



Health Reform Update – Week of April 7, 2014

By Mark Hobrarcz

CONGRESS

House passes Ryan budget plan despite Republican defections

For the fourth consecutive year, the House has passed a symbolic budget plan advanced by Budget Committee chair Paul Ryan (R-WI) that would balance the budget by privatizing Medicare, converting Medicaid into block grants, and slashing spending for health and social services (see Update for Week of March 31st).

A dozen Republicans voted against the Ryan budget, insisting that it does not cut enough spending from the federal budget. They object to Rep. Ryan's insistence that the plan stay in accord with the spending caps under the latest bipartisan budget compromise (H.R. 3547) that extends through fiscal year 2015 (see Update for Week of January 13th).

However, the more conservative budget offered by the Republican Study Committee failed to pass with 97 Republicans joining every Democrat in opposing it. That plan would have imposed deeper cuts to discretionary spending in order to balance the budget more quickly than the Ryan plan (four years instead ten). It also included Social Security cuts, which Rep. Ryan avoided.

Senate Democrats are very likely to reject the Ryan plan in its entirety as they are working from the spending caps set in the December compromise and not proposing a budget resolution this year.

House fails to pass bipartisan ACA exemption for expatriate plans

The House failed to pass a bill this week that would exempt expatriate plans covering Americans working abroad from the individual and employer mandates under the Affordable Care Act (ACA).

Recent Internal Revenue Service (IRS) guidance already exempts most expatriate health plans from the individual and employer plans, but only through 2017 (see Update for Week of March 31st). H.R. 4414 would make that exemption permanent.

The measure was sponsored by Rep. John Carney (D-DE) and supported by 52 House Democrats and the U.S. Chamber of Commerce. It received a clear majority of votes on the House floor. However, because it was called up under a suspension of House rules it required a two-thirds majority vote and failed to pass.

Republican leaders indicated the bill was likely to be recalled after the Easter recess.

Bill to smooth out distribution of Ryan White funds divides advocates

Several consumer advocates came out this week in opposition to a bipartisan bill that would ensure federal Ryan White Program payments for patients with HIV/AIDS do not vary by more than five percent among states.

The annual reauthorization for the Ryan White Program remains pending although the most recent extension expired at the September 30th end of the last fiscal year. The reauthorization measure introduced by Reps. Renee Ellmers (R-NC), Eddie Bernice Johnson (D-TX), and Bennie Thompson (D-



MS) would address the disparity in funding among and within states with high HIV/AIDS populations and ensure the payments are more equitable, evidence-based, and target effective interventions. Rep. Ellmers states that the correction is necessary because rates of HIV/AIDS in traditionally-high cities like Charlotte have declined while increasing in other parts of North Carolina, yet the cities still receive more Ryan White funding per patient.

H.R. 4270 won praise from the AIDS Healthcare Foundation but other groups such as AIDS United, The AIDS Institute, and the National Alliance of State and Territorial AIDS Directors (NASTAD) insist that the measure is premature until they can evaluate the impact of the Affordable Care Act (ACA) after at least one year of full implementation. AIDS United also objected to provisions creating Ryan White Savings Accounts that require those who receive Ryan White services to be under the care of a primary care team led by an HIV medical provider.

The AIDS Institute suggested that the bill is unnecessary for states that expand Medicaid pursuant to the ACA. More than two-thirds of Ryan White recipients already have health insurance coverage with most covered under state Medicaid programs.

RAND study shows ACA has increased employer-sponsored coverage, reduced uninsured

A new study released this week by the RAND Corporation found that the Affordable Care Act (ACA) has expanded coverage to 9.3 million Americans, with most of the gains coming from employer-sponsored coverage.

The survey from last September through March 28th showed that the national uninsured rate dropped precipitously from 20.5 percent to the current rate of 15.8 percent, consistent with the 15.6 percent rate also reported this week by Gallup (the lowest since 2008). It credits the ACA with expanding coverage to 14.5 million Americans while causing another 5.2 million to initially lose coverage, for a net gain of 9.3 million.

However, enrollment in employer-sponsored plans increased by 8.2 million (7.2 million of whom were previously uninsured). This outpaced the 5.9 million gain in Medicaid (3.6 million of whom were previously uninsured) and the 3.9 million added through ACA Marketplaces (1.4 million previously uninsured).

RAND attributed the increase in employer-sponsored coverage to more Americans returning to the workforce as the economy improves. They also acknowledged that the individual mandate under the ACA may compel workers to increasing elect job-based coverage that they previously declined.

Researchers acknowledge that the survey failed to capture the surge in enrollment that occurred in the days just before the March 31st open enrollment deadline, or the 400,000 consumers that have since enrolled in Marketplace plans (see below).

FEDERAL AGENCIES

Departing HHS Secretary says 7.5 million have enrolled in private Marketplace plans

The outgoing Secretary for the Department of Health and Human Services (HHS) told members of the Senate Finance Committee this week that more than 7.5 million consumers have now signed-up for qualified health plans offered by Affordable Care Act (ACA) Marketplaces.

The increase from the 7.1 million that HHS reported at the end of the March 31st open enrollment period was due to those allowed to enroll by April 15th if online glitches prevented them from completing applications (see Update for Week of March 31st). It also includes some enrollment from the 15 state-



based Marketplaces that was not previously reported. For example, Covered California alone enrolled 70,000 consumers in qualified health plans (QHPs) during the first nine days of April and expects that up to 340,000 more could still sign-up by April 15th. In New York, nearly 422,000 have now selected QHPs with more than 43,000 enrolling after March 31st.

Secretary Sebelius stated that HHS still does not have figures on how many new enrollees were previously uninsured or have already paid plan premiums, but that HHS would provide them to Congress as they are received from insurers. She also does not anticipate any additional delays in ACA implementation following the latest extension of the open enrollment deadline until April 15th (see Update for Weeks of March 17th and 24th).

However, the Secretary did indicate that HHS may withhold money for administrative expenses to states like New Jersey whose antiquated or flawed computer systems are contributing to a backlog of more than 400,000 Medicaid applications (see Update for Week of March 31st). She insisted that if the federal government could adequately upgrade their online functionality that states could do so as well, although the National Association of Medicaid Directors and state officials have largely blamed continued glitches with the federal data hub for not transmitting the needed data on Marketplace applicants that are deemed eligible for Medicaid.

After the hearing, the Obama Administration announced that the Secretary was resigning effective April 11th. Sebelius has faced calls for her resignation from Republican lawmakers since the flawed rollout of the federal Marketplace web portal last fall (see Update for Week of November 11th). She is expected to be replaced by Sylvia Mathews Burrell, who was unanimously confirmed last year by the Senate as Office of Management and Budget (OMB) Director. Ms. Burrell served in several capacities under the Clinton Administration and formerly headed the Wal-Mart Foundation.

Initial Marketplace enrollees were more likely to use specialty drugs

An analysis of early enrollment in the Affordable Care Act (ACA) health insurance Marketplaces found that enrollees were far more likely to need specialty drugs for chronic conditions.

The survey by the nation's largest pharmacy benefits manager Express Scripts determined that more than one percent of the prescriptions claims submitted for Marketplace enrollees in January or February were for the highest-cost medications that are typically placed by insurers in a specialty tier. Less than one percent of all commercial health plan subscribers required these specialty drugs. However they account for more than 25 percent of prescription drug expenditures.

The ratio is even higher for HIV/AIDS patients that were nearly four times more likely to require specialty drugs. Overall, six of the ten costliest medications for Marketplace enrollees were specialty drugs, compared to only four out of ten in the non-Marketplace population.

Express Scripts acknowledged that the survey fails to include the 2.5 million enrollees that signed-up in March and early April. Past experience with Marketplaces like Medicare Part D or the Federal Employees Health Benefit Plan show that late sign-ups tend to be younger and less costly populations (see Update for Week of November 11th).

CMS backtracks on Medicare Advantage cuts amid Congressional pressure

The Centers for Medicare and Medicaid Services (CMS) announced this week that payments for Medicare Advantage plans will increase by 0.4 percent in 2015 instead of the 1.9 percent cut the agency initially proposed.

The reductions were called for under the Affordable Care Act (ACA) as a way to bring MA payments more in line with traditional Medicare. The Congressional Budget Office (CBO), Medicare



Payment Advisory Commission (MedPAC), and others had recommended a lower rate of growth in order to curb these overpayments and Congress used the \$156 billion in “savings” to fund other ACA provisions such as subsidies for mid-to-low income Americans to purchase Marketplace coverage (see Update for Week of February 7, 2011).

CMS claims that it reversed course and voided the payment cuts because of changes in various risk factor assessments for the plans, as well as a decrease in Medicare spending overall. However, the Obama Administration had faced intense pressure from Congressional Democrats in competitive races not to cut MA payments in an election year.

Despite the slight increase, America’s Health Insurance Plans (AHIP) predicts that MA plans will still see an effective cut of roughly three percent, as CMS also confirmed that it will terminate the oft-criticized ACA demonstration that gave quality bonuses to highly-rated MA plans (see Update for Week of October 15, 2012). These payments helped shield those plans from the planned reductions in the rate of payment growth. However, the three percent effective cut is still nearly half of the 5.9 percent that AHIP initially projected (see Update for Week of February 24th).

According to the Avalere Health consulting firm, MA plans now cover about 16 million enrollees or 30 percent of the entire Medicare program enrollment.

CMS issues unprecedented release of Medicare physician payment data

The Centers for Medicare and Medicaid Services publicly released Medicare physician payment data this week for the first time since 1979,

The move comes in response to a federal judge’s decision last year to lift the injunction that had made Medicare payments to individual doctors confidential (see Update for Week of June 3rd). Dow Jones and Co., the publisher of the *Wall Street Journal*, sought access to the database to promote transparency after stories it sought to publish on Medicare fraud and abuse were thwarted by CMS’ refusal to provide the data. A bipartisan group of Congressional lawmakers led by Senators Charles Grassley (R-IA) and Ron Wyden (D-OR) were also pushing for full disclosure.

The American Medical Association (AMA) opposed the release, insisting that the data could contain errors and thus “mislead the public into making inappropriate and potentially harmful treatment decisions and will result in unwarranted bias against physicians that can destroy careers.” They unsuccessfully urged CMS to let physicians review the data for discrepancies before it was published but dropped initial plans to sue CMS in an effort to block the release.

The data detailed the \$77 billion paid under Medicare Part B to more than 880,000 providers that served at least 11 Medicare enrollees in 2012 and provided specifics on the names and address of the physician, the services provided, and the amount providers received. Individual patient information was omitted due to privacy laws.

While the data shows that most physicians received relatively modest payments, nearly one-quarter of all payments went to just two percent of physicians. Specialists predictably garnered the highest reimbursement, especially radiation oncologists that each received more than \$1 million on average.

Some individual physicians also were paid exceptionally high sums. A group of 100 physicians accounted for \$610 million in reimbursements for 2012, while one ophthalmologist alone was paid \$21 million. Several dozen eye and cancer specialists each were paid more than \$4 million.

CMS stressed that such large payouts are not automatically indicative of fraud or over-utilization, claiming it could result simply from practices that treat a disproportionate number of high-cost patients.



Proponents of the release insist that the unprecedented transparency would be a boost to consumers. However, other commentators argued that health insurers and hospitals would be the ultimate winners, as access to payment data gives them greater leverage in price negotiations.

Prior to last year's court decision, CMS for the first time released Medicare data on hospital charges to the most common inpatient and outpatient procedures (see Update for Week of June 3rd and Update for Week of May 8th). They showed a similar wide variance in prices not only from state to state, but even within states or metropolitan areas.

Cost of drugs used by Medicare doctors can vary “astonishingly” by region

An analysis of the Medicare physician payment data released this week by the Centers for Medicare and Medicaid Services (CMS) shows an “astonishingly” wide cost range for the Part B drugs administered by physicians.

Part B drugs made up \$8.6 billion of the \$77 billion Medicare paid to physicians in 2012. However, *The Washington Post* found that of the roughly 4,000 physicians that were paid more than \$1 million each, the majority of these payments were for injectable or infusion drugs administered by physicians and paid under Part B.

Several of the physicians on that list emphasized that the high cost of the drug is largely to blame for their exceptional claims history. Typically, Medicare reimburses physicians for the price of the drug plus six percent.

The chief lobbying group for the pharmaceutical industry, the Pharmaceutical Research and Manufacturers of America (PhRMA), disputed that claim, insisting that drug costs have “dropped significantly in recent years and [are] lower than growth in medical costs overall.”

However, the analysis also found that Medicare spending on physician-administered drugs varied widely across the country. For example, physicians in Huntsville, Alabama, Sarasota, FL and Fresno, California billed nearly \$600 per Medicare enrollee for Part B drugs furnished in a medical facility during 2012. However, that figure was five times higher in Boise, Idaho and Mason City, Iowa, without any apparent explanation for the disparity.

OMB reviewing proposed rule clarifying who qualifies for discounted 340B drugs

The Health Resources and Services Administration (HRSA) has submitted proposed regulations to the Office of Management and Budget (OMB) that would clarify eligibility standards for the federal Section 340B drug discount program.

Since 1992, the 340B program has required most drug companies to provide 20-50 percent discounts to participating hospitals that treat low-income and uninsured patients. However, there has been no formal definition identifying which providers are eligible to participate.

The proposed rule will more clearly define the eligibility criteria for hospitals, off-site facilities, and patients, as well as set compliance standards for contract pharmacy arrangements. The OMB paperwork clearance is expected to be issued by June, at which point the rule will be published for public comment.

The two-year bipartisan budget accord worked out last winter (H.R. 3547) separately allocated \$6 million for HRSA to investigate pricing for prescription drugs under the federal 340B program (see Update for Week of January 13th). The Government Accountability Office (GAO) and Republican lawmakers previously found that “non-profit hospitals are essentially profiting from the 340B program...without passing those savings to its patients” (see Update for Week of September 19, 2011).



HRSA had insisted that it lacked adequate funding to perform the greater oversight sought by Congress and the pharmaceutical industry.

HEALTH CARE COSTS

Americans experienced slight improvement in ability to pay medical bills from 2011-2013

A new analysis released this week by the National Center for Health Statistics found that the ability of Americans to pay their medical bills has slightly improved since 2011.

According to the survey of 87,500 Americans under age 65, 21.7 percent reported difficulty paying medical bills during the first half of 2011 compared to 19.8 percent in 2013.

The group reporting the most difficulty was the “near poor” who could not qualify for Medicaid but earned too little to afford private coverage (defined as 100-200 percent of the federal poverty level). Roughly a third of this population reported difficulty paying medical bills, a rate that did not improve from 2011 to 2013. This rate is also higher than the 28.6 percent for those defined as “poor” who more often qualify for Medicaid.

The survey was completed prior to the opening of the Affordable Care Act Marketplaces.

STATES

Maryland

Maryland becomes 31st state requiring parity in coverage for oral and IV cancer drugs

Governor Martin O'Malley (D) signed legislation this week making Maryland the 31st state to require that cost-sharing amounts for health insurance coverage of oral cancer drugs are no less favorable than those for intravenous cancer treatments.

The measure (H.B. 625/S.B. 641) had unanimously cleared the House and Senate last month (see Update for Week of March 10th). It applies to all health plans issued or renewed in Maryland on or after January 1, 2016.

Missouri and Kentucky recently enacted weaker provisions of similar legislation that allows for slightly higher cost-sharing for oral cancer drugs (see Update for Week of March 10th and Week of March 31st).

Missouri

Republicans push higher Medicaid asset limit as an alternative to ACA expansion

Republican lawmakers that are adamantly opposed to participating in the Medicaid expansion under the Affordable Care Act (ACA) have instead proposed to increase the asset limit for the Medicaid program as a way to break the legislative stalemate on the issue.

The alternative plan would still forgo the roughly \$2 billion per year in federal matching fund that would be provided through an ACA expansion. Despite the backing of Governor Jay Nixon (D), the Missouri Chamber of Commerce, and some House Republicans, all Senate Republicans are refusing to bend on their opposition to accepting any federal funding to expand (see Update for Week of February 24th).



The opposition was so intense that lawmakers scuttled an unrelated Medicaid overhaul bill last week out of concern that it would be viewed as a precursor to an eligibility expansion. However, that bill contained a provision that would double the asset limits first imposed in 1968 that have never been increased for inflation. Those limits bar individual residents from qualifying if they have more than \$1,000 in assets (excluding one car and home) or \$2,000 for married couples—the same asset limits set by the federal Social Security Income (SSI) program that automatically is linked to Medicaid in most states.

Had those limits kept up with inflation, they would stand today at \$6,700 for individuals and \$13,500 for married couples. Doubling those limits would fall far short of these threshold but still expand Medicaid to nearly 8,200 elderly and disabled residents in Missouri at an eventual annual cost of about \$160 million in combined federal and state funds.

Montana

Insurance commissioner endorses Medicaid expansion ballot measure

Insurance Commissioner Monica Lindeen (D) announced last week that she is officially endorsing a proposed ballot referendum to decide whether Montana will participate in the Medicaid expansion under the Affordable Care Act (ACA).

The measure (I-170) will appear on the November ballot if supporters obtain 24,175 signatures from registered voters, which must include at least five percent of voters in at least 34 of the 100 state House districts. ACA opponents are simultaneously collecting signatures for a contrary ballot initiative (I-171) that would bar the state from expanding Medicaid or using state funds to implement any ACA provisions.

The Montana Supreme Court unanimously blocked efforts last week to block state officials from approving either initiative. Opponents of I-170 had insisted that the budget office for Governor Steve Bullock (D) falsely claimed the Medicaid expansion would save Montana money by 2017.

The Governor has repeatedly sought to participate in the ACA expansion but been stymied by the Republican-controlled legislature (see Update for Week of March 25, 2013).

Nevada

ACA Marketplace faces class action lawsuit over flawed web portal

Applicants that paid premiums for plans offered in the Nevada Health Link Marketplace filed a class action lawsuit this week in the U.S. District Court of Nevada after not being provided coverage.

The lawsuit against the state of Nevada, the Marketplace, and its lead contractor Xerox alleges “gross negligence”. At least 40 consumers are already part of the class action, although the list of pending applicants for Nevada Health Link exceeds 10,500.

Governor Brian Sandoval (R) insists that the state followed proper contracting procedures in awarding the \$75 million contract to Xerox, which edged out Deloitte Consulting on the state’s scoring criteria. The Governor claimed that state officials have no discretion to select the second-highest scoring bidder.

The decision has been very controversial, fueled by the fact that Nevada since had to award Deloitte a \$1.5 million contract to fix the flawed web portal created by Xerox (see Update for Week of February 24th). Continued technological failures prevented Nevada Health Link from enrolling more than 42,000 consumers during the inaugural open enrollment period, which was only a third of its initial projection and below even its revised projection of 50,000 (see Update for Week of February 10th).



Despite enrollment being only half of its anticipated total, the Nevada Health Co-Op created by Affordable Care Act loans was a bright spot for Nevada Health Link, garnering more than a 33 percent market share due largely to monthly premiums that were the lowest for Las Vegas area consumers.

Virginia

House and Senate remain at odds over Medicaid expansion

The Senate approved a budget plan this week that includes a private-sector alternative to the Medicaid expansion under the Affordable Care Act (ACA) similar to the model federally-approved for Arkansas, Iowa, and Michigan (see Update for Week of December 9th).

Marketplace Virginia was a substitute for the two-year traditional Medicaid expansion that Governor Terry McAuliffe (D) proposed after the General Assembly adjourned its regular session without agreeing on a budget (see Update for Week of March 10th). However, despite the support of key Senate Republicans and the Virginia Chamber of Commerce, Marketplace Virginia was backed by only one Republican in the Republican-controlled House and immediately blocked by House Appropriations Chairman Chris Jones (R).

Republican lawmakers continue to insist that Medicaid expansion must be divorced from the budget and receive a stand-alone vote. Democrats are refusing to separate the two unless House Republican leaders support some form of Medicaid expansion instead of adopting a “just say no” position.

As a result, the House and Senate adjourned the special session this week without any budget agreement or a timetable to return. The government will shut down at the June 30th end of the fiscal year if agreement on a two-year budget or temporary extension is reached.

Governor signs legislation requiring navigator registration

Governor Terry McAuliffe (D) signed legislation this week that would require navigators assisting applicants for the federally-facilitated Marketplace (FFM) operated in Virginia to register with the State Corporation Commission starting September 1st.

The measure (H.B. 1043/S.B. 542) gives the Commission discretion to determine if the federal standards for navigators are sufficient or the commonwealth should impose additional standards. A federal court in Missouri has already held that state defaulting to the FFM cannot impose their own higher standards (see Update for Weeks of January 20th and 27th) and proposed rules from the Obama Administration would prohibit states from imposing standards that prevent navigators from performing their designated duties (see Update for Weeks of March 17th and 24th).