Health Reform Update – Weeks of September 14 and 21, 2015

CONGRESS

Justice Department ask appeals court to dismiss House lawsuit over cost-sharing subsidies

The Obama Administration filed their expected appeal this week of a legal challenge to cost-sharing subsidies provided by the Affordable Care Act (ACA).

A federal judge appointed by President George W. Bush took the admittedly unprecedented step last week of granting standing to House lawmakers to hear their lawsuit seeking to prevent the departments of Treasury and Health and Human Services from issuing $175 billion in subsidies over ten years without a specific congressional appropriation (see Update for Weeks of August 31st and September 7th). The Justice Department is asking the U.S. District Court of Appeals for the District of Columbia Circuit to overturn that decision and dismiss the lawsuit, as the lower court did for the plaintiffs' claim that the Administration lacked the authority to delay the ACA employer mandate.

The appeal claims that allowing the lawsuit to proceed would "for the first time in our nation's history" let the judicial branch intervene in legislative disputes between the executive and legislative branches and thus violate the constitutional separation of powers doctrine.

PhRMA and AHIP attack Clinton plan to cap out-of-pocket drug costs

The heads of the Pharmaceutical Research and Manufacturers of America (PhRMA) and America's Health Insurance Plans (AHIP) were quick to rebuke proposals this week from former Senator and Secretary of State Hillary Clinton (D) that seek to reign in out-of-pocket costs for specialty drugs.

Secretary Clinton, the front-runner for the Democratic presidential nomination, released her plan to coincide with public outrage over the decision by Turing Pharmaceuticals to dramatically hike the cost of a life-saving medication by 4,000 percent. After pharmaceutical groups like PhRMA and BIO took the rare step of disavowing themselves from Turing's action, chief executive officer Martin Shkreli ultimately agreed to curb the price increase for the 62-year old drug Daraprim (which went from $17.50 to $750), but has yet to disclose a new price level.

Clinton insisted that her proposal would drive down the costs of prescription drugs by $100 billion over ten years, mostly through long-sought Democratic proposals to expand drug rebates under Medicare, increase generic competition by banning "pay to delay" patent litigation settlements, allow for drug re-importation from other countries and give Medicare the authority to negotiate lower drug prices for Part D—authority that is specifically prohibited by the Affordable Care Act (ACA). She argued that they were necessary to curb "excessive profiteering" and "outrageous" price hikes by drugmakers.

These proposals largely mirror those sought by her main rival Senator Bernie Sanders (I-VT) in legislation he reintroduced earlier this month (S.2023). While Clinton's plan notably does not include Sander's proposal for drug manufacturers to disclose pricing information, the centerpiece of her plan goes a step further that S.2023 by capping out-of-pocket costs for specialty medications to $250 per month, comparable to caps instituted earlier this year by the Covered California health insurance Marketplace created by the ACA and sought or implemented in several other states (see Update for Weeks of May 18th and 25th).

Former Centers for Medicare and Medicaid Services (CMS) Administrator Marilyn Tavenner (who now heads AHIP) insisted that imposing "arbitrary" out-of-pocket caps or "[forcing] government

negotiation on prescription drug prices" without addressing the "underlying price of the drug" would simply result in higher premiums for consumers. She also criticized Clinton for appearing to place the blame on insurers by expanding the authority of states under the ACA to block or modify "excessive, double-digit rate increases without clear justification." Tavenner urged Clinton to instead focus on "greater transparency around drug pricing and more competition in the market."

PhRMA President John Castellani was equally critical of Clinton's plan, claiming that it was "driven by a false notion that spending on medicines is fueling overall health care cost growth" and warning that it would "restrict patients' access to medicines" and "result in fewer new treatments."

Clinton released additional proposals later in the week that include new refundable tax credits of up to $5,000 for low-income families (and $2,500 for individuals) that could be applied towards out-of-pocket costs not covered by insurers. The tax credits would be available only to those ineligible for Medicare whose out-of-pocket expenses exceed five percent of their annual income.

Health plans would also be required to cover three sick visits per year that do not count towards a subscriber's annual deductible.

House effort to repeal ACA tax on high-cost plans now has bipartisan majority

Two bipartisan measures to repeal the Affordable Care Act (ACA) tax on high-cost or so-called "Cadillac" health plans have now gained the support of 228 of the 438 House members.

The *Middle Class Health Benefits Tax Repeal* Act sponsored by Rep. Joe Courtney (D-CT) (H.R. 2050) has at least 143 cosponsors while a related measure introduced by Rep. Frank Guinta (R-NH) (H.R. 879) has another 85. Both are expected to be marked up in the House Ways and Means Committee this fall.

Senator Bernie Sanders (I-VT), who is seeking the Democratic presidential nomination, reintroduced his own bill this week to repeal the 40-percent excise tax, which does not go into effect until 2018 but is a major source of projected revenue under the ACA. Despite the backing of seven prominent Senate Democrats, the bill's proposal to offset the cost loss of $87 billion over ten years by increasing taxes on the wealthiest Americans is not likely to draw the necessary Republican support.

The "Cadillac" tax applies to the portion of each worker's employer-sponsored health benefits that exceed set thresholds (initially $10,200 for self-only coverage and $27,500 for family coverage). The tax was intended to keep large employers like IBM or Verizon from offering overly-generous coverage that result in over-utilization and consequently higher medical spending and premiums. However, a public-private coalition of labor unions, health insurers and business groups such as the Alliance to Fight the 40 and the National Business Group on Health (NBGH) contend that the tax effectively penalizes employers with sicker or older workers or those in riskier jobs, as well as employers based in more expensive parts of the country.

NBGH reported last month that surveys show that at least one benefit plan offered by nearly half of large employers will be subject to the 40 percent tax, despite advance cost-cutting measures. A recent survey by the Kaiser Family Foundation predicted that about 26 percent of employers offering health benefit plans would be subject to the tax in 2018, a figure that would rise up to 42 percent by 2028 unless employer eliminate benefits, hike deductibles, or further narrow their provider networks (see Update for Weeks of August 17th and 24th).

Should a repeal bill pass both chambers, President Obama has pledged to veto it. However, the front-runner for the Democratic presidential nomination, Hillary Clinton, has hinted that she may support a "Cadillac" tax repeal.

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FEDERAL AGENCIES

HHS says 17.6 million have gained coverage through ACA

The Department of Health and Human Services (HHS) released new figures this week showing that about 17.6 million consumers have gained health insurance due to the Affordable Care Act (ACA).

The figure represents roughly a seven percent increase from last spring, when HHS reported that about 16.4 million had gained coverage (see Update for Week of March 16th). It includes nearly ten million that have paid for premiums in federal and state Marketplaces, as well as young adults allowed to remain on their parents' group coverage and those made newly-eligible for Medicaid in 30 states.

The agency estimates that roughly 10.5 million consumers remain uninsured despite being eligible to enroll in Marketplace plans and that this group likely represents those hardest to reach through enrollment and marketing efforts. Roughly half of the remaining uninsured are young adults between the ages of 18-34, many of whom often forgo coverage until they need it. More than a third belong to minority groups where language or other cultural issues can often create barriers to enrollment. According to HHS, 40 percent of this uninsured group has incomes that put them in "working class" populations that are often caught in the coverage gap created by states refusing to participate in the ACA Medicaid expansion.

The HHS Secretary noted that since the ACA Marketplaces opened in October 2013, the uninsured rate has falling most precipitously among Latino American adults (11.5 percent), compared to 10.3 percent for African American adults and six percent among white adults.

HHS will focus enrollment efforts during the upcoming open enrollment period (starting November 1st) on uninsured consumers in five major metropolitan areas (Miami, Chicago, Dallas, Houston, and northern New Jersey).

The Congressional Budget Office predicts that after the 2016 open enrollment period, more than 21 million individuals will be covered through ACA Marketplace plans.

Census data shows nearly nine million uninsured Americans gained coverage during 2014

The percentage of Americans without health insurance dropped by nearly three percentage points from 2013 and 2014, according the latest figures released last week by the U.S. Census Bureau.

The decrease from 13.3 percent to 10.4 percent translates to a net gain of 8.8 million insured Americans. The three percent drop is the largest that the Census has recorded since it started using this tracking measure in 2008.

Despite the coverage gain, the Census found that 33 million people remain uninsured. In addition, the gains in coverage were not equal among every category, even though every age, income group, and ethnicity improved in every state.

For example, the largest increases were among those with employer coverage (3.2 percent) and those becoming eligible for Medicaid (two percent), due primarily to 30 states electing to participate in the Medicaid expansion under the Affordable Care Act (ACA). The latter was reflected by the fact that the uninsured fell most precipitously for consumers with the lowest income (4.5 percent for those earning less than $25,000 per year and five percent for those earning $25,000-$50,000 per year). For those earning above $100,000, the uninsured rate fell by only less than a percentage point.

Similarly, the uninsured rate fell most precipitously for those ethnic groups most likely to be uninsured (more than four percent for Latinos, Asians, and African Americans).

Texas continues to lead the nation with the highest uninsured rate, despite falling below 20 percent for the first time in a decade. However, it has now eclipsed California for the most net uninsured residents (more than five million) thanks to California's decision to expand Medicaid while Texas chose not to do so.

Massachusetts continues to have the lowest uninsured rate at only 3.3 percent despite dropping only 0.4 percent, as it did prior to the ACA. This was due to the landmark health reforms in 2007 that became the model for the ACA.

Kentucky had the largest drop in their uninsured rate at nearly six percent, thanks largely to huge gains in Medicaid and Marketplace coverage.

Medicare Advantage premiums remain stable despite jump in enrollment

The Centers for Medicare and Medicaid Services (CMS) announced this week that premiums for private Medicare Advantage (MA) plans will remain mostly stable for 2016 due to a "competitive and transparent marketplace."

The average monthly premium for MA plans will drop by 31 cents to $32.60, while 59 percent of plan participants will not see any increase in their premiums. According to CMS, the relatively flat premiums should increase enrollment next year to 17.5 million consumers, or nearly a third of total Medicare enrollment. That translates to nearly a nine percent increase, on top of the comparable increase from 2014 to 2015.

CMS officials note that average premiums will have decreased next year by nearly ten percent since the enactment of the Affordable Care Act (ACA), while enrollment will have spiked by more than 50 percent. They were quick to emphasize that the success of the program contradicts claims by ACA opponents that the ACA's effort to restrict the growth in MA payments would limit benefits and enrollment.

Analysts with the Avalere Health consulting firm also pointed out that roughly 79 percent of Medicare enrollees currently have access to a MA plan that does not charge any premiums for 2015 and 48 percent of MA enrollees are enrolled in such zero-premium plans.

CMS anticipates that premiums for Medicare Part D will likewise remain stable for 2016. They claim this is due to reductions in per beneficiary spending below the catastrophic level that offsets the increased per beneficiary spending above the catastrophic level (which is about $7,500 for 2015).

New study shows 340B program is larger than previously estimated

A new study released last week by the Community Oncology Alliance (COA) concluded that the federal 340B drug discount program is significantly larger than previous estimates have shown.

Researchers at the Berkeley Research Group (BRG) found that much of the growth is concentrated in oncology drugs. For example, 340B hospitals accounted for 58 percent of all Medicare Part B hospital outpatient drug reimbursements in 2013. For just oncology drugs, 340B hospitals accounted for over 60 percent of reimbursements. During the study period of 2010-2013, both metrics increased 43 and 47 percent respectively.

The study also documented that the average Part B reimbursement for oncology drugs is 52 percent higher in 340B hospitals than community cancer clinics (when compared on a per Medicare beneficiary basis). During the same study period, 340B hospitals saw a 123 percent increase in total Part

B reimbursement for oncology drugs compared to a 31 percent increase at non-340B hospitals and a five percent decrease for community oncology clinics.

COA used the findings to support their argument that the 340B program has "grown way beyond the original congressional intent" and that Congress should act to reduce the "huge profit incentives for hospitals, and its role as a major driver of cancer care costs." They reference the recent Government Accountability Office (GAO) study concluding that this "financial incentive to maximize Medicare revenues through the prescribing of more or more expensive drugs at 340B hospitals…raises potential concerns about the appropriateness of the health care provided to Medicare Part B beneficiaries."

HEALTH CARE COSTS

Kaiser analysis shows only a 3.1 percent average silver plan premium hike for major cities

A Kaiser Family Foundation analysis of preliminary rate filings by insurers shows only a 3.1 percent average increase for 2016 for major cities in 12 states and the District of Columbia (and only a one percent post-subsidy hike).

The initial review compared premiums from 2015 to 2016 only for the second-lowest cost silver tier "benchmark" plan upon which the Affordable Care Act (ACA) premium tax credits and cost-sharing subsidies are based. They were also limited to premiums for a 40 year old non-smoker earning $30,000 per year.

The highest average increase of nearly 23 percent was for residents in Portland, Oregon. However, this increase was nearly wiped out (to only 0.2 percent) for those receiving ACA subsidies.

Albuquerque, New Mexico was the only other city that Kaiser found to have a double-digit average increase (at 11 percent). That increase was unchanged for subsidy recipients. (Albuquerque also saw nearly a 12 percent decline from 2014 to 2015).

Four cities actually reported average decreases (Hartford, Detroit, Los Angeles, and Seattle). Seattle was the only city for which the decrease exceeded ten percent (at 10.1 percent). This the second year in a row that "benchmark" premiums have fallen in Seattle by roughly ten percent.

"Benchmark" premiums for the 12 cities had actually decline on average by 1.3 percent last year, so premiums for 2016 are actually increasing by about four percent overall.

The average increase for the lowest-cost silver tier plans for the same 40 year old is slightly higher at 4.2 percent (and 2.5 percent post-subsidy). This is largely due to significantly higher average premiums in three cities (Providence, Richmond, and Seattle). However, the average increase among lowest-cost silver plans is much lower for Portland Oregon (13.3 percent compared to 22.8 percent for "benchmark" plans).

Four percent increase in employer plan premiums is lowest in a decade

The most recent annual survey of employer health benefits released by the Kaiser Family Foundation shows that premiums for employer-based coverage are increasing by an average of only four percent this year for both individual and family coverage.

The four percent increase from 2014 is the smallest bump in a decade and follows several years of five percent annual growth since 2005 compared to 11 percent annual growth from 1999 to 2005. The percentage of both large and small employers offering health coverage also remained "statistically unchanged", as did the number of workers enrolled in employer-sponsored plans.

According to the survey of nearly 2,000 large and small companies, annual premiums now average $6,251 for single coverage and $17,545 for family coverage. Individual workers contributed an average of $90 per month for their coverage, compared to $413 per month for family plans. (This is an increase from $75 and $333 respectively in 2010).

Kaiser study shows deductibles are outpacing wage increases

A new study released this week by the Kaiser Family Foundation shows that increases in average deductibles for employer health plans have far outpaced wage increases over the past five years.

According to the study, average deductibles for large group plans exceeded $1,300 this year and broke $1,800 for small employers. One in five workers now must satisfy an annual deductible of at least $2,000.

The current averages are more than six times the $900 annual average in 2010 (when the Affordable Care Act (ACA) was passed) and have increased seven times faster than wages since that time. Researchers attribute some of the increase to high deductibles required by lower-tier bronze and silver plans in the new health insurance Marketplaces. Other employers also increased deductibles in order to respond to separate costs imposed by the ACA, including the 40 percent excise tax on high-cost or "Cadillac" plans that will not go into effect until 2018 (see above).

While employers have increasingly relied on higher deductibles to shift costs to workers, the study also notes that plan premiums have been far lower than in years past (see above).

According to The Commonwealth Fund, the greater share of worker costs is increasingly causing more to forgo needed care due to cost. Their data shows that 40 percent of privately-insured individuals forgo care when their deductible equals at least five percent of their income.

STATES

Federal audits find that state ACA Marketplaces are still not fully operational

Audits performed by the Government Accountability Office (GAO) and the Office of the Inspector General (OIG) for the Department of Health and Human Services (HHS) found that the 14 state-based Marketplaces (SBMs) created pursuant to the Affordable Care Act (ACA) lack adequate controls to ensure that benefits and subsidies are received only by eligible applicants.

The results released this week follow-up on the August OIG report that similarly found inadequate internal controls in the federally-facilitated Marketplaces (FFMs) during the inaugural open enrollment period. HHS insists that those deficiencies have since been corrected.

However, the GAO review of the 14 SBMs operating as of February 2015 revealed many of the same problems, concluding that no state was "fully operational" in the four designed performance categories. For example, the GAO found that that New York financial management functions (like collecting premiums) remained only partially completed. Meanwhile, the OIG review of 45 randomly selected applications showed that NY State of Health failed to follow federal regulations in 28 cases (or 62 percent of the sample). However, the OIG auditors were unable to identify any specific instance where a deficiency led to an applicant receiving improper benefits.

The Vermont SBM received the highest score, despite early struggles with technological glitches that severely impaired initial enrollment. It was deemed by GAO to be fully operational in three of the four categories (receiving only a partial score for hub services).

The Connecticut SBM, whose software has been imported to the Maryland SBM (see Update for Weeks of March 17 and 24, 2014), surprisingly received only a partially operational score in all four categories despite its enrollment success. GAO specifically cited Access Health CT for relying on manual processes instead of automation, which caused delays in determining an applicant's citizenship or potential Medicaid eligibility.

GAO also blamed the federal Centers for Medicare and Medicaid Services (CMS) for "conditionally pass[ing] all of th[e] states without fully ensuring that they had conducted all required system testing and demonstrated that their systems were ready for production."

A separate OIG audit found other security and technical vulnerabilities in consumer data collected under the ACA for both FFMs and SBMs. CMS insists that they have been correcting the deficiencies in that data repository (which includes income, employment, and citizenship information) since early this year.

Arizona

Medicaid seeks to impose premiums, work requirements, and five-year limit on all enrollees

Officials with the Arizona Health Care Cost Containment System (AHCCCS) released details of their proposed federal waiver this week that would impose premiums and copayments for all enrollees, institute a new work requirement, and limit lifetime Medicaid enrollment to no more than five years. Enrollees that fail to pay premiums for six months or report income or work status changes could also be automatically disenrolled from Medicaid.

The proposed Section 1115 demonstration waiver would require approval from the Obama Administration, which thus far has rejected lifetime limits and work requirements proposed by conservative lawmakers in other states (see Update for Weeks of April 6th and 13th). In addition, the Administration has limited the situations in which premiums could be charged for those earning less than 100 percent of the federal poverty level (see Update for Weeks of June 8th and 15th) and not allowed automatic benefit terminations for failure to report income or pay premiums.

One feature of the new waiver proposal may be considered by the Administration as it resembles the health savings accounts that were recently incorporated into alternatives to the Medicaid expansion under the Affordable Care Act (ACA) that were federally-approved for Indiana and Michigan (see Update for Week of July 20th). The accounts would primarily be funded through enrollee premiums, though employers and charitable organizations like PSI would also be able to contribute funds. Enrollees may use funds in their account to pay for supplemental benefits not covered by an AHCCCS managed care plan. However, the account would be maintained and managed by third-party administrators.

The proposed waiver is the results of two measures enacted last session by the Republican-controlled legislature and signed into law by Governor Doug Ducey (R). It made Arizona the first state to try and modify their traditional ACA expansion. Governor Ducey's predecessor had made Arizona the first Republican-controlled state to participate in the traditional expansion (see Update for Week of June 10, 2013). However, the hospital assessment used to fund that mechanism is currently facing a legal challenge filed by Republican lawmakers (see Update for Weeks of August 17th and 24th).

District of Columbia

Public hearing scheduled on bill to limit specialty drug copayments

The Committee on Business, Consumer, and Regulatory Affairs has scheduled an October 28th public hearing on B21-32, the *Specialty Drug Copayment Limitation Act of 2015*.

Introduced in January, the bill would limit the amount of copayment or coinsurance that individuals must pay for a prescribed specialty drug to $150 per month for up to a 30-day supply (see Update for Week of January 19th).

Individuals and representatives of organizations who wish to testify at the public hearing should contact Faye Caldwell of the Committee on Business, Consumer, and Regulatory Affairs by October 26th at fcaldwell@dccouncil.us.

Florida

Proposed rule would clarify "good cause" bases for switching Medicaid managed care plans

The Agency for Health Care Administration (AHCA) is holding a Rule Development Workshop on October 1st relating to draft regulations that defines the "good cause" situations in which Medicaid managed care enrollees can switch plans. Florida's Statewide Medicaid Managed Care program requires nearly all Medicaid enrollees to be covered under the capitated plans but allows them to switch plans under certain "good cause" circumstances. The proposed rule would clarify that these circumstances include a documented disruption in his or her treatment or plan of care, the inability of the plan to provide services in his or her region, or the enrollee missed open enrollment due to a temporary loss of eligibility.

Massachusetts

Committee to hold hearing on impact of specialty drug costs

The Joint Committee on Public Health has scheduled a September 29th public hearing on H.B. 2072, which would require that the Health Policy Commission annually conduct an analysis on the impact of specialty drug costs on Massachusetts' cost containment benchmark. The bill would require a report to be issued to the legislature on July 1st of every year as well as annual cost containment hearings.

Witnesses at the public hearing must include at least three pharmaceutical companies, one of which does business in specialty pharmacy.

North Carolina

Governor signs bill to fully privatize Medicaid

Governor Pat McCrory (R) signed legislation this week that will transform Medicaid from fee-for-service to a fully managed care system by 2019, depending on federal approval.

H. 372 was passed earlier in the week by the Republican-controlled legislature after several years of wrangling over the extent that Medicaid would rely on private managed care plans to provide coverage for medical services (managed care had previously only applied to behavioral services under Medicaid).

Under H. 372, the state will ultimately switch to a model that contracts with only three managed care plans to cover Medicaid enrollees statewide. However, the legislation also calls for the creation of up to ten locally-operated networks of doctors and hospitals or provider-led entities (PLEs) that will offer plans across six newly-created regions of the state. Medicaid benefits will be the same statewide, regardless of whether the enrollee is in a managed care plan or a PLE.

The House had initially passed legislation that would have solely relied on PLEs (see Update for Week of August 10th), which they favored 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 preferred instead to start with MCOs. Similar to Medicaid managed care models in

place in 39 other states, all plans will receive a per-patient capitated payment and be responsible for any cost overruns.

The bill requires North Carolina to submit a request for a federal demonstration waiver by June 2016 and implement the model no later than 18 months after receiving federal approval.

The legislation specifically does not allow North Carolina to participate in the Medicaid expansion under the (ACA, as lawmakers rejected all Democratic amendments to do so (see Update for Week of August 10th). Governor McCrory and several Republican leaders have opened the door to that possibility in the future and insisted this week that he was continuing to assess whether to expand Medicaid once certain Medicaid reforms were implemented (see Update for Weeks of February 9th and 16th). The Governor has suggested that some form of "private sector" alternative may be considered—similar to that which has been federally-approved for six states. However, the preliminary model he has discussed with the Obama Administration included work requirements for able-bodied adults that have been stripped out waivers the Administration ultimately approved for Pennsylvania, Indiana, and Michigan (see Update for Weeks of April 6th and 13th).

Washington

Marketplace eliminates premium aggregation for individual Marketplace

After weeks of warnings, the Washington Healthplanfinder started requiring consumers enrolled in qualified health plans (QHP) to make direct payments to insurers as of September 24th.

Washington was one of only four states (including Massachusetts, Rhode Island, and Vermont) that exercised the option under the Affordable Care Act (ACA) to aggregate individual Marketplace premiums and then forward combined funds to insurers. However, the governing board voted last December to stop acting as a "middleman" and require direct payments to the 16 participating insurers, which is the norm in most ACA Marketplaces.

The move is intended to prevent persistent technological glitches with the web portal from causing missed payments, lapsed coverage, and incorrect bills (see Update for Weeks of August 17th and 24th). It will apply to all 155,000 enrollees in the individual Marketplace, but not the small group Marketplace, which the ACA requires to use premium aggregation.

As of late August, only about a quarter of enrollees were sending payments directly to insurers (including only about 21 percent for the dominant carrier Premera Blue Cross).

Healthplanfinder officials stress that the change will not affect the calculation or application of premium tax credits and cost-sharing reductions provided under the ACA.