



Health Reform Update – Week of October 31, 2016

CONGRESS

Congress remains on election recess. Both chambers are slated to return on November 14th.

FEDERAL AGENCIES

CMS hints that action on third-party premium assistance is forthcoming

The Centers for Medicare and Medicaid Services (CMS) official overseeing the web portal for federally-facilitated Marketplaces (FFMs) stated last week that the agency will likely respond this month to insurer requests to limit third-party premium assistance from non-profit organizations.

Aetna and other insurers had partly blamed the availability of such third-party assistance for skewing the risk pools toward costlier patients and causing higher than projected losses during the initial years of the Affordable Care Act (ACA) Marketplaces (see Update for Week of August 15th). Insurers specifically alleged that premium assistance from provider-affiliated charities were steering patients (particularly those undergoing dialysis) away from Medicare and Medicaid and towards higher-paying Marketplace plans.

The anecdotal allegations prompted CMS to issue a Request for Information (RFI) soliciting public comments on the extent to which this practice was actually occurring and what limits may need to be placed on premium assistance from charitable groups (see Update for Week of August 15th). They also caused CMS to retreat from earlier plans to address the issue in its Notice of Benefit and Payment Parameters for 2018, despite prior acknowledgements that deliberately making a plan unaffordable for high-cost patients likely violates the ACA anti-discrimination provision (see Update for Week of September 12th).

The vast majority of public comments refuted the insurer allegations, emphasized the importance of maintaining this critical lifeline for consumers with chronic or life-threatening conditions, and pointed out that bona-fide independent charities like PSI are required to provide assistance based upon financial need (see Update for Week of October 24th). Major stakeholders like the American Hospital Association had previously urged CMS to preserve charitable premium assistance while creating “guidelines” ensuring that it is not available for those eligible for Medicare or Medicaid, based solely upon financial need, and covers enrollees for an entire policy year (see Update for Week of August 22nd).

CMS regulations currently give Marketplace insurers discretion whether to accept third-party charitable assistance and insurers in at least 38 states have already decided to refuse (see Update for Week of June 20th). A Congressional bill to require insurers accept such assistance (H.R. 3742) now has more than 140 bipartisan cosponsors.

CMS has not indicated what action they plan to take on third-party premium assistance, though previous rulemaking had hinted that it will include limits on when such assistance would be allowed (see Updated for Week of June 20th). The chief executive officer for www.healthcare.gov assured insurers last week that CMS is “highly sensitive” to their concerns about charitable assistance “steering” consumers into Marketplace plans.



Final rule limits use of short-term plans that do not comply with ACA

The Department of Health and Human Services (HHS) and two other agencies finalized regulations late last week limiting the use of short-term health insurance plans that fail to comply with the Affordable Care Act (ACA).

Under the rule, such plans are now limited to a three-month coverage term and can no longer be offered starting January 1, 2018. Insurers had been allowed to offer short-term coverage that expired in under one year (see Update for Week of June 20th). However, America's Health Insurance Plans (AHIP) and the BlueCross BlueShield Association have blamed the prevalence of such limited benefit and low-cost plans for siphoning healthier and lower-cost subscribers away from the ACA Marketplace risk pools. Because short-term plans need not comply with the ACA guaranteed issue mandate, they are typically not available to those with higher-cost conditions.

The final rule largely mirrors the earlier proposal, except that the agencies agreed to extend the termination date from April 1, 2017 to January 1, 2018 (see Update for Week of June 20th). It is expected to impact about 800,000 to one million subscribers enrolled in short-term coverage.

Uninsured rate falls to new record low

The latest survey data from the Centers for Disease Control and Prevention found that the nation's uninsured rate fell to 8.9 percent for the first six months of 2016, the lowest six-month rate that the agency has ever recorded.

CDC had reported earlier this fall that the uninsured rate hit a record low of 8.6 percent for the first quarter of 2016 (see Update for Week of September 12th).

The CDC data shows that the uninsured rate for working age adults remained much higher (12.4 percent) but fell all the way down to five percent for children under age 18. It also reveals that nearly 39 percent of consumers with private insurance coverage are enrolled in high-deductible health plans, up dramatically from only 25.3 percent when the Affordable Care Act (ACA) was enacted in 2010.

STATES

Premium increases are 12 percent higher in states fighting ACA implementation

According to an analysis completed this week by www.ACAsignups.net, premiums will increase next year by an average of nearly 12 percent more in states that are resisting the Medicaid expansion and other key provisions of the Affordable Care Act (ACA).

The Marketplace premium and enrollment tracking website weighs premium increases by insurer enrollment and calculated an average weighted rate hike of about 22 percent for the 31 states (and the District of Columbia) that have expanded Medicaid compared to nearly 29 percent for those that refused to participate. The disparity is even more dramatic for the 12 states (and DC) creating their own state-based Marketplace under the ACA compared to those defaulting to the federal web portal (17 percent for the former, 28 percent for the latter).

The website also contrasted the weighted average increase for states that allowed "grandmothered" or transitional plans that failed to comply with the ACA for up to three years (see Update for Week of March 3, 2014). The former had an average increase nearly ten percent higher than the latter (28.4 percent compared to 18.8 percent).



When accounting for all three factors, the website found that states that fully-implemented the major provisions of the ACA limited premium increases to 18.2 percent compared to 29.8 percent in hold-out states. An analysis released last week by the Obama Administration found that Marketplace premiums overall are increasing next year by an average of 22 percent (see Update for Week of October 24th).

The website identified 17 states with unsubsidized rate hikes average more than 30 percent, including seven which are over 40 percent (Arizona, Illinois, Minnesota, Montana, Oklahoma, Tennessee, and West Virginia). However, it acknowledged that the overall weighted average increase for this group may be skewed by two states. The first is ACA-resistant Oklahoma, where the lone Marketplace insurer (Blue Cross and Blue Shield) is increasing premiums by an average of 76 percent. The second is ACA-compliant Minnesota, where the Basic Health Plan (BHP) siphoned away significant numbers of Marketplace enrollees. Minnesota is one of only two states (including New York) participating in the BHP option under the ACA (see Update for Week of October 10th).

However, the website notes that both states have fairly low Marketplace enrollment totals (only 164,000 for Oklahoma), their impact on the overall increase may be only marginal. By contrast, the 13.2 percent average increase for Covered California more heavily pulls down the weighted average for ACA-complaint states because it has more than 2.2 million enrollees.

CIGNA abandons plans to expand Marketplace presence

CIGNA announced this week that it will participate in the same number of Affordable Care Act (ACA) Marketplaces as 2016, despite previous plans to expand into three additional states.

For the 2017 open enrollment period that started this week, CIGNA is offering plans in a total of seven Marketplaces. They withdrew from the Marketplaces in Arizona, Georgia, and Texas but added three others (Illinois, North Carolina, and Virginia). As with 2016, they will continue to participate in the Marketplaces for Colorado, Maryland, Missouri, and Tennessee.

CIGNA officials had announced earlier this year that they would serve ten total Marketplaces for 2017 but abandoned those plans as shortfall in ACA reinsurance payments and other factors led to insurer concerns about the long-term profitability and stability of the Marketplaces (see Update for Week of August 15th).

Health insurance giant Anthem Blue Cross and Blue Shield expressed similar concerns this week in suggesting that they may also withdraw from some of their ACA Marketplaces (see below).

Anthem threatens to pull out of ACA Marketplaces after enrollment comes in below projections

Anthem Blue Cross and Blue Shield became the latest major insurer this week to threaten to exit Affordable Care Act (ACA) Marketplaces if the “regulatory environment” does not allow for changes to the composition of the Marketplace risk pools, such as limiting special enrollment periods (see Update for Weeks of February 22nd and 29th), increasing reinsurance and risk corridor payments (see Update for Week of October 24th), and repealing the ACA excise tax on health insurers.

Anthem was one of the few nationwide insurers that had pledged to remain in all 14 of their ACA Marketplaces for 2017, even as competitors United Healthcare, Aetna, and Humana pulled out of all or most of theirs (see Update for Week of August 15th). However, the 889,000 Marketplace enrollees that Anthem reported for the end of the third quarter was well-below projections, forcing Anthem officials to publicly re-evaluate their Marketplace commitment for 2018 and subsequent years.

Analysts promptly speculated whether Anthem was employing a similar negotiating tactic to Aetna, which had threatened to withdraw from their Marketplaces if the Department of Justice (DOJ)



continued to block their proposed merger with Humana (see Update for Week of August 15th). DOJ is likewise suing to prevent Anthem's acquisition of CIGNA, with the trial scheduled to start later this month.

California

Ballot referendum to cap prescription drug prices may not pass

Recent polling for Proposition 61 shows that most undecided Californians are now opposing the ballot referendum that 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 (VA) (see Update for Week of April 18th).

Only 16 percent of respondents opposed the *California Drug Price Relief Act* as recently as September, with roughly half in favor of the measure and 34 percent undecided. The level of support has not significantly changed in new polls. However, most of the undecided voters shifted to the opposition column following weeks of intense counter-lobbying by the pharmaceutical industry, which spent more than \$100 million to prevent its passage. An equal share of respondents now support and oppose Proposition 61 (47 percent) with only six percent undecided.

However, concerns expressed by consumer advocacy groups representing HIV and Hepatitis C patients (such as Project Inform and the Treatment Action Group) may also be engendering opposition to the measure. These groups stated as early as last summer that the measure takes the "wrong approach" to reducing prescription drug costs, as drug manufacturers could simply respond to the new caps by raising the prices they charge the VA (see Update for Week of July 25th).

In addition, the consumer groups note that rebates and discounts offered by drug manufacturers are typically confidential, making it difficult to determine whether a state agency is paying less than the VA. Because of this lack of transparency, the state Legislative Analyst's Office has already acknowledged that the impact of Proposition 61 would be "highly uncertain" (see Update for Week of July 25th).

Proposition 61 is still backed by the AIDS Healthcare Foundation, the California Nurses Association, and AARP, who claim the measure would save several hundred million dollars a year on the more than \$4 billion that California now spends on medicines for roughly 5-7 million people.

The polling data showed that voters will likely be divided along partisan lines, with Democrats largely favoring Proposition 61 and Republicans mostly opposed. Voting preferences may also split along other demographic criteria, as most respondents under age 40 favor the measure (as do most Latino or African American respondents), while 59 percent of seniors are opposed.

A nearly identical measure is on the ballot next year in Ohio (see Update for Week of January 4th). The primary difference between the Ohio Price Standards Initiative and Proposition 61 is that the latter exempts drugs purchased or procured from Medicaid managed care programs. The AIDS Healthcare Foundation is the primary donor behind both referendums.

The VA receives mandatory drug discounts under federal law and thus tends to pay the lowest prices. A 2005 report by the Congressional Budget Office showed that the VA paid 42 percent of list price on average for name-brand drugs while Medicaid was paying 51 percent. The gap between the VA and Medicare or private insurers was even larger (see Update for Week of July 25th).

Blue Shield again owes subscribers millions in ACA rebates

For the second year in a row, Blue Shield of California will be forced to make sizeable premium refunds to insurers for failing to meet the profit caps imposed by the Affordable Care Act (ACA).



Roughly 30,000 small employers (covering 240,000 employees) will receive \$25 million in rebates from the insurer for overcharging consumers during 2015. That will translate to about \$58 per worker.

Blue Shield was forced to pay nearly \$85 million in rebates to individual and small group subscribers for the first full year of ACA implementation in 2014—by far the highest in the nation—and a pending lawsuit alleges that even that amount was far too low (see Update for Weeks of July 27 and August 3, 2015). The rebates were due because Blue Shield far exceeded the minimum medical-loss ratio under the ACA, which requires insurers to spend no more than 20 percent of premium revenue on profit and administrative expenses.

The Department of Managed Health Care intervened and limited 2016 premium increases by Blue Shield to an average of 4.6 percent (in both the individual and small group markets). Under the negotiated order, Blue Shield also agreed to profit margin caps (of 1.41 percent for individual coverage and 1.67 percent for small groups). However, those will not go into effect until 2017 (see Update for Weeks of October 5 and 12, 2015).

State regulators also stripped Blue Shield of its non-profit tax exemption after the Franchise Tax Board determined that the company was failing to use its unlawful and "extraordinarily high surpluses" of more than \$4 billion to make coverage more affordable (see Update for Week of March 16, 2015).

Six other insurers in California also exceeded the ACA medical loss ratio but each was required to pay only hundreds of thousands of dollars in rebates.

Blue Shield has the largest market share in the Covered California Marketplace created pursuant to the ACA (see Update for Weeks of February 8th and 15th).

Anthem sued for forcing consumers into bare-bones coverage

Consumer Watchdog filed lawsuit this week asking the Los Angeles County Superior Court to force Anthem Blue Cross to stop automatically renewing PPO policies that no longer include out-of-network coverage.

Effective January 1st, Anthem is converting their PPO option into an exclusive provider organization (EPO), which provides zero coverage for costs incurred out of the EPO network. The consumer group alleges that Anthem is effectively "railroading existing members into bare-bones plans" without properly disclosing the change in renewal notices, which simply stated that their policy would automatically renew if the subscriber took no action by December 15th. In addition to monetary damages, they are seeking a court order requiring that Anthem renew the plans as PPOs.

Louisiana

Medicaid expansion turns state budget deficit into surplus

A new fiscal report by the Department of Health and Hospital shows that the Medicaid program is in its strongest financial position in six years following Louisiana's participation in the Medicaid expansion under the Affordable Care Act (ACA).

New Governor John Bel Edwards (D) used an executive order to make Louisiana the 31st state (plus the District of Columbia) to participate in the ACA expansion (see Update for Week of January 4th). The infusion of federal matching funds after the July 1st effective date will leave the program with a \$2.85 million surplus at the June 30th end of the current budget cycle, instead of the \$395 million shortfall that was initially projected.



Louisiana has enrolled nearly 332,000 resident into Medicaid as a result of the expanded eligibility criteria. It is on track to enroll more than 402,000 by June 30th and exceed its initial target of 375,000 expansion enrollees.

Minnesota

Governor wants special session to debate competing plans to curb Marketplace premiums

Governor Mark Dayton (D) proposed late last week that lawmakers convene a special session to consider his plan to use the state's \$313 million surplus to fund consumer rebates for MNSure enrollees that do not qualify for premium or cost-sharing subsidies under the Affordable Care Act (ACA).

Consumers in the MNSure Marketplace are facing a staggering 59 percent average increase in premiums for the open enrollment period that started November 1st. This increases (which range from 5-67 percent) lead all state-based Marketplaces and trail only three of the federally-facilitated Marketplaces (see Update for Week of October 24th). They have become a major political liability for Democratic lawmakers that once trumpeted Minnesota's status of having the lowest Marketplace premiums in the nation (see Update for Week of September 29, 2014).

The Governor's plan would provide monthly rebates equal to 25 percent of the MNSure premiums for about 123,000 consumers. According to the Governor's office, it would reduce the average premium increase from 59 percent to 16 percent.

House Democrats proposed a slightly different plan last week that would provide MNSure consumers with a one-time rebate that would ensure they do not spend more than ten percent of their annual income on Marketplace premiums (see Update for Week of October 24th). However, their plan would also require eliminating a \$31 million tax cut for tobacco companies, in addition to redirecting surpluses from the Health Care Access Fund and Comprehensive Health Association Fund.

Republicans that control the House has thus far proposed far more limited relief, such as seeking a federal waiver that would allow MNSure consumers eligible for ACA subsidies to receive those subsidies outside of the Marketplace.

New Jersey

Appropriations committee passes legislation limiting surprise out-of-network bills

The Assembly Appropriations Committee advanced legislation this week that would make New Jersey the latest state to protect consumers from surprise bills from out-of-network providers when receiving in-network care.

A.1952 was unanimously approved with amendments. The bill specifically requires providers to notify patients (prior to scheduling an appointment) what services will be provide in-network or by out-of-network contractors, as well as the estimated amount the patient will be billed for each service. It also limits charges from out-of-network providers if a patient receives "medically necessary services at any health care facility on an emergency or urgent basis" or if "inadvertent out-of-network services" are rendered. The definition of "inadvertent" includes those situations (such as lab testing) where medical care covered under a managed care plan is provided by an out-of-network provider to a patient utilizing an in-network facility.

Under the bill, providers would be prevented from billing patients in "inadvertent" circumstances in excess of the deductible and cost-sharing amount applicable to in-network services. When services are furnished on an emergency or urgent basis, the insurer or provider may initiate binding arbitration if they cannot agree on a reimbursement rate within 30 days.



An identical measure has yet to be heard in the Senate Budget and Appropriations Committee (S. 1285). The bills were introduced last session but failed to advance past their initial committees.

California was the most recent state to enact a similar prohibition (see Update for Week of October 10th). Florida and Connecticut also passed comparable laws earlier this year (see Update for Week of April 18th).