Health Reform Update – Week of August 22, 2016

CONGRESS

Congress remains on recess until September 6th.

FEDERAL AGENCIES

AHA urges to CMS to expand third-party premium payment to non-profit charities

The American Hospital Association (AHA) sent a letter this week to the Centers for Medicare and Medicaid Services (CMS) urging the agency to require that Marketplace insurers accept third-party premium and cost-sharing assistance payments from non-profits, the same as CMS regulations require them to do for federal and state health care programs.

At least 102 bipartisan members of Congress have signed onto legislation (H.R. 3742) backed by Patient Services Inc. that would require CMS to take this action. CMS has consistently resisted calls to do so, despite acknowledging in its Notice of Benefit and Payment Parameters rule for 2017 that it was considering such a requirement.

CMS' reluctance has been in part due to complaints from some of the nation's largest insurers that such charitable assistance could be used to steer patients with certain costly illnesses away from Medicare and Medicaid and towards higher-reimbursing Marketplace plans (see Update for Week of August 15th). Insurers claim this practice is causing risk pools to skew towards sicker populations, adversely affecting the bottom line of insurers and causing more of them to exit the Marketplaces.

However, AHA's letter claimed that dramatic Marketplace losses are "largely the result of inaccurate assumptions about the needs of the newly enrolled in the first years of the marketplaces" and recommended that CMS focus on ways to increase the enrollment of healthier and less costly individuals instead of suppressing the enrollment of sicker populations. It insisted that allow third-party assistance from non-profits can balance the risk pools by boosting the enrollment of younger, healthy enrollees with lower incomes.

AHA did support guidelines that would ensure third-party premium and cost-sharing assistance is not available for those eligible for Medicare or Medicaid, basing assistance solely upon financial need, and covering enrollees for an entire policy year.

The letter also echoed insurer calls for limiting the use of special enrollment periods (SEPs) and requiring enrollees to document their eligibility for SEPs, complaints that have already caused CMS to start requiring such verification and eliminate several SEPs (see Update for Weeks of February 22nd and 29th).

Federal Marketplace consumers will be able to compare provider networks in only six states

Consumers using the web portal for federally-facilitated Marketplaces (FFM) at www.healthcare.gov will eventually be able to compare the breadth of provider networks across Marketplace plans. However, the Centers for Medicare and Medicaid Services (CMS) announced last week that the comparisons will initially only be available for six "pilot" states starting with the 2017 open enrollment period.

The six states have yet to be selected by CMS, which will use the initial data to better understand how consumers will use information on provider network breadth as part of their purchasing decision. CMS will then expand the number of pilot states in future years until it is available in all FFM states as the agency's 2017 Notice of Benefit and Payment Parameters rule initially envisioned.

The data will allow consumers to compare provider networks for adult primary care providers, pediatricians, and hospitals during the upcoming open enrollment period, but may also expand to additional provider types in subsequent years.

HEALTH CARE COSTS

Study credits ACA for reducing per capita drug spending while boosting utilization

A new RAND Corporation study published this week in *Health Affairs* revealed a "dramatic increase" in prescription drug use among uninsured individuals who either gained private coverage or Medicaid between 2013 and the full implementation of the Affordable Care Act (ACA) in 2014. However, it credited the Affordable Care Act (ACA) for reducing out-of-pocket spending on prescription drugs, despite the jump in utilization.

Researchers reviewed drug data for 6.7 million individuals and found that individuals who gained Medicaid filled 79 percent more prescriptions on average, yet their out-of-pocket spending per prescription declined by 58 percent (or $205 on average). Those who gained private coverage filled 28 percent more prescriptions with 29 percent lower out-of-pocket costs per prescription (or $86 on average).

Those with at least one chronic condition who gained coverage benefited from even larger decreases in out-of-pocket spending ($279 on average).

Harvard study blames lack of negotiating authority, monopolies for high drug prices

A new analysis released this week by the Harvard Medical School concludes that the "most important factor" contributing to high prices for prescription drugs is the existence of government-protected "monopoly" rights for drug manufacturers.

Researchers reviewed data from January 2005 through July 2016 comparing drug prices in the United States and other countries. It specifically found that the inability of government agencies to negotiate drug prices or not coverage those with prices they deem excessive is unique to the United States and a major reason it has the highest drug prices in the world.

However, it primarily blamed a "patent system that allows drug manufacturers to remain the sole manufacturer of drugs they've patented for 20 years or more", citing the exclusivity drug manufacturers receive for certain products, such as orphan drugs. FDA backlogs of generic drug applications also delay competition for brand-name products.

Manufacturer practices such as "pay for delay" patent infringement settlements that delay the introduction of lower-cost generics were also cited by researchers as a contributing factor, as drug prices decline to 55 percent of their original brand name cost once there are two generics on the market and to 33 percent of original cost with five generics.

The study also concluded that high drug prices cannot be justified solely on the basis of the research and development costs needed to bring a drug to market, including orphan drugs. Researchers noted that such research is typically funded by federal grants from the National Institutes of Health or

venture capital. They determined that drug manufacturers spend only 10-20 percent of their revenue on research and development and based drug prices largely on "what the market will bear".

STATES

Most Marketplace enrollees will not experience major premium hikes in 2017

A new study released this week by The Commonwealth Fund confirmed that 2017 consumers in the health insurance Marketplaces created by the Affordable Care Act (ACA) will pay average premiums that are higher than 2016, but that in most cases the increases will be largely mitigated by higher premium tax credits.

Researchers stressed that the expiration of the ACA's temporary reinsurance program is directly responsible for the lion's share of the premium increases, as the risk stabilization payments lowered Marketplace premiums over the past three years by as much as 14 percent. However, with roughly 83 percent of all Marketplace enrollees receiving premium tax credits under the ACA, average premiums are not likely to rise for this group by much more than the four percent post-subsidy increase for 2016.

The study also emphasizes price competition and not structural flaws are to blame for driving some of the nation's largest insurers (including Aetna, Humana, and UnitedHealth Care) out of most of their Marketplaces. Researchers point to a recent analysis by the Urban Institute showing that these insurers were typically the least price-competitive in their Markets (i.e. their plans were the most costly), thus they attracted far fewer healthier and more price-sensitive consumers than they projected.

Researchers did follow the lead of the Robert Wood Johnson Foundation and recommended that Congress and/or CMS extend the ACA's reinsurance program past 2016, as CMS is currently considering (see Update for Week of August 15th). Alternatively, states could follow the lead of Alaska and create their own reinsurance programs (see Update for Week of July 18th). Either through federal or state action, a permanent reinsurance program similar to that created for Medicare Part D plans would help to restrain premium increases for insurers whose risk pools skew more towards costlier populations.

HHS study shows Medicaid expansion strengthens Marketplace risk pools and lowers premiums

The U.S. Department of Health and Human Services released a report this week showing that consumers in states that have not expanded Medicaid under the Affordable Care Act (ACA) pay an average of seven percent more in Marketplace premiums.

The analysis was based on 2015 premiums for federally-facilitated Marketplaces. It found that in the states that had expanded Medicaid by that point, the risk pools were comprised mostly of individuals earning above 138 percent of the federal poverty level (FPL), while the opposite was true for non-expansion states

Last month, Louisiana became the 31st state to expand Medicaid under the ACA (see Update for Week of June 20th). An unrelated Urban Institute study also released this week determined if any of the remaining 19 states participating in the ACA expansion, they would draw down $7-8 in federal funds for each dollar they spent (over the next ten years). If all 19 states expanded, federal spending on ACA premium and cost-sharing subsidies would fall by up to $129.1 billion while state spending on uncompensated care would drop by up to $27.1 billion. Over the next ten years, Mississippi would have the most to gain, followed closely by Tennessee and Alabama.

Health insurance start-up Oscar quits two ACA Marketplaces

Oscar Insurance Corporation announced this week that it will no longer participate in two Affordable Care Act (ACA) Marketplaces next year after losing more than $180 million over two years on Marketplace business.

The small start-up promotes itself as a narrow network alternative to larger health insurers and targeted only limited markets in the Marketplaces for California, New Jersey, New York, and Texas. It has just about 130,000 enrollees across all four states.

For 2017, Oscar will no longer offer plans for its 26,000 consumers in the New Jersey Marketplace, citing its restrictions on narrow networks. It will also limit plans only to the San Antonio metro area within the Texas Marketplace, ending its plan offerings for the Dallas-Fort Worth metro area due to an "unpredictable insurance market".

Oscar will remain in the Los Angeles and New York City metro areas and expand coverage in 2017 to San Francisco consumers.

<u>California</u>

Study shows California has extended coverage to nearly three-quarters of previously uninsured

A new survey released this week by the Kaiser Family Foundation found that 72 percent of Californians that were uninsured as recently as 2013 now have minimum essential health coverage following full implementation of the Affordable Care Act (ACA).

The state's decision to expand Medicaid under the ACA directly resulted in one-third of this amount, while 11 percent enrolled in coverage via the Covered California Marketplace created pursuant to the ACA.

Of those who remain uninsured, nearly 60 percent are actually eligible for Medi-Cal or ACA subsidies to purchase Marketplace coverage, yet have not enrolled. Nearly half of those who remain uninsured cited cost as the primary barrier to coverage.

Legislature approves bill requiring notification of unreasonable rate hikes

The legislature has sent legislation to Governor Jerry Brown (D) that would require health insurers send consumers a written notice whenever state regulators determine that a premium increase is "unreasonable" and not based on increases in medical costs.

Under existing state law, both the Department of Managed Health Care and the Department of Insurance review plan increases in premiums. However, legislation that would give them the authority to modify or reject rate hikes was not reintroduced this year after stalling in several prior sessions. A ballot referendum to achieve the same goal was also defeated (see Update for Week of November 3, 2014).

As a result, the agencies can simply exercise the authority provided under the Affordable Care Act (ACA) to require that insurers publicly justify any premium increase found to be unreasonable (see Update for Week of August 29, 2011). If signed by the Governor, S.B. 908 would make sure that each subscriber is aware of the agency's decision by requiring insurer notification at least 60 days before the policy renewal date or ten day before the start of the next open enrollment period.

Governor Brown has not indicated whether he will sign the bill. It is opposed by America's Health Insurance Plans, the Association of California Life and Health Insurance Companies and the California Association of Health Plans.

Colorado

Board recommends broader (but not full) coverage of hepatitis C drugs

The Medicaid Drug Utilization Review Board formally recommended last week that Colorado's Medicaid program extend coverage for anti-viral hepatitis C drugs to patients in the final three stages of liver damage and to women of childbearing age with hepatitis C at any stage of liver damage.

Colorado currently limits coverage of hepatitis C drugs only to those in the final two stages of liver disease, following the lead of Oregon, Illinois, and at least 31 other states (see Update for Weeks of January 11th and 18th). State officials insist that they cannot afford to cover hepatitis C drugs for all Medicaid enrollees, citing the more than $26.6 million it has spent to cover only 326 patients since 2013.

The American Civil Liberties Union has threatened to file suit against the state if it does not extend coverage to hepatitis C drugs to all Medicaid enrollees. At least four states have already done so following a determination by the Centers for Medicare and Medicaid Services (CMS) and a federal court in Washington that such rationing of hepatitis C drug coverage violates anti-discrimination provisions of federal Medicaid law (see Update for Week of June 20th).

Florida

UnitedHealth Care subsidiary will not enter Marketplace for 2017

Harken Health Insurance Company announced earlier this month that it no longer plans on entering the Affordable Care Act (ACA) Marketplace for Florida next year.

Harken, a subsidiary of UnitedHealth Care, began offering coverage in the Chicago and Atlanta areas for 2016, using a managed care model that includes a network of primary care clinics and personal counselors to guide members through enrollment options. They had planned on offering Marketplace coverage in Miami-Dade and Broward counties for 2017, but have now decided to postpone expansion plans until at least the following year.

Harken's reversal means that the ACA Marketplace in Florida will only have eight participating insurers for 2017, down from ten this year. (That number could further decline if Humana does not receive the 44 percent average premium increase it claims that it needs to remain.) CIGNA is the lone insurer coming on board after it left the Florida Marketplace just for 2016.

Plan availability will vary dramatically within Florida as UnitedHealth Care's defection means that only Florida Blue will be available to consumers in 44 of Florida's 67 counties. Only those in the Orlando, Tampa-St. Petersburg, and Miami-Ft. Lauderdale areas will have two or more Marketplace insurers from which to choose. However, these areas constitute more than 85 percent of all enrollees in the Marketplace.

Marketplace insurers are seeking an average overall premium increase of 13.3 percent. The Office of Insurance Regulation is expected to announce final approved premiums next week.

Georgia

BCBS gets higher rate hike after Aetna withdrawal

The Department of Insurance has agreed to allow Blue Cross and Blue Shield of Georgia increase Affordable Care Act (ACA) Marketplace premiums by an average of 21.4 percent in response to Aetna's withdrawal for 2017.

Georgia is one of 11 states where Aetna announced last week that it will no longer participate (see Update for Week of August 15th), currently leaving BCBS as the only insurer that will offer plans

statewide in all 159 counties. Since most of Aetna's 90,000 Marketplace enrollees in Georgia will have no choice but to enroll in BCBS or leave the Marketplace entirely, state regulators gave BCBS the opportunity to increases its approved 15.1 percent average rate hike for next year.

Regulators submitted the final premiums to the U.S. Department of Health and Human Services (HHS) this week. All five of the remaining Marketplace insurers received double-digit increases for next year, led by Humana at a whopping 67.5 percent and Harken Health (a UnitedHealth Group subsidiary) at 51 percent. (Kaiser Permanente received a 17.6 percent average increase). However, under the ACA, HHS can only require BCBS or other insurers to publicly justify any double-digit rate hikes and cannot modify or reject the increases (see Update for Week of August 29, 2011).

BCBS, which is the state's largest insurer, insisted this week that they are "committed to the exchange in Georgia" and have no plans to withdraw. Nearly 600,000 Georgians enrolled in Marketplace coverage for 2016, an increase of more than nine percent from 2015.

Kentucky

Governor seeks federal approval to overhaul Medicaid expansion

Governor Matt Bevin (R) submitted his proposed Section 1332 waiver this week that threatens to terminate Kentucky's existing Medicaid expansion if the federal government does not allow the state to charge higher premiums and copayments, as well as establish lock out periods and work requirements.

Former Governor Steve Beshear (D) had made Kentucky the only southern state to participate in the Medicaid expansion under the Affordable Care Act (ACA), prior to Louisiana's expansion earlier this year (see Update for Week of June 20th). Governor Bevin had pledged to end Beshear's expansion as part of his campaign last fall, but decided instead to try and make Kentucky the eighth state to secure federal approval for a private-sector alternative that uses ACA expansion funds to purchase Marketplace coverage for those made newly-Medicaid eligible (see Update for Weeks of February 8th and 15th).

However, the waiver that the Governor released for public comment last spring included provisions that consistently have been rejected by the Centers for Medicare and Medicaid Services (CMS), including high premiums and copayments on Medicaid enrollees earning below 100 percent of the federal poverty level and provisions locking enrollees out of coverage for certain periods of time if they fail to make timely payments (see Update for Week of July 25th). In addition, the Governor including a work requirement that CMS has already stripped out of plans submitted by conservative governors in other states (see Update for Week of November 30th).

The Governor refused to remove or alter these provisions in his final waiver, despite significant opposition from consumer and provider groups during the public comment period. His waiver also left little room for compromise, insisting that the Commonwealth will only continue the ACA expansion if his terms are met.

The Medicaid expansion had allowed Kentucky to achieve the second-greatest reduction in its uninsured rate since the implementation of the ACA (following Arkansas) (see Update for Week of January 4th). More than 400,000 Kentuckians would be forced to find other coverage if the expansion were terminated for 2017, most of whom were uninsured before the expansion took effect.

Michigan

Two non-profits pull all PPO options from ACA Marketplace

Two non-profit carriers announced this week that they are withdrawing all of their PPO plan offerings from the Affordable Care Act (ACA) Marketplace in Michigan.

Health Alliance Plan (HAP) and Priority Health cited the recent decision of UnitedHealth Care and Humana to exit the Marketplace for 2017 as the reason for their withdrawal (see Update for Week of July 18th). However, both HAP and Priority Health will continue to make its HMO plan options available on the Marketplace.

As a result of their decision, Blue Cross and Blue Shield (BCBS) of Michigan is the only Marketplace insurer that will offer PPO options for 2017. The dominant insurer is seeking a nearly 19 percent average increase in plan premiums to compensate for more than $70 million in Marketplace losses, far below the 39 percent hike sought by Humana before their exit but higher than all but two of the ten remaining insurers in the Marketplace. (Overall, Marketplace insurers are seeking a 17.5 percent average increase).

Priority Health, which is seeking nearly a 14 percent average premium increase, insists that it will offer more individual plan options than any other Marketplace insurer for 2017, including BCBS.

North Carolina

Despite CIGNA entrance, most Marketplace consumers will have choice of only one plan

Despite nearly $300 million in losses, Blue Cross and Blue Shield (BCBS) of North Carolina reiterated this week that it is no longer planning on leaving the Affordable Care Act (ACA) Marketplace and will continue to offer coverage statewide in 2017.

Competition from UnitedHealth Group and Aetna was not enough to prevent BCBS from upping Marketplace premiums for 2016 by more than 32 percent on average. They are seeking only an 18.8 percent average increase for 2017 but have instead sought to offer only 24 plans, including the elimination of all platinum-tier coverage. (Aetna would have received a 24.5 percent average increase had they stayed).

BCBS will face only nominal competition in 2017 from new entrant CIGNA, which will offer coverage in six counties surrounding Raleigh-Durham. Marketplace consumers outside of that metropolitan area will only be able to choose from BCBS offerings.

BCBS sued the federal government last June seeking to recover funds they are owed for 2014 and 2015 through the ACA's temporary risk corridor and reinsurance program (they have only received 13 percent of funds to which they are entitled) (see Update for Week of June 20th). However, that program ends after 2016.

The North Carolina Insurance Commissioner (an ACA proponent) has been conducting an investigation since last February into more than 1,000 formal complaints from consumers unable to purchase BCBS Marketplace coverage during open enrollment periods due to software flaws. BCBS insists that such problems are resolved and will not recur during 2017 open enrollment.

North Carolina enrolled nearly 615,000 consumers in Marketplace coverage for 2016, the third-highest total for any federally-facilitated Marketplace (trailing only Florida and Texas).

Tennessee

Insurance commissioner grants dramatic hikes to prevent Marketplace "collapse"

Insurance Commissioner Julie Mix McPeak (R) insisted this week that dramatic rate hikes granted by her office were needed to prop up an Affordable Care Act (ACA) Marketplace that was "very near collapse".

For the third year in a row, Blue Cross and Blue Shield (BCBS) of Tennessee is the only insurer that will sell coverage statewide in 2017. The state's dominant insurer has incurred nearly $500 million in Marketplace losses from 2014-2016.

Following the departure of UnitedHealth Care, the commissioner allowed BCBS (as well as competitors CIGNA and Humana) to upgrade their proposed rate hikes, similar to the actions taken in Georgia (see above), Minnesota (see Update for Week of August 15th), and other states. The commissioner granted CIGNA and Humana 44-46 percent average increases without taking any action to modify their proposals. BCBS asked for a received a whopping 62 percent average increase.