



Health Reform Update – Week of March 31, 2014

By Mark Hobracczk

CONGRESS

President signs temporary extension of Medicare physician payment cut

President Obama signed a one-year delay this week preventing a 24 percent cut in Medicare physician reimbursement that would have gone into effect April 1st.

H.R. 4302 easily cleared the Senate after overcoming its main obstacle in the House last week (see Update for Weeks of March 17th and 24th). The measure continues the current 0.5 percent increase through the end of the year followed by flat payments through March 2015. The timing of the ongoing two percent cut in Medicare reimbursement imposed by the budget sequester (see Update for March 25, 2013) would be modified to help offset the \$15.8 billion cost of the delay by increasing the cut to four percent in the first six months of the fiscal year and zero percent during the second six months.

The American Medical Association opposed the temporary “patch” urging Congress to instead reach another consensus on a permanent repeal of the sustainable growth rate formula that causes the 21-30 percent cuts every year without Congressional intervention. A previous bipartisan accord fell apart when the more conservative members of the House tied it to a five-year delay in the individual mandate under the Affordable Care Act (see Update for Week of March 10th).

Four of five struggling state-based Marketplaces will not seek federal relief

Despite meeting their initial target of seven million enrollees nationwide, not all Affordable Care Act (ACA) Marketplaces are back on track following the flawed rollout last fall.

Directors from five of the state-based Marketplaces still struggling with limited online functionality testified this week before the House Government Oversight and Reform committee about the steps they are taking to correct continued technological glitches. All five (Hawaii, Maryland, Massachusetts, Minnesota, and Oregon) are likely to be the subject of two ongoing federal audits (see Update for Week of March 10th). As a result, all but Hawaii were adamant that they would be able to rectify their website issues with the remaining funds from “ample grant awards” furnished through the ACA.

However, Hawaii acknowledged that they will seek additional federal relief, as they were only able to enroll about 7,600 consumer, which brought in only a small fraction of their projected revenue. Their executive director testified that the state will need another \$15 million on top of the \$100 million ACA grants already allocated for 2015, or else they will have to dramatically raise fees on participating insurers through legislation currently pending in the state Senate (see Update for Week of March 10th).

Democrats join House Republicans in backing bill to change threshold for employer mandate

Eighteen House Democrats sided with Republicans this week to pass a bill that would increase the threshold for penalties under the employer mandate imposed by the Affordable Care Act (ACA).

The bill (H.R. 2575) would change the law’s definition of full-time employee from 30 to 40 hours per week. Bill sponsor Todd Young (R-IN) insisted it was necessary to curtail the incentive for employers to substitute part-time for full-time work in order to skirt the per employee assessment for companies with at least 50 full-time workers that fail to provide minimum essential coverage.



Democrats supporting the measure include those most at risk in this fall's midterm elections including Ron Barber (D-AZ), Ami Bera (D-CA), Patrick Murphy (D-FL), and Nick Rahall (D-WV). However, even if the measure attracted enough Senate Democrats to clear that chamber, President Obama has already pledged to veto it, citing Congressional Budget Office (CBO) estimates that H.R. 2575 would cost \$74 billion over ten year in reduced penalties, leave one million fewer Americans with employer-based coverage, shift most of these workers to Medicaid or Marketplace coverage, and leave the rest uninsured.

Some Democratic leaders in the Senate such as Dick Durbin (D-IL) have indicated that they are willing to come up with a "constructive bipartisan" fix but did not support the change to 40 hours proposed by H.R. 2575.

Latest version of RyanCare would still privatize Medicare, block grant Medicaid, repeal ACA

For the fourth consecutive year, the House appears poised to pass a budget plan introduced by Budget Committee chairman Paul Ryan (R) that would repeal the entire Affordable Care Act (ACA), give states a lump-sum to spend as they wish for Medicaid, and convert Medicare into a "premium support" program where enrollees would receive subsidies to purchase private coverage.

The latest incarnation of "RyanCare" (H.Con.Res. 96) would slash roughly \$5 trillion in federal spending over the next decade (or a 29 percent reduction from current levels). Nearly 70 percent of the proposed savings come from programs that serve persons with limited means, with \$2.7 trillion from Medicaid and the ACA subsidies that help those earning 100-400 percent of poverty purchase coverage in the new health insurance Marketplaces.

The stated goal of these drastic cuts would be to balance the federal budget by 2024, which has not occurred since the last year of the Clinton Administration. However, even the \$5 trillion proposed by chairman Ryan would not accomplish this end without the dramatic growth in the economy that he predicts would results.

House Democrats quickly pointed out that the Ryan budget not only does not account for the net cost of repealing the ACA (projected by the Congressional Budget Office), it also reinserts the Medicare cuts under the new law. The budget is likely to be more of a campaign tool for the upcoming mid-term elections than a starting point for budget negotiations, as prior versions have been wholly rejected by the Democratically-controlled Senate.

Opponents claimed that the "symbolic" nature of the latest proposal is reinforced by Ryan's decision to reinstate the cap on Medicare spending per beneficiary that he included in his initial "premium support" plan but later removed in an effort to attract bipartisan support (see Update for Week of April 2, 2012). Medicare beneficiaries would have to pay out-of-pocket for costs above the cap--a much harder political sell.

Ryan's "premium support" model would give Medicare beneficiaries a subsidy to buy health insurance from a menu of private plans plus a government plan (similar to current ACA Marketplaces plus the "public option" that Democrats proposed but removed from the final law). Participating insurers would submit bids for premiums and subsidy levels would be determined by the average bid in each region (instead of the second lowest-bid in last year's proposal).

FEDERAL AGENCIES



Marketplace enrollment surpasses initial target despite flawed rollout

President Obama announced this week that the health insurance Marketplaces created by the Affordable Care Act (ACA) have signed more than 7.1 million Americans up for private coverage as of the close of the inaugural open enrollment period this week.

Exceeding the seven million target figure initially set by the Congressional Budget Office (CBO) seemed highly improbable after the flawed rollout of the federal web portal serving 36 states, and limited online functionality for five other state-based Marketplaces (SBMs) (see Update for Week of November 11th). However, more than two million consumers enrolled in March alone, and the President emphasized that the final tally is likely to rise significantly further as those who had tried but were unable to complete applications online will be given until mid-April. Furthermore, the tallies for several SBMs have yet to be included in the 7.1 million total.

Aetna, Cigna, and the Blue Cross and Blue Shield Association (BCBSA) confirmed estimates offered last week by Health and Human Services (HHS) Secretary Kathleen Sebelius that between 80-85 percent of enrollees have already paid their first month's premium (see Update for Weeks of March 17th and 24th). Health insurers in Covered California likewise reported that more than 85 percent of enrollees had paid plan premiums (see below). Republican lawmakers demanded but have yet to receive actual data from Marketplace insurers on the number of enrollees already paying premiums (see Update for Week of March 10th).

BCBSA calculated that member plans signed-up 1.7 million Marketplace consumers by March 1st, before the late surge in the last month of open enrollment. Cigna estimated this week that it has enrolled 750,000-one million in ACA plans, two-thirds of which came through the Marketplace while the remainder subscribed directly through Cigna.

Nearly 12 million have gained Medicaid/CHIP since October 1st, despite continued glitches

The Centers for Medicare and Medicaid Services announced this week that more than three million Americans gained Medicaid or Children's Health Insurance Program (CHIP) coverage in February, bringing the total for the first five months of open enrollment to 11.7 million. Enrollment grew by 8.3 percent in Medicaid expansion states compared to only 1.6 percent in opt-out states.

Despite a failed Marketplace website (see Update for Week of March 10th), Oregon witnessed a nearly 35 percent spike in Medicaid enrollment, due to an innovative "fast track" program to quickly enroll applicants whose income and residency data are already on file with CHIP or food stamp programs. West Virginia (33.5 percent), Vermont (32.3 percent) and Colorado (22.8 percent) were other expansion states that saw dramatic increases.

Some non-expansion states also experienced significant enrollment bumps due to simplified application procedures under the ACA and the law's individual mandate, both of which caused a "woodwork effect" where eligible but unenrolled residents finally signed-up for Medicaid. Florida had an 8.2 increase, while both Montana and Idaho approached seven percent.

Despite the dramatic numbers, overall Medicaid and CHIP figures have actually been depressed by continued glitches with the federally-facilitated Marketplace (FFM) that has prevented roughly 400,000 applications from persons that appear to qualify for Medicaid or CHIP from being transmitted to at least 24 of the 36 applicable FFM states. (Georgia and Michigan are among those that have not received any applications from the federal data hub). A nearly equal number remain in limbo as states are trying to sort out duplicate applications sent from the FFM for those that are already enrolled in either program. Virginia, South Carolina, and Texas report that 35-40 percent of applications received from the federal data hub are duplicates.



Enrollment in Medicaid, CHIP, or the small business Marketplaces continues year round.

IRS gives temporary exemption from individual and employer mandate for expatriate plans

The Internal Revenue Service (IRS) is giving businesses with overseas workers a limited exemption from certain reporting mandates under the Affordable Care Act (ACA).

Employers and health plan administrators covering expatriates are generally obligated to design and administer group plans to properly comply with applicable mandates and tax rules. The temporary relief to be published April 14th by the IRS (under Bulletin 2014-16) will allow an expatriate plan to exclude 50 percent of its direct premiums for purposes of determining the annual insurer fee under the ACA. In addition, expatriate plans will not be required to comply with ACA requirements for plan years starting before January 1, 2016 so long as they comply with the applicable mandates under pre-ACA versions of federal ERISA law and the Internal Revenue Code.

The frequently answered question (FAQ) document makes clear that IRS will treat coverage provided under an expatriate group health plan as a form of "minimum essential coverage" that will satisfy the individual and employer mandates under the ACA.

To qualify for this temporary transitional relief, an expatriate plan must be a "group health plan with respect to which enrollment is limited to primary insureds who reside outside of their home country for at least six months of the plan year and any covered dependents, and its associated group health insurance coverage." This definition does not extend to self-insured health coverage provided for expatriate employees or those working outside the country for less than six months. These subscribers must still comply with all applicable ACA mandates.

CMS to initially rely on insurer good faith for resolving consumer complaints

The Centers for Medicare and Medicaid Services (CMS) issued guidelines last month acknowledging that it will simply assume that qualified health plans (QHPs) operating in the federally-facilitated Marketplace (FFM) are working in good faith to resolve consumer complaints during the first year of operations, so long as the plans are working collaboratively with the agency and communicating with consumers.

In the new guidance, CMS states that consumer complaints should largely be dealt with at the issuer level, but identifies some situations that should be brought to CMS by QHPs, such as when enrollment records are missing or consumers believe they eligible for a tax credit that is not indicated in the enrollment data.

The guidelines create two levels for casework. Level 1 is a case in which waiting could jeopardize an enrollee's health or ability to attain, maintain, or regain maximum function. It also can include a situation where waiting for a non-urgent case resolution could threaten the consumer's ability to enroll in a QHP through the FFM. Level 2 represents all other non-urgent cases. These can be re-designated Level 1 if repeatedly brought to the attention of federal or state officials with no resolution.

CMS requires QHPs to resolve Level 1 cases within 72 hours, while Level 2 cases must be wrapped-up within 15 calendar days after the case is created. CMS acknowledges that during the first year there may be "unavoidable" situations that prevent QHPs from meeting these timeframes. As a result, CMS will consider QHPs to be in compliance so long as they are making "good faith" efforts at resolution, such as forwarding appropriate issues to CMS in a timely manner and effectively communicating with account managers and consumers. However, CMS emphasizes that a QHP will not be considered to be operating in "good faith...where the failure to act within required timeframes may jeopardize the health, safety, or life of the consumer."



To manage complaints, QHPs are required to use the Health Insurance Casework System (HICS), similar to the complaint tracking system used by Medicare Advantage and Part D plans.

STATES

California

Latinos and young adults lead late surge in Covered California enrollment

Covered California announced this week that more than 1.22 million consumers have enrolled in private Marketplace plans, with 416,000 signing-up just in the last month of open enrollment.

Despite their continued success in enrolling more than 20 percent of all Marketplace consumers nationwide, enrollment among Latino populations continued to lag. Covered California had engaged in extensive marketing and outreach to Latino groups that are viewed as critical to the success of the Marketplace as they represent more than half of the state's uninsured population and 46 percent of those eligible for Affordable Care Act (ACA) subsidies to purchase Marketplace coverage. However, the majority of uninsured Latinos are considered to be the younger and healthier populations needed to help spread the insurance risk within the Marketplace and keep premiums affordable.

The outreach efforts had begun to show improvement in February as the percentage of Latinos enrolling in the Marketplace had increased to 28 percent from only five percent during the initial rollout (see Update for Week of February 17th). A 65 percent jump in Latino enrollment during March caused this overall figure to rise to 36 percent during the last month of open enrollment, enabling Covered California to pull on target with its goal of 265,000 Latino subscribers.

Executive Director Peter Lee told members of Congress this week that improvements to Covered California's Spanish language website, additional bilingual employees, and advertisements targeting Latinos were likely responsible for the boost (see Update for Weeks of January 20th and 27th).

An unrelated survey by Enroll America showed that Latinos were just as likely to enroll in a Marketplace plan as other groups, but only after they had been contacted four times. Mistrust of how their application information would be used was cited as a major factor depressing Latino enrollment nationwide and President Obama ultimately had to publicly assure Latinos that undocumented family members would not be deported simply because a relative applied for Marketplace coverage (see Update for Week of March 10th).

Covered California also pulled far ahead of national figures in terms of young adult enrollment, rising from 26.5 percent of sign-ups initially to more than 32 percent by the end of open enrollment. The 344,000 adults age 18-34 that have now selected plan is 162 percent of Covered California's preliminary target of 212,000.

Connecticut

Committee approves measure that would strengthen network adequacy standards

The Joint Committee on Insurance passed S.B. 392 on March 20th, which would require health insurers and managed care organizations to maintain adequate networks of health providers.

The bill was motivated largely in response to participating insurers choosing to dramatically narrow networks for plans offered in the Marketplace created by the Affordable Care Act (ACA) in order to keep premiums affordable. Similar to federal regulations proposed last week, S.B. 392 sets minimum standards beyond the accreditation requirements set by the National Committee for Quality Assurance or Utilization Review Accreditation Commission (see Update for Weeks of March 17th and 24th).



S.B. 392 requires insurers to annually report to the insurance commissioner the number of enrollees and participating in-network providers for each of their plans. It gives the commissioner discretion to assess the adequacy of each network through an actuarial analysis done at the time of initial licensure and annually at license renewal.

The actuarial analysis must be done in consultation with the state healthcare advocate and specifically determine if:

1. The network includes a sufficient number of geographically accessible participating providers for the number of enrollees in a given region,
2. Enrollees can choose from at least five primary care providers within a reasonable travel time and distance,
3. A network includes sufficient providers in each area of specialty practice to meet enrollee needs.
4. The network improperly excludes any class of appropriately licensed providers.

S.B. 392 also allows the commissioner to conduct or undertake any activity he determines reasonably necessary to assess a network's adequacy.

Florida

Medicaid expansion remains a non-starter despite support of Senate Republicans

House Republican leaders continue to refuse to engage in any discussion this session of expanding Medicaid, despite the urging of a broad coalition of provider, business, and consumer groups.

Senator Rene Garcia (R) resurrected the Medicaid expansion bill from last session that passed the Republican-dominated Senate but was blocked by House Republicans refusing to accept any federal funds to expand (see Update for Weeks of January 20th and 27th). However, neither his bill (S.B. 710) or companion legislation in the House (H.B. 869) have received a hearing and are expected to languish so long as House Speaker Will Weatherford (R) and House leadership remain adamantly opposed to even considering the contentious issue during an election year. Even key Republican committee chairman supporting the expansion such as Senator Joe Negron (R) and Rep. Aaron Bean (R) are not willing to push the issue this session.

Groups like the Safety Net Hospital Alliance of Florida point out that Florida is forgoing nearly \$1 billion every 45 days by opting-out of the expansion, while ultimately increasing uncompensated care costs on hospitals and ACA penalties on large employers.

Health-related measures advance despite Medicaid expansion stalemate

The legislative stalemate on Medicaid expansion has not prevented other health-related measures from advancing since the session opened in early March.

An HIV-testing measure back by The AIDS Institute (H.B. 1225) unanimously passed the House Health and Human Services Committee this week. It would reduce the paperwork burden on providers by allowing an HIV-test to be offered without obtaining written consent. Providers must notify patients before an HIV-test is performed and patients may verbally decline.

House and Senate committees passed legislation (S.B. 824/H.B. 465) also requiring that Hepatitis C (HCV) screening be offered to persons born from 1945-1965, except for those being treated for life-threatening emergencies, those previously offered or receiving an HCV test, or those that lack the capacity to provide consent. According to The AIDS Institute, more than half of the 300,000 Floridians living with HCV do not know they are infected.



Patient access legislation backed by the Florida Medical Association, The AIDS Institute, and the newly-created Florida Bleeding Disorders Coalition (that includes PSI) also cleared both House and Senate committees last week. H.B. 1001/S.B. 1354 makes several changes to formulary and prior authorization requirements to improve continuity of care and help ensure patients have access to the full range of therapeutic options for their condition. Specifically, the measures would require Medicaid managed care plans to include newly-approved drugs on their preferred drug lists (PDLs) while they are awaiting review for inclusion and ensure plans continue to cover drugs removed from PDLs whenever the prescriber attests to their medical necessity. It also creates a standard electronic prior authorization (PA) form to streamline the process and reduce waiting times, as well as require insurers to act on PA requests within two business days.

Both the House and Senate have already passed budgets that include \$500 million in tax cuts and a \$1.2 billion surplus. Neither currently contains any increase or reductions for the AIDS Drug Assistance Program or AIDS Insurance Continuation Program.

The Florida Department of Health is proposing a regulatory change that would limit eligibility in HIV/AIDS Patient Care Programs only those that are currently symptomatic.

Kentucky

House and Senate pass legislation requiring equal cost-sharing for oral and IV cancer drugs

The House unanimously passed legislation that would make Kentucky the 30th state to require health plans not require higher cost-sharing for oral cancer drugs as compared to intravenous medications. S.B. 148 also unanimously passed the measure on March 20th but must reconcile changes in the bill before it receives the expected approval from Governor Steve Beshear (D).

Similar to Wisconsin and a handful of other states, a Senate amendment will allow plans to be in compliance with this “parity” requirement if the cost-sharing for the oral drugs do not exceed \$100 for a 30-day supply (see Update for Weeks of March 17th and 24th).

Maine

Two ACA implementation bills face certain veto

The House and Senate are preparing to send two bills to Governor Paul LePage (R) that would implement key provisions of the Affordable Care Act (ACA), despite his pledge to veto them.

The Governor vetoed two bills last session that would allow Maine to participate in the Medicaid expansion under the ACA and promises to do likewise to L.D. 1487, compromise legislation sought by moderate Republicans that would expand Medicaid while also expanding the use of Medicaid managed care. That measure currently stands two votes short of the needed majority to override the Governor’s veto (see Update for Week of March 10th).

The House and Senate passed an additional measure this week (L.D. 1345) that would create a state-based Marketplace pursuant to the ACA as a precursor to moving to a single payer system by 2017, similar to the model being created in Vermont (see Update for Week of May 23, 2011). It also currently lacks a veto-proof majority.

Michigan

Medicaid expansion alternative goes into effect

The Michigan Department of Community Health (MDCH) began accepting applications on April 1st for the Healthy Michigan program, which is the state’s “private sector” alternative to the Medicaid expansion under the Affordable Care Act (ACA).



Michigan is one of three states with a federally-approved alternative (see Update for Week of December 16th-January 3rd). Similar to Arkansas and Iowa, Michigan will use the ACA matching funds to cover those earning 100-133 percent of the federal poverty level in the federally-facilitated Marketplace instead of traditional Medicaid. However, the Obama Administration will allow Healthy Michigan to impose a different type of cost-sharing by requiring some populations 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 a \$2 copayments for office visits.

Healthy Michigan is expected to cover 320,000 residents during its first year alone, rising to 470,000 by 2021. As of April 2nd, MDCH had already received nearly 27,300 Medicaid applications and enrolled more than 15,100 in the Healthy Michigan expansion.

Michigan becomes 11th state approved to shift dual-eligibles into managed care

The Centers for Medicare and Medicaid Services (CMS) approved a demonstration project in Michigan that will shift people who are eligible for both Medicare and Medicaid into managed care plans starting in 2015.

Michigan is the 11th state to receive a federal waiver for the three-year pilot created by the Affordable Care Act (ACA). They are designed to test whether federal and state officials and save money by better coordinating the care of low-income patients who are elderly or have disabilities. However, the demonstrations have been beset by access and quality of care concerns that have limited applications from the 26 states that initially expressed interest (see Update for Week of October 28th).

Under Michigan's waiver, about 100,000 dual-eligibles will be enrolled in managed care plans through Michigan Health Link starting in January. If they failed to choose a plan by April, the state will automatically enroll them in a plan, though enrollees can then opt-out and elect to stay in traditional Medicare, Medicare Advantage, or a Part D prescription drug plan.

Pennsylvania

House adopts resolution requiring specialty tier drug pricing study

The House unanimously passed a resolution this week that would require the Legislative Budget and Finance Committee to conduct a study on the impact that specialty tier coinsurance for prescription drugs has on access and patient care. Sponsored last year by Rep. Jim Christiana (D), H.R. 348 would require the Committee to submit its report and recommendations by July 15th.

A similar resolution passed the Senate last fall (see Update for Week of October 21st).

South Carolina

Lawmakers reject bill banning Affordable Care Act implementation

The Republican-controlled Senate voted 33-9 last week to defeat a measure (H.3101) that would have explicitly banned state agencies and employees from implementing provisions of the Affordable Care Act (ACA) and required the navigators created by the law to be state-licensed.

According to the National Conference of State Legislatures (NCSL), six states have already enacted measures seeking to ban ACA implementation. Although the legislature passed a largely-symbolic bill last year that declared certain provisions of the ACA such as the individual mandate to be null and void, Republican leaders warned that actually barring state regulators from following federal law could open the state up to lawsuits.