



Health Reform Update –Week of June 23, 2014

CONGRESS

Democratic bill would prevent mid-year changes in Medicare Advantage physician networks

New legislation introduced this week would require health insurers that participate in Medicare Advantage (MA) to finalize their physician networks at least 60 days before open enrollment.

The Medicare Advantage Participant Bill of Rights Act (S.2552) is intended to prevent mid-year changes to physician networks that force MA enrollees to incur higher out-of-network charges or switch physicians. It was sponsored by Senator Sherrod Brown (D-OH) and Richard Blumenthal (D-CT) in response to United Healthcare dropping physicians from their MA networks in early 2014 (including 81-primary care physicians and 1,440 medical specialists just in Connecticut).

Rep. Rosa DeLauro (D-CT) has introduced companion legislation in the House.

FEDERAL AGENCIES

HHS says employers may delay new employee coverage for four months

Final rules issued by the departments of Health and Human Services (HHS), Treasury, and Labor will allow employers offering group coverage to delay coverage for up to 30 days longer than spelled out under the Affordable Care Act (ACA).

The ACA statute prohibited group health plans (including “grandfathered” plans exempt from some other ACA provisions) from imposing more than a 90-day waiting period on coverage. However, the final rules will not define “orientation periods” in which an employer and employee have a chance to determine whether they wish to proceed with employment as part of the 90-day waiting period, so long as the orientation period does not exceed 30 days.

The rule essentially will allow employers to delay coverage for new employees for up to a total of 120 days. It becomes effective on August 25th.

Proposed rules allow for auto-renewal of Marketplace coverage

The Centers for Medicare and Medicaid Services (CMS) released proposed rules and guidance this week that will allow coverage for roughly 95 percent of consumers in the federally-facilitated Marketplace (FFM) to automatically renew for 2015.

Under the auto-renewal feature, those earning less than 500 percent of the federal poverty line (FPL) will receive notices from the FFM informing them that to change plans or update their income levels and subsidy amounts, they will need to take the step of notifying federal and plan officials.

If tax returns show that a consumer’s income has risen above 500 percent of FPL, the FFM will stop providing subsidies at the end of 2014 and renew the person’s coverage. Consumers who believe that they still qualify for subsidies will have to send documentation to the FFM.

According to CMS, roughly 100,000 of the more than five million FFM consumers will have to reapply for subsidies. The agency notes that about 88 percent of federal workers that purchase coverage



through the Federal Employee Health Benefits Program (FEHBP) are automatically renewed each year under a similar feature.

The proposed rules allow state-based Marketplaces (SBMs) to use the FFM auto-renewal feature or any “alternative procedures approved by [CMS] based on a showing by the [SBM] that the alternative procedures would facilitate continued enrollment in coverage for which the enrollee remains eligible, provide clear information about the process [and] provide adequate program integrity protections.”

Public comment on the proposed rules, including what standards it should apply to alternatives sought by SBMs, will be accepted for 30 days.

CMS says drugmakers, GPOs should submit sunshine laws data by June 30th

The Centers for Medicare and Medicaid Services (CMS) reiterated this week that it will not grant the drug industry’s request to delay the June 30th deadline for manufacturers and group purchasing organizations (GPOs) to register and report financial relationships with physicians.

The deadline is the second phase of the *Physician Payment Sunshine Act* provisions that were incorporated as part of the Affordable Care Act (ACA). The Pharmaceutical Research and Manufacturers of America (PhRMA) had sought a 30-day delay earlier this month, insisting that glitches and error messages in website CMS created for the Open Payments program have hindered the registration process and made it difficult to confirm the accuracy of the data.

CMS has not indicated how it will handle registration delays resulting from the glitches.

HEALTH CARE COSTS

PwC predicts “modest” jump in health spending after years of decline

A new analysis released this week by PricewaterhouseCoopers’ Health Research Institute predicts that health care spending will increase by 6.8 percent in 2015, up from a 6.5 percent projected increase for this year.

If such increases materialize, they would mark the first increase in health care inflation since the height of the recession in 2009. However, even a 6.8 percent jump would still be well below the double-digit spikes in annual health care costs that occurred for over a decade prior to the recession.

Researchers attributed the economic recovery and changes in the health industry over the past several years (including enactment of the Affordable Care Act (ACA)) for the resumption in health spending. However, they noted that the continuing trend of employers and insurers increasing deductibles and imposing other disincentives for consumer spending could restrain the rate of growth to only 4.8 percent in 2015.

The report found that two-thirds of the 1,000 employers surveyed now offer high-deductible health plans and nearly one-fifth of them only offer such plans. In addition, about one-third were considering offering coverage from a private insurance exchange, which typically provide a wide variety of coverage options, including high-deductible plans.

PwC’s prediction comes at the same time that the U.S. Bureau of Economic Analysis (BEA) announced an unexpected drop in health care spending for the first quarter of 2014. Analysts including PwC had expected the full implementation of the ACA to drive a 6.5-10 percent jump in health care spending for 2014. However, health care spending actually declined by 1.4 percent to start the year,



causing the overall gross domestic product (GDP) to surprisingly decline by nearly three percent. BEA blamed the decline in health care spending for almost two-thirds of the drop in GDP.

STATES

California

Senate advances bill limiting prescription drug cost-sharing

The Senate Health Committee passed A.B. 1917 this week, which would prohibit cost-sharing for a 30-day supply of any single prescription from exceeding 1/12 of the annual out-of-pocket limits set by the Affordable Care Act (ACA). For a drug that has a time-limited course of treatment of three months or less, this limit would be set at one-half of the annual out-of-pocket limit for the time-limited course of treatment.

The measure cleared the Assembly late last month, which revised the cap from 1/24 of the annual out-of-pocket limit to 1/12 (see Update for Week of June 2nd). The Health committee amended A.B. 1917 to clarify that the limits apply to self-only coverage. It now moves to the Senate Appropriations Committee prior to a full floor vote.

A.B. 1917 would effectively spread out the cost-sharing for the highest tier specialty drugs over a full year instead of forcing consumers to pay all at once and is backed by consumer groups like Health Access California.

Legislature approves bill to diversify Covered California board membership

The legislature approved S.B. 972 this week, which would widen the eligibility criteria for joining the board of Covered California.

The measure now heads to Governor Jerry Brown (D). If signed, it will allow enrollment assisters, information technology experts, and health insurance marketers to serve on the board for the health insurance Marketplace that California created pursuant to the Affordable Care Act. The diversification of the board was motivated by technological and logistical problems that Covered California experienced during the inaugural open enrollment period, including long wait times for the Marketplace web portal, limited support for Spanish-speaking populations, and erroneous provider directories (see Update for Week of February 17th).

Colorado

Proposed premiums for individual market vary widely

Proposed premiums for the individual marketplace released this week by the Division of Insurance show both substantial increases and decreases for 2015.

Preliminary rate filings show that the largest proposed increase of 17.5 percent belongs to Denver Health. Kaiser Permanente, the insurer with the largest market share in Colorado's Affordable Care Act (ACA) Marketplace, is also seeking to increase rates by seven percent on average, while Anthem Blue Cross and Blue Shield is seeking a five percent average hike.

However, two non-profit carriers are seeking a sizeable rate cut for 2015. Colorado Access proposed a 22 percent decrease, while the Colorado HealthOP cooperative created with ACA loans (which garnered 12 percent of the ACA Marketplace) plans to cut average premiums by ten percent.

As expected, the Division's federally-approved plan to consolidate geographic rating areas will lower premiums for Colorado's resort counties, which were the highest in the nation by slightly increase



rates for other rural parts of the state (see Update for Week of June 2nd). However, rural northeast counties will actually see a decrease of about 20 percent.

According to the Division, 312 of the roughly 1,000 individual health plans offered in the state will be sold through the Connect for Health Colorado Marketplace. Final rates and plan options will be approved by the Division in September.

District of Columbia

CareFirst rate hikes fare outpace all other Marketplace insurers

The dominant health insurer for the District of Columbia is seeking premium hikes for all plans offered in the Affordable Care Act (ACA) Marketplace for 2015.

Preliminary rate filings released this week by the Department of Insurance, Securities and Banking show that only CareFirst BlueCross BlueShield is proposing such across-the-board increases. They also revealed that the amounts sought by Care First are far more than the three other insurers participating in DC Health Link.

CareFirst is seeking to hike individual PPO rates by 4.1 percent for silver plans and up to 15.3 percent for platinum plans. For individual HMO plans, the increases range from 8.1 percent for the silver plan to 24.1 for the catastrophic option.

By contrast, Aetna is holding silver plan rates steady, cutting individual PPO premiums for lower-level bronze and catastrophic plans, and proposing only a 4.4 percent increase for gold plans. However, Aetna does not offer the highest-level platinum option.

The contrast is more dramatic for individual HMO plans, where Kaiser Permanente wants to cut catastrophic premiums by more than 18 percent (instead of the 24 percent hike for CareFirst) and increase platinum rates by only five percent instead of the 19 percent jump sought by CareFirst.

The remaining insurer, UnitedHealthcare, is seeking to cut small business rates across-the-board by eight percent.

Because DC is one of five state-based Marketplaces that followed the “active purchaser” model, final rates could be substantially revised following the Department’s review and negotiations. Several insurers downgraded initially 2014 premiums substantially in order to ensure they would be allowed to participate.

The ability to exclude plans based on price has enabled Marketplace premiums in the District to remain lower than the national average (\$293 per month lowest silver-level plan compared to \$310 nationwide).

Idaho

Marketplace adds competition from non-profit insurance cooperative

The Department of Insurance approved the application from Mountain Health Cooperative (CO-OP) to participate in the Affordable Care Act (ACA) Marketplace for 2015.

Dominant insurers faced significant competition from the new non-profit CO-OPs in several states, which were created by loans provided through the ACA (see above). Mountain Health CO-OP was one of 23 that participated in Marketplaces nationwide, and garnered more than 12,000 consumers in Montana’s federally-facilitated Marketplace (FFM).



Idaho is in the process of transitioning from the FFM model to a state-based Marketplace for 2015. Four other insurers from 2014 are expected to again participate next year (Blue Cross of Idaho, PacificSource, Select Health, and BridgeSpan).

Louisiana

Legislature passes resolution to study the adverse impact of high cost-sharing levels

The House and Senate both unanimously passed a resolution earlier this month (H.C.R. 203) urging the Department of Insurance (DOI) to study the “proliferation of benefit plans containing high enrollee cost-sharing provisions” and their impact on enrollee ability to meet those obligations. DOI is asked to report its findings to legislative committees by January 1st.

Massachusetts

Massachusetts settles with contractor that botched rollout of ACA Marketplace

Governor Deval Patrick (D) announced this week that the commonwealth will pay \$35 million to the Canadian information technology firm that botched upgrades needed to make the existing Massachusetts Health Connector compliant with the Affordable Care Act (ACA).

CGI Federal, which also was responsible for the flawed rollout of all 36 federally-facilitated Marketplaces and several other state-based models (see Update for Week of February 17th), already received \$17 million from Massachusetts. The commonwealth had already decided to purchase off-the shelf software from a different contractor for 2015 open enrollment (see Update for Weeks of April 28th and May 5th), but needed to negotiate a settlement with CGI to resolve its intellectual property rights to certain software used to build the web portal.

The agreement also prevents either side from suing the other. However, Attorney General Martha Coakley (D) insisted this week that her office would continue to investigate whether the commonwealth can recover up to \$12 million from CGI under Massachusetts’ Fair Claims Act.

Including the settlement amount, Massachusetts has now spent \$90 million of the initial \$174 million it received in federal grants to upgrade its existing Marketplace that first opened in 2007 and became the model for the Affordable Care Act (ACA) versions. However, the botched rollout caused Massachusetts to enroll less than 32,000 consumers in private Marketplace plans, tying it with the District of Columbia for the worst performance nationwide in terms of enrolling eligible consumers (see Update for Week of April 14th).

Michigan

Medicaid expansion enrollment breaks 300,000 in first 11 weeks

The Department of Community Health (MDCH) announced this week that the Healthy Michigan Plan has reached 301,645 enrollees since enrollment started on April 1st.

The “private sector” alternative to the Medicaid expansion under the Affordable Care Act (ACA) was projected to enroll 320,000 during the full first year of enrollment, and reach 477,000 by next year (see Update for Week of March 31st). Governor Rick Snyder (R) and MDCH officials credit low wait times, emphasizing that new enrollees have been able to apply in-person and receive an eligibility determination within 30 minutes.

Michigan is one of three states (besides Arkansas and Iowa) with a federally-approved “private sector” alternative where the newly-eligible Medicaid population (up to 138 percent of the federal poverty level) are instead covered under private plans offered by the federally-facilitated Marketplace (see Update for Week of December 9th). Pennsylvania (see below) and Tennessee are pursuing similar alternatives.



Marketplace insurers seeking only 2.2 percent average premium increase

Insurers participating in the Affordable Care Act (ACA) Marketplace operated in Michigan are likely to see only an average premium hike of 2.2 percent for 2015, according to an analysis of preliminary rate filings released this week by PricewaterhouseCoopers.

The average monthly premium sought by insurers is \$326.74, lower than the national average of \$360. The consultants credited Michigan's highly competitive individual health insurance market for the "modest" increase, emphasizing that Marketplace consumers will have a choice of 345 plan options offered by 16 insurers.

Although four of these insurers are seeking rate hikes of at least nine percent (including Blue Cross and Blue Shield of Michigan) and one (Aetna) seeking a 17.6 percent hike., this is balanced out by several insurers slashing premiums by a comparable amount (including a 21.5 percent cut by Molina Healthcare of Michigan and 7.2 percent by Consumer Mutual Insurance of Michigan)..

New Hampshire

Medicaid expansion coverage will start August 15th

Governor Maggie Hassan (D) and the Department of Health and Human Services announced this week that consumers can apply for Medicaid expansion coverage starting July 1st for coverage that will be effective August 15th.

The Republican-controlled Senate earlier this year dropped their long-standing opposition to participating in the Medicaid expansion under the Affordable Care Act (ACA), paving the way for the creation of the New Hampshire Health Protection Insurance program (see Update for Weeks of March 17th and 24th). Though it makes all consumers earning up to 138 percent of the federal poverty level eligible for Medicaid, adults age 19-64 that have access to employer-sponsored coverage will have their premiums paid by the state Health Insurance Premium Program (HIPP). Those without employer coverage will be enrolled in managed care plans offered by Well Sense and the New Hampshire Healthy Families in the Voluntary Bridge to Marketplace Program. If cost-effective, others may elect to purchase private plans offered by the state partnership Marketplace.

The program will sunset in 2017 if all parts do not receive the required federal approval.

New York

Non-profit cooperative garners largest share of ACA Marketplace

The New York State of Health Marketplace created by the Affordable Care Act (ACA) released new enrollment figures this week showing that nearly one of every five of the 370,000 consumers that enrolled in private coverage selected plans offered by a non-profit health insurance cooperative (CO-OP).

Health Republic is one of 23 consumer-controlled CO-OPs nationwide that were created by loans provided by the ACA and are competing with traditional heavyweights in both state-based and federally-facilitated Marketplaces (see Update for Week of June 9th). It beat out insurance giants Empire Blue Cross and Emblem Health by garnering 19 percent of New York State of Health, relying on lower premiums and a provider network that gave consumers access to leading hospitals that were excluded by other carriers, including Memorial Sloan Kettering Cancer Center.

However, Health Republic has drawn the ire of Congressman Darrell Issa (R-CA). The chairman of the House Government Oversight Committee insists that because it is a spin-off from the for-profit Freelancers Union it should have been ineligible for the ACA loans.



In addition to the 370,000 that selected qualified health plans (QHPs), roughly another 900,000 were determined eligible for Medicaid or SCHIP while 10,000 obtained coverage through the Small Business Health Options Program (SHOP). The Department of Health estimates that within three years more than 560,000 will be covered under QHPs and 440,000 will select SHOP plans.

New York State of Health estimates that 93 percent of those newly covered by Medicaid were uninsured at the time of enrollment, as were 63 percent of those in the individual market.

Although about 40 percent of the state's population live in New York City, the five boroughs accounted for more than half of all Marketplace enrollees (with Brooklyn and Queens topping the list).

The proportion of young adult enrollees in New York State of Health is roughly consistent with national averages (see Update for Week of April 14th). One-third of consumers are below age 35 while 51 percent are below 45.

New Yorkers were more willing than consumers in other states to select the most generous but most costly platinum coverage (13 percent compared to five percent nationwide.)

Pennsylvania

Nine insurers seek to participate in Medicaid-expansion alternative sought by Governor

Governor Tom Corbett (R) announced this week that at least nine insurers have already signed-up for his Healthy Pennsylvania alternative to the Medicaid expansion under the Affordable Care Act (ACA).

The Governor's plan is largely modeled on the "private sector" alternatives already federally-approved for Arkansas, Iowa, and Michigan (see above). Starting this coming January, it would use the ACA matching funds for the expansion to instead cover the newly Medicaid eligible population under the federally-facilitated Marketplace (FFM) operated in Pennsylvania.

The Governor submitted his proposal to the Centers for Medicare and Medicaid Services (CMS) last winter and negotiations started in April following a public comment period. CMS is likely to substantially modify the Governor's plan as it includes higher cost-sharing than it has previously allowed, as well as employment and wellness requirements that have been rejected for other states. The Governor has already agreed to relax several of these requirements in an effort to secure federal approval (see Update for Weeks of April 28th and May 5th).

Among the nine insurers that have signed-up, only one (Independence Blue Cross) would be offered statewide.