



Health Reform Update – Week of July 13, 2015

CONGRESS

GAO finds that ACA subsidies are still going to fictitious consumers

A Senate Finance Committee hearing this week focused on new findings from the Government Accountability Office (GAO) showing that the Centers for Medicare and Medicaid Services (CMS) is still unable to accurately verify eligibility for premium subsidies offered under the Affordable Care Act (ACA).

GAO's undercover probe found last summer that auditors were able to use fake identities to successfully obtain subsidized coverage in federally-facilitated Marketplaces in 11 out of 12 attempts (see Update for Week of July 21st). GAO officials testified this week that the Marketplaces have since re-enrolled all 11 fictitious individuals for 2015. Although the Marketplaces did subsequently terminate coverage for six of the fictitious individuals after failing to receive documentation verifying eligibility, auditors were able to reinstate subsidized coverage for five of the six (including an average monthly subsidy increase of ten percent).

Finance chairman Orrin Hatch (R-UT) seized on the findings as evidence that “the administration has been preoccupied with signing up as many applicants as possible, ignoring potential fraud and integrity issues along the way.” He also insisted that CMS has been “uncooperative” in providing GAO with information needed to pursue their investigation.

GAO officials identified several gaps in program integrity controls that still have not been addressed by CMS. The Office of Inspector General for the Department of Health and Human Services made similar findings last year (see Update for Weeks of June 30 and July 7, 2014). A follow-up report with corrective recommendations will be released by GAO later this year.

The ranking Democrat on the panel, Senator Ron Wyden of Oregon, took issue with GAO for refusing to turn over the 11 fictitious cases to CMS or providing copies of requested income tax returns, which are the primary means of verifying income eligibility for subsidy recipients.

New nominee for CMS Administrator could spark confirmation battle

The White House announced last week that it has nominated Andy Slavitt to serve as the permanent administrator for the Centers for Medicare and Medicaid Services (CMS).

Slavitt has been acting administrator since Marilyn Tavenner stepped down last February (see Update for Week of January 12th). Tavenner was the only CMS administrator to receive Senate confirmation since 2006. She has subsequently moved on to head America's Health Insurance Plans (AHIP).

As with Tavenner, Slavitt also has close ties to the insurance industry, having served as an executive vice president at the Optum subsidiary of UnitedHealth Group during the period that it was helping CMS fix software and technical flaws in the federal Marketplace web portal (see Update for Week of November 11, 2013). Senate Republican leaders including Majority Leader Mitch McConnell (R-KY) and Finance chairman Orrin Hatch (R-UT) quickly signaled that such a “conflicted history in the medical services industry” could create a tough road for his required Senate confirmation. Senator Hatch even suggested that CMS' willingness to cooperate into the ongoing Government Accountability Office probe into fraudulent subsidy payments for Marketplace consumers (see above) could ultimately determine whether Slavitt is confirmed.



The Department of Health and Human Services (HHS) has already had to issue an ethics waiver for Slavitt, requiring him to recuse himself from all matters involving UnitedHealth, including contracts for analytic and consulting work furnished by the Lewin Group. UnitedHealth is currently the largest carrier of Medicare Advantage plans.

Proposals to repeal ACA provisions through reconciliation likely to slide into September

House Budget Committee Chairman Tom Price (R) confirmed this week that his committee will wait until after the August recess to consider measures that would repeal or defund Affordable Care Act (ACA) provisions through budget reconciliation.

The fiscal 2016 spending resolution that Congress passed earlier this year (S.Con.Res. 11) had set a July 24th deadline for authorizing committees in the House and Senate to report their reconciliation proposals (see Update for Week of May 4th). However, Chairman Price indicated that it will now likely be September at the earliest before such proposals are introduced.

The reconciliation process would allow Republicans to move legislation through the Senate with only a bare majority, instead of the 60 vote threshold required to break a filibuster and allow bills to be considered. However, the reconciliation measures must directly impact revenue or spending.

House Republicans have increasingly sought to focus reconciliation proposals on “welfare programs” instead of ACA repeal provisions, which would face a certain Presidential veto. The U.S. Supreme Court’s decision last month to uphold ACA subsidies for all states likewise sapped some momentum from calls to use reconciliation to repeal parts of the ACA (see Update for Week of June 22nd).

Gallup survey shows that adult uninsured rate hits a new record low

The number of uninsured Americans fell to a new record low over the second quarter of 2015, according to the latest Gallup-Healthways Well-Being Index.

The monthly tracking survey of 44,000 adults found that the nation’s uninsured rate has plunged a full six points since the health insurance Marketplaces created by the Affordable Care Act opened in October 2013. The 0.5 percent drop over the second quarter now brings the uninsured rate for working-age adults down to 11.4 percent, the lowest ever recorded (see Update for Weeks of April 6th and 13th).

The largest decrease in the uninsured rate has occurred among Latinos and low-income groups. Individual health plans have seen the biggest coverage gain while the percentage of working-age adults covered under employer plans has remained stable since October 2013 at nearly 43.5 percent.

FEDERAL AGENCIES

Study shows higher than expected cost from new Medicaid adults

The chief actuary for the Centers for Medicare and Medicaid Services (CMS) acknowledged this week that the cost of covering adults made newly-eligible for Medicaid under the Affordable Care Act (ACA) was significantly higher than expected during the first year of full ACA implementation.

According to the actuary’s report, newly-eligible adults incurred average medical costs of \$5,517, which is roughly \$1,000 higher than CMS had projected. The report attributed the higher cost to “pent-up demand” for medical care and predicted that initial costs would fall in subsequent years.



The figures instantly became fodder for Republican lawmakers in the 22 states that have refused to participate in the ACA expansion, citing fears of higher than expected costs.

The actuary's report found that expansion enrollees accounted for 4.3 million or three-quarters of all 5.7 million new enrollees in 2014.

Study confirms that provider networks are more narrow in ACA Marketplaces

A new analysis released this week by Avalere Health consultants validates long-standing complaints that consumers in Affordable Care Act (ACA) Marketplaces are restricting access to care.

Researchers found that Marketplace consumers during the 2015 open enrollment period had access to roughly one-third fewer physicians and hospitals on average than those enrolled in employer-sponsored coverage. The narrow provider networks upon which Marketplace insurers have increasingly relied have also resulted in Marketplace consumers having access to 42 percent fewer cancer and cardiac specialists, 32 percent fewer mental health and primary care physicians, and 24 percent fewer hospitals.

The study relied upon health plan data for the largest rating region in each of the five states that had the highest Marketplace enrollment for 2015 coverage (California, Florida, Georgia, North Carolina and Texas).

Previous studies found that up to 70 percent of Marketplace plans narrowed their provider networks in order to offer more attractive premiums for the inaugural open enrollment period, forcing the Centers for Medicare and Medicaid Services and several states to broaden minimum standards for network adequacy (see Update for Weeks of March 17 and 24, 2014). California was among those states where Marketplace networks actually became narrower for 2015 (see Update for Week of September 29th). However, a Georgetown University and Urban Institute last May found that even though provider networks under the Covered California Marketplace were more lean, the quality of care was at least the same or better than their commercial plan counterparts.

STATES

Alaska

Governor to circumvent legislature on Medicaid expansion

Governor Bill Walker (I) announced this week that he will rely on a fiscal maneuver to expand Medicaid to nearly 42,000 low-income Alaskans by September 1st without the approval of the Republican-controlled legislature.

Participating in the Medicaid expansion under the Affordable Care Act (ACA) would bring Alaska roughly \$146 million in matching funds for fiscal year 2016 and more than \$1 billion by fiscal 2021. To do so, Governor Walker will send his funding plan to the Legislative Budget and Audit Committee, which reviews requests to accept non-general funding when the legislature is out of session. The committee will issue a non-binding recommendation on whether to accept the plan within 45 days. The legislature has the same 45 days to call a special session to pass their own expansion.

Alaska governors have only relied upon such a maneuver on seven other occasions. The move is certain to inflame already contentious relations between Governor Walker and conservative lawmakers that have steadfastly opposed his previous efforts to expand Medicaid since assuming office last January (see Update for Weeks of March 2nd and 9th). Lawmakers stripped the Governor's expansion plan from the fiscal 2016 budget and tried to insert a line item prohibiting him from using ACA funds to expand Medicaid, before the Legislative Affairs agency ruled that line item unconstitutional.



Ohio Governor John Kasich (R) had to use a similar fiscal maneuver in order to circumvent opposition from his state's Republican-controlled legislature (see Update for Week of October 21, 2013).

California

Senate committee passes amended Assembly bill to limit out-of-pocket drug costs

The Senate Health Committee made further amendments this week to Assembly-passed legislation that would limit out-of-pocket costs for prescription drugs.

The amended version of A.B. 339 passed the committee with only two dissenting votes and now moves to Appropriations. The committee had substantially amended the measure after receiving it from the Assembly, changing the limit from 1/24 of the annual out-of-maximum allowed by the Affordable Care Act to \$250 for a 30-day supply of a single drug (see Update for Weeks of June 29th and July 6th). Those amendments also relaxed a controversial prohibition on moving all drugs for a specific condition into tiers that impose the highest cost-sharing.

The latest amendments retain those changes but add a sunset clause that would terminate the \$250 out-of-pocket limit on January 1, 2021. They also add language stating that the bill “prohibit[s] the formulary....or health insurers from discouraging the enrollment of individuals with health conditions and from reducing the generosity of the benefit for enrollees or insureds with a particular condition.”

Assembly advances bill to expand Medi-Cal to undocumented immigrants

The Assembly Health Committee passed S.B. 4 this week by a 12-6 margin. The controversial bill would expand Medi-Cal coverage to roughly 240,000 undocumented children under age 19, while allowing an unspecified but capped number of undocumented 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 previously cleared the Senate with the support of a handful of Republicans who insisted that it would reduce uncompensated care burdens on emergency rooms (see Update for Week of June 1st).

Massachusetts

Hearing set for bill that would limit out-of-pocket costs for prescription drugs

The Joint Committee on Financial Services has set a July 21st hearing on legislation that would limit consumer out-of-pocket costs for specialty drugs and other prescription medications.

Sponsored by Rep. Marjorie Decker (D), H.828 would require separate out-of-pocket limits for prescription drugs that cannot exceed the minimum annual deductible for high-deductible health plans set by the Affordable Care Act. The limitation would apply to individual and group plans, including health maintenance organizations (see Update for Week of March 23rd).

New Hampshire

New law creates medical cost transparency commission

Governor Maggie Hassan (D) signed H.B. 330 this week, which creates an oversight commission on medical cost transparency.

The 13-member commission is charged with providing assistance that will further develop the New Hampshire HealthCost Internet website, as well as make recommendations to the legislature by November 1, 2016 on any needed legislation to help residents make informed health care decisions. The



commission must be composed of state lawmakers, the commissioners for both the insurance and health departments, and one member each from the insurance industry, medical society, and state hospital association.

Oklahoma

Insure Oklahoma receives another one-year extension despite lack of Medicaid expansion

Governor Mary Fallin (R) and the Oklahoma Health Care Authority announced this week that the Centers for Medicare and Medicaid Services (CMS) has granted their request to extend the federal waiver for Insure Oklahoma through the end of 2016.

The demonstration program relies on a combination of \$35 million in state tobacco tax revenue and \$64 million federal Medicaid funds to provide subsidized health coverage for nearly 18,000 low-income Oklahomans. About 3,700 Oklahoma businesses and 17,900 individuals currently participate in the program, which was created by the legislature in 2005.

Insure Oklahoma has two different options. Under the employer option, the state pays about 60 percent of the premium cost, with the employer and the employee picking-up 25 and 15 percent respectively. Employees who earn up to 200 percent of the federal poverty level (FPL) are eligible.

The second option is for individuals working for small businesses that do not offer health insurance, or those who are temporarily unemployed and looking for work. To qualify, an employee must earn no more than 100 percent of FPL.

Oklahoma has continued to receive one-year extensions of the Insure Oklahoma waiver in lieu of expanding Medicaid under the Affordable Care Act, which would provide Medicaid coverage to roughly 144,000 of the state's 632,000 uninsured residents (according to Kaiser Family Foundation). The state was not one of the nine for which CMS has threatened to terminate federal demonstration waivers if they do not expand Medicaid (see Update for Week of May 4th).