



Health Reform Update –March 7-25, 2016

CONGRESS

Senate report claims CMS ignored consultant warnings that ACA cooperatives would fail

The Senate Permanent Subcommittee on Investigations issued a new report last week accusing the Department of Health and Human Services (HHS) of ignoring consultant warnings that the Consumer Operated and Oriented Plans (CO-OPs) created with Affordable Care Act (ACA) loans were essentially set-up to fail.

A dozen of the 23 CO-OPs have been shut down after being unable to pay outstanding medical claims (see Update for Week of November 30th), resulting in the loss of nearly \$1.2 billion of the \$2.4 billion in ACA loans. However, the report issued by subcommittee chairman Senator Rob Portman (R-OH) found that the independent accounting firm retained by HHS, Deloitte Consulting LLP, had told HHS officials in both 2012 and 2014 that the CO-OP program was poorly designed and managed and would result in the failure of most of the non-profit cooperatives without significant structural changes.

According to panel investigators, Deloitte warned HHS about defective enrollment strategies that allowed CO-OPs to rely on unrealistically low premiums that could not produce enough revenue to cover the health demographics of enrollees. HHS was specifically informed that CO-OPs in Colorado, Louisiana, and Utah all relied on “unreasonable projections of their own growth.” All three have failed.

Despite the additional lack of adequate management and oversight at many of these CO-OPs, the report found that HHS failed to take any corrective action for over a year “nor did it put any co-op on enhanced oversight.” All CO-OPs were given “passing grades” even after five were ultimately subject to corrective action in September 2015. CMS never took any corrective action against five of the 12 failed CO-OPs.

During a hearing held last week on the report, Senator Portman scoffed at claims by the acting administrator for the Centers for Medicare and Medicaid Services that some of the loans to failed CO-OPs would ultimately be recovered.

The Government Accountability Office issued a concurrent report suggesting that HHS oversight of CO-OPs ultimately “evolved” to focus on performance and sustainability.

HHS refuses House Democrats’ request to send warning about high drug prices

The Department of Health and Human Services (HHS) has rejected the March 2nd request from a group of House Democrats to break drug manufacturer patents whenever high drug prices restrict consumer access to the product.

The letter from Rep. Doggett (D-TX) had asked that HHS order the National Institutes of Health to issue guidance on the application of the “march-in rights” authority granted to HHS by Congress in 1980. According to the letter, HHS could break the patent for any drug whose price makes it is no longer “available to the public on reasonable terms.” Rep. Doggett argued that simply issuing the guidance would discourage “price gouging”, however the HHS Secretary claimed that “the statutory criteria [are already] sufficiently clear and additional guidance is not needed.”



The Secretary did affirm that the agency would “use its [march-in-rights] authority when presented with a case where the statutory criteria are met” but cautioned that this authority is “strictly limited”. NIH has rejected the only two requests it has received in the last 12 years.

MedPAC recommends cut in Part B payments for 340B drugs, new changes to Part D

The Medicare Payment Advisory Commission released its annual March report to Congress last week, which included its expected recommendation that Medicare payments for Part B drugs purchased by safety net providers participating in the federal Section 340B drug discount program should be cut by ten percent of the average sales price (ASP).

MedPAC suggests that Congress should restrict how hospitals use the savings from 340B by requiring them to go towards a pool to pay uncompensated care costs.

Hospital and physician groups continue to oppose limitations on how savings are used and argue that the cuts serve only to benefit the pharmaceutical industry and move the influential MedPAC commission into an area that is not part of their mission (see Update for Weeks of January 11th and 18th). However, 14 of the 17 commissioners previously cited concerns about the 340B program unintentionally spurring hospital acquisitions of physician practices and thus increasing costs for Medicare (see Update for Week of December 7th). In addition, they were persuaded by 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),

MedPAC also approved a draft recommendation that may be included in their June report to Congress, which resurrects the Centers for Medicare and Medicaid (CMS) proposal to eliminate two protected drug classes under Medicare Part D (antidepressants and immunosuppressants). CMS was forced to withdraw its recommendation two years ago (which also included antipsychotics) in the face of broad stakeholder opposition (see Update for Week of March 10, 2014). MedPAC insists that protected drug classes are no longer needed for these two categories because they now have adequate generic competition.

The draft recommendations for the June report would also exclude manufacturer drug discounts within the Part D coverage gap from the calculation of enrollees’ true out-of-pocket spending (or TrOOP), as well as eliminate the five percent enrollee coinsurance above the out-of-pocket threshold.

FEDERAL AGENCIES

HHS says nearly 40 percent of Marketplace enrollees are new consumers

The Department of Health and Human Services (HHS) published its final report this week on the third open enrollment period that concluded January 31st, showing that of the 12.7 million consumers that either automatically renewed coverage or signed-up for a plan, nearly five million or 38.5 percent were new customers and 3.5 million (or 27.5) percent represented the critical age 18-34 demographic.

Roughly 76 percent of all enrollees signed-up through the federal web portal that HHS operated for 38 states. Another 24 percent enrolled through state-based marketplaces.

As in prior years nearly 83 percent of all consumers were eligible for the premium tax credits offered by the Affordable Care Act (ACA). The credits averaged \$290 per month, reducing post-subsidy premiums to an average of \$106 per month.



About 8.8 million individuals paid their first month premium by the end of 2015, an increase of nearly 40 percent from 2014 though still 3.5 percent below CMS projections due to a 25 percent rate of attrition (i.e. enrollees who dropped coverage or failed to pay premiums). HHS data revealed that roughly 500,000 enrollees had their coverage terminated after being unable to verify their legal residency status while 1.2 million had their premium tax credits adjust after failing to document their income. Both of these factors contributed to the high attrition rate.

In order for HHS to meet its target of ten million enrollees by the end of 2016, the attrition rate would have to be reduced to no more than 21 percent.

New rules require Marketplace plans to be rated according to network adequacy

The Department of Health and Human Services (HHS) published new regulations earlier this month requiring that insurers participating in the federally-facilitated Marketplaces (FFMs) created by the Affordable Care Act use labels informing consumers about the limitations of each plan's provider network

The move is the latest in a series of efforts by HHS to address mounting consumer complaints about the significantly narrower provider networks utilized by Marketplace insurers in an effort to keep premiums and unexpected losses in check. While consumers previously were able to determine only if their physician or provider was in the plan's network, they had no reliable means to determine the breadth of the provider network. The new rule specifically requires plans to now indicate how the breadth of their provider network compares to other plans offered in the same geographic area.

In addition to the labels, the rule will require "continuity of care" in cases where a physician or provider is dropped from the network without cause. In these cases, consumers must be allowed to continue their treatment with that physician or provider for 90 days.

The rule also makes insurance counseling from navigators available to FFM consumers year-round, instead of just within the annual open enrollment period. It also expands their duties to include instructing consumers how to use their coverage, appeal denials, and obtain exemptions.

HHS used the rule to update the maximum out-of-pocket limits for 2017 to \$7,150 for an individual and \$14,300 for a family.

Studies blame specialty drugs for driving increases in prescription drug spending

Data from the Department of Health and Human Services (HHS) revealed a 13 percent jump in prescription drug spending in 2014, a spike that agency officials termed "remarkable" following the "subdued" increase the year prior.

HHS blames specialty drug costs for the 2014 spike and noted that preliminary estimates suggest a similar jump in drug spending for 2015. The agency currently estimates that drug spending will total about \$457 billion for 2015 or 16.7 percent of all health care spending.

The HHS report contrasted somewhat with the annual survey released last week by the nation's largest prescription benefit manager, Express Scripts. It showed that the average price of brand-name drugs jumped by 16.2 percent in 2015 (and more than 98 percent since 2011). According to Express Scripts, price increases broke 20 percent for one-third of all brand name prescription drugs.

The Express Scripts survey showed that the overall rate of drug spending increase fell by nearly half from the 10.1 percent increase in 2014. However, this may be partly attributable to the fact that the report for the first time included patient copayments and manufacturer rebates. Average monthly drug copayments for Express Scripts consumers actually dropped last year by 3.2 percent.



Researchers attributed much of the increase to the 17.8 percent jump in specialty drug spending, since specialty drugs currently account for 37.7 percent of costs for Express Scripts clients. In addition, the Food and Drug Administration approved 33 new specialty drugs last year.

The survey also revealed that spending increases for the second year of the Affordable Care Act Marketplace averaged 13.6 percent, which was far higher than for other public or private plans handled by Express Scripts. This was attributed to an 8.6 percent increase in utilization due to newly-insured populations entering the Marketplace and no longer needing to forgo care they could not afford.

HHS demonstration to reduce Medicare Part B drug costs draws swift opposition

The Centers for Medicare and Medicaid Services (CMS) unveiled its plan last week to test new models for reimbursing prescription drugs furnished under Medicare Part B.

Part B typically covers intravenous medications provided in physician offices or hospital outpatient centers and reimburses under a formula that pays providers the average sales price (ASP) of the drug plus six percent. However, that formula has long been criticized by the Medicare Payment Advisory Commission (MedPAC) and others for creating an incentive for providers to use expensive products since reimbursement is based on the percentage of drug prices.

Under the two-part proposal introduced by CMS, this formula would change to ASP plus 2.5 percent, in addition to a flat daily \$16.80 fee per drug. The second phase that would not start until 2017 would experiment on five models from the private sector, such as varying payments based on a drug's effectiveness or target disease state, as well as eliminating beneficiary copayments for those drugs deemed to be "high-value medications."

Although the proposal has the backing of AARP and physician groups, hospitals, pharmacies, drugmakers, and other provider groups immediately lined up in opposition to the changes, insisting that they were developed "without thoughtful consideration and stakeholder input." Several Congressional Republicans that chair key committees also blasted CMS' proposal to vary the "experiment on seniors" based on where they live, which they claim will disrupt patient care and limit access.

CMS is seeking public comments for 60 days for implementing the first stage of the proposal.

STATES

Connecticut

Committee advances bill to restore drug copayment assistance for dual eligibles

The Joint Committee on Aging unanimously passed legislation earlier this month that would require the Department of Social Services (DSS) to resume paying Medicare Part D prescription drug copayments that exceed \$15 per month for individuals who are eligible for full Medicaid benefits and have Part D coverage. These payments had been eliminated in fiscal year 2015.

H.B 5283 now awaits consideration by the full House.

Florida

Two consumer protection bills await Governor's signature

The legislature sent two House-passed consumer protection bills this week to the desk of Governor Rick Scott (R).



The first measure (H.B. 1175) would make health care costs more transparent for consumers by requiring that the Agency for Health Care Administration (AHCA) create a website identifying the estimated price for an episode of non-urgent treatment prior to seeking care from a physician, hospital, ambulatory surgery center, or medical equipment supplier (similar to websites already created in California and New Hampshire). Providers also would be required to provide patients with a list of anticipated charges within seven business days of a written request (see Update for Weeks of January 11th and 18th). The measure cleared both chambers with only one dissenting vote.

The second measure (H.B. 221, S.B. 1442) would protect Florida consumers from surprise out-of-network medical bills incurred when consumers received treatment from out-of-network contractors at an in-network facility. Similar protections recently passed the legislatures in both (S.B. 158) and Hawaii (S.B. 2668) and are being considered in other states including California (see above), Hawaii, Minnesota, and Vermont. They also were included in federal Marketplace standards finalized last month by the Obama Administration (see Update for Weeks of February 22nd and 29th) as well as the federal budget proposed by the President (see Update for Weeks of February 8th and 15th).

Governor signs KidCare expansion into law

Governor Rick Scott (R) signed Medicaid conforming legislation last week (H.B. 5101) that includes a provision to expand KidCare coverage to roughly 17,000 children of legal immigrants.

The legislation eliminates the current five-year waiting period for legal immigrants under Florida's version of the State Children's Health Insurance Program (SCHIP) (see Update for Weeks of January 11th and 18th). Because it draws down federal SCHIP funds, the state incurs no new costs for covering the newly-eligible children. The expansion unanimously cleared the House before being incorporated into the larger bill by the Senate (see Update for Week of February 22nd).

Florida is now the 29th state to allow lawfully-residing immigrant children to qualify for coverage

Indiana

Governor to sign bill preventing changes to Medicaid expansion without legislative approval

Governor Mike Pence (R) signed legislation this week codifying his expansion of Medicaid into law and preventing future governors from making changes without legislative approval.

The Governor successfully made Indiana one of only seven states to receive a federal waiver allowing it to create a "private-sector alternative" to expanding Medicaid under the Affordable Care Act (ACA) (see Update for Weeks of January 26 and February 2, 2015). The Governor's plan builds upon the health savings account demonstration waiver that was already in place prior to the ACA. Since it was called the Healthy Indiana Plan, the latest incarnation is called the Healthy Indiana Plan 2.0. It covers more than 370,000 Indianans, including 235,000 previously uninsured and able-bodied adults.

S.B. 165 is intended to make the 2.0 plan permanent once its temporary federal approval expires in 2018. The bill sponsor, Senator Pat Miller (R), insisted that codifying the plans provisions would strengthen Indiana's hand in negotiating an extension, which the federal government will only grant if Indiana can show that requiring even the poorest enrollees to make contributions towards HSAs (used to purchase coverage) reduces unnecessary care.

However, bill opponents including Rep. Charlie Brown (D) insisted that S.B. 165 was simply an effort to strong arm the federal government into restoring a cap on participation that was part of Healthy Indiana prior to the ACA but removed from Healthy Indiana 2.0 (see Update for Weeks of January 26 and February 2, 2015). It also would allow a Republican-controlled legislature to prevent changes to the program should Pence lose to his Democratic challenger.



Only a handful of Republicans opposed S.B. 165, which received a two-thirds majority in each chamber.

Maryland

Senate approves legislation to adopt stricter rules on network adequacy

Legislation that would authorize the Insurance Commissioner to adopt stricter rules on network adequacy by the end of 2017 unanimously passed the Senate last week and will be heard in the Assembly Health and Government Operations Committee on March 31st. Under S.B. 929 sponsored by Senator Katherine Klausmeier (D), the rules would apply to all health plans issued or renewed in Maryland after January 1, 2019.

Montana

Medicaid expansion enrollment and revenue are outpacing projections

The legislative committee created to oversee Montana's expansion of Medicaid under the Affordable Care Act (ACA) reported this week that nearly 38,300 residents have been enrolled since the expansion started on January 1st.

The figure far exceeds the state's initial projection that 23,000 of the roughly 70,000 newly-eligible residents would enroll during the entire first year. In addition, the expansion has already saved the general fund more than \$3 million, while \$21 million in ACA matching funds have allowed the state to pay more than \$38 million in health services.

Montana was the seventh state to receive a federal waiver to create an alternative to the ACA expansion (see Update for Week of December 7th). Nearly 25,000 are being covered under traditional Medicaid (Native Americans, the "medically frail", and those earning less than 50 percent of the federal poverty level), while the remainder are covered through Blue Cross and Blue Shield of Montana.

In a compromise with Republican legislators, Governor Steve Bullock (D) agreed that the newly-eligible population earning from 50-138 percent of the federal poverty level could be charged premiums capped at two percent of income (see Update for Week of December 7th). The committee noted that the state has already collected about 68 percent of the average \$31 monthly premium and that total collections have brought in about \$367,000.

Despite the "incredible" early success of the program, opponents led by Senator Bob Keenan (R) are still pledging to introduce repeal legislation when the legislature reconvenes next year, with Rep. Art Wittich (R) insisting that it is no surprise that "people will over-utilize free stuff."

New Hampshire

House approves Medicaid expansion renewal with modifications

The House voted for a second time last week to renew the New Hampshire Health Protection Program (NHPP) for an additional two years beyond its automatic expiration at the end of this year.

The reauthorization measure (H.B. 1696) now heads to the Senate where it is expected to pass despite several modifications to the Medicaid expansion program. These include copayments for non-urgent use of emergency rooms and requirements that enrollees be employed or pursuing work (see Update for Weeks of February 8th and 15th). However, the House included a severability provision ensuring the program's renewal even if the work requirement is not approved by the Obama Administration, which has stripped out similar provisions in most of the seven other states that have federally-approved alternatives to the Medicaid expansion under the Affordable Care Act (ACA).



H.B. 1696 funds the expansion through premium tax on private health plans serving the expansion population, voluntary donations from acute care hospitals, and transfers from the state high-risk pool. The program will automatically terminate if these funding sources become insufficient to cover the state share of costs (which the ACA caps at ten percent starting in 2020).

New Mexico

Marketplace enrollees flock to non-profit cooperative despite its financial struggles

Officials with the New Mexico Health Insurance Exchange (NMHIX) created pursuant to the Affordable Care Act (ACA) released new figures last week showing that Molina Healthcare garnered the largest market share at the close of the 2016 open enrollment period.

Roughly 37 percent of all NMHIX consumers selected coverage through Molina. However, nearly 35 percent chose New Mexico Health Connections, a figure that was somewhat surprising given the struggles of other non-profit health insurance cooperatives created with ACA loans (see above). Health Connections has already reported losses of \$4.3 million during the first year of NMHIX participation.

Presbyterian Health Plan signed-up another 21 percent while the remaining NMHIX insurer CHRISTUS Health Plan garnered only seven percent.

The four insurers benefited from this year's withdrawal of the state's dominant insurer, Blue Cross and Blue Shield of New Mexico, which refused to participate in NMHIX after its request for a 51.6 percent rate hike (to cover more than \$19 million in losses) was rejected by state regulators (see Update for Weeks of August 31st and September 7th).

Utah

Governor expected to sign partial Medicaid expansion, despite lack of federal approval

The Senate gave final approval last week to a compromise bill that will expand Medicaid only to 16,000 of the 125,000 Utahns that would become eligible if Utah participated in the Medicaid expansion under the Affordable Care Act (ACA).

Democratic leaders strongly objected to the limited expansion, calling it "less than crumbs" compared to the Healthy Utah alternative to the ACA expansion that was advanced last session by Governor Gary Herbert (R) after receiving tentative federal approval (see Update for Weeks of October 5th and 12th). However, Governor Herbert is expected to sign H.B. 437 by March 30th in order to resolve the legislative impasse over expanding Medicaid, even though the Obama Administration has yet to approve any partial expansion plan.

House Majority Leader Jim Dunnigan (R) backed the limited expansion, even though it will only guarantee Medicaid coverage to 12 months even though it will only help roughly 12,500 childless adults and 3,800 adults with children earning up to almost 55 percent of the federal poverty level (FPL). H.B. 437 opponents note that the bill still leaves everyone earning from 55-100 percent of FPL without access to either Medicaid or premium subsidies offered by the ACA.

Senator Jim Dabakis (D) pointed out that Utah was turning down more than \$420 million in ACA matching funds by only partly expanding. H.B. 437 will instead only use \$70 million in federal funds and cost the state only \$30 million, with 45 percent of that cost covered by a hospital assessment (see Update for Weeks of February 22nd and 29th).

Vermont

Senate passes bill requiring greater transparency of drug formularies

The Senate passed legislation last week that would require all health plans participating in the



Vermont Health Benefit Exchange created pursuant to the Affordable Care Act (ACA) to increase consumer transparency relating to prescription drug formularies. The bill (S.216) specifically would force plans to post a searchable database online in which consumers can determine the cost-sharing amounts for covered drugs, including which drugs are placed into specialty tiers requiring higher cost-sharing.

S.216 would also require the Department of Vermont Health Access to use the same dispensing fee in its reimbursement formula for prescription drugs under the federal Section 340B drug discount program as it applies to non-340B drugs furnished to Medicaid enrollees.

Provisions capping prescription drug cost-sharing at the annual out-of-pocket maximums under the ACA were removed from the original legislation, as were those that would have required plans to cover prescription drugs legally purchased from Canada through Vermont's I-SaveRx program to be covered on the same benefit terms as other covered drugs.

The measure now moves onto the House Committee on Health Care.

Washington

Governor vetoes premature bill creating task force on prescription drug costs

Governor Jay Inslee vetoed legislation earlier this month that would have created a task force to recommend measures to reduce patient out-of-pocket costs for prescription drugs.

S.B 6569 would have required that the task force include representatives from patient groups, drug manufacturers, health insurers and the insurance commissioners, hospitals and pharmacists, businesses, and other purchasers. The task force was to be charged with creating “fairness” for patients by proposing changes that would impact the affordability and access to prescription medications, including the use of health benefit designs with specialty tier cost-sharing.

The task force was scheduled to start July 1st with recommendations due to the legislature by December 1st. However, Governor Inslee stated that despite his support for the “worthy bill”, it could not be enacted until the legislature reaches agreement on a supplemental operating budget for 2016-2017, which is a “greater legislative priority.”

House and Senate bills would limit prescription drug cost-sharing

House and Senate measures that would limit consumer cost-sharing for prescription drugs have been reintroduced in the special legislative session that started earlier this month.

The bills (H.B. 2602 and S.B. 6320) would each cap the copayment, coinsurance, or other cost-sharing at \$100 for a 30-day supply of an individual prescription drug, starting January 1st. For non-grandfathered individual or small group plans, the annual deductible for outpatient drugs all could not exceed \$500. Each measure would allow for inflationary increases in these limits.

Both bills were previously introduced during the regular session but failed to advance (see Update for Weeks of January 25th and February 1st).