



Health Reform Update – Weeks of January 25 and February 1, 2016

CONGRESS

House fails to override President's veto of ACA repeal bill

House Republicans failed this week to override President Obama's veto of legislation that would repeal many of the key provisions of the Affordable Care Act (ACA).

The House was not expected to succeed as it would have required substantial Democratic support to reach the two-thirds majority needed to override a veto. The effort came up more than three dozen votes short and the Senate is not expected to hold a similar vote.

The legislation was the 63rd effort by Republican lawmakers to dismantle the ACA but the first to reach the President's desk. Republican leaders justified the largely-symbolic effort on the basis that it demonstrated how Republicans could repeal the entire law through the budget reconciliation process with a Republican president and a their current Senate majority. Reconciliation bills need only 51 votes instead of the 60-vote margin required to break a Senate filibuster.

House Speaker Paul Ryan (R-WI) repeated his assurances this week that Republicans would soon put forward a plan to replace the ACA (see Update for Week of January 4th), while House Majority Leader Kevin McCarthy (R-CA) stated that the party will start forming "task forces" to develop those plans.

White House is willing to scale back "Cadillac" tax on high-cost health plans

The chief economic adviser for President Obama announced this week that the President was prepared to raise the threshold for the Affordable Care Act tax on high-cost health plans in an effort to quell increasing calls from Democratic lawmakers to eliminate the entire tax.

The 40 percent "Cadillac" tax applies to the portion of each worker's employer-sponsored health benefits that exceed set thresholds (initially \$10,200 for self-only coverage and \$27,500 for family coverage). A group of 101 conservative and liberal economists have urged Congress to keep the tax, which they insist is needed to prevent large employers like IBM or Verizon from offering overly-generous coverage that leads to overutilization of health services and higher premiums (see Update for Weeks of September 14th and 21st).

However, a public-private coalition of labor unions, health insurers, and business groups such as the Alliance to Fight the 40 and the National Business Group on Health (NBGH) contend that the tax effectively penalizes employers with sicker or older workers or those in riskier jobs, as well as employers based in more expensive parts of the country. NBGH reported last summer that surveys show that at least one benefit plan offered by nearly half of large employers will be subject to the 40 percent tax, despite advance cost-cutting measures (see Update for Weeks of August 17th and 24th).

Republican bills to repeal the "Cadillac" tax have drawn enough support from Democratic lawmakers (including Minority Leader Nancy Pelosi) that opponents of the tax now hold a majority in the House (see Update for Weeks of September 14th and 21st). As a result, the President agreed to sign an omnibus spending bill last month that included a two-year delay in the "Cadillac" tax until 2020 (see Update for Week of January 4th).



Because the delay was widely interpreted as a prelude to full repeal, the President is now proposing to raise the threshold to the average premium for gold tier plans, at least in states where the average premium now exceeds the threshold.

CBO downgrades projections for Marketplace enrollment

The latest budget and economic forecast released last week by the Congressional Budget Office's (CBO) predicts that enrollment in Affordable Care Act (ACA) Marketplaces will increase in 2016 by only 13 million consumers (11 million of whom will receive ACA subsidies), far less than their earlier projection of 21 million (with 15 million receiving subsidies). Researchers base the downgrade on their assumption that the remaining uninsured or more likely to be ineligible for ACA subsidies and thus more likely to purchase coverage directly from an insurer.

Despite the lower projections, CBO still projects that the number of Marketplace and Medicaid enrollees will continue to rise over the next decade. However, this will increase Medicaid expenditures in 2016 by 8.8 percent and ACA subsidy payments by 47 percent. CBO had previously anticipated that higher spending caused by the ACA's coverage expansions would be offset by revenue sources like the law's taxes on medical device manufacturers and high-cost health plans (see above). However, it notes that the expected repeal of those currently-suspended revenue sources would add \$256 billion to the deficit over the next ten years (see Update for Week of January 4th).

CBO also found spending for major health programs in 2015 (including Medicare, Medicaid, and CHIP) has exceed Social Security outlays for the first time in history, following a 13 percent increase. Medicaid expenditures accounted for much of this increase after spiking by 16 percent (or \$36 billion) due to newly-eligible enrollees in states participating in the ACA's Medicaid expansion. According to CBO, "average monthly enrollment of newly eligible Medicaid beneficiaries was 55 percent higher in 2015 than in the previous year." However, Medicaid enrollment in 2016 is expected to be only one-third of the rate of increase recorded in 2015.

Medicare also saw the "fastest rate of growth recorded for the program since 2009." The seven percent (or \$34 billion) jump in spending during 2015 was due largely to a three percent increase in Medicare enrollees and "an escalation in the number or cost of services... particularly under [the] Part D [Prescription Drug Program]."

FEDERAL AGENCIES

CMS allows CO-OPs to sell non-Marketplace plans in effort to boost sustainability

CMS released new guidance this week clarifying that the non-profit health insurance cooperatives created with Affordable Care Act (ACA) loans may sell others forms of health insurance aside from qualified health plans (QHPs) offered in ACA Marketplaces.

A dozen Consumer Operated and Oriented Plans (CO-OPs) have failed in recent months while federal auditors have found only one (in Maine) that has been profitable (see Update for Week of December 7th). The financial struggles have heightened Congressional scrutiny over CO-OP funding, forcing the acting Administrator for the Centers for Medicare and Medicaid Services (CMS) to conduct financial audits and seek to recover more than \$1.17 billion in start-up loans (see Update for Weeks of January 11th and 18th).

The acting Administrator also pledged to issue agency guidance that would give CO-OPs additional flexibility and ability to attract private investors. Allowing QHPs to offer large group policies, Medicaid managed care and Medicare Advantage plans, and dental and vision coverage is part of that



effort. However, CO-OPs are still required to ensure that at least two-thirds of their policies are QHP products.

In addition, the FAQ confirmed that CMS will not require CO-OPs to make payments on their ACA loans if those payments would result in financial distress or default or prevent the CO-OP from making payments to subscribers.

Avalere study says standardized ACA plans could cut out-of-pocket costs

A new analysis released this week by Avalere Health concludes that an Obama Administration proposal to standardize health plans sold through Affordable Care Act Marketplaces could significantly reduce out-of-pocket costs for consumers.

The Notice of Benefit and Payment Parameters that set the standards for Marketplace plans in 2017 sought to create six standard plan options at the bronze, silver and gold tiers of coverage. Bronze plans would have a uniform \$6,650 annual deductible, which would decrease to \$3,500 for silver plans, and \$1,250 for gold plans (see Update for Week of November 30th). Deductibles in silver and gold level plans would not apply to prescription drugs, primary care visits, or specialist visits. Instead, the plans would apply a flat copayment.

Avalere acknowledged that it was difficult to ascertain the full impact of the proposal as the standardized plans would not be required to be offered by Marketplace insurers and could come with markedly higher premiums. However, their analysis noted that three-quarters of all silver tier Marketplace plans currently require enrollees to meet deductibles before covering specialty drugs, while half apply the deductible to generic drugs. One-third also require subscribers to meet their deductible before covering primary care visits.

Avalere concluded that despite the uncertainty, standardized plans would reduce out-of-pocket costs for those with costly medical conditions who could better spread out costs throughout the year instead being faced with huge up-front deductibles.

America's Health Insurance Plans is opposing the proposal, which is expected to be finalized by CMS next month.

New rule on Medicaid outpatient drug costs implements ACA changes

The Centers for Medicare and Medicaid Services (CMS) released a long-awaited final rule on Medicaid reimbursement for covered outpatient drugs (CODs) last week.

The rule is effective on April 1st and intended to create a "fairer" reimbursement methodology for Medicaid providers and pharmacies. It implements several Affordable Care Act (ACA) changes to the Medicaid drug rebate program, as well as formulas to determine Average Manufacturer Price (AMP) and federal upper limits (FULs). In addition, CMS claims it will save federal and state governments \$2.7 billion over five years, improve enrollee access to prescription drugs, provide pharmacies with incentives to use generics, and give state officials more tools to manage Medicaid drug costs.

The ACA had increased the rebate percentages for certain Medicaid drugs and required CMS to recalculate the FUL amounts, as they sometimes exceeded the market prices for multiple-source drugs. However, it lacked specific definitions of AMP for inhalation, infusion, instilled, implanted, or injectable drugs (such as hemophilia clotting factor).

Under the final rule, states are required to specify that reimbursement methods to pharmacies that buy drugs through the federal Section 340B drug discount program for safety net providers are consistent with actual acquisition cost requirements.



FDA orphan drug approvals set record for second consecutive year

The Food and Drug Administration (FDA) announced last week that it approved 21 new orphan drugs to treat rare diseases in 2015.

The total represents nearly half (47 percent) of all novel new drugs that the FDA approved for the year. It also marks the second consecutive year in which the FDA approved more orphan drugs than any prior year in the agency's history.

STATES

Florida, California again lead nation in Marketplace enrollment

The Department of Health and Human Services (HHS) announced this week that more than 12.7 million consumers selected or were automatically enrolled in Marketplace coverage during the 2016 open enrollment period that ended on January 31st. The figures are an increase of roughly 15 percent over the 2015 period and above HHS projections last fall (see Update for Week of November 30th).

Roughly three-quarters of this total (or 9.6 million consumers) enrolled via the federally-facilitated Marketplace (FFM) that HHS operated this year for 38 states. Another 3.1 million enrolled through Marketplaces created by states, with 400,000 coming through the Basic Health Program that Minnesota and New York set-up for those earning only 133-200 percent of the federal poverty level (see Update for Weeks of August 17th and 24th).

As with last year, Florida again led all Marketplaces in total enrollment (with more than 1.7 million enrollees). California's state-based Marketplace was close behind at 1.6 million, while 1.3 million enrolled in Texas, which had eight of the highest ten regions nationwide that had the strongest growth.

States that saw the greatest rate of growth in Marketplace enrollment were Oregon (31 percent), Utah (25 percent), Iowa (22 percent), South Dakota (22 percent) and Nevada (20 percent). Oregon and Nevada both defaulted to the federal web portal after persistent glitches in their state models severely depressed enrollment during the first year (see Update for Week of June 2, 2014).

The HHS Secretary highlighted the fact that 42 percent or roughly four million of the 9.6 million FFM enrollees were new to the Marketplace, with 61 percent of this group signing-up as early as possible within the open enrollment period. However, the proportion of young adults age 18-34 moved only slightly higher during the 2016 period (to 28 percent), which was disappointing news to health insurers that insist the ratio needs to be about ten percentage points higher in order to ensure broad enough risk pools to remain financially viable.

Alaska

Moda's exit leaves individual market with only one health insurer

The Division of Insurance announced last week that Moda Health has been barred from selling or renewing policies in Alaska's individual market, including the federally-facilitated Marketplace operated pursuant to the Affordable Care Act (ACA).

Moda's exit is due to more than \$58 million in losses that the insurer incurred in 2015, due largely to the shortfall in ACA reinsurance payments for insurers with an exceptional number of costly claims that has caused at least a dozen non-profit health insurance cooperatives to also fail (see Update for Week of November 30th). Moda had received approval from the Division to increase 2016 premiums by nearly 40



percent in an effort to stay viable. However, the losses forced Moda's capital reserves to shrink to the point where it could no longer continue operations.

Moda's departure leaves individual market consumers in Alaska with only one insurer from which to choose. Premera Blue Cross and Blue Shield also incurred losses due to an exceptional number of costly claims (just over 24 percent of claims for 2015 came from only 37 of Premera's 8,500 individual subscribers), forcing it to increase premiums in 2016 by more than 38 percent. However, the insurer has substantially more capital reserves.

The Division will permit Moda's 9,800 individual subscribers to enroll in other coverage during a special enrollment period following the termination of their Moda plans. Those that switched to Premera before the end of open enrollment on January 31st will have coverage starting March 1st.

Despite Moda's exit and substantially higher 2016 premiums, enrollment in the Alaska Marketplace is slightly ahead of the pace for 2015. The average premium for benchmark plans (the plan to which ACA subsidies are tied) increased by 31.5 percent in Alaska for 2016, after already leading the nation in 2015. Anchorage, Alaska is one of only seven metropolitan areas across 49 states where the benchmark increase is at least 30 percent higher in 2015.

Due to the dramatic rate hikes, Premera has actually proposed that lawmakers create a tax on all health plans offered in Alaska (including the small and large group markets) to fund a supplemental state reinsurance program that would help cover the cost of exceptional claims. In its absence, the lack of competition in the individual market is likely to further increase premiums despite the state's expansion of Medicaid last year (see Update for Weeks of August 17th and 24th).

The Oregon Insurance Division took a similar action against Moda Health, which was that state's third largest insurer. However, Oregon has nine remaining carriers in the individual market.

California

Marketplace director insists that UnitedHealthcare and not ACA is to blame for substantial losses

The executive director for Covered California blasted claims this week by insurance giant UnitedHealthcare that its \$1 billion in losses on Marketplace business are due to flaws in the Affordable Care Act (ACA).

UnitedHealthcare currently participates in roughly two dozen ACA Marketplaces nationwide, including California. Since November, company officials have strongly hinted that they may exit the Marketplaces in future years have undertaken numerous cost-containment efforts to minimize 2016 losses (see Update for Week of November 30th). This includes refusing to accept third-party premium assistance from charitable groups like PSI in nearly all of their two dozen Marketplaces—a move intended to circumvent the guaranteed issue mandate under the ACA that prevents discrimination against costlier patients (see Update for Weeks of October 5th and 12th).

However, Covered California director Peter Lee was sharply critical of UnitedHealthcare for suggesting that the Marketplaces were not financially viable or sustainable, insisting that its effort to "throw the ACA under the bus [were] not anchored in reality." He pointed to an Urban Institute report released last week, which concluded that much of UnitedHealthcare's losses were self-inflicted. The report noted that UnitedHealthcare's decision to stay out of the Marketplaces for 2014 caused it to lack actual claims data upon which to base pricing decisions. As a result, the insurer set 2015 premiums substantially above its competitors and offered far broader provider networks.

The director also pointed out that the nation's second-largest health insurer, Anthem, was turning a profit on Marketplace business in and out of California, despite Marketplace enrollment running about 30 percent below their initial projections.



UnitedHealthcare along with other major health insurers have been lobbying the Obama Administration to tighten rules on special enrollment periods (SEPs) and promptly fill the \$2.5 billion shortfall in the ACA's reinsurance and risk corridors program. The Urban Institute report did validate these insurer concerns, noting that the Administration's repeated efforts to boost Marketplace enrollment by extending deadlines and creating new SEP triggers does create a "moral hazard" by letting healthier and less costly consumers wait until they need health insurance to enroll (see Update for Weeks of January 11th and 18th). Furthermore, the Administration's failure to pay insurers no more than roughly 12 percent of what they were due under the ACA for exceptional claims costs forced many smaller insurers and cooperatives out of the Marketplaces (see Update for Week of December 7th).

However, despite the valid concerns, the lead author for the Urban Institute report concludes that there is no evidence "that shows the exchanges are really in trouble" and that the failure of struggles of any single insurer "isn't a sign markets are unsustainable."

New bill would require consumer notification for "unreasonable" premium increases

Senator Ed Hernandez (D), chair of the Senate Health Committee, introduced legislation this week that would require individuals and small business owners to be notified by the insurer whenever premium increases are deemed by the Department of Insurance to be "unreasonable" or "unjustified,"

Under S.B. 908, subscribers under plans with "unreasonable" rate hikes would be afforded a special enrollment period to shop for other lower-cost coverage. The measure was proposed by the Health Access consumer group.

Georgia

New bill would limit cost-sharing for specialty medications

Rep. Lee Hawkins (R), vice-chair of the Health and Human Services Committee, introduced legislation this week that would limit cost-sharing for covered specialty drugs to \$200 for a 30-day supply or \$1,000 per insured per plan year (\$2,000 per insured family). Specialty drugs would be defined as a high-cost drug used to treat complex or rare medical conditions.

The bill (H.B. 875) would also force insurers to standardize definitions of drug tiers and post on applicable websites all drug formularies, drug costs, and prior authorization requirements. All prior authorization approvals for specialty drugs could not be changed for the duration of the plan year.

Idaho

Senate panel holds first-ever hearing on Medicaid expansion

The Senate Health and Welfare Committee held a public hearing this week on a Democratic-sponsored measure to expand Medicaid pursuant to the Affordable Care Act (ACA).

The hearing was the first to be held by the legislature on any Medicaid expansion proposal since the ACA's enactment and was attended by so many supporters that two overflow rooms had to be created. The measure introduced last week by Senator Dan Schmidt (D), a family physician, would allow Idaho to participate in a traditional ACA expansion, which would extend coverage to an estimated 78,000 adults caught in the gap between current Medicaid eligibility and the threshold for ACA subsidies to purchase Marketplace coverage.

The director of critical care at Eastern Idaho Regional Medical Center testified that "the Legislature's refusal to pass Medicaid expansion has likely resulted in over 1,000 deaths in the state." However, despite the backing of state provider, consumer, and business groups, committee chair Lee Heider (R) acknowledged that Senator Schmidt's bill (S.1204) will likely not receive a vote as it would



require Idaho to accept federal funds. The committee is instead waiting for Governor Butch Otter (R) to formally introduce his state-funded alternative, even though such a limited expansion is highly unlikely to receive the needed federal approval (see Update for Week of December 7th).

The legislature has rejected all attempts to expand Medicaid despite two pro-expansion recommendations from the Governor's own Medicaid Redesign Workgroup, calling it a "no brainer" to save up to \$173 million over ten years (see Update for Week of January 12, 2015).

Hawaii

New legislation would create prescription drug discount program based on manufacturer rebates

Rep. Marcus Oshiro (D) introduced two bills last week that would create a pharmaceutical discount program for all residents under which the state would negotiate manufacturer rebates on drugs that are offered at discounted prices to program participants.

H.B. 1681 and H.B. 1682 were both referred to the committees on Health, Consumer Protection, and Finance. They would establish the Hawaii Rx Program and the Rx Plus Program, the latter of which would be restricted to those residents earning less than 350 percent of the federal poverty level. Drug manufacturers can voluntarily choose whether to participate in the program. However, those that opt-out may have their products placed on the prior authorization list or formularies for Medicaid.

Both bills would give the Department of Human Services authority to contract with third-parties to administer any part of the programs.

Kansas

Hospital association drafts Medicaid expansion bills modeled on Indiana alternative

Committees in the House and Senate introduced twin bills this week that would create an alternative to the Medicaid expansion under the Affordable Care Act (ACA), similar that which was federally-approved for Indiana.

The identical measures drafted by the Kansas Hospital Association (KHA) would make roughly 150,000 non-disabled adults eligible for KanCare, the state's Medicaid managed care program. As with Indiana, it would require the newly-eligible population to pay up to two percent of their income into health savings accounts that would be used to purchase coverage. However, it would also terminate coverage for enrollees that fail to pay these premiums.

The House measure was introduced in the Federal and State Affairs Committee by Rep. Susan Concannon (R), a former medical foundation director who is one of three Republicans that House Speaker Ray Merrick (R) removed from the House Health and Human Services Committee this year due to their support for Medicaid expansion (see Update for Week of November 30th). The Speaker and Governor Sam Brownback (R) immediately declared their opposition to the bills, although the Governor has hinted that he may consider a limited expansion that is "budget neutral" and imposes a work requirement. However, the Obama Administration has consistently stripped out work requirements from the seven Medicaid expansion alternatives that it has approved (see Update for Week of November 30th).

According to KHA, their expansion plan would bring in roughly \$183 million in new revenue next year and \$240 million by 2020. It would be funded not only through enrollee premiums but a drug rebate program and "privilege taxes" on managed care plans participating in KanCare.

Expansion proponents believe that the recent closure of rural hospitals due to uncompensated care costs can provide the needed momentum to overcome conservative opposition to the bills. However, Governor Brownback sought this month to pin the blame on the closures to Medicare reimbursement cuts triggered by the ACA.



Kentucky

New bill limits prescription drug cost-sharing only for certain health plans

Rep. James Kay (D) introduced new legislation this week that would limit prescription drug cost-sharing for certain health plans.

Under H.B. 321, at least 25 percent of plans that cover essential health benefits (apart from the lowest bronze tier and catastrophic tier of coverage) would be required to use benefit designs in which the maximum copayment could not exceed 1/12 of the maximum annual out-of-pocket limit set by the plan for individual coverage. In addition, these plans would be unable to require subscribers to pay coinsurance for any prescription drug that is not part of the plan's formulary or any non-formulary drug otherwise covered under the plan.

At least one of the plans shall not require enrollee to pay deductible for covered prescription drugs and the amount of cost-sharing for any specific drug could not exceed the amount of the copayment specified in the plan's summary of benefits and coverage.

The measure was referred to the Banking and Insurance Committee. It would be effective January 1, 2017.

New Hampshire

Republican leaders seek to reauthorize Medicaid expansion

The House Finance Committee held a public hearing last week on legislation that would extend New Hampshire's participation in the Medicaid expansion under the Affordable Care Act (ACA).

New Hampshire is one of only seven states with a federally-approved alternative to the ACA expansion, in which the state can use ACA matching funds to purchase private coverage. The New Hampshire Health Protection Program (NHPP) was initially enacted in 2014, but secured Republican support only by including a sunset provision that would automatically terminate the program at the end of 2016 (when ACA funding for the expansion dips below 100 percent) without legislative re-authorization (see Update for Week of June 23, 2014). The committee is currently considering legislation sponsored by Rep. Joe Lachance (R) that would extend the NHPP by two years, by only if additional work requirements for "able bodied adults" and enrollee copayments are included. In addition, the bill (H.B. 1696) seeks to impose fees on hospitals and insurers to help defray the state portion of expansion costs after 2016, which starts phasing down to 90 percent by 2020 (and subsequent years).

More than 45,000 residents are currently enrolled in NHPP and would lose coverage if the program is not re-authorized. However, some of the more conservative members of the Republican-controlled House including Rep. Pam Tucker (R) remain opposed to any form of expansion and testified against the bill during this week's hearing, insisting that federal funding is "unreliable" and that the expansion shifts insurance costs onto other residents.

The re-authorization has the support of Senate President Chuck Morse (R), Senate Majority Leader Jeb Bradley (R), and seven other Republican co-sponsors. It is also backed by Governor Maggie Hassan (D), the chief justice of the New Hampshire Superior Court, the New Hampshire Medical Society, hospital groups, business leaders, and consumer organizations.

Washington

New bill would limit cost-sharing for prescription drugs

Rep. Brady Walkinshaw (D) introduced new legislation last month (H.B. 2602) that would limit cost-sharing for any individual prescription drug to no more than \$100 for a thirty-day supply. For a non-



grandfathered individual or small group health plan, the annual deductible for outpatient drugs would not be allowed to exceed \$500.

The measure was referred to the House Health Care and Wellness Committee. It would be effective on January 1, 2017.