



Health Reform Update – Week of June 22, 2015

CONGRESS

U.S. Supreme Court preserves ACA subsidies for federal Marketplace consumers

The Supreme Court of the United States (SCOTUS) ensured today that roughly 6.7 million consumers in federally-facilitated Marketplaces (FFM) can continue receiving the premium tax credits and cost-sharing subsidies offered by the Affordable Care Act (ACA).

At least four justices voted after last fall's midterm elections to hear the legal challenge brought by The Competitive Enterprise Institute on behalf of four individuals that would be exempt from the ACA's individual mandate but for the subsidies (see Update for Week of November 10th). However, only the court's three most conservative justices ultimately agreed with the challengers' claims that Congress intended to force states to create their own ACA Marketplaces by denying the law's subsidies to the 34 states that defaulted to the FFM.

Associate Justice Anthony Kennedy had warned during oral arguments that such a premise would amount to the type of unconstitutional coercion that the court barred in 2012, when it required that states be allowed to opt-out of the ACA's Medicaid expansion without penalty (see Update for Weeks of March 2nd and 9th). Although Kennedy had voted then to strike down the entire ACA, he agreed in this case with Chief Justice John Roberts and the court's liberal justices that the full context of the law showed Congress hardly intended to tell states "either create your own exchange or we'll send your insurance market into a death spiral", but rather sought to make subsidies available to all consumers regardless of where they reside.

The high court's 6-3 decision was the first on this issue that did not follow partisan divisions. Republican-appointed justices on two lower courts had struck down the FFM subsidies, while Democratic-appointed judges on the U.S. Fourth Circuit Court of Appeals deemed it "absurd" to conclude that the words "established by the state" in one ACA provision limited subsidies only to state-based Marketplaces when reading the law "as a whole" (see Update for Weeks of August 25th and September 1st).

The majority opinion agreed with the Fourth Circuit's decision, while slightly departing from its reasoning. Whereas the Fourth Circuit found that the Internal Revenue Service (IRS) should be given deference to interpret the words "established by the state", the majority insisted that subsidies were so integral to the ACA that Congress would never have left it up to federal agencies to determine who would receive them.

Instead, the majority opinion took pains to point out that the ACA essentially copied the Massachusetts model that broadened coverage via an individual mandate combined with subsidies to ensure affordability, as well as required insurers to offer guaranteed issue coverage with community rating. Given that Congress spelled out how a "death spiral" would result in the market if all of these components did not work together, the majority found it "implausible" that Congress would extend all but the subsidies nationwide, insisting that "Congress passed [the ACA] to improve health insurance markets, not to destroy them."

As a result, the court upheld the statute's meaning itself, preventing the IRS from redefining its own interpretation under a future Administration. This effectively put the challengers in a worse position than before their lawsuit.



The dissent by Associate Justice Antonin Scalia insisted that the court should not be in the position of reading Congress' mind and rely instead on the "plain meaning" of the words "established by the state", even if an absurd outcome results. It accused the high court of applying such "interpretive somersaults" only for laws it favors and suggested that "ObamaCare" be renamed "SCOTUSCare" because of the way that it has now twice been reshaped by SCOTUS.

The decision avoids putting ACA-resistant states in the predicament of either creating their own Marketplace or watching premiums in their FFM skyrocket by an average of 255-287 percent without the subsidies (according to Avalere Health and the Kaiser Family Foundation). Roughly 87 percent of FFM consumers currently receive the subsidies, which averaged \$268 per month in 2014 and reduced monthly premiums by an average of 72 percent (from \$374 to \$105) (see Update for Weeks of March 2nd and 9th).

House passes repeal of Medicare cost-cutting board, but loses support of Democratic sponsor

The House passed legislation this week that would repeal the Independent Payment Advisory Board (IPAB) created by the Affordable Care Act (ACA), prior to the appointment of any board members.

H.R. 1190 drew the support of 11 Democrats that fear ceding Congressional authority over Medicare spending cuts to an unelected panel of bureaucrats. Rep. Linda Sánchez (D-CA) had sponsored the bill along with Phil Roe (R-TN). However, she did not vote in favor of her own bill after Republicans sought to offset the \$7.1 billion cost (over ten years) by further draining the Prevention and Public Health Fund that the ACA created to cover the cost-sharing charges for certain preventive services. Rep. Sanchez noted that Republicans have already cut into the fund for similar offsets in 2012 (see Update for Week of April 15, 2013) and insisted that she would not "support gutting a great provision in the ACA to get rid of a bad one."

The IPAB has drawn political attacks from the outset (see Update for Week of March 7, 2011) and its board members have never been appointed as Republican lawmakers have refused to submit their nominations (see Update for Week of May 6, 2013). It is tasked with issuing recommendations to cut Medicare costs whenever spending exceeds pre-set targets—recommendations that would automatically go into effect unless Congress enacts equivalent cuts. However, due to historically low rates of health care spending, the Department of Health and Human Services does not expect that costs would exceed the necessary targets to trigger IPAB recommendations until at least 2019 (see Update for Week of March 16th).

As with the House-passed repeal of the ACA's medical device tax, President Obama has pledged to veto H.R. 1190 should it clear the Senate (see Update for Weeks of June 8th and 15th) and proposed to strengthen the IPAB as part of his proposed budget (see Update for Weeks of January 26th and February 2nd). The U.S. Supreme Court rejected a challenge to the IPAB earlier this year, stating that it could not be heard until the panel was actually created (see Update for Week of March 30th).

Senate and House appropriations bills would block Affordable Care Act funding

The Senate Appropriations Committee advanced legislation this week that would cut \$3.6 billion from fiscal year 2015 funding for the Department of Health and Human Services (HHS) while barring any appropriations for the risk corridor program and state-based Marketplaces created pursuant to the Affordable Care Act (ACA). This includes a 28 percent cut in program management funding for the Centers of Medicare and Medicaid Services, which oversees ACA implementation.

Although the National Institutes of Health would receive a \$2 billion increase under the bill, other departments would see sizeable cuts. For example, the budget for the Centers for Disease Control and Prevention (CDC) would be slashed by nearly four percent (or \$251 million), while the Social Security Administration would fall by \$185 million and the Department of Labor by \$575 million. The measure would also eliminate 44 government programs at a savings of \$1.26 billion.



Republicans that control the panel blocked Democratic amendments that would have boosted funding above the discretionary funding caps imposed by the ongoing budget sequester (see Update for Week of August 1, 2011).

The Senate version of the HHS appropriations bill still allocates funding for the Agency for Healthcare Research and Quality (AHRQ), which was established under the ACA to explore delivery system reform and patient-centered care. However, a competing House version would defund AHRQ entirely.

Funding for HHS in the House bill would be \$3.7 billion below fiscal 2015 and also bar new funding for ACA implementation (including rescinding unspent funds for certain programs), while adhering to the sequester's caps. NIH would also receive a funding increase (\$1.1 billion), while CDC funding equal the \$7 billion sought by the President.

The House Appropriations Committee had not advanced legislation funding the departments of HHS, education, or labor in six years. The lack of a specific appropriation for ACA funding has become the subject of a federal lawsuit filed by House members, alleging that the Administration is unconstitutionally shifting funds from other sources to pay for the law's premium and cost-sharing subsidies (see Update for Week of June 1st).

21st Century Cures legislation delayed as most of \$106 billion cost is not offset

The Congressional Budget Office (CBO) issued its cost estimate this week for the *21st Century Cures Act* (H.R. 6), the measure recently approved by the House Energy and Commerce Committee that seeks to overhaul the drug approval process and streamline medical research (see Update for Weeks of May 18th and 25th).

If enacted at the October 1st start of federal fiscal year 2016, the CBO score projects that implementing the legislation will cost \$106.4 billion from 2016-2020 while reducing net direct spending by only \$11.9 billion from 2016-2025.

The vast majority of the new spending (\$105.6 billion) would be for provisions implemented by the National Institutes of Health. Provisions administered by the Food and Drug Administration (FDA) would cost another \$872 million. This figure is close to the FDA's own estimate of more than \$900 million, but is \$300 million over what the bill mandates in funding for the agency.

The lack of required offsets threatens to derail the legislation despite bipartisan support. Of the nearly \$12 billion identified thus far, \$5.4 billion from selling oil from the Strategic Petroleum Reserve is considered a "non-starter." Another \$4.9 billion would have come by delaying reinsurance payments to Medicare Part D plans. However, Energy and Commerce chairman Fred Upton (R-MI) was forced to jettison that proposal this week in the face of opposition from health insurers, pharmacy benefit managers, and lawmakers on the House Ways and Means Committee.

A provision granting manufacturers an additional six months of drug exclusivity if an existing drug is approved to treat a rare disease may ultimately be removed from the legislation, as CBO found it would cost the federal government about \$869 million from 2016-2015 by delaying the entry of lower-cost generics and biosimilars.

Chairman Upton had sought a floor vote by late June. However, it is not yet clear if the vote will occur before the summer recess unless additional offsets can be identified.

Three agencies finalize changes to ACA-mandated benefit summaries

The Centers for Medicare and Medicaid Services (CMS), Internal Revenue Service, and Department of Labor published regulations on June 16th that finalize changes to the summary of benefits and coverage (SBC) required by the Affordable Care Act (ACA) for group and individual health plans.

The SBC is a standardized, eight-page form that allows consumers to make apples-to-apples comparisons of plan options and understand how to use their coverage. It must be provided to individuals when they are applying for coverage, upon enrollment, when changes to the plan would prompt a change in the SBC content, and upon request.

The form has been in use since an initial set of regulations were finalized three years ago (see Update for Week of February 6, 2012). However, a proposed rule issued last winter sought to make some modest changes (see Update for Week of January 5, 2015). These include clarifying that plans are not required to provide a second SBC to individuals when they enroll if there have been no changes in SBC content when they applied for coverage. In addition, the SBC must now state whether the plan provides minimum essential coverage (MEC) and minimum value, which determine whether enrollees are subject to the individual mandate or eligible for premium tax credits (plans currently could provide that information in separate correspondence).

However, the final rule did not adopt some changes sought by consumer advocates. These include making SBCs available to employees eligible for a special enrollment period. Also, plans that have separately administered benefits can still provide separate and partial SBCs.

Consumer groups were also disappointed that the threshold for determining when an SBC must be provided in languages other than English was not lowered in the final rule. Currently, plans must make SBCs available in only four languages including Spanish and Chinese.

The agencies note in the final rule that future changes may be forthcoming, based on consumer testing and input from the National Association of Insurance Commissioners.

Study shows more than 40 percent of silver-level Marketplace plans relied on narrow networks

A University of Pennsylvania study funded by the Robert Wood Johnson Foundation has found that 41 percent of nearly 400 physician networks used by silver-level Marketplace plans in 2014 employed networks that include no more than 25 percent of available physicians. By contrast, only 11 percent of plans were considered “extra large” because they covered at least 60 percent of physicians in their area.

Researchers noted that plan type was not an effective indicator of network size. Roughly 80 percent of Marketplace plans are either health maintenance organizations (HMOs) or preferred provider organizations (PPO). However, even though HMOs typically do not cover out-of-network care, more than half of HMO physician networks for Marketplace plans were either “small” (10-25 percent of available physicians) or “very small” (less than ten percent). Conversely, only a quarter of PPO plans had small or very small networks, even though PPOs typically cover providers that are outside of the plan network.

Narrow provider networks were among the leading complaints by Marketplace enrollees during the first year of open enrollment, forcing the federal Centers for Medicare and Medicaid Services to adopt a standard requiring Marketplace plans to “maintain a network that is sufficient in number and types of providers ... to assure that all services will be accessible to enrollees without unreasonable delay” (see Update for Weeks of March 17 and 24, 2014).



STATES

Kaiser study is latest to find modest premium increases for 2016 silver-level plans

A Kaiser Family Foundation study became the latest this week to find only a modest increase in proposed premiums for 2016, based on preliminary rate filings in selected states.

Two analyses released last week by Avalere Health and HealthPocket showed that proposed premiums for individual subscribers among certain silver-level plans would increase by an average of 6-12 percent (see Update for Weeks of June 8th and 15th). The Avalere study focused on rates for all of eight states while HealthPocket only surveyed metropolitan areas in 45 states

The Kaiser study likewise measures preliminary 2016 premiums for major metropolitan areas in 11 states (including the District of Columbia). It determined that the average proposed increase for benchmark plans across all of these cities is 4.4 percent for 2016 (compared to two percent for 2015). Benchmark plans are the second lowest-cost silver plans for which the premium and cost-sharing subsidies under the Affordable Care Act are based.

As with the earlier studies, Kaiser found significant variation across the country. The study showed the premiums are likely to increase by an average of 16.2 percent in Portland, Oregon yet fall by an average of 10.1 percent in Seattle, Washington.

The level of competition stayed the same or increased in nine of the 11 states surveyed by Kaiser. Only Michigan and the District of Columbia reported a fewer number of participating plans.

California

Senate committee amends Assembly-passed bill to limit prescription drug cost sharing

The Senate Health Committee amended a measure this week that would limit out-of-pocket costs for prescription drugs to 1/24 of the annual out-of-pocket limit applicable to individual coverage for a supply of up to 30 days. A July 8th hearing has been scheduled on the latest version.

The measure cleared the Assembly earlier this month on a 48-30 vote after several amendments, including a clarification that the cost-sharing limits apply only to covered outpatient prescription drugs that constitute essential health benefits under the Affordable Care Act (ACA) (see Update for Weeks of May 18th and 25th). The most recent amendments include limiting application of the cost sharing limits to non-grandfathered group coverage starting July 1, 2016 and non-grandfathered individual coverage starting January 1, 2017. Cost sharing amounts should apply to a plan's annual out-of-pocket maximum and cost-sharing limits for high deductible health plans would also not apply until an enrollee's deductible has been satisfied for the year.

The amended bill would also require plans to maintain a pharmacy and therapeutics committee that shall be responsible for developing, maintaining, and overseeing any drug formulary list.

A provision barring plans from placing most or all of the drugs to treat a specific condition on the highest cost tiers of a formulary has still been retained (see Update for Weeks of February 9th and 16th).

Covered California negotiated lower premiums by providing utilization data to insurers

A new study released by the University of California-San Francisco shows that data showing lower than expected use of inpatient and emergency room care by Covered California enrollees allowed state officials to negotiate more affordable premiums for enrollees in the health insurance Marketplace.



Researchers from the Department of Health Care Services and Office of Statewide Health Planning and Development compiled the 2012 data, which Covered California used to contradict insurer claims that new Marketplace enrollees would be sicker and more costly than their traditional subscribers. When confronted with the data during negotiations, insurers “covering the majority of enrollees decreased their proposed 2015 rates, saving consumers tens of millions of dollars in potential premiums.”

Covered California is only of only a handful of state-based Marketplaces following the “active purchaser” model allowed by the Obama Administration, where the Marketplace can exclude carriers with higher premiums even if they meet all minimum standards for participation (see Update for Week of May 27, 2013).

Florida

Governor drops federal coercion lawsuit over Low Income Pool funds

Governor Rick Scott (R) announced this week that he will drop his federal lawsuit against the Obama Administration for unduly trying to coerce Florida to expand Medicaid pursuant to the Affordable Care Act (ACA).

The Governor had pledged just last week to continue the lawsuit until the state was able to reach a “long-term solution” to the loss of federal funding for the Low Income Pool (LIP) waiver, which helps offset uncompensated care costs for Florida hospitals (see Update for Weeks of June 8th and 15th). It is not clear what changed caused the sudden change in the Governor’s position, although he credited the lawsuit for getting the federal Centers for Medicare and Medicaid Services to commit to a “short-term solution” that phased-out the LIP funds over two years instead terminating all funds on June 30th (see Update for Week of June 1st).

A federal judge had already rejected the Governor’s request for a preliminary injunction against the LIP cuts (see Update for Weeks of June 8th and 15th). Governor Scott insisted that the Administration’s act of tying any LIP extension to the state’s willingness to expand Medicaid represented the type of unconstitutional coercion that the U.S. Supreme Court sought to prevent when it let states opt-out of the ACA expansion without penalty (see Update for Week of May 4th).

Maine

Legislature overrides Governor’s veto of bill requiring transparency for prescription drug costs

Both the House and Senate voted this week to override the veto of L.D. 636 by Governor Paul LePage (R).

Consistent with the Affordable Care Act (ACA), the measure requires that insurance carriers offering Maine policies make specific cost information for prescription drugs publicly available on their websites. This includes the full prescription drug formulary for each plan with updates posted within 72 hours of any change. In addition, the posted information must show the cost-sharing requirements for each drug, including a description of how they will be applied (or not applied) to the plan deductible or out-of-pocket limit.

All utilization review requirements and coverage restrictions must also be included, as must the amount of coverage made available via out-of-network providers.

New Jersey

New bill would limit plan cost sharing for prescription drugs

Assemblyman Daniel Benson (D), the Deputy Speaker pro tempore, introduced legislation this week that would require health insurers to limit cost sharing for prescription drugs.



Under A.4595, individual and small group plans that are not bronze-level or catastrophic plans as defined by the Affordable Care Act must limit out-of-pocket costs (including coinsurance or copayments) to no more than \$100 per month for each prescription drug (for up to a 30-day supply of any single drug). For bronze coverage, that limit shall be increase to \$200 per month for up to a 30-day supply.

In the case of high-deductible plans (HDHP), the cost sharing limits will apply across the benefit Design, including before and after any applicable deductible is reached.

As with comparable legislation introduced in other states, A. 4595 also requires the plans to allow enrollees to request an exception to any formulary. However, the bill does not include a prohibition on plans moving all or most drugs for a specific medical condition into specialty tiers, as is currently proposed in California and other states (see above).

New York

Governor expected to make New York first state to recognize pregnancy as qualifying event

New York could become the first state in the nation to classify pregnancy as a "qualifying event" for health insurance enrollment under a new bill expected to be signed by Governor Andrew Cuomo (D).

Both chambers approved the bill last week (S.5972/A.6780B). It would allow pregnant women to enroll in private, employer-sponsored, and Marketplace plans at any time during the year, instead of just during annual open enrollment periods. Currently, pregnant women outside of open enrollment had to wait until a "qualifying event" such as marriage, divorce, childbirth, adoption, gaining citizenship, etc. would trigger a special enrollment period. However, pregnancy was not defined as one of these qualifying events by the Affordable Care Act, which according to the comptroller for New York City often forced pregnant women to incur up to \$20,000 in out-of-pocket costs for prenatal and maternity care.

A similar measure has already cleared the Assembly in California (A.B. 1102).