



Health Reform Update – Week of December 7, 2015

CONGRESS

ACA repeal bill may be delayed as CBO projects increased deficits in future years

The Congressional Budget Office (CBO) may have halted momentum on Senate-passed legislation to repeal key provisions of the Affordable Care Act (ACA), as the non-partisan budget scorekeeper predicted this week that it would actually increase federal deficits in years after 2025.

Although the new score projects that eliminating the individual and employer mandates, Medicaid expansion, and ACA subsidies would initially cut the budget deficit by nearly \$296 billion in the first ten years, CBO found that the loss of \$91 billion in ten-year revenue from the 40 percent excise tax on high-cost or “Cadillac” health plans would have the opposite effect in subsequent years and thus violate the budget neutral conditions of the reconciliation process, which allowed the Senate to pass the bill with less than 60 votes (see Update for Week of November 30th). As a result, House and Senate Republican leaders were quick to suggest that the House may delay voting on the bill (H.R. 3762) until early next year, although they insisted the delay would be due to work on separate legislation to fund the government and extend certain tax breaks.

The adverse impact on the deficit was the reason Senate Majority Leader Mitch McConnell (R-KY) initially proposed only suspending the “Cadillac” tax until 2025 (from its inception in 2018). It also is pushing some Democrats to instead include only a two-year delay as part of the tax extenders package. Although all but nine Senate Democrats voted for an outright repeal of the “Cadillac” tax, but that was part of a bill that the President had pledged to veto. It is less clear that Democrats could override the President’s veto of a stand-alone measure to repeal the “Cadillac” tax without an equivalent offset for one of the ACA’s major sources of revenue.

MedPAC deciding whether to cut Medicare payments for 340B drugs by ten percent

The Medicare Payment Advisory Commission (MedPAC) is debating a ten percent cut in Medicare payments for outpatient drugs furnished to safety-net providers that participate in the federal Section 340B drug discount program.

Commissioners will vote in January whether to include the draft recommendation as part of its annual report to Congress in March. Several expressed a reluctance this week to move into the 340B area. However, commissioners cited concerns about the 340B program having the unintended effect of spurring hospital acquisitions of physician practices and thus increasing costs for Medicare.

Congress has heavily criticized the Health Resources and Services Administration (HRSA) since 2011 when federal auditors claimed that 340B providers were reaping “windfall profits” when using discounted 340B drugs to also treat Medicare or private insurance patients (see Update for Weeks of July 1 and 8, 2013). A Government Accountability Office (GAO) report earlier this year found that Medicare Part B drug spending was substantially higher per beneficiary at 340B hospitals than at non-participating hospitals and recommended that Congress consider eliminating financial incentives for 340B providers to overprescribe (see Update for Weeks of June 29th and July 6th).

The draft MedPAC recommendation was based largely on briefing materials concluding that 340B hospitals were not sufficiently using drug savings to expand community services. This includes an Avalere Health study showing that 40 percent of 340B hospitals provided less than the national median share of uncompensated care (see Update for Week of March 23rd),



FEDERAL AGENCIES

Federal Marketplace adds nearly 800,000 consumers as first deadline approaches

The latest figures released by the Department of Health and Human Services show that 2.84 million consumers have signed-up for 2016 coverage in the 38 states using the federal web portal.

Total enrollment increased by more than 804,000 during the fifth week of open enrollment. Consistent with previous years, it is expected to climb further as the December 15th deadline for January 1st coverage approaches. Roughly one million of the 2.84 million enrollees are new consumers.

Florida continues to lead all federal Marketplace states with nearly 600,000 enrollees, almost doubling the second closest state of Texas with just over 317,000. North Carolina, Georgia, Pennsylvania, and Virginia are the next closest states though none has more than 200,000 enrollees.

CMS says no more grace periods for Marketplace consumers that miss enrollment deadline

Centers for Medicare and Medicaid Services (CMS) officials confirmed this week that federally-facilitated Marketplace (FFM) consumers will not get a grace period to sign-up for 2016 coverage if they miss the January 31st close of open enrollment and do not qualify for a special enrollment period (SEP) due to a qualifying life event.

Nearly 944,000 FFM consumers used the SEP period to enroll in 2015 coverage (see Update for Week of August 10th). Most qualified for special enrollment due to a life event such as marriage, divorce, or a change in family size or citizenship status. These events also include a loss of minimum essential coverage or eligibility for the premium tax credits offered by the Affordable Care Act (ACA).

However, 15 percent (or 144,000 consumers) qualified because they did not realize until filing their taxes that they were subject to tax penalties under the ACA's individual mandate (see Update for Week of August 10th). These consumers were still required to pay the penalty but allowed to enroll in 2015 coverage after the open enrollment deadline (see Update for Weeks of March 2nd and 9th).

In an effort to boost open enrollment for 2016, CMS emphasized this week that a similar SEP will not be available to consumers who are subject to the individual mandate and miss the January 31st deadline. The 144,000 FFM consumers that took advantage of last year's grace period was also dramatically below initial projections (see Update for Week of March 30th).

The early CMS announcement sought to assuage concerns from insurers like UnitedHealth Group, which hinted late last month that it may exit the two dozen Marketplaces in which it participates. UnitedHealth had complained that previous grace periods were causing consumers to delay sign-ups and making it difficult for insurers to accurately predict Marketplace enrollment.

For 2016, penalties under the individual mandate rise to \$695 or 2.5 percent of taxable income. It will be increased by a cost-of-living adjustment in subsequent years. According to the Kaiser Family Foundation, the average household penalty will actually rise from \$661 to \$969. Those eligible for ACA subsidies that choose to remain uninsured will face an average penalty of \$738 per household while other households could pay an estimated \$1,450 on average.

Individual PPOs are lifting annual out-of-pocket limits for out-of-network care

Robert Wood Johnson Foundation researchers reported last week that an increasing number of preferred provider plans (PPOs) are eliminating annual limits on out-of-pocket (OOP) costs for out-of-



network coverage, in response to the new OOP limits that the Affordable Care Act (ACA) requires for in-network care.

According to the new study, 45 percent of silver-tier PPO plans coming into the individual market for the first time in 2016 have no ceiling on the amount of OOP costs that subscribers may incur when they go to out-of-network providers, and 30 percent of silver-level PPOs have no such limit. This is a dramatic increase from 2015, when only 14 percent had no annual maximum.

The lack of OOP limits for out-of-network care can be found among the PPOs offered by some of the nation's largest insurers. For example, all of UnitedHealth's plans in Arizona have no such limits while Blue Cross and Blue Shield has removed them for the first time from their PPO plans offered in Illinois, New Mexico, and Oklahoma.

The trend threatens to impose surprise costs on subscribers who either assume that the in-network caps required by the ACA to also apply to out-of-network care or are unaware that care provided at an in-network facility is actually being rendered by out-of-network contractors (see Update for Week of November 30th). For 2016, the ACA limits annual OOP costs for in-network care to \$6,850 for individuals and \$13,700 for family coverage.

Although most PPOs previously had out-of-network limits, they tended to be much higher than OOP limits for in-network care. For example, the mean OOP cap last year for out-of-network care in individual market silver-level PPOs was \$16,700.

Study finds that HIV drug access remains limited under silver Marketplace plans

A new analysis released last week by Avalere Health found that access to HIV/AIDS drugs continues to be restricted by silver-level Marketplace plans despite the efforts of several state insurance departments to curb discriminatory insurer practices.

According to researchers, silver plans in 31 states (and the District of Columbia) cover less than seven of the ten most common drug treatment options or stick HIV/AIDS consumers with more than \$200 per month in cost-sharing charges. Only 16 percent of silver Marketplace plans cover all ten of the top HIV/AIDS drug regimens and charge less than \$100 a month.

The AIDS Institute cited the study as "more ammunition showing that many plans are engaging in discriminatory plan designs." They had joined with the National Health Law Program last year in filing a federal civil rights complaint against four Marketplace insurers in Florida who were moving all or most HIV/AIDS drugs into specialty tiers with exceptionally high coinsurance amounts (see Update for Week of June 2, 2014). That practice was determined to be discriminatory by both the U.S. Department of Health and Human Services and Florida Office of Insurance Regulation (see Update for Week of February 23rd), which entered into settlement agreements that forced the insurers to move away from specialty tier coinsurance for HIV/AIDS drugs, at least for benchmark silver-tier plans.

STATES

Arkansas

State agency issues notice of intent to continue Medicaid expansion alternative

The Department of Human Services released a public notice last week stating its intent to ask the federal government for permission to continue its Medicaid expansion waiver past its expiration date on December 31, 2016.



Arkansas was the first state to receive federal approval to use matching funds provided under the Affordable Care Act (ACA) to purchase Marketplace coverage for those made newly-eligible for Medicaid under the expansion (see Update for Week of September 25, 2013). Six other states have since received federal approval for similar models (see Update for Week of November 30th).

According to the draft extension application that is open for public comment this month, the so-called "Private Option" has successfully provided coverage to more than 225,000 Arkansans and has resulted in one of the nation's steepest declines in uninsured (see Update for Week of August 10th). However, the program has met stiff opposition in a legislature that is now fully under Republican control and the latest annual renewal was made contingent on the state making future reforms to narrow the program (see Update for Weeks of January 26th and February 2nd).

As a result, Governor Asa Hutchinson (R) created an advisory group shortly after assuming office in January that is charged with making recommendations on the "Private Option". These are expected to include his proposals to require those earning 100-138 percent of the federal poverty level (FPL) to pay premiums capped at two percent of income, move lower-income beneficiaries into less-expensive traditional Medicaid, eliminate non-emergency coverage, and mandate job training programs (see Update for Weeks of August 17th and 24th).

The draft extension application notes that the final waiver amendment application next spring will likely incorporate the recommendations from this Health Reform Legislative Task force.

California

Largest California insurers among few to post Marketplace profits nationwide

Data from the U.S. Department of Health and Human Services (HHS) revealed this week that the largest insurers in California were among the few health plans nationwide that profited from selling Marketplace plans in 2014.

The figures were released as part of the temporary risk corridors and reinsurance program created by the Affordable Care Act (ACA), which is intended to compensate insurers with substantially higher claims cost than anticipated. However, the program currently has a \$2.5 billion shortfall as most insurers incurred \$2.87 billion in losses on 2014 Marketplace business (see Update for Week of September 28th). According to HHS, the three largest California insurers (Blue Shield, Kaiser Permanente, and Anthem Blue Cross) accounted for half of the \$362 million in total profits earned by Marketplace insurers in 2014.

Analysts point out that the federally-facilitated Marketplace and most state-based Marketplaces were plagued by technical glitches during the early months of the 2014 open enrollment period that severely depressed initial enrollment and contributed to the disproportionate number of insurers losing money (see Update for Week of November 11, 2013). The three California insurers benefited from the fact that California operated a successful Marketplace that led all states in 2014 enrollment (see Update for Week of April 14, 2014).

Idaho

Health department proposes limited Medicaid expansion alternative

The Department of Health and Welfare (DHW) is meeting with state lawmakers, business groups, and health providers to review the agency's proposal for a state-funded but partial alternative to the Medicaid expansion under the Affordable Care Act (ACA).

To date, the Obama Administration has approved requests from seven states for a federal waiver that allows them to pursue an alternative model to the traditional Medicaid expansion and still receive ACA matching funds (see Update for Week of November 30th). However, the Administration has



consistently refused to approve waiver requests that do not fully expand Medicaid to the threshold set by the ACA (those earning 138 percent of the federal poverty level), despite contrary recommendations from groups like the Urban Institute (see Update for Week of August 10th).

Under the plan outlined by DHW, the state would pay primary care providers about \$30 million to cover basic preventive health care for people in the so-called coverage gap between Idaho's current Medicaid eligibility limits and the minimum threshold for ACA subsidies (those earning 100 percent of poverty). The payments would total roughly \$32 per month per covered individual but would not compensate for the costs for emergency room or acute care, hospitalizations, or prescription drugs.

Senator Lee Heider, chair of the Health and Welfare Committee, and Rep. Fred Wood, chair of the analogous House committee, even though it failed to spell out how the \$30 million in payments would be raised. Idaho's cigarette tax is one of the nation's lowest and a repeated target for health reform proposals. However, both cautioned that increasing the cigarette tax could siphon away some support from the expansion alternative.

The proposal will likely not receive federal approval but may serve as a starting point in negotiations with CMS. The legislature previously had rejected all attempts to expand Medicaid despite two pro-expansion recommendations from the Governor's own Medicaid Redesign Workgroup, calling it a "no brainer" to save up to \$173 million over ten years (see Update for Week of January 12th).

Governor Butch Otter (R) backed the expansion alternative pushed by the workgroup (see Update for Week of March 11, 2013). He also made Idaho one of the few Republican-led states to create its own health insurance Marketplace under the ACA (see Update for Week of November 10, 2014), even though it is temporarily defaulting to the federal web portal (see Update for Week of August 10th).

DHW officials acknowledged that their plan is likely to be significantly altered by the January 11th opening of the legislative session. For these reasons, the Idaho Hospital Association and other stakeholders refused to immediately back the plan, stating that it "is not Medicaid expansion and, as a result, it does not fully address all of the needs that are out there."

Maine

Nation's only profitable CO-OP will stop accepting new enrollees after January 1st

Community Health Options announced this week that it will cease all new individual enrollments for 2016 on January 1st due to significant losses it incurred in the third quarter of 2015. The decision applies not just to the federally-facilitated Marketplace (FFM) in Maine, but also to the state partnership Marketplace in New Hampshire to which they expanded in 2015.

The Consumer Operated and Oriented Plan (CO-OP) was one of 23 created with Affordable Care Act (ACA) loans. However, it was the only one to turn a profit in 2014, according to the U.S. Department of Health and Human Services (HHS) (see Update for Weeks of August 31st and September 7th).

Community Health was also the most successful of the CO-OPs, enrolling 257 percent of their project target for 2014 and dominating Maine's FFM. It garnered 83 percent of all enrollees in 2014 when it competed solely against Maine's dominant insurer Anthem Blue Cross and Blue Shield, and maintained an 80 percent market share even when pitted against an additional competitor (Harvard Pilgrim) in 2015.

However, Community Health's success far outpaced initial projections and its ability to pay claims. Once remaining ACA funding was rescinded by Congress (see Update for Weeks of December 24 and 31, 2012) and the ACA reinsurance program paid only 12.6 percent of their obligated reimbursement (see Update for Weeks of October 5th and 12th), Community Health started incurring substantial financial losses.



At least a dozen other CO-OPs have already shut down for the same reasons (see Update for Week of November 30th). However, Community Health officials insisted that they have sufficient reserve funds to continue to serve existing enrollees that renew for 2016 as well as accept new group enrollments. Their chief executive officer remained optimistic that Community Health could start selling new plans “at some point in the not-so-distant future”, especially if HHS honors its pledge to reimburse carriers with exceptional claims for the full amount of the reinsurance payments to which they are entitled.

Unlike struggling CO-OPs in other states, Community Health did not seek a massive premium increase in an effort to pay claims. Instead, it sought and received only a 0.5 percent rate hike for 2016. Overall, premiums in the Maine FFM range only from an average decrease of 1.73 percent to an average increase of 0.54 percent.

According to a Kaiser Family Foundation analysis, the average pre-subsidy premium for benchmark plans in Maine will actually fall by 1.2 percent from 2015. Benchmark plans are the second-lowest cost silver plan upon which ACA premium and cost-sharing subsidies are based.

Enrollment in Maine’s FFM jumped during 2015 to the point where nearly 60 percent of eligible residents used it to purchase coverage (compared to only 36 percent in 2014) (see Update for Weeks of June 29th and July 6th).

South Dakota

Governor backs full Medicaid expansion as part of proposed budget

Governor Dennis Daugaard.(R) released his proposed budget this week for fiscal 2016, which included a plan to fully expand Medicaid pursuant to the Affordable Care Act (ACA).

The Governor had previously only supported a partial expansion to cover the roughly 26,000 South Dakotans caught in the coverage gap between current Medicaid eligibility and the threshold for ACA subsidies at 100 percent of the federal poverty level (FPL). However, the Obama Administration has twice rejected his partial expansion requests and has thus far only approved “private sector” alternatives in seven other states that expanded fully up to the 138 percent of FPL threshold set by the ACA (see Update for Week of November 30th).

Governor Daugaard’s proposal to fully expand to 55,000 South Dakotans via a similar “private sector” model received an informal “go ahead” from the Obama Administration earlier this fall (see September 28th). However, his support for the plan came with several caveats that may not be realized.

The first is that the expansion cannot rely on additional state general fund dollars. Even though the state hospital association backs the plan, there has not been any agreement announced that would fund the expansion through a provider assessment, similar to plans in Arizona, Tennessee, and Utah.

The second is that the Obama Administration must fund 100 percent of the costs for Medicaid-eligible Native Americans through the Indian Health Services. Under the ACA, states are obligated to assume ten percent of the costs for the newly-eligible Medicaid population starting in 2020.

The Governor pledged not to pursue the expansion without the support of Native American tribes nor circumvent the legislature via an executive order. However, legislative approval currently appears unlikely as House Republicans such as Rep. Don Haggar were quick to denounce the plan, insisting that support for any form of Medicaid expansion that accepts federal funds is “definitely not there”. The House has even rejected bills that use only state funds for limited expansions (see Update for Week of February 24th).



Virginia

Hospital association no longer opposes provider contributions to fund Medicaid expansion

The Virginia Hospital and Healthcare Association (VHHA) sent a letter this week to Governor Terry McAuliffe (D) stating its conditional support for a "provider contribution" that would help fund the expansion of Medicaid under the Affordable Care Act (ACA).

Similar assessments have been backed by hospital groups in states like Arizona, Tennessee, and Utah (see Update for Weeks of October 5th and 12th). However, they had been steadfastly opposed by VHHA until concerns over the commonwealth's future share of costs helped doom prior expansion bills.

As a result, VHHA now backs such a funding mechanism so long as the provider contribution program is administered by the private sector, lawmakers protect against contribution funds being diverted to other budget items, and any savings generated by the program goes to assist struggling rural hospitals.

Despite the concession, Republican leaders insisted that they will continue to block any efforts by Governor McAuliffe to expand Medicaid. The Governor made only a symbolic pitch to expand Medicaid last session (see Update for Week of February 23rd) after a bitter standoff in 2014 led to a government shutdown that was resolved only when the Senate shifted to Republican control due to a party switch by one Senator (see Update for Week of September 15, 2014).

Wyoming

Governor includes Medicaid expansion in budget proposal

Governor Matt Mead (R) released his two-year budget proposal calling for the legislature to expand Medicaid when they reconvene in February and cut funding to a number of other state programs in order to cover the shortfall created by falling prices for oil and gas.

Conservative lawmakers in both chambers have steadfastly opposed any form of Medicaid expansion for Wyoming despite the Governor's backing of legislative proposals that would create a "private sector" alternative that was already federally-approved for seven states (see Update for Weeks of February 9th and 16th). However, Governor Mead emphasized that projections from the Department of Health show that the budget shortfall could be largely filled with the \$268 million that participating in the Affordable Care Act (ACA) expansion would bring to the state.