



Health Reform Update – Week of April 18, 2016

CONGRESS

MedPAC recommends changes to Part D cost-sharing, protected drug classes, and reinsurance

The Medicare Payment Advisory Commission (MedPAC) unanimously voted at their April public meeting last week to recommend that Congress make several changes to the Medicare Part D prescription drug program.

The three-part recommendation includes a proposal to eliminate two protected drug classes under Part D (antidepressants and immunosuppressants), similar to a plan that was scuttled in 2014 by the Centers for Medicare and Medicaid Services (CMS) in the face of stakeholder opposition (see Update for Week of March 10, 2014). Eliminating the protected class designation would mean that Part D plans could include only lower-cost generic versions of these drugs under their formularies. This recommendation also proposed to permit plan sponsors to use additional tools to manage specialty drug benefits as well as streamline the process for making changes to drug formularies.

The second set of recommendations also urge Congress to eliminate all enrollee cost-sharing above the out-of-pocket threshold for Part D (currently \$4,850) and exclude manufacturer discounts within the Part D coverage gap from counting towards an enrollee's true out-of-pocket (TrOOP) spending. Part D's individual reinsurance subsidy would also be lowered from 80 to 20 percent (although the overall 74.5 percent subsidy for basic benefits would be maintained).

Lastly, MedPAC suggests the Congress should change the low-income subsidy under Part D (similar to a proposal by President Obama in his fiscal year 2015 budget) so that copayments for enrollees with incomes at or below 135 percent of the federal poverty level would be lowered while cost-sharing for all enrollees would be eliminated or reduced for generic or preferred multi-source drugs, as well as new biosimilars.

MedPAC staff projected that implementing all three sets of recommendations would save Medicare more than \$10 billion over five years.

FEDERAL AGENCIES

HHS report shows that 2016 Marketplace premiums are lower than initial rate filings projected

According to a new report released last week by the Department of Health and Human Services (HHS), the average premiums for health insurance Marketplaces created pursuant to the Affordable Care Act (ACA) increased eight percent from 2015 to 2016 and only four percent for the 85 percent of consumers receiving premium tax credits.

The authors of the report emphasized that the actual premium increases were far less than the double-digit premium increases that were widely reported during the open enrollment period, which were based solely upon preliminary rate filings. This coincides with an Urban Institute study last fall showing that the premiums for the lowest cost silver plans in 20 states increased by only 4.3 percent from 2015 to 2016, or far less than the "20 to 40 percent" requested increases upon which media outlets initially focused (see Update for Week of November 30th).

HHS researchers pointed out that 43 percent of 2015 Marketplace enrollees actually shopped around and switched plans for 2016, which reduced premiums by an average of \$42 per month. An



unrelated study from Avalere Health largely confirmed these findings, noting that only about a third of 2015 Marketplace consumers kept their coverage for 2016, concluding that “exchange consumers are extremely price sensitive.”

HHS officials also stressed that the enhanced rate review authority granted by the ACA further reduced preliminary rate increases by \$1.5 billion for 2016.

BCBS study shows Marketplace enrollees are sicker and more costly

A new reported released last week by the Blue Cross and Blue Shield Association (BCBSA) provided further support for insurance industry claims that costs to cover consumers in Affordable Care Act (ACA) Marketplaces are far greater than anticipated.

The study shows that enrollees in individual Marketplace plans offered in both 2014 and 2015 were sicker and thus more costly than subscribers in employer-sponsored coverage. According to researchers, Marketplace enrollees had significantly higher rates of diabetes, depression, and heart disease, pushing insurer costs for Marketplace subscribers 22 percent higher on average (\$559 per Marketplace subscriber compared to \$457 per employer-sponsored subscriber).

The findings are not surprising as Congress predicted that a surge of newly-insured enrollees or those transitioning from high-risk pools would increase insurer costs during the first three years after implementation of the ACA. However, the BCBSA study points out that insurers have received only about 12 percent of the federal risk adjustment and reinsurance payments that the ACA intended to compensate for the costs of covering sicker and more costly subscribers (see Update for Week of November 30th).

CMS will allow small business Marketplaces to use direct enrollment through 2018

The Centers for Medicare and Medicaid Services (CMS) is allowing state-based Small Business Health Options Programs (SHOPs) created pursuant to the Affordable Care Act (ACA) to continue allowing direct enrollment through participating insurers through 2018, if they are unable to provide enrollment through an online web portal and have already been utilizing direct enrollment.

CMS will require each SHOP that wants to continue the direct enrollment option to submit a plan to CMS describing how the employer will receive an eligibility determination from the SHOP, how eligible employees and dependents will enroll in a SHOP qualified health plan, and how the SHOP plan issuer will conduct enrollment consistent with applicable rules and policies.

For 2019 and beyond, state-based SHOPs should either have online functionality in place or either default to the federal web portal (www.healthcare.gov), enter into a shared or regional SHOP with other states, or submit a Section 1332 waiver seeking federal permissions to waive online enrollment requirements.

HEALTH CARE COSTS

Avalere study shows that specialty drug access has slightly improved under Marketplace plans

Avalere Health researchers have found that consumers with high-cost conditions like cancer, HIV and multiple sclerosis have better access to high-cost specialty drugs under 2016 silver-level plans offered by Affordable Care Act (ACA) Marketplaces, compared to silver-level coverage in 2015.

The AIDS Institute and National Health Law Program had filed a civil rights complaint with the Department of Health and Human Services (HHS) in 2014, pointing out that Marketplace plans in several



states (including Florida and Illinois) were moving all drugs for certain high-cost conditions into specialty tiers requiring a percentage coinsurance (see Update for Week of June 2, 2014). HHS concurred that the practice may violate the anti-discrimination provision of the ACA and directed state officials certifying qualified health plans for the federally-facilitated Marketplace to evaluate whether insurer benefit designs were discriminatory (see Update for Week of February 23, 2015).

The new report by Avalere examined how silver-level plans have since handled 20 classes of medications that are used to treat complex and expensive diseases. It specifically found that for five classes of drugs (two used to treat cancer, two that treat HIV and one class of multiple sclerosis drugs), fewer plans in 2016 were moving all drugs in the class to their highest-coinsurance tier.

However, researchers emphasized that Marketplace plans still rely heavily on the practice. For example, the percentage of silver-level plans (the most popular plan tier) placing all antiangiogenic cancer drugs into their highest-coinsurance tier dropped only from 57 to 50 percent in 2015. Roughly 25 percent of silver plans applied more than 40 percent coinsurance for this class of drugs in 2015, a figure that fell to 15 percent for this year.

Similarly, the percentage of silver plans placing HIV protease inhibitors into their top plan fell only from 14 to ten percent in 2016, while the percentage of plans charging subscribers more than 40 percent of the total cost of these drugs fell by only three percent in 2016 (from nine percent the previous year).

The AIDS Institute stated that although it was “pleased” with the progress, the goal remains that “there should be no plans” using specialty tier coinsurance to discriminate against persons with high-cost conditions.

PhRMA-backed studies show high out-of-pocket costs limit access to specialty drugs

Two new studies released earlier this month by the University of Pennsylvania have found evidence that requiring insurance subscribers to pay a percentage of the total cost for specialty drugs has significantly restrict access to those drugs.

The studies, which were published in the American Journal of Managed Care, conclude that “high out-of-pocket costs for specialty drugs appear to pose a very real barrier to treatment.” The first study focused on specialty drug coinsurance for three conditions that representation the largest share of specialty drug spending (rheumatoid arthritis, cancer and multiple sclerosis). The latter study specifically focused on how specialty drug coinsurance under Medicare Part D is “reducing or delaying use of a lifesaving class of leukemia therapies.”

Both studies were funded by the Pharmaceutical Research and Manufacturers of America. The first study was also supported by Pfizer.

Prescription drug spending reached record high in 2015

A new report released earlier this month by the IMS Institute for Healthcare Informatics found that United States spending for prescription drugs rose 12 percent last year to a record high of \$425 billion, before taking into account manufacturer discounts and patient assistance programs that actually slowed the net rate of growth.

Researchers attributed the continued climb to the introduction of breakthrough medicines for cancer and Hepatitis C, noting that drugs approved just within the last two years are responsible for more than half of the growth in overall spending. Costs for specialty drugs—which represent \$151 billion in spending—increased by an even faster rate (20 percent).



Researchers predict that prescription drug spending will rise steadily through at least 2020, when it is expected to reach as high as \$640 million.

STATES

UnitedHealthcare withdraws from at least 22 ACA Marketplaces

Insurance giant UnitedHealthcare followed through this week on earlier threats to exit the health insurance Marketplaces created by the Affordable Care Act (ACA) due to an estimated \$650 million loss in Marketplace business for 2016.

The health insurance giant had sat out of the Marketplaces during the inaugural year before jumping into two dozen for 2015. It currently offers plan in 34 state and federal Marketplaces

However, UnitedHealthcare's premiums were not competitive (it was the most expensive plan in Arkansas and Michigan according to Kaiser Family Foundation) and the insurer drew a far more limited and sicker subscriber base than it anticipated. The costlier case mix, combined with the shortfall in ACA reinsurance payments that were intended to compensate insurers for high-cost subscribers (see Update for Week of November 30th) led UnitedHealthcare to incur major losses during its first year of Marketplace business (which only makes up less than 800,000 of its 48 million subscribers).

UnitedHealthcare had also complained that the Obama Administration was too flexible with special enrollment rules, causing many consumers to delay signing-up for coverage until they were sick and preventing insurers from setting premiums that accurately predicted enrollment (see Update for Week of December 7th).

UnitedHealthcare did not identify the "handful" of Marketplaces in which it will remain for 2017, although regulators in New York, Nevada, Virginia, and Wisconsin confirm that the insurer has not notified them of any plans to exit those Marketplaces. However, regulators in 22 states including Alabama, Arizona, Arkansas, Colorado, Florida, Georgia, Iowa, Kansas, Maryland, Massachusetts, Michigan, Missouri, Nebraska, North Carolina, Pennsylvania, Texas and Washington have already acknowledged that UnitedHealthcare will exit their Marketplace.

Data from the Kaiser Family Foundation shows that while UnitedHealthcare's exit will have only a "minimal" impact on overall premiums (less than one percent on average) it could substantially hike premiums rural areas with limited competition. UnitedHealthcare was one of only two Marketplace insurers competing in 29 percent of the counties in which it currently offers coverage and its exit could cause premium spikes in states like Arizona, Iowa, Nebraska, and North Carolina.

In an effort to curb losses, UnitedHealthcare is likely to continue to pursue cost-containment measures in its remaining Marketplaces, including its refusal to accept third-party premium assistance payments from charitable organizations like PSI (see Update for Week of November 30th).

The director of the nation's largest Marketplace in California blamed UnitedHealthcare earlier this year for its losses, insisting that they were "self-inflicted" and the result of poor business decisions, including very narrow provider networks that deterred enrollment (see Update for Weeks of January 25th and February 1st). He noted that the nation's second-largest health insurer, Anthem, was turning a profit on Marketplace business in and out of California, despite Marketplace enrollment running about 30 percent below their initial projections.

Other insurers such as CIGNA have announced plans to expand their Marketplace participation for next year, despite facing the same barriers as UnitedHealthcare (CIGNA participated in only seven Marketplaces for 2016).



Arkansas

Governor vetoes budget provision that would have terminated Medicaid expansion alternative

Governor Asa Hutchinson (R) used his line-item veto authority this week to remove a provision in the Medicaid budget that would have terminated the popular Private Option program that has expanded Medicaid coverage to more than 250,000 Arkansans.

Arkansas was the first state in the nation to receive federal approval for a private sector alternative to the Medicaid expansion under the ACA (see Update for Week of September 25, 2013). The so-called Private Option uses ACA matching funds for the expansion to instead purchase private Marketplace coverage for those made newly-eligible for Medicaid.

However, the waiver first secured by Governor Mike Beebe (D) in 2013 has met with stiff opposition from conservative lawmakers that have since gained control of the governorship and legislature. It requires annual renewal, which it managed by only one vote last year and conservatives insisted that it would not be reauthorized this year if reforms were not implemented that would increase enrollee cost-sharing, impose “work encouragement” requirements, move lower-income enrollees into traditional Medicaid, and terminate those that fail to pay premiums (see Update for Weeks of January 26 and February 4, 2015).

Governor Hutchinson called a special legislative session earlier this month to secure approval for the changes that he insists have received conceptual approval from the Obama Administration (see Update for Weeks of February 8th and 15th). However, a handful of conservative lawmakers have used the session to try and block the Private Option by refusing to approve a Medicaid budget that funded it.

To end the impasse, the Governor had to rely on an unusual move that urged Private Option supporters to vote in favor of the budget bill that terminated the Private Option on December 31st. Governor Hutchinson then followed-through on his promise to strip out the termination provision.

The Governor is expected to have more than the simple majority of votes needed to uphold his line-item veto, which will allow the Private Option to continue providing coverage after December 31st. Republican leaders insisted that the Governor’s maneuver would be challenged in court.

California

Senate health committee advances drug price transparency legislation

The Senate Health Committee approved legislation earlier this month that would require on prescription drug manufacturers to give purchasers a 60-day advance notice and written justification for any double-digit price increase within a 12-month period.

The bill measure authored by Senator Ed Hernandez (D) (S.B. 1010) would mandate that the notice be sent to public insurers such as Medi-Cal and the Public Employees’ Retirement System, as well as private health plans and some lawmakers. In addition, it would set a 30-day notice requirement before manufacturers could sell any new prescription medication that costs more than \$10,000 per course of treatment and also require health plans to disclose the percentage of premiums they spend on prescription drugs..

Bill supporters, including the California Association of Health Plans, labor unions, and consumer advocacy groups, insist that prior notification would give purchasers time to negotiate prices and seek rebates or alternatives. However, pharmaceutical groups opposing the bill claim that compliance with such notice requirements would be “almost impossible.”



Senator Hernandez noted that California already imposes a 60-day notice requirement upon health insurers whenever they raise premiums and that his bill would simply extend that workable requirement to drug manufacturers.

The Senate Appropriations Committee has set a May 2nd hearing on S.B. 1010. The Assembly Health Committee is considering separate legislation (A.B. 2436) that would give consumers information on what their health plans pay for their prescription medication and how much the same drug costs in Canada, Germany and Mexico.

Voters will get their chance to weigh in on the issue in November when the California Drug Price Relief Act will be on the ballot. The referendum would prohibit state agencies that run health care programs from paying more for prescription drugs than the lowest price paid to the federal Department of Veteran Affairs (see Update for Week of January 4th).

Covered California sets new quality, cost, and transparency standards on plans and providers

Covered California released new quality and cost standards that will gradually be imposed on both insurers and hospitals over the next seven years.

The first-in-the-nation standards are intended to not only to improve the quality of care provided within the Marketplace created pursuant to the Affordable Care Act (ACA) but increase pricing transparency for consumers. They will allow the Covered California board to reduce hospital payments by at least six percent if they fail to meet quality standards or give bonuses of an equal amount for over-performing hospitals. In addition, health plans would be required to identify hospital and physicians that are performing poorly on a variety of quality metrics or charging too much for care. These providers could be dumped from a plan's provider networks starting in 2019.

However, the provision that has drawn the most opposition from insurers relate to plan transparency as they require health plans to disclose the rates they negotiate with individual providers. Covered California officials insist that such transparency will better enable subscribers to be educated consumers and identify the price they will be required to pay in advance—as they are able to do for any other product.

Florida

Governor signs bills that boost price transparency, protect consumers from surprise charges

Governor Rick Scott (R) signed two consumer protection measures last week that had passed the legislature with a rare show of bipartisan support (see Update for March 7-25, 2016).

The first measure (H.B. 1175) makes 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 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. In such cases, consumers would be responsible only for in-network cost-sharing.

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, Georgia, Hawaii, Minnesota, Missouri, New Jersey, and Vermont. New York has already implemented a mandatory dispute resolution system for



cases where patients receive care from out-of-network contractors at in-network facilities and California is considering a similar model.

Protection against surprise medical bills was also 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).

Idaho

Governor will not call special session or take executive action on Medicaid expansion

Governor Butch Otter (R) announced earlier this month that he will not call a special legislative session to consider expanding Medicaid under the Affordable Care Act (ACA) nor will he take executive action to do so.

The Governor conceded defeat after a House committee blocked funding for his limited state-funded alternative to the ACA expansion, which would have at least provided some Medicaid coverage to roughly 78,000 residents caught between current Medicaid eligibility and the threshold for premium tax credits under the ACA (see Update for Weeks of February 22nd and 29th)

Governor Otter insisted that he will continue to work with an interim legislative committee to study how Idaho should proceed. However, the legislature has ignored recommendations of the Governor's two prior working groups to fully expand Medicaid under the ACA (see Update for Week of March 11, 2013).

Louisiana

Hospital opposition stalls proposals to charge copays for newly-eligible Medicaid enrollees

The House Health and Welfare Committee withdrew three bills earlier this month that would have required copayments for those made newly-eligible for Medicaid on July 1st.

One of the measures (H.B. 492) was supported by new Governor John Bel Edwards (D), who issued an executive action immediately upon assuming office this year to expand Medicaid under the Affordable Care Act (ACA) over the opposition of the Republican-controlled legislature (see Update for Week of January 4th). Enrollment in the expansion program will start June 1st and coverage begins July 1st. The expansion is expected to save Louisiana \$677 million during the first five years, due to ACA matching funds.

The Governor's bill would have require enrollees pay an \$8 per visit fee for non-emergency care provided in the emergency room, as well as for "non-preferred" prescription drugs. However, the measure was opposed by the Louisiana Hospital Association, insisting that such copays would be an "uncollectable...administrative burden."

Representative Jack McFarland (R) has indicated that he will resurrect the bill before the end of the session.

Maine

Governor pledges to issue sixth veto of Medicaid expansion legislation

The House and Senate have passed a measure seeking to make Maine the eighth state to receive federal approval for a private sector alternative to the Medicaid expansion under the Affordable Care Act (ACA). However, as with five previous Medicaid expansion bills that have cleared the legislature (see Update for Week of April 21, 2014), L.D. 633 did not pass by a sufficient margin to override the promised veto from Governor Paul LePage (R), who opposes any form of expansion.



The latest proposal would allow individuals earning up to 100 percent of the federal poverty level (FPL) to be covered through traditional Medicaid, while those earning 100-138 percent of FPL would receive subsidies to purchase private coverage in the federally-facilitated Marketplace operated in Maine.

Nebraska

Legislature blocks Medicaid expansion vote for fourth straight year

Republican leaders in Nebraska's unicameral legislature have blocked a proposal from Senator Kathy Campbell (R) to create an alternative to the Medicaid expansion under the Affordable Care Act (ACA) that has already been federally approved for seven states.

The legislature has now blocked any form of Medicaid expansion from receiving a floor vote for four consecutive years, even though the most recent bill addressed concerns raised during prior sessions (see Update for Week of February 23, 2015). For example, L.B. 1032 would have created only a three-year pilot project, been funded through tobacco settlement funds and not general revenues, and purchase private Marketplace coverage for newly-eligible Medicaid enrollees, most of whom would be charged nominal copayments.

funded not through General Revenue funds, but through money from the tobacco settlement. It also proposed using private insurance and requiring minor co-pays.

Ohio

Draft waiver would require Medicaid enrollees contribute to HSAs

The Department of Health released a draft earlier this month of his proposed federal waiver that would allow Ohio to make roughly 1.5 million Medicaid enrollees contribute to health savings accounts (HSAs) or lose coverage.

The changes, which are not currently expected to receive federal approval, would not be effective until 2018. The draft is open for public comment until May.

Governor John Kasich (R) had initially proposed that contributions be required only of those earning more than 100 percent of the federal poverty level (FPL). However, the Republican-controlled legislature replaced his proposal with a plan that would require all non-disabled adults on Medicaid, regardless of income, pay up to \$99 a year or \$8.25 a month, into a HSA. The state would then contribute \$1,000 per year to help enrollees pay for needed services.

The Ohio plan is modeled after a similar program that Indiana has operated for seven years and recently tailored to federal requirements in order to receive a federal waiver to create its Medicaid expansion alternative (see Update for Weeks of January 26 and February 2, 2015). However, Ohio already has a traditional Medicaid expansion in place, so the Centers for Medicare and Medicaid Services (CMS) is expected to similarly narrow down Ohio's waiver request once submitted before the June 30th deadline.

Oklahoma

Health Care Authority proposes Medicaid expansion alternative in lieu of provider rate cuts

The Oklahoma Health Care Authority asked Governor Mary Fallin (R) and legislative leaders last week to make Oklahoma the eighth state to create a private sector alternative to the Medicaid expansion created by the Affordable Care Act (ACA).

The plan would expand the existing Insure Oklahoma program that provides state subsidies to small businesses to help them pay employee health insurance premiums. It would make roughly 175,000 working age adults earning up to 138 percent of the federal poverty level eligible for the program, which charges sliding scale premiums to enrollees, as well as offering financial incentives for



healthy behaviors. In addition, 175,000 pregnant women or children now enrolled in Medicaid would receive tax credits to help cover the costs of private coverage, a move that would save the state an estimated \$60 million.

The Authority's Medicaid Rebalancing Act consistently avoids the politically-toxic work "expansion" even though it would specifically be funded with nearly \$900 million in ACA matching funds over the first four years. The cost to the state is estimated at \$100 million.

The expansion plan is intended to avoid 25 percent cut in Medicaid provider payment rates that the Authority proposed just last week, which would be the largest in state history and set Medicaid rates at least than 65 percent of what Medicare pays for the same services. The Authority's director insisted that such cuts would directly lead to access problems for enrollees as many rural providers either shut their doors, move out of state, or consolidate with larger providers.