

Health Reform Update – Week of October 15, 2018

CONGRESS

Senate Republicans block effort to undo HHS rule allowing short-term health plans

Senate Democrats fell one vote short this week in their effort to pass a resolution seeking to use the Congressional Review Act (CRA) to roll back the Trump Administration's recently finalized rule increasing the use of short-term health plans that do not need to comply with the Affordable Care Act (ACA).

The final rule removed the Obama Administration's three-month limit on short-term health coverage and extended it up to the pre-ACA limit of 364 days (see Update for Week of August 13th). Insurers offering these plans will be allowed to limit benefits, impose annual and lifetime caps, and deny coverage to persons with pre-existing conditions or charge higher premiums based on health status. Opponents insist that allowing such "junk" plans will siphon away healthier and lower-cost consumers from the risk pools from ACA Marketplaces, essentially relegating ACA-compliant coverage to a high-risk pool for those with costly medical conditions (see Update for Week of September 10th).

Senator Tammy Baldwin (D-WI) secured the support of every Senate Democrat for her resolution (S.J.Res.63) that was largely intended to force Republicans to take a controversial vote to undermine the ACA only weeks before a midterm elections in which polling by Kaiser Family Foundation and other groups show that voters increasingly favor preserving the ACA. Senator Susan Collins (R-ME) was the lone Republican to support the resolution, allowing Vice President Mike Pence to break the tie and defeat it. However, the resolution was not expected to be heard in the House and the President had already pledged to veto it should it reach his desk.

California has already responded to the final rule by outlawing the use of short-term health plans entirely while several other Democratically-controlled states have acted to limit their use to three or six months (see Update for Week of September 10th). The short-term health plan rule is also the target of a federal lawsuit brought by seven patient advocacy groups, which will be heard next week (see Update for Week of October 1st).

Bipartisan Senate legislation would protect consumers from surprise medical bills

A bipartisan group of Senators released draft legislation last month that would protect patients from surprise medical bills from out-of-network providers when they seek in-network care.

Surprise billing frequently occurs in the emergency room setting where services are often rendered by contracted physicians or ancillary providers that are not in the same network as the in-network hospital and patients are typically not in position to prospectively inquire about out-of-network charges. The same situation can also occur when patients require either ground or air ambulance services.

According to The Commonwealth Fund, at least 21 states have already enacted some protections from consumers facing surprise bills in these situations. However, only those implemented in California, Connecticut, Florida, Illinois, Maryland, and New York are considered "comprehensive" and states are prevented by federal law from applying these protections to the 61 percent of privately-insured employees covered under self-insured plans.

The draft legislation sponsored by Senators Bill Cassidy, MD (R-LA), Michael Bennet (D-CO), Chuck Grassley (R-IA), Tom Carper (D-DE), Todd Young (R-IN) and Claire McCaskill (D-MO) would essentially limit a patient's out-of-pocket liability from out-of-network providers to what he or she would have incurred for in-network care, although the providers could seek additional reimbursement from the insurer.

Senators Maggie Hassan (D-NH) and Jeanne Shaheen (D-NH) followed by introducing their own bill last week (S. 3592), which would largely follow the model in the draft bill by removing the patient from the dispute over out-of-network charges. However, instead of prescribing a minimum payment rate from insurer to provider, S.3592 would create a “binding arbitration” process to determine the appropriate provider payment rate in surprise out-of-network scenarios. The arbiters would specifically be allowed to consider Medicare rates or negotiated network rates in making their determination.

FEDERAL AGENCIES

CMS says federal Marketplace premiums for benchmark plans will slightly decline in 2019

The Centers for Medicare and Medicaid Services (CMS) announced this week that benchmark premiums for the 39 states defaulting to the federally-facilitated Marketplace (FFM) will fall next year by an average of 1.5 percent to \$406 per month.

Benchmark plans are the second-lowest cost silver-tier plan in the Marketplace. They are the most popular plan selection since the amount of the ACA’s premium tax credits are tied to the cost of the benchmark plan.

The premium declines are the first since the Affordable Care Act (ACA) was fully implemented in 2014 and a dramatic departure from average benchmark premiums that spiked by 37 percent in 2018 and 25 percent the year before. Analysts credited most of the premium decreases next year to the fact that insurers increased 2018 premiums by more than was necessary to reflect the uncertainty about if and how Congress would repeal the ACA and the Trump Administration’s last minute decision to eliminate the law’s cost-sharing reductions (see Update for Week of November 6th). As a result, they are being forced to rebate excess profits under the ACA’s medical-loss ratios that caps profit and overhead at 20 percent of premium revenue.

However, CMS Administrator Seema Verma touted her agency’s approval of reinsurance programs for seven states as a primary factor in insurers choosing to reduce 2019 rates (see Update for Week of September 10th). CMS also noted that plan competition will be up significantly, as an additional 23 insurers will participate in FFMs next year while 29 insurers will expand their coverage areas. This includes the decision by Blue Cross Blue Shield insurers such as Anthem and Wellmark to return to Marketplaces they exited last year (see below). As a result, the number of counties served by only one FFM insurer will fall from 56 to 29 percent.

Marketplace consumers in Tennessee will see the biggest drop in benchmark premiums, down 26.2 percent from last year to an average of \$449 per month (for a 27 year old non-smoker). The dominant insurer, BlueCross BlueShield of Tennessee will decrease all premiums by an average of 15 percent to \$3,110 month—though still the highest in the nation (see Update for Week of August 27th). Benchmark premiums in that state’s Marketplace had increased by more than 56 percent in 2017 and 2018 as it struggled to maintain even one participating insurer in many counties (see Update for Weeks of June 12 and 19, 2017).

FFM consumers in New Hampshire, New Jersey, New Mexico, and Pennsylvania (see below) will also benefit from double-digit declines in benchmark premiums (from 14-16 percent) on average. Overall, average benchmark premiums will fall in 16 FFMs, including Ohio and Virginia (see below). However, Arizona, Maine, Missouri, and Wisconsin are the only FFMs that will see more than a five percent drop.

Despite the aggregate decline, several states will still see dramatic increases in benchmark premiums for 2019. FFM consumers in North Dakota, Delaware, and Hawaii will see the highest average jump (at 20.2, 16.1, and 12.5 percent respectively), due largely to limited competition. Other states that will experience 7-10 percent average increases include Kentucky, Montana, Nebraska, Oregon, and West Virginia.

FFM premiums for the lowest-cost silver plans will fall by a comparable one percent average to \$288 per month. However, in that case that most dramatic average declines belong to New Hampshire, Iowa, and Tennessee (by 22.7, 19.5, and 14.5 percent respectively). New Hampshire and Iowa had seen average increases for these plans skyrocket by 77-88 percent last year. The highest lowest-cost silver plan average increase of 10.5 percent will be found in Florida, even though insurers in that state will receive only a 5.2 percent average increase across all plans (see Update for Week of August 27th).

Proposed rule would require drug manufacturers to disclose list prices in television advertising

The Centers for Medicare and Medicaid Services (CMS) released proposed regulations this week that would require manufacturers to disclose the list price of prescription drugs in their direct-to-consumer (DTC) advertisements.

The proposal was part of the President's drug pricing "blueprint" outlined earlier this year (see Update for Week of May 7th). It would apply to all prescription drugs covered by Medicare and Medicaid except those with list prices of less than \$35 per month. List prices would be defined as those initially charged to direct purchasers (such as distributors or wholesalers) before accounting for rebates and other financial terms that can alter the price. The rule would require the price reflect the cost for either a typical 30-day regimen or course of treatment.

The Pharmaceutical Research and Manufacturers of America (PhRMA) pre-emptively announced their opposition to the proposal, insisting that it would mislead consumers and violate the constitutional First Amendment rights of manufacturers, citing similar criticisms from the Association of National Advertisers. The trade group recommended that companies instead be allowed to voluntarily use DTC advertising to refer consumers to websites that will provide them with pricing details. This includes a clearinghouse that member companies would develop by April 2019 that would let consumers and providers search for information on pricing, out-of-pocket costs, and available financial assistance for drugs sold by different manufacturers.

CMS Administrator Seema Verma disclosed later in the week that the agency was also preparing to shortly release proposed regulations that would make changes to the six protected drug classes under Medicare Part D, as well as alter the program's catastrophic benefit (which kicks in once enrollees pass through the "doughnut hole") in order to shift risk away from the government and onto Part D plans. Under the Obama Administration, intense stakeholder opposition forced CMS to withdraw a previous proposal to eliminate at least two of the six protected classes, for which Part D plans must cover "all or substantially all drugs" (see Update for Week of March 10, 2014). The Administrator did not identify how the forthcoming proposal may differ from that earlier plan.

The biannual regulatory plan also released last week by the Department of Health and Human Services (HHS) indicates that the agency intends to eventually propose regulations exempting certain manufacturers from required drug rebates under Medicaid, as well as modernizing the approval pathway that the Affordable Care Act (ACA) created for high-cost biologic drugs.

Social Security benefits to increase by nearly three percent for 2019

The Social Security Administration (SSA) announced this week that beneficiaries will receive a 2.8 percent increase in benefits for 2019.

The automatic cost-of-living adjustment (COLA) is set by law and is based on inflation. Next year's increase is the largest since benefits rose by 3.6 percent in 2012 and far exceeds the minimal increase in prior years (0.3 percent in 2016 and none in 2015). The major increase for 2019 reflects the fact that inflation is currently at a six-year high.

For low-income individuals receiving Supplement Security Income (SSI) benefits, the maximum federal payment for 2019 will be \$771 per month, up from \$750 this year.

Medicare premiums and deductible to rise slightly for 2019

The Centers for Medicare and Medicaid Services (CMS) announced last week that the monthly premium and annual deductible for Medicare Part B enrollees will increase slightly for 2019.

Enrollees in the optional Part B program (that largely covers outpatient and physician services) will now pay \$135.50 in monthly premiums (up from \$134) while the annual deductible increased by \$2 to \$185. The annual deductible for Part A (inpatient care) will rise to \$1,364, up \$24 from 2018.

CMS officials stressed that roughly two million low-to-moderate income Part B enrollees (or 3.5 percent of all enrollees) will pay less than the full monthly premium due to statutory hold-harmless provision. This provision prevents CMS from raising Part B premiums for roughly 70 percent of Social Security recipients by more than their annual cost of living adjustment (see above).

STATES

Hawaii

Regulators limit average 2019 premium increases to 5.3 percent

The Department of Commerce and Consumer Affairs posted final 2019 premiums this week for the only two health insurers participating in the individual market.

The Department dramatically reduced the 28.6 percent average premium increase proposed by Kaiser Permanente down to 12.9 percent, pursuant to state law that requires rates not be excessive, inadequate, or unfairly discriminatory. Kaiser controls about 43 percent of the roughly 31,500 consumers enrolled in the Affordable Care Act (ACA) Marketplace for Hawaii.

The leading Marketplace insurer, Hawaii Medical Service Association (an independent licensee of the Blue Cross and Blue Shield Association) had their 2.72 percent proposed average increase reduced by the Department to an average decline of 0.37 percent.

The reductions led to a weighted overall premium increase of 5.3 percent for individual market consumers in and out of the Marketplace. The Department estimated that their reductions will save consumers more than \$20 million.

Both insurers were allowed to use premiums increases for silver-tier plans to account for the Trump Administration's elimination of ACA cost-sharing reductions (CSRs), as was the case for the 2018 plan year (see Update for Week of November 6th). As a result, consumers purchasing the "benchmark" silver-tier plans to which the ACA premium tax credits are tied will see a 12.5 percent average increase in "benchmark" premiums—the third-highest increase for any federally-facilitated Marketplace (see above).

Insurers noted that rate increases would have been lower had Hawaii enacted proposed legislation creating a state-alternative to the ACA's individual mandate penalties that were repealed last year, as well as a bill authorizing the state to seek federal approval for a reinsurance program that would compensate insurers for exceptional claims, as seven other states have already received (see Update for Week of May 28th). Both bills stalled this session but are expected to be renewed next year.

Governor David Ige (D) did sign legislation making Hawaii one of the handful of states to curb the Trump Administration's allowance of short-term limited-benefit plans that do not comply with the ACA, which opponents insist will force Marketplace premiums to increase as younger and healthier consumers shift into non-compliant coverage (see Update for Week of July 7th). The bill (H.B. 1520) prevents short-term plans from extending coverage beyond the 90-day

limit set by the Obama Administration (see Update for the Week of June 20, 2016), following Trump Administration regulations extending that limit by up to 364 days (see Update for Week of February 26th).

Maryland

Attorney General asks U.S. Supreme Court to reinstate drug price-gouging law

Attorney General Brian Frosh (D) announced this week that he has filed an appeal asking the U.S. Supreme Court to reinstate Maryland's unprecedented law protecting consumers from "unconscionable" increases in prices for essential off-patent or generic drugs.

Governor Larry Hogan (R) had allowed the law to go into effect without his signature, despite expressing concerns that it may be unconstitutional (see Update for Weeks of May 29 and June 5, 2017). H.B. 631 had authorized the Attorney General to take legal action against generic manufacturers or wholesale distributors who could not justify price increases. The health department would also notify the Attorney General whenever three or fewer manufacturers are actively manufacturing and marketing an essential off-patent drug, the wholesale acquisition cost (WAC) increases by 50 percent or more in one year, or if the WAC for a 30-day supply exceeds \$80.

The Association for Accessible Medicines (formerly the Generic Pharmaceutical Association) immediately sued to block the law from going into effect but was initially rebuffed the U.S. District Court for the District of Maryland (see Update for Week of October 2, 2017). However, in a 2-1 ruling a panel for the Fourth Circuit U.S. Court of Appeals overturned the lower court's ruling and ordered it to grant the injunction sought by AAM, concluding that Maryland could not regulate out-of-state drug transactions under the Commerce Clause to the U.S. Constitution (see Update for Week of April 16th). The full appellate court refused to reconsider the decision (see Update for Week of July 23rd).

Attorney General Frosh insists that the appellate ruling is incorrect because it takes away Maryland's ability to "protect consumers from predatory commercial practices that originate out of the state, even though they are directed into the state and will directly harm its citizens."

At least 16 other states including Colorado, Illinois, Louisiana, and New Hampshire had advanced similar price-gouging prohibitions modeled on the Maryland law (see Update for Week of February 26th). However, none have chosen to enact their legislation until its constitutional validity is resolved.

New Jersey

New bill would provide continuous guaranteed issue rights to Medigap applicants of Medicare age

Senator Joseph Vitale (D) introduced legislation last month that would provide continuous guaranteed issue rights to Medigap applicants aged 65 and older who are also receiving benefits under Medicare Part B.

Currently in New Jersey, applicants for Medigap (i.e. Medicare supplemental insurance) are provided guaranteed issue rights only during a one-time, six-month open enrollment period when they enroll in Part B or experience a qualifying life event, such as a loss in Medigap coverage. The bill (S.2895) would prevent Medicare enrollees from unknowingly forfeiting the chance to purchase Medigap coverage later in life by extending those guaranteed issue protections.

Guaranteed issue means that an insurer cannot deny coverage or discriminate in pricing based on the health status, claims experience, receipt of health care, or medical condition of any applicant, nor can they exclude benefits based on an applicant's pre-existing medical condition.

The bill was referred to the Senate Health, Human Services and Senior Citizens Committee.

Ohio

Return of dominant insurer holds 2019 premium increases to roughly a six percent average

The Department of Insurance announced this week that 2019 premium increases for Affordable Care Act (ACA) Marketplace insurers offering individual coverage will be limited to an average of 6.3 percent.

Although the increases are well-above the 1.5 percent decrease in average premiums for all 39 of the federally-facilitated Marketplaces (FFMs) operated under the Affordable Care Act (ACA) (see above), it is a stark contrast to the 2018 plan year when Marketplace consumers in Ohio faced individual market premiums that spiked by 21 percent on average. Department officials credited increased competition for the dramatic decline, as ten insurers will participate next year (up from eight in 2018) and the number of counties with only one insurer will drop from 42 to 16.

The decision by Anthem Blue Cross and Blue Shield to re-enter Ohio's Marketplace was a major factor in limiting premium increases, even though their coverage will largely be limited to 25 counties in the southeastern part of the state. Anthem had controlled 28 percent of the Marketplace for the 2017 plan year but abruptly chose to leave for 2018 due to the "uncertainty" over how and if key ACA provisions (including the cost-sharing reductions) would survive repeal efforts by Congressional Republicans and the Trump Administration (see Update for Weeks of May 29 and June 5, 2017). Anthem's exit left 20 of Ohio's 88 counties without any participating insurers, forcing other insurers to belatedly expand their coverage areas (see Update for Week of August 28, 2017).

Startup insurer Oscar Health Plan (which just entered the Marketplace for 2018) received the largest premium increase, averaging more than 22 percent for gold-tier coverage. Oscar specifically blamed "misguided decisions in Washington to eliminate the individual mandate and create short-term plans that are a poor substitute for [ACA] plans" for the increase, even though it has elected to increase its coverage area into Columbus for next year.

CareSource, which received a nearly 18 percent average rate hike for Marketplace plans offered in 60 Ohio counties, also blamed the individual mandate for increasing costs by providing incentives only for "consumers with the greatest health care needs to enroll."

Pennsylvania

Individual market premiums fall by average of 2.4 percent despite Trump Administration "sabotage"

Final rates released this week by the Insurance Department revealed that individual market health insurers will decrease premiums for 2019 by a statewide, weighted average of 2.4 percent.

The decline is 7.3 percent lower than the preliminary rates initially proposed by insurers earlier this year and 3.1 percent below the rates modified by the Department last summer (see Update for Week of July 23rd). It is in stark contrast to the nearly 31 percent average increase granted to insurers after the last two years (see Update for Week of June 11th).

Insurance Commissioner Jessica Altman (D) attributed increased competition for the dramatically lower premiums, noting that four of the five participating insurers are expanding their plan options for 2019 and a new insurer (Pennsylvania Health and Wellness, Inc.) has entered the market. As result, consumers in 20 of the state's 67 counties will have an additional insurer in the Affordable Care Act (ACA) Marketplace while 31 counties will see additional plan offerings, with offerings doubling in Lehigh and Northampton counties. Only eight counties will be limited to one participating insurer—down from 20 for this year.

Average Marketplace premiums will fall by as much as 20 percent for Capitol Advantage Assurance Company and seven percent for certain plans offered by Highmark and Keystone Health Plans. No carrier received an average increase of more than 7.8 percent for any of their Marketplace plan offerings.

Pennsylvania insurers made clear in their rate filings that their lower premiums came despite having to add six percent across-the-board to account for the Trump Administration's repeal of individual mandate penalties under the ACA and their allowance for short-term and association health plans that need not comply with the ACA. Without this add-on, Marketplace consumers not receiving ACA premium tax credits would have paid more than \$500 less next year.

Virginia

Insurance bureau reduces average 2019 premium increase for individual consumers to nine percent

The Bureau of Insurance released final approved premiums this week for the individual health insurance market showing that consumers will see rates increased by an average of nine percent for 2019.

The Bureau reduced premiums from the average 13 percent increase that insurers sought earlier this year (see Update for Week of May 7th). However, monthly premiums will still average \$796.29 next year, up from the \$732.45 average in 2018. (Consumers in the small group market will actually see a slight decrease from \$530.48 to \$529.30 on average).

Eight insurers will participate in the federally-facilitated Marketplace to which Virginia continues to default (despite retaining state control over some plan management functions). Virginia had one of the healthiest Marketplaces until the 2018 plan year when Aetna and UnitedHealthcare departed after the Trump Administration starting threatening to eliminate Affordable Care Act (ACA) cost-sharing reductions shortly before the start of open enrollment (see Update for Week of August 14th). However, it was the subsequent decision by Anthem Blue Cross Blue Shield and Optima Health Plan to dramatically slash the number of counties it served that caused 2018 premiums to skyrocket by an average of 69 percent and left up to 70 percent of localities with only one insurer. As a result, Albemarle County (which includes Charlottesville) had the highest premiums in the nation for 2018 (averaging \$1,012 per month) since they were served only by Optima (see Update for Week of November 6th).

Anthem's decision to now expand its coverage area for 2019 (from 68 to 110 cities and counties) was credited by regulators with helping to hold premium increases in line, particularly in Albemarle County. Virginia Premier Health Plan (owned by the Virginia Commonwealth University Health System) will also join the Marketplace, but only serve about 4,000 consumers in the Richmond area. CIGNA is expected to continue to lead in overall Marketplace enrollment (serving about 29 percent of Marketplace consumers), while Kaiser and Optima Health Plan are likely to continue serving around 20 percent. Average monthly premiums for central Virginia Marketplace consumers will range from \$584 for CIGNA to \$761 for Optima.

Piedmont Community Health Care (which is expanding into three new coverage areas for 2019) had initially proposed a staggering 46.5 percent average increase (see Update for Week of May 7th) but received only an 11.94 percent average hike from the Bureau. Group Hospitalization and Medical Services (which serves only one rating area in northern Virginia) had their proposed 64 percent rate hike reduced to 45.10 percent.

The Bureau allowed individual market insurers to increase 2019 premiums to account for the Trump Administration's ultimate elimination of the CSRs last year (see Update for Week of November 6th) and all eight participating carriers elected to add the CSR cost solely to silver-tier plans offered in the Marketplace.

Medicaid expansion enrollment to begin November 1st

Governor Ralph Northam (D) announced this week that those earning less than 138 percent of the federal poverty level can start applying for new Medicaid expansion on November 1st after the federal government approved the commonwealth's State Plan Amendment (SPA).

Republican and Democratic lawmakers reached a compromise on the Medicaid expansion last spring after Democrats made dramatic electoral gains in the assembly the previous fall (see Update for Week of May 28th). In



exchange for dropping their opposition to participating in the Affordable Care Act (ACA) expansion, Republicans were able to get the Governor and Democrats to agree to seek federal approval to also impose work requirements on adults made newly-eligible for Medicaid. That federal waiver request is currently out for public comment.

Medicaid coverage will start January 1st for those applying in November and December. The expansion is expected to add roughly 400,000 newly-eligible enrollees to Medicaid.

Virginia is the 34th state to participate in the Medicaid expansion under the ACA. Voters in Idaho, Nebraska, and Utah will decide next month whether their states should do likewise (see Update for Week of September 10th), while Montana's existing expansion will only continue if a comparable ballot referendum is approved by voters.

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