2012) and the program shut down in 2014. Governor Doug Ducey (R), who signed the state legislation restoring KidsCare after five Republican Senators provide sufficient support for passage (see Update for Week of May 16th), emphasized that the federal government will pay the full $4.7 million cost for the first year.

The Georgetown University Health Policy Institute concluded in 2014 that Arizona families who were forced to switch from KidsCare to private Marketplace coverage likely paid more and received fewer benefits.

California

Patient advocates are starting to oppose ballot initiative to lower drug prices

A ballot referendum this fall that is intended to lower prescription drug prices for Californians has drawn surprising opposition from consumer advocates who fear it would lead to little savings and may actually result in price increases.

Drugmakers have already spent nearly $70 million to defeat Proposition 61, also known as the Drug Price Relief Act. The referendum would prohibit state programs such as Medi-Cal from more than the lowest price for a drug that is currently paid by the federal Department of Veterans Affairs (VA). The VA receives mandatory drug discounts under federal law and thus tends to pay the lowest prices. A 2005 report by the Congressional Budget Office showed that the VA paid 42 percent of list price on average for name-brand drugs while Medicaid was paying 51 percent. The gap between the VA and Medicare or private insurers was even larger.

Proposition 61 has drawn national attention, including the support of Senator Bernie Sanders (I-VT), a former presidential candidate. It is backed by the AIDS Healthcare Foundation, the California Nurses Association, and AARP, who claim the measure would save several hundred million dollars a year on the more than $4 billion that California now spends on medicines for roughly 5-7 million people.

However, advocacy groups for HIV and Hepatitis C patients (such as Project Inform and the Treatment Action Group) insist that the measure takes the wrong approach to reducing drug costs. They and other advocates have started raising concerns that once drugmakers are forced to lower prices for state programs, they might seek to raise the prices that they charge the VA and commercial health plans.

In addition, they note that rebates and discounts offered by drug manufacturers are typically confidential, making it difficult to determine whether a state agency is paying less than the VA. Because of this lack of transparency, the state Legislative Analyst's Office acknowledged that the impact of Proposition 61 would be "highly uncertain."

Vermont became the first state earlier this year to enact legislation requiring greater consumer transparency for pharmaceutical costs (see Update for Week of June 20th). A similar measure continues to advance in the legislatures for California and at least six other states. A comparable voter referendum in Ohio has survived three legal challenges from the Pharmaceutical Research and Manufacturers of America and may appear on the November ballot if supporters can garner enough signatures (see Update for Week of January 4th).

Indiana

Medicaid expansion enrollees can no longer be locked-out for failing to complete paperwork

The Centers for Medicare and Medicaid Services (CMS) sent a July 29th letter to Indiana officials stating that it can no longer "lock-out" enrollees in the state's Medicaid expansion if they fail to timely complete renewal paperwork.

CMS made Indiana one of only seven states to receive a federal waiver allowing it to create a "private-sector alternative" to expanding Medicaid under the Affordable Care Act (ACA) (see Update for Weeks of January 26 and February 2, 2015). The plan put forward by Governor Mike Pence (R), the Republican vice presidential nominee, built upon a health savings account (HSA) demonstration waiver that Indiana already had in place prior to the ACA. Since it was called the Healthy Indiana Plan, the latest incarnation is called the Healthy Indiana Plan 2.0. It covers more than 370,000 Indianans, including 235,000 previously uninsured and able-bodied adults.

However, the CMS approval came with the condition that Indiana must show that its provisions do not harm access to care (in order to receive an extension in 2018). CMS hired the Urban Institute to

conduct this evaluation, which specifically will examine provisions requiring the lowest-income enrollees to pay premiums, locking-out enrollees for six months if they fail to make required HSA contributions or complete renewal paperwork, and whether Indiana could continue not to cover non-emergency transportation services past 2016.

Governor Pence objected to the CMS survey, insisting that it was unnecessary since a Lewin Group analysis commissioned by his Administration already showed the adverse impact of these provisions upon access to care was "minimal".

The Governor continues to seek CMS approval to restore a cap on participation that was part of the Healthy Indiana Plan (HIP), but removed by CMS as a condition of HIP 2.0 approval.

Maryland

Largest Marketplace insurer increases its proposed rate hike for 2017

CareFirst BlueCross BlueShield (BCBS) announced this week that rate hikes it previously sought from the Maryland Insurance Commission will not be adequate to cover losses on its Marketplace business.

CareFirst had proposed a 12 percent average increase for HMO plans sold on the Marketplace, with a 30 percent hike for PPO plans. However, the state's dominant insurer is now seeking an average increase of almost 28 percent for HMO plans and nearly 37 percent for PPO offerings.

CareFirst officials insist that the dramatic hikes are needed because claims data from the first five months of 2016 show higher costs than the insurer anticipated for "somewhat older individuals and those with more chronic medical conditions."

The commission will consider the revised request at an August 15th public hearing. The advocacy group Consumer Health First had already objected to the initial hikes after a study it commissioned blamed CareFirst for not adequately controlling their own costs.

Oregon

Regulators help failed CO-OP members move to other plans, approve double-digit rate hikes

The Department of Consumer and Business Services (DCBS) announced this week that the 11,800 members of the failed Oregon Health Consumer Owned and Operated Plan (CO-OP) can apply the out-of-pocket (OOP) costs that they have already accrued to any other plan offered by carriers in the individual market. (Insurance regulators in Illinois and Ohio are negotiating similar agreements for failed CO-OPs in their states.)

The Oregon Health CO-OP was forced to cease operations on July 31st and DCBS created a special enrollment period starting July 11th for individual subscribers to choose other coverage in or out of the Marketplace that would be effective August 1st (see Update for Week of July 18th). However, premium and cost-sharing subsidies offered by the Affordable Care Act (ACA) will only be available within the Marketplace.

Oregon Health was the second CO-OP to fail within Oregon since last year, after a shortfall in ACA reinsurance payments left unable to pay medical claims (see Update for Week of November 30th). Only seven of the 23 non-profit insurance cooperatives created with ACA start-up loans remain in operation (see Update for Week of July 18th).

Oregon Health is one of three Oregon insurers (including LifeWise and Trillium) that will be leaving the Marketplace for 2017. Seven insurers will remain. However, several that offered plans statewide in 2016 have announced plans to limit their coverage areas next year to mostly metropolitan

areas. This includes BridgeSpan (which will drop three rural counties), Moda Health Plan (which will drop ten counties), and PacificSource (which will offer coverage in only six counties), and Providence Health Plan (which will eliminate coverage for 17 of the state's 36 counties). Only one carrier (Zoom+Performance Health Plan) will expand coverage, though only by one county.

Oregon's largest carrier, Regence Blue Cross and Blue Shield, does not participate in the Marketplace but still plans to eliminate individual market coverage for ten counties in 2017.

Insurers in and out of the Marketplace will largely receive their requested 2017 premium increases for the individual market. Rate hikes range from 9.8 percent for Health Net (which does not participate in the Marketplace) to 29.3 percent for Moda Health Plan, with a weighted average of roughly 24 percent.

As with last year, state regulators actually required insurers such as Health Net and ATRIO to increase their premiums in order to ensure the carriers remain solvent if they incur unexpected losses from an exceptional number of high-cost claims (see Update for Weeks of June 8 and 15, 2015).

Pennsylvania

Governor signs bill allowing for interchangeable copies of biologic drugs

Governor Tom Wolf (D) signed legislation last week making Pennsylvania one of at least 23 states to regulate a pharmacist's substitution of biosimilar drugs for their brand-name reference product.

S.B. 514 largely follows model legislation supported by the Biotechnology Innovation Organization (BIO). It would only allow biosimilar substitution of biosimilar products deemed interchangeable by the FDA and only if the pharmacy informs the patient of the substitution and retains a record of the biosimilar dispensed.

The Affordable Care Act (ACA) created the first regulatory pathway for approval of biosimilar drugs. Although the Food and Drug Administration (FDA) is in charge of determining whether a biosimilar is "interchangeable", it is up to states to judge whether one product may be substituted in place of a physician prescription and whether a pharmacist must inform patients or physicians if they make a substitution.

Utah

CMS requires new public comment period on partial Medicaid expansion

The Centers for Medicare and Medicaid Services (CMS) sent a July 15th letter to the Department of Health requiring state officials to publicly disclose more fiscal and enrollment data before CMS will decide whether to approve the state's plan to expand Medicaid to 11,000 residents earning up to 55 percent of the federal poverty level (FPL).

Governor Gary Herbert (R) signed the partial expansion plan into law last spring over the objections of Democratic lawmakers who referred to it as "less than crumbs" (see Update for March 7-25, 2016). However, H.B. 437 was a compromise with conservative lawmakers opposed to any form of expansion and is not likely to be approved by CMS, which has yet to approve any partial Medicaid expansion under the Affordable Care Act (ACA).

The Governor secured tentative federal approval last fall for his Healthy Utah plan to expand Medicaid for roughly 146,000 Utahns earning up to 138 percent of FPL—the threshold set by the ACA (see Update for Weeks of October 5th and 12th). The partial expansion will instead guarantee Medicaid coverage only for 12 months to just an estimated 12,500 childless adults and 3,800 adults. H.B. 437 opponents note that the bill still leaves everyone earning form 55-100 percent of FPL without access to either Medicaid or premium subsidies offered by the ACA.

Utah would have received more than $420 million in ACA matching funds under the Governor's plan. However, H.B. 437 will instead only receive $70 million in federal funds and cost the state just $30 million, with 45 percent of that cost covered by a hospital assessment (see Update for Weeks of February 22nd and 29th).

According to CMS, the agency will issue its decision on the partial expansion once Utah holds an additional public comment period.

Wyoming

Marketplace premium hikes remain in single digits despite only one participating insurer

Despite only one of two states with only one participating Marketplace insurer for 2017, consumers are likely to benefit from the second-lowest average premium increase nationwide.

Only insurers in the Rhode Island Marketplace have proposed a lower average rate hike than then 7.4 percent average sought by Wyoming Blue Cross and Blue Shield (BCBS). Because Wyoming remains one of only three states without an effective rate review process (see Update for Week of July 18th), premium increases are reviewed by the federal government. However, the 7.4 percent increase is likely to go into effect as it is not high enough to meet the double-digit threshold for the federal Centers for Medicare and Medicaid Services to determine if it is "unreasonable" and reflective of medical inflation (see Update for Week of August 29, 2011).

The 7.4 percent average increase sought by Wyoming BCBS is higher than the six percent average hike they received for 2016, which was roughly the same as the average nationwide increase for benchmark silver-tier plans.

Roughly 22,000 consumers are currently enrolled in Marketplace coverage offered by Wyoming BCBS, which has been the lone carrier since WINHealth stopped offering coverage after 2015 (see Update for Week of October 5th and 12th). Wyoming has the highest percentage of Marketplace enrollees receiving subsidies (92 percent), with the subsidy amount averaging $459 per month.