

Health Reform Update December 16, 2013 – January 3, 2014

CONGRESS

Bipartisan budget deal is signed into law

President Obama signed H.J. Res. 59, into law on December 26th after it was passed by the Senate before the holiday recess.

The Bipartisan Budget Act of 2013 raises federal spending caps for both fiscal years 2014 and 2015 that were set by the ongoing budget sequester, in an effort to remove the annual threat of a government shutdown for the next two years (see Update for Week of December 9th). However, it extends the sequester's two percent Medicare reimbursement cut (although the cut is staggered so that it is 0.9 percent higher in the first six months and 0.9 percent less thereafter).

The most notable other provisions impacting Medicare and Medicaid are the three-month reprieve from the 24 percent cut in Medicare physician payments while Congress formulates a permanent fix, and a delay in Affordable Care Act (ACA) cuts in Medicaid payments for safety-net hospitals. The latter will provide additional relief to providers in states that elected not to participate in the ACA's Medicaid expansion for 2014 (see Update for Week of August 6 and 13, 2012).

The law also extends two Medicaid programs until March 31st as recommended by the Medicaid and CHIP Payment and Access Commission (MACPAC) created by the ACA. It allocates \$200 million to continue the Qualifying Individual (QI) program, which helps pay all or part of Medicare Part B premiums for certain Medicaid beneficiaries. The Transitional Medical Assistance (TMA) program, which provides medical coverage for certain families who become ineligible for medical assistance because of increased earnings, is also extended.

Congress typically extends TMA for one or two years, but MACPAC is urging Congress to make the funding permanent to help states budget for the future with more confidence, particularly as they decide whether to expand Medicaid (see Update for Week of March 18th).

Congresswoman seeks to extend PCIP coverage through 2014

Rep. Michelle Lujan Grisham (D-NM) introduced H.R. 3783 on December 16th, which would extend Pre-Existing Condition Insurance Plans (PCIPs) through 2014.

The Affordable Care Act (ACA) allocated \$5 billion for the temporary high-risk pools that were slated to expire December 31st. The Obama Administration has extended PCIP coverage for existing enrollees through January in an effort to smooth their transition to ACA Marketplaces, many of which were largely non-functional for the first month of open enrollment (see Update for Week of December 9th).

H.R. 3783 would appropriate an additional \$1.5 billion to continue the extend PCIP coverage for all of 2014. It is likely to face stiff opposition from conservative lawmakers, many of whom opposed an effort by Republican leadership to supplement PCIP funding last summer (see Update for Weeks of July 1st and 8th).

Senators introduce companion to House bill equalizing coverage of oral and IV cancer drugs

Senators Al Franken (D-MN) and Mark Kirk (R-IL) introduced the Cancer Treatment Parity Act of 2013 (S.1869) on December 19th. The measure is the companion to H.R. 1801 introduced by Rep. Brian Higgins (D-NY) last summer, which has 66 cosponsors. It would require parity in health insurance coverage for oral cancer medications and intravenous chemotherapy.

Similar legislation has already been enacted in at least 27 states (see Update for November 18th–December 6th). It would prevent specialty tier coinsurance under prescription drug benefits from being applied to oral cancer drugs and making them prohibitively more expensive than intravenous treatment that is typically covered as a medical benefit.

House bill would allow drug re-importation from other countries

Reps. Keith Ellison (D-MN) and Dana Rohrabacher (R-CA) introduced The Personal Drug Importation Fairness Act of 2013 (H.R. 3715) on December 12th. The measure would allow for the re-importation of prescription drugs from certain countries deemed to have comparable safety standards to the United States, including Australia, Canada, Israel, Japan, New Zealand, Switzerland, South Africa, and countries in the European Union. The drug imported must have the same active ingredients, route of administration, and strength as an FDA-approved product and the purchase must be accompanied by a valid prescription for a supply not exceeding 90 days.

More than a dozen states (including Illinois, Kansas, and Montana) have considered similar measures that would allow their residents to purchase their drugs abroad, often at a much lower cost. To date, only Maine has enacted such a law (last October). Even though drug re-importation remains prohibited by federal law, Food and Drug Administration enforcement has been inconsistent and often overlooked for individual consumers.

Past Congressional efforts to allow drug re-importation have been blocked by industry opposition and were left out of legislation creating the Medicare Part D drug benefit and Affordable Care Act.

FEDERAL AGENCIES

Late enrollment surge brings Marketplace total to more than two million

The Department of Health and Human Services (HHS) announced this week that about 2.1 million people enrolled in private plans offered through Affordable Care Act (ACA) Marketplaces by year's end, while more than 3.9 million people have been determined eligible for Medicaid or the Children's Health Insurance Program (SCHIP)

The figures, which include both new determinations and renewals, are a dramatic improvement from the nearly 365,000 that were enrolled as of November 30th (see Update for Week of December 9th). However, HHS did not identify how many have actually paid their first premiums since the deadline was extended until December 24th. It also did not provide critical demographic details on age, state of residence, or prior insurance status.

Despite the lack of Marketplace functionality over the first 4-6 weeks of open enrollment, Avalere Health pointed out that the 2.1 million Marketplace enrollees now falls only slightly behind their previous estimates of 2.4 million enrollees by December 31st, based on a similar enrollment trend when Medicare Part D was first implemented. However, it remains well behind the 3.3 million target set by the Administration for December 31st.

Several state-based marketplaces including Connecticut, Kentucky, and New York (see below) are actually exceeding the targets set by the Administration last September. Even Colorado, which has

been one of the SBMs beset by similar technological glitches as the federal Marketplace (see Update for Week of December 9th), has now enrolled 16,000 more private plan subscribers than initially projected.

Marketplace enrollment will need to accelerate even further in order to meet HHS' projection of seven million enrollees by the March 31st close of open enrollment. However, that target no longer appears entirely out of reach, as it did before the web portal for the federal Marketplace was overhauled (see Update for November 18th – December 6th).

Relaxed rules credited for surge in Marketplace enrollment

According to the Department of Health and Human Services (HHS), over one million of the 2.1 million that have enrolled in private Marketplace plans (see above) signed-up just days before the December 24th deadline to purchase coverage that would be effective January 1st.

Although HHS had predicted a late “surge” consistent with the experience in other health insurance marketplaces (see Update for Week of November 11th), analysts largely attributed the vast number of late enrollees to HHS' decision on December 20th to allow those whose individual policies were canceled to buy the catastrophic or “bare bones” Marketplace plans that were to be restricted only to those under age 30. HHS also let this group claim a “hardship exemption” from the individual mandate that would have forced them to buy minimum essential coverage in 2014 for pay a tax penalty.

The health insurance industry has strenuously objected to the Obama Administration's willingness to relax enrollment rules in response to their cancellation of over five million individual policies that do not comply with the new consumer protections under the ACA. They insist that without these provisions remaining in effect, the initial pool of Marketplace enrollees will skew towards the older and more costly, even though they based 2014 premiums on the presumption that at least 39 percent of enrollees would be from younger and healthier populations.

Although it has yet to release such demographic data (see above), HHS claimed this week that all but 500,000 of the five million plus subscribers whose individual plans were canceled have been able to enroll in upgraded Marketplace plans or “deficient” plans that the Administration allowed insurers to temporarily continue or reinstate (see Update for November 18th–December 6th). HHS also noted that large pharmacy chains CVS and Walgreens will provide short-term transitional coverage of drugs for subscribers of canceled plans that can show they enrolled in a Marketplace plan.

A new study by the Kaiser Family Foundation refuted industry claims of a “death spiral” if Marketplace enrollment of younger and healthier consumers does not meet projections. Kaiser found that insurers would still make a “small profit” even if only half as many young adults enroll, as they would still constitute more than 25 percent of overall individual plan enrollments.

Despite their concerns about the demographics of the Marketplace risk pools, America's Health Insurance Plans (AHIP) acknowledged that a “majority” of did voluntarily agree to extend the initial deadline for premium payment until January 10th (with coverage retroactive to January 1st), in an effort to facilitate enrollment and “reduce consumer confusion”. Most Marketplaces granted similar extensions, although Covered California would not move their payment deadline past January 6th.

CMS issues proposed methodology for Basic Health Plan payments

The Centers for Medicare and Medicaid Services (CMS) published a proposed methodology on December 23rd that details the process and data sources needed to compute federal 2015 payments for states electing to participate in the Basic Health Program (BHP).

The Affordable Care Act (ACA) created the BHP to provide states with an alternate means to cover those earning 133-200 percent of the federal poverty level (FPL) that would otherwise be eligible for the new health insurance Marketplace. The methodology supplements CMS' proposed rule last fall in

which the agency laid out the parameters for states to administer these programs (including eligibility and enrollment) but left out specific payment information (see Update for Week of September 23rd).

States that participate in the BHP will receive additional federal funding while CMS will save money since it will pay only 95 percent of the amount of ACA subsidies that BHP enrollees would have received had they remained in the Marketplace. The methodology spells out how CMS will arrive at a total federal BHP payment amount based on multiple and distinct “rate cells” in each state that will account for age range, geographic variations, type of coverage, household size, and income range.

CMS emphasizes that the “rate cells” will only be used to calculate the federal BHP payment amount, adding that “a state implementing BHP would not be required to use these rate cells or any of the factors in these rate cells as part of the state payment to the standard health plans participating in BHP or to help define BHP enrollees’ covered benefits, premium costs, or out-of-pocket cost-sharing levels.”

States operating their own Marketplaces must submit the required data to CMS not later than January 20th, including premium rate for the second lowest cost silver plans by geographic area. This is the plan upon which premium tax credits under the ACA are based.

CMS was criticized by Democratic lawmakers for delaying BHP implementation until 2015 in order to focus on other Marketplace regulations (see Update for Weeks of January 28th and February 4th). However, some state-based Marketplaces (SBMs) sought the delay fearing the BHP option could threaten the financial viability of their Marketplace by siphoning away enrollment during the critical early stage of development (see Update for Week of July 25, 2011). Two of these SBMs (California and Hawaii) already face dramatic deficits due to lower than anticipated enrollment (see below).

GAO finds that ACA raised individual premium costs but eliminated largest deductibles

A new report from the Government Accountability Office (GAO) concludes that the Affordable Care Act (ACA) has raised annual premium costs for many health plans now sold on the individual market but eliminated the largest deductibles that were included in plans before the ACA took effect.

The ACA caps annual out-of-pocket costs in 2014 at no more than \$6,350 for individuals and \$12,700 for families. GAO’s comparison of individual plans sold before and after the ACA found that in some markets like Chicago the \$2,400 increase in annual premiums for a 55-year old couple may be more than offset by the reduction in the annual deductible from \$30,000 to \$12,700.

FDA approvals declined despite expedited process for rare disease drugs

The Food and Drug Administration (FDA) approved only 27 new drugs in 2013, compared to 39 the year before, a decline the agency attributed on a lower than expected number of applications.

FDA officials stressed that 2012 was an outlier year, as the 39 approvals were the highest since 1997. The 27 approvals for 2013 were closer to the normal average over the past five years of 28 annual approvals.

The FDA did approve treatments for rare diseases in record time, thanks to the “breakthrough therapy” designation created by reauthorization legislation in 2012 (see Update for Week of June 18, 2012). The agency has already approved 36 of the 120 requests it has received (rejecting 58).

Figures released earlier in December by Deloitte and Thomason Reuters showed that the average internal rate of return from pharmaceutical research and development fell to around 4.8 percent in 2013 from 7.2 percent in 2012 and 10.5 percent in 2010. However, over the same four-year period the average cost of developing new medicines rose 18 percent to \$1.3 billion.

HEALTH CARE COSTS

Insurers blame premium increases on rising medical costs, not Affordable Care Act

According to a new survey by The Commonwealth Fund, rising medical costs accounted for more than three-quarters of the largest premium hikes sought by health insurers from July 2012 to June 2013.

The Commonwealth Fund claims that its analysis is the first ever to take a national look at the explanations that the Affordable Care Act (ACA) requires health insurers to file with federal and state authorities to justify any double-digit rate hike (see Update for Week of August 29, 2011). Researchers reviewed 311 plan filings covering 150 or more subscribers in the individual and small-group markets and found that not only did less than half attributed any part of their rate hike to the new ACA consumer protections, they also documented that the ACA accounted for only a small portion of their proposed rate increases.

By contrast, rising prices for medical care remained far and away the primary factor driving the higher premiums.

STATES

California

Large insurers control 96 percent of initial Marketplace enrollment

Despite pledges by Covered California officials that the new Affordable Care Act (ACA) Marketplace would increase competition, four of California's individual market giants still control 96 percent of Marketplace enrollment.

Anthem Blue Cross holds the largest share of Covered California enrollees (30 percent), just as it leads in individual market subscribers. Blue Shield of California and Kaiser Permanente are close behind at 27 and 24 percent respectively, while Health Net controls 16 percent.

Covered California director insisted that the figures present a one-sided picture of Marketplace competition, as the four insurers are not all offering plans in every county. He pledged to release details on insurer enrollment by region next week.

However, Covered California did release data showing that 61 percent of Marketplace consumers selected the mid-level silver plans to which premium and cost-sharing subsidies are tied. The lowest-cost bronze plans attracted 20 percent of consumers, while 10 percent purchased the highest-cost platinum plans. Only eight percent chose a gold plan.

Through November, 86 percent of Marketplace consumers qualified for premium subsidies, a figure that is even higher than the 75 percent in New York (see below) or previous projections by the Congressional Budget Office and various consultants such as Avalere Health, Kaiser Family Foundation, RAND, and the Urban Institute (see Update for Week of September 2nd).

Covered California faces \$78 million deficit in 2015

Despite a \$13.95 per policy fee that is among the highest in the nation, the Covered California health insurance marketplace faces a \$78 million deficit when Affordable Care Act (ACA) Marketplaces must be self-sustaining in 2015.

The budget estimates for fiscal year 2015-2016 are based on lower than expected Marketplace enrollment. Even though California leads the nation in total enrollment and experienced a surge of subscribers shortly before the initial deadline to purchase January 1st coverage, the number of sign-ups still lags behind initial projections.

If enrollment fails to meet expectations by the end of the open enrollment period on March 31st, Covered California officials may be forced to increase the per policy fee on participating insurers, a move that could decrease the number of participants, reduce competition, and increase premiums in a Marketplace already dominated by four of the state's largest individual health plan insurers (see above).

Other state-based marketplaces (see Hawaii below) face similar predicaments.

Hawaii

Committee chairs weigh reorganization to make Marketplace fiscally sustainable

The Hawaii Health Connector is not fiscally sustainable in the short-term due to lower than anticipated enrollment and should be converted from a non-profit to a state agency, according to testimony this week from state officials and insurers participating in the Affordable Care Act (ACA) Marketplace.

While most state-based Marketplaces (SBM) have outperformed their federal counterparts and met or exceeded enrollment targets (see above), Hawaii is one of a handful of SBMs where enrollment was severely hampered by technological glitches that rendered the Marketplace initially non-functional (see Update for Week of October 21st). The Connector was unable to begin open enrollment until mid-October and had only 683 enrollees in private Marketplace plans through December 7th.

The non-profit received \$204 million in ACA grants to initially operate the Marketplace. However, the Connector has already spent \$100 million of this amount. More than half was spent to build the flawed website, while the Connector has spent nearly \$293,000 on each successful applicant through the portal—a figure that Rep. Bert Kobayshi (D) and other lawmakers found incredulous. Once the federal funds are depleted, the Connector must fund its \$40 million in operating costs for 2015 with the two percent per policy fee charged to the two participating insurers, or increase the fee to the point where the Insurance Commissioner claimed that Marketplace premiums would increase 8-10 percent.

However, the limited amount of policies sold from the 300,000 projected consumers means that the Connector will be severely underfunded when the Marketplaces must be self-sustaining by 2015. The Connector's interim executive director, who was named at year's end, testified that the Marketplace must enroll at least 10,000 individuals and 40,000 small-business workers by June 30th to meet that ACA requirement.

In an effort to avoid dramatically higher fees and premiums, the human services director urged lawmakers to put the non-profit under the jurisdiction of her agency or the insurance department in order to gain better control over expenses. Rep. Angus McKelvey (D) chair of the House Committee on Consumer Protection and Commerce, pledged to introduce legislation next session to do exactly that, while his counterpart heading the House Committee on Health agreed to review all governance options for the Marketplace.

Michigan

CMS partially approves Healthy Michigan alternative to Medicaid expansion

The Centers for Medicare and Medicaid Services (CMS) has approved Michigan's request for a federal waiver to pursue an alternative to the Medicaid expansion under the Affordable Care Act (ACA).

The Healthy Michigan plan enacted by the Republican-led legislature last summer is largely modeled on similar private sector alternatives already approved for Arkansas and Iowa (see Update for Week of December 9th). Under these models, ACA funding would allow those earning from 100-133 percent of the federal poverty level (FPL) to purchase private Marketplace coverage instead of enrolling in Medicaid.

However, CMS allowed Healthy Michigan to impose a different type of cost-sharing by requiring that same populations to contribute up to two percent of their income to a health savings account that the

state will use to pay their out-of-pocket medical expenses—similar to the alternative sought by Indiana. Nearly every participant will also be required to pay \$2 copayments for office visits.

CMS side-stepped the most controversial provision of the Healthy Michigan plan, namely its requirement that Medicaid enrollees seek Marketplace coverage after 48 months or pay even higher premiums (see Update for Week of September 16th). This provision will require a second waiver.

New York

Marketplace enrollment surges past initial projections

After a rush of late interest, the NY State of Health Marketplace created by the Affordable Care Act (ACA) reported that 230,624 residents enrolled in either private or public insurance option by the December 24th deadline to receive coverage starting January 1st.

Enrollment jumped by 34 percent from December 9th through 16th and has continued to surge to 241,522 only six days after the deadline. Of those sign-ups, 175,146 are in private Marketplace plans and another 66,376 are in Medicaid, which raised its income limit to 138 percent of the federal poverty level effective January 1st.

According to NY State of Health, about 75 percent of those enrolling in private Marketplace plans qualified for ACA subsidies, consistent with projections by the Congressional Budget Office and groups like Avalere Health, RAND, and the Urban Institute (see Update for Week of November 11th). However, NY State of Health has yet to release demographic data showing how many enrollees are from the critical younger and healthier populations needed to ensure the financial viability of the Marketplace.

Unlike other state and federal Marketplaces, the enrollment figures for New York far surpassed the target of 102,500 sign-ups by December 31st that was set by the Obama Administration. It is likely to also far exceed the 218,000 private Marketplace sign-ups forecast for the March 31st close of the initial open enrollment period.

NY State of Health officials set a goal of 1.1 million enrollees by the end of 2016 and are currently expecting to meet or surpass that target.

Ohio

State Supreme Court denies challenge to Ohio's Medicaid expansion

The Ohio Supreme Court has narrowly denied a challenge from six conservative lawmakers seeking to invalidate the Medicaid expansion approved by Governor John Kasich (R) and the state Controlling Board.

By a 4-3 margin, the Court held that the Governor received the necessary authorization to accept and spend federal funds under the Affordable Care Act (ACA) to expand Medicaid effective January 1st. The Court's found that the lawmakers lacked standing to challenge the approval granted last October by the seven-member Controlling Board (see Update for Week of October 21st), which has the authority to approve expenditures of funds despite legislative opposition.

Majority Republicans have consistently voted to block the Medicaid expansion, even inserting a provision in the state budget last June that would bar the Governor from participating. However, it was vetoed by Governor Kasich (see Update for Week of May 27th).

Governor Kasich was one of only eight Republican governors that supported his state's participation in the Medicaid expansion under the ACA. He successfully persuaded two Republican lawmakers on the Controlling Board to support the expansion, providing the 5-2 margin for approval (see Update for Week of October 21st).

Oregon***Emergency rules require that Medigap be offered to those losing individual health plans***

The Insurance Division issued emergency rules earlier in December that requires guaranteed issue of Medicare supplemental or Medigap benefits when a Medicare enrollee loses individual health plan coverage through no fault of their own.

The rules are in response to the mass cancellation of individual health plans nationwide in order to avoid upgrading them to comply with the new Affordable Care Act (ACA) consumer protections that went into effect January 1st (see Update for Week of November 11th). While Oregon statutes require guaranteed issue of Medigap coverage when a Medicare enrollee loses employer-sponsored coverage, they had remained silent about the loss of individual health plan benefits.

Although the Insurance Division did allow Oregon insurers to continue or reinstate ACA-deficient plans consistent with President Obama's directive (see Update for November 18th – December 6th), not all insurers have chosen to do so. As a result, the Insurance Division sought to protect the limited number of Medicare enrollees that rely on individual health plans coverage in place of Medigap.

Vermont***New legislation would broaden ACA cost-sharing subsidies***

Rep. Paul Poirier (I), the ranking member of the Health Care Committee, introduced legislation on December 19th that would increase the actuarial value of Affordable Care Act (ACA) Marketplace plans for certain recipients of the law's cost-sharing subsidies.

The ACA makes such subsidies available to those purchasing a mid-level silver plan in the Marketplace and earning 100-250 percent of the federal poverty level (FPL). Those at the lower-end of this scale (earning less than 150 percent of FPL would pay only six percent of covered health care costs which goes up to 27 percent for those at the upper end of the scale.

However, H.594 would modify this share of costs for those at or above 150 percent of FPL, ensuring that everyone from 150-300 percent of FPL pay only 13 percent of covered health care costs—the same share the ACA sets for those earning from 100-150 percent of FPL.

Vermont has already set lower cost-sharing limits than the ACA requires for those earning from 200-350 percent of FPL (see Update for Week of February 25th). For example, while the maximum deductible under the ACA is \$1,900 for those at 200-250 percent of FPL Vermont set it at only \$700 for individual and small group plans in and out of the Marketplace. The out-of-pocket maximum for this income group is also \$1,600 instead of \$3,200.

While these amounts are below ACA maximums, they are still significantly more than uninsured Vermonters at those income levels previously paid through the state-subsidized Catamount Care program. These could also be the cost-sharing limits that remain in place when Vermont plans to move to a single-payer system in 2015 (see Update for Week of May 23, 2011).

Virginia***New bill would require state licensure of navigators and other Marketplace assisters***

Delegate Robert Marshall (R) pre-filed H.B. 136 on December 18th, which would require navigators and other assisters that help facilitate enrollment in Affordable Care Act (ACA) marketplaces to be licensed by the State Corporation Commission. The legislation specifically identifies certified application counselors (CAC) within the type of assisters that require licensure.

Health Care for American Now (HCAN) has identified 13 other Republican-led states that have already imposed licensure or registration standards that are so restrictive that they are likely to suppress Marketplace enrollment (see Update for Week of September 23rd).

Washington***Treasury department allows all eligible small businesses to claim ACA tax credits***

The U.S. Treasury Department announced in December that it will allow qualifying small businesses in Washington to receive the Affordable Care Act (ACA) tax credits that help pay for up to 50 percent of their employees' health insurance premiums.

Washington is one of only two states that are not operating their Small Business Health Options Program (SHOP) created by the ACA on a statewide basis. However, by limiting coverage to only two counties (Clark and Cowlitz) they prevented qualifying small businesses in other counties from being able to claim the tax credit without a federal waiver.

Under the waiver granted by Treasury, companies with less than 50 employees can receive the tax credit for non-Marketplace plans. Kaiser Foundation Health Plan of the Northwest is the only insurer participating in the SHOP Marketplace, although 12 other insurers offer coverage in the entire small group market.