



### Health Reform Update – Week of February 24, 2014

By Mark Hobrarcz

#### CONGRESS

##### *House bill to soften employer mandate receives adverse CBO score*

The Congressional Budget Office (CBO) concluded this week that the House Republican bill increasing the Affordable Care Act (ACA) threshold for a full-time employee would actually increase the federal deficit by roughly \$74 billion over the next decade.

The measure would allow penalties under the ACA's employer mandate to be assessed only if employers fail to provide minimum essential coverage (MEC) to those working at least 40 hours per week, instead of 30 under the current law. According to CBO, this would increase the deficit in two ways. Not only would the revenue from employer mandate penalties dramatically decline, but up to one million fewer workers would receive employer-based coverage forcing them to either remain uninsured or try and enroll in Medicaid, SCHIP, or the ACA Marketplaces.

The *Save American Workers Act* (H.R. 25757) had cleared the House Ways and Means committee on a party line vote (see Update for Week of February 3<sup>rd</sup>) and was slated for a full House vote as early as next week. However, it is not clear what impact the CBO score will have on the vote. Of the bill's 208 cosponsors, seven had been Democrats.

The employer mandate has already been delayed until 2015 for employers with at least 100 workers (see Update for Weeks of July 1<sup>st</sup> and 8<sup>th</sup>) and until 2016 for those with 50-99 employees (see Update for Week of February 10<sup>th</sup>).

#### FEDERAL AGENCIES

##### *CMS clarifies that non-profits can assist with Marketplace premiums*

The Centers for Medicare and Medicaid Services (CMS) clarified earlier this month that non-profit charitable organizations such as PSI can continue to assist consumers with qualified health plan (QHPs) premiums in the health insurance Marketplaces created by the Affordable Care Act (ACA).

The February 7<sup>th</sup> FAQ was in response to concerns raised by PSI and other consumer groups after the CMS' November 4<sup>th</sup> FAQ stated that it "discourages this practice and encourages issuers to reject third party payments", at least for hospitals, healthcare providers, and other commercial entities. That response created significant confusion as it appeared to differ from the earlier determination by the Secretary of Health and Human Services that QHPs were private and not public plans and thus not subject to the prohibition on premium and copayment assistance for a "federal health care program" under Section 1128B of the Social Security Act (see Update for Week of October 28<sup>th</sup>).

PSI had previously confirmed that the HHS Office of Inspector General concurred with this determination by the HHS Secretary and deferred to CMS on whether the confusing FAQ required further explanation. CMS' clarifying language in the February FAQ explicitly states that:

"The concerns addressed in the November 4, 2013 FAQ would not apply to payments from a private, not-for-profit foundation if...they are made on behalf of QHP enrollees

who satisfy defined criteria that are based on financial status and do not consider enrollees' health status [and the] premium and any cost sharing payments cover the entire policy year.”

It is not yet clear if CMS' favorable clarification signals that it will require all Marketplace insurers to accept third-party premium and cost-sharing assistance from federal Ryan White AIDS Drug Assistance Programs (see Louisiana below).

### ***Marketplace enrollment exceeds four million despite mixed results for young adults, co-ops***

The Centers for Medicare and Medicaid Services (CMS) announced this week that enrollment in the health insurance Marketplaces created by the Affordable Care Act (ACA) has now exceeded four million consumers.

The figure represents a 21 percent jump from the 3.3 million enrolled by January (see Update for Week of February 10<sup>th</sup>). However, it still lags far behind the seven million that CMS initially projected would enroll through the March 31<sup>st</sup> end of the inaugural open enrollment period.

Vice President Biden acknowledged this week that the Marketplaces were not likely to meet the seven million target. A spokesperson also indicated that the White House is scaling back its projection that young adults age 18-34 would make up 40 percent of all Marketplace enrollees, noting that the Massachusetts Health Connector upon which the ACA models are based never exceeded 34 percent.

The insurance industry has insisted that 38-39 percent of the Marketplace risk pool needs to be young adults in order to ensure they are financially viable. However, a Kaiser Family Foundation study claims that insurers can still make a “small profit” if only 25 percent enroll (see Update for Week of January 13<sup>th</sup>).

The most recent demographic breakdown from CMS showed that about 27 percent of Marketplace enrollees through January were young adults. The next demographic detail should be released in mid-March.

The National Alliance of State Health Co-Ops (NASCHO) separately announced this week that roughly 300,000 of the four million Marketplace sign-ups (or 7.5 percent) have enrolled in the not-for-profit, consumer-owned and -operated health insurance plans (co-ops) established under the ACA. The co-ops currently compete in the Marketplaces for 23 states, where they have garnered 15-20 percent of enrollment.

However, co-op enrollment has varied widely among the Marketplaces, causing the figures to be distorted by a handful of co-ops that have been very successful. For example, CoOpportunity Health enrolled above 50,000 individuals in Iowa and Nebraska, or more than 400 percent of the plan's initial projections for the inaugural open enrollment period. Kentucky Health Cooperative and Maine Community Health Options have enrolled 60-80 percent of their state's Marketplace enrollments respectively, while co-ops in Montana, New Mexico and New York have also garnered a large share of the enrollment market. The co-ops in Kentucky, Massachusetts, and Montana have already announced plans to expand next year into neighboring states, based on their initial results.

By contrast, other co-ops have struggled mightily. Connecticut's HealthyCT has enrolled about 1,700 individuals or roughly three percent of the market, while Evergreen Health co-op in Maryland has signed-up only about 600. Health co-ops in Illinois in Michigan are also lagging far behind projections as they were unable to offer premiums that were any lower than other Marketplace plans.

Overall, co-ops were able to offer the lowest premium in only one-third of the Marketplaces in which they participate. However, NASCHO claims that competition from co-ops has still been able to lower Marketplace premiums by an average of 8.5 percent.

The House Oversight and Government Reform committee is continuing to investigate the financial viability of the co-ops, citing Office of Management and Budget predictions that roughly 43 percent of the \$2.1 billion ACA loans used to create the co-ops may not be paid back. House Republicans successfully eliminated the remaining \$2.3 billion in ACA funding for co-op loans as part of earlier deficit reduction compromises, preventing new co-ops in the 27 states without one (see Update for Weeks of December 24 and 31, 2012).

### ***CMS extends ACA subsidies to consumers from states with failed Marketplace websites***

The Centers for Medicare and Medicaid Services (CMS) announced this week that it will allow consumers that were unable to enroll in state-based Marketplaces experiencing severe technological glitches to still receive retroactive premium and cost-sharing assistance provided under the Affordable Care Act (ACA).

The move came as a surprise as subsidies had previously not been available to consumers purchasing non-Marketplace coverage, even if their income otherwise made them eligible. To receive the subsidies, consumers must be able to demonstrate that they unsuccessfully attempted to enroll in the Marketplace and instead purchased a non-Marketplace plan that still complies with ACA standards.

Although most of the 15 state-based Marketplaces have largely outperformed their federal counterparts, several have still been hampered by flawed web portals. Oregon has lacked any online enrollment capability since the start of open enrollment (see Update for Week of February 17<sup>th</sup>) while Maryland fired their contractor just this week after fixes have been unsuccessful (see below). Hawaii, Massachusetts, Minnesota, and Nevada (see below) are other states where enrollment has been significantly curtailed by technological glitches.

### ***CMS actuary acknowledges that ACA will hike premiums for most small business workers***

Republican leaders pounced this week on a report from the chief actuary for the Centers for Medicare and Medicaid Services (CMS) that acknowledged the Affordable Care Act (ACA) would increase premiums for nearly two-thirds of small business workers with employer coverage.

House Speaker John Boehner (R-OH) blasted the agency for delaying and then quietly-releasing the negative report, which was mandated by the debt ceiling compromise codified in the *Budget Control Act of 2011*. The report blames the community rating provisions under the new law for the premium increases, specifically the requirement that premiums vary by no more than 300 percent based on age and the prohibition on any variance based on health status.

The report did emphasize that their estimate comes with "a rather large degree" of uncertainty as the ultimate impact could vary dramatically depending on the "mix of firms that decide to offer coverage." CMS concedes that RAND Corporation studies have already projected "minimal" premium increases as a result of these provisions and notes that the share of workers actually seeing a premium decrease could be higher than the 35 percent they project.

CMS also points out that the number of individuals affected in 2014 will be limited because many small businesses renewed their plans early and half the states have allowed extensions of pre-ACA rating rules due to the President's decision to allow ACA-deficient plans to continue at least through 2014 (see Update for November 18<sup>th</sup>-December 6<sup>th</sup>).

### ***Narrow provider networks influence Marketplace consumers less than premium cost***

The latest Kaiser Family Foundation monthly tracking poll reaffirms that purchasing decisions by Affordable Care Act (ACA) Marketplace consumers remain influenced largely by premiums.

The survey of over 1,500 adults found that a majority (54 percent) of those that are uninsured or purchase individual plan coverage would select a low-premium plan with narrow provider networks over

higher-premium plans that offer a broader choice of providers. This is the group most likely to purchase Marketplace coverage.

However, Kaiser acknowledges that the results for the Marketplace group change dramatically (falling to 35 percent) when respondents are informed that they may not be able to see their current physician or hospital under the cheaper plan. The figures were also reversed when including non-Marketplace consumers, as 51 percent of all respondents said they would prefer a higher-cost plan with a wider provider network.

Previous studies found that up to 70 percent of Marketplace plans narrowed their provider networks in order to offer more attractive premiums for 2014, forcing CMS to already propose broader network adequacy standards for next year (see Update for Week of February 3<sup>rd</sup>) and give consumers the flexibility to switch to broader network plans for this year (see Update for Week of February 10<sup>th</sup>).

A majority (56 percent) of all respondents also said that the ACA should be kept in place now that it is fully in effect. Nearly a third (31 percent) still favors total repeal.

Most respondents (54 percent) also indicated that they have yet to be affected by the ACA. However, 29 percent report that they have been negatively impacted—up from 23 last fall.

### ***CMS proposes further rate cut to Medicare Advantage, implements Part D discounts for 2015***

The Centers for Medicare and Medicaid Services (CMS) announced a proposed 1.9 percent cut this week in Medicare Advantage (MA) payments for 2015.

The news stirred some controversy as insurers had been told by CMS in December that rates for the private managed care plans would largely remain “flat”. However, final MA rates may eventually be lower or higher than 1.9 percent depending on the metric that measures the estimated growth in per-capita expenditures for Medicare beneficiaries.

In the agency’s annual “call letter”, CMS also notified insurers that it is ending the Affordable Care Act (ACA) demonstration program that allowed it to offer bonus payments based on quality ratings given to each plan. Republican lawmakers had been investigating the propriety of payments under the demonstration after the Government Accountability Office (GAO) had criticized CMS for extending bonuses to plans earning only three out of five stars without Congressional approval (see Update for Week of October 15, 2012).

America’s Health Insurance Plans (AHIP) insisted that the loss of the quality bonuses and the restricted rate of growth in MA payments put into place by the ACA mean that participating insurers will face an effective cut of roughly 6-7 percent and premium increases of \$420-900 per year. (AHIP claims that a 2.3 percent cut for 2014 was in reality a six percent cut when combined with other ACA changes.)

Republican leaders and even some Democrats claimed that the cuts support their claims that the MA program was being undermined to fund the ACA. CMS defended the cuts as part of Congress’ intent under the ACA to bring historic overpayments to MA plans in line with physician and hospital reimbursement under traditional Medicare.

The CMS call letter also formalizes the continued narrowing of the Medicare Part D coverage gap under the ACA. For 2015, the required discounts within this so-called “doughnut hole” will increase from 52.5 to 55 percent on covered brand-name drugs and from 28 to 35 percent on covered generic drugs.

### ***Medicare provider payment appeals on hold***

The Office of Medicare Hearings and Appeals announced earlier this month that appeals filed by beneficiaries will take priority over those sought by hospitals, physicians, and other health-care providers.

The move is intended to alleviate the nearly two year wait for a beneficiary to reach a hearing (and an additional nine months for a decision). Consumer advocates had long sought to prioritize beneficiary hearings, pointing out that many die during this delay.

According to the chief administrative law judge (ALJ), the office has a backload of nearly 357,000 claims, after caseloads soared 184 percent while the number of ALJs remained about the same. In addition, Medicare's decision to hire private auditors to investigate overbilling has further slowed the appeals process.

The Office of the Inspector General for the Department of Health and Human Services found in 2012 that ALJs had to reverse payment denials 72 percent of the time for hospitals but only 28 percent for beneficiaries. The bonuses auditors received for "flagging" hospital claims was largely blamed for providing an incentive to back-up the appeals pipeline with inappropriate denials.

The American Hospital Association objected to Medicare's decision to prioritize beneficiary claims, arguing instead that the audits should simply be halted.

## STATES

### Arkansas

#### ***Expected House vote to sustain Medicaid expansion delayed indefinitely***

The House appeared certain late last week to reauthorize Arkansas' novel Medicaid expansion after Speaker Davy Carter (R) announced that he had secured the needed three-fourths majority following the narrow Senate passage (see Update for Week of February 17<sup>th</sup>). However, the final vote that had been declared all but a formality was indefinitely delayed after the Speaker lost two needed votes, forcing a week-long negotiation between lawmakers and the Department of Human Services over enrollment limits and marketing/outreach bans sought by the conservative holdouts.

The broad outlines of the latest deal would set an open enrollment period from January 1<sup>st</sup>-March 31<sup>st</sup> of each year in which those earning 100-138 percent of the federal poverty level could enroll in the state partnership Marketplace (funded with ACA expansion dollars). Outside of that period, they could still enroll in traditional Medicaid. However, it is not clear what would happen to the roughly 96,500 newly-eligible Medicaid residents that are already enrolled in Marketplace plans through the federally-approved expansion alternative.

The final vote to reauthorize the expansion is now expected to occur early next week.

### Louisiana

#### ***Court temporarily bars Marketplace insurers from refusing ADAP premium assistance funds***

A federal court ruled this week that insurers participating in Louisiana's federally-facilitated Marketplace under the Affordable Care Act (ACA) must at least temporarily continue to accept premium assistance payments under from federal AIDS Drug Assistance Programs (ADAPs).

Lambda Legal and individual plaintiffs with HIV/AIDS had filed the lawsuit after Blue Cross and Blue Shield of Louisiana announced it would stop accepting the payments starting March 1<sup>st</sup>, and two of the other three remaining Marketplace insurers followed (see Update for Week of February 10<sup>th</sup>).

The court granted Lambda Legal the 14-day reprieve after determining that it was "likely to succeed on the merits" of its claim due to the non-discrimination provisions of the ACA. By contrast, it noted that plaintiffs' health could decline if the premium assistance was stopped pending a final decision, while continuing the existing policy of accepting Ryan White/ADAP funds would not harm the insurers.

The federal Centers for Medicare and Medicaid Services (CMS) has already reminded all Marketplace insurers that “Federal rules do not prevent the use of Ryan White funds to pay for health care plans” and “encouraged” them to accept such payments. However, CMS concedes that encouragement may not be enough and is “considering amending those rules to require issuers to accept these payments....given the importance of access to care for people with HIV/AIDS” (see Update for Week of February 10<sup>th</sup>).

### ***New Senate bill would bar specialty tier coinsurance, limit other drug costs***

Senator Edwin Murray (D), vice chair of the Labor and Industrial Relations committee, pre-filed legislation this week that would put new limits on out-of-pocket (OOP) costs for prescription drugs while prohibiting the use of percentage coinsurance for the highest-cost specialty medications.

Under S.B. 165, health plans could not create prescription drug specialty tiers that require the insured to pay a percentage of the drug’s costs instead of a flat copayment. Overall cost-sharing for a particular drug also could not exceed 500 percent of the lowest amount of cost-sharing required for formulary drugs.

Plans that set an OOP limit for benefits other than prescription drugs must include one of the following options that results in the lowest OOP drug cost:

- (1) OOP for prescription drugs shall be included under the plan's total OOP limit for all benefits.
- (2) OOP for prescription drugs per plan year shall not exceed \$1,000 per insured or \$2,000 per family.

### Maryland

#### ***Health department fires developer of flawed Marketplace portal***

The Maryland Health Connection announced this week that it has fired the lead contractor responsible for the failed web portal for the Affordable Care Act (ACA) health insurance Marketplace.

Continued technological problems with the website built by Noridian Healthcare Solutions has forced state officials to consider abandoning it altogether and defaulting to the federally-facilitated model (see Update for Weeks of January 20<sup>th</sup> and 27<sup>th</sup>). The website failures have caused Maryland to lag near the bottom in Marketplace performance enrolling only 4.4 percent of eligible enrollees through January.

Maryland-based Optum/QSSI will now assume the role of lead contractor, after coming on board in December to repair problems with the portal. Maryland has already paid Noridian \$65 million of the \$193 million five-year contract it signed in 2012. It is not yet clear whether the state can recoup some of these costs and the transition plan being negotiated could impose a six-month waiting period before any such claims could be filed. State officials estimated this week that flaws in the existing website will cost Maryland at least \$30.5 million in unnecessary Medicaid spending over the next two fiscal years.

Although other states had similar technological glitches during the first few weeks of open enrollment, legal disputes between Noridian and a subcontractor that it fired prevented many early problems with the web portal from being promptly corrected (see Update for Week of December 9<sup>th</sup>). Noridian also relied on “off-the-shelf” software that was “ready-made”, instead of designing a new system specific to Maryland’s Marketplace.

Maryland is not alone in firing its lead contractor as the Centers for Medicare and Medicaid Services (CMS) has already had to replace CGI Federal after the flawed rollout of the federally-facilitated Marketplaces operated in 36 states (see Update for Week of January 6<sup>th</sup>). At least seven of the 15 state-based Marketplaces have also relied on CGI Federal (see Update for Week of January 13<sup>th</sup>).

Despite similar problems with its lead contractor Xerox, state officials in Nevada took the opposite approach this week and elected to hire an outside contractor to work with Xerox in pursuing fixes. The

Nevada Health Link recently had to cut its enrollment projection in half due to the limited functionality of its web portal (see Update for Week of February 10<sup>th</sup>).

#### Missouri

##### ***House Republicans offer Medicaid expansion alternative despite Senate opposition***

Rep. Noel Torpey (R) filed legislation this week that (H.B.1901) that would allow Missouri to accept federal funds to expand Medicaid under the Affordable Care Act (ACA), but do so through private health plans.

The “private sector” alternative largely follows the model federally-approved for Arkansas, Iowa, and Michigan (see Update for Week of January 6<sup>th</sup>). Those are the high-end of the expansion population (earning 100-138 percent of poverty) would be covered in the federally-facilitated Marketplace while those earning below 100 percent of poverty would be covered under Medicaid managed care plans. All of the newly-eligible population would be required to pay sliding-scale premiums up to one percent of income, while most would also be subject to mandates that they participate in the workforce. The latter requirement is not likely to gain federal approval and was recently stripped from a comparable model proposed by Pennsylvania Governor Tom Corbett (R)(see Update for Week of February 17<sup>th</sup>).

The Missouri Chamber of Commerce and several House Republicans back the legislation, although every Senate Republican has already rejected consideration of any Medicaid expansion plans (see Update for Week of February 3<sup>rd</sup>).

#### South Dakota

##### ***House rejects Medicaid expansion***

House Republicans have overwhelmingly rejected two Medicaid expansion measures, including an alternative plan that would only use state funds.

A Democratic amendment to an unrelated bill would have allowed South Dakota to participate in the Medicaid expansion under the Affordable Care Act (ACA) but was defeated on a largely party-line vote. However, Republicans were split on a measure introduced by Rep. Scott Munsterman (R) that would have used \$14 million per year in state funds to provide coverage for up to 4,000 uninsured low-income residents that worked full-time. It was still rejected on a 45-24 vote.

Rep. Munsterman acknowledged that his bill (H.B. 1244) would be less efficient than a traditional expansion, which would bring in roughly \$200 million in federal matching funds. However, only two House Republicans have expressed any support for accepting the federal funds.

Governor Dennis Daugaard (R) opposed the state-only alternative and has indicated that he will only accept the ACA expansion funds if the Obama Administration allows South Dakota to design its own program (see Update for November 18<sup>th</sup>-December 6<sup>th</sup>).

The State Affairs committee deferred two other Democrat-backed Medicaid expansion measures last week. The first (H.B. 1210) would expand Medicaid under the ACA was the second was a resolution (H.J.R. 1007) that would leave the decision to the voters.

#### Tennessee

##### ***Flurry of bills seek to impede ACA implementation***

The House passed legislation this week (H.B. 937) that would prohibit state officials from participating in any Medicaid expansion authorized by the Affordable Care Act (ACA). A comparable bill (S.B. 804) remains pending in the Senate.

Tennessee is one of only four states that have yet to decide whether to participate in the expansion since the U.S. Supreme Court gave all states the discretion to opt-out without penalty (see

Update for Week of July 2, 2012). Governor Bill Haslam (R) has opposed a full ACA expansion but is pursuing the feasibility of “private sector” alternatives similar to those federally-approved for Arkansas, Iowa, and Michigan (see Update for Week of January 6<sup>th</sup>). A successful amendment to H.B. 937 specifically would prohibit the Governor from pursuing a federal waiver or obligating the state to any expansion without legislative approval.

The measure is just one of several bills seeking to block or hinder implementation of ACA provisions that will be heard in committees during March. These include:

- H.B. 1770/S.B. 1888 that would prohibit state entities from establishing or administering any regulatory scheme to operate the ACA.
- H.B. 1886/S.B. 2234 that would bar insurers from accepting any payments under the temporary reinsurance and risk corridor program under the ACA meant to compensate them for extraordinary losses over the next three years (see Update for Weeks of January 20<sup>th</sup> and 27<sup>th</sup>).
- H.B. 2129/S.B. 2155 that would require health insurers to notify subscribers how much of any premium increases is due to the ACA.
- H.B. 2248/S.B. 2131 that would prohibit local education agencies from including information on the ACA in TennCare and SCHIP mailings to families (see Update for Weeks of January 20<sup>th</sup> and 27<sup>th</sup>).

### Utah

#### ***Governor backs Arkansas-style alternative to Medicaid expansion***

Governor Gary Herbert (R) officially threw his support this week behind a “private sector” alternative to the Medicaid expansion under the Affordable Care Act (ACA) that largely mirrors the model already federally-approved for Arkansas, Iowa, and Michigan (see Update for Week of January 6<sup>th</sup>).

The Governor has insisted that “doing nothing” is not an option and has opposed efforts by the most conservative members of the legislature to pursue a stripped-down expansion model that relies only on state funds (see Update for Week of February 17<sup>th</sup>). Under the Governor’s plan, Utah would become the fourth state (and the third headed by a Republican governor) to seek a federal waiver allowing it to use ACA matching funds to instead cover at least a portion of the newly-eligible population under private plans offered in the federally-facilitated Marketplace. (Indiana, Pennsylvania, and Tennessee are considering a similar approach).

Governor Herbert said the waiver would be for three years and the exact amount of assistance would depend on an individual's ability to work, household income, access to employer-sponsored coverage or family health insurance, and individual health care needs. Participants getting coverage through the waiver would have to pay sliding-scale copayments (up to two percent of income) while parents with children on Medicaid would have the option to enroll their entire family in Marketplace plans.

### Virginia

#### ***General Assembly moves to end SCHIP waiting period***

The House and Senate have passed legislation (H.B. 586/S.B. 416) eliminating the requirement that children under age 19 must be uninsured for at least four months to be eligible for the Family Access to Medical Insurance Security program (FAMIS). Virginia’s version of the federal State Children’s Health Insurance Program (SCHIP) already would have been required to reduce the waiting period to 90 days under new Affordable Care Act (ACA) regulations (see Update for Week of February 17<sup>th</sup>). According to the Department of Planning and Budget, it was thus decided that the entire waiting period should be dropped as it was “seldom enforced.”

The Department of Medical Assistance Services estimates that removing the waiting period will allow approximately 30 individuals per year to gain FAMIS coverage.

Colorado and Pennsylvania took similar legislative action last year. However, more than 30 states continue to impose SCHIP waiting periods.