



Health Reform Update –Week of July 14, 2014

CONGRESS

CBO predicts that ACA cost controls will curb federal health spending

A new report from the Congressional Budget Office (CBO) concluded this week that cost control measures in the Affordable Care Act (ACA) will help to restrain the growth in spending for federal health care programs over the next 25 years.

The non-partisan budget scorekeeper does warn that Social Security, Medicare, and Medicaid outlays will push the national debt to “unsustainable” levels. However, combined with ACA premium assistance and cost-sharing subsidies, total health spending is now expected to equal eight percent of gross domestic product (GDP) in 2039, instead of the 8.1 percent that CBO projected next year. The difference comes to about \$250 billion in 2014 dollars.

The lower estimate is a result of CBO downgrading its projection of Medicare spending in 2039 from 4.9 percent of GDP to 4.6 percent, based on the latest available Medicare data from 2012. Overall, CBO cut its ten-year spending forecast for Medicare and Medicaid by \$1.23 trillion.

In addition to the ACA cost controls, cuts in Medicare payments due to the ongoing budget sequester are factored in, as is the Medicare physician payment reduction that Congress has forestalled every year since 1997.

CBO also projected that the Medicare trust fund will remain solvent until 2030, five years longer than their previous forecasts. However, annual spending projections from trustees have been delayed from their customary release in March until the end of July. Last year’s report extended the date of insolvency to 2026, two years later than projected in their 2012 report.

House spending bill targets ACA funding again

The House passed its version of the fiscal year 2015 financial services spending bill (H.R. 5016) this week. The measure omits funding sought by the White House to implement more than 40 provisions of the Affordable Care Act (ACA), including the Internal Revenue Service’s administration of premium tax credits and enforcement of the individual and employer mandates. The measure also seeks to prevent any transfer of funds from the Department of Health and Human Services for ACA implementation.

H.R. 5016 is likely to be largely-symbolic as it passed almost exclusively with Republican support and is expected to be blocked by the Democratically-controlled Senate. The lack of progress on all appropriations measures for fiscal year 2015 means that Congress is likely to rely on a temporary spending resolution to keep the government operating past the September 30th end of the fiscal year and through the November elections, leaving a full-year spending bill up to the next Congress.

FEDERAL AGENCIES

CMS exempts territories from ACA market reforms

Centers for Medicare and Medicaid Services (CMS) Administrator Marilyn Tavenner notified United States territories this week that the agency has reversed its position on whether they will be subject to all of the market reforms under the Affordable Care Act (ACA).



The ACA statute required health insurers in the territories to comply with certain reforms such as bans on pre-existing conditions, essential health benefits (EHB), and restrictions on insurer profits. These reforms amended the Public Health Services (PHS) Act, which defines territories as states for the purpose of the Act.

However, the ACA's individual mandate and premium tax credits were not an amendment to the PHS Act and part of separate ACA provisions that applied solely to states. As a result, CMS has insisted since last summer that residents in territories could not be compelled to buy affordable coverage nor receive premium assistance under the ACA.

Territorial officials argued vehemently that requiring insurers to accept everyone regardless of health status without simultaneously expanding the risk pool to include less costly subscribers is destabilizing their individual marketplaces as few if any insurers are willing to offer policies. As a result, the Administrator issued a letter stating that "after a careful review of this situation...[CMS] has determined that the new provisions of the PHS Act enacted in title I are appropriately governed by the definition of 'state' set forth in that title."

According to the Administrator, CMS will issue regulations affirming that health insurers in territories are now exempt from the ACA's requirements for guaranteed issue, EHB, medical loss ratios, community rating, rate review, and a single risk pool. (Residents remain exempt from the individual mandate and ineligible for premium assistance). The exemption will apply immediately, regardless of when the regulations are promulgated.

The Administrator notes that territories will be required to return any of the unspent federal grants they have received, such as those for rate review or navigator assistance. However, because the exemption is prospective, funds already spent do not have to be returned.

New Medicaid enrollments near seven million

The Centers for Medicare and Medicaid Services (CMS) announced this week that 6.7 million people have newly-enrolled in Medicaid and the Children's Health Insurance Program (CHIP) from the opening of Affordable Care Act (ACA) Marketplaces last fall through May 31st.

The latest figures through May 31st show an 11.4 percent increase in May alone. Enrollment increased by 17 percent among the 25 states and the District of Columbia that have already expanded Medicaid under the ACA, compared to only three percent in non-expansion states.

In 38 states that reported relevant data, more than half of all Medicaid and CHIP enrollees were children.

Analysis of 2015 out-of-pocket costs for ACA plans shows no consistent trend

A new study released this week by HealthPocket examined out-of-pocket costs under the initial 2015 rate filings for nine states and found that some out-of-pocket costs for Affordable Care Act (ACA) plans will likely increase while others may decline.

The maximum allowed annual out-of-pocket (OOP) limit will increase for all ACA plans in 2015 from \$6,350 for individuals to \$6,600 (and \$12,700 to \$13,200 for families). However, insurers can offer plans with lower OOP caps and most silver and platinum plans sought to do so in these nine states.

Proposed deductibles are set to fall for all plan levels except platinum across the nine states. The most popular silver-level plans to which premium subsidies are tied saw a proposed decrease of nine percent, with a higher decrease (12 percent) for gold plans and only a one percent decline for the less



generous bronze plans. By contrast, deductibles for platinum plans may jump a staggering 43 percent among the most generous platinum plans.

Expenses for doctor and specialist visits also vary dramatically among metal tiers. Copayments are now more commonly used for primary care visits compared to coinsurance, where a patient is charged a percentage of the overall cost (the reverse was true for bronze plans in 2014). However, coinsurance remains the most common charge for specialist visits among all plans in the nine states, and that amount increased by 17 percent within the rate filings.

Silver and gold plans both saw decreases in doctor and specialist fees, while platinum plans saw an increase in the rate filings for the nine states.

HealthPocket analyzed the rate filings for Arizona, Connecticut, Indiana, Maine, Michigan, North Carolina, Rhode Island, Tennessee, and Virginia. Proposed rates are subject to review and modification in several of these states.

Kaiser study finds that navigators are key to Marketplace enrollment

An analysis released this week by the Kaiser Family Foundation concludes that navigators and other Marketplace assisters helped educate more than 10.6 million consumers about the new health insurance options available under the Affordable Care Act (ACA). However, it also found that up to 24 percent of assisters had to turn away consumers because they lacked the resources to meet the demand for their services during the peak of open enrollment.

Kaiser stressed that assisters will continue to play a “key role” in facilitating Marketplace enrollment for 2015. The Centers for Medicare and Medicaid Services has already made \$60 million in additional assister grants available for next year and promulgated new rules limiting the ability of states to prevent assisters from carrying out their ACA-proscribed duties (see Update for Week of June 2nd).

CMS creates Medicaid Innovation Accelerator Program to help states coordinate reforms

The Centers for Medicare and Medicaid Services (CMS) has created a portal on its website to help states coordinate Medicaid innovation efforts with CMS and each other.

The Medicaid Innovation Accelerator Program (IAP) was created based on recommendations CMS received from the National Governors Association's Health Care Sustainability Task Force. It will invest \$100 million over five years in technological services for CMS to help states expedite Medicaid payment and delivery systems reforms.

As part of the IAP, the agency will identify and circulate information on state efforts to develop new delivery and payment models, improve quality measurement across programs, and help coordinate communication among states so that they can more quickly learn from each other about which reforms are working well. However, the \$100 million will not go to states but instead be spent within CMS, which will give states access to the IAP through the website portal.

HRSA will use interpretative guidance to circumvent injunction on 340B rule

The Health Resources and Services Administration (HRSA) revealed this week that it will shortly issue an interpretative guidance to implement the Affordable Care Act (ACA) provision allowing for Section 340B discounts for non-orphan uses of orphan drugs.

A federal court issued an injunction last spring against HRSA's implementing rules that the pharmaceutical industry argued went beyond the authority granted by the ACA (see Update for Week of



June 9th). However, HRSA is claiming that the court's prohibition applies only to legislative rulemaking and not interpretative guidance.

The 340B drug discount program allows safety net providers that care for low-income patients to obtain drugs at substantially reduced prices from manufacturers participating in the Medicaid rebate program. The ACA expanded the 340B drug discount program to cancer centers, critical access hospitals, rural referral centers, and sole community hospitals for outpatient drugs, but excluded orphan drugs. However, HRSA issued proposed regulations last summer stating that participating facilities could still receive the 340B discounts for orphan drugs if they planned to use the drugs to treat conditions that are not part of the orphan indication.

The Pharmaceutical Research and Manufacturers of America (PhRMA) insists that nothing in the ACA or any other federal statute gives HRSA the authority to extend the discounts to orphan drugs, even for other indications or off-label uses. The court limited HRSA's rulemaking authority on 340B to ceiling prices, dispute resolution, and civil monetary penalties. However, it conceded that the issue of whether interpretative guidance constituted rulemaking was a "gray area".

PhRMA has already filed a motion with the court in June to push HRSA to comply with the court's ruling and not extend the discounts. However, HRSA officials stand by their interpretation and were backed this week by Rep. Henry Waxman (D-CA), the primary authority of the 340B legislation in the early 1990s.

STATES

Non-expansion states now account for 60 percent of uninsured

According to the latest Health Reform Monitoring Survey (HRMS) from the Urban Institute, 60 percent of the nation's uninsured population resides in the 25 states that have opted-out of the Medicaid expansion under the Affordable Care Act (ACA) as of June 2014.

Researchers note that these primarily southern or rural states (including Florida and Texas) already accounted for half of the nation's uninsured rate before the ACA Marketplaces opened last fall, even though they represent only 46 percent of the nation's population. The study also projects that the 60 percent will continue to rise since the uninsured will fall more precipitously in expansion states where 71 percent of their uninsured qualify for ACA subsidies (compared to only 44 percent in non-expansion states). Several other states have or are expected to expand their Medicaid programs subsequent to June 2014 through federally-approved "private sector" alternatives (including Indiana, New Hampshire, and Pennsylvania.)

CMS sends warning letters to seven more states with Medicaid backlogs

Six states responded this week to demands by the Centers for Medicare and Medicaid Services (CMS) that they develop contingency plans within ten days to address persistent backlogs of more than 2.9 million Medicaid applications (see Update for Weeks of June 30th and July 7th).

Alaska, California, Kansas, Michigan, Missouri and Tennessee received the letters last week, while seven others (Arkansas, Georgia, Illinois, Indiana, North Carolina, Virginia and Wyoming) were sent similar limits on July 9th.

California, with the largest backlog of more than 600,000 applicants, plans to cut that figure nearly in half by August, and reducing it by 33 percent since May (see Update for Week of June 2nd). Technological shortcomings remain the main impediment, as computer systems still need to add an



automated process to identify and get rid of duplicate applications, as well as updated self-service portals to can catch errors.

Tennessee received the harshest letter for failing to meet almost all of the seven “critical success factors” that the agency outlined in Medicaid eligibility and enrollment rules, as well as missing CMS’ deadline to upgrade its online enrollment capability by nearly a year (see Update for Weeks of June 30th and July 7th). However, Tennessee officials insisted this week that the state was being unfairly targeted due to unrealistic timelines required by CMS given the limited resources that states received.

Tennessee’s \$35 million online Medicaid eligibility system has been delayed until September or nearly a year after CMS’ deadline. As a result, CMS noted that Tennessee is unable to accept a single, streamlined application, convert existing state income standards to the ACA’s Modified Adjusted Gross Income, respond to FFM inquiries, or verify eligibility from the federal data hub. However, Tennessee officials argue that the delay in the computer system has not prevented more than 125,000 residents from enrolling in Medicaid since January 1st, even though the state has yet to expand Medicaid under the ACA.

Three states that remain unable to receive Medicaid applications from the federally-facilitated Marketplace (FFM) emphasize that they are enrolling applicants through non-electronic means. All three (Alaska, Kansas, and Michigan) expect to start receiving FFM data in the next several weeks.

Maryland

Legislators assured the glitch in Connecticut Marketplace software will not affect Maryland

Officials with the Maryland Health Benefit Exchange board were forced this week to assure legislators that programming flaws in the software it is importing from Connecticut’s successful Marketplace will be corrected with federal funds before the November 15th start of open enrollment.

Maryland is one of five states that created their own Marketplaces in 2014 but are seeking to either move to the federally-facilitated model for 2015 or replace their Marketplace software entirely (see Update for Week of June 9th). The board elected to use the technology infrastructure relied upon by the successful state-based Marketplace in Connecticut. However, AccessHealth CT subsequently revealed that more than 6,000 subscribers in that their Marketplace were adversely impacted by software flaws that left more than 900 paying customers without coverage, incorrectly enrolled other private plan subscribers into Medicaid, or sent erroneous bills to insurers (see Update for Week of June 2nd).

AccessHealth CT insists that a permanent fix will be completed this week, and exchange officials told lawmakers that corrections to the Maryland website will be finished by July 25th. However, the problems may prevent the Marketplace from doing live testing before November 15th.

Board officials informed lawmakers that the Obama Administration has already approved their decision to import Connecticut’s technology. The Maryland Marketplace has been the subject of federal audits (see Update for Weeks of March 17th and 24th) and will face two separate state audits starting this week.

Massachusetts

New Marketplace software passes initial tests

The board for the Massachusetts Health Connector Board announced this week that the web portal rebuilt with software from hCentive has been successfully tested. As a result, the Connector has received approval from the Centers for Medicare and Medicaid Services (CMS) to continue developing the health insurance Marketplace while concurrently planning to default to the federally-facilitated Marketplace (FFM) in the event that the software fails to pass another round of testing in early August.



Massachusetts was among five state-based Marketplaces that scrapped their initial software after persistent technological glitches went uncorrected (see Update for Weeks of April 28th and May 5th). However, the Connector's failure was particularly embarrassing for Massachusetts given that the Connector first created in 2007 was the model for all Affordable Care Act Marketplaces.

The board approved a \$97.6 million budget for fiscal year 2015 that includes a significant increase in staffing under the assumption that the hCentive product will be successfully implemented.

Michigan

Healthy Michigan Plan surpasses first-year enrollment goal

Governor Rick Snyder (R) announced this week that his Healthy Michigan Plan to expand Medicaid has already surpassed its first-year goal of 322,000 enrollees.

More than 323,000 consumers have signed-up as of July 10th with more than 230,000 already placed into a private plan. The "private sector" alternative to the traditional expansion under the Affordable Care Act (ACA) is expected to use federal matching funds to ultimately purchase private Marketplace coverage for at least 500,000 consumers that earn up to 138 percent of the federal poverty level (see Update for Week of March 31st).

Enrollment did not start until April 1st due to legislative delays in getting the plan enacted. However, it quickly hit 300,000 enrollees in just ten weeks (see Update for Week of June 23rd). The Governor credits low wait times for the program's popularity, noting that most have been able to apply in-person and receive an eligibility determination within 30 minutes.

By contrast, North Dakota officials acknowledged this week that only 10,600 have enrolled in their Medicaid expansion since January 1st, which represents only about half the amount the state initially projected and a third of the number projected by the Kaiser Family Foundation.

Missouri

New law creates new health insurance program for unborn children

Governor Jay Nixon (D) signed S.B. 716 into law last week, which includes a provision creating a new Children's Health Insurance Program (CHIP) to cover low-income unborn children.

The new Show-Me Healthy Babies program will be part of the Department of Social Services. For an unborn child to be eligible, the mother must not be eligible for Medicaid coverage nor have access to affordable employer-subsidized health insurance. Household income must also be no more than 300 percent of the federal poverty level unless a lower amount is set by the General Assembly.

S.B. 716 also includes an unrelated provision reducing the time in which a health insurer must make a determination of benefits from two working days to 36 hours, including one working day after obtaining all necessary information regarding a proposed admission, procedure, or service.

New Mexico

Marketplace board debates whether to move to state-based model for 2015

The board for New Mexico Health Connections held a special meeting last week to review the progress of efforts to convert the Affordable Care Act (ACA) Marketplace to a state-based model and debate whether to do so for the 2015 open enrollment period that starts in November.

New Mexico was one of 36 states that defaulted fully or partly to federal control over its Marketplace in 2014. However, it created a "hybrid" approach similar to Utah that retained state control



over the small group portion of the Marketplace while defaulting to the federally-facilitated Marketplace (FFM) for individual health plans (see Update for Weeks of May 13 and 20, 2013).

New Mexico had already received federal certification for a state-based Marketplace and intended to transition to full state control once the necessary technology infrastructure was in place. Idaho has also elected to move from federal to state control in 2015 (see Update for Week of June 23rd), although the state-based Marketplaces in Nevada and Oregon are reverting back to the FFM model due to software failures (see Update for Week of June 2nd).

New York

Marketplace will have website, applications translated into seven languages

The NY State of Health Marketplace created by the Affordable Care Act (ACA) announced this week that it will translate the online web portal and paper applications into Spanish and six other languages for the 2015 open enrollment period starting November 15th.

The lack of any language other than English was the predominant criticism of the Marketplace during the inaugural open enrollment period and often cited as the main reason that other large states outpaced New York in overall enrollment (even though New York enrollment broke one million). The NY State of Health director acknowledged that officials initially placed a priority on website functionality in order to avoid the software glitches that plagued most federal and state-based Marketplaces. However, with the Urban Institute predicting that more than one-third of Marketplace consumers in New York will be non-English speakers by 2016, the director insists that improving accessibility for all applicants is now the priority for 2015.

In addition to translating the website and applications, NY State of Health is also training nearly 9,000 consumer assisters how to better explain the different eligibility requirements to immigrant populations.

North Carolina

Governor opens door to Medicaid expansion alternative

Governor Pat McCrory (R) hinted for the first time this week that he may support expanding Medicaid under the Affordable Care Act (ACA) if the Obama Administration allows North Carolina to craft its own “private sector” alternative similar to federally-approved models in Arkansas, Iowa, and Michigan (see Update for December 16th–January 3rd).

The Governor has steadfastly refused to allow any expansion while the legislature debates a controversial Medicaid reform plan. However, he insisted this week that has “not closed that door” once “we fix the current system.”

Governor McCrory joined several other governors in meeting last week with new Health and Human Services Secretary Sylvia Mathews Burwell to discuss what waivers HHS may grant to their states. Indiana, Pennsylvania, Tennessee, and Utah are among the states seeking federal approval for their Medicaid expansion alternatives (see Update for Week of June 2nd).

However, it is unclear whether the Republican supermajority in North Carolina’s legislature would back any alternative plan submitted by the Governor, as it previously rejected any consideration of the issue under the Governor’s Democratic predecessor. Governor McCrory also signed a measure backed by the House Speaker and Senate President that prohibited any governor from expanding Medicaid without legislative approval (see Update for Week of March 4, 2013).

Oregon

Oregon may become first state to limit costly new Hepatitis C drug



The legislature appears prepared to make Oregon the first state to limit the availability of a costly new “cure” for Hepatitis C to Medicaid enrollees.

The issue is set to be debate on July 31st, as a legislative committee must decide whether only patients facing serious liver damage should have Medicaid coverage for the Sovaldi drug, which costs \$84,000 per a three-month course of treatment.

The exceptional price tag has already caused U.S. Senator Ron Wyden (D-OR), who chairs the Finance Committee, to join with ranking member Chuck Grassley (R-IA) in demanding data from Gilead Sciences justifying why a drug that was predicated to be profitable at a price of \$36,000 now costs 133 percent more (see Update for Weeks of June 30th and July 7th).

Limiting Sovaldi coverage only to those most in need could save Oregon \$128 million over the coming year. The Oregon Health Plan is unique among state Medicaid programs in that it is allowed to engage in such explicit rationing of care based on cost and quality measures under a federal demonstration waiver secured during the Clinton Administration. A cost evaluation completed by the Oregon Health Sciences University has already questioned Sovaldi's effectiveness and accused early reviewers of the drug of having financial ties to Gilead. Senators Wyden and Grassley have requested that Gilead disclose all payments to researchers as well as the three professional associations that issued favorable guidelines regarding Sovaldi.

Arkansas' Medicaid program is currently being sued in federal court for denying coverage to an FDA-approved drug for cystic fibrosis (Kalydeco) that costs \$300,000 per year, in a case that may impact on other state decisions involving costly drug therapies.

Wisconsin

Only one-third of adults that lost Medicaid coverage enrolled in Marketplace plans

The Department of Health Services (DHS) revealed this week that only one of every three adults that lost Medicaid coverage last year were able to enrollment in qualified health plans (QHP) offered by the federally-facilitated Marketplace (FFM) operated in Wisconsin.

Governor Scott Walker (R) had refused to allow Wisconsin to participate in the Medicaid expansion under the Affordable Care Act (ACA). His alternative, which has yet to be federally-approved, expanded basic Medicaid coverage only for everyone earning up to 100 percent of the federal poverty level (FPL), instead of the 138 percent threshold under the ACA. However, at the same time he eliminated coverage for adults earning 100-200 percent of FPL, who had been coverage under Wisconsin's previous Medicaid expansion program (BadgerCare Plus) (see Update for Week of November 11th).

DHS figures showed that roughly 57,000 lost BadgerCare Plus as a result of the Governor's action, while only 19,000 were able to transition into a Marketplace plan. The Governor had predicted that up to 90 percent of those losing coverage would be able to purchase Marketplace plans.

DHS also announced that more than 97,500 newly-eligible adults enrolled in the basic Medicaid coverage as of June 30th for those earning up to 100 percent of FPL.

According to the Wisconsin Insurance Commissioner, more than 130,000 consumers have purchased QHPs through the FFM.