



Health Reform Update – Week of September 28, 2015

CONGRESS

Stopgap funding bill postpones government shutdown fight

President Obama signed a stopgap spending bill this week (H.R. 719) that will fund the government for ten weeks past the September 30th end of the federal fiscal year.

The temporary measure buys time for lawmakers to negotiate a full-year spending package, including Democratic demands to adjust the caps on non-discretionary spending imposed by the ongoing budget sequester (see Update for Week of August 1, 2011). It also does not resolve the continued split among Congressional Republicans as to whether to allow the federal government to shut down after December 11th if Democrats do not agree to defund Planned Parenthood. Republicans last shut down the government two years ago in an effort to defund the Affordable Care Act (see Update for Week of October 14, 2013).

Budget negotiations may be accelerated by the Department of Treasury's announcement this week that Congress must act by November 5th to raise the nation's debt ceiling. House Republicans have used previous debt ceiling increases to leverage spending reductions, including the ongoing sequester (see Update for Week of August 1, 2011).

Ways and Means passes measure to repeal five ACA provisions through reconciliation

After more than 50 symbolic votes to repeal all or part of the Affordable Care Act (ACA), House Republican leaders advanced their latest legislation this week to get rid of "the five worst parts of the law."

The difference between earlier efforts and the latest bill is that it would repeal select ACA provisions via the reconciliation process for budget-related matters. That means that it would require only a bare majority in the Senate, so that the bill could presumably reach the president's desk with only Republican support. Democrats used the same reconciliation process to enact key parts of the ACA after losing their filibuster-proof 60-seat Senate majority in 2009.

The reconciliation measure would repeal the controversial individual and employer coverage mandates under the ACA, as well as the independent Medicare cost-cutting board. In addition, it would remove two of the law's major revenue sources, namely the 40-percent excise tax on high-cost on "Cadillac" health plans (that goes into effect in 2018) and the 2.3 percent tax on medical device manufacturers.

A group of 101 conservative and liberal economists joined forces this week to support the "Cadillac" tax, which they insist is needed to curb overutilization of health services. However, it increasingly is losing support in the House as repeal proponents now hold a bipartisan majority (see Update for Weeks of September 14th and 21st).

A separate measure passed by the House Energy and Commerce Committee would also repeal the fund create by the ACA to cover cost-sharing for certain preventive services.

President Obama has pledged to veto any repeal provisions that pass both chambers. However, Republicans are hopeful that significant bipartisan support for repealing the Medicare board and both taxes will persuade him to allow at least those three provisions to be removed. It is not clear how the \$118 billion in lost revenue from such repeals would be offset.



Democratic leaders challenged Republicans to specify how they would replace the individual mandate under the ACA, pointing to Congressional Budget Office (CBO) projections showing its repeal would leave 14 million more Americans uninsured and increase individual plan premiums by 20 percent.

House passes bills broadening ACA's small employer definition, individual mandate exemptions

The House adopted two bills this week that would make minor changes to the Affordable Care Act (ACA).

The first measure that passed on a voice vote would let states continue to define a small employer as those with 50 or fewer workers. The bill (H.R. 1624) had drawn the support of 47 House Democrats, as the ACA's plan to expand the small employer definition would require mid-size companies with 51-100 employees to start abiding by ACA rules governing the small group market, including essential health benefits, minimum actuarial values, and premium rating restrictions. They also will start being subject to employer mandate penalties for failing to provide minimum essential coverage (MEC) to workers. According to America's Health Insurance Plans (AHIP), this change would have increased premiums by an average of 18 percent for nearly two-thirds of the 3.4 million workers in these mid-sized companies (see Update for Weeks of August 31st and September 7th).

The White House indicated this week that President Obama is likely to sign H.R. 1624 after it also passed the Senate by voice vote later in the week.

The House also passed a measure by voice vote (H.R. 2061) that would add an exemption to the ACA's individual mandate for those who rely solely on a religious method of healing and for whom the required purchase of minimum essential coverage would be inconsistent with their religious beliefs. It had four Democratic cosponsors.

President will consider bill allowing clinical trial participation for recipients of SSI and Medicaid

The House passed the *Ensuring Access to Clinical Trials Act* this week by voice vote. The measure sponsored by Senator Ron Wyden (D-OR) (S.139) would ensure that those receiving both Supplemental Security Income (SSI) and Medicaid can participate in rare disease clinical trials without jeopardizing their eligibility for benefits. The bill passed the Senate in July and will now move on to President Obama, who is expected to sign it.

S. 139 basically repeals the sunset of this policy, which was first enacted by Congress in 2010. It indefinitely extends the policy so that up to \$2,000 per year in clinical trial compensation is excluded from resources for both SSI and Medicaid. Bipartisan support for the bill was bolstered by a review from the Government Accountability Office (GAO) that found no negative impact from the policy change.

First bill introduced to increase bonuses for Medicare Advantage plans serving poor enrollees

Senators Rob Portman (R-OH) and Bob Casey (D-PA) introduced legislation this week (S. 2104) that seeks to boost funding for Medicare Advantage (MA) plans that are penalized for poor star ratings because they enroll a high percentage of low-income beneficiaries.

The star rating system was created as part of the quality bonus system for MA plans authorized by the Affordable Care Act (see Update for Week of October 15, 2012). It was intended to encourage enrollees to enroll in higher quality plans and according to the Centers for Medicare and Medicaid Services (CMS) it accomplished that goal has more than one-third of plans receive at least four of five stars, a 28 percent jump during the initial years (see Update for Week of September 23, 2013).



However, many MA plans objected to the program, arguing that those enrolling a high-percentage of low-income enrollees should not be punished with low star ratings (which ultimately result in program termination). A recent RAND Corporation study commissioned by CMS appeared to support the industry's objection, though noting the overall negative impact was small. In addition, CMS' own internal audits have shown that higher star ratings did not always translate to better quality measures (see Update for Week of September 23, 2013).

Under, S. 2014, CMS would no longer be able to terminate MA participating plans with low star ratings. The bill would also create a one-year demonstration for MA plans that both enroll a high percentage of low-income beneficiaries and have low star ratings that exclude them from bonuses.

S. 2104 basically creates two sets of eligibility criteria. Under the first set, plans must have a rating between 3.25 and four stars and at least 45 percent of enrollees must either be eligible for low-income subsidies or be dually eligible for Medicare and Medicaid. Plans in the second set must have a rating from 3-4 stars and at least 60 percent of enrollees must receive low-income subsidies or be duals.

The Medicare Payment Advisory Commission (MedPAC) has expressed concerns in the past about the bonus system penalizing MA plans serving low-income subscribers. However, CMS elected last spring not to implement proposed plans to halve the weights given to seven rating factors that many commentators insist are disadvantaging plans serving large number of low-income enrollees (see Update for Weeks of April 6th and 13th).

Bipartisan bill would exclude orphan drugs from the ACA tax on drugmakers

Rep. Leonard Lance (R-NJ) introduced the *Orphan Drug Fairness Act* this week. The measure (H.R. 3618) would exclude orphan drugs from the calculation used to assess the annual tax on pharmaceutical manufacturers imposed by the Affordable Care Act (ACA). It was referred to the House Energy and Commerce Committee and cosponsored by both Democrats and Republicans.

FEDERAL AGENCIES

Insurers will receive only a fraction of ACA risk corridor payments due to \$2.5 billion shortfall

The Affordable Care Act (ACA) reinsurance and risk corridors program that temporarily compensates Marketplace insurers for the costs of enrolling sicker and more costly patients suffered a \$2.5 billion shortfall during its first year of operation, according to the Centers for Medicare and Medicaid Services (CMS).

As a result of the unexpected shortfall, insurers will receive only 12.6 percent of the \$2.87 billion they were slated to receive this year through the risk corridor portion of the program. This represents the \$362 million pool of available funds collected from Marketplace insurers that did relatively well.

Another \$7.9 billion will be issued in reinsurance payments for 2014 claims, while \$4.6 billion will be transferred to insurers through the risk adjustment mechanism that shift funds from plans with a healthier case mix to those whose risk pools were skewed towards more costly subscribers.

Both the risk corridor and reinsurance programs expire after 2016. Only the risk adjustment mechanism is a permanent feature.

The risk corridor payments are funded through the revenue that insurers contribute under the ACA (such as the 3.5 percent user fee for federally-facilitated Marketplace insurers). Congress has blocked the Obama Administration from using other funds to cover the shortfall through a rider it attached to last year's omnibus spending bill for fiscal year 2015 (see Update for Week of December 1st).



Congressional Republicans have long sought to curtail or eliminate the risk corridor and reinsurance payments, terming them an “insurer bailout” (see Update for Week of January 20 and 27, 2014). Senator Marco Rubio (R-FL), a presidential candidate, made his *ObamaCare Taxpayer Bailout Prevention Act* the first piece of legislation he introduced in the 114th Congress (see Update for Week of January 5th). The bill (S.123) sought to repeal the entire program.

Former CMS Administrator and current head of America’s Health Insurance Plans Marilyn Tavenner urged Congress this week to ensure that the risk corridor program was adequately funded, as insufficient payments would threaten the financial viability of insurers that are now required under the ACA to accept applicants regardless of medical history and limit premium variation for sicker subscribers.

The reduced risk corridor payments have already been blamed from causing the collapse of two of the non-profit insurance cooperatives created with ACA loans (see Update for Weeks of September 14th and 21st). Both Health Republic Insurance of New York and CoOpportunity Health of Iowa attracted far more consumers than they anticipated. However, they not only were unable to access additional loans due to Congressional spending cuts, but also would have received only a fraction of the expected risk corridor payments based on their case mix (only \$20 million of the expected \$147 million for CoOpportunity).

Inconsistencies and discrepancies in the data used to calculate risk corridor payments caused CMS to delay its scheduled mid-August release until this month (see Update for Week of August 10th).

HHS proposes new anti-discrimination standards that prohibit certain benefit designs

The Office of Civil Rights (OCR) for the Department of Health and Human Services (HHS) issued long-awaited proposed rules last week that clarify the types of provider and insurer discrimination that are prohibited by Section 1557 of the Affordable Care Act (ACA).

The new regulations add sex and gender identity to existing discrimination bans based on disability, health status, race, national origin, and native language. They fully implement the ACA’s anti-discrimination prohibition that has technically been in effect since the law’s enactment but lacked specificity.

The new standards specifically prohibit hospitals from refusing to treat patients that do not speak English or doctors turning away transgender patients. They also prohibit insurers from denying women coverage for maternity care.

Unlike the Notice of Benefit and Payment Parameters directive that HHS issued to Marketplace insurers for 2016, the rules do not specifically state that placing “most or all drugs for a specific condition on a high cost-sharing tier” may constitute impermissible discrimination (see Update for Week of February 23rd). However, they do “[prohibit] health insurance issuers in the non-grandfathered individual, small and large group markets from employing benefit designs that will have the effect of discouraging the enrollment of individuals with significant health needs in health insurance coverage”. In addition, plans cannot design marketing materials to be more appealing to certain populations compared to others.

PSI is submitting comments asking HHS to specify that refusing third-party premium assistance from non-profit charitable organizations may qualify as prohibited discrimination, as it has “the effect of discouraging enrollment of individuals with significant health needs.” At least 28 insurers in 23 states are currently refusing to allow such charitable assistance (see Update for Week of May 4, 2015).

HHS OCR is accepting public comments on the proposed rules through November 9th.



GAO finds a total lack of CMS oversight over network adequacy under Medicare Advantage

The Centers for Medicare and Medicaid Services (CMS) is failing to ensure that Medicare Advantage (MA) plans have adequate provider networks, according to a Government Accountability Office (GAO) report released this week.

The GAO review was requested by Senators Richard Blumenthal (D-CT), Sherrod Brown (D-OH), and Sheldon Whitehouse (D-RI). It found numerous deficiencies in CMS' oversight on network adequacy including a definition that fails to account for how often providers practice in one location or accept new patients. In addition, nearly half (46 percent) of the surveyed providers listed in certain directories were duplicates while another nearly nine percent were no longer practicing.

GAO specifically blamed CMS for failing to take any actions to assess the accuracy of network data submitted by plans or detail how plans should terminate provider agreements. In response, CMS has agreed to develop rules to bolster its network adequacy oversight.

HEALTH CARE COSTS

Drug costs drive highest premium increase in five years for federal employees

The enrollee share of premiums Federal Employees Health Benefit Program (FEHBP) will increase by an average of 7.4 percent for 2016, representing the largest increase since 2011.

According to the Office of Personnel Management (OPM) that administers the popular health insurance program for federal employees and retirees, the premium hike is in line with increases in private-sector employer-sponsored health plans, which are projected to climb by 4-5 percent on average. While the 7.4 percent jump is above the four percent average increases witnessed over the past four years, OPM insists that it is still "relatively modest" compared to the double-digit increases experienced in the years before the Affordable Care Act was implemented.

OPM blamed the hike on "an uptick in drug costs [that have had] a disproportionate effect on the FEHBP." This is because unlike most employer coverage the FEHBP provides full coverage to retirees. For example, prescription drugs account for nearly 27 percent of the total costs in the FEHBP compared to only ten percent on average for other employer plans.

OPM officials insisted that benefit and cost-sharing levels will remain fairly stable and that a wide variation in premium increases among the 250 participating plans give enrollees plenty of opportunities to mitigate the rate hikes by shopping around.

The federal government pays 70 percent of the premium for FEHBP enrollees, resulting in biweekly premiums for enrollees in the Blue Cross and Blue Shield standard FEHBP option of \$100.18 for individual coverage (and \$238.24 for family coverage). FEHBP is the largest employer-sponsored health insurance program in the country, with four million enrollments covering 8.2 million people.

Marketplace premiums are comparable to employer-based coverage for middle-income enrollees

According to an analysis released last week by The Commonwealth Fund, adults enrolled in individual coverage through employer-based plans pay roughly the same premiums as individuals enrolled through Marketplace plans under the Affordable Care Act (ACA).

The survey found that roughly 60 percent of adults with Marketplace coverage and 55 percent of adults in employer-sponsored plans paid less than \$125 per month for individual coverage. These cost similarities are due to the prevalence of ACA subsidies, as they decrease at higher incomes when



subsidies are not available. For example, 68 percent of adults earning more than 250 percent of the federal poverty level (the threshold for the ACA cost-sharing subsidies) spent \$125 a month or more on Marketplace coverage, compared to only 37 percent of adults in employer-sponsored plans. A higher percentage of all adults were also enrolled in high deductible plans through the Marketplace than in employer-sponsored plans (43 percent compared to 34 percent).

STATES

Arkansas

Governor delays transition of individual Marketplace to state control

Governor Asa Hutchinson (R) informed the Obama Administration this week that the planned transition of its health insurance Marketplace from partial federal control to full state control is “on pause at this point” until he receives additional feedback on his proposal to limit the state’s popular “private option” to the Medicaid expansion under the Affordable Care Act (ACA).

Arkansas is one of seven states that operate their Marketplace in a partnership with the federal government. The Governor insisted that the current partnership model is “proven and is working” and questioned the need to transition to an “unknown” state-based Marketplace (SBM) and the “risk associated with it” if the federal government approves the “private option” reforms he requested (see Update for Weeks of August 17th and 24th).

Previous Governor Mike Beebe (D) made Arkansas the first state to obtain federal approval for a “private option” alternative, where the state uses ACA expansion funds to purchase Marketplace coverage for those made newly-eligible for Medicaid (see Update for Week of September 23, 2013). Nearly 250,000 Arkansans have enrolled through the “private option” since its inception, resulting in one of the steepest drops in uninsured population nationwide (see Update for Week of August 10th).

However, the program has met stiff opposition in a legislature that is now fully under Republican control and the latest annual renewal was made contingent on the state making future reforms to narrow the program (see Update for Weeks of January 26th and February 2nd). The Governor insists that he wants to continue the “private option” but agreed to bow to “political realities” and ask for federal permission to require those earning 100-138 percent of the federal poverty level to pay premiums capped at two percent of income, move lower-income beneficiaries into less-expensive traditional Medicaid, eliminate non-emergency coverage, and mandate job training programs (see Update for Weeks of August 17th and 24th). Those who are eligible for both Medicaid and employer-sponsored insurance must also enroll in the latter, with the state covering their cost-sharing obligations.

Governor Hutchinson acknowledged that several of these changes, most notably the job training requirement, are not likely to meet federal approval based on the Obama Administration’s rejection in other states (see Update for Weeks of February 9th and 16th). The “private option” is set to expire in December 2016 without a legislative renewal.

The Arkansas Health Insurance Marketplace Board has been using a \$99 million federal establishment grant to prepare to switch the individual Marketplace to state control starting in January 2017. The Governor’s delay applies only to the individual Marketplace transition. The small business Marketplace is still expected to transition to full state control in January 2016.

Hawaii

State innovation waiver released for public comment

Hawaii became the first state earlier this month to post for public comment its request for a federal “state innovation waiver” that would exempt it from certain Affordable Care Act (ACA) provisions.



Section 1332 of the ACA allows states to request waivers from key ACA coverage provisions, if they pursue reforms that ensure coverage is equally affordable, comprehensive, and accessible while not increasing the federal budget deficit. While these so-called “state innovation waivers” allow states to avoid certain controversial ACA provisions like the individual and employer mandates, states must preserve core ACA features such as guaranteed issue and community rating (i.e. limiting premium increases based on age, gender, or medical history).

These waivers can take effect as early as 2017 with the required federal approval, which will not be provided until a state has held public hearings and accepted public comments on their proposals.

The draft waiver that Hawaii released for public comment would allow the state to preserve the Hawaii Prepaid Health Care Act, the statewide employer mandate that Hawaii has been the only state allowed to operate under federal ERISA waiver obtained back in 1974. Prepaid is stricter and broader than the ACA requirements for the small group market, as it requires “virtually every employer with at least one permanent, full-time worker to purchase employee health insurance coverage” instead of those with at least 50 workers. Furthermore, full-time workers are defined under Prepaid as those working 20 or more hours per week, compared to the higher 30-hour threshold in the ACA.

Prepaid also requires minimum coverage that is equivalent to gold or platinum tier coverage under the ACA (i.e. an actuarial value of at least 80 percent). Furthermore, employees cannot be charged more than 1.5 percent of wages, compared to a sliding scale of two to 9.5 percent under the ACA. Maximum limits on out-of-pocket costs are also more favorable than under the ACA.

As a result, Hawaii is seeking a waiver from lower ACA requirements that would “diminish” Hawaii’s prepaid plans in the small group market. Hawaii has been unsuccessful in its attempts to reconcile Prepaid with the Small Business Health Options Program (SHOP) or resolve technical impediments with the SHOP portal. It shut down the web portal last June and required small employers to enroll directly with health plans.

Hawaii’s waiver thus proposes to eliminate the infrastructure requirement for the SHOP Marketplace, as well as the requirements that the SHOP must include Consumer Oriented and Operated Plans and multi-state plans, as well as give consumers the choice of more than one plan option.

Hawaii is specifically not seeking a waiver for ACA requirements for individual consumers and will continue to operate its individual Marketplace (the Hawaii Health Connector) in a partnership with the federal government, which means it will rely on the federally-facilitated Marketplace (FFM) to handle eligibility and enrollment. State officials chose to default to the FFM last spring after unsuccessful efforts to resolve technical issues that were too complex for its limited budget to handle (see Update for Week of May 11th). Because of its Prepaid system, Hawaii had the smallest number of uninsured in the nation (only about 100,000), meaning it simply could not generate the plan interest or consumer enrollment needed to fund operations.

New York

State regulators shut down nation’s largest ACA cooperative to avoid insolvency

Under pressure from the federal Centers for Medicare and Medicaid Services (CMS), state regulators have ordered Health Republic of New York to cease operations after December 31st.

The action was needed to prevent the plan’s financial insolvency and protect more than 210,000 consumers enrolled in the Consumer Oriented and Operated Plan (CO-OP) from disruptions in coverage. Health Republic becomes the fourth CO-OP in the nation to be forced out of business this year (following those in Louisiana, Nebraska, and Nevada) after low premiums attracted more enrollees than the plans could cover (see Update for Week of January 19th) and Congress slashed their Affordable Care Act (ACA)



funding by 65 percent as part of bipartisan deficit reduction agreements (see Update for Weeks of December 24 and 31, 2012).

The Government Accountability Office (GAO) confirmed earlier this year that enrollment for at least eight of the 23 non-profit cooperatives created with ACA loans outpaces their ability to pay claims (see Update for Week of June 1st), while Standard and Poors predicted that most would become insolvent as they had a median ratio of debt to remaining funds of only around 53 percent (see Update for Weeks of February 9th and 16th). CMS has consistently refused to prop up struggling CO-OPs by diverting emergency funding from other ACA funding streams (see Update for Week of January 12th).

Health Republic used low premiums to attract more than 150,000 members in just its first year and 210,000 by the end of the second open enrollment period, making it the second most popular choice of all 16 insurers participating in the NY State of Health Marketplace. However, it had lost roughly \$53 million by mid-2015 causing CMS officials to warn state regulators that it may become insolvent.

NY State of Health elected to order to Health Republican to immediately stop accepting new members this week in an effort to give consumers “ample opportunity to switch to a different plan” during the next open-enrollment period that starts November 1st. All of Health Republic’s individual plans will cease operating in December while the terminate dates for their small group plans will vary.

South Dakota

Governor’s office says Medicaid expansion proposal receives federal “go ahead”

A senior advisor to Governor Dennis Daugaard (R) stated this week that his plan to expand Medicaid pursuant to the Affordable Care Act (ACA) has received an initial “go ahead” from the Secretary for the U.S. Department of Health and Human Services (HHS).

Details of the plan have not been publicly released but they are expected to follow the “private sector” alternative that has already been federally-approved for six states. It would also cover everyone earning up to 138 percent of the federal poverty level (FPL), after two earlier proposals by the Governor to expand only to 100 percent of FPL were rejected by HHS (see Update for Week of March 23rd).

Roughly 26,000 South Dakotans fall into the coverage gap between existing Medicaid eligibility and the 100 percent of FPL threshold at which ACA subsidies are provided to help purchase Marketplace coverage. Another 22,500 South Dakotans earn from 100-138 percent of FPL and would also be eligible for Medicaid under the Governor’s plan.

The Governor’s advisor insisted that “Secretary Burwell expressed an openness to consider some of the options we’re looking at.” However, it remains unclear whether the Governor included provisions popular with other conservative governors to impose work requirements or premiums for those under 100 percent of FPL—both of which HHS has consistently denied (see Update for Weeks of April 6th and 13th).

The South Dakota State Medical Association applauded Governor Daugaard for being “open-minded” to the expansion, given the hostility to any form of expansion among Republican lawmakers. House Republicans have voted steadfastly against any expansion proposals, including those that would use only state funds (see Update for Week of February 24, 2014).