Health Reform Update – Week of August 10, 2015

CONGRESS

House members seek new rule on charitable assistance for Marketplace premiums

Thirty-seven House Democrats signed on to a "Dear Colleague" letter last week urging the Centers for Medicare and Medicaid Services (CMS) to revise last year's interim final rule that allowed insurers in Affordable Care Act Marketplaces to deny third-party premium assistance from charitable groups like PSI.

Rep. Doris Matsui (D-CA) spearheaded the letter at the request of PSI Government Relations, which followed similar letters sent last year by Senator David Vitter (R-LA), Senator Bill Cassidy (R-LA), and Rep. Cedric Richmond (D-LA) (see Update for Week of June 2, 2014). The signatories asked that CMS immediately modify the interim final rule so that Marketplace insurers are required to accept charitable assistance, just as CMS mandated that they accept premium assistance from state and federal programs like the Ryan White HIV/AIDS Program. They warned that patients with rare and chronic diseases will lose access to coverage and care without this additional requirement.

Since the interim final rule, at least 28 insurers in 23 states have exercised the discretion afforded by CMS to refuse premium assistance from non-profit charitable organizations and others have indicated that they will start doing so in 2016 (see Update for Week of May 4th). As a result, PSI Government Relations has secured commitments from Reps. Richmond and Kevin Cramer (R-ND) to drop a bipartisan bill after the summer recess that will affect this change legislatively, should CMS fail to act.

Urban Institute recommends expanded ACA subsidies and partial Medicaid expansions

The Urban Institute issued a new report this week urging Congress and the Obama Administration to make several changes to improve the Affordable Care Act (ACA) in future years, including enhanced premium and cost-sharing subsidies and partial expansions of Medicaid.

The report recognizes that the premium and cost-sharing subsidies under the ACA are "substantial" but insists that they are "still inadequate for many individuals and families." According to the researchers, this is especially true for those earning from 250-400 percent of the federal poverty level (FPL) who are eligible for premium tax credits but not cost-sharing subsidies. They claim that the ACA does not provide this group with "financial assistance that is sufficient to make coverage affordable according to the law's definition of what is affordable." For example, individuals in this income range are required to pay 8.10 to 9.5 percent of income to obtain coverage under a 70 percent actuarial value Marketplace plan (i.e. silver plan), but the ACA itself exempts them from the individual mandate to obtain minimum essential coverage if their cost is more than eight percent of their annual household income.

Furthermore, the report criticizes the ACA for failing to account for out-of-pocket (OOP) spending when setting this "affordability standard" at eight percent of income. Researchers note that although a subsidized premium may be "reasonably low relative to income", high deductibles and other cost-sharing can still make coverage unaffordable and create barriers to care. They insist that the cost-sharing subsidies under the ACA do little to reduce these OOP costs, particularly for those earning 200-250 percent of FPL.

The report emphasizes that "at every income level at or below 300 percent of FPL", the Massachusetts model upon which the ACA was based requires individuals to pay less for their health insurance coverage than does the ACA schedule. As a result, the Urban Institute specifically

recommends that Congress raise the ACA threshold for cost-sharing reductions form 250 percent of FPL to the 300 percent level set in Massachusetts, whose consumer contribution requirements are "widely seen as affordable and [where] participation rates remain very high."

Researchers also proposed a modified premium tax credit schedule that would base the credits upon the second lowest cost gold tier plan (with an 80 percent actuarial value), instead of pegging it to the second lowest cost silver plan. They point out that gold plans have significantly lower OOP costs and a median 2015 deductible of only $1,000 for individual coverage, compared to $2,900 for silver plans. The annual OOP maximum for the gold tier is also lower ($4,000 in 2015 compared to $6,350 for silver plans).

The second most prominent proposal is for the Centers for Medicare and Medicaid Services (CMS) to move-off their insistence that states fully expand Medicaid up to the threshold set by the ACA (138 percent of FPL) in order to receive ACA matching funds. CMS has thus far refused to consider proposals from conservative-led states like Oklahoma, Utah, and Wisconsin to expand only to the 100 percent of FPL threshold for ACA premium tax credits (see Update for Weeks of August 6 and 13, 2012). However, should Congress base the tax credits on gold tier coverage as the Urban Institute recommends, this would make Marketplace coverage more affordable for the 100-138 percent of FPL population thus lessening their need for the Medicaid expansion and providing less political resistance for the 21 states that have refused to fully expand.

The report also acknowledges that many state-based Marketplaces (SBMs) have faced great difficulties in maintaining financial self-sufficiency after initial federal grant funding was no longer available in 2015. It also points out that only 6-10 of the 14 SBMs have been able to develop "well-functioning" information technology systems needed to operate the Marketplace web portals and many are thus "not as consumer friendly as they ought to be." In addition, researchers identified several "back-end" functions of the federally-facilitated Marketplace (FFM) that are still inadequate despite the dramatic improvement in most "front-end functions" following the initially flawed rollout of the FFM (see Update for Week of November 11, 2013).

As a result, the Urban Institute is urging Congress to provide $4-6 billion in additional IT funding over the next ten years to improve the FFM and well-functioning SBMs, and encourage flawed SBMs to use the federal web portal (as are SBMs like Hawaii, Idaho, Nevada, and Oregon). The report also highlights the critical need for "well-trained and operated" Marketplace assisters and call centers and urges Congress to provide sufficient funding to ensure they can be maintained "throughout the year" and not treated as "temporary or intermittent employees available only during open enrollment periods."

Researchers also stress that at least $3-5 billion should be provided over the next ten years to enhance regulatory oversight over the private insurance market. The report notes that oversight and enforcement functions at the state level were provided with "very little federal resources" by the ACA apart from short-term federal grants to boost state rate review capabilities (see Update for Week of August 29, 2011). As a result, most states have provided insufficient attention to problems of network adequacy, discriminatory benefit designs, insurer transparency, and compliance with the ACA essential health benefit requirements. It points out that five states (Alabama, Missouri, Oklahoma, Texas, and Wyoming) have chosen not enforce any of the ACA's market regulatory reforms and left these functions entirely up to CMS.

The Urban Institute also urges the Internal Revenue Service (IRS) to fix the so-called "family glitch" that links eligibility for ACA premium tax credits to worker-only coverage rather than family coverage. IRS could issue a new interpretation of the ACA at no cost to the federal government, which would enable individuals with employer-sponsored coverage to be eligible for tax credits if the cost of the covering his or her family exceeds 9.5 percent of household income. This would enable more workers to be eligible for premium tax credits. It notes that Senator Al Franken (D-MN) proposed legislation in 2014 to enact a similar fix. However, the legislative approach would likely require additional revenues as it would not be included in the ACA's baseline.

The report points out that the 9.5 percent affordability threshold for subsidy eligibility is inconsistent with the eight percent affordability threshold for the individual mandate exemption. However, researchers recognize that "the government cost of eliminating this inequity [by lowering the former] would be large" and thus are not recommending such a change "at this time."

The Urban Institute also acknowledges that the substantial cost of their proposals ($453-559 billion over ten years) makes many of them untenable with the current Congress. Should a future Congress wish to consider them, the report recommends raising these revenues through a higher Medicare payroll tax on wages, extending Medicaid drug rebates to Medicare, and replacing the ACA's "Cadillac tax" for high-cost health insurance plans that starts in 2018 (see Update for Week of February 23rd) with a cap on the tax exclusion for contributions to employer-based health insurance.

However, researchers stress that some of the changes can be accomplished through executive action or new regulations at limited governmental cost, such as lowering the Medicaid expansion threshold or fixing the "family glitch".

FEDERAL AGENCIES

CDC data shows uninsured rate below ten percent for first time in history

The Centers for Disease Control and Prevention (CDC) reported this week that the nation's uninsured rate has fallen below ten percent for the first time in the more than five decades that the agency has tracked such data.

The CDC's National Health Interview Survey from January-March 2014 had found that the overall uninsured rate fell to 13.1 percent during the first three months after full implementation of the Affordable Care Act (ACA) (see Update for Week of September 15th) and 11.5 percent over the entire year. However, the most recent survey from January-March 2015 shows that nearly 16 million fewer Americans are uninsured since January 2014, dropping the nation's uninsured rate down to 9.2 percent.

Similar to the findings of other surveys, the CDC report shows a marked difference in uninsured rates for states that expanded Medicaid pursuant to the ACA and the 21 states that are still opting-out. For example, the uninsured rate for under age 65 adults in expansion states has fallen from 18.5 percent in 2013 to 10.5 percent for this year, compared to a drop of only six percent (from 23 percent) among opt-out states.

The CDC figures differ somewhat from other studies in that they include both Medicare and non-Medicare adults. CDC calculates the uninsured rate for adults age 18-64 to currently be at 13 percent.

However, CDC's findings still track closely with the most recent biannual survey from Gallup, which showed that the uninsured rate for working-age adults fell by one-third from 17.3 percent in 2013 to 11.7 percent after the first half of 2015. Gallup also found that the uninsured rate dropped more precipitously in states that expanded Medicaid and created or partnered with the federal government on their own ACA Marketplace (7.1 percent) compared to states that adopted only one or neither of these reforms (5.3 percent).

According to Gallup, Arkansas and Kentucky saw the largest drops (13 and 11 percent respectively), while California, Oregon, Rhode Island, and Washington also experienced declines near or above ten percent. The uninsured rate has now fallen to or below five percent for six states (Connecticut, Hawaii, Iowa, Massachusetts, Minnesota and Vermont), compared to before the ACA when Massachusetts was the only state where more than 95 percent of its population had health insurance.

The Gallup survey found a precipitous drop in the uninsured for only one state that did not expand Medicaid, as Mississippi experienced a decline from 22.4 to 14.2 percent. Of the 14 states that had uninsured rates above 20 percent prior to January 2014, only Texas remains above that threshold.

Federal Marketplaces add nearly 944,000 consumers through special enrollment period

New data released this week by the Centers for Medicare and Medicaid Services (CMS) shows that almost 944,000 have used a special enrollment period (SEP) to sign-up for coverage in one of the 37 states using the web portal for the federally-facilitated Marketplace (FFM).

The figure records SEP enrollment from the February end of the second open enrollment period through June 30th. It includes those who were eligible to sign-up due to standard qualifying events such as loss of essential health coverage, marriage, divorce, or a change in family size, citizenship status, or eligibility for premium tax credits offered by the Affordable Care Act (ACA). For 2015, CMS also allowed consumers to use the SEP if they did not realize they were subject to the ACA's individual mandate until filing their 2014 taxes (see Update for Weeks of March 2nd and 9th), or if they were unable to enroll due to Marketplace errors or glitches.

CMS did not indicate how many of the 944,000 SEP enrollees actually paid their first month premium or remain insured. The agency acknowledges that total federal and state Marketplace enrollment had declined from 11.7 million at the end of the second enrollment period down to 10.2 million by the end of March, due to enrollees that failed to pay premiums.

However, the CMS data did show that of the 944,000 that used the SEP, half qualified due to a loss of essential health coverage, 19 percent were deemed ineligible for Medicaid or the Children's Health Insurance Program, and 15 percent were those subject to the individual mandate for 2014 that were eligible due to the one-time grace period.

Consumers that signed-up during the SEP were also younger than those choosing plans during the regular open enrollment period, with 64 percent being between the ages of 18 and 54.

OIG finds more verification problems among recipients of ACA subsidies

The results of the latest audit by the Office of the Inspector General (OIG) for the Department of Health and Human Services (HHS) confirmed this week that the premium tax credits offered by the Affordable Care Act (ACA) are frequently being received by consumers that are not eligible for them.

The audit became the latest to find that the Centers for Medicare and Medicaid Services (CMS) and the Internal Revenue Service are unable to adequately verify eligibility for the tax credits within the federally-facilitated Marketplace (FFM). The ACA limits the tax credits only to those earning from 100-400 percent of the federal poverty level. However, the OIG found "inconsistencies" with 20 of the 45 applications they tracked, which in several cases revealed that CMS was not disqualifying applicants that failed to provide adequate income documentation so long as they made a "good faith effort" to do so.

The OIG findings come on the heels of testimony from Government Accountability Office (GAO) officials, who found that CMS approved 11 of 12 fictitious applications for subsidized coverage during 2014 and allowed all 11 to re-enroll in coverage for 2015 (see Update for Week of July 13th). CMS officials had insisted before Congress last month that many of the problems that OIG identified in a similar audit last year (see Update for Weeks of June 30 and July 7, 2014) have already been resolved.

Discrepancies force CMS to postpone release of data on risk corridor payments

The Centers for Medicare and Medicaid Services (CMS) announced this week that it has delayed releasing data on risk corridors payments made to insurers under the Affordable Care Act, due to inconsistencies in the data.

The reinsurance and risk corridors payments were intended to compensate Marketplace insurers for the costs of enrolling patients that were sicker and more costly than anticipated. Even though the temporary program is slated to end in 2016, Republican lawmakers have repeatedly sought to block or eliminate the payments, terming them an "insurer bailout" (see Update for Week of January 20 and 27, 2014).

STATES

Arizona

Only three of 13 Marketplace carriers seek double-digit rate hikes for 2016

State rate filings show that only three of the 13 carriers participating in the Affordable Care Act (ACA) Marketplace for individuals are seeking premium increases of at least ten percent for 2016.

Assurant Health has proposed the most dramatic increase at 70 percent, but has since announced that it will leave the health insurance market for 2016. Blue Cross and Blue Shield is seeking a 21.4 percent hike, while Health Net's filing also breaks ten percent. Final premiums are subject to modification by state regulators and will be announced prior to the November 1st start of open enrollment.

Enrollment in Meritus took off in 2015 after the non-profit cooperative created with ACA loans dramatically lowered premiums. Meritus is now covering roughly 56,000 Marketplace consumers, up from only 3.500 in 2014. Even though CO-OPs in other states were forced to seek double-digit rate hikes to ensure they could pay claims for unexpected spikes in enrollment (see Update for Weeks of February 9th and 16th), Meritus has elected to seek only a single-digit rate hike for 2016.

More than 205,000 consumers signed up for Marketplace plans by the end of the 2015 open enrollment period, nearly half (48 percent) of whom were new to the Marketplace. However, about 40,000 failed to pay their first month's premium and were dis-enrolled after March 31st.

Arizona's Marketplace will remain under federal control due to a law signed last spring by Governor Doug Ducey (R) prohibiting Arizona from transitioning to state control (see Update for Weeks of April 6th and 13th). It also prevents state employees from serving as enrollment assisters for the Marketplace.

Illinois

Half of Marketplace carriers seek double-digit rate hikes for 2016

State rate filings show that five of the ten insurers participating in the Affordable Care Act (ACA) Marketplace for individual subscribers are seeking rate increases of at least ten percent for 2016.

Assurant Health had the most dramatic increase at 42 percent but has since elected to leave the health insurance market entirely for 2016. Blue Cross and Blue Shield of Illinois is seeking rate hikes of up to 38 percent, insisting that actuarial data from 2014 shows that subscribers have been sicker and more costly than the insurer projected when it set its initial premiums.

As with Meritus in Arizona (see above), the lone non-profit cooperative participating in the Marketplace has limited their proposed increase to single-digits, despite a spike in enrollment that

occurred after it lowered premiums by 20-30 percent. Land of Lincoln Health had struggled to enroll just under 3,500 subscribers for 2014 (or four percent of their target), but increased that number to more than 50,000 (or 20 percent of the entire Marketplace) after dramatically cutting premiums.

The Department of Insurance has yet to publish proposed increases for the other carriers and is in the process of reviewing and modifying rates prior to the November 1st start of open enrollment.

New Jersey

Assembly bill to limit prescription drug cost-sharing now has Senate companion

Senate Majority Leader Loretta Weinberg (D) introduced S. 3142 this week, which is the Senate companion to legislation previously filed in the Assembly that would require health insurers to limit cost-sharing for prescription drugs (see Update for Week of June 22nd).

Both bills (S. 3142 and A.4595) are identical. They require individual and small group plans that are not bronze or catastrophic plans as defined by the Affordable Care Act to limit out-of-pocket costs (including coinsurance or copayments) to no more than $100 per month for each prescription drug (for up to a 30-day supply of any single drug). For bronze coverage, that limit shall increase to $200 per month for up to a 30-day supply.

In the case of high-deductible plans, the cost sharing limits will apply across the benefit design, including before and after any applicable deductible is reached.

As with comparable legislation introduced in other states, the bills require the plans to allow enrollees to request an exception to any formulary. However, they do not include a prohibition on plans moving all or most drugs for a specific medical condition into specialty tiers. At least four states (California, Connecticut, Louisiana, and Oregon) have seen a similar prohibition removed from proposed legislation (see Update for Week of July 13th).

North Carolina

Senate passes bill to privatize but not expand Medicaid

The Senate passed H.B. 372 this week by a 34-10 margin, which would put the delivery of all Medicare items and services into the hands of Medicaid managed care organizations (MCOs) and provider-led entities (PLEs). The so-called Medicaid "transformation" bill would also create a statewide health information exchange network and raise Medicaid payments for primary care physicians to Medicare levels.

H.B. 372 would apply to more than 90 percent of the state's 1.8 million Medicaid enrollees, with the exception of dual eligibles that are enrolled in both Medicaid and Medicare. However, the House-passed plan relied solely on PLEs and not MCOs, a key distinction will require a conference committee to reconcile. PLEs are groups of hospitals and physicians that manage care for no more than 30,000 patients at a time and would receive a capitated fee from the state to cover all of its Medicaid enrollees.

The House had mostly favored PLEs over the accountable care organization (ACO) model being tested under the Affordable Care Act (ACA), under which hospitals and physicians would share risk with the state (see Update for Week of October 17, 2011). By contrast, H.B. 372 calls for PLEs to assume all of the financial risk.

However, Senate Republicans did not want to wait for the five-year transition that it would take to get PLEs running and voted instead to start with MCOs. Whichever plan is ultimately enacted, it would require a federal waiver before being implemented.

The Senate soundly rejected an amendment filed by Senator Terry Van Duyn (D) that would have expanded Medicaid pursuant to the ACA. Senator Van Duyn noted that Governor Pat McCrory (R) and other Republican leaders had signaled that they may support some form of Medicaid expansion if North Carolina first reformed their Medicaid program to control costs (see Update for Weeks of February 9th and 16th). However, conservative Senators like budget committee chairman Harry Brown (R) and Ralph Hise (R) were adamant that they would never support participating in any form of an ACA expansion. They insisted that expansion has blown a hole in the budget of every state that has done so, even though Senator Van Duyn pointed out that Ohio currently has a $2 billion budget surplus due to the federal matching funds it has received from participating in the full ACA expansion since 2014.