Health Reform Update – Week of September 30th, 2013

CONGRESS

Democrats open to minor ACA changes only after government reopens and debt limit raised

Senate Democrats remained adamant this week that it will not consider any Republican demands to repeal or revised provisions of the Affordable Care Act (ACA) until the House passes "clean" resolutions funding the federal government and raising the nation's debt ceiling.

The federal government shut down on October 1st after the most conservative members of the House Republican caucus successfully demanded that Speaker John Boehner (R-OH) attach riders to a temporary spending resolution that would at least delay full implementation of the ACA by one year, if not entirely defund it. However, House leaders quickly pared back their demands after public opinion polls overwhelmingly disapproved. (According to Quinnipiac University, 72 percent opposed shutting-down the government to block the ACA).

Senate Majority Leader Harry Reid (D) refused to consider efforts by conservative Republicans to fund only those government functions they supported, as well as attach riders to delay the individual mandate by one year or deny subsidized coverage to members of Congress and their staff (see below). However, he also rejected a bipartisan push to repeal the 2.3 percent medical device tax under the ACA, insisting that only a "clean" resolution to reopen the government would receive a vote. Repealing the device tax has the support of about 17 centrist Democrats in the House. The full Senate also supported repeal in a non-binding resolution passed earlier this year, and Senate leaders including Dick Durbin (D-IL) indicated that it may be considered as part apart from the budget and debt ceiling impasse.

At the end of the week, it appeared that Speaker Boehner was recruiting support from more moderate members of his caucus to pass a "clean" spending and debt ceiling resolution with Democratic help (and without a majority of House Republicans). If the debt ceiling is not raised by October 17th, the nation will default for the first time on its existing debt obligations (see Update for Week of September 23rd).

The ongoing shutdown of the federal government will not impact enrollment in the Affordable Care Act (ACA) health insurance marketplaces that started this week (see below), nor it affect benefits provided to Medicare or Medicaid enrollees. However, it will slow drug approvals and reviews by the Food and Drug Administration (FDA) after 45 percent of its staff was furloughed this week.

FEDERAL AGENCIES

Members of Congress, staff must purchase gold coverage from SHOP marketplace

The Office of Personnel Management (OPM) published final rules this week that will require members of Congress and their staff to purchase only gold-level coverage in the Small Business Health Options Program (SHOP) marketplace for the District of Columbia if they want to continue their existing subsidy from the federal government.

A provision inserted into the Affordable Care Act (ACA) by Senator Charles Grassley (R-IA) required lawmakers and staffers to purchase coverage in the new health insurance marketplaces. Under proposed regulations released last summer, OPM codified a bipartisan compromise that allowed the federal government to continue to subsidize for members Congress and their staff, as it currently does under the Federal Employees Health Benefits Plan (FEHBP), would go towards the purchase of

exchange coverage (see Update for Week of August 5th). The rules allow a government subsidy up to $5,000 a year for individual coverage and $11,000 for families, compared to FEHBP which subsidizes up to 75 percent of the cost of coverage.

Members of Congress and their staff will not be eligible for premium tax credits or cost-sharing provided by the ACA to those earning 100-400 percent of the federal poverty level (FPL). They also cannot continue their federally-subsidized coverage if they purchase coverage from a marketplace other than the SHOP version for the District of Columbia.

Open enrollment for members of Congress and their staff will not be allowed until November 11th, consistent with the open enrollment period for their FEHBP coverage, which will automatically terminate on December 31st. They will have 112 gold-level plan options from which to choose.

The rule defines staff as those that work in the official office for the Senator or Representative, and not committee staff, which can remain in FEHBP. In a major change from the proposed rule, retired members and staff will also be allowed to remain in FEHBP. In addition, the amount of time in a SHOP plan with a federal contribution counts toward the five years of coverage a member or aide must have through to get federal retiree health benefits.

OPM explained that members and staff were being funneled through the SHOP instead of the individual marketplace because the SHOP is "designed to provide employer-sponsored group health benefits" and also "ensures that members of Congress and congressional staff do not have additional choices in the individual exchanges with a government contribution that other individuals lack."

House Republicans have been fighting back efforts by more conservative members of their caucus to attach riders to continuing spending resolutions that would reopen the government only if this subsidy for members of Congress and their staff is eliminated (see above).

BCBSA and OPM announce new multistate plan options for ACA marketplaces

The Blue Cross and Blue Shield Association (BCBSA) and the Office of Personnel Management (OPM) announced new multistate plan options this week that will be part of the health insurance marketplaces created pursuant to the affordable Care Act (ACA).

Under its federal contract, BCBSA will offer 154 individual plans in 30 states and the District of Columbia. The products will vary by state and in many cases provide consumers with access to a nationwide network of providers.

The ACA required at least two multistate plans in every state by 2017 (with at least one being a non-profit organization), and at least 60 percent of states in 2014. However, BCBS remains the only insurer that has applied. According to OPM, at least five insurers have expressed interest and may file applications in the future.

OPM points out that BCBS will be offering multistate plans in at least two marketplaces (New Hampshire and West Virginia) that had only one participating insurer for 2014. Fifteen of the other 28 states in which BCBS will offer multistate plans have defaulted to the federally-facilitated marketplace.

The multistate plan was also supposed to be offered in the ACA marketplaces for small businesses starting in 2014, but BCBS will only make such coverage available in the marketplaces for Alaska, Maryland, Virginia and the District of Columbia.

BCBS will offer 36 individual and small business plan options to Alaska consumers, far more than the next highest number of options (12) that it will make available in Pennsylvania.

HHS release premiums for specific carriers in federal marketplace states

The Department of Health and Human Services (HHS) posted premiums for more than 78,000 individual and small business marketplace plans this week on its www.healthcare.gov website. The data lists each plan by insurer and the plan name and the monthly premium rate for a child, a 27-year-old, a family with 30-year-old parents and two kids, a single-parent family with two 30-year-olds, and a 40-year-old couple without children". However, the tables do not identify deductibles and copayments that are provide once applicants select a plan through the system.

The tables do confirm that federally-facilitated marketplace plans will offer all the most generous but most costly platinum level plans, in addition to the bronze, silver, gold, and catastrophic plan levels. According to the Georgetown University Health Policy Institute, only California, Massachusetts, New York, and Vermont are requiring carriers in their state-based marketplaces to offer platinum coverage (see Update for Week of August 12th). Some carriers in Delaware's partnership marketplace, although West Virginia's partnership marketplace will not (see Update for Week of September 23rd).

The premium data had initially been promised to Congress by mid-September but delayed until the start of open enrollment on October 1st (see Update for Week of September 16th).

Avalere confirms that competition in federal marketplaces will vary widely

According to the latest analysis of Affordable Care Act (ACA) marketplaces released this week by Avalare Health will have "meaningful competition", even though 16 of the 36 states operated fully or partly by the Centers for Medicare and Medicaid Services (CMS) have only 1-3 insures operating in their individual marketplaces. Avalere noted that another 11 states have more than ten insurers.

Federal officials documented this wide variability in a study it released last week in advance of the start of open enrollment for the marketplaces, acknowledging that premiums were markedly higher in those states with less than three insurers (see Update for Week of September 23rd). Avalere reached a similar conclusion in its prior analysis of 12 state-based marketplaces (see Update for Week of September 2nd).

Most federal marketplace consumers will be offered a Blue Cross and Blue Shield plan as the second-lowest cost silver plan option (the plan to which ACA premium tax credits are tied). BCBS dominates the individual market in most states and is the only insurer participating in every state, federal, or partnership marketplace under the ACA.

Avalere found that in a sampling of 13 states with full or partial federal control over their ACA marketplace, the second-lowest-cost silver plan was associated with BCBS in eight of the 13 states, a national Humana or Coventry plan in two of the 13 states, a local plan in two of the 13 states, and a Medicaid/Medicare Advantage plan in one state.

These 13 states were Arkansas, Florida, Georgia, Illinois, Indiana, Michigan, North Carolina, New Jersey, Ohio, Pennsylvania, Texas, Virginia and Wisconsin. They are expected to have the most enrollees.

PhRMA files federal lawsuit to block rule requiring 340B discount for orphan drugs

The Pharmaceutical Research and Manufacturers of America (PhRMA) filed a lawsuit in federal district court this week in an effort to block federal regulations that require discounted prices for orphan drugs sold to certain safety net providers.

The final rule published last summer by the Health Resources and Services Administration (HRSA) allows safety net providers that were made eligible for the federal 340B drug discount program by the Affordable Care Act (ACA) to buy previously-excluded outpatient orphan drugs at 340B prices. This exception applies so long as the medications are used to treat common conditions and not the rare diseases that prompted the orphan drug designation.

Since 1992, the 340B program allows nonprofit hospitals, community health centers, hemophilia treatment centers, HIV/AIDS clinics and other similar facilities that serve a large proportion of under- or uninsured patients to purchase medications at reduced prices. The ACA expanded the program to include several other types of providers, such as critical access hospitals that serve primarily Medicare and Medicaid patients.

For example, under the new rule a manufacturer like Roche would have to sell a blockbuster drug like Rituxan to 340B providers for its rheumatoid arthritis patients, but could still charge its usual price for orphan drug indications like chronic lymphocytic leukemia (a rare blood cancer).

STATES

Marketplace wait times cut down after high demand impedes early enrollment

The Department of Health and Human Services (HHS) announced this week that it has made substantial progress in reducing technical glitches that caused long wait times or halted enrollment in at least 47 of the new Affordable Care Act (ACA) health insurance marketplaces that opened on October 1st.

Demand for both state and federally-operated marketplaces were dramatically higher than anticipated, causing only handfuls of applicants to be able to actually purchase a plan. The website for the 36 states operated all or partly by the federal government also shut down entirely for part of day one, as did those for state-based marketplaces in at least Hawaii, Maryland, Minnesota, New York, and Washington.

According to HHS, during the first two days the federal marketplace website at www.healthcare.gov had more than seven million visitors while the call center handled more than 300,000 inquiries. It emphasized that this was a higher volume than companies like Southwest Airlines receive in an entire month, and seven times more than www.medicare.gov has ever handled at one time.

Potential federal marketplace applicants by either phone or website were often forced to wait from 30 minutes to several hours during the first two days of open enrollment. HHS insisted that by week's end it had reduced times to enroll by phone by half and through the website by a third. However, HHS officials do not intend to release data on how many applicants actually enrolled until late November.

Several state-based marketplaces including Connecticut, Kentucky, Maryland, Rhode Island, and the District of Columbia did release data showing that hundreds of applications were approved, while handfuls of applicants already selected or even purchased plans this week. However, they emphasized that enrollment will likely only "trickle" in until December 15th, as consumers are likely to "shop around" until payment is actually due on December 15th for coverage that will start January 1st. (The initial open enrollment period will continue until March 31st.)

Despite a late start in marketplace implementation, Kentucky was hailed this week as the one state that was best prepared for the high volume, as it has already processed 3,500 completed applications from over 118,000 visitors to its marketplace website. Colorado's Connect for Health marketplace registered over 2,000 new accounts in its first two days, nearly a third of which came in through "web chats" indicated strong interest from younger "tech savvy" consumers that are critical to the success of the marketplaces.

Alaska

Governor to decide by December 15th whether to participate in Medicaid expansion

Aides to Governor Sean Parnell (R) announced this week that he would decide by December 15th whether Alaska should participate in the Medicaid expansion under the Affordable Care Act (ACA).

Alaska remains one of only four states that have yet to reach a decision on whether to accept the ACA funds to expand (see Update for Week of September 2nd), which are available to states starting on January 1st.

The Governor has been an ardent opponent of the ACA, returning previous federal grants to create a state-based health insurance marketplace and strengthen state review of premium increases. However, he has yet to rule out participating in the expansion, which would extend coverage to roughly 40,000 uninsured Alaskans earning up to 138 percent of the federal poverty level.

The Governor's deputy health policy director indicated that he was awaiting a report on the costs and benefits of expanding that is being prepared by the Department of Health and Social Services, and will make his decision as part of the proposed budget he presents to the Legislature.

Arkansas

More than 55,000 Arkansans express intent to participate in Medicaid expansion alternative

More than 55,000 of over 154,000 low-income Arkansans have notified state officials that they intend to enroll in the "private sector" alternative to the Medicaid expansion that was approved last week by the Obama Administration (see Update for Week of September 23rd).

Starting January 1st, Arkansas will begin enrolling those made Medicaid-eligible by the Affordable Care Act (ACA) into the new health insurance marketplace that will be jointly operated with the federal Centers for Medicare and Medicaid Services (CMS).

The Department of Human Services (DHS) previously mailed out letters to those it identified through the Supplement Nutrition Assistance Program as potentially-eligible for the Medicaid expansion and received a notice of intent to enroll from more than one-third of the recipients. However, those returning the letters had to acknowledge in writing that the "private sector" option could be abruptly terminated if the promised federal funding under the ACA fails to materialize.

About half of the 500,000 people expected to participate in the partnership marketplace are expected to enroll through the "private sector" option.

California

Governor signs bill limiting state ability to conceal ACA marketplace records

Governor Jerry Brown (D) signed legislation this week (S.B.332) that would strip the existing authority of state agencies to conceal vendor contracts and other records for the Covered California health insurance marketplace.

Authorizing legislation gave the Affordable Care Act (ACA) marketplace unprecedented secrecy, as vendor contracts could be shielded from public disclosure for one year and the amounts paid hidden indefinitely. Other Covered California records that could be kept secret included those that reveal recommendations, research, or strategy, or instructions to employees, as well as board meeting minutes.

This secrecy contrasted sharply with states like Massachusetts, Maryland, and Minnesota that subject their state-based ACA marketplace to most state open records law, while Idaho and New Mexico will do likewise once their exchange go from federal or partnership status to a state marketplace (see Update for Week of May 6th). It also extended well beyond those afforded to other state health programs, such as the Healthy Families SCHIP, which withholds payment information only for four years (see Update for Week of August 19th).

However, effective immediately S.B. 322 subjects Covered California records to the state Public Records Act. As a result, it opens all of these documents to public inspection and mandates that the rates of payment be open to inspection for three years. The law still allows for a one-year delay in the release of records for qualified health plan contracts.

Florida

Florida has licensed only 34 of 150 navigators as marketplace opens

According to the Department of Financial Services, Florida licensed only 34 of 150 entities that applied to be navigators at the start of open enrollment this week in the Affordable Care Act (ACA) health insurance marketplace.

The Department had blamed technology glitches with the required federal online training for the lag in approving licenses. However, the state was identified by Health Care America Now (HCAN) as one of 13 states engaging in "navigator suppression" by imposing burdensome and unnecessary requirements to prevent them from facilitating marketplace enrollment (see Update for Week of September 23rd).

Georgia

Georgia has the greatest variation in marketplace premiums

Georgia has the greatest variation in premiums under the health insurance marketplaces created by the Affordable Care Act (ACA), according to an analysis released this week by Kaiser Health News.

Georgia is one of 36 states where the federal government is fully or partly operating the marketplace. Premiums for these marketplaces that were disclosed this week by the Obama Administration upon the opening of open enrollment (see above) revealed that 40-year old enrollees in rural southwest Georgia will pay for than double the amount charged to metro Atlanta residents for the lowest-cost silver plan ($81 per month compared to $238).

The more than 100 percent variation in premiums far exceeded the next closest state of Wisconsin (at 82 percent).

The dramatic variation results from the lack of competition among marketplace plans in that part of the state. Blue Cross and Blue Shield of Georgia is the only marketplace insurer offering plans in all counties of Georgia, giving it a virtual monopoly over the two southwest regions of the state. An analysis by the Obama Administration showed that rates were significantly lower in areas with at least three participating insurers (see Update for Week of September 23rd).

Georgia licensed only four marketplace navigators at start of open enrollment

Insurance Commissioner Ralph Hudgens (R) acknowledged this week that the his department licensed only four navigators as the start of open enrollment in the health insurance marketplace created under the Affordable Care Act (ACA).

According to Health Care America Now (HCAN), Georgia is among the 13 states engaging in "navigator suppression" by imposing burdensome and unnecessary requirements upon the navigators that will help facilitate marketplace enrollment (see Update for Week of September 23rd). Hudgens himself acknowledged that the state law enacted last session requiring navigators to undergo the same licensure and certification requirements as insurance brokers was intended to do "everything in our power to be an obstructionist" (see Update for Week of August 26th).

The department stated that 23 navigators have already passed the state licensure exam but still must undergo fingerprinting and background checks, while another 17 are scheduled to take the exam.

The Centers for Medicare and Medicaid Services (CMS) has strongly objected to the fingerprinting and background checks, insisting that they are not required for existing Medicare counselors that have handled the same role as navigators for decades without incident (see Update for Week of September 16th).

The consumer advocacy group Georgia Watch estimates that Georgia will have less than 100 navigators as a result of the added requirements.

Maryland

Marketplace explores alternative ways to enroll after "significant bottleneck"

Officials with the Maryland Health Connection marketplace created pursuant to the Affordable Care Act (ACA) acknowledged this week that they are trying to develop "alternative ways" for prospective applicants to create online accounts after a surge in demand crashed the web portal during the first day of open enrollment.

The state-based marketplace claims it was able to actually enroll less than 100 people by week's end despite the portal being down until noon on day one, but a "significant bottleneck" has prevented "thousands" from being able to even set-up the accounts to start the application process. The website had more than 105,000 unique visitors during the first two days of open enrollment.

Since visitors cannot even different plan options or determine subsidy eligibility without the accounts, officials are scrambling to find ways to allow them create the accounts by phone or in person.

Massachusetts

Differences in ACA marketplace and Connector exchange require many to re-enroll

Hundreds of Massachusetts residents started enrolling this week in individual plans offered by the new Affordable Care Act (ACA) marketplace.

Even though Massachusetts created a health insurance marketplace in 2007 that became the model for the ACA version, differences in the two marketplaces will require more than 100,000 enrollees in the Commonwealth Connector to enroll instead in the ACA marketplace or lose their existing coverage. Despite website capacity glitches that Connector officials characterized as "minor", at least 105 applications were completed by week's end.

The ACA expands the number of Massachusetts residents that may be eligible for subsidized coverage. Under the Connector, premium subsidies were only available to those earning up to 300 percent of the federal poverty level, compared to 400 percent under the ACA. The state-based ACA marketplace in Massachusetts will also offer the most generous but most costly platinum coverage, whereas the Connector only offered the bronze, silver, and gold plans that are also required by the ACA.

Connector enrollees will now have the choice under the ACA marketplace of making the premium tax credit advanceable and reconciled during their annual federal tax filing should their income change during the year. Under the Connector, the monthly premium for enrollees was reduced each month based on income.

Pennsylvania

Resolution would require Senate study of specialty tier drug pricing

The Senate Public Health and Welfare Committee unanimously passed a resolution this week that would direct the Legislative Budget and Finance Committee to study the impact of specialty tier prescription drug pricing upon access to care for Pennsylvanians (see Update for Week of March 25th). Sponsored by the Committee's vice chair Bob Mensch (R), S.R. 70 would require Budget and Finance to submit its report to the Senate by January 30, 2014.