Health Reform Update – Week of August 15, 2016

CONGRESS

GAO faults CMS for failing to verify accuracy of Medicare Part B drug pricing data

A new Government Accountability Office (GAO) report released on August 1st concludes that the Centers for Medicare and Medicaid Service (CMS) needs to do a better job verifying the accuracy of claims data it uses to set Medicare Part B payment rates.

Part B reimburses for drugs typically administered by a physician or in a physician office, such as those that are infused. The current formula pays physicians 106 percent of the average sales price (ASP), although the ongoing Medicare sequestration lowers that by about two percent.

These payment rates are calculated quarterly by CMS based on price and volume data reported by drug manufacturers. However, members of Congress and the Medicare Payment Advisory Commission (MedPAC) have questioned the accuracy of these payments.

GAO interviewed CMS, the Inspector General for the Department of Health and Human Services, and drug manufacturers in confirming that CMS is failing to "routinely verify the underlying data, which is inconsistent with federal internal control standards." In particular, GAO recommended that Congress require all drug manufacturers to submit Part B price data, as currently only those that participate in the Medicaid drug rebate program must do so. GAO noted that without all companies submitting data, the pricing data used by CMS does not reflect the true ASP of all drugs sold.

Furthermore, GAO found that CMS "typically does not verify" pricing data submitted by manufacturers and instead relies on the company self-attestation of their accuracy.

The investigative watchdog for Congress noted that CMS has "resisted" prior GAO recommendations on Part B drugs, but pledged to implement the changes proposed by GAO in this report (GAO-16-594).

FEDERAL AGENCIES

CMS considers limiting third-party premium assistance from non-profits

The Centers for Medicare and Medicaid Services (CMS) issued a Request for Information (RFI) this week soliciting public comments within 30 days on how the agency should limit premium and cost-sharing assistance made by non-profit charitable organizations.

The move is in direct response to anecdotal complaints from the nation's largest insurers that some providers or provider groups are using such third-party payments to improperly steer consumers otherwise eligible for Medicare or Medicaid into qualified health plans (QHPs) with higher reimbursement levels. Executives with Aetna, Anthem, the Blue Cross and Blue Shield Association, and UnitedHealth Group have blamed third-party assistance for contributing to sicker and more costly risk pools, ultimately forcing Aetna and UnitedHealth Group to leave most of their Affordable Care Act (ACA) Marketplaces for 2017 (see below).

UnitedHealth Group also recently sued the American Renal Association in an effort to prevent premium assistance payments made through the American Kidney Fund (AKF). Dialysis Patients Citizens, which helps patient gets assistance from groups like AKF, countered with their own lawsuit

against Blue Cross and Blue Shield of Idaho for refusing to accept non-profit premium assistance, insisting that it violates ACA provisions barring discrimination against persons with pre-existing conditions.

The RFI appears targeted at provider-affiliated groups, and not bona-fide independent charities such as Patient Services Inc. (PSI) that operate with the approval of multiple advisory opinions from the Inspector General for the Department of Health and Human Services (HHS). CMS concurrently sent a letter to all dialysis centers and facilities participating in Medicare warning them that using premium assistance payments to delay the enrollment of qualified consumers into Medicare or Medicaid may result in civil monetary penalties.

The RFI and concurrent public statements from CMS officials were more supportive of the insurers' position than the agency's proposed Notice of Benefit and Payment Parameters for 2017 that suggested CMS might require Marketplace insurers accept non-profit premium assistance, the same as they are now required to do for state and federal health programs like the Ryan White HIV/AIDS Program (see Update for Week of November 30th). At least 99 members of Congress from both parties have backed a Congressional bill pursued by PSI (H.R. 3742) that would force CMS to impose that requirement and South Carolina Rep. Tommy Stringer (R) has already introduced comparable legislation in his state (H.5317).

However, opposition from America's Health Insurance Plans (headed by former CMS Administrator Marilyn Tavenner) and the Marketplace exits of dominant insurers have not only caused CMS to reconsider, but led insurance commissioners in at least two states (Idaho and Minnesota) to issue regulations allowing non-profit premium and cost-sharing assistance only from independent charities unaffiliated with providers who base their assistance on financial need (such as PSI). According to *Inside Health Policy*, other state insurance regulators are considering similar actions.

CMS may continue reinsurance payments for Marketplace insurers

In addition to limiting non-profit premium assistance (see above), the Centers for Medicare and Medicaid Services (CMS) hinted last week that new regulations are forthcoming that should "strengthen" the Marketplaces created by the Affordable Care Act (ACA) by ensuring broader risk pools for participating insurers.

The blog post from CMS's Marketplace chief executive officer specifically suggested that CMS may create a new reinsurance program following the December 2016 end of the temporary three-year reinsurance program created by the ACA. Under the program, participating insurers whose claims costs exceed a threshold of $2 million would receive supplemental payments from a pool of funds to which all insurers contribute. Although the new program would benefit fewer insurers than the one created by the ACA (and offer smaller payments), insurers leaving the Marketplaces have cited the lack of any reinsurance payments starting in 2017 as a major reason why they chose to do so.

The announcement specifically credited a new state reinsurance program in Alaska for reducing 2017 premium increases by the lone Marketplace insurer (Premera Blue Cross and Blue Shield) from 40 percent to ten percent (see Update for Week of July 18th).

CMS insists that it is weighing the new program (as well as other Marketplace changes) solely to assuage concerns of nervous insurers and not because the risk pools are actually drawing large number of so-called "sicker" and more costly consumers. The agency issued the blog post concurrent with its release of 2014 and 2015 data showing that per-enrollee costs remained stable in the Marketplaces (actually falling by 0.1 percent), while they increased by 3-6 percent in the broader individual market.

CMS officials insist that the data shows the Marketplace risk pools attracted healthier consumers in their second year of operation (2015) and argued that the data indicates premium increases will likely stabilize in coming years. However, critics point out that the flawed rollout of the Marketplace web portals

in 2014 likely depressed the number of healthier consumers in the first year enrollment figures and that the healthier 2015 risk pools were just an expected correction and not likely to be a long-term trend. The head of America's Health Insurance Plans (former CMS Administrator Marilyn Tavenner) termed CMS' interpretation of the data as "overly optimistic", insisting that the Marketplace risk pools remain flawed.

A policy brief released this week by the Robert Wood Johnson proposed that CMS create a permanent reinsurance program, similar to the one in place for Medicare Part D.

Marketplace premiums to increase dramatically but still remain below CBO projections

The Kaiser Family Foundation (KFF) released an analysis earlier this month showing that average benchmark premiums for 17 major cities are likely to jump by nine percent in Affordable Care Act (ACA) Marketplaces, compared to only a two percent increase in 2016.

Researchers claimed that the accelerated growth is due largely to the expiration of the ACA's temporary reinsurance and risk corridor payments, which helped to stabilize premiums in the initial years of full ACA implementation by compensating those insurers with exceptional numbers of sicker and more costly subscribers. They note that several insurers also underestimated per enrollee health care costs in setting premiums for prior years.

However, the study also stressed that despite the dramatic rate hike, premiums for benchmark plans (i.e the second-lowest cost silver plans) to which premium subsidies are tied) remain about 12 percent below the initial projections by the Congressional Budget Office (CBO) in 2009. CBO had estimated that as a result of the ACA benchmark premiums would average about $5,200 for single coverage in 2016, compared to the $4,583 average tallied by Kaiser.

Researchers attributed the lower average to "strong competition" in the ACA Marketplaces, as well as a continued slowdown in health care cost growth that started during the economic recession preceding the ACA. However, they cautioned that recent Marketplace exits by major insurers such as UnitedHealth Group (see Update for Week of April 18th), Humana, and Aetna (see below) could diminish competition and put upwards pressure on future premiums.

Employer coverage has remained stable among large employers, but eroded for small groups

A new report released last week by the Employee Benefit Research Institute found that the number of large employers providing employee health coverage has held steady since full implementation of the Affordable Care Act (ACA) in 2014, despite a continued decrease in the number of small employers offering coverage.

The survey showed that more than 95 percent of companies with 100 or more workers offered coverage prior to 2014 and continue to do so. However, only 74 percent of companies with 25-99 employees still provide employee coverage, with the most precipitous drop (down from 59 to 23 percent) among those with fewer than ten workers.

Researchers cite several factors for the erosion in small employer coverage including more sensitivity to premium increases and fears of rising healthcare costs, as well as the greater of availability of individual market coverage through the new ACA Marketplaces.

CMS will end ACA subsidies for consumers enrolled in both Marketplace and Medicaid/CHIP

CMS announced last week that it will shortly notify consumers enrolled in federally-facilitated Marketplace (FFM) plans and Medicaid or the Children's Health Insurance Program (CHIP) that the premium and cost-sharing assistance they currently receive through the Affordable Care Act (ACA) will be terminated in 30 days.

The agency did not reveal the potential number of consumers that may be affected by this change, although earlier estimates place the number at around two percent of all federally-facilitated Marketplace enrollees (or 100,000 consumers). The initial notice will direct FFM consumers to immediately update their coverage information on www.healthcare.gov to ensure they are not enrolled in Medicaid or CHIP and at risk of losing the subsidies. Those that fail to make any changes will receive the termination notice 30 days following the first notice.

STATES

Aetna pulls out of Marketplaces in all but four states

Aetna, the nation's third largest insurer, announced this week that it will dramatically curtail its participation in Affordable Care Act (ACA) Marketplaces for 2017.

The move came as a surprise since Aetna had stated as recently as May that it would expand from 15 to 20 Marketplaces next year, including moving into states like Kansas where UnitedHealthcare is departing (see Update for Week of May 16th). Aetna's chief executive officer now claims that second-quarter financials showing a loss of more than $300 million on Marketplace business for 2016 is the basis for their withdrawal. However, Aetna officials hinted in a July letter to the Department of Justice (DOJ) that it may choose to reverse course should Aetna's planned merger with Humana not be approved. As a result, it appears that Aetna's withdrawal from all but four Marketplaces may be a negotiating tactic following the lawsuit DOJ filed to block the merger—a case that will not be heard until December.

Starting with the 2017 plan year, Aetna now plans to participate only in the Marketplaces for Delaware, Iowa, Nebraska, and Virginia. All but Delaware are operated by the federal government.

Aetna left the door open for a return to other Marketplaces "if the exchange risk pool stabilizes". However, federal regulations prohibit them from doing so for at least five years.

Marketplace competition will decline significantly in 2017

According to the Robert Wood Johnson Foundation (RWJF), the loss of major insurers Aetna, UnitedHealthcare, and Humana from most of the Affordable Care Act (ACA) Marketplaces that they previously served will significantly limit competition next year but likely impact mostly consumers in rural areas.

The Kaiser Family Foundation had already predicted last spring that the number of rural counties with only one participating Marketplace insurer would triple in 2017 (up to 664 counties), following UnitedHealthcare's departure from 31 of 34 Marketplaces (see Update for Week of April 18th). However, that was before Humana announced it would leave four of its 15 Marketplaces (see Update for Week of April 18th) and Aetna decided to exit 11 of 15 Marketplaces (see above).

In addition, several Blue Cross and Blue Shield plans have also announced plans to withdraw from certain Marketplaces or scale-back the number of counties they serve, while 16 of the 23 non-profit Consumer Owned and Operated Plans (CO-OPs) created by ACA loans have already failed (see Update for Week of July 18th). CO-OP plans typically offered the lowest premiums in each Marketplace.

Overall, 13 Marketplace insurers are planning to withdraw in 2017 while only seven smaller insurers are coming onboard. As a result, Kaiser now predicts that one out of every four counties nationwide may have only one participating insurer, although competitors still have time to fill the void before open enrollment starts on November 1st. Several smaller insurers have already chosen to jump in to limited markets, including UnitedHealth subsidiary Harken Health Plan in south Florida. At least one

larger insurer (CIGNA) plans to actually expand their coverage in 2017 (including into underserved rural counties in North Carolina)

Both RWJF and Kaiser stressed this week that Marketplace consumers in most major metropolitan areas (including those in large states like California, New York and Texas) will still have at least three participating insurers from which to choose in 2017. However, the level of participation varies greatly by region. Consumers living in metropolitan areas in the northwest, Midwest, and New England states will only be minimally impacted by the insurer exits. By contrast, those in Arizona, the Carolinas, and Georgia are likely to have two or fewer insurers from which to choose.

Arizona will be particularly hard hit as four of its eight participating insurers from 2016 are withdrawing from the Marketplace. Its largest urban area of Phoenix will be served by only CIGNA and Phoenix Health Plan, while a dozen other counties will have only one insurer and Pinal County currently has none.

Georgia will drop from nine to six Marketplace insurers, while Florida will from 19 to 11 (though it appears only two will serve all 67 counties).

The loss of Aetna now means that South Carolina will join Alabama, Alaska, and Wyoming as the only states with only one insurer (Blue Cross and Blue Shield).

Three more CO-OPs sue federal government over ACA risk corridor payments

Six of the seven surviving Consumer Owned and Operated Plans (CO-OPs) created with Affordable Care Act (ACA) start-up loans are now suing the federal government in hopes of reducing the millions they must pay larger insurers under the ACA's risk corridor program.

The three-year risk corridors programs was meant to stabilize Marketplace premiums by making insurers with healthier and less costly risk pools compensate those that took on sicker and more costly subscribers. However, the result has been to force small non-profit competitors like Evergreen Health in Maryland to pay that state's dominant carrier CareFirst Blue Cross and Blue Shield more than $22 million or 26 percent of its total premium revenue.

Evergreen Health was the first CO-OP to sue the federal government in order to block these payments, which it insists would cause it to become insolvent (see Update for Week of June 20th). Over the last two weeks, three others have filed similar federal lawsuits (Minuteman Health in Massachusetts and New Hampshire, Health Connections in New Mexico, and Community Health Options (CHO) in Maine and New Hampshire).

Minuteman and Health Connections are required to pay $16.7 million and $14.5 million respectively in ACA risk corridor payments. CHO is the only remaining CO-OP that does not have to make a risk corridor payment for 2015 (see Update for Week of July 18th) and is suing to recover $22.9 million that it claims it is owned by the federal government, which it must have to offset $31 million in losses for 2015, causing it to be put into receivership with the Bureau of Insurance (see Update for Week of December 7th). It was the only one of 23 CO-OPs to turn a profit in 2014, garnering a staggering 83 percent share when it was the only competitor to Anthem Blue Cross and Blue Shield (see Update for Weeks of August 31st and September 7th).

Enrollment lags among state-based small group Marketplaces, despite strong competition

A Commonwealth Fund review of the Small Business Health Options Program (SHOP) created by the Affordable Care Act (ACA) found that enrollment lags below expectations 13 of the 17 states that operate a state-based SHOP (plus the District of Columbia) despite robust competition from three or more insurers.

The study found that New York and California have each enrolled over 3,600 small groups (covering approximately 42,000 lives). However, five other state-based SHOPs enrolled fewer than 200 small groups. The researchers also found that the average employer group size in state-run SHOPs is consistently below ten employees.

According to the authors, the results show that SHOPs are primarily attracting the "micro-group" market often underserved by brokers and least likely to offer employer coverage prior to the ACA.

California

Sponsor pulls drug price transparency bill that was watered down by amendments

Senator Ed Hernandez (D) withdrew his legislation this week that would have required drug manufacturers to justify treatment costs and price hikes, even though it had cleared the House Appropriations Committee last week and appeared likely to pass the full House.

The measure (S.B. 1010) initially would have required that drug manufacturers provide state agencies and health insurers a justification for increasing the wholesale acquisition cost (WAC) of the drug by more than ten percent or $10,000 for brand-name drugs (within a 12 month period). The same justification would be required for price increases on generic drugs of at least $100 per month or more than 25 percent.

Drug manufacturers would have to provide at least a 60-day notification of any such price increase (similar to existing state requirements on individual and small group insurers) and issue an actuarial justification within 30 days of that notification.

The bill passed the Senate earlier this summer (see Update for Week of June 20th). However, in order to secure passage, the House Appropriations Committee raised the reporting threshold for brand-name drugs to the same 25 percent threshold as for generic drugs. The panel also removed the requirement that drug manufacturers provide justification for price increases and delayed by one year the effective date for the 60-day notification requirement.

According to Senator Hernandez, these amendments significantly "watered down" S.B. 1010 to the point where it could no longer accomplish its goal of "shedding light on the reasons precipitating skyrocketing drug prices" and "making sure drug companies played by the same rules as everyone else in the health care industry."

California was among roughly a dozen states that considered drug price transparency measures this year. However, only Vermont has enacted such legislation (see Update for Week of June 20th).

Colorado

Single-payer ballot initiative will fail to pay for itself without higher taxes

The second in a series of analyses conducted by the Colorado Health Institute concludes that a single-payer initiative on the November ballot would achieve universal coverage for all Coloradans but not without a much higher level of taxes than initially proposed.

The study of ColoradoCare finances determined that if passed by the voters, Amendment 69 would meet its goal of cutting billions of dollars in administrative costs and using that savings to cover the remaining 6.7 percent of Coloradans who remain uninsured following the Affordable Care Act (ACA).

Revenues from a ten percent payroll tax (starting in December 2018) must account for at least two-thirds of ColoradoCare's funding in order for it to remain in the black. However, researchers with the non-partisan institute predict that the designated revenues will not be able to keep up with increasing

health costs, causing it to face deficits of $253 million in its first year and $7.8 billion over the next decade.

Similar tax projections doomed Vermont's earlier plan to transition to a single-payer system by 2017 (see Update for Week of December 1st 2014).

Starting January 1, 2019, Amendment 69 would substitute ColoradoCare in place of the Connect for Health Colorado, the state-based Marketplace created pursuant to the ACA.

Minnesota

Rate hike proposals delayed as individual market insurers evaluate impact of BCBS exit

The Department of Commerce announced this week that it will grant the additional time sought by Minnesota insurers to revise their 2017 rate proposals in light of the sudden withdrawal from the market of the state's largest insurer.

Blue Cross and Blue Shield (BCBS) of Minnesota stated last month that it would stop selling most individual market policies in 2017 due to projected losses of more than $500 million over the next three years. As a result, other insurers will likely have to assume the costs of covering BCBS's 103,000 subscribers, including those with costlier conditions.

Insurers had asked state regulators for more time to evaluate whether the potential increase in enrollees would require higher premiums than they proposed in submissions filed last May. After receiving federal approval for a delay, Commerce officials have given individual market insurers until September 1st to file new rate proposals.

The Department will still review rate filings to ensure compliance with Affordable Care Act (ACA) consumer protections, including an actuarial justification for any double-digit increase (see Update for Week of August 29, 2011). Final rates will be set by October 1st.

BCBS will still offer HMO policies for 2017 that comes with exceptionally narrow provider networks. These plans will be offered both in and out of the MNSure Marketplace that Minnesota operates pursuant to the ACA.

BCBS is the second major insurer to pull out of MNSure, following Preferred One (see Update for Week of September 15, 2014).

New York

Despite robust competition, Marketplace plans receive double-digit premium increases for 2017

The Department of Financial Services (DFS) issued final approved premium increases last month for 2017 insurers participating in the individual and small group markets.

Average premiums will increase by 8.3 percent for small group plans, but jump to a 16.6 percent average for consumers in the individual market. DFS regulators emphasized that the increases were due not only to increasing medical and drug costs, but also the expiration of the three-year risk stabilization programs created by the Affordable Care Act (ACA).

For the third year in a row, DFS regulators reduced the average premium hikes proposed by insurers. However, for 2017 the final rates are only slightly below those initially sought (17.3 percent in the individual market and 12 percent for small groups). This is compared to far more dramatic reductions in years prior (nearly seven percent in 2015).

Critics note that the sudden reluctance of regulators to reduce rate hikes may be in response to public criticism over the failure of the state's Consumer Owned and Operated Plan (CO-OP) created with ACA loans, who regulators now acknowledge had premiums that were too low and attracted more subscribers than the plan (Health Republic) could handle (see Update for Week of September 28th). Their more cautious approach in 2017 was reinforced by the fact that DFS actually increased premiums for four smaller carriers beyond the small increases the insurers proposed and granted rate hikes of as high as 29.2 percent without any changes.

DFS did dramatically reduce average premium increases sought by two of the state's larger insurers. Empire HealthChoice HMO had their 25 percent average hike downgraded to only about 15 percent while UnitedHealthcare was only allowed a 28 percent average increase instead of the 45.6 percent it sought. New York was one of only three Marketplaces in which UnitedHealthcare planned to remain for 2017, so it remains to be seen whether the lower rate hike will cause it reverse course (see Update for Week of July 18th).

Analysts were somewhat surprised by the size of the increases granted by DFS given the robust level of competition in the NY State of Health Marketplace. All but two of New York's individual market carrier participated in the Marketplace in 2016, and one (Crystal Run) received an 80.5 percent increase.

WellCare is exiting the Marketplace for 2017, bringing the total number of participants down to 16 for the individual Marketplace (and nine for the small group version). However, WellCare will continue offer the Essential Plan—New York's basic health plan option under the ACA.

New York is one of only two states (besides Minnesota) that exercised that option (see Update for Weeks of August 17 and 24, 2015) and it drew nearly 380,000 enrollees earning from 138-200 percent of the federal poverty level away from the Marketplace (which now only has an effectuated enrollment of about 225,000 consumers compared to 407,000 before the Essential Plan started in 2016). The Essential Plan also dramatically reduced the percentage of Marketplace enrollees receiving ACA subsidies (from 70 to 55 percent).

Despite the broad number of insurers, Fidelis Care has by far the largest market share in NY State of Health at 26 percent, while Empire Blue Cross and Blue Shield (BCBS), Oscar Health Plan, Metro Plus, and Health First each have about ten percent. The remaining third is spread thinly among the other carriers (including UnitedHealthcare).

Empire BCBS, Oscar, and UnitedHealthcare all cut broker commissions in 2016 indicated that they do not intend to attract large numbers of consumers to their Marketplace plans (Oscar only offers plans in nine counties).

Oregon

Insurance department allows rate hikes in order to ensure statewide coverage

In an effort to ensure competition in rural areas, the Department of Consumer and Business Services (DCBS) has agreed to allow four health insurers to raise premiums in the individual market so long as they offer statewide coverage.

DCBS had already approved final premiums for 2017. However, their limits forced four insurers to seek to restrict their coverage areas to mostly metropolitan areas (see Update for Week of July 25th). As a result of the negotiations, BridgeSpan Health and Regence Blue Cross and Blue Shield (the state's largest carrier) will continue to offer statewide coverage in exchange for premiums that are 3-6 percent higher on average than those previously approved last month. Providence Health Plan will receive a five percent average bump, while rates for ATRIO Health Plans will rise by 2-8 percent on average.

The expansion of coverage will ensure that every county will continue to have at least two carriers offering plans both on and off of the Marketplace.