

Health Reform Update – Weeks of May 13 and 20, 2013

CONGRESS

Senate confirms first CMS Administrator since 2006

The Senate voted 91-7 last week to confirm the re-nomination of Marilyn Tavenner to be the first permanent administrator of the Centers for Medicare and Medicaid Services (CMS) since 2006.

Tavenner has served as acting administrator since the recess appointment of Donald Berwick expired in 2011. Dr. Berwick never received a confirmation hearing due to past comments that Republicans claim endorsed health care rationing (see Update for Weeks of November 21 and 28, 2011).

Despite broad bipartisan support, Tavenner did not receive a confirmation hearing last year due to election year politics and had her re-nomination briefly blocked by Senator Tom Harkin (D-IA), who protested her decision to divert money from the Affordable Care Act's Prevention and Public Health Fund to cover cost overruns in the new federal health insurance marketplace (see Update for Week of May 6th).

House Democrats cite two new studies refuting "rate shock" claims by ACA opponents

Ranking House Energy and Commerce member Henry Waxman (D-CA) released a new analysis this week in advance of the committee's hearing on the impact of Affordable Care Act (ACA) market reforms on individual health plan premiums.

Energy and Commerce leaders had claimed that internal industry documents show that rates for new individual plans could skyrocket by an average of 96 percent next year due to the new guaranteed issue and community rating requirements (with another 73 percent jump for renewals). The report also warned of a pending "rate shock" that could spike premiums by up to 413 percent and increase rates in all but five states (ME, MA, NJ, NY, and VT) where these reforms were already instituted.

The report follows-up on an Oliver Wyman study that House Republicans widely circulated last winter (see Update for Week of January 7th). It claimed that the ACA provision preventing insurers from varying premiums by more than 300 percent based on age will cause a 42 percent hike in individual plan premiums for those aged 21-29, four million of whom are uninsured. Premiums would also increase 31 percent for those in their 30s, while the aged 60-64 group would see only a one percent bump.

A separate report from the conservative American Enterprise Institute predicted that 25 percent will be the median increase nationwide as a result of guaranteed issue and community rating in 2014.

However, an Oliver Wyman actuary testified before E&C in March that their findings were being distorted (see Update for Week of March 11th). While they acknowledge premiums will rise for some younger subscribers as a result of the new 3:1 age rating band, they will not increase overall by the amounts cited by Republicans, and in fact the consultant expects that "most people will see a decrease in the amount of premiums they pay, primarily due to the premium subsidies offered through the ACA."

The latest analysis by House Democrats cited rate filings for 2014 that have already been released in five states (RI, VT, MD, OR, and WA) in order to argue that the ACA appears to be actually reducing premiums, even before tax credits are taken into account. For example, in Washington (see below), consumers will see average reductions of 21 percent or \$1,120 a year for the lowest bronze-level plans and 25 percent or \$1,875 per year for silver plans. In Oregon (see Update for Week of May 6th)

consumers will save an average of 32 percent or \$1,370 per year for bronze plans and 36 percent or nearly \$2,700 per year for silver plans.

Premiums released later this week for the Covered California exchange (see below) also came in “below expectations”, but were not part of the Democrats’ analysis.

Rep. Waxman emphasized that premiums in many cases will be even lower because, according to the Congressional Budget Office, 86 percent of individuals who received coverage through the new ACA exchanges will receive tax credits, with the average credit reducing costs by over \$5,000 per year.

A separate study from the left-leaning Center for American Progress (CAP) also found this week that higher costs will only affect about three percent of people between ages 19 and 29 who buy individual coverage but will not be eligible for premium subsidies.

CBO downgrades estimates on ACA costs, coverage, and revenues

The Congressional Budget Office (CBO) released updated projections this week on the impact of the Affordable Care Act (ACA).

The non-partisan scorekeeper now estimates that roughly 13 million Americans will gain Medicaid coverage from the ACA expansion, as more states appear inclined to participate. This is up slightly from the 12 million it predicted last summer (see Update for Weeks of July 23rd and 30th), but far below the 21 million that were expected to become Medicaid eligible before the U.S. Supreme Court allowed states to opt-out without penalty (see Update for Week of June 25th). Despite this gain, CBO now only expects 25 million to gain health insurance coverage once the ACA is fully implemented, down from 27 million last year and 34 million after the ACA was enacted.

The continued slowdown in health care spending growth (see Update for Week of May 6th) has caused CBO to also downgrade the amount of revenue to be generated by the ACA’s 40 percent tax on high-cost or “Cadillac” health plans (see above), which was initially forecast to bring in \$137 billion over the next decade (once it starts in 2018). CBO now predicts that only \$80 billion will be raised from the tax. Mercer Inc. had projected in 2011 that 61 percent of employers would be hit with the tax. However, the National Business Group on Health doubts that projection will hold, insisting that employers will trim benefits, raise deductibles, and press hospitals for better rates in order to get below the \$10,200 benefit threshold for the tax.

The lower revenue collected through the “Cadillac” health plan tax means that the cost of fully implementing the ACA is likely to raise \$40 billion to \$1.36 trillion over ten years.

However, the most dramatic change in CBO’s forecast is the downgrade in the federal budget deficit as a result of the higher taxes on the wealth enacted as part of the year-end deal to avert the “fiscal cliff” (see Update for Weeks of December 24th and 31st). CBO now predicts the deficit will shrink to \$642 billion, the lowest it has been since 2008, and less than half the shortfall in 2009 when it exceeded ten percent of the nation’s gross domestic product (GDP).

CBO now estimates the deficit will fall to 2.1 percent of GDP by 2015, coming in below the 2.3 percent target called for by the President’s deficit reduction commission in 2010 and without the severe Medicare and Medicaid cuts sought by the House Republican budget plan for 2011 and 2012.

House Republicans vote to repeal Obamacare.....again

The House voted last week to repeal the entire Affordable Care Act (ACA), the third such vote such Republicans took control of the chamber in 2011.

Reps. Jim Matheson (D-UT) and Mike McIntyre (D-NC) were the Democrats to side with every Republican in passing H.R. 45. Combined with 34 other votes to repeal or defund parts of the ACA, House Republicans have now spent 15 percent of legislative time since 2011 voting to impede the law.

Conservative Republicans are exploring options for further hindering ACA implementation as part of the next fight over raising the debt ceiling. Members of the Republican Study Committee met with CBO to inquire how much savings can be generated from delaying both exchange and Medicaid expansion.

A crack in Democratic constituencies was revealed this week when prominent labor unions began pushing for substantial reforms to the ACA. The United Union of Roofers, Waterproofers and Allied Workers even went so far as to call for a full repeal.

The United Food and Commercial Workers International Union (UFCW) and the International Brotherhood of Teamsters are upset that the tax credits offered by the ACA to low-to-moderate income workers will not be made available to the roughly 20 million union members covered by multi-employer or Taft-Hartley plans. Unions are arguing that the lack of subsidies could force their members to purchase either more expensive or less comprehensive coverage in the new health insurance exchanges.

Unions also object to the tax on “Cadillac” plans or the extra generous coverage that they often negotiate in lieu of wage increases. Unions fear these bargaining gains could be lost as a result.

House Republicans set sights on navigator grants for federal marketplace

Two subcommittees for the House Oversight and Government Reform committee held a hearing this week to grill Centers for Medicare and Medicaid Services (CMS) officials about how the agency proposes to use \$54 million in grants to entities that will help facilitate enrollment in the federal health insurance marketplace (see Update for Week of April 1st).

Panel Republicans such as Rep. James Lankford (R-OK) blasted CMS for “lax standards” that could potentially allow felons to serve as navigators in order to extract personal financial and medical records from applicants. Rep. Paul Gosar (R-AZ) insisted that the 30 hours of training that CMS intends to require is “absolutely inadequate,” while others claimed that the navigator grants are illegal because CMS is allowing state-based exchanges to use them to fund “in-person assisters”, which are essentially the same as navigators but skirt the ban on federal exchange grants being used for navigators.

Subcommittee Republicans continue to press CMS to turn over a detailed accounting of how the \$54 million in navigator grants will be spent in the 35 states where CMS is operating a federal marketplace or partnership exchange, as well as the agency’s attempt to procure additional funding for other related programs to boost enrollment. Despite the limited funding, CMS reports that it has already received over 830 letters of intent to apply for the navigator grants by the June 7th deadline. Rep. Matt Cartwright (D-PA) and other Democrats insisted that the Republican attacks on these grants are merely part of a campaign to undermine the success of the ACA by depressing enrollment.

CRS report says HHS Secretary can take place of Medicare cost-cutting board

The Congressional Research Service (CRS) sent a memo last week to Senator Tom Coburn (R-OK) acknowledging that the Department of Health and Human Services (HHS) Secretary could act in place of the Independent Payment Advisory Board (IPAB) if implementation is blocked.

The Affordable Care Act (ACA) empowered the controversial cost-cutting panel with making recommendations on Medicare spending cuts whenever preset targets are exceeded, which would automatically go into effect if equivalent cuts are not enacted by Congress. According to the Medicare actuary, these targets were not exceeded for 2014, meaning the earliest the recommendations would be triggered is 2015 (see Update for Weeks of April 22nd and 29th).

However, at least 20 House Democrats have sided with prior Republican efforts to repeal the IPAB, fearing it would cede control to Medicare spending decisions away from Congress and into the hands of 15 “unelected bureaucrats.” Republican leaders in the House and Senate have also refused to make their designated appointments to the panel (see Update for Week of May 6th).

The CRS memo emphasizes that should Republicans impede implementation of the IPAB, the ACA directs the HHS Secretary instead make the required recommendations “regardless of the reason that the IPAB has not submitted a proposal within the required time frame.” The Secretary’s recommendations would likewise automatically go into effect if Congress does not pass equivalent cuts.

FEDERAL AGENCIES

CMS mitigates blow to safety net hospitals in states that do not expand Medicaid

The Centers for Medicare and Medicaid Services (CMS) issued proposed regulations last week that would lessen the amount of federal funding for indigent care that safety net hospitals will lose under the Affordable Care Act (ACA).

The ACA begins to phase-down disproportionate share hospital (DSH) funds by \$18 billion starting in 2014, which are intended to help offset the uncompensated care costs of hospitals that who treat large numbers of uninsured (i.e. more than 25 percent of its case-mix must be low-income). However, Congress assumed the need for DSH funds would decline once states were required to expand Medicaid to everyone earning up to 138 percent of the federal poverty level (FPL).

The U.S. Supreme Court decision giving states the discretion to opt-out of the expansion without penalty meant that safety net hospitals in non-expansion states would actually incur higher uncompensated care costs as a result of the DSH phase-down (see Update for Week of July 2nd). In an effort to lessen the blow on those hospitals from the \$500 million in DSH cuts for 2014 and \$600 million in 2015, CMS is proposing to instead allocate them fairly evenly across expansion and non-expansion states. As a result, hospitals in states with fairly low levels of uninsured and low-income will receive a far larger DSH cut than initially planned while those in states with high uncompensated care costs will receive a smaller cut.

The decision temporarily removes a major incentive for reluctant states to still participate in the expansion, as even the most ardent conservative opponents of the ACA faced intense pressure from state hospital associations to expand. CMS notes in the proposed rule that it has not decided whether to impose the full force of the much larger DSH cuts on non-expansion states in 2017 (\$1.8 billion) 2018 (\$5 billion), or 2019 (\$5.6 billion).

The move was widely praised by hospital groups. A bill introduced earlier this month by Rep. John Lewis (D-GA) and backed by the American Hospital Association would have imposed a full two-year delay in DSH cuts. President Obama’s proposed budget for fiscal year 2014 had sought to delay the DSH cuts until fiscal year 2015.

CMS plans to finalize the rule so that the lesser cuts go into effect October 1st “unless Congress enacts the President’s Budget proposal.”

CMS lowers federal PCIP rates for most services, but not prescription drugs

The Centers for Medicare and Medicaid Services (CMS) announced late last week that it will lower reimbursement rates paid to the 23 federally-operated Pre-Existing Condition Insurance Plans (PCIPs) to current rates paid by Medicare.

Under its interim final rule, most services will be subject to the lower reimbursement, except for prescription drugs, organ transplants, dialysis, and durable medical equipment. In the limited situations in

which federal PCIP managers cannot use Medicare provider reimbursement rates, the PCIP must pay either 50 percent of billed charges or an amount set using a "relative value scale pricing methodology".

The rule also prohibits plans from trying to make-up for the lost reimbursement by "balance billing" patients for any amounts greater than their cost-sharing obligation.

Lowering payment rates represents the latest effort by CMS to stay within the \$5 billion that Congress allocated for the temporary program created by the Affordable Care Act (ACA), which expires at year end. CMS halted new enrollment in all federal and state-operated PCIPs earlier this year after average annual claims per enrollee exceeded \$32,000 or 2.5 times the claims paid by state high-risk pools that predate PCIPs (see PCIP Update for Week of February 11th).

Other recent cost-containment efforts by CMS for federal PCIPs include eliminating the payment of referral fees to agents and brokers, requiring enrollees to buy specialty drugs from in-network pharmacies, eliminating two of three plan options, increasing the maximum out-of-pocket limit for in-network services, and increasing the coinsurance rate for patients who have met the deductible requirement. Starting in May, CMS is also requiring state-operated PCIPs to shift to a fixed-payment contract from June-December or else shut down their programs and put enrollees into the federal PCIP.

House Republican leaders pulled their recent proposal to supplement the PCIPs with \$3.7 billion in funding from the Prevention and Public Health Fund after more conservative members refused to vote for a measure that they believed would legitimize a key provision of "Obamacare" (see Update for Weeks of April 22nd and 29th). Energy and Commerce health subcommittee chair and bill sponsor Joe Pitts (R-PA) pledged to put forward a modified version in "a couple of weeks" that would mollify conservatives by draining the entire prevention fund, which was created by the ACA to provide free cost-sharing for certain preventive care. Even if approved by the House, the measure is certain to fail in the Senate unless funds are obtained from other sources.

In a separate announcement, CMS also identified ten of the state-operated PCIPs that will continue operating their programs after January 1st. These are Alaska, Connecticut, Maryland, Maine, Montana, New Jersey, Oklahoma, Rhode Island, Illinois, and Wisconsin. CMS will assume control of the remaining 17 state-operated PCIPs.

CMS lets states simplify Medicaid enrollment to accommodate influx of new enrollees under ACA

The Centers for Medicare and Medicaid Services (CMS) issued new guidance late last week instructing state officials how they could best simplify enrollment in Medicaid.

The letter would allow states to use data that food stamp applicants have already submitted, a practice that a few states permit for children, as well keep adults enrolled in Medicaid for up to a year even if their income increases enough to make them ineligible. The National Academy for State Health Policy praised the latter as a "big deal" that would help mitigate the "churning" of people on and off Medicaid that so greatly interferes with their access to continuous care. Thirty-two states now use this option for children.

To help states deal with the demands of increased enrollment starting January 1st, they will have the option in the first three months of next year to extend the Medicaid renewal period by up to 90 days.

HEALTH CARE COSTS

Express Scripts predicts huge jump in specialty drug costs

The annual forecast released this week by Express Scripts predicts that U.S. spending on specialty drugs will jump by 67 percent through the end of 2015, at which time three of the four most costly prescription therapy classes will be for a specialty drug condition.

According to the report, the robust pipeline of new biologics and physicians delaying patient treatment until new drugs are on the market will boost spending for eight of the top ten specialty therapy classes over the next three years. Specialty conditions like cancer, multiple sclerosis, and rheumatoid arthritis will command higher drug spending than any other therapy class except diabetes.

Hepatitis C drug spending is also expected to quadruple over the next three years, by far the largest percentage increase among therapy classes. By the end of 2015, spending on medications for Hepatitis C will exceed that of much more common conditions, including high blood pressure. This increase will be caused by new interferon-free medications expected to gain FDA-approval in 2014, as well as an increase in diagnoses related to new screening guidelines.

Express Scripts predicts that the new regulatory pathway for less costly biosimilars will help to mitigate the rising cost of specialty medications, saving consumers \$250 billion between 2014 and 2024 if the 11 most likely biosimilar candidates are launched in the U.S. market.

Specialty drug spending will raise despite the predicted four percent decline in overall spending for traditional prescription drugs by the end of 2015 due to generic medications. Only two of the top ten traditional therapy classes (diabetes and attention disorders) are likely to have spending increases over the next three years (up to 24 and 25 percent respectively).

STATES

Exchange participation varies widely by state

Several more Affordable Care Act (ACA) health insurance exchanges released their list of participating health plans over the past two weeks, revealing a wide variance across the country.

Large insurers such as Aetna, Humana, and United Health had indicated that they would be very selective about the exchange markets in which they would participate, with Aetna likely to offer plans in no more than 14 exchanges and UnitedHealth projecting only 10-25 (see Update for Week of May 6th). By contrast, WellPoint announced this week that it will participate in all 14 exchanges where it holds a Blues license, regardless of whether the marketplace is state or federally-operated (CA, CO, CT, GA, IN, KY, ME, MO, NV, NY, NH, OH, VA, and WI.)

Aetna and UnitedHealth did opt-out this week from the nation's largest exchange, Covered California (see below), and UnitedHealth also chose not to participate in the Colorado exchange despite offering products in the non-exchange market.

A third prominent health insurer, CIGNA, also will not be part of the individual exchange in California. However, the three insurers together comprise only seven percent of California's individual market, while the three that make-up 87 percent of the individual market (Anthem Blue Cross, Blue Shield of California, and Kaiser Permanente) all will participate.

A surprising 28 insurers will participate in Rhode Island (16 in the individual exchange, 12 for the small group exchange), while 15 will participate in Oregon (see Update for Week of May 6th), and 17 have applied in Colorado (see below). All three of these states are running their own exchanges.

Smaller states like Montana announced very limited exchange participation. The federal marketplace in that state will offer plans only from three insurers (Blue Cross Blue Shield of Montana, PacificSource Health Plans and the new Montana Health CO-OP created by the ACA).

California

Individual premiums for "active purchaser" exchange come in below expectations

The “rate shock” that Congressional Republicans warned about this week for individual premiums has not only failed to materialize in Maryland, Oregon, Rhode Island, Vermont, and Washington (see above), it also was not found in the rates announced this week for the nation’s largest state.

The Covered California health insurance exchange, which plans to cover more than five million Californians, announced that 13 plans will participate, with two of the state’s largest individual health plan insurers, Blue Shield of California and Anthem Blue Cross, offering coverage to all of the 19 geographic rating regions. Kaiser Permanente will also offer coverage to all but three central coast counties, while at least three and up to six plans will be available in every region. Several of these are local plans that until now have served only Medi-Cal patients but will start offering coverage to the general public, giving exchange subscribers access to 80 percent of the state’s hospitals and physicians.

Proposed premiums in the individual exchange will range from only two percent above to 29 percent below the 2013 average for small business plans in California’s most populous regions. The actual rates are well below those forecast for Covered California by Milliman consulting, which had predicted that the average silver-level plan (to which the premium tax credits under the Affordable Care Act (ACA) are tied) would have a \$450 monthly premium and that the ACA would boost premiums by up to 20 percent for those earning more than 400 percent of FPL (see Update for Week of March 25th).

By contrast, the monthly premium for the most affordable silver plan will average only \$276 for all types of silver plans across all regions (and \$321 for all silver plans), and that is before factoring in the premium tax credits for which 2.6 million Californians will be eligible. For example, a 40 year old earning only 150 percent of FPL would pay an average monthly premium of only \$40 for the most affordable silver plan, while the premium for the lower-level bronze plan would be entirely covered by the tax credit.

For those earning more than 400 percent of FPL (or about \$46,000 a year), silver plan premiums will range \$338-396 per month. If that same person earns only half that amount, the tax credits will bring their premiums down to \$188-247 per month, depending on which health insurer they choose.

Contrary to predictions, rates for the youngest subscribers remained affordable. Monthly bronze plan premiums for a 21 year old will range from \$0-185 and \$44-230 for silver plans. Catastrophic plans for young invincibles (under age 30) range from \$136-168 for a 21 year old.

The premium amounts are also below the \$5,200 annual average predicted by the Congressional Budget Office. The Covered California commissioner credited the “active purchaser” exchange model authorized by the legislature for restraining rates through competition. The exchange selected only the 13 most affordable plans out the 32 that bid.

The commissioner acknowledged that premiums will increase for some subscribers compared to what they now pay, but emphasized their benefit package will be broader. Blue Shield of California stated that their members will only see an eight percent average increase, far below the 20 percent predicted by Milliman and increases of up to 96 percent predicted by Congressional Republicans (see above).

Covered California will finalize contracts with the 13 plans by June, when it also expects to announce plans and rates for the small group exchange. Individual exchange plans will not be able to modify their proposed rates unless the Insurance Commissioner finds their rates to be unreasonable.

Governor formally endorses Medicaid expansion under ACA, abandons his alternate approach

Governor Jerry Brown (D) backed California’s participation this week in the Medicaid expansion under the Affordable Care Act (ACA), abandoning his alternative that would have required each of the state’s 58 counties to provide care for low-income people in their communities.

The legislature still has to approve the expansion, even though competing bills (A.B. 1x-1 and S.B. 1x-1) have passed the Assembly and Senate (see Update for Week of March 4th). Each would add roughly 1.6 million Californians to Medi-Cal starting January 1st.

The Governor's initial budget earmarked \$350 million to cover the increased enrollment. In his revised budget for the coming fiscal year, the Governor reiterated that he still wants to redirect the lion's share of the money as the Medi-Cal expansion will mean far fewer people are covered under county programs. Under his proposal, the counties will give up \$300 million in the first year, \$900 million in year two and \$1.3 billion in the third year after the Medi-Cal expansion takes place.

Governor Brown is also proposing to shift responsibility for a number of health services, including a state takeover of a program that provides care to children with special health care needs.

Colorado

Governor signs Medicaid expansion into law

Governor John Hickenlooper (D) signed S.B. 200 into law last week, which accepts federal funding under the Affordable Care Act (ACA) to expand Medicaid for everyone earning up to 138 percent of the federal poverty level (FPL).

The expansion is expected to add 160,000 adults to Colorado Medicaid. The Governor cited studies showing that participating in the ACA expansion could save Colorado more than \$280 million over ten years. However, most Republicans opposed the measure, insisting that the state could not count on the federal government to fulfill their obligation under the ACA to fund 100 percent of the expansion through 2016, and then at least 90 percent thereafter.

The Governor also signed H.B. 1266 into law, which aligns Colorado insurance law with the new market reforms in the ACA.

Proposed premiums "vary wildly" for Colorado exchange plans

Though specific rates have yet to be released, the Department of Insurance (DOI) disclosed this week that the premiums proposed by the 17 plans seeking to participate in the new state-based health benefit exchange "vary wildly" and in many cases do not comply with plan standards set forth by the Affordable Care Act (ACA) and implementing federal regulations.

Ten carriers including Cigna, WellPoint, Humana and Kaiser Health are planning to offer about 150 plans through the individual exchange, while seven carriers will offer roughly 100 products in the small group exchange. Unlike California (see above), Colorado's exchange follows the "clearinghouse" model where every plan that meets minimum federal and state standards must be allowed to participate. However, DOI noted that several of the filings did not meet the minimum requirements for essential health benefits or the new medical-loss ratios that limit insurer profits. DOI will review and modify the rate filings by July 31st.

Rates for other state exchanges such as California (see above), Oregon, and Washington (see below) have come in below expectations. Two exchange plans in Oregon voluntarily downgraded their rates after they were able to compare their newly standardized plans with other exchange plans and realized they were extreme outliers (see Update for Week of May 6th).

Florida

House Republicans block Medicaid expansion, but keep \$8 monthly premiums for themselves

House Republicans not only blocked any expansion of Medicaid prior to the end of the legislative session, they also voted to keep their own premiums for state employee health coverage to a mere \$8.34 per month (or \$30 per month for families).

According to the Kaiser Family Foundation, these premiums are one-sixth of what state senators and most state employees in Florida will pay, and one-tenth of the cost to the average private-sector worker. It's also less than the \$25 a month that several House Republicans wanted to charge poor

Floridians for bare-bones coverage under a state-funded alternative to participating in the Medicaid expansion under the Affordable Care Act.

Speaker Will Weatherford (R) did not offer any public explanation of why House Republicans did not approve the Senate-passed increase in premiums, which was also sought by Governor Rick Scott (R). He did pledge to address the issue next session.

Roughly 24,000 supervisors and managers in Florida state government (including lawmakers) receive a better deal on premiums than other state workers. However, the Senate sought to eliminate this discrepancy, so that Senators now pay \$50 per month (or \$180 per month for families).

Taxpayers pay nearly \$600 a month to subsidize the cost for each individual House member, which affords coverage with no deductible and copayments for office visits that do not exceed \$40. Supporters of the Medicaid expansion seized on the fact that the alternate plan offered by the House would cost low-income Floridians three times as much yet provide only one-third of the benefits.

Iowa

Federal approval unclear for Medicaid expansion compromise

Governor Terry Branstad (R) compromised with Democratic lawmakers this week on a plan to expand Medicaid for everyone earning up to 100 percent of the federal poverty level (FPL) and cover those earning from 100-138 percent in the new federal health insurance marketplace created by the Affordable Care Act (ACA).

The Governor had previously supported only a partial expansion to 100 percent of FPL, despite the Obama Administration's refusal to allow ACA matching funds for anything but a full expansion under to 138 percent of FPL (see Update for Week of March 25th). However, he softened his opposition to covering the 100-138 percent population in the federal marketplace, stating that he had received sufficient assurances that the promised federal funding would not dissipate in future years.

The compromise plan that passed both the Democratic Senate and Republican House this week would allow ACA funds for the expansion to cover marketplace premiums for those earning 100-138 percent of FPL, but only for the first year. In subsequent years, subscribers will be required to engage in certain wellness programs and healthy behaviors to avoid paying up to two percent of their premiums.

Senate President Pam Jochum (D) and Health committee chairman Jack Hatch (D) acknowledged that federal approval for the compromise plan was uncertain, as it differs from Arkansas' federally-approved plan to cover all newly Medicaid-eligible populations in their state's partnership exchange (see Update for Week of March 25th).

Governor Branstad, who becomes only the ninth Republican governor to support an ACA expansion, is expected to sign the budget measure (S.F. 446) within the next 30 days.

Massachusetts

Employer coverage not likely to erode under ACA, based on Massachusetts' experience

A new report released this week by PricewaterhouseCoopers found that the landmark Massachusetts health reforms upon which the Affordable Care Act (ACA) was largely based will not erode employer-sponsored health insurance.

The consulting firm's findings actually showed a one-percent increase in rates of employer-sponsored coverage in Massachusetts after implementation of its 2006 reforms, while the rest of country experienced a six percent decline due to the economic recession. The authors conclude that the ACA is likely to engender similar demand, because the penalties upon employers for not providing adequate or affordable coverage are far more severe under the ACA than they were in Massachusetts.

The study emphasizes that employer-sponsored coverage has undergone a decade long decline long before the ACA was implemented (see Update for Week of April 15th).

Nebraska

Governor signs bill that would create commission to oversee state-based insurance exchange

Governor Dave Heineman (R) signed L.B. 384 last week. The measure called the Nebraska Exchange Transparency Act will create a stakeholder commission to provide oversight, recommendations, and transparency regarding the implementation and operation of state-based health insurance exchange that complies with the Affordable Care Act, even though the Governor previously defaulted to the federal marketplace for at least 2014.

New Mexico

Exchange board reverses course, will initially partner with feds on individual exchange

The New Mexico Health Insurance Alliance overseeing the new state-based health insurance exchange has decided to initially pursue a federal-state partnership for the individual market as it cannot upgrade its information technology infrastructure in time for October 1st open enrollment.

The Obama Administration recently permitted such a “hybrid” approach for Utah, which already operated an existing small group health insurance exchange (see Update for Week of May 6th). New Mexico likewise will operate its own exchange for small businesses starting October 2013, but leave enrollment in the individual exchange to the federal marketplace. However, New Mexico will retain control over determining the qualified health plans and benefit packages that will be offered in the individual exchange. It will also handle the marketing and outreach functions, as well as training and certification of navigators that will facilitate individual exchange enrollment (see above).

New Mexico had already been federally-certified for a full state exchange. However, the Alliance board voted for the initial partnership because the federal Centers for Medicare and Medicaid Services had set a May 20th deadline for state-based exchanges to demonstrate eligibility and enrollment functionality. The board was appointed just last month and only recently contracted with Getinsured.com to build and maintain the computer system needed for the individual exchange (see Update for Weeks of April 22nd and 29th). It still intends to assume full control over the exchange when open enrollment for the second year begins on October 1, 2014.

Rhode Island

Senate passes ban on gender rating

The Senate passed S.B. 201 this week, which would prohibit gender rating consistent with the Affordable Care Act (ACA). The ban would start for individual or small group plans on January 1, 2014 and large group plans on January 1, 2015. Medicare supplemental plans are excluded.

Virginia

Virginia becomes sixth state approved for dual-eligible demonstration under ACA

Virginia became the sixth state this week to receive federal approval to participate in a three-year demonstration to better coordinate care for people eligible for Medicare and Medicaid.

The Centers for Medicare and Medicaid Services (CMS) announced that 78,600 dual-eligibles in five regions will be enrolled in managed-care plans when the demonstration begins in 2014. The effort will be phased in, with the initiative starting in February in the Central Virginia and Tidewater regions.

Individuals will first be able to opt in to the program. Beneficiaries who do not make a choice about whether or not to join the program will then be enrolled through a process that is designed to match beneficiaries with the most appropriate plan for the individual's medical needs.

Patients will also be allowed to continue to see their physicians as they transition into the program, which will be known as Commonwealth Coordinated Care. The plans will oversee their primary care, preventive services, acute care, mental health and long-term-care services.

According to Governor Bob McDonnell (R), Virginia should save about \$11.3 million in Medicaid funding during the first year of the demonstration, which was authorized by the Affordable Care Act.

At least 26 states initially submitted proposals to participate in the demonstration, which allows states to share in the savings from transitioning dual-eligibles into capitated plans. Massachusetts, Washington, Ohio (see Update for Week of December 17th), Illinois (see Update for March 4th) and California (see Update for Week of March 25th) have already been approved. New York and Wisconsin are among the states expected to soon be approved.

CMS has slowed approval of the demonstrations, pushing most into 2014 after sharp criticisms from lawmakers, Medicare experts, and hospital groups that it was moving far too quickly to safeguard access and quality (see Update for Weeks of July 23rd and 30th). In response to the complaints, CMS has been denying requests to “lock-in” enrollees, forcing Virginia and other states to allow them to change plans or leave the demonstration whenever they please.

As a result, several states have withdrawn applications or scaled back proposals. Arizona, New Mexico, and Tennessee are among the states that no longer wish to participate. California has delayed its demonstration until January 2014 while Hawaii will not be ready until 2015 at the earliest. New York has elected not to pursue only a capitated model, dropping plans for a “managed fee-for-service” alternative, although Minnesota and Oregon are working on similar initiatives.

Washington

“Rate shock” from ACA fails to materialize in rate filings

The Office of the Insurance Commissioner released proposed premiums this week that were submitted by health insurers for 2014, the first year that the market reforms from the Affordable Care Act (ACA) go fully into effect. While the filings show that rates will vary dramatically among the types of plans and across age ranges, the “rate shock” that the insurance industry and ACA opponents had promised failed to materialize (see above)

The lack of “rate shock” was particularly true for rates in the new Washington health insurance exchange created pursuant to the ACA. For example, Premera Blue Cross currently offers individual plans for 21-year-old non-smokers at a monthly cost of \$325 with a deductible of \$1,800. In the exchange, that same person in the state’s most populous country could purchase a similar Premera plan with a lower deductible at a rate of \$276, for a total cost decrease of 15 percent.

Premera’s proposed rates contrast dramatically with warnings from its executive vice president (EVP), who just last year had predicted a 50-70 percent premium jump due to the guaranteed issue and community rating requirements under the ACA. A Premera spokesperson clarified this week that the EVP’s predictions came before the Obama Administration provided additional guidance to insurers on how they can mitigate premium increases.

According to the Insurance Commissioner, one of the most popular plans in Washington is a basic LifeWise plan that covers essentials with a deductible of nearly \$2,000. A 21-year-old non-smoker in King County would currently pay \$160 but only \$162 next year. A 40-year-old in the same position would have their rates rise from \$294 a month to \$326 a month, for an increase of 11 percent.