



Health Reform Update –Week of June 16, 2014

CONGRESS

Louisiana Republicans reiterate that CMS should let charities subsidize Marketplace premiums

Senator David Vitter (R-LA) and Rep. Bill Cassidy (R-LA) continued to put pressure this week on the Department of Health and Human Services (HHS) to remove provisions of an interim final rule that give Marketplace plans discretion to prohibit premium and cost-sharing assistance from charitable groups.

PSI and other non-profit organizations have urged members of Congress to demand the change, which would be consistent with HHS guidance and Medicare policy. In response, outgoing HHS Secretary Kathleen Sebelius confirmed last month that non-profit charities are permitted to subsidize Marketplace premiums under existing HHS rules and guidance (see Update for Week of June 2nd).

Senator Vitter and Rep. Cassidy wrote a second letter to HHS this week emphasizing that the Secretary's response to their initial May 14th letter was insufficient because the interim final rule could change her non-binding opinion once it goes into effect. Both members want HHS to formally adopt Medicare's policy that explicitly allows premium and cost-sharing assistance from bona fide charities.

CMS insists it has the legal authority to make reinsurance payments to Marketplace insurers

The Centers for Medicare and Medicaid Services (CMS) provided a legal analysis this week to House Energy and Commerce committee leaders disputing that the agency lacks the authority to reimburse insurers for exceptional losses under the reinsurance and risk corridor program authorized by the Affordable Care Act (ACA).

Section 1342 of the ACA allocated \$5 billion for the temporary three-year program, which Republicans insist amounts to an "insurer bailout" and "slush fund" (see Update for Weeks of January 20th and 27th). Senator Jeff Sessions (R-AL) and other Republican lawmakers claim that the law actually leaves this funding for a future Congress to appropriate and absent such an appropriation CMS cannot issue the payments to insurers.

However, the director of the Center for Consumer Information and Insurance Oversight (CCIO) within CMS insists that the agency is authorized to make such payments under its program management appropriation from Congress, as well as its statutory authority to levy user fees.

New Department of Health and Human Services (HHS) Secretary Sylvia Burwell informed the committee this week that the agency has yet to make or receive any payments under Section 1342 but "intends to begin collections and payments in fiscal year 2015." She also reiterated HHS' position that such payments will be budget neutral, as supported by a recent cost estimate from the Congressional Budget Office (see Update for Week of March 10th).

Committee Republicans scoffed at the notion that the payments would be budget neutral, insisting that information it collected from 15 for-profit insurers and 23 non-profit cooperatives that serve about 75 percent of Marketplace enrollees show that the vast majority expect to receive nearly \$730 million in payments from HHS due to a lower mix of younger and healthier adults than initially anticipated after the Obama Administration extended ACA-deficient plans for three years (see Update for Weeks of March 3rd). Republican leaders cited the testimony of a University of Houston law professor claiming that



the risk corridor programs will likely cost HHS more money than projected because the “partial backstop on [insurer] losses” creates an “incentive for insurers to under-price their premiums to be competitive.”

Rep. Elijah Cummings (D-MD) disputed Republican claims that the mix of initial Marketplace enrollees would result in higher risk corridor payments than anticipated, providing his own data that showed that overall Marketplace enrollment exceeded insurer expectations by four percent and enrollment in the 18-34 age group surpassed projections by almost 11 percent.

Two House Democrats seek hearing on cost for new Hepatitis C drug

Two House Energy and Commerce Committee Democrats called this week for committee leaders to hold hearing on the impact of a costly new Hepatitis C drug on Medicare Part D and other federal health care programs.

Ranking members Henry Waxman (D-CA) and Diana DeGette (D-CO) expressed concerns that without the statutory authority to negotiate lower drug prices, the \$1,000 per pill (or \$84,000 per treatment) price tag for recently-approved Sovaldi could limit coverage options for other drugs. They emphasized that both Georgetown University and the Kaiser Family Foundation found that Part D coverage of Sovaldi will by itself increase Medicare drug spending by eight percent (or \$6.5 billion) in 2015.

Waxman and DeGette noted that Medicaid and the Veteran’s Affairs program enrollees can receive Sovaldi at a substantial discount, as can consumers in other counties. However, Part D enrollees are hit with the full cost of the drug.

Both members insist that they have yet to receive a “compelling justification” from the Solvadi’s manufacturer Gilead Sciences about why the drug is priced so high, as well as an explanation of the discounts offered for Sovaldi and the potential public health impact if insurers refuse coverage. The price of drug has already sparked fears among Medicaid managed care plans that they will incur substantial losses for 2015 since their capitated contract rates were already set before the drug was approved.

The \$84,000 cost has also sparked a clash between the lead lobby groups for drug manufacturers and insurers, as they have taken turns over the past two weeks to blame the other for the prohibitive out-of-pocket costs that consumers must incur for the highest-cost specialty drugs (see Update for Week of June 9th).

FEDERAL AGENCIES

HHS claims ACA subsidies reduced average Marketplace premium to \$82

According to a Department of Health and Human Services (HHS) report released this week, premium subsidies provided through the Affordable Care Act (ACA) have reduced the average premium within the 36 federally-facilitated Marketplaces (FFM) by 76 percent (from \$346 to \$82).

The analysis found that roughly 3.2 million FFM consumers are paying less than \$100 per month (or 69 percent of those receiving subsidies). Premiums for roughly 46 percent are below \$50 per month.

Consumers from states like Mississippi and Georgia paid even less after accounting for premium subsidies (an average of \$23 and \$54 respectively). However, average post-subsidy premiums in states like North Dakota and New Jersey were significantly higher (\$132 and \$142 per month respectively). HHS did not have data from the 15 state-based Marketplaces.



Those enrolled in the most popular silver-level plans (upon which the amount of the premium subsidies is based) paid only an average of \$69 per month.

HHS is trumpeting the findings at the same time that early rate filings show an increased level of Marketplace competition for 2015 (see Update for Week of June 9th). In the ten states for which data is available, HHS found that at least 27 insurers will join a Marketplace for the first time this fall.

The report emphasizes that benchmarks premiums are expected to fall by four percent for every insurer added to the Marketplace. On average, FFM consumers are expected to have a choice of five insurers and 47 plan options next year.

A separate survey released this week by the Kaiser Family Foundation found that 57 percent of all Marketplace enrollees were previously uninsured (most for at least two years). Another 72 percent reported that they purchased coverage because of the premium subsidies provided by the ACA.

Study shows premiums will increase next year for eight of nine states

The latest analysis from Avalere Health consultants shows that Marketplace consumers in eight of nine states will likely experience higher premiums for 2015, though the increases are likely to be consistent with those experienced prior to the Affordable Care Act (ACA).

The study surveyed preliminary rate filings for Connecticut, Indiana, Maine, Maryland, Oregon, Rhode Island, Vermont, Virginia, and Washington. Oregon was the only state where rates are expected to fall (by 1.4 percent of \$3 per month). It also has the lowest average premium at \$197 per month, with average silver-level plan premiums at \$272 per month, or nearly \$200 less than Vermont (which has the highest average silver-level premiums).

Overall, monthly premiums in silver-level plans are likely to rise by eight percent (from \$324 to \$350). These increases range from a low of 2.5 percent of \$8 per month in Rhode Island to 16 percent or \$54 per month in Indiana.

The disparity in average premiums is also likely to widen for 2015. Indiana has the greatest differential with monthly premiums ranging from \$211 in some areas to \$587 per month in others.

Avalere emphasized that the initial rate proposals can be rejected or modified by insurance commissioners in several states, so the final rates could be significantly altered.

Avalere's finding mesh with other studies showing that initial rate filings nationwide are seeking low double-digit increases that are roughly in line with annual premium hikes before the ACA was fully implemented (see Update for Week of June 9th).

Federally-facilitated marketplace will have simplified application for 2015

According to software engineers that helped fix the glitch-plagued www.healthcare.gov website last fall, the portal will have a simplified application installed for the 2015 open enrollment period this fall.

Dubbed "Application 2.0", the simplified format is intended "for people who don't have complicated financial assistance needs." Federal officials are comparing the feature to the 1040-EZ form that the Internal Revenue Service provides for taxpayers.

Despite the addition, other "back-end" issues remain unresolved and will likely be unavailable when open enrollment starts November 15th. This includes an electronic system to pay insurers that caused significant delays during the first open enrollment period (see Update for Week of January 6th).



HRSA standing by 340B rule despite adverse court decision

The Health Resources and Services Administration (HRSA) that oversees the federal 340B drug discount program stated this week that it will move forward with its planned regulation allowing participating hospitals to receive discounts on orphan drugs when used for non-orphan conditions.

The change is part of rules implementing 340B changes mandated by the Affordable Care Act (ACA). However, the U.S. District Court for the District of Columbia granted an injunction last month sought by the pharmaceutical industry, which had argued that HRSA lacked the statutory authority to extend the discounts (see Update for Week of June 9th).

HRSA announced this week on the Department of Health and Human Services (HHS) website that it believes the court opinion does not invalidate its interpretation of the applicable ACA provision and stands by its proposed regulation. This is different from court filings from HHS counsel last week stating that the agency would either appeal the decision or replace the rule.

The move was backed by Safety Net Hospitals for Pharmaceutical Access, a trade group for hospitals that participate in the 340B program, which was pleased that HHS "is holding fast on its well-reasoned and legally valid interpretation on the use of orphan drugs in the 340B program."

GAO calls for oversight of Medicaid managed care payments

A report released this week by the Government Accountability Office (GAO) calls for the Centers for Medicare and Medicaid Services to require states increase their oversight of Medicaid managed care plans.

The report requested by Senator Orrin Hatch (R-UT) criticizes Medicaid auditors for focusing their efforts on reducing fraud and waste in fee-for-service payments while largely ignoring capitated payments for Medicaid managed care. It specifically blames CMS for not requiring states to audit managed care payments and calls on the agency to not only support states by actually helping to audit existing plans.

HEALTH CARE COSTS

United States continues to rank worst among health systems for 11 countries

The Commonwealth Fund's latest survey of health care systems in other countries ranked the United States last in quality of care when compared to ten other industrialized nations.

The United States has consistently ranked at the bottom of The Commonwealth Fund's four comparable analyses from 2004-2014, despite spending far more per capita (\$8,508) on health care. Only Norway at \$5,669 even approaches the spending level of the United States. The survey also cited poor outcomes due to administrative hassles, lack of consumer transparency, and inability to coordinate care.

The Commonwealth Fund notes that the survey was completed before the Affordable Care Act (ACA) reforms went fully into effect on January 1st, which may eventually boost the United States' ranking. However, researchers conclude that the structural problems within the United States' system as so pervasive that they cannot be remedied simply by expanding access to care via the ACA.

The United Kingdom ranked the highest on the survey, spending only \$3,405 per person on health care, an improvement from 2004 when it ranked third due to a lack of specialists and lengthy waiting times for elective care. The Commonwealth Fund notes that the United Kingdom has since undergone substantial reforms to address these deficiencies.



Australia, New Zealand, Switzerland, Canada, France, Germany also ranked highly in terms of health outcomes, quality and efficiency.

STATES

Uncompensated care drops 30 percent in Medicaid expansion states

A reported released this week by the Colorado Hospital Association (CHA) concludes that uncompensated care costs for hospitals dropped by roughly 30 percent in states that expanded Medicaid pursuant to the Affordable Care Act (ACA).

Researchers attributed not only the drop in uncompensated care to the Medicaid expansion, but also a 25 percent decrease in the number of self-pay patients at hospitals. However, they stress that it remains unclear whether the drop in uncompensated care will be sufficient to fully offset the gradual phase-down of federal disproportionate share hospital (DSH) payments for indigent care that has been delayed until 2016 (see Update for Week of December 9th).

CHA's survey of 465 hospitals nationwide is consistent with the findings of smaller studies, such as an analysis from the Arkansas governor's office showing a 24 percent decline in uncompensated care costs for hospitals in that state (and a 30 percent drop in uninsured hospital admissions). Tenet Healthcare also reported a 33 percent reduction among its expansion state facilities, versus a slight increase in uncompensated care costs in non-expansion states.

Two more states enact navigator licensure laws

Louisiana and Oklahoma became the latest states to enact their own state laws imposing licensure, training, and registration requirements on navigators and other assisters that help facilitate enrollment in health insurance Marketplaces created by the Affordable Care Act (ACA).

Oklahoma Governor Mary Fallin (R) signed H.B. 3286 last month, which requires background checks and an annual \$50 registration for navigators, in-person assisters, and certified application counselors (CACs). It imposes fines upon those that fail to maintain records of all employees for three years after termination, as well as other prohibited activities such as advising about which health plan is better or otherwise recommending a specific plan, receiving commissions or anything of value from insurers or consumers, soliciting persons known to be insured or going door-to-door, engaging in voter registration, and providing any false or misleading information. The law is effective September 1st.

Louisiana Governor Bobby Jindal (R) signed H.B. 764 this week. The legislation sets different requirements for navigators versus other assisters like CACs. Navigators are required to obtain a two-year license after completing a background check, fingerprinting, and up to 30 additional hours of state training, while non-navigator assisters must be registered with the state. The law gives the insurance commissioner discretion to set additional requirements, as well as those for registration of non-navigator personnel. It became effective June 12th.

New standards issued by the Obama Administration allow states to impose additional requirements on navigators and other assisters, including licensure, training, background checks, and fingerprinting. However, it specifically bars any state from enacting laws or regulations that prevent navigators or other assisters from carrying out their duties prescribed by the ACA (see Update for Week of June 9th). At least 20 states have enacted state laws that have been viewed by ACA supporters as "navigator suppression" and Missouri's onerous navigator law was already invalidated by a federal court on that basis (see Update for Weeks of January 20th and 27th).



Minnesota

Consultant finds that two-thirds of MNSure Marketplace systems remain non-functional

The consultant hired to recommend how to fix the glitch-plagued web portal for Minnesota's health insurance Marketplace reported this week that two-thirds of its operating systems remain "absent or not functioning as expected."

The MNSure Marketplace created by the Affordable Care Act (ACA) hired Deloitte Consulting last April to assess the outstanding software flaws that severely depressed enrollment during the inaugural open enrollment period (see Update for Week of April 14th). Deloitte review of the performance of lead contractor Maximus and PricewaterhouseCoopers (PwC) found that 47 of the 73 high-level functions required of a "robust" Marketplace are non-functional and that 41 of those 47 must be fixed before the November 15th start of open enrollment for 2015.

Deloitte stressed that the most significant flaws remain the inability to handle changes in coverage due to qualifying life events such as marriage or childbirth, as well as processing renewals for both private plans and Medicaid. In addition, Deloitte recommend a full restructuring of MNSure's management. (Deloitte did not specifically recommend whether MNSure to retain either Maximum or PwC.)

Despite the persistent flaws, 238,000 Minnesotans were able to secure coverage through MNSure during the first open enrollment period, with 51,500 selecting private plans. This dramatically reduced Minnesota's uninsured rate to five percent, second only to Massachusetts (see Update for Week of June 9th).

Montana

Medicaid expansion initiative will not appear on November ballot

A consumer-backed voter referendum on whether Montana should participate in the Medicaid expansion under the Affordable Care Act (ACA) will not appear on the ballot this fall after supporters failed to get the 24,175 valid signatures needed by this week's deadline.

Healthy Montana had pushed the I-170 initiative intended to circumvent expansion opposition from the Republican-controlled legislature and had the backing of the Insurance Commissioner (see Update for Week of April 7th). They collected over 25,000 signatures, but were unable to confirm the validity of all signatures by the deadline. (Roughly 30 percent of signatures are typically invalid, according to Healthy Montana).

Legal challenges from ACA opponents had prevented Healthy Montana from starting the process of collecting signatures until March. The organization plans to renew its effort for the next election cycle. If approved, an estimated 70,000 Montanans would gain Medicaid coverage from the expansion.

New Hampshire

Marketplace provider networks will greatly expand for 2015

The Insurance Department disclosed this week that every New Hampshire hospital will be included in the provider networks for three of the five carriers seeking to participate in the state partnership Marketplace (SPM) created by the Affordable Care Act (ACA).

The SPM participant for 2014, Anthem Blue Cross and Blue Shield, came under heavy criticism for severely limiting its provider network in order to keep premiums affordable (see Update for Week of September 16th). The dominant insurer excluded ten of the state's 26 acute-care hospitals including some of the most prominent.





Four other insurers besides Anthem plan to compete in the Marketplace for 2015, including two non-profit insurance cooperatives (CO-OPs) created by the ACA (see Update for Week of June 9th). The preliminary rate filings submitted by the plans show that Anthem increased the number of hospitals in their network from 10 to 17 in response to the enhanced competition. Harvard Pilgrim will offer a plan that includes all hospitals in its provider network, as will the Maine Community Health Options CO-OP (although this plan will initially only be available in four eastern counties).

The Obama Administration has already taken regulatory steps to broaden Marketplace provider networks for 2015 (see Update for Weeks of March 17th and 24th).

If the proposals are approved by the Insurance Department, the number of plans available to consumers in the individual Marketplace will increase from 14 to more than 50. Final approval will be issued in September after public comments are received through July 8th.

Ohio

Governor signs bill to require parity in oral and IV cancer medications

Governor John Kasich (R) signed legislation this week making Ohio the 32nd state to require that cost-sharing amounts for health insurance coverage of oral cancer drugs are no less favorable than those for intravenous cancer treatment, after it cleared the Senate and House with only one dissenting vote (see Update for Week of April 7th). However, S.B. 99 is somewhat weaker than comparable laws in other states in that it would exempt insurers if they can show that compliance over at least six months would justify at least a one percent increase in premiums. Insurers will also be deemed in compliance if the cost-sharing for oral cancer drugs does not exceed \$100 per prescription fill.

S.B. 99 is effective starting January 1st and also applies to Medicaid coverage.

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).

Virginia

Governor vetoes Medicaid expansion prohibition, vows to move forward administratively

Governor Terry McAuliffe (D) used his line item veto authority this week to remove a provision in the two-year budget plan enacted by the Republican-controlled legislature that sought to prohibit any Medicaid expansion without legislative approval (see Update for Week of June 9th).

The Governor pledged to pursue the Medicaid expansion through administrative means such as an executive order, instead of waiting for the legislature to reconvene in 2015. He indicated that he was likely to support the “private sector” alternative previously agreed to by Democrats and moderate Republicans before Democrats lost control of the Senate (see Update for Week of June 2nd). A similar model has already been federally-approved for Arkansas, Iowa, and Michigan (see Update for Week of January 6th).