



## Health Reform Update – Week of September 8, 2014

### CONGRESS

#### ***House passes bill to extend ACA-deficient group plans***

House Republicans passed legislation this week with the support of 25 Democrats that would allow insurers to continue to sell group health plans through 2018 that fail to comply with the Affordable Care Act (ACA).

H.R. 3522 was sponsored by Rep. Bill Cassidy (R-LA), a physician who is challenging Senator Mary Landrieu (D-LA) this fall. He insisted that the measure would allow the Obama Administration to keep their promise that “if you like your plan, you can keep it.” It goes beyond the Administration’s decision to give insurers the discretion to extend existing ACA-deficient plans through 2016 (see Update for Week of March 3<sup>rd</sup>) and would also allow non-compliant policies to be offered to new enrollees. However, H.R. 3522 would prohibit them from being sold within ACA Marketplaces.

The White House promptly pledged to veto the legislation, although it is not expected to be considered by the Democratically-controlled Senate prior to the midterm elections this fall. Similar legislation to grandfather individual health plans (H.R. 3350) was also passed by the House last year but failed to move in the Senate (see Update for Week of November 11<sup>th</sup>).

The Congressional Budget Office (CBO) did estimate this week that H.R. 3522 would increase federal revenues by \$1.25 billion from fiscal 2015- 2024 as employees spend less on health premiums. It predicted that up to two million consumers would enroll in the non-compliant group plans by 2016. However, it warned that a larger pool of consumers in ACA-deficient plans could cause premiums for ACA-compliant plans to spike, as the latter would likely be skewed towards older and sicker populations.

This week’s vote was the first on an ACA issue since the House attempted to exempt expatriate health plans from the law’s individual and employer mandates last spring (see Update for Weeks of April 28<sup>th</sup> and May 4<sup>th</sup>). The House had previously voted on an anti-ACA measure every week during 2014.

#### ***House Republicans say increased NIH, FDA funding off the table for medical innovation bill***

House Republicans this week announced that increased funding for the National Institutes of Health (NIH) and Food and Drug Administration (FDA) was likely not to be part of draft legislation for its 21<sup>st</sup> Century Cures Initiative slated for January 2015.

The medical innovation legislation to be proposed by the House Energy and Commerce Committee is instead expected to shift funds from other organizations, such as the Patient-Centered Outcomes Research Institute created by the ACA— a move sure to meet with broad Democratic opposition.

The committee held several roundtables over the summer to debate the measure, which included testimony from NIH and FDA officials insisting that more consistent funding streams were the best means to spur innovation. However, House Republicans insisted that the panel should focus on private sector innovation instead of greater levels of federal funding.

At a committee roundtable, NIH Director Francis Collins told lawmakers that the best way to facilitate medical innovation would be to provide more consistent funding to NIH, FDA, and other research



agencies. However, GOP lawmakers countered that instead of increasing federal funding, they are looking for ways the government could encourage private sector innovation.

Rep. Bill Cassidy (R-LA), a physician, questioned whether NIH is efficiently using the funds already allocated by Congress, insisting that it may be focusing too many resources on research for HIV/AIDS instead of Alzheimer's disease and other neurological disorders that are increasing in prominence.

Private sector witnesses such as the chairman of the Milken Institute have urged Congress to offer higher tax deductions to boost private investment in federal research, noting that some countries provide companies with deductions of up to 50 percent.

### ***Emergency room use dropped once young adults allowed to remain on parents' health plans***

A new study released this week by Stanford University shows emergency room use among young adults aged 19-25 declined by more than two percent after the Affordable Care Act (ACA) allowed that population to remain on their parents' group health plans.

A review of 2009-2011 state hospital records in California, Florida, and New York found young adults had a decrease of 2.7 emergency room visits per 1,000 people compared to older populations. The relative change of 2.1 percent occurred after the ACA provision went into effect in September 2010 for 2011 plan years.

The largest decreases were among young women (three percent) and young African-Americans (3.4 percent). They contrast sharply with the steady rise in emergency room visits in the decade prior to the ACA.

## **FEDERAL AGENCIES**

### ***FTC sues drugmakers over "pay-to-delay" deals***

The Federal Trade Commission (FTC) filed a lawsuit this week charging several drugmakers with violating federal antitrust laws via "pay-to-delay" generic drug settlements that harm competition and increase prices to consumers.

The lawsuit is the first since the U.S. Supreme Court ruled last year that patent litigation settlements that delay the market entrance of lower cost generics may be subject to greater antitrust scrutiny (see Update for Week of June 17, 2013). It singles out several drugmakers including Abbott Laboratories for reaping "ill-gotten gains" by "sham" agreements that forced consumers to overpay for a billion-dollar testosterone replacement therapy.

The FTC has crusaded for years against these settlements (which topped out at 40 in 2012) claiming they cost consumers \$3.5 billion per year and delay market entrance by an average of 17 months (see Update for Week of March 18, 2013). President Obama and a bipartisan group of lawmakers have supported the FTC's efforts over the past three Congresses to secure legislation that would presume all "pay-to-delay" settlements violate federal antitrust law unless the parties can demonstrate it does not hinder competition (see Update for Week of March 25<sup>th</sup>). However, the bills have been repeatedly blocked by both Republicans and Democrats from states with a heavy drug industry presence (see Update for Week of April 23, 2012).

The Supreme Court refused to declare "pay-to-delay" delays presumptively illegal unless the companies can demonstrate they do not harm competition. Instead, it put the burden on the FTC to determine on a case-by-case basis whether each agreement violates the long-standing "rule of reason"



doctrine, which states that a practice is anticompetitive if it poses an “unreasonable restraint of trade” (see Update for Week of June 17, 2013).

### ***CMS will not initially enforce 90-day notice standard for plan cancellations***

The Centers for Medicare and Medicaid Services (CMS) announced last week that it will not take enforcement action this year against insurers that fail to send cancellation notices to individual plan subscribers at least 90 days before plan renewal.

In order to comply with the statutory 90-day notice requirement, the CMS guidance notes that insurers would need to send the notices by October 3<sup>rd</sup> for 2014 plans. However, since the open enrollment period for 2015 coverage starts November 15<sup>th</sup>, CMS has agreed for this year to relax the requirement and require notices to be sent consistent with the timeframes for renewal notices (which must be sent before the first day of open enrollment).

According to CMS, the change will avoid the situation where consumers “could potentially receive discontinuance notices without being able to take prompt action to shop for new coverage.” However, CMS emphasizes that in future years open enrollment periods will be more closely aligned with the 90-day discontinuance notice standard.

Individual health plan insurers abruptly cancelled more than five million plans that failed to comply with the Affordable Care Act (ACA) in the weeks surrounding the start of the inaugural open enrollment period last fall, causing mass confusion and a political liability for the Obama Administration that led to their decision to let states extend the ACA-deficient plans (see Update for Week of November 11<sup>th</sup>). However, America’s Health Insurance Plans insists that the number of plan cancellations this year will be “fairly low”.

### ***CMS issues second round of ACA navigator grants, new funds for minority enrollment***

The Centers for Medicare and Medicaid Services (CMS) awarded \$60 million this week to 90 non-profit groups that will help facilitate enrollment in Affordable Care Act (ACA) Marketplaces for the 2015 plan year.

The grants only apply to navigators serving federally-facilitated Marketplaces (FFMs) that are expected to be operated in 34 states for 2015. The total amount is slightly less than the \$67 million that was awarded for the 2014 plan year and were received largely by existing navigators.

The largest grants went to navigators in states with the highest uninsured rates, including \$5.4 million to the University of South Florida (USF) and \$4.6 million to the United Way of Metropolitan Tarrant County (Texas). USF’s grant was increased by \$1.2 million from a year ago, since it will now serve the entire state by adding heavily populated counties in south Florida.

Two non-profits in Georgia will split a \$3.3 million grant, after the University of Georgia was excluded due to a new state law banning state government entities from serving as ACA navigators or other forms of assisters (see Update for Weeks of April 28<sup>th</sup> and May 5<sup>th</sup>).

CMS also released \$3.2 million in new funding this week to 13 organizations that will help educate and encourage racial and ethnic minorities to enroll in FFM coverage. The grantees (which include universities, non-profits, and charities) fall under the agency’s Partnership to Increase Coverage in Communities (PICC).

Minority enrollment was lower than anticipated in several states for 2014, even though African-Americans and Latinos have far higher uninsured rates than other populations. African-Americans accounted for only 16.7 percent of FFM enrollment, while Latinos registered a mere 10.7 percent. State-



based Marketplaces like California struggled with perceptions among Latino populations that enrolling in coverage may lead to the identification and punishment of undocumented family members (see Update for Week of February 17<sup>th</sup>).

### ***CMS will not terminate low-performing Medicare Advantage or Part D plans for 2015***

The Centers for Medicare and Medicaid Services (CMS) announced this week that it has reversed course and will not terminate any Medicare Advantage and Part D plans at the end of this year that failed to receive three stars in any of the last three years under the Star Ratings quality measurement program.

Final regulations issued last spring had reiterated CMS' intention to terminate such plans for 2015 and CMS emphasized this week that it will do so for 2016 plans. CMS has already ended the controversial bonus payments connected to the star ratings that were created pursuant to the Affordable Care Act (see Update for Week of April 7<sup>th</sup>).

## **HEALTH CARE COSTS**

### ***Employer survey shows premium increases for job-based coverage have slowed post-ACA***

According to a new report from the Kaiser Family Foundation, family premiums for employer-based health insurance rose by only three percent in 2014, which ties with 2010 for the lowest recorded increase since the data started being tracked in 1999.

The average family plan from employers now costs \$16,834 per year, according to the survey of more than 2,000 companies. However, 2014 was the third consecutive year that the rate of increase has slowed.

Premiums for single coverage through employers remained roughly the same as just over \$6,000 per year.

Critics and supporters of the Affordable Care Act (ACA) debated the impact of the new law on the slowdown, with both acknowledging that it predated the ACA. However, Kaiser notes that 2014 was a relatively stable year for employer-based coverage, as the percentage of workers covered at the companies surveyed (62 percent) did not appreciably change during the year despite warnings that the ACA would erode coverage.

In addition, workers bore roughly the same percentage of the premium as they have for the past several years (about 29 percent for family coverage and 18 percent for single plans), nor was there a statistically significant change in deductible amounts for 2014 (which had previously increased 47 percent since 2009 to more than \$1,200 for single coverage). Workers paid an average of \$4,823 toward a family plan premium in 2014 and \$1,801 toward the premium for a single plan.

The survey did find that the percent of covered workers potentially liable for more than \$6,350 in out-of-pocket costs under employer plans were cut by half in 2014 (to seven percent from 14 percent). The ACA capped out-of-pocket costs at this level, although some employers could go over that amount for 2014.

Researchers warn that the employer mandate under the ACA could change this dynamic once it goes into effect in 2015 (or 2016 for those with 50-100 employees). However, they note that 92 percent of companies with 50 or more workers already offer employee health coverage. A separate report from Moody's analysts concurred that the mandate will thus have little effect on the vast majority of employers.



Kaiser noted that employer-based premiums rose by an average of 191 percent since 1999, with the fastest growth occurring by 2004. Since that time, annual premiums have increased by less than ten percent each year.

## STATES

### ***Blues plans captured the largest share of ACA Marketplaces nationwide***

A new Avalere Health analysis found that WellPoint and independent Blue Cross Blue Shield plans captured the largest share of Affordable Care Act (ACA) Marketplaces in 12 of the 15 states surveyed (including the District of Columbia).

Avalere noted that WellPoint controls the largest market share in California, Colorado, Connecticut, Indiana, and Virginia, while other Blues plans dominate in the District of Columbia, Florida, Maryland, Michigan, Rhode Island, Vermont and Washington. (Both WellPoint and Blue Shield of California control more than half of the Covered California Marketplace). However, in states like Maine and New York the Blues plans actually lost out to the new non-profit Consumer Operated and Oriented Plans (COOP) created with ACA loans.

Blues plans aggressively pursued Marketplace consumers and were the only insurer offering coverage in every Marketplace nationwide. Avalere notes that it is too early to assess whether their dominant position in most Marketplaces was due to name recognition or pricing. However, it confirmed earlier findings that carriers with the largest market share often sought the highest premium increases. For example, Avalere's review of proposed and final rates for 2015 showed that carriers with the largest market share requested at least a nine percent rate hike in nine of the 15 states.

Updated surveys by PricewaterhouseCoopers show that while the average rate hike in 33 states is seven percent (as of August 27<sup>th</sup>), Blues plans are seeking increases that are typically above nine percent.

### ***MHPA asks CMS to let states reset Medicaid rates for costly drugs***

Medicaid Health Plans of America (MHPA) is urging the Centers for Medicare and Medicaid Services (CMS) to let state Medicaid programs and contracted Medicaid managed care organizations adjust capitated payment rates during the year.

The proposal would let plans account for costly drugs that come onto the market midyear and impose unanticipated losses under the previously negotiated rates. It is in direct response to the new hepatitis C "cure" Sovaldi, whose \$84,000 per treatment price tag has already forced several Medicaid programs to ration coverage (see Update for Week of July 28<sup>th</sup>).

MHPA emphasizes that it would be better for Medicaid enrollees if plans could account for these unanticipated costs midyear instead of having to curb patient access by restricting the availability of Sovaldi and other high-cost drugs only to those most in need.

The association also warns CMS not to set a "one-size-fits-all" medical loss ratio (MLR) as part of the agency's first upgrade to Medicaid managed care regulations since 2002. MHPA insists that Medicaid enrollees have "unique" sets of needs compared to privately insured patients and often require more care coordination and disease management (which translates to higher administrative costs). As a result, a standard MLR that caps administration and profit would "threaten many types of innovative programs" and penalize Medicaid managed care plans that serve these more costly populations.

### Alaska



## **Insurance department says Marketplace insurers will hike rates 27-37 percent**

The Division of Insurance announced this week that consumers in the federally-facilitated health insurance Marketplace operate in Alaska says consumers can expect to pay 27-37 percent more next year for coverage, easily ranking as the highest average increase in the nation.

As with 2014, only two insurers will participate in next year's marketplace. Premera Alaska, which enrolled 7,000 consumers in Marketplace plans, will hike rates by an average of 37 percent, while Moda Health, which enrolled 6,000 consumers, will see premiums increase by 27 percent on average.

Premera officials blamed the closing of the state's high-risk pool for the rate spike, insisting that it has absorbed a "disproportionate" number of costly patients with serious medical conditions. The company insists that it will lose \$4 million this year despite ACA reinsurance payments intended to offset exceptional claims costs, claiming that only 33 of Premera's 7,000 Marketplace customers have cost the company more than \$7 million as of June 30<sup>th</sup>.

Premera insists that it has agreed to absorb significant losses for an additional year instead of forcing the 70 percent rate hike on consumers that would be needed for the insurer to "break even".

State regulators point out that nearly 90 percent of consumers in Alaska's Marketplace currently receive ACA subsidies to help defray the higher cost of their plans.

### Arkansas

#### **GAO says Medicaid expansion alternative will be \$778 million more costly**

A new report released this week by the Government Accountability Office (GAO) found that Arkansas' private sector alternative to the Medicaid expansion under the Affordable Care Act (ACA) has cost \$778 million more than had the state participated in the traditional expansion.

Arkansas was the first state to receive federal approval to use ACA matching funds to instead cover the newly-eligible Medicaid population in private Marketplace plans (see Update for Week of September 23, 2013). However, shortly after the U.S. Supreme Court gave states the discretion to opt-out of the traditional ACA expansion without penalty, the Congressional Budget Office (CBO) warned that it covering the newly-eligible population in private Marketplace plans instead of Medicaid would cost states roughly \$3,000 more per enrollee (see Update for Weeks of July 23 and 30, 2012).

Arkansas officials disputed this estimate and commissioned a separate study claiming that their private sector alternative would be no more than 13-14 percent more costly. It argued that their model would likely be budget neutral as increased Marketplace competition would ultimately lower premiums (see Update for Week of March 18, 2013).

The Centers for Medicare and Medicaid Services (CMS) had also claimed the private sector models they approved would be budget neutral, citing spending caps that were part of the final waivers. However, GAO noted that the caps were based on "hypothetical costs...without requesting any data to support the state's assumptions." It concluded that the \$4 million cap approved for the Arkansas waiver was \$778 million more than the state would have spent under actual payment rates for traditional Medicaid.

GAO also criticized CMS for failing to adhere to these spending caps, pointing out that all of the similar models approved by the agency allow states the flexibility to adjust the caps upward whenever costs are higher than projected. The non-partisan watchdog pointed out that such budget neutrality is a requirement of any Section 1115 demonstration waiver approved by CMS, yet the agency has consistently failed to enforce these provisions in at least 11 other waivers.



CMS has yet to comment on whether GAO's admonishment will impact how or if it approves future Medicaid expansion alternatives. Pennsylvania received federal approval this week (see Update for Weeks of August 25<sup>th</sup> and September 1<sup>st</sup>), while the agency has reached a "conceptual agreement" with Utah (see below) and is still accepting public comments on a proposal from Indiana. Republican governors in Tennessee and Wyoming have indicated that they may soon submit their own plans (see Update for Weeks of August 25<sup>th</sup> and September 1<sup>st</sup>).

#### Kansas

##### ***Medicaid managed care plans continue to lose money in second year of KanCare***

The three Medicaid managed care plans participating in KanCare lost nearly \$73 million during the first half of 2014 after losing \$110 million for all of 2013, according to testimony this week by Department of Health and Environment (DHE) officials.

Governor Sam Brownback (R) launched the full transition of Medicaid enrollees to managed care on January 1, 2013 based on similar models in states like Arizona, Florida, and Tennessee, moving them into either Amerigroup, UnitedHealthcare Community Plan or Sunflower Health Plan. Each insurer received \$394- \$483 million from the state, but their costs have far exceeded this amount.

Rep. Jim Ward (D) of the KanCare oversight committee expressed concern that the companies would eventually pull out of KanCare to avoid such future losses, causing a "huge disruption" in care for Medicaid enrollees. DHE officials insisted that each plan was contractually committed for three years, but could decide not to continue participating after that point. The agency will attempt to adjust rates mid-year to mitigate some of the losses.

Governor Brownback, who is facing a tough re-election challenge, had predicted that relying on managed care would save Medicaid \$1 billion over five years without cutting eligibility, services or provider payments. DHE insists that despite the high initial costs, the transition is working in terms of better care coordination, citing an increase in primary care usage and drop in emergency room visits.

#### New Mexico

##### ***Average premiums in ACA Marketplace to fall 1-2 percent on average***

The Superintendent of Insurance announced this week that premiums charged by insurers in the Affordable Care Act (ACA) Marketplace will fall next year by an average of 1-2 percent.

The decrease is attributed to increased competition from an additional insurer, CHRISTUS Health Plan. The Superintendent noted that three of the four insurers from last year (New Mexico Health Connections, Blue Cross and Blue Shield of New Mexico, and Molina Healthcare) will consequently offer lower premiums for some plan offerings, leading to the modest overall decline.

Only Presbyterian Health Plan (PHP) increased rates across the board. However, PHP is the lone insurer offering the most generous platinum-level coverage in 2015.

New Mexico joins Arkansas as the only two states thus far to announce an overall decline in 2015 Marketplace premiums, although states like Montana and Washington are expecting only 1-2 percent increases (see Update for Weeks of August 25<sup>th</sup> and September 1<sup>st</sup>)

#### New York

##### ***State regulators reduce 2015 premium increases by half***

The Department of Financial Services (DFS) announced this week that premiums for New York's individual and small group markets will increase in 2015 by 5.7 and 6.7 percent respectively.



Regulators stressed that the rate hikes were roughly half of what insurers had initially sought, and remain more than 50 percent lower than before the state created its health insurance Marketplace under the Affordable Care Act (ACA).

For the entire individual market, average premium increases range from 13.04 percent for Health Republic Insurance of New York to a decrease of 15.32 percent for UnitedHealthcare of New York.

The New York Health Plan Association insisted that DFS reductions could force some of their insurers to reduce plan offerings.

#### Vermont

#### ***Average Marketplace premiums to increase by roughly 8-11 percent***

The Green Mountain Care Board (GMCB) overseeing Vermont's transition to a single-payer health care system announced this week that it has approved 2015 premiums for Vermont Health Connect.

Vermont's version of the health insurance Marketplace authorized by the Affordable Care Act (ACA) was beset during its inaugural year with software failures and glitches (see Update for Week of June 9<sup>th</sup>). The two participating insurers, Blue Cross and Blue Shield (BCBS) of Vermont and MVP Health Care, have still agreed to return, though they both sought substantial premium increases due to regulatory changes that will allow consumers to remain in ACA-deficient plans (see Update for Week of March 3<sup>rd</sup>).

The lack of competition has caused Vermont Health Connect to have some of the nation's highest premiums, despite the Board's authority to modify or reject excessive rate hikes. The Board did reduce BCBS' increase from an average of 9.8 percent to 7.7 percent, while MVP will increase premiums by 10.9 percent on average instead of the 15.3 percent they initially proposed. BCBS signed-up 92 percent of Vermont Health Connect consumers for 2014, much as they control the individual marketplace overall.

The Board rejected BCBS' claim that lower payments from the ACA reinsurance program would result in greater potential losses from extraordinary claims. It concluded that BCBS could adapt by simply lowering surplus funds and adjusting pharmacy cost estimates.

#### Virginia

#### ***Governor backs-off his push for full Medicaid expansion under ACA***

Governor Terry McAuliffe (D) issued an executive order this week authorizing a limited plan to expand state health insurance coverage for 20,000 uninsured adults with mental illness and 5,000 children of state workers. In addition, the order seeks to improve care for people already covered under Medicaid and boost outreach efforts to those who qualify but are not enrolled.

The move pales in comparison to the 400,000 uninsured that would become Medicaid-eligible had Virginia participated in the expansion under the Affordable Care Act (ACA). The Governor had vowed to continue pursuing the full expansion administratively after Republicans regained control over both legislative chambers this summer. However, he ultimately bowed to political realities in proceeding with a far more modest expansion.

The expansion of mental health coverage will still require legislative approval for \$80 million in annual funds past this year, which is far from certain given the current climate in the House. Despite support from Senate Republicans for a private sector alternative to the Medicaid expansion similar to that already federally-approved in four states, House Republicans have steadfastly opposed any expansion once the governor was elected last fall (see Update for Week of March 10<sup>th</sup>). The partisan stalemate



nearly led to a state government shutdown before Senator Puckett (D) agreed to resign in exchange for a political appointment and shift Senate control to Republicans (see Update for Week of June 9<sup>th</sup>).

Lawmakers will resume debate on this issue next week when a special session commences (see Update for Week of June 30<sup>th</sup> and July 7<sup>th</sup>). The governor insists he is not abandoning his ultimate plan to participate in the full ACA expansion.

#### Utah

#### **Governor announces “conceptual deal” with Obama Administration on Medicaid expansion**

Governor Gary Herbert (R) announced this week that he has reach a “conceptual agreement” with the federal Centers for Medicare and Medicaid Services on 95 percent of his private sector alternative to the Medicaid expansion under the Affordable Care Act (ACA).

Federal approval would make Governor Herbert the tenth Republican governor to agree to participate in the ACA expansion, following Pennsylvania’s Governor Corbett last week (see Update for Weeks of August 25<sup>th</sup> and September 1<sup>st</sup>). As with Pennsylvania, Governor Herbert’s plan has sliding-scale cost-sharing. However, he also had to drop his “work requirement” that would make receipt of ACA subsidies contingent upon a newly-eligible enrollee holding or actively searching for a job. CMS will instead allow Utah to require able-bodied enrollees to accept the state’s help to look for work, although the details still need to be ironed out.

The requirement would apply to roughly one-quarter of the estimated 75,000 Utahns that are largely unemployed and yet earn too much to qualify for Medicaid, while earning too little to meet the threshold for ACA subsidies. Roughly 73 percent of this group currently work or qualify for disability.

Similar to alternatives already approved for Arkansas, Iowa, Michigan, and Pennsylvania, the Healthy Utah proposal advanced by Governor Herbert would allow Utah to use the \$258 million in ACA matching funds to cover newly-eligible enrollees in private health plans instead of Medicaid. However, it is only a three-year pilot project that would require legislative approval at the initial and renewal stage. Such approval is far from certain as conservative lawmakers have thus far only backed far more modest proposals (see Update for Week of February 24<sup>th</sup>).