Health Reform Update – Week of June 1, 2015

CONGRESS

Ways and Means votes to repeal ACA medical device tax and Medicare cost-cutting board

The House Ways and Means Committee voted this week to repeal the Affordable Care Act (ACA) tax on medical device manufacturers and the law's controversial Medicare cost-cutting board, sending the bills to the House floor the week of June 15th.

Both measures have had significant bipartisan support in past years. However, Rep. Ron Kind (D-WI) was the lone committee Democrat to support H.R. 160, one of several bills (including S. 149) that would repeal the 2.3 percent device tax. Other Democrats led by Rep. Xavier Becerra (D-CA) objected to the refusal of Republicans to offset the $26 billion in revenue that would be lost by the repeal.

The House has voted three times to repeal the medical device tax since its 2010 enactment but each measure died in the Senate, which was held by Democrats until this year.

The Independent Payment Advisory Board (IPAB) repeal drew the support of seven Democrats, including bill cosponsor Linda Sanchez (D-CA), who feared ceding control over Medicare spending cuts away from Congress and into the heads of "unelected bureaucrats". However, other Democrats refused to back the measure (H.R. 1190) until the IPAB actually comes into existence and Republicans propose an offset for the $7.1 billion in lost revenue over ten years. President Obama has pledged to veto any such repeal and in fact proposed strengthening the IPAB as part of his fiscal 2016 budget (see Update for Weeks of January 26th and February 2nd).

GAO questions ability of CO-OPs to offer lower premiums and stay afloat

The Government Accountability Office (GAO) confirmed this week that low premiums offered by the consumer operated and oriented plans (CO-OPs) created through Affordable Care Act (ACA) loans may cause many of them to become insolvent.

According to GAO, the non-profit insurance CO-OPs offered the lowest average premiums in 54-63 percent of the rating areas for the 22 states in which they participated during 2014 (depending on the metal tier plan selected). For silver tier plans, average CO-OP premiums were up to ten percent lower in 20 percent of the rating areas and 10-30 percent lower in 31 percent. However, for the most generous platinum tier, average CO-OP premiums were lower than other plans in 89 percent of rating areas where they competed directly.

The low premiums enabled at least eight CO-OPs to attract an unexpected number of enrollees (five more than doubled their initial projections). In several cases, this caused claim costs to far outpace the funding allocated under the ACA, 65 percent of which had been slashed by Congress as part of bipartisan deficit reduction agreements (see Update for Weeks of December 24 and 31, 2012). At least two CO-OPs have already been liquidated as a result (see Update for Week of January 19th).

However, CO-OPs only enrolled roughly 470,000 consumers during the inaugural open enrollment period, with the remaining CO-OPs attracting only 15 percent of that total and ten of these failing to meet half of their initial target.

A recent study by Standard and Poors concluded that most CO-OPs are likely to become insolvent, noting that for all CO-OPs the median ratio of debt to remaining funds was only around 53 percent, while 11 CO-OPs had even worse ratios (see Update for Weeks of February 9th and 16th).

The Centers for Medicare and Medicaid Services had disbursed about two-thirds of the $2.4 billion in ACA loans. However, it has refused to shift funds from other sources to bail out insolvent CO-OPs (see Update for Week of January 12th).

Federal judge demands more details in House ACA lawsuit against President Obama

U.S. District Judge Rosemary Collyer held oral arguments last week on the Obama Administration's motion to dismiss a lawsuit against two Affordable Care Act (ACA) provisions filed by House Republicans.

The unprecedented lawsuit had largely been regarded as "symbolic" (see Update for Week of July 28th). However, Judge Collyer (an appointee of President George W. Bush) aggressively questioned both parties about the claim by House Republicans that the Department of Health and Human Services lacks the authority to issue premium subsidies authorized by the ACA when Congress refused to appropriate funds for that purpose in 2014.

House Speaker John Boehner (R) had insisted that the President was abusing his executive authority by funding the subsidies through alternative sources. Judge Collyer appeared to give at least some credence to the claim, insisting that the Administration was "dodging" her specific questions and demanding more details by June 15th on whether an annual appropriation was required for spending that was made mandatory by the ACA statute.

Judge Collyer did not address House's secondary claim that the Administration lacked the executive authority to delay the employer mandate under the ACA.

FEDERAL AGENCIES

Total Marketplace enrollment fell by 1.5 million in March

The Department of Health and Human Services (HHS) released a new report this week showing that the total number of enrollees in private Marketplace plans fell 11.7 million at the end of February to 10.2 million through March 31st.

The 10.2 million includes enrollment in both state-based Marketplaces (SBMs) and federally-facilitated Marketplaces (FFMs), but does not reflect most of the 147,000 that signed-up for FFM coverage through the special enrollment period that ran from March 15th through April 30th (see Update for Week of March 30th). HHS attributed the decline from February figures to those who either voluntarily dropped coverage or failed to timely pay their premiums. However, it still exceeds the revised target of 9.1 million enrollees that HHS set prior to the 2015 open enrollment period (see Update for Weeks of February 9th and 16th).

According to the report, about 87 percent of FFM consumers (or nearly 6.4 million enrollees) receive premium tax credits under the Affordable Care Act (ACA) that averaged $272 per month for the 2015 open enrollment period (nearly the same as the $276 average for 2014). These subsidies could be struck down by the U.S. Supreme Court later this month (see Update for Week of March 2nd and 9th), causing premiums to increase by an average of 287 percent based on figures from the Kaiser Family Foundation.

An adverse decision would have the greatest impact on Florida, which leads all Marketplaces with more than 1.3 million enrollees, 93.5 percent of whom are receiving an average subsidy of $294 per month and could see average premium rises by 359 percent. Alaskans receive the highest average subsidy at $536 per month, resulting in a 520 percent increase in average premiums if the subsidies are invalidated.

Pennsylvania Governor Tom Wolf (D) submitted an application to HHS seeking to convert the FFM Marketplace to a SBM if the ACA subsidies are struck down, while still using the federal web portal and call center (see Update for Week of May 4th). Delaware Governor Jack Markell (D) made a similar application for his state partnership Marketplace (SPM).

Nationwide, about 85 percent of all Marketplace enrollees are receiving premium tax credits while just over 57 percent qualified for cost-sharing subsidies under the ACA. More than two-thirds of all enrollees (68 percent) are enrolled in silver-level plans upon which the premium and cost-sharing assistance are based.

HHS also announced this week that enrollment in Medicaid and the Children's Health Insurance Program increased to more than 71 million by February. That figure is more than 21 percent higher than the total enrollment in the months before the ACA Marketplaces opened in October 2013.

Former CCIIO chief forces CMS to disclose proposed double-digit rate hikes

The Centers for Medicare and Medicaid Services (CMS) announced this week that they have started disclosing proposed hikes in 2016 premiums of at least ten percent.

The move is a "huge step forward" according to former Missouri Insurance Commissioner Jay Angoff, who was also the first director of the Center for Consumer Information and Insurance Oversight (CCIIO) within CMS. The agency had previously not been releasing any premium data until the start of the annual open enrollment period. Angoff filed a federal lawsuit last fall on behalf of the Consumers Council of Missouri, arguing that consumers should have an opportunity to review and challenge premium increases before they are finalized, especially in states like Missouri where state regulators lack the authority to modify or reject excessive rate hikes (see Update for Week of September 29th).

In briefs filed in response to Angoff's lawsuit, CMS agreed to release only the proposed premium data for double-digit rate hikes. The Affordable Care Act (ACA) gave CMS the authority to require that health plans publicly disclose the actuarial data justifying any "unreasonable" rate hike, which for the time being CMS has presumptively determined to be increases of at least ten percent (see Update for Week of August 29, 2011). State insurance departments will decide whether any double-digit rate hike is justified by medical cost inflation and other factors. CMS continues to assume this role for five states that still lack effective rate review authority for their individual and small group markets.

CMS posted proposed double-digit increases for plans in and outside of the Marketplaces created by the ACA for those states defaulting to the federal web portal at www.healthcare.gov. They are displayed at www.ratereview.healthcare.gov, which also includes data on rate-reviewed submissions that already took effect in 2015. However, Angoff noted that insurers redacted significant portions of the actuarial data justifying these increases (citing trade secret or competitiveness concerns) and insisted that the plaintiffs would continue pushing for "greater transparency".

Although the ACA does not give CMS authority to do more than publicly shame insurers for unreasonable rate increases, the agency previously reported that this heightened transparency resulted in roughly $1.2 billion in lower rate hikes in 2012 alone (see Update for Week of September 9, 2013). CMS claimed that proposed rate hikes dropped that year by 12 percent in the individual market and 19 percent in the small group market due to these provisions.

The CMS announcement this week emphasized that the published data on proposed premiums are not adjusted for premium and cost-sharing subsidies under the ACA. More than 80 percent of federally-facilitated Marketplace consumers purchase coverage for less than $100 per month last year, after accounting for an average premium tax credit of $263 per month. The proposed increases are also likely to change dramatically once reviewed by state or federal regulators.

CMS pledges to publish final rates no later than November 1st, the start of the open enrollment period for 2016. The agency came under heavy criticism last year for delaying open enrollment until November 15th, which critics claim was intended to avoid electoral repercussions (see Update for Week of September 29th).

STATES

California

Senate approves bill expanding Medi-Cal to undocumented immigrants

A first-in-the-nation measure that would expand Medi-Cal coverage to an estimated 1.5 million undocumented immigrants cleared the Senate this week and now heads to the Assembly.

S.B. 4 would make about 240,000 children under age 19 eligible for Medi-Cal while allowing an unspecified but capped number adults to sign-up for a separate program that provide the same services, contingent upon available funding. Those with higher incomes would alternatively be permitted to purchase Covered California coverage, subject to a federal waiver.

The measure had to be scaled-back from earlier version that would have offered state-subsidized coverage in Covered California, at an estimated cost of up to $740 million (see Update for Week of May 4th). The latest version was supported by a handful of Republicans including Senator Andy Vidak, who claimed it would mitigate the uncompensated care costs of treating undocumented immigrants in emergency rooms.

Marketplace enrollees still struggle with affordability, but rate plans high for access

Survey data released this week by the Kaiser Family foundation showed that 44 percent of more than 4,500 Californians reported difficultly paying Covered California premiums and chose to go without insurance, compared to only 25 percent of those enrolled in employer coverage or other private plans.

The Covered California director acknowledged that even a $70 premium is “still a struggle” for an individual earning only $25,000 per year, noting that the “Affordable Care Act is providing “nobody with a free lunch.” However, he stressed that California’s active purchaser Marketplace model has done more than most states in holding down premiums, which rose last year only by an average of 4.2 percent. He also pointed out that the same survey showed that nearly three-quarters of Covered California enrollees rated their coverage as excellent or good (compared to 88 percent for other private coverage) and 91 percent said it was “easy” to receive coverage through their usual source of medical care (the same percentage as for other private plan enrollees).

Connecticut

Governor considers broad bill that increases transparency for prescription drug costs

Governor Daniel Malloy (D) is expected to sign a wide-ranging bill that passed the House and Senate this week and would impose new transparency provisions on hospital and health insurers.

S.B. 811 focuses on hospital consolidation but includes provisions sought in S.B. 24 and other legislation that would require health insurers to post prices and cost-sharing for certain covered benefits

on various websites. For example, insurers would have to detail "in an easily readable and understandable format" the coverage exclusions applicable to each policy, the restrictions on the use or quantity of covered benefits including prescription drugs, and all cost-sharing and out-of-pocket expenses that subscribers can be expected to incur for prescription drugs (including specific coinsurance percentages for specialty drug tiers). Links to this information must also be made available on the websites for the AccessHealh CT Marketplace and Department of Insurance.

S.B. 811 specifically requires the Insurance Commissioner to evaluate whether the tier structures and cost-sharing used by drug formularies violate the anti-discrimination provisions of the Affordable Care Act (ACA). However, lawmakers did not include the explicit prohibition sought by consumer advocates that would prevent insurers from placing all or most drugs for a given condition onto a specialty tier. A stricter prohibition was included as part of S.B. 24 but removed after the Connecticut Association of Health Plans and the Department insisted that such a restriction could create "unintended consequences if carriers are limited in their formulary flexibility" (see Update for Week of March 30th).

Other provisions attempt to prevent "surprise billing" from hospitals and health insurers. It limits the subscriber's financial responsibility to in-network maximums whenever they receive emergency care from out-of-network providers or are not notified that the provider is not in their network.

Florida

House votes down amended Medicaid expansion plan as government shutdown looms

For the second consecutive year, the House has rejected a Senate plan to expand Medicaid pursuant to the Affordable Care Act (ACA).

Republicans dominate both legislative chambers in Florida. However, House Republicans remained resolutely opposed to accepting any federal funds to expand Medicaid, insisting that doing so would ultimately turn into a "boondoggle" for Florida, costing taxpayers far more than the ten percent share of costs that the ACA requires states assume starting in 2020. They adjourned the regular session early in an effort to avoid further debate on the issue (see Update for Week of May 4th).

On the other hand, Senate Republicans are equally adamant that Florida needs to accept the $50 billion in federal matching funds over the next decade that will exponentially more than cover the budget deficit that will be created on July 1st after the federal government will start to phase-out the state's $1.2 billion Low Income Pool waiver that helps offset hospital costs for uncompensated care (see Update for Weeks of May 18th and 25th). They passed their Medicaid expansion plan (S.B. 2) this week with only three dissenting votes.

The impasse has forced lawmakers into a special session in an effort to avoid a government shutdown at the end of this month. Senate Republicans proposed several amendments to S.B. 2 that have been supported by conservative lawmakers in other states, including an automatic sunset clause and a work requirement for able-bodied adults that would cut the number of newly Medicaid-eligible enrollees by half—even though Senate Health Policy Committee chair Aaron Bean (R) acknowledged that the latter has not received federal approval in other states (see Update for Weeks of April 6th and 13th). They also agreed to remove the requirement that enrollees first be required to enroll in a Medicaid managed care plan for six months (see Update for Weeks of May 18th and 25th).

However, the amendments changed few minds and the measure was easily defeated 72-41 in the House, forcing lawmakers to start considering severe spending cuts in other areas in order to pass a balanced budget by June 30th.

Governor Rick Scott (R), who initially supported expansion, opposed the Senate plan and is instead seeking federal approval to offset the loss of LIP funds by relying on local hospitals and local governments to raise $900 million in financing to draw down the $1.2 billion in federal funds. Hospitals

would be rewarded with a ten percent profit (or $100 million) and increased reimbursement rates from Medicaid managed care plans.

The Florida Safety Net Hospital Association strongly opposed the Governor's plan, which he acknowledges will result in a net revenue loss of at least $214 million for all hospitals.

White House economists released a report this week claiming that expanding Medicaid under the ACA would not only save the state $790 million through greater preventive care for at least 750,000 Floridians but prevent 900 premature deaths.

Hawaii

Hawaii becomes fourth state Marketplace to revert back to federal web portal

The board overseeing the non-profit Hawaii Health Connector voted unanimously this week to shut down the state-based Marketplace (SBM) created pursuant to the Affordable Care Act (ACA) and default to the federally-facilitated Marketplace (FFM).

The move makes Hawaii the fourth SBM to do so as a result of unresolved software flaws and technological glitches that have severely depressed enrollment. Nevada, New Mexico, and Oregon both defaulted to the FFM for the 2015 open enrollment period (see Update for Week of June 2, 2014).

The federal Centers for Medicare and Medicaid Services (CMS) had asked Governor David Ige (D) to shift to the FFM after the Connector failed to be self-sustaining by January 2015 as required by the ACA. CMS has agreed to provide $18 million of the $20 million that the state now estimates will be required for the transition.

The Connector needed to nearly double its number of enrollees in order to continue operations and was set to increase the two percent per policy assessment that funds operations the 3.5 percent applied to FFM policies, starting in July (see Update for Week of May 11th). However, the legislature agreed to appropriate only $2 million of the $5.4 million that the Connector needed to stay afloat.

The three-phase transition plan approved by the board will cease all small group Marketplace enrollment on June 15th and individual Marketplace enrollment on September 30th. The nearly 38,000 individual Marketplace enrollees will need to re-enroll in the FFM by October 15th, two weeks prior to the November 1st start of the open enrollment period for 2016. All of the Connector's 33 employees will be laid off by May 1st.

Although Hawaii will rely on the FFM for technological functions, it will continue to oversee outreach and consumer support activities.

Michigan

New bill would limit out-of-pocket costs for prescription drugs

Senator David Robertson introduced S.B. 354 last week, which would require health plans using a tiered formulary for prescription drugs to limit out-of-pocket (OOP) expenses to $100 for up to a 30-day supply of any single drug. Aggregate OOP expenses also must not exceed 50 percent of the annual limit set by the Affordable Care Act (currently $6,600 for an individual).

Similar to specialty tier bills introduced in other states, S.B. 354 includes an allowance for subscribers to request an exception to the drug formulary. However, it does not include a prohibition against insurers moving all or most drugs for a specific condition into the highest drug tier, even though several states and the federal Centers for Medicare and Medicaid Services have determined such a practice to be discriminatory (see Update for Week of February 23rd).

Senator Robertson is vice-chair of the Finance Committee. However, the measure was referred to the Insurance Committee.

New York

Assembly passes single-payer bill despite failure in Vermont

The Assembly this week overwhelmingly passed legislation that would establish a single-payer health care system in New York.

The *New York Health Act* sponsored by Assemblyman Richard Gottfried (D), chair of the Health Committee, would fund the universal healthcare program through a progressive income tax and employer assessments. A.B. 5062 easily passed by an 89-47 margin, however it is not expected to clear the Republican-controlled Senate.

Neighboring Vermont had passed a law that put the state on the path to single-payer by 2017 (see Update for Week of May 23, 2011). However, it ultimately decided not to proceed after the required taxes were projected to far exceed initial estimates (see Update for Week of December 15, 2014).

Assemblyman Gottfried insisted his bill "bears very little resemblance to Vermont" and proposes a different financing system. He argued that it would actually result in $45 billion in lower state health spending by 2019, largely by reducing the administrative costs associated with private insurers. Gottfried also claimed that the new nine-percent income tax would only apply on income between $25,000-$50,000 and graduate up to 16 percent only for income above $200,000. The New York Health Plan Association insisted that such figures were "unrealistic" and "utopian".

The Assembly previously passed a single-payer bill in 1992 but the Senate stalled action on that measure after incoming President Bill Clinton proposed a comprehensive employer mandate.

Washington

Enrollment in small group Marketplace jumps dramatically prior to 2016 expansion

The Washington Healthplanfinder announced this week that more than 100 small businesses have signed-up for coverage through the small group Marketplace created pursuant to the Affordable Care Act (ACA).

Officially called Washington Healthplanfinder Business, the Marketplace started slowly with only one insurer (Kaiser Permanente) offering coverage in just two counties to 11 small businesses in 2014. However, more than 535 employees are now covered through the 100 participating businesses and two new insurers (Moda Health Plan and UnitedHealthcare) will offer 47 plans statewide.

In addition, Washington Healthplanfinder Business will start allowing companies with 50-99 workers to purchase coverage starting November 1st, since the employer mandate under the Affordable Care Act (ACA) will start for those employers in 2016. Currently, only small companies with less than 50 employees (which remain exempt from the employer mandate) can participate.