



Health Reform Update –Week of July 21, 2014

CONGRESS

Appellate courts split on whether ACA subsidies for federal Marketplace are illegal

A majority of a three-judge panel for the U.S. District of Columbia Court of Appeals granted conservative plaintiffs their first victory this week in their challenges to the validity of premium subsidies offered under the Affordable Care Act (ACA). However, a contrary ruling from a unanimous panel for the U.S. Fourth Circuit Court of Appeals may set-up another showdown in the U.S. Supreme Court if the split is not resolved by the full courts this fall.

In the aftermath of the U.S. Supreme Court's decision to uphold the entire ACA, conservative think tanks such as the American Enterprise Institute and Cato Institute backed several attacks on the subsidies themselves, insisting that the text of the ACA statute only permitted them to be offered to consumers in health insurance Marketplaces created by states (see Update for Week of July 9, 2012).. Federal district courts for the District of Columbia and Virginia both rejected this argument, concluding that Congress clearly sought to make the subsidies available in both state-based and federally-facilitated Marketplaces (FFM), as to exclude them from the latter would defeat the very purpose of the ACA.

However, two Republican-appointed judges on the D.C. panel concluded “with reluctance” that “Section 36B [of the ACA] plainly makes subsidies available only on [Marketplaces] established by the state” despite the “significant consequences” that they acknowledge will result if such an opinion is upheld. The lone judge appointed by a Democratic president dissented, arguing that such an interpretation is “implausible” when the provision is not pulled out of context but instead read as part of the ACA “as a whole”.

The decision has no immediate impact as the White House immediately pledged to appeal to the full appellate court. Seven of the D.C. court's 11 judges were appointed by Democrat presidents, including four recent appointees of President Obama.

The conservative plaintiffs are likewise expected to appeal the Fourth Circuit's denial of their claim to the full court, where eight of the 14 judges were appointed by Democrat presidents, as were all three judges that upheld the lower court's decision.

The full appellate courts are expected to issue their rulings in the fall. Should both courts find for the plaintiffs and the U.S. Supreme Court decline to hear an appeal, the subsidies could presumably be stripped away from FFM consumers for the 2015 open enrollment period starting November 15th.

However, if the conflict in the panel decisions remains in place, the Supreme Court would be expected to hear their appeal. This means that a final decision would likely not be reached before June 2015 and FFM subsidies would not be removed before the 2016 open enrollment period.

Two similar cases have yet to be heard in the Indiana and Oklahoma district courts. As a result, the Supreme Court could wait for those to be resolved, potentially delaying any resolution past 2016.

The Supreme Court has the option of granted an expedited consideration that could considerably speed up their review. However, they previously rejected requests for expedited consideration of other ACA challenges.



The loss of FFM subsidies could make coverage unaffordable and effectively deny access to care for millions of consumers in up to 34 states where the federal government is expected to fully or partly operate Marketplaces in 2015. According to the Robert Wood Johnson Foundation, roughly 4.5 million FFM consumers received ACA subsidies in 2014. Avalere Health previously found that the loss of subsidies would raise premiums by 76 percent for FFM consumers (see Update for Week of June 2nd).

Federal judge dismisses Senator's lawsuit seeking to block ACA subsidies for Congress

The chief judge for the U.S. District Court for the Eastern District of Wisconsin dismissed a lawsuit this week brought by Senator Ron Johnson (R-WI) challenging federal rules that require members of Congress and staff to obtain health coverage through the Affordable Care Act (ACA) Marketplace.

The lawsuit sought to block final rules issued by the Office of Personnel Management (OPM) last year that allowed members of Congress and staff to continue to receive subsidized health insurance coverage once the ACA was fully implemented January 1st. However, instead of having 75 percent of their costs subsidized under the popular Federal Employees Health Benefit Plan (FEHBP) marketplace, members and their staff will only receive a subsidy of up to \$5,000 a year for individual coverage and \$11,000 for families if they purchase gold-level coverage in the Small Business Health Options Program (SHOP) Marketplace for the District of Columbia (see Update for Week of September 30th).

Senator Johnson and several conservative lawmakers such as Senator David Vitter (R-LA) insisted that the rules were an “abuse of executive authority”, even though those rules were supported by Republican leadership (see Update for Week of January 6th). In the lawsuit, Senator Johnson argued that they would create a “conflict” within his office by making him to decide which staff members should qualify for the subsidies, and cause voters to view him negatively by forcing him to participate in an ACA program that he publicly insists is “illegal”.

Judge William Griesbach, an appointee of President George W. Bush, held that a mere belief that a federal program is “illegal” is not grounds to bring suit. He concluded that Senator Johnson failed to make any actual showing that voters gained a negative opinion of him solely because 40 members of his staff were receiving the subsidized Marketplace coverage and noted that the Senator himself exercised his ability to buy private coverage outside of the Marketplace.

GAO investigation provides further evidence that CMS, IRS are unable to verify subsidy eligibility

Preliminary results from an undercover investigation by the Government Accountability Office (GAO) showed that auditors were able to use fake information on income and citizenship status to erroneously qualify for Affordable Care Act (ACA) subsidies in 11 of 12 attempts.

Republican leaders of the House Ways and Means oversight subcommittee that requested the investigation pounced on the results this week as further evidence that the Internal Revenue Service (IRS) is unable to verify income and eligibility for Marketplace applicants and renewed calls for the agency to stop distributing premium and cost-sharing subsidies until it can accurately do so (see Update for Week of June 2nd). However, GAO auditors stressed that the sample size was too small “to draw conclusions about fraud in the Obamacare marketplaces.”

GAO used government funds to pay the premiums for the fake accounts. It reported this week to the subcommittee that even though GAO was directed to provide supporting documents, the contractor hired to process the applications was not required to authenticate the phony documents they provided. As a result, GAO continues to receive subsidized coverage for 11 fictitious individuals.

The GAO investigation comes on the heels of a review by the Health and Human Services (HHS) Inspector General (OIG) that identified nearly three million inconsistencies in applications filed through federally-facilitated Marketplaces (FFM) (See Update for Weeks of June 30th and July 7th). OIG



specifically found that the Centers for Medicare and Medicaid Services (CMS) is unable to resolve applications errors manually and lacks the basic capabilities needed to address discrepancies in data reported by applicants and those on file in federal databases (such as income and citizenship).

Although CMS acknowledges the inconsistencies and insists it is taking steps to correct them, the OIG determined that less than one percent of the 330,000 inconsistencies that CMS could address have been actually resolved (see Update for Weeks of June 30th and July 7th). The agency informed the subcommittee this week that it intends to shortly start terminating Marketplace coverage or subsidy eligibility for applicants that fail to provide supporting documentation (though it declined to provide a timeline). It also emphasized that the IRS automatically will resolve any underpayments or overpayments when subsidy payments or compared to individual tax returns early next year.

Democratic lawmakers pointed out that individuals willfully submitting fake information in the manner that GAO auditors did would be subject to fines up to \$25,000 and other criminal penalties.

Democratic lawmakers create caucus to push for Medicaid expansion in holdout states

A group of 33 Democratic lawmakers announced this week that they have created the State Medicaid Expansion Caucus to encourage states that have yet to expand Medicaid under the Affordable Care Act (ACA) to accept the federal matching funds to do so.

Reps. Hank Johnson (D-GA) and G.K. Butterfield (D-NC) will co-chair the caucus, which also has members from Alabama, Arizona, Louisiana, Maine, Florida, Pennsylvania, Texas, Tennessee, South Carolina, Virginia, and Wisconsin. Arizona is the only one of these states to participate in the ACA expansion, although Pennsylvania has requested federal approval for a private-sector alternative similar to the model currently operating in Arkansas, Iowa, and Michigan.

To date, 26 states and the District of Columbia have expanded Medicaid under the ACA to those earning up to 138 percent of the federal poverty level. However, Indiana, Pennsylvania, Tennessee, and Utah have submitted or plan to shortly submit alternative proposals for federal approval (see Update for Week of June 2nd) while North Carolina and Virginia are among the states still debating whether to expand (see Update for Week of July 14th).

FEDERAL AGENCIES

IRS caps initial individual mandate penalties at \$2,448 per person

The Internal Revenue Service (IRS) set limits this week on the amount of tax penalties that will be assessed for those failing to buy health insurance coverage that they can afford.

For the 2014 tax year, the penalties will be capped at \$2,448 per person and \$12,240 for a family of five. This amount is equal to the national average annual premium for a bronze level health plan. However, only those with annual incomes above \$244,800 would benefit from the cap. Others will be subject to the Affordable Care Act (ACA) limit for 2014 of one percent of their annual income.

The ACA increases the tax penalties in subsequent years. For 2015, it will be two percent of income or \$325, whichever is higher.

According to the IRS, violators will owe the IRS one-twelfth of the annual penalty for each month that they or their dependents do not have minimum essential coverage and fail to qualify for an exemption. The IRS can also deduct the penalty from tax refunds due to those who fail to pay. However, the ACA statute bars the IRS from imposing any liens or criminal penalties.



The Congressional Budget Office (CBO) estimates that four million Americans will be subject to the penalty by 2016 and 12 million would qualify for an exemption. However, only a fraction of that 12 million had sought an exemption by April (see Update for Week of April 28th and May 5th).

Harvard study says ten million adults have gained coverage since ACA Marketplaces opened

A Harvard University study published this week in the *New England Journal of Medicine* is the latest to show a dramatic decline in the nation's uninsured since the health insurance Marketplaces under the Affordable Care Act (ACA) opened last fall.

Using survey results from Gallup and the Department of Health and Human Services (HHS), researchers concluded that 10.3 million working-age adults gained private or public coverage in the second quarter of 2014, corresponding to a 5.2 percent fall in the rate of uninsured (to 16.3 percent). Latinos, African-Americans, and young adults experienced the largest gains in coverage.

States that expanded Medicaid saw the greatest decline in their uninsured rate (5.1 percent) while there was no statistical change in those that opted-out of the expansion.

The Harvard estimates exceed the coverage gains previously calculated by Gallup (nearly ten million), The Commonwealth Fund (9.5 million adults) and the Urban Institute (eight million) (see Update for Weeks of June 30th and July 7th). The Congressional Budget Office (CBO) had predicted that the ACA would reduce the uninsured rate by 12 million over 2014, although 42 million Americans would still be left without coverage.

HRSA issues interpretative rule on 340B drug discounts, renews focus on delayed "megarule"

The Pharmaceutical Research and Manufacturers of America (PhRMA) is challenging an interpretative rule issued this week by the Health Resources and Services Administration (HRSA), which PhRMA insists is a "government power play" to circumvent a federal court injunction barring HRSA from extending mandatory drug discounts under the federal 340B program to orphan drugs used for non-orphan indications (as required by the Affordable Care Act).

PhRMA appeared to have successfully blocked the final rule last month (see Update for Week of June 9th) and is objecting to HRSA's apparent effort to nullify their legal victory "simply by issuing a 'new' regulation with the 'same effect' as the one being challenged in court" (and make it effective as of July 21st). However, even though the U.S. District Court for the District of Columbia limited HRSA's rulemaking authority on 340B to ceiling prices, dispute resolution, and civil monetary penalties, it conceded that the issue of whether interpretative guidance constituted rulemaking was a "gray area" (see Update for Week of July 14th).

The legal wrangling over has already forced HRSA to miss its June target date for releasing its so-called "megarule", which represents the first comprehensive set of regulations for the 340B program that has been largely operated for 22 years on different sets of regulatory guidance. The "megarule" is intended to address frequent criticism from Congress and the Government Accountability Office (GAO) in recent years that HRSA lacks adequate oversight to ensure safety net providers receiving the discounts are not reaping improper windfalls and that manufacturers are providing the best prices for the drugs consumers (see Update for Weeks of July 1 and 8, 2013).

STATES

Florida far exceeds other states in ACA rebates to consumers



The Department of Health and Human Services (HHS) announced this week that health insurance consumers will receive more than \$332 million in rebates by August 1st thanks to the limits on profit and overhead imposed by the Affordable Care Act (ACA).

Starting with the 2011 plan year, the ACA required individual and small group plans to spend at least 80 percent of premium revenue on direct medical care and no more than 20 percent on administration (or 85 and 15 percent for large group plans). Those that fail to comply have to rebate the difference to consumers every year, either through direct refunds or reductions in future premiums.

According to HHS, consumers have now received nearly \$2 million in rebates as a result of these medical-loss ratios (MLRs) and saved nearly \$9 billion in lower up-front premium costs (with \$3.8 billion attributable to 2013). On average, overhead has also dropped from 13.1 to 12.2 percent since 2011.

The HHS report showed that health insurers are gradually adjusting their practices to adhere more closely to the MLRs, as the \$332 million to be refunded for 2013 is lower than the \$504 million from 2012, which was nearly half of the \$1.1 million in initial rebates from 2011.

However, nearly 100 health insurers still owe at least \$1 million to consumers for 2013. Florida Blue leads the way with more than \$10.1 million, while Neighborhood Health Plan must rebate more than \$6 million. Aetna, Cigna, Humana, and UnitedHealth Group also owe consumers significant amounts.

Florida insurers far and away owe more rebates than any other state, thanks largely to Florida Blue and Health Options, Inc. whose \$20 million in rebates constitutes nearly half of the \$41.7 million state total. Nearly \$6 million of Health Options \$10 million total came from the large group market, while Florida Blue's entire \$10 million are owed to small group subscribers.

Florida also has by far the highest number of individual market subscribers owed rebates (981,273), with more than 14 percent of the nation's total. Golden Rule Insurance leads the pack with \$4.1 million in rebates for the individual market, while five other insurers owe at least \$1 million.

Even though the \$41.7 million owed by Florida insurers leads the nation, it is far below the \$124 million they owed for 2012, demonstrating a dramatic improvement in meeting the MLRs. The average rebate of \$65 for Florida families is also below the national average of \$80 for 2013.

The next highest state for total rebates is Maryland at \$17.3 followed by Massachusetts at \$15 million and Missouri at \$14.6. States that have roughly the same or greater population than Florida rank just behind Missouri, as California insurers owe only \$11.9 million in rebates, slightly less than both New York (\$12.1) and Texas (\$13.7 million).

Minnesota leads the nation in highest average rebates at \$522 per family. However, this is due to owing only about \$523,000 in overall rebates, by far the lowest for a state of its size. New York and California owe only \$37 and \$39 per family respectively, also the lowest for states with any significant population base.

The National Association of Medicaid Directors (NAMd) sent a letter this week opposing plans by the Centers for Medicare and Medicaid Services (CMS) to impose similar MLRs on Medicaid managed care plans as part of a forthcoming proposed rule.

Premium increases are limited to less than ten percent for 18 states

The latest study on proposed health insurance premiums for 2015 confirms that increases are likely to be consistent those experienced prior to the implementation of the Affordable Care Act (ACA).



According to a PricewaterhouseCoopers (PwC) analysis of preliminary rate filings, average rate hikes should remain in single digits for ten of the 18 states with available data, for an overall average increase of about eight percent. The highest average increase found by PwC was a 15 percent proposed hike in Indiana, while rates may actually fall by one percent in Rhode Island.

However, PwC did find wide variations among different plans to be offered within a state. For example, Oregon's proposed rates range from a 28 percent average hike to an average decrease of 21 percent (for an overall average of only 2.2 percent).

The findings are consistent with earlier analyses by consultants like Avalere Health (see Update for Week of June 16th). PwC researchers attributed increased competition from a flood of new entrants for holding 2015 premium increases in check (see Update for Weeks of June 30th and July 7th).

Express Scripts says states will spend more than \$55 billion on new Hepatitis C drug

A new study from the pharmacy benefit manager Express Scripts concludes that the latest "cure" for the Hepatitis C virus (HCV) would bust state budgets if Medicaid programs make it available for all eligible patients.

Gilead Sciences has been criticized in recent weeks for the price of its new Sovaldi drug, which costs \$1,000 per pill or \$84,000 for 12-week course of treatment. The cost has forced states like Oregon to contemplate whether to save \$128 million per year by limiting Medicaid coverage to Sovaldi only to those most in need (see Update for Week of July 14th). U.S. Senators Ron Wyden (D-OR) and Chuck Grassley (R-IA) are also demanding that Gilead provide data justifying the cost, claiming that it initially predicted the drug would be profitable at a price of only \$36,000 (see Update for Weeks of June 30th and July 7th).

Express Scripts latest analysis determined that even if with 23 percent discount mandated by the Medicaid rebate program, Sovaldi (and the combination medication ribavirin) would cost Medicaid programs \$55.2 billion nationwide. Louisiana would pay \$294 per resident, the highest per capita cost in the nation.

Express-Scripts previously predicted that Sovaldi would increase HCV drug costs in the United States by more than 1,800 percent from 2013 to 2016 and has threatened to boycott the drug if the price was not lowered. Gilead has shown no indication that the price will be altered, insisting that it is far cheaper than alternative treatments like liver transplantation. It reported this week that Sovaldi has beat expectations with \$3.5 billion in sales since it was approved by the Food and Drug Administration last December.

Arkansas

State proposes adding health saving accounts to Medicaid expansion alternative

The Department of Human Services (DHS) is proposing to expand Arkansas' Medicaid expansion alternative by adding Health Independence Accounts for most of the newly-eligible population in 2015.

Arkansas became the first state in the nation to receive federal approval for a "private sector" alternative to the traditional expansion set forth in the Affordable Care Act (ACA). Under the plan, ACA matching funds would be used to purchase private Marketplace coverage for those earning from 100-138 percent of federal poverty level (FPL) instead of enrolling them in traditional Medicaid. This population would also be subject to federally-approved copayments (see Update for Week of September 23rd).

State officials are now seeking to add a requirement that nearly all enrollees earning from 50-138 percent of FPL must contribute from \$5 to \$25 to health savings accounts or incur copayments (that are



capped at five percent of income by federal Medicaid rules). Those already enrolled in Marketplace plans could also avoid their copayments for 2015 by making the monthly contributions.

Medicaid will contribute \$15 to the account each month that an enrollee makes a contribution. Enrollees can also roll-over up to \$200 in unused funds from one year to the next, which can be used even if they leave Medicaid for private coverage.

DHS will open the public comment period on August 1st and intends to secure federal approval and make the accounts effective February 1st. However, consumer advocates expressed skepticism this week that the required contributions for those earning less than 100 percent of FPL would depress enrollment in a popular program that has already enrolled nearly 177,000 low-income Arkansans by the end of June, pointing to studies from the Kaiser Family Foundation showing that even nominal copayments on this population caused Medicaid enrollees in Oregon and other states to forgo care.

DHS officials pointed out that Michigan has already received federal approval for a similar model (see Update for Week of December 9th), while Indiana is awaiting approval to do so (see Update for Week of June 2nd). However, the Indiana proposal seeks to impose a \$2,500 deductible for the health savings accounts and eliminate benefits for the 100-138 percent of FPL population that fails to make the required contributions.

Senator seeks early innovation waiver under ACA

Senator David Sanders (R) stated this week that he will file legislation in the next session authorizing Arkansas to seek a federal innovation waiver allowed under the Affordable Care Act (ACA).

The Senator was one of the architects of the state's "private sector" Medicaid expansion alternative (see above) and would like the state go far beyond that popular model in coming years. Section 1332 of the ACA allow states to waive key provisions of the law in order to experiment with innovative models that are expected to expand coverage on at least a comparable basis. However, the ACA does not allow the innovation waivers to begin before 2017.

Senator Sanders is urging Congress to move up the 2017 start date, although Senate legislation to do so failed in 2010. His bill would make Arkansas the first to seek an innovation waiver, but Vermont is planning to do so in order to implement its plan to move a single-payer system by 2017 (see Update for Week of May 23, 2011).

Hawaii

New unified web portal will make Marketplace and Medicaid systems compatible

The Office of Information Management and Technology (OIMT) briefed lawmakers this week on its efforts to create a single web portal at www.hawaii.gov that will direct consumers to either the Hawaii Health Connector, Medicaid, or the state QUEST program for low-to-middle income residents.

Hawaii's initial effort to create a state-based Marketplace pursuant to the Affordable Care Act (ACA) was plagued throughout the initial enrollment period with software flaws and glitches that delayed the Connector's online web portal for one month (see Update for Week of October 21st) and greatly depressed overall enrollment. OIMT officials informed lawmakers that only about one of every four uninsured Hawaiians were able to gain coverage since the Connector opened, and fewer than 8,000 residents enrolled in private coverage through the Connector (one of the lowest rates in the nation).

The primary impediment was the incompatibility of different computer systems operated by the Connector and Medicaid. Those referred by the Connector to the Department of Human Services (DHS) to first determine Medicaid eligibility were caught in a bottleneck of over 11,000 unprocessed applications.



As a result, OIMT intends to build and test an integrated system for both the Connector and Medicaid before open enrollment starts again on November 15th. It determined that directing applicants to the existing state government website and then adding a link to connect them to either the Connector or Medicaid would be the most efficient method.

However, the Connector is facing a budget crunch after the legislature provided only one third of its \$4.7 million budget request and the \$204 million it received in federal Marketplace establishment grants expires at the end of 2014. The Connector largely relied on a two percent fee from participating plans to be self-sufficient in 2015, as required by the ACA. However, lower than anticipated enrollment has greatly reduced the anticipated revenue it is receiving from that fee (see Update for Week of March 31st).

Montana

Montana saw net increase population with health insurance coverage

Insurance Commissioner Monica Lindeen (D) announced this week that slightly more than 30,000 Montanans have gained insurance coverage so far during 2014.

The Commissioner attributed the opening of the new health insurance Marketplace under the Affordable Care Act (ACA) for the increase, which reduced Montana's uninsured rate of 20 percent (one of the nation's highest) down to 16.9 percent.

According to the Commissioner's survey of insurers, 26,429 Montanans gained coverage in the individual insurance market while another 8,739 gained Medicaid coverage (even though Montana has opted-out of the ACA expansion). However, Montana saw a 5,150 decrease in the small group market due to consumers migrating to individual coverage, leaving a net gain of 30,018 insureds.

North Carolina

Senate approves full transition to Medicaid managed care

In a party line vote, the Republican-controlled Senate gave tentative approval this week to a measure that would convert Medicaid into an independent agency run by a politically-appointed board and transition away from fee-for-service into capitated plans offered by health maintenance organizations (HMOs) and accountable care organizations (ACOs).

An earlier version of H.B. 1181 unanimously passed the House earlier this month, before more dramatic changes were added by the Senate. If the Senate gives full approval as expected, it is not clear that either the Republican-controlled House or Governor Pat McCrory (R) would back the measure in its current form. The Governor opposes removing Medicaid from the Department of Health and Human Services (HHS) and favors simply expanding the use of provider-led ACOs without forcing them to compete for Medicaid managed care contracts with large commercial insurers.

The North Carolina Medical Society has also adamantly opposed the full transition to managed care, warning that enrollees with costly conditions will likely incur similar discrimination that occurred under Medicaid managed care experiments in Florida, Georgia, Kentucky, and Illinois.

Tennessee

Class-action alleges that Tennessee is willfully denying Medicaid coverage to eligible applicants

Three consumer advocacy groups filed a class-action lawsuit this week accusing Tennessee officials of adopting policies that willfully deprive Medicaid coverage from thousands of residents in order to "demonize the federal government" and "score political points."



The lawsuit was filed in the U.S. District Court for the Middle District of Tennessee by the Southern Poverty Law Center (SPLC), the Tennessee Justice Center (TJC) and the National Health Law Program (NHeLP) on behalf of plaintiffs who have incurred major health problems while waiting for months for their Medicaid applications to be processed. It comes on the heels of a letter from the Centers for Medicare and Medicaid Services (CMS) identifying Tennessee as the worst state in the nation for meeting the enrollment guidelines set forth by the Affordable Care Act (ACA).

Tennessee has responded to CMS' demand for the state to address its backlog of more than one million Medicaid applications largely by blaming the delays on the federally-facilitated Marketplace (FFM) operated in the state (see Update for Week of July 14th). However, the advocacy groups accuse state officials of deliberately "throwing a monkey wrench in their own Medicaid program" and using the subsequent delays as justification for not expanding Medicaid pursuant to the ACA.

The groups claim that Tennessee currently makes it more difficult than any other state to enroll in Medicaid, documenting that state officials have stopped accepting in-person applications at county offices and are forcing all applicants to go through the FFM. They also emphasize that the enrollment delays of several months are violating federal law requiring Medicaid applications to be processed in 45 days. The lawsuit asks the court to compel state officials to hold a hearing on any application that exceeds that time limit.