



## Health Reform Update – Week of September 22, 2014

### CONGRESS

#### ***Appeals court rejects claim that employer mandate must immediately be implemented***

The Seventh U.S. Circuit Court of Appeals rejected the latest challenge this week to the employer mandate under the Affordable Care Act (ACA).

The lawsuit filed by the Association of American Physicians and Surgeons is similar to the one authorized over the summer by House Republicans (but yet to be filed), as it claims that the Obama Administration lacked the constitutional authority to delay the employer mandate past the January 1, 2014 implementation date set by the ACA and must immediately do so (see Update for Week of July 28<sup>th</sup>). However, the panel of three judges appointed solely by Republican presidents found that the plaintiffs lacked standing to bring the claim since they could not show they suffered any direct harm from the delay.

The conservative-leaning physician group had actually argued that because of the delay, fewer people were able to get coverage through their cash-only medical practice since they would not have had to incur the expense of buying their own insurance or paying the ACA tax penalty for not doing so.

The Seventh Circuit decision upholds a lower court ruling dismissing the lawsuit on the same grounds. The physician group can still seek an *en banc* review from the entire Seventh Circuit panel.

The employer mandate is currently slated to go into effect in January 2015 for companies with more than 100 employees, but not until January 2016 for those with 50-100 workers (see Update for Week of February 10<sup>th</sup>).

#### ***MACPAC warned that most Medicaid enrollees unaware of renewal requirement***

Researchers warned the Medicaid and CHIP Payment and Access Commission (MACPAC) this week that most Medicaid enrollees surveyed do not realize they need to renew their coverage for 2015, even if their personal circumstances have not changed.

The findings from six focus groups in Chicago, Denver, and Portland, Oregon show that many states have yet to notify enrollees of the renewal requirement. While navigators and other assister personnel created by the Affordable Care Act (ACA) have helped determine whether Marketplace applicants are Medicaid-eligible, most respondents complained that those personnel were not useful to them once they were enrolled.

### FEDERAL AGENCIES

#### ***Marketplaces to add at least 77 new carriers in 2015***

The Department of Health and Human Services (HHS) announced this week that Marketplaces created pursuant to the Affordable Care Act (ACA) expect to see a 25 percent increase in competition for 2015, which are likely to lower premiums for consumers in the markets with the largest number of new participants.

Overall, 77 new insurance carriers will enter the Marketplaces for the first time. Among the 36 federally-facilitated Marketplaces (FFM), the total number of participants will increase from 191 to 248 (a 30 percent increase), when accounting for the ten insurers that are leaving such as PreferredOne in



Minnesota (see Update for Week of September 15<sup>th</sup>). Six additional insurers will participate in the eight state-based Marketplaces (SBMs) that have reported data (for an additional total of 67). However, seven SBMs (including the glitch-plagued Hawaii, Massachusetts, Nevada, Oregon, and Vermont models) have yet to do so.

California was the only Marketplace reporting a decrease (from 12 to ten insurers). The number of participants will double in four states (Indiana, Missouri, New Hampshire, and West Virginia), while Indiana (moving from four to ten insurers) and New Hampshire (from one to five) will see the greatest increases. No change is expected in at least 11 states.

Among FFM, Michigan, Ohio, and Texas are expected to have the highest number of participating insurers next year at 16. Pennsylvania and Wisconsin are close behind with 15 and Florida at 14. By contrast, Pennsylvania was the leading FFM state in 2014 with only 14 carriers.

The SBM in New York, which had 16 carriers in 2014, will increase to a nation-leading 17 next year. Among other SBMs, Colorado is expected to have 12 carriers while California and Washington will each have ten (as will Illinois' state partnership Marketplace).

HHS previously estimated last June that every new carrier translates into an average of four percent lower premiums for consumers in that region. The impact may be more dramatic in states like New Hampshire and West Virginia that had only one participating insurer in 2014.

According to the report, more than 80 percent of Marketplace consumers lived in a region served by at least three insurance carriers in 2014, and 96 percent of consumers could choose between at least two carriers. Each region averaged of five carriers offering an average of 47 plan options.

The report does not assess the impact of Marketplace insurers broadening the coverage area within a given state, which may have an even greater impact on premiums. For example, during 2014 only one Marketplace insurer covered every county in states like Georgia, Florida, and Mississippi, leading to highly disparate premium levels across the state. However, Georgia (which will increase from five to nine Marketplace insurers) will now have at least one competitor in every county, a move that is expected to bring down the nation's second-highest average Marketplace premiums (see Update for Weeks of June 30<sup>th</sup> and August 7<sup>th</sup>). Mississippi, which had competition in only four counties, is expected to see premiums for its dominant Marketplace insurer drop next year by 25 percent due largely to the entrance of a third competitor (see Update for Week of August 4<sup>th</sup>). HHS also claims that three new entrants to Florida's Marketplace (most notably UnitedHealthcare) are expected to lower silver-plan premiums in some metro areas by up to 17 percent, as well as most rural areas that were served in 2014 solely by Florida Blue (see Update for Week of August 4<sup>th</sup>).

### ***Medicaid expansion reduced hospital uncompensated care costs by \$5.7 billion***

The Department of Health and Human Services (HHS) estimated this week that the Affordable Care Act (ACA) will lower uncompensated care costs for hospitals by 16 percent in 2014.

The savings translate to roughly \$5.7 billion. Almost three-quarters of this amount (\$4.2 billion) will accrue in the 26 states (including the District Columbia) that elected to participate in the Medicaid expansion under the ACA by midyear (two additional states are already planning to participate for 2015).

The report found that uncompensated care costs in opt-out states will still be nine percent below previous levels (or \$1.5 billion), due to the "woodwork" effect that increased Medicaid rolls through simplified application procedures, the individual mandate, and other provisions of the ACA.

HHS based the savings on projections that 10.3 million fewer people will be uninsured this year, with Medicaid enrollment increasing by eight million (see Update for Week of September 15<sup>th</sup>).



The figures are consistent with earlier projections by state hospital associations, who have lobbied heavily for the expansion nationwide, forcing even conservative-leaning states like Arizona, Arkansas, Indiana, Ohio, Pennsylvania, and Tennessee to expand Medicaid or seek to do so.

Earlier this month, PricewaterhouseCoopers found that the nation's five largest for-profit health systems are already reaping financial benefits from the Medicaid expansion in their states. For example, the number of self-pay patients at hospitals within Tenet Healthcare, Community Health Systems, and HCA Holdings already fell this year by 46-48 percent.

The HHS report shows that broader Medicaid coverage has driven a substantial increase in hospital volume in expansion states, which had already increased from 4-31 percent from early 2013 to early 2014. By contrast, opt-out states saw no statistically significant increase in hospital volume.

According to the HHS, bad debt or charity care had peaked at more than \$50 billion by 2012. As recently as 2009, Families USA found that this cost was increase premiums for family health insurance coverage by roughly \$1,000 per year.

### ***HHS redesigns Marketplace web portal amidst new questions about security, transparency***

The Department of Health and Human Services (HHS) revealed this week that it is redesigning [www.healthcare.gov](http://www.healthcare.gov) for the 2015 open enrollment period, so that 70 percent of consumers will be able to use a shorter and simpler online application format.

Consumers using the federal web portal will have fewer screen pages, mouse clicks, and questions to navigate. However, the streamlined format will be available only for first-time applicants and not for those that have previously obtained coverage through the federally-facilitated Marketplace (FFM). It is also not intended for those with "complicated" household situations, according to HHS.

An initial set of questions will determine whether the new or old format is suitable for each applicant. These include questions about whether everyone in the household lives at the same permanent address and whether dependents live with a parent but are not on their tax return. They also inquire about citizenship status.

The new format will allow online accounts to be created on a single screen instead of multiple screens. Flaws in the account creation process were responsible for much of the initial backlog of applications during the inaugural enrollment period (see Update for Week of November 11<sup>th</sup>).

In addition, HHS is adding a "backward navigation" feature so that consumers for the first-time can correct information on previous screens without having to start over.

The changes come amidst security flaws in the web portal that were identified last week by the Government Accountability Office (GAO) (see Update for Week of September 15<sup>th</sup>). A subsequent report this week from the HHS Office of Inspector General (OIG) found three of the most serious level of security flaws in databases inspected earlier this year (see below), although OIG acknowledges that HHS has taken corrective steps since that time, including the use of automated tools to test security configuration settings on all [www.healthcare.gov](http://www.healthcare.gov) databases.

GAO also raised new questions this week about the lack of transparency in FFM expenditures, as they were unable to even track how many HHS employees had been shifted to FFM work from other divisions within the agency.



### **Medicaid and CHIP enrollment grew by 14 percent over the past year**

According to the latest figures released this week by the Centers for Medicare and Medicaid Services (CMS), enrollment in Medicaid and the Children's Health Insurance Program grew by almost eight million people from July 2013 to July 2014, an increase of roughly 14 percent.

The grand total of 67 million people will increase further once missing data from Connecticut and Maine are added.

CMS emphasized that enrollment grew by more than 20 percent in states that expanded Medicaid on January 1<sup>st</sup>. By contrast, opt-out states experienced only a five percent rate of growth.

### **SHOP Marketplace premiums are less costly than small group market**

Premiums for the Small Business Health Options Program (SHOP) created by the Affordable Care Act (ACA) are coming in an average of seven percent lower than small group plans offered outside the health insurance Marketplaces, according to a new analysis of early rate data compiled by the National Opinion Research Center at the University of Chicago.

Based on their review of rate filings in 26 states (15 of which are building their own SHOP Marketplaces), the premium disparity for mid-level plans is translating to roughly \$220 in annual savings.

Researchers acknowledged that the findings are "surprising", given that insurers have expressed far less interest in the SHOP Marketplaces compared to their counterpart for individual and family subscribers. As a result, they concluded that the initial lack of interest may be causing participating insurers to price their SHOP products lower in order to attract interest.

However, researchers warn that as with the individual Marketplaces, lower premiums are often offered only for plans with far more narrow networks than non-Marketplace plans, leaving many consumers often caught off-guard by the unavailability of certain physicians or providers.

### **Avalere finds that Marketplaces largely rely on specialty tiers to control costs for orphan drugs**

A new Avalere Health analysis published in the Journal of Managed Care and Specialty Pharmacy concluded that the health insurance Marketplaces created pursuant to the Affordable Care Act (ACA) vary widely in terms of coverage for 11 different orphan drugs used to treat rare diseases like Huntington disease, Gaucher disease, sickle cell anemia, hydatidosis, and advanced soft tissue sarcomas.

The study funded by Novartis Pharmaceuticals surveyed 84 formularies for lower-tier bronze and silver plans in 15 states that are expected to account for more than 60 percent of total Marketplace enrollment nationwide. These include California, Florida, Texas, New York, New Jersey, Ohio, Pennsylvania, and Virginia. Although it showed that showed that on average Marketplace plans covered these drugs 65 percent of time, it specifically found that the lower-cost bronze plans were much less likely to do so.

Researchers found that restrictions on coverage varied widely depending on the drug. For example, only six percent of plans required prior authorization or other utilization management controls for Albenza (hydatidosis) compared to nearly 75 percent for Xenazine (Huntington disease). However, more than 70 percent of plans placed the orphan drugs onto specialty tiers requiring subscribers to pay a coinsurance amount, which in the silver plans ranged from 10-50 percent of the cost of the drug.



Only those drugs that were physician-administered were largely able to avoid the specialty tier coinsurance, as they were included in the plan's medical benefit instead of pharmacy benefits. These included drugs like Soliris, Ceredase, Cerezyme, Eleyso, and Vpriv.

Avalere Health acknowledged that the new out-of-pocket limits required by the ACA offer orphan drug consumers some financial protection from specialty tier coinsurance. However, they stressed that consumers will still face access problems if they cannot afford to pay the full maximum (currently \$6,350 for individuals and \$12,700 for families) within the first or second month of therapy.

## STATES

### ***Latino uninsured rate cut by half in states that expanded Medicaid***

Survey results released this week by The Commonwealth Fund show states expanding Medicaid under the Affordable Care Act (ACA) have dramatically reduced the uninsured rate among Latino populations.

Latinos are historically the most likely group to be uninsured, making the ability to enroll them in coverage critical to the success of the ACA. Marketplaces in states like California struggled during the inaugural open enrollment period to reach the Latino population, for reasons that included limited Spanish-speaking outreach to fears among Latino applicants that providing income or citizenship data could result in the deportation of undocumented family members (see Update for Week of February 17<sup>th</sup>). Overall, only 10.7 percent of federally-facilitated Marketplace (FFM) enrollment was Latino, a far lower rate than expected (see Update for Week of September 8<sup>th</sup>).

However, some states did ultimately have success reaching Latinos. According to the survey, a late surge in Latino enrollment allowed California to reduce the uninsured rate among Latinos by half, with 61 percent of eligible Latinos gaining coverage. Connecticut likewise saw disproportionate sign-up rates among uninsured Latino residents (see Update for Week of September 15<sup>th</sup>).

For all states, the uninsured rate among Latinos aged 19-64 dropped from 36 percent last year to 23 percent by June 2014. Young Latino adults (under age 35) fell from 43 to 23 percent during that same time, while the uninsured rate among non-elderly adults that speak predominantly Spanish—the group most likely to be uninsured—was cut from 49 to 30 percent. In total, nearly 68 percent of Latinos that gained coverage through the ACA were previously uninsured.

Low-income Latinos that qualified for Medicaid also saw dramatic coverage gains. The uninsured rate dropped from 46 to 28 percent among this group. However, nearly all of this increase occurred in states participating in the ACA expansion of Medicaid, where the Latino uninsured rate was cut by more than half from 35 to 17 percent. In contrast, the Latino uninsured rate for non-expansion states stayed at 33 percent, even though those states (including Florida and Texas) account for more than 20 million Latinos—60 percent of whom would gain Medicaid coverage if their state expanded to the ACA threshold.

Despite the progress, the survey did confirm that awareness of the ACA's expanded coverage options continues to lag among Latinos. Only half of the Latinos surveyed were aware of the ACA Marketplaces compared to three-quarters of Caucasian respondents. In addition, only 29 percent of eligible Latinos applied for coverage through the Marketplace, compared to 47 percent for Caucasians. However, Latinos that visited the Marketplace were more likely to purchase private coverage or enroll in Medicaid (66 percent to 47 percent).



## ***OIG finds continued security flaws in Marketplace data for Kentucky and New Mexico***

A new report released this week by the Inspector General for the U.S. Department of Health and Human Services concludes that while the federally-facilitated Marketplace has taken steps to protect income and citizenship data provide by consumers (see above), applications in several state-based Marketplaces remain at risk of being comprised due to weak security controls.

The report specifically cited Kentucky and New Mexico for security measures that often did not comply with federal standards. The latter was unable to make its planned SBM operational for the 2015 open enrollment period and will once again default to the FFM, after the IG report found 64 flaws in the web portal and 74 other vulnerabilities in the databases as late as March.

The security flaws that the IG report found for Kentucky related primarily to interagency coordination of data transfers, and not to the web portal or databases themselves.

### California

## ***Consumer advocate sues two more Marketplace insurers for narrow provider networks***

The advocacy group Consumer Watchdog filed suit this week against two additional health insurers, alleging that they misled consumers about the size of their provider networks, leaving them with substantial and unanticipated out-of-pocket costs.

Earlier class action lawsuits that the group filed against Anthem Blue Cross of California and two other insurers focused on plans offered in Covered California, the state's Marketplace created pursuant to the Affordable Care Act (ACA) (see Update for Week of August 18<sup>th</sup>). Erroneous provider directories plagued all insurers in Covered California during the early part of the inaugural open enrollment period (see Update for Week of October 21<sup>st</sup>) and the suits largely claim that insurers failed to disclose the errors until it was too late for subscribers to change coverage (see Update for Weeks of June 30<sup>th</sup> and July 7<sup>th</sup>).

Consumer Watchdog's latest lawsuit makes similar allegations against QHPs offered by Blue Shield of California. However, it also targets non-Marketplace plans offered by CIGNA, claiming that the insurer moved all specialists out-of-network when beneficiaries with certain conditions were about to reach the annual out-of-pocket limit.

The narrow network complaints follow a pattern of insurer actions nationwide that consumer groups insist are intended to evade the ACA's new ban on pre-existing condition denials. For example, The AIDS Institute filed a discrimination complaint against Marketplace plans in states like Florida that moved all drugs for certain costly conditions like HIV/AIDS into specialty tiers that require subscribers to pay a percentage of the drug cost (see Update for Week of June 2<sup>nd</sup>). Other insurers have sought to prohibit charitable organizations like PSI from assisting with Marketplace premiums (see Update for Week of June 16<sup>th</sup>).

Governor Jerry Brown (D) did sign a measure this week that requires greater insurer oversight (S.B. 964) and specifically seeks to raise network adequacy standards through separate annual reviews of Covered California, Medi-Cal managed care, and individual market plans. However, he vetoed A.B. 2088, which would have made limited plans in the large-group market supplemental to comprehensive coverage. This consumer protection already exists in the individual and small employer market but was sought by Consumer Watchdog and other advocates to prevent employers from using a loophole to evade the full intent of the ACA (see Update for Weeks of August 25<sup>th</sup> and September 1<sup>st</sup>).



### ***Small business Marketplace retains insurers, adds coverage options***

Covered California officials revealed this week that their Small Business Health Options Program (SHOP) will retain the same six participating insurers as 2014, but add additional plan options and flexibility.

California was one of the few states that went ahead and created their own SHOP last year, even though the Obama Administration delayed the federally-facilitated Marketplace for small groups and gave states discretion to do likewise (see Update for November 18<sup>th</sup>-December 6<sup>th</sup>). The state also required more than one plan option to be available to small business workers, although they also had discretion to let participating small employers limit coverage to only a single plan until 2016 (see Update for Week of June 2<sup>nd</sup>).

While small business employees could choose among several plans, all of the SHOP plans could only offer a single benefit level in 2014. Covered California announced that will change for next year, as Health Net, Kaiser Permanente, and Western Health Advantage will make two benefit levels available starting October 1<sup>st</sup>.

At least 1,714 small employers have participated in the Covered California SHOP through July, enrolling more than 11,500 workers and dependents.

Blue Shield of California, Chinese Community Health Plan and Sharp Health Plan are the other three participating SHOP insurers.

### Colorado

#### ***Average Marketplace premiums to rise by only one percent***

Colorado became the latest state this week to approve only nominal increases in 2015 premiums for the health insurance Marketplaces created pursuant to the Affordable Care Act (ACA).

The average rate hike of just 1.18 percent announced by the Division of Insurance is comparable to the increases expected in states like Massachusetts, Montana and Washington (see Update for Week of September 15<sup>th</sup>). Arkansas, New Mexico, and Oregon are actually predicting average premiums to fall slightly (see Update for Week of September 8<sup>th</sup>). According to Pricewaterhouse Coopers, preliminary rate filings in over 33 states show that average rates nationwide are likely to increase only by about seven percent on average, although Alaska, Florida, Indiana, Tennessee, and Virginia are projecting double-digit hikes (see Update for Week of September 8<sup>th</sup>).

A total of 20 carriers will offer consumers 1,072 plan options for both the individual and small group versions of the Marketplace. Rates in the individual version are expected to be slightly lower (for an average increase of only 0.71 percent).

Earlier this year, the Division realigned the geographic rating areas within the state to help bring down premium costs for the mountain resort areas, which saw the highest Marketplace premiums in the nation for 2014 (see Update for Week of June 2<sup>nd</sup>). According to the Division, including these areas within other western counties are now expected to lower their 2015 premiums by 5-7.44 percent. The Kaiser Family Foundation also found that premiums in the Denver metro area are expected to fall by 15.6 percent on average, the largest decrease in the nation (see Update for Weeks of August 25<sup>th</sup> and September 1<sup>st</sup>).

Due to large numbers of seasonal and part-time workers in the mountain resorts, Colorado typically has a very high uninsured rate. However, the Kaiser Family Foundation found that the ACA has dropped its uninsured rate by nearly half (16 percent to nine percent) since the opening of the Marketplaces and expansion of Medicaid.



### **Marketplace expects 30 percent attrition in 2015 enrollment**

Connect for Health Colorado (CHC) officials acknowledged this week that enrollment figures for 2105 are not expected to match the total of 146,000 consumers that signed-up through August.

According to CHC projections, only 114,000 of those enrollees will carry over into the 2015 open enrollment period for the Marketplace that starts November 15<sup>th</sup>. About ten percent of the 146,000 have already dropped out due to non-payment of premiums, consistent with nationwide figures. Another 20,000 are expected to do so in the coming months for a variety of reasons, including changes in job status, income, relocation, or health status.

By the end of the 2015 open enrollment period, CHC only expects a high-end total of 128,500 consumers and acknowledges that enrollment could fall as low as 54,500. The mid-level projection of 80,000 would represent a roughly 30 percent attrition rate from 2014.

Meeting the high-end estimate will be critical to the fiscal sustainability of the Marketplace, as ACA grants will no longer be available for 2016. The 1.4 percent levy on Marketplace premiums is expected to bring in \$5.4 million for 2014 based on the 114,000 that CHC expects to carry-over by year end. Another \$14 million will be raised from assessments on non-Marketplace plans sold to 920,000 Coloradans, while CHC will continue to receive about \$12-13 million from the defunct state high-risk pool.

CHC hopes to double the number of enrollees that are signed-up with the assistance of navigators or other assisters. Only six percent used assisters in 2014, compared to 29 percent that enrolled through brokers and agents.

#### Michigan

##### ***New measure would limit out-of-pocket costs for tiered formulary drugs***

Senator David Robertson (R) introduced S.B. 1083 this week, which requires that insurers using tiered formularies for prescription drugs must limit out-of-pocket (OOP) expenditures for a 30-day supply of a single drug to no more than \$100. Annual OOP limits also must not be greater than 50 percent of the maximum limit set by the Affordable Care Act (currently \$6,350 per individual or \$12,700 per family).

The measure, which would be effective six months after enactment, specifically does not prohibit the use of tiered cost-sharing structures, but does require an exceptions process that would allow a non-formulary drug to be covered as a formulary drug in certain situations.

S.B. 1083 was referred to the Committee on Insurance.

#### New Jersey

##### ***New bill would allow pharmacist to offer premiums and rebates without regard to age***

Senator Peter Barnes (D) introduced S.2384 last week, which would allow pharmacists to offer premiums or rebates on drugs furnished to customers regardless of age. Current law prohibits such premiums or rebates to customers under 60 years of age. The bill is a companion measure to A.3201, which was introduced last spring but remains in committee.

#### Ohio

##### ***New measure would limit out-of-pocket costs for specialty drugs in individual and group plans***

Senator Capri Cafaro (D) introduced S.B. 364 this week, which would limit total out-of-pocket (OOP) costs for specialty drugs under individual and group health plans (including state or public employee benefit plans).



The measure, which would be effective January 1<sup>st</sup>, specifically would limit cost sharing for specialty drugs to no more than \$150 for a one-month supply. It requires an exception process where subscribers can request that a specialty drug not listed on a preferred drug formulary may be covered and subject to the same cost sharing requirements as formulary drugs.