

Health Reform Update – Week of July 9, 2018

CONGRESS

Ways and Means Committee advances bills that would delay ACA mandates, expand health-savings accounts

The House Ways and Means Committee marked-up a package of eleven health reform bills this week in an effort to further roll-back or delay key provisions of the Affordable Care Act (ACA).

The measure that gained the most attention (H.R. 4616) would retroactively repeal the ACA's mandate that large employers provide minimal and affordable essential coverage or pay a per employee assessment (see Update for Week of December 18th). The Obama Administration delayed the mandate until 2015 for companies with more than 100 workers and 2016 for those with 50-100 employees (see Update for Week of February 10, 2014).

Despite the Trump Administration's effort to weaken or eliminate other ACA provisions, the Internal Revenue Service has continued to enforce this "employer mandate" as it would bring in more than \$200 billion over the next decade, according to the Congressional Budget Office (see Update for Week of November 13th). The Kaiser Family Foundation predicts the assessment will be levied on roughly eight percent of companies with 50-199 workers who currently fail to offer minimum essential coverage that meets the ACA affordability threshold.

The same bill, which passed on a straight party-line vote, would further delay the ACA's 40 percent excise tax on high-cost health plans until 2023. This "Cadillac" tax had been slated to go into effect in 2018 but previously delayed until 2022 (see Update for Week of January 22nd).

Delaying both the employer mandate and Cadillac tax is projected to cost \$40 billion over the next decade due to lost revenue. However, Republican leaders blocked efforts by Democrats to postpone the vote until offsets were identified.

Other measures that passed with only Republican support include H.R. 6311, which would allow consumers to use ACA premium tax credits to purchase any health plan they choose, not just those offered within the ACA Marketplaces. It would also eliminate the restriction preventing those age 30 or more from purchasing limited-benefit catastrophic health plans within the Marketplaces.

Several measures would expand the use of health savings accounts (HSAs). These include H.R. 6306, which would increase the annual contribution limit so that it matches the plan's annual deductible and out-of-pocket maximum. An amendment offered by Rep. Lloyd Doggett (D-TX) that would have prevented HSAs from discriminating based on pre-existing conditions was defeated on a straight party-line vote.

One measure that received bipartisan support was H.R. 6199, which would repeal an unpopular provision of the ACA that prevents over-the-counter products from being eligible for reimbursement by flexible spending plans or HSAs. A separate measure (H.R. 6313) that would allow FSA funds to roll-over from year to year was backed only by Republicans.

Chairman Kevin Brady (R-TX) expects the bills to move to the House floor as part of a broader reform package by the end of July, along with a measure by Rep. Erik Paulsen (R-MN) to permanently repeal the ACA's tax on medical device manufacturers.

House hearings focus on GAO recommendation to boost oversight of 340B contract pharmacies

The House Energy and Commerce Subcommittee on Health held two hearings over the past several weeks to examine the recent Government Accountability Office (GAO) report urging greater oversight over the Section 340B drug discount program.

The 340B program allows hospitals that serve a certain threshold of low-income patients to purchase some prescription drugs at a discount in order to cover other areas of uncompensated care. However, the program has come under increased scrutiny after earlier audits by GAO and the Office of Inspector General (OIG) for the Department of Health and Human Services (HHS) found that discounts were not always benefiting low-income, uninsured individuals and could be used by participating safety net providers to reap “windfall” profits (see Update for Weeks of July 1 and 8, 2013).

A report by the full committee earlier this year found that 340B drug savings are not properly being passed on from participating safety net providers to consumers and called on Congress to increase and standardize reporting and audit requirements and provide the Health Resources and Services Administration (HRSA) with greater authority and resources to conduct adequate oversight (see Update for Week of January 8th). This led to a flurry of at least 15 House and Senate bills that would heighten reporting and transparency requirements for 340B providers (see Update for Week of March 19th).

While there has been broad bipartisan agreement about the need to clarify the intent of the 340B program and establish more clearly-defined rules on eligibility, committee Democrats and hospital groups have pushed back against many of the proposals debated by the committee, including suspending or freezing enrollment (as would be done under H.R. 4710), reducing the number of 340B hospitals, or raising the Disproportionate Share Hospital (DSH) percentage for participation in the program. Instead, Democrats have largely urged greater parity in HRSA oversight of covered entities and drug manufacturers, noting that HRSA has conducted 831 audits of participating hospitals in the past five years but only 17 audits of drug manufacturers.

The subcommittee hearing focused on GAO’s latest report last month that criticized “lax” HRSA oversight of pharmacies with which 340B providers contract to distribute drugs. It found that less than two percent of participating providers have been audited and offered seven specific recommendations to strengthen HRSA oversight, including improving the data used in the audit process and providing greater clarity of HRSA guidance to providers, especially as it relates to preventing duplicate discounts under the Medicaid drug rebate program.

HRSA disagreed with four of the GAO’s recommendations, including a requirement to make providers register every contract with pharmacies and those that would make participating providers explain how they are correcting deficiencies identified in audits. The agency insisted the new requirements would unnecessarily make audits take longer and delay repayments to drug manufacturers.

The GAO report was requested by committee chair Greg Walden (R-OR) and health subcommittee Chair Michael Burgess (R-TX), who insisted that further investigation by the committee was warranted.

The Senate Health, Education, Labor, and Pensions Committee just concluded a series of hearings on similar 340B reforms. However, committee chair Lamar Alexander (R-TN) believed forthcoming legislation was unlikely during an election year (see Update for Week of June 25th).

FEDERAL AGENCIES

CMS surprisingly suspends risk adjustment payments in wake of adverse court decision

The Centers for Medicare and Medicaid Services (CMS) announced this week that it will at least temporarily halt all Affordable Care Act (ACA) risk adjustment payments due to insurers for 2017-2018, a surprise move that could potentially cause further premium increases for the 2019 plan year.

The risk adjustment payments were one of the three premium-stabilization programs created under the ACA, but the only one that did not expire after 2016. The program spreads the expense of high-cost enrollees across insurers

within both the individual and small-group health insurance markets by forcing insurers with lower-risk enrollees to subsidize costs for insurers with higher-risk enrollees, based on a CMS formula.

The program had the unintended effect of forcing most of the Consumer Oriented and Operated Plans (CO-OPs) created with ACA loans to dissolve, as they used low premiums to attract sizeable numbers of lower-risk enrollees and were forced to make risk adjustment payments to dominant insurers beyond what they could afford (one of the four surviving CO-OPs, Montana Health Cooperative, owes nearly 20 percent of its revenue as its 2017 risk adjustment payment). Two of these small, non-profit cooperatives (New Mexico Health Connections and Minuteman Health of Massachusetts and New Hampshire) filed federal lawsuits seeking to block the payments on the basis that the CMS formula was flawed (see Update for Week of August 15, 2016).

The federal district courts issued conflicting decisions. Judge Dennis Saylor in Massachusetts upheld the formula, however Judge James Browning in New Mexico sided with insurers in ruling that part of its implementation was not adequately justified. (Both judges were appointed by President George W. Bush).

Prior to asking appellate courts to resolve the conflicting decisions, CMS Administrator Seema Verma surprisingly suspended the risk adjustment payments, leaving insurers unsure about if and when they will receive the \$10.4 billion due for their 2017 business (payments that were scheduled to be made this fall). These payments can constitute a significant portion of insurer revenue, representing 11 percent of all premium dollars in the individual market for 2016. For 2017, Blue Shield of California is due nearly \$700 million, followed closely behind by other Blue Cross Blue Shield plans like Florida Blue (\$618 million) and Anthem (\$522 million).

Kaiser Permanente led all insurers with more than \$928 million owed, while Centene and Humana also are required to pay huge sums (\$853 million and \$689 million).

The move was largely interpreted by the industry as an additional attempt to sabotage the ACA Marketplaces, whose financial viability has greatly improved from 2017 (see Update for Week of June 25th). Analysts with S&P Global Ratings warned that such an abrupt suspension “would be [such] a big hit to [insurer] financial position” that it could cause insurers to “reprice [premiums] for the coming year” or choose to leave the ACA Marketplaces altogether.

Blue Cross Blue Shield of Tennessee promptly announced that it would increase 2019 individual market premiums by an average of \$649 per enrollee due to CMS’s suspension of risk adjustment payments. The insurer had previously predicted that premiums would remain relatively flat from 2018 to 2019 as its ACA business has remained profitable since 2017.

Expecting other insurers to soon follow suit, Washington Insurance Commissioner Mike Kreidler (D) quickly decided to let insurers submit two sets of rate filings based on whether CMS makes the risk adjustment payments. Other states are expected to follow this approach.

For second consecutive year, CMS dramatically slashes funding for ACA navigators

The Centers for Medicare and Medicaid Services (CMS) announced this week that it will dramatically slash funding for navigators and other in-person assisters for the 2019 plan year.

The navigator program helps consumers sign-up for coverage in the new health insurance Marketplaces created by the Affordable Care Act (ACA). However, Administrator Seema Verma insisted that such assistance was “ineffective” and “failed to enroll a meaningful number of people.”

The 72 percent cut will slash funding from \$36 million in 2018 to only \$10 million next year. It follows last year’s 90 percent cut in the marketing and outreach budget for federally-facilitated Marketplaces (FFMs) (see Update for Week

of November 13th), reducing the total funding to only 16 percent of the initial \$63 million budgeted by the Obama Administration.

Critics insisted that the move was a further act of “sabotage” by the Trump Administration, which had already cut the open enrollment period in half, terminated ACA cost-sharing reductions for insurers, suspended insurer risk adjustment payments (see above), repealed individual mandate penalties that helped ensure balanced risk pools, and are seeking to allow a proliferation of low-cost “junk” plans that will further siphon healthier and less costly consumers away from the Marketplaces. They pointed that navigators and in-person assisters were often needed to reach consumers that were the most difficult to sign-up for coverage, such as those who do not speak English or live in very rural areas.

The funding cuts do not apply to the 12 ACA Marketplaces created and operated by states, who set their own budgets for in-person assistance and outreach.

CMS to cut Medicare Part B reimbursement for newly-introduced drugs

The Centers for Medicare and Medicaid Services released their proposed Medicare Physician Fee Schedule (MPFS), which sets Medicare Part B reimbursement for calendar year 2019.

Under the proposed rule, physicians that administer Part B drugs would be reimbursed three percent less next year for new Part B drugs that have been on the market for less than three months. After that time, reimbursement would shift back to the current formula, which pays providers six percent above the wholesale acquisition cost (WAC).

President Trump first floated such a change in his fiscal year 2019 budget proposal (see Update for Week of February 26th), which had been first recommended by the influential Medicare Payment Advisory Commission (MedPAC). It was part of a package of reforms that would also eliminate a series of different Medicare reimbursement rates into a single payment level and scale back the amount of billing documentation that providers must submit.

The change was not part of the drug pricing reform blueprint proposed earlier this year by the President (see Update for Week of May 7th).

CMS issues updated Marketplace enrollment data showing more consumers are paying first month premiums

The Centers for Medicare and Medicaid Services (CMS) released a package of three reports last week revealing that the number of Marketplace consumers who paid their first month’s premium actually increased slightly for 2018, despite Trump Administration efforts to weaken or repeal the Affordable Care Act (ACA).

The “snapshot” indicated that effectuated enrollment in both federal and state Marketplaces climbed to 10.6 million for February 2018, which was 300,000 higher than the same month the year before. Although Marketplace premiums spiked by an average of 27 percent nationwide, the average premium tax credit under the ACA increased by even more (39 percent) as most insurers were allowed to increase premiums for silver-tier plans to compensate for the Administration’s sudden elimination of cost-sharing reductions (CSRs) that were due to insurers (see Update for Week of April 16th). As a result, the total number of Marketplace consumers who qualified for premium tax credits also rose from 84 percent to 87 percent over the same time period.

CMS Administrator Seema Verma insisted that the reports showed that Marketplace plans are “unaffordable and forcing unsubsidized middle-class consumers to drop coverage”, demonstrating the need for the limited-benefit short-term and association health plans being offered by the Administration (which do not comply with ACA consumer protections) (see Update for Week of May 28th). She cited data showing that 63 percent of uninsured consumers who visited the web portal for federally-facilitated Marketplaces over the past 2018 open enrollment period indicated that they did not enroll in coverage due to premium cost. This was up significantly from 52 percent in 2017.

STATES

Bright Health becomes latest insurer to expand ACA Marketplace presence

Insurer start-up Bright Health announced this week that it will double the number of Affordable Care Act (ACA) Marketplaces in which it participates, becoming the 14th insurer to agree to expand its Marketplace presence for 2019.

Bright Health, which launched in 2016, already offers Marketplace coverage for consumers in the Phoenix and Denver metro areas, as well as Birmingham, Alabama. For 2019, it will not only add the Tucson metro area in Arizona, but move into New York City, as well as four metro areas in Ohio and three metro areas in Tennessee.

The expansion decision came after Bright Health added Andy Slavitt to its board of directors, who formerly served as acting Centers for Medicare and Medicaid Services administrator under the Obama Administration. It follows a trend of insurers seeking to expand into Marketplaces that are showing increasing profitability, despite Trump Administration efforts to weaken or replace key provisions of the ACA. For example, Medica recently agreed to enter the Oklahoma Marketplace, which was served last year by only one insurer (as well as move into the Missouri Marketplace) while start-up insurer Oscar Health elected to enter Marketplaces in Arizona, Florida, and Michigan (see Update for Week of June 25th).

According to the Robert Wood Johnson Foundation, no insurers are currently expected to exit ACA Marketplaces for 2019, due not only to improved profit margins but CMS' recent decision to allow insurers to continue "silver-loading" premiums to compensate for the President's termination of ACA cost-sharing reductions last year (see Update for Week of June 11th). However, RWJF cautions that insurers could choose to exit Marketplaces following CMS' decision this week to suspend risk adjustment payments to insurers instead of an appeal of an adverse lower court ruling (see above).

Colorado

Marketplace premiums to increase by less than six percent for 2019

The Division of Insurance released preliminary rate filings this week showing that average individual health plan premiums offered in the Marketplace created pursuant to the Affordable Care Act (ACA) will increase by only 5.94 percent for 2019.

The modest increase is a dramatic turnaround from 34.3 percent spike that Marketplace insurers received last year following the Trump Administration's sudden elimination of the ACA cost-sharing reductions (CSRs) due insurers (see Update for Week of November 13th). Colorado was one of only four states where the insurance commissioner did not allow the cost of the lost CSRs to be loaded only onto the silver-tier plans to which they were tied. As a result, it was spread out among consumers in all metal tiers.

Silver-tier consumers will see the highest average increase next year (12.3 percent), since the insurance commissioner will allow "silver-loading" (see Update for Week of June 11th). Gold-tier premiums will increase by about half that amount (6.5 percent), while premiums for the lowest-cost bronze plans will increase only slightly by 0.9 percent on average.

The Marketplace will have the same seven participating insurers as 2018, with Anthem Blue Cross Blue Shield actually seeking to lower premiums by up to an average of 2.64 percent for their two plan options. These include Kaiser Permanente (which controls about a third of the Marketplace) and start-up Bright Health (see above). As with last year, all counties will have at least one participating Marketplace insurer.

The legislature was unable to pass H.B. 1392 earlier this year, which sought to create a reinsurance program for insurers with exceptional claims, similar to federally-approved programs in Alaska, Minnesota, and Oregon. The bill was intended to lower premiums by up to 30 percent for the mountain resort areas in Colorado where premiums are among

the highest in the nation. Although it passed the House, it stalled in a Senate committee after employers objected that the assessment used to fund the state share of costs would not be applied equally on all insurers.

Hawaii

Governor signs bills preserving ACA protections, restricting short-term health plans

Governor David Ige (D) signed two bills this week that seek to protect consumers from federal efforts to weaken or dismantle key provisions in the Affordable Care Act (ACA).

S.B. 2340 codifies three of the most popular ACA consumer protections into state law. This includes the provisions allowing young adults to remain on their parents' group plans until age 26, the prohibitions on increasing premiums based on gender or health status, and the requirement that insurers offer coverage to everyone regardless of pre-existing conditions.

H.B. 1520 would bar any short-term health plans from extending coverage beyond the 90-day limit set by the Obama Administration (see Update for the Week of June 20, 2016), following Trump Administration regulations extending that limit by up to 364 days (see Update for Week of February 26th). In addition, it would prevent insurers from selling or renewing short-term coverage to any consumer who was eligible to purchase coverage through the ACA Marketplace during the previous calendar year (either through open or special enrollment periods). Because most Hawaiians are eligible for Marketplace coverage if they are legal residents, not on Medicare, and not incarcerated, this provision would severely restrict the market for short-term coverage.

Both measures unanimously passed the House and Senate and were backed by major insurers and provider groups including Kaiser Permanente and the Hawaii Medical Association.

Hawaii was among a dozen states that considered legislation this session to create a state-alternative to the ACA's individual mandate, as well as a reinsurance program to compensate insurers for exceptional claims. However, both bills failed to advance before session adjourned (see Update for Week of May 28th).

Maine

House fails to override veto of Medicaid expansion funding

The House failed this week to override the veto by Governor Paul LePage (R) of legislation that appropriate funds for the Medicaid expansion that went into effect July 1st.

The immediate effect of the veto remains unclear until the Maine Supreme Judicial Court resolves the Governor's appeal of a lower court decision ordering him to submit the required federal paperwork to implement the expansion (see which was overwhelmingly approved by voters last fall (see Update for Week of November 6th). The Supreme Court has agreed to let the governor delay compliance with that order pending his appeal (see Update for Week of June 25th). However, enrollment in the expansion commenced as planned last week.

The Governor has insisted that he could not submit the required state plan amendment until funds for the ten percent state share of the expansion were appropriated by the legislature. However, the lower court found that Maine had adequate reserves to fund the expansion through fiscal year 2019 and could not use the lack of an appropriation as justification to delay compliance with a voter mandate. Therefore, it is not clear that the governor's veto of the appropriation legislation he requested would have any impact on the lower court's ruling.

The Governor insisted that the \$55 million the legislature appropriate under L.D. 837 for the first-year of the expansion was less than half of what was needed, even though studies from Manatt Health and other consulting groups have disputed his claim (see Update for Week of December 18th).



Governor LePage, who has vowed to “go to jail” before he expands Medicaid, had previously vetoed six previous Medicaid expansion bills passed by the Democratically-controlled legislature (see Update for Week of April 18, 2016).

Nebraska

Republican lawmakers sue to block Medicaid expansion from appearing on November ballot

Senator Lydia Brasch (R) and former Senator Mark Christensen (R) filed a lawsuit in the Lancaster County District Court seeking to block a ballot referendum this fall that would let voters decide whether Nebraska should participate in the Medicaid expansion under the Affordable Care Act (ACA).

The consumer group Insure the Good Life announced earlier in the week that it had submitted more than 133,000 valid signatures to the Secretary of State, which is far in excess of the 84,268 signatures required to place the referendum on the November ballot. If successful, it would expand Medicaid to roughly 90,000 Nebraskans earning up to 138 percent of the federal poverty level (FPL) while bringing Nebraska more than \$1 billion in federal matching funds over ten years.

However, both Senators insisted that the petition drive was constitutionally flawed because it seeks to “exercise legislative power specifically reserved to the executive branch.” They claimed that each would be directly harmed by the expansion because it would have a negative impact on property taxes and reduce or alter public benefits for their children.

If validated by the Secretary of State, Nebraska would become the third state behind Idaho and Utah with a Medicaid expansion ballot referendum this fall (see Update for Week of June 11th). Maine became the first state last year where Medicaid expansion was approved by the voters (see Update for Week of November 6th), although Maine’s governor continues to fight its implementation in court (see above).

New Mexico

Marketplace board weighs transition back to full state control

The New Mexico Health Insurance Exchange (NMHIX) issued a Request for Information (RFI) on June 25th seeking input on how it may transition back to state-based Marketplace (SBM) while offering an “improved user experience” for consumers, carriers, brokers, and non-profit partners.

The legislature originally created NMHIX as a non-profit public corporation governed by a 13-member board of directors. The Exchange created its own web portal but severe software and technology glitches during the inaugural open enrollment period forced it to default to the federal web portal for 2015 (see Update for Week of June 2, 2014).

New Mexico had remained one of five state-based Marketplaces (including Arkansas, Kentucky, Nevada, and Oregon) that were using the federal web portal while maintaining state control over other Marketplace functions, such as marketing, outreach, and in-person assister training. However, the RFI notes that the Trump Administration’s recent changes to the user fee structure for those five states has prompted the board to consider transitioning back to full state control over the Marketplace, including potentially designing a new web portal.

State control would allow the board to combat the massive federal funding cuts for marketing, outreach, and in-person assisters (see above), as well as extend the open enrollment period beyond the six-week limit imposed by the Trump Administration.

Rhode Island

Governor signs bill authorizing state reinsurance program

Governor Gina Raimondo (D) signed legislation this week making Rhode Island the latest state that will seek federal approval to create a reinsurance program for insurers with exceptional claims.



The payments are intended to replace the temporary reinsurance program under the Affordable Care Act (ACA) that expired after 2016. The Trump Administration has already approved reinsurance programs created by Alaska, Minnesota, and Oregon, which have been credited with dramatically reducing premium spikes that resulted after the ACA reinsurance program expired (see Update for Week of December 18th). New Jersey and Wisconsin have waiver applications pending while at least ten other states are considering or have passed legislation that would authorize such a waiver.

The Rhode Island bill (H.8351) gives the director for the HealthSourceRI Marketplace created pursuant to the ACA the discretion to submit the required State Innovation Waiver to the federal government and set the parameters for the program. It follows the recommendation of the Market Stability Workgroup convened by the Insurance Commissioner and HealthSourceRI director that urged the legislature to also create a state alternative to the individual mandate under the ACA (following the lead of Massachusetts, New Jersey, and Vermont) and limit the use of short-term health plans (see Update for Week of June 11th). Legislation restricting short-term health plans (S.2931) did pass the Senate but remains under consideration in the House.

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