

Health Reform Update – Week of November 4th, 2013

CONGRESS

CMS Administrator says 800,000 can still be enrolled in ACA marketplaces by December

For the second time in two weeks, Health and Human Service (HHS) Secretary Kathleen Sebelius and Centers for Medicare and Medicaid Services (CMS) Administrator Marilyn Tavenner were grilled by a congressional committee over the continued failures of the federal marketplace web portal.

Both Republican and Democratic lawmakers remained skeptical of Tavenner's estimation before the Senate Health, Education, Labor and Pensions Committee that 800,000 consumers could still be enrolled in marketplace coverage by November 30th. Both Tavenner and Secretary Sebelius identified several hundred functional fixes in the web portal that have been identified and are in the process of being fixed and insisted that the portal is performing better with each passing day and displaying plan details "in just seconds" instead of minutes. However, the failure of the federal data hub for the third time in two weeks (see Update for Week of October 28th) did little to assuage frustrated lawmakers, as all state and federal marketplaces rely on it for access to the federal agency databases needed to verify marketplace and tax credit eligibility (see below).

Secretary Sebelius acknowledged before the Senate Finance Committee that enrollment numbers that will be released next week will be "very low". She did not dispute documents released by the House Oversight and Government Reform Committee last week showing only 248 sign-ups in the first two days of open enrollment (see Update for Week of October 28th), nor did she say whether HHS would break-out the data to show how many consumers enrolled in each plan tier.

House Ways and Means Committee chairman Dave Camp (R-MI) subpoenaed the CMS Administrator to provide the data by week's end. Republicans also continued to pound on HHS and CMS for not delaying open enrollment despite written concerns expressed by contractors as early as last June about the ability of the portal to protect the privacy of consumer's Social Security numbers and other sensitive financial information.

However, criticisms were equally sharp from Democrats, with chairman Max Baucus (D-MT), one of the ACA's architects, questioning how HHS could not anticipate the glitches that have plagued the system and chastising the Secretary for not being more forthcoming about problems once they occurred.

House Oversight and Government Reform Committee chairman Darrell Issa (R-CA) pledged this week to subpoena the White House's chief technology officer if he does not appear at that committee's first hearing on the marketplace failures next week, which will focus on testimony from information technology officials at CMS. However, Administration officials have claimed to date that Todd Park is too busy repairing the marketplace web portal and cannot testify until December. Chairman Issa has already subpoenaed marketplace contractors and the HHS Secretary (see Update for Week of October 28th).

The chief information officer for CMS that oversaw development of the federal marketplace portal has already agreed to resign on November 15th. Ten Republican lawmakers have continued to demand the resignation of the HHS Secretary, though not Administrator Tavenner.

HHS and AHIP oppose extending open enrollment deadline due to marketplace failures

The Chief Operating Officer (COO) for Humana informed investors this week that the health insurer was cutting its estimate of Affordable Care Act (ACA) marketplace enrollment by half due to the continued failures of the online portal and federal data hub.

Humana had predicted that it would enroll 500,000 consumers in marketplace plans by the March 31st deadline for open enrollment. However, after a meeting last week between insurance executives, President Obama, and federal officials, the COO reduced that estimate to 250,000 and indicated that the March 31st deadline was likely to be extended along with an unspecified delay in the individual mandate.

In her appearance before the Senate Finance Committee this week (see above), Health and Human Services (HHS) Secretary Kathleen Sebelius continued to insist that any such delays are “not an option” (see Update for Week of October 28th). Centers for Medicare and Medicaid Services (CMS) officials also rejected such claims.

America's Health Insurance Plans (AHIP) has steadfastly opposed an open enrollment extension or individual mandate delay, arguing that both “could have a destabilizing effect on insurance markets, resulting in higher premiums and coverage disruptions.” The insurance industry’s top lobbying group stressed that marketplace premiums for 2014 were based on the presumption that individuals would be compelled to buy coverage they can afford by March 31st. The American Academy of Actuaries issued a similar warning to Congress this week, stressing that both delays would also increase the federal deficit.

Despite these negative consequences, congressional pressure to delay both provisions continues to mount as vulnerable Democrats become increasingly frustrated at the limited functionality of the federal marketplace web portal and federal data hub. Senator Jeanne Shaheen (D-NH) is preparing legislation to extend the open enrollment period. Senator Joe Manchin (D-WV) is pushing legislation (S.1671) that would delay the individual mandate by at least a full year, although Majority Leader Harry Reid (D-NV) would not commit this week to allowing a floor vote on the measure.

During a tense meeting with the White House this week, Senate Democrats appeared to grant the Administration’s request to give them a “little breathing room” and hold back on legislative fixes until after CMS’ November 30th target to repair the marketplace.

Survey shows marketplace consumers lack of cost details is key impediment to enrollment

Concerns about costs and affordability outpaced technical glitches as the main cause for delayed enrollment among Affordable Care Act (ACA) marketplace consumers, according to a survey released this week by The Commonwealth Fund.

Researchers identified 682 individual market or uninsured consumers that may be eligible for the ACA marketplaces. Of this group, 17 percent had shopped for marketplace plans or Medicaid options, either online, in person with a counselor, on the phone, or by mail. The Commonwealth Fund found 20 percent had already enrolled in coverage, while another 58 percent were planning to enroll by the March 31st end of open enrollment.

However, the key finding of the survey was that 48 percent of those who did not enroll cited affordability as the primary barrier and not the ongoing disruptions in the marketplace web portal. However, The Commonwealth Fund acknowledged that the two issues may be intertwined, since the website glitches have prevented many consumers from learning whether they are eligible for premium tax credits and cost-sharing reductions that will help them afford marketplace plans. More than 42 percent of this group said they could not afford the plan cost-sharing while 37 percent experienced technical difficulties and were unable to access certain parts of the website.

FEDERAL AGENCIES

Insurers say early pool of ACA marketplace applicants is older than expected

According to the *Wall Street Journal*, health insurers are reporting that enrollees in Affordable Care Act marketplace plans have been older than anticipated during the first month of open enrollment.

Insurers expected the average age of new enrollees to be around 40 years old, but several companies have indicated that the majority are over age 50. For example, Wisconsin-based Arise Health plan claims more than 50 percent of its 150 enrollees are over age 50, Michigan-based Priority Health reports an average age of 51 (up from 41 in current year plans), and insurance giant WellPoint says most of its enrollees in Connecticut's state-based marketplace (SBM) are between 55-64. Kentucky's SBM also indicates that nearly 40 percent of the 4,631 enrollees in private plans are older than 55, while only 24 percent are under 34.

The data contrasts slightly with preliminary marketplace data in states like Connecticut, which reported that 29 percent of the first 1,157 applications processed were for consumers aged 18-34 (see Update for Week of October 7th).

Obama Administration officials insist that an initially higher age distribution is not usual and reiterated its earlier claim that most young enrollees will wait until the open enrollment deadline to sign-up, consistent with the experience in the Massachusetts Connector exchange that is the model for the ACA marketplaces (see Update for Week of October 28th).

OMB confirms that sequester has cut \$85 million in FDA user fee revenue

The Office of Management and Budget confirmed this week that the ongoing sequester has already drained about \$85 million in user fees from the Food and Drug Administration (FDA) budget, out of the \$210 million or 5.1 percent that will be eventually cut.

In a letter this week to Rep. Anna Eshoo (D-CA), OMB affirmed that the across-the-board cuts imposed last spring are reducing this private revenue source, instead of limiting public spending as intended. It urged Congress to pass legislation exempting user fees from sequestration, noting that current budget proposals for next year retain the sequester's spending caps (see Update for Week of October 14th). However, the bipartisan House bill introduced last summer (H.R. 2725) has only 64 cosponsors while the Senate version (S.1413) has only six.

The FDA relies on the fees from medical device and pharmaceutical manufacturers for roughly 40 percent of its budget to complete product safety reviews and approvals.

OMB noted that although the sequestered fees remain in FDA accounts, they will be "unavailable unless they are subsequently appropriated by Congress."

STATES

State-based ACA marketplaces continue to show mixed results

The 15 state-based marketplaces (SBMs) created by the Affordable Care Act (ACA) continue to show mixed results, although most have not been plagued by the severe glitches that have hampered the web portal for federal marketplace states (see Update for Week of October 14th).

Despite initial error codes and interoperability issues, Washington has the highest published enrollment among all marketplaces, enrolling about 55,000 individuals in both public and private plans and expecting to reach 130,000 by January 1st. New York, Colorado, and Kentucky are close behind at roughly 37,000, 37,000, and 31,500 individuals respectively, with Kentucky adding nearly 1,000 individuals per day. However, most of the enrollees in all of these states have been Medicaid (see Update for Week of October 28th).

The largest SBM in California will not release its enrollment figures until the federal marketplace does so next week (see above), although it indicates that over 272,000 applications have been started.

States with modest enrollment include Minnesota (over 11,000), Connecticut (over 7,000), and Rhode Island (over 4,640) (see Minnesota and Connecticut articles below).

By contrast, other states lag well behind. Hawaii only opened in mid-October (see Update for Week of October 14th), Oregon still cannot handle any online applications (see Update for Week of October 21st). Nevada consumers have started over 8,800 applications but SBM glitches have prevented actual enrollment numbers from being released.

Kaiser report finds that most ACA tax credit recipients will be concentrated in five states

Consumers in five states are projected to comprise about 40 percent of the 17 million people who will qualify for Affordable Care Act (ACA) tax credits next year, according to a new analysis by the nonpartisan Kaiser Family Foundation.

More than two million tax credit recipients will reside in the state of Texas, which consistently leads the nation with more than one-quarter of its population uninsured. This represents nearly two-thirds of the 3.1 million Texans that will be eligible to shop in the new ACA health insurance marketplace.

California and Florida will each likely have more than one million recipients, while New York and Pennsylvania will have 779,000 and 715,000 respectively. North Carolina, Georgia, Ohio, Virginia and Illinois round out the list of states with exceptionally high numbers of residents receiving tax credits.

Kaiser emphasized that only two states (California and New York) among the top ten are operating their own state-based marketplace. This is likely to increase the demand upon the federal marketplace, as it must determine subsidy eligibility for an unexpectedly high number of applicants.

Kaiser estimates that 29 million Americans will eventually look for coverage on in the ACA marketplaces, although only a fraction of them are expected to sign-up for 2014. Of those expected to enroll, Kaiser estimates that 12 million will buy coverage without the benefit of tax credits.

California

Insurance commissioner requires Blue Shield to delay plan cancellations by three months

Blue Shield of California announced this week that the Department of Insurance has required the insurer to delay for three months the cancellation of more than 115,000 individual health plans that do not meet Affordable Care Act (ACA) requirements.

Insurers nationwide are cancelling millions of plans that were either offered after the enactment of the ACA or have been significantly altered and lost the “grandfather” protection from the higher standards under the new law (see Update for Week of October 28th). In California, they will affect roughly half of all individual health plan subscribers, whose premiums under upgraded post-ACA coverage is expected to rise by 30 percent on average.

The director for Covered California insisted this week that the cancellations would benefit the new health insurance marketplace by nudging younger, healthier, and less costly consumers into marketplace plans and away from substandard “junk” insurance. Having a broader risk pool will help the marketplace keep premiums affordable, since the costs for sicker subscribers will be offset by less costly subscribers.

However, Insurance Commissioner Dave Jones (D) faulted Covered California for requiring participating insurers to terminate their substandard individual plans effective December 31st. He acknowledged that he had little power to stop the immediate terminations, but was able to force Blue Shield to comply with their 90-day notice requirement and extend the plans until March 31st.

Blue Shield warned that the delay could potentially subject subscribers to liability for two deductibles and lose out on premium tax credits offered by Covered California plans for those earning 100-400 percent of the federal poverty level (FPL).

The 90-day delay does not affect Anthem Blue Cross (see below), Kaiser Permanente, Health Net, or other California insurers that have canceled individual plans for over one million subscribers.

Anthem Blue Cross sued over policy cancellations

Two California residents are suing insurance giant Anthem Blue Cross, alleging they were misled into giving up previous coverage that had been grandfathered under the Affordable Care Act (ACA).

The separate lawsuits ask the Los Angeles County Superior Court to block any cancellations of individual policies that do not comply with the ACA until subscribers are allowed back into grandfathered plans that need not comply with the ACA until their benefit, premium, or cost-sharing design is significantly altered.

The plaintiffs allege that Anthem pressed subscribers to move into non-grandfathered plans without notifying them that the plans would be terminated before the ACA went fully into effect.

Connecticut

State-based marketplace taking bids to work around failure of federal data hub

Access Health CT, the health insurance marketplace that Connecticut created pursuant to the Affordable Care Act (ACA), announced this week that it is accepting bids from contractors that can verify applicant income, citizenship, and eligibility for federal and state health care programs.

The move is intended to circumvent the federal data hub, a critical marketplace component that links marketplaces with data from the Internal Revenue Service, Social Security Administration, and Department of Homeland Security. However, the data hub temporarily failed again this week after two brief shut downs previously paralyzed all state and federal marketplaces (see Update for Week of October 28th).

The chief information officer at AccessHealth CT acknowledged that the cost of the private outsourcing has yet to be determined but that it can be absorbed by the \$45 million in federal exchange establishment funds received by the state. Their online infrastructure has received high marks for reliability (see Update for Week of October 21st) and AccessHealth CT has already been able to perform seven of the 14 federal data hub functions in-house. This includes billing arrangements, which AccessHealth CT transferred to participating insurers rather than trying to coordinate with federal officials.

Access Health CT has been among the few marketplace success stories, enrolling 7,615 people in its first month. Over 4,000 of these enrollees (or 53 percent) were private plan enrollments instead of Medicaid, which is by far this highest proportion nationwide.

Minnesota

ACA marketplace adds insurers in rural counties, nearly 11,000 have enrolled statewide

Officials with MNSure announced this week that nearly 11,000 Minnesotans have enrolled in health insurance coverage (covering an estimated 31,447 people when including families) through the Affordable Care Act (ACA) marketplace since open enrollment started on October 1st.

However, consistent with most other states (except Connecticut above), the vast majority of new enrollees were in the Medicaid program, as only 1,800 have purchase private marketplace coverage. MNSure projects that 300,000 uninsured Minnesotans will eventually enroll.

The Department of Commerce and Department of Health also reached agreement with participating insurers this week to add seven new health insurance coverage options for MNSure consumers in rural Olmstead and Dodge counties. Although MNSure has the lowest average marketplace premiums in the nation (see Update for Week of September 23rd), premiums in these

counties were much higher due to very limited coverage options. Residents will now have two new plan options in the each of the bronze, silver, and gold levels, as well as an additional catastrophic plan.

MNSure officials acknowledged this week that the low premiums do have a downside, in that they prevent some consumers from being eligible for premium tax credits under the ACA. A Kaiser Family Foundation study (see above) confirmed this anomaly, finding that only 90,000 Minnesotans will likely be eligible for the tax credits, compared to 300,000 in neighboring Wisconsin.

The affordability cap under the ACA creates this situation, as consumers can only get a tax credit when the dollar value of the premium for the second lowest-cost silver plan exceeds 9.5 percent of annual income for those earning at 400 percent of the federal poverty level (the cap is reduced for those at lower income levels). Thus, when the premium remains below that cap, no tax credit is available.

New Hampshire

Competing Medicaid expansion alternative set for November 21st vote

Democrats and Republicans opened the special legislative session this week by promptly setting a November 21st date to vote on competing alternatives to the Medicaid expansion under the Affordable Care Act (ACA).

The Democratic-controlled House and Governor Maggie Hassan (D) are backing a plan drafted by a special legislative panel that uses the federal funding provided by the ACA to help working individuals get insurance through their employer, while enrolling most others into Medicaid managed care. Under that Democratic plan, only people earning between 100-138 percent of the federal poverty level (FPL) will be given premium assistance to purchase ACA marketplace plans in 2015 (see Update for Week of October 7th).

The House version also repeals the ban on the state operating its own ACA marketplace that was enacted when the legislature was fully under Republican control (see Update for Week of April 30, 2012).

By contrast, the Senate (with a 13-11 Republican majority) would use ACA funds to pay premiums for about 24,000 low-income workers with access to employer-sponsored insurance and give about 34,000 other residents access to Medicaid managed care for one year. In subsequent years, those without employer-sponsored coverage would be provided premium assistance to purchase private marketplace plans, including those earning 100-138 percent of FPL.

The Republican plan would contain work or training requirements along with co-pays, deductibles and wellness initiatives, and sunset in 2016 without legislative reauthorization. However, even these provisions were not enough to satisfy conservative groups such as the Republican Liberty Caucus of New Hampshire, who insisted that any Medicaid expansion was a “further erosion of state sovereignty.”

Both plans would require federal waivers and approval would be far from certain since they differ significantly from the Medicaid expansion alternative that the Obama Administration has already approved for Arkansas, which covers all of the newly-Medicaid eligible population in marketplace plans (see Update for Week of September 23rd).

New Mexico

Insurance superintendent extends policy cancellations by one year for 11,000 subscribers

Blue Cross Blue Shield of New Mexico (BCBSNM) worked out a deal this week with the Superintendent of Insurance that will allow roughly 11,000 members enrolled in individual plans that do not comply with the ACA to remain in those plans for one year.

BCBSNM has about 17,000 members in individual plans that were in effect prior to enactment of the Affordable Care Act (ACA) and are therefore “grandfathered” or exempt from the new ACA standards until they make significant changes to their benefit, premium, or cost-sharing design. Although these

members can remain in these substandard plans indefinitely, these will see a 10.2 percent premium hike this year.

However, another 11,000 BCBSNM members are enrolled in non-grandfathered plans that were offered after the ACA was passed or have significantly changed. These members threatened to become among the millions nationwide whose plans are being cancelled when the ACA goes fully into effect this January (see Update for Week of October 28th).

Under the deal between BCBSNM and the insurance superintendent, members in non-grandfathered plans that renew by December 1st can now remain in those plans until November 30, 2014 (although their premiums will rise 9.2 percent). After that they will have to select a plan that complies with the ACA.

Lovelace Health System is the only other New Mexico insurer that has thus far asked for similar extension.

Virginia

New Governor will seek to expand Medicaid, but face opposition from split legislature

Virginians elected Terry McAuliffe (D) this week to replace the term-limited Governor Bob McDonnell (R). However, Republican gains in the House of Delegates and potential loss of control in the Senate make it very unclear whether he can fulfill his campaign pledge to participate in the Medicaid expansion under the Affordable Care Act (ACA).

Standing in the Governor-elect's way is the Medicaid Innovation and Reform Commission created last session as part of a budget compromise that requires three phases of reforms to be accomplished as a precursor to accepting the \$23 billion in ACA funds slated for Virginia over the next ten years (see Update for Week of March 25th). The first phase of these federally-approved reforms to expand Medicaid managed care and coordinate care for dual-eligibles is already underway while Governor McDonnell has already sought federal approval for the second phase to significantly increase Medicaid cost-sharing.

The Commission is also slated to vote as early as December on the proposal by Health and Human Resources Secretary Bill Hazel, MD to pursue a "private sector" alternative that would use private brokers to enroll uninsured adults in private plans with commercial benefits at per capita rates that shift the risk of managing their care to insurers (see Update for Week of October 21st). In order to reverse course and pursue the traditional Medicaid expansion for everyone earning up to 138 percent of the federal poverty level, Governor-elect McAuliffe would need the support of three of five Delegates on the Commission, as well as three of five Senators.

Without that support, it remains very unclear whether the Governor-elect could change the composition or focus of the Commission with legislation. He can offer executive amendments only at the invitation of the Appropriations or Finance committees—an invitation that the Republican-controlled committees did not extend to Republican Governor McDonnell.

Republicans still hold a veto-proof majority in the House of Delegates, as Democrats gained only one seat. Two special elections also must still decide which party will ultimately gain control in the evenly-split Senate. The first will replace Senator Ralph Northam (D) who was elected Lt. Governor and can now break any tie votes. The second will replace the victor in the race for Attorney General between Senators Mark Obenshain (R) and Mark Herring (D), which is entering a recount.

The traditional expansion sought by Governor-elect McAuliffe did have the support of key Republican leaders last session, such as Senators Walter Stosch (R) and Emmett Hanger (R), as well as House Appropriations chair Riley Ingram (R) (see Update for Week of February 25th). However, expansion proponents fear that these Republicans may reverse their support now that it is being pursued by a Democratic governor, given the adversarial posture promptly taken by Speaker Howell (R) this week.

Wyoming

Spike in Medicaid demands refocuses debate on expansion alternatives

The Joint Labor, Health and Social Services Committee met this week to debate three alternatives to participating in the Medicaid expansion under the Affordable Care Act (ACA) but will not endorse a particular option until January.

The primary alternative recommended by the Department of Health (DOH) and Governor Matt Mead (R) would create a “middle ground” between private insurance and traditional Medicaid. It would offer more limited benefits, while making recipients share in the cost of their care.

However, committee co-chairs Senator Charlie Scott (R) and Rep. Elaine Harvey (R) want to pursue the “private sector” option that the Obama Administration approved for Arkansas (see Update for Week of September 23rd), where the state would accept the ACA funds for the expansion but instead purchase private plan coverage for the expansion population through the federal marketplace. The version advanced by Senator Scott imposes additional requirements that enrollees work and contribute to the cost of their care. However, DOH concluded that an Arkansas-style model would be more expensive than the traditional expansion, consistent with prior estimates from the Congressional Budget Office (see Update for Weeks of July 23 and 30, 2012).

It is not clear that any version can clear the Republican-dominated legislature this year, as a traditional expansion plan (S.F. 122) received only one vote in the Committee last session despite the support of the Wyoming Hospital Association and a DOH study showing it would save the state \$47.5 million in spending compared to the \$80 million cost of opting-out (see Update for Week of January 21st). However, an internal debate among Republicans over whether to expand was recently renewed when new Medicaid applications spiked even before open enrollment in the ACA marketplace started. As a result, DOH is averaging 3,250 monthly applications for this year, up 70 percent from two years ago.

Because of Wyoming’s small size, the traditional Medicaid expansion would benefit only an estimated 17,000 adults, which is roughly 20 percent of the state’s uninsured population. However, Wyoming’s current eligibility requirements are stricter than most states, as a single mother with one child would have to earn less than \$800 a month to qualify for Medicaid.

The Medicaid expansion may prove critical for Wyoming because a lack of competition for federal marketplace consumers left it with the highest average premiums for marketplace plans at \$516 per month for the second lowest-cost silver plan (see Update for Week of September 23rd). The state’s dominant insurer, Blue Cross and Blue Shield has only one competitor, WINhealth, whose marketplace enrollment was at a near standstill until the past week when WINhealth reports that 40 of its 90 enrollees have signed-up. The insurer is now receiving 6-10 applications per day (BCBS has not released its enrollment data).