



Health Reform Update – Week of July 20, 2015

CONGRESS

Senate not likely to act on scaled back 21st Century Cures Act until later this year

House Energy and Commerce Committee chairman Fred Upton (R-MI) urged the Senate this week to take action by the end of the year on the 21st Century Cures Act (H.R. 6), even if it ends up being far less reaching than the measure that overwhelmingly passed the House earlier this month (see Update for Weeks of June 29th and July 6th).

The Senate Health, Education, Labor and Pensions (HELP) Committee has moved at a decidedly slower pace than the House on their version of the medical innovation legislation, which is intended to facilitate the development of breakthrough cures for rare disorders by removing regulatory obstacles. Commentators including Avalere Health consultants are expecting a scaled-back version of the House bill to be released by the HELP Committee sometime in September, which will have some overlap but be far more narrow in scope.

However, chairman Upton urged the HELP committee this week to adopt a faster timetable, as the Senate version currently would not be marked up until the end of the year, pushing a floor vote into the 2016 election season when bipartisan consensus will be far more difficult to achieve. Funding authorized by the bill could also begin as early as the October 1st start of the federal fiscal year if the House and Senate could enact a reconciled bill by that time.

Study predicts \$16 billion in annual savings if Congress allows for negotiated Part D drug prices

A new study released this week by Carleton University and the Public Citizen advocacy group predicts that the federal government could save from \$15.2 billion to \$16 billion per year if Congress allowed Medicare to negotiate Part D drug prices with manufacturers and obtain the same price paid by Medicaid or the Veterans Health Administration.

Researchers cited the experience of 27 of 31 countries in the Organization for Economic Cooperation and Development (OECD) that have been able to purchase a select group of medications at less than half of available prices in the United States. The study found that American costs per capita for pharmaceuticals are \$1,010 or more than twice the \$498 average paid by OECD countries.

The authors concluded that the federal government was “pouring money down the drain” by overpaying for prescription drugs as a result of Congress’ prohibition in the Medicare Modernization Act of 2003 that bars the Centers for Medicare and Medicaid Services from negotiating drug prices. However, drugmakers have insisted that such negotiations would negate incentives to offer favorable rebates to Part D plans and would ultimately lead to higher premiums and foregone prescriptions. They also claim that the OECD countries cited in the study “spend a higher percentage of their health care dollars on prescription medications” than the United States.

However, the authors pointed out that “even with its rebates [Part D] spends 198%, almost twice the median of the amount paid for brand name drugs in the 31 OECD countries. And based on other analyses, even within the U.S., Medicare Part D pays on average 73% more than Medicaid and 80% more than VBA for brand-name drugs.”

IRS says individual mandate penalties averaged \$200 in 2014 for 7.5 million Americans

The Internal Revenue Service (IRS) announced this week that about 7.5 million Americans have already paid an average penalty of \$200 for not having health insurance last year.

The Affordable Care Act (ACA) required that Americans who could afford to purchase minimum essential coverage (MEC) must do so starting in 2014. According to the IRS, about 76 percent of taxpayers indicated on their 2014 returns that they had done so for the entire year.

Preliminary figures released by the agency show that of the 135 million of 150 million expected returns that have already been filed, the vast majority satisfied the ACA's individual mandate. Another 12 million were exempt from the mandate by law or regulation, including those for whom the lowest cost plan option would exceed eight percent of their income.

However, nearly 300,000 taxpayers who paid the tax penalty under the individual mandate were entitled to an exemption but failed to claim it. The IRS will send letters to these taxpayers informing them that they generally can have up to three years to file an amended tax return.

Overall, the IRS has already collected \$1.5 billion from the individual mandate penalty, which was less than \$100 for roughly 40 percent of taxpayers. The penalty for 2014 was \$95 or one percent of taxable income but rises to \$325 or two percent of taxable income for the 2015 tax year.

In addition to the individual mandate penalty, the IRS reported that roughly 2.7 million taxpayers claimed approximately \$9 billion in premium subsidies under the ACA, with the average subsidy totaling \$3,400. About 40 percent of taxpayers claimed a subsidy of less than \$2,000, another 40 percent claimed \$2,000-5,000, and 20 percent claimed \$5,000 or more.

Only about ten percent of subsidy recipients received the correct subsidy amount based on their 2014 income. Among taxpayers who claimed a subsidy, about 1.6 million were required to refund money to the IRS because their actual income was higher than projected when they applied. The average repayment was about \$800.

IRS OIG asked to investigate why ACA premium subsidy recipients are not filing tax returns

Senate Finance Chairman Orrin Hatch (R-UT) asked the Office of the Inspector General (OIG) for the Internal Revenue Service (IRS) this week to investigate why roughly 710,000 taxpayers that received premium subsidies under the Affordable Care Act (ACA) have yet to either file their taxes in order to reconcile the subsidies with their actual income, or seek an extension.

Senator Hatch estimated that those taxpayers received more than \$2.4 billion worth of tax credits, given that IRS reported that the average credit was worth \$3,400 (see above). Despite acknowledging that "it is likely that not all of these are fraudulent" he insisted that "because of the marketplace's lax integrity controls...there is reason to believe that a significant portion are fraudulent." He based his suspicions on a Government Accountability Office investigation where auditors were able to renew 11 of 12 fictitious applications for subsidies (see Update for Week of July 13th).

Treasury officials informed subsidy recipients that they will automatically be ineligible for premium assistance in future years if they do not reconcile the tax credits they received with their 2014 income.



Medicare solvency remains unchanged, but trustees warn of huge Part B premium hikes

The latest annual report on the Medicare trust fund from the program's trustees predicts that Medicare will require structural changes to remain solvent beyond 2030, at which point incoming payroll taxes and other revenues will only cover 86 percent of program costs.

Although this prediction has remained unchanged from last year, the trustee's report provided some worrisome conclusions for stakeholders. It showed that per beneficiary costs rose by 2.3 percent in 2014, which was the largest increase in three years. Medicare costs had been growing at historically low levels during 2012 (0.1 percent) and 2013 (0.3 percent), allowing the insolvency date to be extended by an additional 13 years.

However, the 10.9 percent spike in prescription drug costs under Part D appears to have reversed that trend. The trustees attribute the spike to the cost of new breakthrough treatments for Hepatitis C, which can exceed \$84,000 for a 12-weeks course of treatment.

The trustees project that per beneficiary spending increases will actually decline by one percent for 2015 but then resume its upward trajectory for four consecutive years, peaking at 5.3 percent in 2019.

The increase in Medicare costs is likely to create a political dilemma for the Obama Administration, as it may cause the controversial Independent Payment Advisory Board (IPAB) created by the Affordable Care Act (ACA) to be triggered for the first time in 2017. The IPAB must make recommendations on Medicare spending cuts whenever costs exceed targeted growth rates—recommendations that automatically go into effect if Congress does not enact equivalent cuts.

The House voted earlier this year to repeal the IPAB, with the support of 11 Democrats who fear ceding control over Medicare spending away from Congress (see Update for Week of June 22nd). However, even if the measure clears the Senate, there was little pressure on President Obama to sign such a repeal until the IPAB actually goes into effect. Legal challenges to the IPAB have also been rejected on the grounds that they are premature. The trustees' report may thus provide new momentum to efforts to block the IPAB.

However, the most ominous prediction in the trustees' report is the warning that Medicare Part B premiums could skyrocket by 52 percent for 2016 (up to \$159.30 per month). The report attributes the staggering jump not only to higher costs for outpatient health services, but the fact that Social Security is not expect to allow for a cost of living increase next year. Health and Human Services Secretary insisted later this week that 70 percent of Part B enrollees will not see any increase for 2016 and that the agency may exercise several "policy options" that would mitigate any sizeable increases for others.

The trustee report offered good news overall for Social Security, whose general trust fund will remain solvent one year longer than previously estimated (through 2034). However, Social Security's disability program remains in dire straits and is currently expected to exhaust its reserves by next year, without Congressional intervention. If that occurs, the program will only be able to pay 81 percent of scheduled benefit payments.

New CMS guidance clarifies requirements for seeking State Innovation Waivers

The Centers for Medicare and Medicaid Services (CMS) released guidance documents this week providing new information regarding State Innovation Waivers under the Affordable Care Act (ACA).

Starting January 1, 2017, states may seek waivers from certain ACA requirements including the controversial individual and employer mandates, as well as premium and cost-sharing subsidies for qualified health plans (QHPs). Final rules issued in 2012 allowed such waivers to be granted only if they are deficit neutral and enable states to pursue alternative coverage strategies that are at least as



comprehensive as the ACA and retain some key ACA protections such as coverage for all essential health benefits (see Update for Week of February 20, 2012).

The fact sheet and accompanying frequently answered questions (FAQ) documents clarify that CMS will release state applications for public notice and comment before approval decisions are issued within 180 days of a completed application. They detail which specific ACA provisions can be waived but stress that in no case will the State Innovation Waivers (also called Section 1332 waivers) modify existing state Section 1115 demonstration waivers (under which several Medicaid managed care expansions operate). In addition, no State Innovation Waivers will be allowed to start prior to the January 1, 2017 effective date set by the ACA.

Colorado, Hawaii, Massachusetts, Oregon, and Vermont are among the states that have already considered applying for such a waiver. Vermont sought to do so as part of its transition to a single-payer health system in 2017. However, that plan has since been abandoned due to cost (see Update for Week of December 1st).

STATES

California

Covered California to add two new insurers for 2016

State rate filings obtained by the *Los Angeles Times* show that UnitedHealth Group and Oscar are likely to start selling coverage through the Covered California Marketplace for 2016.

UnitedHealth Group, the nation's largest health insurer, sat out of most of the Affordable Care Act Marketplace during the first year, but joined roughly two dozen for 2015. After exiting the entire individual market in California in 2013, it had sought to participate statewide next year in Covered California. However, the Marketplace adopted new rules earlier this year barring insurers already established in the state pre-ACA but not participating in the Marketplace from subsequently entering the Marketplace and selling statewide coverage until 2017 (see Update for Week of January 13th). As a result, UnitedHealth Group will be limited to the five of the state's 19 rating areas that are "underserved" meaning they have fewer than three participating insurers. This includes rural counties in northern California, as well as Santa Barbara, San Luis Obispo and Ventura counties.

The second insurer, Oscar, is a start-up that currently offers coverage in New Jersey and New York. It is seeking to cover the southern California market, including Los Angeles, both in and out of Covered California.

Florida

Medicaid managed care plans seek 12 percent rate hike to cover prescription drug costs

Managed care plans serving nearly all of Florida's Medicaid beneficiaries insisted this week that state regulators need to increase reimbursement rates by 12 percent next year in order to offset the rising cost of prescription drugs and increased numbers of physician visits.

The secretary for the Agency for Health Care Administration (AHCA) quickly rejected the request from the Florida Association of Health Plans (FAHP), insisting that the plans are "likely jeopardizing their profitability" by "setting higher contracting rates for hospitals than what is allowed for in state law" and instead seeking to raise costs for Florida taxpayers.

Florida had moved to fully privatize Medicaid last year (see Update for Week of August 4th) and the secretary warned that her agency would not allow the subsequent savings to be erased by such a



steep rate increase. She noted that the program is on track to reduce costs by 5.1 percent per member per month.

However, FAHP insists that Medicaid managed care plans are incurring “substantial losses”. AHCA has already offered a 6.4 percent payment increase to offset unanticipated costs and claims that higher increases are unwarranted since first year rates were based on the plans’ own proposals.

New rates for 2015-2016 must be worked out by September 1st.

Maryland

Lead contractor agrees to \$45 million settlement over failed Marketplace portal

Noridian Healthcare Solutions has agreed to pay Maryland \$45 million to settle claims that it botched the 2013 rollout of the web portal for the Maryland Health Benefit Exchange.

State officials terminated its contract with lead contractor Noridian just four months after the web portal crashed on the first day of operations and persistent technological glitches prevented it from being fully operational during the entire inaugural open enrollment period. Maryland eventually scrapped the portal and imported the technology from the successful Marketplace in Connecticut at a cost of \$41 million to state taxpayers (see Update for Weeks of March 17 and 24, 2014).

The board for the Maryland Health Benefit Exchange unanimously approved the settlement this week. However, it still requires approval from the Centers for Medicare and Medicaid Services (CMS) as much of the \$73 million that Maryland paid to Noridian came from federal exchange establishment grants. Maryland and CMS will have to work out how much of the \$45 million will be returned to CMS.

Noridian refused to accept liability as part of the settlement and insisted this week that the Marketplace exceeded its initial enrollment goals despite its technological limitations.

Former Governor Martin O’Malley (D) had initiated the lawsuit against Noridian and other contractors such as IBM. These suits remain pending under the new administration of Governor Larry Hogan (R), who praised the settlement but blamed the fiasco on the O’Malley administration. Hogan’s election last fall was largely attributed to the failure his opponent, Lt. Governor Anthony Brown, to distance himself from the fiasco after serving as the director of O’Malley’s office of health reform.

Maryland Congressman Andy Harris (R) has previously requested several federal investigations into the potential misuse of federal exchange establishment grants and lack of appropriate state oversight (see Update for Week of March 10th). The Exchange Board had been given permission by the legislature to award contracts for the Marketplace without the typical state agency oversight.

Michigan

Medicaid expansion improved appointment availability for enrollees

A University of Michigan study published this week in *Health Affairs* found that Medicaid enrollees in Michigan had a slightly easier time scheduling doctor appointments after the state expanded the program pursuant to the Affordable Care Act (ACA).

Michigan is one of only six Republican-controlled states that agreed to participate in the ACA expansion. It is also one of six to receive a federal waiver to purchase private Marketplace or Medicaid managed care coverage for the newly-eligible population (those earning up to 138 percent of the federal poverty level). However, Michigan was also allowed to increase cost-sharing for higher-income enrollees and incorporate health savings accounts, similar to the waiver approved for Indiana (see Update for Weeks of October 20th and 27th).



The expansion has proven to be very popular in Michigan, with enrollment passing its first-year projection of 300,000 enrollees in just over three months (see Update for Week of July 14, 2014). Critics had claimed that the expansion would overwhelm Medicaid providers and limit access for enrollees. However, researchers posing as patients found that 55 percent of clinics offered an appointment to Medicaid enrollees after the April 2014 expansion, compared to only 49 percent beforehand. (Michigan law requires Medicaid beneficiaries to see a doctor within three months of receiving coverage.)

Researchers did find a slight decrease in appointment availability for privately insured patients (declining from 88 to 86 percent).

New Hampshire

Governor signs parity bill for oral anti-cancer drugs

Governor Maggie Hassan (D) signed H.B. 508 into law this week, making New Hampshire one of at least 40 states (including the District of Columbia) to require that that insurance coverage for oral chemotherapy drugs is at least equivalent to coverage for intravenous chemotherapy, starting in 2017.

Utah

Working group agrees to “conceptual framework” for Medicaid expansion

Republican leaders announced late last week that they have agreed upon a "conceptual framework" to expand Medicaid under the Affordable Care Act (ACA) but released few details about the legislation that they will submit during an expected special session later this year.

The “Gang of Six” lawmakers appointed by Governor Gary Herbert (R) specifically rejected the Governor’s Healthy Utah plan that would use ACA matching funds to cover newly-eligible enrollees in private Marketplace plans, similar to federally-approved alternatives in six other states (see Update for Weeks of October 20th and 27th). That plan passed the Senate, but was rebuffed by House conservatives in favor of a far leaner Utah Cares plan. However, the “Gang of Six” also rejected Utah Cares, since it includes a work requirement that is not likely to receive federal approval (see Update for Week of February 23rd).

In their place, the framework agreed to by the working group would accept ACA funds to expand Medicaid for those earning up to 138 percent of the federal poverty level (FPL). However, it would fund state’s share of the cost after 2016 through a new assessment on hospitals, physicians, and pharmaceuticals, similar to the tax used to fund the ACA expansion that is currently being challenged in Arizona (see Update for Week of May 4th).

Governor Herbert largely endorsed the agreement. However, because it was negotiated entirely behind closed doors and not released, it remains unclear whether all or part of the newly-eligible population would be covered under private Marketplace or managed care plans, similar to the Governor’s approach, or via a traditional Medicaid expansion.

The Utah Hospital Association also agreed to help pay up to \$25 million of the expected \$78 million state share of the cost starting in 2020. However, they wanted to make sure the legislative plan requires that physicians and pharmaceuticals are required to also “pay their fair share” of the costs before backing the plan.

The “Gang of Six” strove to meet their self-imposed July 31st deadline, though they had already acknowledged that actual legislation will still take up to two months to formulate (see Update for Weeks of June 29th and July 6th).