

Health Reform Update – Week of June 24, 2013

CONGRESS

Supreme Court decision to overturn DOMA will impact Medicaid and ACA costs

The U.S. Supreme Court struck down a key provision of the federal *Defense of Marriage Act* this week that had denied eligibility for federal benefits to same-sex couples in the 12 states and District of Columbia, which had already legalized same-sex marriage. The landmark decision means that more than 100,000 legally-married same-sex couples must be treated as a family instead of separate individuals, a move that could make them eligible for federal spousal benefits such as family and medical leave, tax-free employer sponsored health coverage, and survivor benefits.

However, treating same-sex couples as a family also can potentially make their household income too high to qualify to Medicaid or tax credits under the Affordable Care Act (ACA). A preliminary analysis from tax firm Jackson Hewitt shows that it could conversely work to the advantage of couples with only one wage earner, as the working spouse may earn too much to qualify as a single individual but could do so as a couple.

The Congressional Budget Office previously estimated that the federal government would save \$1 billion each year through 2014 if it were allowed to recognize marriages of same-sex couples nationwide, despite greater costs under the spousal benefits for Social Security programs and Medicare Part A, as well as dependent coverage under the Federal Employee Health Benefits Program. However, DOMA had also prevented married couples of the same-sex from deferring their enrollment into Medicare Part B even if they are covered by a spouse's health plan, as well as availing themselves of asset transfer protections under Medicaid.

Bipartisan Senate group continues push for greater price transparency

A bipartisan group of senators asked the Government Accountability Office (GAO) this week to study how accessible medical pricing information is to consumers.

The request is part of an ongoing effort to increase competition through health care pricing transparency. The Obama Administration points to voluntary downgrades by health insurance exchange plans as evidence that greater transparency required by the Affordable Care Act (ACA) for proposed exchange premiums is already curbing unreasonable rate hikes (see below).

Senators Ron Wyden (D) and Charles Grassley (R) also introduced legislation this week (S.1180) that would require the Department of Health and Human Services Secretary to make available a searchable Medicare payment database that the public could access at no cost—a move strongly resisted by the provider industry. The bill specifically would remove any *Freedom of Information Act* exemption for data on Medicare provider payments.

Such payment data has been concealed from consumers since Medicare's inception and protected from release since 1978 by a federal court injunction. However, that injunction was recently overturned pending appeal (see Update for Week of June 3rd).

Senator Wyden acknowledged that CMS' recent release of payment data for the most common hospital inpatient and outpatient procedures was a "positive step", though far too limited to enable patients to be able to effectively shop around and compare prices (see Update for Week of June 3rd).

FEDERAL AGENCIES

Federal marketplace moves towards “active purchaser” model by negotiating premiums

The Secretary for the Department of Health and Human Services (HHS) made the surprising announcement this week that federal marketplace created by the Affordable Care Act (ACA) will negotiate premiums with health plans that seek to participate.

HHS officials had previously indicated that the marketplace would follow the “clearinghouse” model that will be in place for most state-based exchanges when open enrollment begins October 1st. This model, already used by Utah, allows any plan that meets minimum federal and state standards to participate. By contrast, five state-based exchanges are preparing to follow the “active purchaser” model already in place in Massachusetts, where the state can selectively contract only with those plans that are most affordable and exclude those that may meet minimum standards.

The early success of these states in holding premiums below projections (see Update for Week of June 17th) appears to have HHS officials reconsidering their approach to the federal marketplace, as the Secretary stated that HHS will “do rate negotiation and make sure that the plans are going to offer consumers the best possible choices.” However, it is not entirely clear that HHS would have the authority to act as a true “active purchaser”, since the ACA did not give the agency authority to modify or reject “unreasonable” rate hikes in either the individual and small group markets—authority that all but about ten states currently have to some extent.

CMS creates ombudsman program to respond to increasing dual-eligible demonstration concerns

A letter from 35 consumer or provider groups urged the Centers for Medicare and Medicaid Services (CMS) this week to institute additional protections against erosions in access and quality of care under the dual-eligible demonstration created by the Affordable Care Act (ACA).

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), California (see Update for Week of March 25th), and Virginia (see Update for Weeks of May 13th and 20th) have already been approved, while New York and Wisconsin were among those expected to soon follow.

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 already postponed implementation until 2014, while its Congressional delegation is urging a further delay (see Update for Week of June 3rd). And according to Avalere Health, seven other states (IL, MA, MI, OH, VA, TX, and WI) have delayed their implementation or applications just in the past month.

Among the ten new protections sought by consumer and provider groups include greater transparency, strict quality measures, enrollment brokers, and an ombudsman program. CMS responded this week to the latter concern by releasing a \$12 million Funding Opportunity Announcement (FOA) through which states can create independent Demonstration Ombudsman Programs to support their current dual-eligible demonstration, monitor beneficiary experiences, and offer recommendations to CMS. Each state can receive from \$275,000 to \$3 million over three years.

Final regulations on individual mandate exemptions largely mirror proposed rule

The Department of Health and Human Services (HHS) published final rules this week defining those who will remain exempt from the Affordable Care Act (ACA) mandate that everyone must buy health insurance they can afford.

The regulation largely mirrors the proposed rule issued earlier this year that expanded the scope of the nine exemptions under the ACA, primarily the one for economic hardship that is to be defined by regulation and not statute (see Update for Weeks of January 28th and February 4th). The final rule does so most dramatically by codifying HHS' earlier commitment that those earning below 138 percent of federal poverty level (FPL) who do not qualify for Medicaid in "opt-out" states would qualify for the hardship exemption (see Update for Week of June 25th). HHS had asked for public comment on whether this exemption should only be lowered to 100 percent of FPL, which is the level at which ACA subsidies are available, but declined to do so.

Under the final rule, HHS and Treasury will also allow individuals to satisfy the individual mandate for an entire month, even if they only had minimum essential health insurance for a single day within that month. Similarly, anyone that meets an exemption for one day of a month will be exempt for the entire month. (The tax penalties are calculated on a month-by-month basis starting January 1st).

The final rule clarifies that those enrolled in self-funded student health insurance, state high-risk pools, Medicare Advantage plans, health care sharing ministries, or foreign health plans will be deemed to have minimum essential coverage and not be subject to the individual mandate. HHS and Treasury will also have flexibility to grant further exemptions for economic hardship "on a case-by-case basis for individuals who face other unexpected personal or financial circumstances that prevent them from obtaining coverage."

Treasury and the Internal Revenue Service (IRS) also issued two related notices. The first clarifies that applicants to Children's Health Insurance Program may receive ACA tax credits during the waiting period to enroll. The second notice provides an exemption for workers whose companies offer insurance with a plan year that is different than the calendar year. Under this exception, employees and dependents in this situation are exempt from the individual mandate until a new plan year begins in 2014.

STATES

BCBS to participate in all exchanges, remain only insurer offering multistate plans

According to the *New York Times*, Blue Cross and Blue Shield (BCBS) is the only insurer that currently intends to participate in every state-based or federally-facilitated health insurance exchange created by the Affordable Care Act (ACA).

While other dominant insurers like Aetna and UnitedHealth Group will participate in only 10-15 exchanges nationwide, the Blue Cross and Blue Shield Association stated this week that they "will have a strong, reliable presence in the new exchanges", since they already dominate the market in a large majority of states. The Association also committed to devoting the resources needed to maximize outreach and enrollment in the online marketplaces, especially in large states like Florida and Texas where the Blues control more than half the individual market.

BCBS also remains the only insurer to publicly declare that it will offer one of the two multistate plans that the Affordable Care Act (ACA) require for every exchange by 2017 (and at least 60 percent of states next year). However, BCBS already provides coverage in all 50 states, leading to fears that the lack of early competition for multistate plans will cause them to be merely clones of existing BCBS plans.

According to the Office of Personnel Management, over 200 insurers have applied to be multistate plans.

National League of Cities selects locations for Medicaid and SCHIP enrollment initiative

The National League of Cities (NLC) announced this week that it has chosen 22 cities to participate in a three-year initiative to help children and families enroll in or retain access to Medicaid or the Children's Health Insurance Program (CHIP).

The initiative is funded through a grant from the Atlantic Philanthropies, which allocated \$1.86 million to the cities over the three-year period. The funding includes planning grants for ten cities followed by two rounds of implementation grants for six cities each. While the focus will be on existing federal programs, cities are allowed to include organizations that will be conducting outreach and enrollment for the new health insurance exchanges created by the Affordable Care Act (ACA).

Selected cities include major metro areas such as Baltimore, MD, Newark, NJ, Las Vegas, NV, and Houston and Dallas, TX. Small cities such as Savannah, GA and Hattiesburg, MS were also chosen.

Arkansas

State officials release draft waiver for private-sector alternative to Medicaid expansion

The Department of Human Services (DHS) released a draft of its waiver request that would allow Arkansas to use Affordable Care Act (ACA) matching funds for expanding Medicaid to instead enroll newly-Medicaid eligible populations in the health insurance exchange created by the law.

The Obama Administration has already tentatively approved the concept, leading several other states with reluctant legislatures to propose similar models (see Update for Week of March 25th). The waiver application is backed by most Republican lawmakers, who assumed control over both legislative chambers this session (see Update for Week of November 5th).

The official waiver application for this so-called "private option" will be submitted by DHS on July 2nd, with a public comment period that will run through July 24th.

The draft application reiterates DHS' claim that the cost of the "private option" will be comparable to the ACA expansion, though Congressional Budget Office (CBO) estimates last summer predict that it will cost states \$3,000 more per enrollee to be covered under exchange plans instead of Medicaid (see Update for Weeks of July 23rd and 30th).

Despite the backing from many Republican lawmakers, staunchly conservative groups like Arkansans Against Big Government are attempting to place a referendum on the November 2014 ballot that would allow voters to void the enabling legislation for the "private option."

California

Medicaid expansion becomes law, while "Walmart loophole" bill stalls

As expected, Governor Jerry Brown (D) signed legislation this week authorizing California's participation in the Medicaid expansion under the Affordable Care Act (ACA). The measure (A.B. X1-1) will add more than 1.6 million residents to Medi-Cal as of January 1st (see Update for Week of June 17th).

The measure was the latest in a series of ACA-related measures passed during the special session called by the Governor to address health reform (see Update for Week of May 6th). However, a measure that would attempt to close the so-called "Walmart loophole" in the ACA stalled in the Assembly this week after a fierce debate.

Assemblyman Jimmy Gomez (D) introduced the measure that would fine large employers that do not pay their workers enough to keep them being eligible for Medi-Cal (see Update for Week of April 15th). Although the ACA will already fine large employers that offer coverage so unaffordable or inadequate that at least one full-time employee becomes eligible for the new health insurance exchanges, A.B. 880 would move down the ACA's affordability threshold (9.5 percent of individual income) to Medi-Cal eligibility

levels and impose an even higher penalty (roughly \$5,000 per full-time employee) whenever either full-time or part-time employees qualify for Medi-Cal. The penalty would raise funds to improve Medi-Cal reimbursement, traditionally among the lowest in the nation.

The measure is supported by the California Labor Federation and United Food and Commercial Workers, but solidly opposed by business groups and Republican lawmakers. It fell eight votes short of the two-thirds majority required, but could shortly be brought back for a reconsideration vote.

Roughly 250,000 large firm workers already receive Medi-Cal. University of California researchers estimate that an additional 130,000 will enroll in Medi-Cal once it expands in 2014.

Colorado

Exchange board braces for sequester cuts

The executive director of the Connect for Health Colorado health benefit exchange revealed this week that the board will need to cut expenses by \$9 million as a result of the ongoing federal budget sequester (see Update for Week of February 25th). However, the 7.5 percent cut to the final \$125 million federal exchange establishment grant the board sought last spring (see Update for Week of May 6th) will not be spread evenly as the board has already committed funds for executed vendor contracts.

Colorado had received two previous exchange implementation grants for \$61 million. After spending more than \$200 million to launch the exchange, the board predicts it will cost \$22-26 million a year to operate once the exchange must be self-sustaining in 2015.

Delaware

House joins Senate in passing legislation that limits specialty tier cost-sharing

The House unanimously approved a substitute measure this week for S.B. 35 that previously cleared the Senate, which would limit patient coinsurance or copayments to \$150 for up to a 30-day supply of any single specialty tier drug (see Update for Week of June 10th). A provision of the bill will allow patients to request an exception to obtain a specialty drug that would not otherwise be available on a health plan formulary. If signed by Governor Jack Markell (D), it would go into effect on January 1st.

District of Columbia

Transparency forces United Healthcare to lower rates for small group exchange

The Insurance Commissioner for the District of Columbia announced this week that public disclosure of proposed premiums caused United Healthcare to promptly cut its rates for the small group exchange created by the Affordable Care Act (ACA).

The insurer had initially proposed to charge \$434 per month for 40 year olds purchasing silver plan coverage (the level for which premium subsidies are based). However, United Healthcare quickly reduced that rate by ten percent to \$392 after proposed rates for all participating plans were released.

A similar situation occurred last month in Oregon where two insurers immediately sought lower premiums after public disclosure showed them to be outliers (see below). The Secretary for the U.S. Department of Health and Human Services used these examples as evidence of how rate transparency is working to increase competition and lower premiums (see Update for Week of June 10th).

The D.C. Insurance Commissioner emphasized that the three other qualified plans in the small group exchange (Aetna, CareFirst, and Kaiser Permanente) can still revise their proposed rates for other 300 plan options they are offering. Rates for the D.C. exchange have largely followed the national trend of being below initial projections (see Update for Week of June 3rd). D.C. remains the only state limiting small group and individual market coverage to exchange plans.

Maine

New laws allow for drug re-importation, pricing transparency

Governor Paul LePage (R) elected to let L.D. 171 become law this week without his signature. The measure allows Maine residents to import prescription drugs from international mail-order pharmacies that are often far less costly than identical versions purchased domestically.

The state had allowed similar purchases in the past. However, Maine's attorney general ruled last year that CanaRX, a Canadian mail-order company serving public and private workers/employers since 2004, could not operate in Maine as it could not be licensed as a pharmacy.

Federal measures to allow drug re-importation have been staunchly opposed by the pharmaceutical industry, the Food and Drug Administration, and the Department of Health and Human Services (under Democratic and Republican presidents alike). However, HHS' position on the issue may be more permissive since Secretary Kathleen Sebelius promoted drug re-importation initiatives while Governor of Kansas.

Governor LePage also signed legislation this week (L.D. 990) requiring all health care providers to publicly disclose prices charged to uninsured patients for their most frequently performed procedures.

Michigan

Governor will not force legislature to return for Medicaid expansion vote

Governor Rick Snyder (R) announced this week that he will not seek to call a special session to debate legislation that would expand Medicaid under the Affordable Care Act (ACA).

The Senate adjourned last week without voting on the House-passed plan that would enact a compromise plan imposing copayments on the upper end of the expansion populations, which would increase after four years if the newly-eligible Medicaid enrollee did not move to the federal marketplace (see Update for Week of June 17th). However, six Republican senators formed a study group that will meet over the summer recess to consider improvements to the H.B. 4714.

The Governor insists that there are sufficient Senate votes to pass H.B. 4714 in its current form when the legislature returns. However, it is not yet clear that the federal government will approve that version or whether the Senate could pass a revised measure in time to be implemented on January 1st.

Mississippi

House votes to reauthorize Medicaid, but rejects any expansion

Governor Phil Bryant (R) called lawmakers back into special session this week to pass the needed reauthorization of the Medicaid program, but directed both chambers not to debate any legislation that would expand Medicaid under the Affordable Care Act (ACA).

The Governor has remained staunchly opposed to any Medicaid expansion, even the private-sector alternative that was tentatively approved by the Obama Administration in neighboring Arkansas (see above), which is backed by several Republican lawmakers in Mississippi. In response, House Democrats have refused to provide the needed votes for the Republican majority to approve an annual reauthorization of Medicaid.

The Governor has threatened to run the Medicaid program via executive order if Democrats allow Medicaid to expire on July 1st (see Update for Week of June 10th). However, Attorney General Jim Hood (D) disputes the Governor's authority to do so.

On the session's opening day, House Democrats finally voted to reauthorize Medicaid, but only if Republicans allowed a vote on Medicaid expansion on despite the Governor's admonition. The expansion amendment failed 65-51.

Two-thirds of the Senate must now pass the reauthorization measure (H.B. 2) by July 1st.

Montana

Insurance Commissioner says exchange rates will be "relatively less expensive"

Montana became the latest state this week where expected premiums in the new health insurance exchange created by the Affordable Care Act (ACA) are likely to be lower than projected.

Insurance Commissioner Monica Lindeen (D) announced that an analysis commissioned by her office revealed the average price of individual plans offered to 40 year old Montanans buying coverage in the federal marketplace will be \$273 per month before applicable subsidies, instead of \$290 month in the individual market.

Lindeen refuted any claims of "rate shock" for younger subscribers as "preliminary figures show that rates haven't skyrocketed." For example, monthly premiums for 25-year-olds are likely to range from \$141-299 a month before any subsidies, depending on how generous a plan they chose. For 55-year-olds, the price of a policy would range from \$313-664 per month before subsidies.

Policies purchased by small businesses on the marketplace will see an even better relative savings, according to the actuarial study. The average monthly cost in the small business exchange will be \$375 per employee per month, compared to \$450 in the small group market.

Montana Blue Cross and Blue Shield (BCBS), the state's dominant insurer serving 250,000 Montanans, will participate in the federal marketplace, along with PacificSource and the new Montana Health Cooperative created by the ACA. However, BCBS will be acquired by Health Care Service Corporation under a deal approved this week by Lindeen.

New Jersey

Assembly and Senate pass Medicaid expansion legislation

The Senate approved identical Assembly-passed legislation this week that would allow New Jersey to participate in the Medicaid expansion under the Affordable Care Act. Governor Chris Christie (R) was one of eight Republican governors in favor of the Medicaid expansion and is expected to sign S.2644 (see Update for Week of February 25th).

Oregon

Exchange board slashes proposed premiums by up to 35 percent

State insurance regulators have slashed proposed premiums for the new Covered Oregon health benefits exchange created pursuant to the Affordable Care Act (ACA).

Proposed premiums released last month were already below projections that feared rates for younger subscribers would skyrocket as a result of the new age rating bands, guaranteed issue, and other ACA market reforms (see Update for Weeks of May 13th and 20th). However, the Insurance Division found that many of those premiums were still "unjustified" as they were not reflective of medical costs and downgraded them by up to 35 percent.

As a result, monthly pre-subsidy premiums for a single, 40 year old non-smoking male in the Portland area will now range from \$166-274 per month for the most basic plan option. The same premiums for FamilyCare Health Plans suffered the largest decrease of 35 percent (down to \$274 on average) while rates for Trillium Community Health were cut by 32.4 percent, Health Net of Oregon fell

27% to \$197 and Providence Health Plans lost over 21 percent (to \$231). Rates for Oregon's dominant insurer, Regence Blue Cross and Blue Shield, were reduced by only 3.4 percent (to \$229).

FamilyCare and Providence had voluntarily asked for double-digit downgrades after they realized their proposed premiums were much higher than other exchange plans. Governor John Kitzhaber (D) stated this week that their move, as well as the Insurance Division's adjustments, proves that the greater transparency and competition afforded by the ACA is effectively curbing unreasonable rate hikes.

Governor to sign ACA-alignment legislation that closes state premium assistance program

Legislation introduced at the request of Governor John Kitzhaber (D) to align Oregon health insurance law with the market reforms under the Affordable Care Act (ACA) passed the Senate this week after previously clearing the House. H.B. 2240 also abolishes the state Office of Private Health Partnership (OPHP) and the Family Health Insurance Assistance Program (FHIAP). The latter pays 50-95 percent of private insurance premiums (or 100 percent for children) for over 5,300 Oregonians that have been uninsured for at least two months and meet certain income guidelines.

Roughly 82 percent of FHIAP enrollees will be eligible to directly transfer to Medicaid while the remaining 18 percent will be directed towards the new CoverOregon health benefits exchange created pursuant to the ACA.

Pennsylvania

Senate Republicans prepare to vote on Medicaid expansion, despite House opposition

Senate Republicans are pushing for an imminent vote on whether Pennsylvania should participate in the Medicaid expansion under the Affordable Care Act (ACA).

The Commonwealth remains one of only a handful of states that have yet to decide whether to expand. Governor Tom Corbett (R) has remained staunchly opposed to accepting federal matching funds for a full expansion to everyone earning up to 138 percent of the federal poverty level unless the Obama Administration agrees to a private sector alternative similar to the Arkansas model, and includes significant concessions, like mandatory job training, benefit cuts, and broad increases in cost-sharing (see Update for Week of June 3rd).

Republican lawmakers have been under intense pressure from provider and business groups to vote for a full expansion under the ACA in order to avoid the higher uncompensated care costs and employer penalties that would result if Pennsylvania opts out. Senate President Pro Tem Joe Scarnati (R) and Senate Majority Leader Dominic Pileggi (R) back the Governor's "Republican-formulated" expansion" and have been setting the stage for a floor vote.

It remains very unclear that the Governor's plan can clear the House, much less get federal approval. Roughly 50 House Republicans came out in opposition this week to any expansion plan, with Rep. Maureen Gingrich (R) comparing the expansion to "socialism". Rep. Matt Baker (R) insisted that the expansion would cause enrollment to explode to the point where one in four Pennsylvanians are served by Medicaid.

Despite the show of force by the most conservative members of the House, Human Services chair Gene DiGirolamo (R) insisted that 15-20 Republicans would join with Democrats to give the Senate plan enough votes to pass, although only a handful have cosponsored his version of expansion legislation (see Update for Week of June 3rd).

The Independent Fiscal Office has concluded that a full ACA expansion would have a positive net budget impact, saving Pennsylvania roughly \$255 million per year through 2021, while RAND predicts it will create up to 39,000 new jobs.