PATIENT SERVICES INCORPORATED

Health Reform Update – Week of August 13, 2018

CONGRESS

New Republican bill would remove the ACA cap on Medicaid drug rebates

The chairman of the House Energy and Commerce health subcommittee Michael Burgess (R-TX) introduced legislation late last month that would eliminate the cap on Medicaid drug rebates created by the Affordable Care Act (ACA) starting on January 1st.

Removing the cap was part of the "blueprint" that the Trump Administration released earlier this year to reduce prescription drug prices (see Update for Week of May 7th). The ACA did not allow the amount of rebates that brand-name drug manufacturers must pay to Medicaid to exceed 100 percent of the average manufacturer price (AMP). However, critics of the cap insist that it "allows for excessive price increases to be taken without manufacturers facing the full effect of the price inflationary penalty established by Congress."

Pew Charitable Trusts, which backs the cap's elimination, estimates that drug manufacturers would be rebating more than AMP for 270 additional drugs in 2017 without the cap being in place. The bill to remove the cap (H.R. 6642) is backed by insurance groups but strongly opposed by the Pharmaceutical Research and Manufacturers of America (PhRMA), who insist that such a "new tax on the industry" would not lower list prices but instead "deepen the price distortions caused by the rebate program."

Democratic report claims Medicare would save $2.8 billion per year with authority to negotiate drug prices

Senate Democrats on the Homeland Security and Governmental Affairs Committee released a new report last week showing that the federal government could save up to $2.8 billion in a single year for just the top 20 most commonly prescribed medications if Congress gave Medicare Part D the same authority to negotiate drug prices that is afforded to the Department of Veterans Affairs (VA) and Department of Defense (DoD).

The analysis commissioned by Senator Claire McCaskill (D-MO) concluded that the VA was able to secure pricing that rose at "significantly lower rates" simply by "getting bulk discounts [that] every business does." However, despite backing Medicare price negotiation authority as a candidate, President Trump has not included it as part of his drug pricing "blueprint" released earlier this year (see Update for Week of May 7th). Both his Secretary for the Department of Health and Human Services and the Pharmaceutical Research and Manufacturers of America (PhRMA) have cited studies insisting that Part D price negotiation would result in restricted access and adverse health outcomes for program beneficiaries.

FEDERAL AGENCIES

Administration finalizes expansion of short-term coverage that does not comply with the ACA

The Departments of Health and Human Services, Labor and Treasury jointly issued regulations last week that finalize the Administration's expansion of short-term health plans that need not comply with key consumer protections under the Affordable Care Act (ACA).

The Obama Administration had limited short-term plans to a duration of no more than three months (see Update for Week of June 20, 2016). However, the latest regulations will allow short-term plans to return to the pre-ACA limit of 364 days (see Update for Week of February 26, 2018). Insurers offering these plans will be allow 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.

HHS emphasizes that short-term plans will be significantly cheaper for consumers, with premiums likely to average about $124 per month instead of $393 per month for an unsubsidized plan in the ACA Marketplaces (see Update for Week of February 26th). In the proposed rule, HHS argued that only up to 200,000 consumers would enroll in short-term plans next year and acknowledged that this number would cause "some increase in premiums", that in turn would cause the federal government to pay more for ACA premium subsidies and expand the federal budget deficit each year by $96-168 million.

However, subsequent studies from the Urban Institute and the Centers for Medicare and Medicaid Services (CMS) own chief actuary predicted that from 1.4 million to 4.2 million consumers would be shifted from ACA-compliant coverage into short-term coverage (see Update for Week of May 28th). Because consumers seeking limited benefit plans tend to be younger, healthier, and less costly, insurers offering ACA-complaint coverage would be left with risk pools skewed heavily towards older and more costly subscribers. As a result, Urban Institute predicted at least an 18 percent spike in premiums (see Update for Week of February 26th) while the CMS actuary warned that insurers would hike premiums to the point where the federal government would have to pay at least $1.2 billion more in ACA subsidies next year and $38.7 billion more over ten years (see Update for Week of May 28th).

Consumer and provider groups as well as key insurers like the BlueCross and BlueShield Association (BCBSA) strongly opposed the expansion of short-term coverage as a return to "junk insurance" that will allow insurers to once again discriminate against subscribers with pre-existing conditions and drive up costs for those who need coverage the most. BCBSA insisted that such "cherry-picking" would separate "the healthiest of customers from those with significant medical needs [thus] raising the cost of comprehensive coverage for all."

The final rule allows the short-term health plans to be renewed for each of two subsequent years so that they can effectively last up to 36 months. However, in apparent expectation of legal challenges, it includes a severability clause that would keep the remainder of the rule in place should courts determine that the renewability provision is invalid.

HHS states in the final rule that federal law prohibits it from going beyond the 36-month renewal limit, forcing it to let states decide whether to do so. However, Secretary Alex Azar publicly encouraged Congress to change that prohibition and allow for guaranteed renewability of short-term coverage nationwide. A bill sponsored last spring by Senator John Barasso (R-WY) (S.2507) would do so but has yet to advance.

Policymakers in several states including Colorado, Hawaii, Maryland, and Vermont have already taken legislative or regulatory action to combat the final rule by limiting the use of short-term health plans, with bills still pending in California (see below), Illinois (see Update for Week of June 25th), and Rhode Island (see Update for Week of July 9th).

Medicare Part D premiums to decline for second consecutive year

The Centers for Medicare and Medicaid Services (CMS) announced earlier this month that the base beneficiary premium for Medicare Part D enrollees is expected to fall from $33.59 to $32.50 for 2019.

The CMS Administrator attributed the decline to agency initiatives to (1) reduce the maximum amount that low-income beneficiaries pay for new biosimilar medicines that provide competition to higher-cost biologics, (2) allow certain generic drugs to be substituted more quickly onto plan formularies during the plan year, (3) increase competition among plans by removing the requirements that certain Part D drug plans must "meaningfully differ" from each other, and (4) boost the number of pharmacy options for beneficiaries by clarifying the "any willing provider" requirement.

America's Health Insurance Plans (AHIP) also credited provisions in the *Bipartisan Budget Act of 2018* that expanded beneficiary discounts for brand-name drugs furnished within the Part D coverage gap from 50 percent to 70

percent, a move that the Congressional Budget Office predicts will save Part D nearly $12 billion over the next decade (see Update for Week of July 23rd).

The annual open enrollment period for Medicare Part D runs from October 15th through December 7th. This differs from the open enrollment period for Affordable Care Act Marketplaces that starts November 1st and ends December 15th for those operated by the federal government (see below).

STATES

Three more states receive federal approval to mitigate rate hikes through reinsurance programs

The federal Centers for Medicare and Medicaid Services (CMS) has approved three additional State Innovation Waivers that will allow Maine, New Jersey, and Wisconsin to operate reinsurance programs to compensate individual health plan insurers for exceptional claims.

The waivers, which were authorized under Section 1332 of the Affordable Care Act (ACA), let states use a mix of federal and state funds to replace the temporary reinsurance payments under the ACA that expired after 2016. They have widely been credited with dramatically reducing premium increases in the three states with previously approved waivers (see Update for Week of December 18th).

For example, Alaska used reinsurance payments for 33 high-cost conditions that were funded solely by the state to cut rate hikes for the 2017 plan year from an average of 43 percent to only seven percent (see Update for Week of July 10, 2017). Once federal funding for 2018 was provided under the Section 1332 waiver, the lone Marketplace insurer, Premera Blue Cross Blue Shield, further reduced premiums by an average of 22.4 percent and announced last week that it would actually decrease premiums for 2019 by an average of 3.9 percent.

Minnesota saw similarly dramatic declines following the approval of its reinsurance waiver last year (see Update for Week of December 18th), cutting premium increases by 13 percent on average for this year and a projected 5-8 percent decline for 2019. Oregon regulators announced last month that 2019 premiums were expected to fall by an average of eight percent for next year thanks in large part to the reinsurance waiver it received late last year (see Update for Week of July 23rd).

Maine, which had a state-funded reinsurance program prior to the ACA, predicts that restarting their program with federal and state funds will lower average rate hikes next year by nine percent, or roughly half of its average increase for 2018 (see Update for Week of June 11th). Wisconsin, which will pay only $34 million of the $200 million in projected reinsurance costs, predicts that 2019 premiums will be 11 percent lower than the 44 percent average increase Marketplace consumers faced in 2018, which caused roughly 25,000 consumers to drop coverage (see Update for Week of February 26th).

New Jersey's federally-approved reinsurance program is unique in that the state share of funding will come from tax penalties assessed under its alternative to the ACA's individual mandate, which Congress repealed starting in 2019 (see Update for Week of May 28th). With the waiver, New Jersey becomes the only state to mitigate premium increases through a reinsurance program and also create an individual mandate. Without these measures, New Jersey's individual market consumers were expected to see premium increases averaging 32 percent next year and 90 percent over the next three years (see Update for Week of March 19th).

Three other states (Idaho, Louisiana, and Maryland) still have reinsurance waivers pending with CMS while at least six others are expected to submit requests later this year (see Update for Week of July 9th).

State-based Marketplaces extend open enrollment deadlines for 2019 plan year

At least four state-based Marketplaces (SBMs) have already taken action to extend their 2019 open enrollment deadlines beyond the December 15th expiration set for federally-facilitated Marketplaces.

The majority of the 12 SBMs extended their open enrollment deadlines for last year after the Trump Administration cut the enrollment period in half (down from January 31st to December 15th). Idaho and Vermont were the only two that adhered to the federal deadline (see Update for Week of November 6th). Three SBMs (California, the District of Columbia, and New York) maintained the same 12-week period as 2017 (November 1st through January 31st), while Colorado, Massachusetts, Minnesota, and Washington were among the states that allowed enrollment into mid-January. (Maryland, Connecticut, and Rhode Island ended open enrollment in late December).

The District of Columbia was the first SBM to announce this year that it will again extend open enrollment through January 31st. California likewise will maintain a 12-week open enrollment period but has decided to move the start date up to October 15th (see Update for Week of March 19th). (All other SBMs and FFMs will start open enrollment on November 1st.)

Minnesota announced this month that its open enrollment period will end on January 13th, while the Colorado Division of Insurance issued draft regulations last week that would permanently set the enrollment period from November 1st through January 15th.

Arkansas

Following successful Kentucky challenge, consumer groups seek to block Arkansas Medicaid work requirements

The National Health Law Program (NHeLP), Southern Poverty Law Center (SPLC), and Legal Aid of Arkansas filed a federal lawsuit this week seeking to block new work requirements imposed by the Medicaid program.

The lawsuit, which was filed on behalf of three low-income Arkansans, is comparable to successful challenge that NHeLP brought earlier this year in the U.S. District Court for the District of Columbia against the work requirements that the Trump Administration approved for Kentucky Medicaid (see Update for Week of June 25th). In that case, Judge James Boasberg (appointed by President Obama) found the work requirements to be "arbitrary" and "capricious" as they were inconsistent with Medicaid's fundamental purpose of providing access to health care and "never adequately considered" that roughly 95,000 enrollees would lose coverage.

Because the Arkansas challenge is based upon the same arguments and decision in the Kentucky challenge, it was immediately assigned again to Judge Boasberg.

The Centers for Medicare and Medicaid Services (CMS) has already approved comparable work requirements in Indiana, and New Hampshire (see Update for Week of May 7th), with similar waiver requests pending from states like Michigan and Wisconsin (see Update for Week of June 11th). Arkansas' was the first to go into effect (on June 1st) following the court's rejection of Kentucky's requirements. Indiana and New Hampshire will not start imposing their work requirements until January 1st.

According to Arkansas Medicaid, more than 5,400 enrollees have already failed the last two months to meet the reporting requirements to prove they are working at least 80 hours per month (or participating in qualifying activities like education or job training). They will lose coverage if they fail to comply for three months.

California

Senate-passed bill to limit charitable premium assistance heads to Assembly floor

The Assembly Appropriations Committee advanced S.B. 1156 this week on an 11-5 vote, sending the Senate-passed measure on to the full Assembly later this month.

S.B. 1156 requires health insurers accept premium assistance payments made by the Ryan White HIV/AIDS Program and other federal and state health programs, as well as Native American tribes, consistent with federal regulations implemented in 2014 (see Update for Week of June 2, 2014). These entities do not need to meet the standards that the bill establishes for others providing third-party premium assistance.

The current bill is opposed by PSI and other charitable non-profits because these new standards would prevent assistance based on diagnosis from being provided to low-to-moderate income consumers. Although the legislation is billed as a consumer protection measure, this "safeguard" goes beyond those proposed by the federal government and would have the unintended effect of preventing those with the costliest of disorders from receiving charitable assistance to afford their coverage (see Update for Week of May 7th).

Under the bill, insurers could also continue to refuse premium assistance from charitable groups (as federal regulations allow) even if they comply with all of the new "safeguards", including providing assistance for a full plan year and notifying applicants of all available coverage options. S.B. 1156 would also create the unnecessary hurdle of requiring those receiving charitable assistance to first apply for and receive a denial from Medicare or Medicaid.

PSI continues to back federal legislation (H.R. 3976) that would require Marketplace plans accept both third-party premium and cost-sharing assistance from non-profit charitable organizations, in addition to those already required by federal regulations, which includes safeguards proposed by CMS (see Update for Week of October 2nd). It now has at least 171 bipartisan cosponsors.

The Assembly also passed S.B. 910 this week, which now heads back to the Senate to approve the Assembly's changes before moving to the Governor's desk, which would explicitly ban short-term health plans that expire in less than 365 days (starting in 2019). This is by far the broadest restriction sought by any state since the Trump Administration sought to greatly expand the use short-term health plans that do not need to comply with the ACA (see above). S.B. 910 is backed by a broad range of consumer groups and insurers (including Blue Shield of California and Kaiser Permanente) (see Update for Week of May 28th).

Nevada

ACA Marketplace to transition back to full state control for 2020

The Board of Examiners announced this week that it has approved Nevada HealthLink's contract with GetInsured to transition to a full state-based Marketplace for 2019.

Nevada Health Link is the health insurance Marketplace that the state created in 2013 pursuant to the Affordable Care Act (ACA). However, the state web portal was beset by initial software and technology glitches, forcing Nevada Health Link to ultimately revert to the federal portal at www.healthcare.gov (see Update for Week of January 25, 2016).

Nevada is one of five states (including Arkansas, Kentucky, New Mexico, and Oregon) that continue to default to the federal web portal while maintaining state control over other Marketplace functions, such as marketing, outreach, and in-person assister training. However, New Mexico is also weighing whether to transition fully to a state-based Marketplace following the Trump Administration's recent increases in the user fees for those five states (see Update for Week of July 9th). For example, Nevada Health Link would now pay $13.2 million to continue defaulting to the federal web portal for 2020 compared to only $5.1 million that it will cost to contract with GetInsured to operate its own state portal.

Get Insured will operate the Marketplace's technology platform for eligibility and enrollment, as well as its call center, when the transition is completed for the 2020 plan year. It currently operates Marketplace technology for California, Connecticut, Idaho, Minnesota, Mississippi, New Mexico, and Washington.

State control would also allow those five states to combat the massive federal funding cuts for marketing, outreach, and in-person assisters (see Update for Week of July 9th), as well as extend the open enrollment period beyond the six-week limit imposed by the Trump Administration (see above).

Nevada Health Link experienced record enrollment for the 2018 plan year despite average premiums spiking by more than 38 percent and the open enrollment period being cut in half (see Update for Week of January 8th).

New Hampshire

Individual market premiums to significantly decline for 2019

The Insurance Department released preliminary rate information this week predicting that median premiums for silver-tier plans purchased by 40-year old non-tobacco users will actually fall by 6.75 percent for 2019.

The decline would be a stark contrast to double-digit increases for the past two years, which exceeded 50 percent for several insurers. State regulators attribute the reversal in large part to the legislature's decision to require those enrolled through the Affordable Care Act (ACA) expansion of Medicaid to be enrolled in Medicaid managed care plans instead of private Marketplace coverage (see Update for Week of May 7th). New Hampshire is one of eight states with a federally-approved waiver to use federal ACA expansion funds to purchase private coverage but is still waiting for the Trump Administration to approve the change.

All three insurers that participated in the ACA Marketplace this year have filed plans to return for 2019. Ambetter has proposed the largest decrease of 15.2 percent on average, while Anthem will reduce premiums by 13.5 percent (and an average 20 percent for non-Marketplace plans). Harvard Pilgrim, which is seeking to cut rates by an average of 7.4 percent, noted that their premiums are 12 percent higher than they would have been had Congress not repealed the tax penalties under the ACA's individual mandate (see Update for Week of December 18th).

New Hampshire is one of seven states operating a federal-state partnership Marketplace, meaning they default to the federal web portal but retain control of plan certification and rate review. State regulators will release final premiums shortly before the November 1st start of open enrollment.

New Mexico

Insurer renews lawsuit after CMS restarts ACA risk adjustment program

New Mexico Health Connections filed its second lawsuit this week against the Centers for Medicare and Medicaid Services (CMS) after the agency refused to adjust the formula for risk adjustment payments under the Affordable Care Act (ACA), despite a court declaring the formula to be flawed.

Health Connections is one of only four remaining non-profit health insurance cooperatives that were created with ACA loans. The other 18 were forced to dissolve largely due to the ACA's risk adjustment program that transfers money from insurers with healthier and less-costly subscribers to those enrolling sicker and more costly subscribers (see Update for Week of November 30, 2015). Because the Consumer Oriented and Operated Plans (CO-OPs) relied heavily on low premiums to compete with established insurers, they tended to attract sizeable numbers of lower-risk enrollees and were forced to make risk adjustment payments to dominant insurers beyond what they could afford (one of the four surviving CO-OPs, Montana Health Cooperative, owes nearly 20 percent of its revenue as its 2017 risk adjustment payment). Two of these small cooperatives (New Mexico Health Connections and Minuteman Health of Massachusetts and New Hampshire) filed federal lawsuits seeking to block the payments on the basis that the CMS formula was flawed (see Update for Week of August 15, 2016).

The federal district courts issued conflicting decisions on those lawsuits. Judge Dennis Saylor in Massachusetts upheld the formula, however Judge James Browning in New Mexico sided with Health Connections in ruling last February

that CMS failed to provide insurers with an adequate explanation for how the payments were calculated (see Update for Week of July 9th).

CMS surprisingly suspended all $10.4 billion in 2017 risk adjustment payments in response to the New Mexico court decision, including the $5 million that Health Connections owed to other insurers in October (see Update for Week of July 9th). However, a bipartisan backlash from Congress quickly forced the agency to issue an emergency rule that restarted the payment but maintained the current formula for the 2017 and 2018 plan years.

Health Connections is seeking an injunction blocking implementation of the emergency rule. The cooperative insists that the October deadline for payments does not constitute "good cause" sufficient for CMS to ignore the required public notice and comment period under the Administrative Procedures Act, especially since CMS has had since the February court ruling to do so.

Health Connections wants the court to force CMS to base the risk adjustment payments upon each insurer's individual average premiums, instead of the statewide average premium used under the current formula. Smaller insurers insist that the current formula creates a "reverse Robin Hood" effect by forcing smaller insurers to subsidize larger insurers that already dominate most local markets.

New York

Federal court rules that ACA risk adjustment program does not nullify comparable state programs

A federal judge decided this week to reject UnitedHealthcare's challenge to halt a state program that required it transfer millions of dollars to competing insurers that accepted sicker and more costly subscribers.

Judge John Koeltl with the U.S. District Court for the Southern District of New York ruled that New York's risk-adjustment program "does not impede the federal program" created under the Affordable Care Act (ACA) and can require additional payments on top of that complementary program so long as they further the purpose of the ACA risk adjustment payments. He rejected the insurer's claim that the ACA program "pre-empted" the state program.

UnitedHealthcare is scheduled in October to receive more than $212 million in ACA risk adjustment payments for 2017. The federal Centers for Medicare and Medicaid Services (CMS) surprisingly suspended 2017 risk adjustments payments to all insurers after lower federal courts split on the validity of the payments, but quickly restarted the program last month in the face of a bipartisan backlash (see Update for Week of July 23rd).

However, UnitedHealthcare will be unable to keep all of the $212 million in ACA risk adjustment funds because of the New York risk adjustment program for the small group market created in 1993. Regulations that modified the program in 2016 required insurers who receive money from the ACA program to pay up to 30 percent of that amount into a state fund that is distributed to other small group insurers in New York.

Virginia

Governor's work group considers creating reinsurance program to mitigate premium increases

A new working group convened this week by Governor Ralph Northam (D) will consider options to stabilize soaring premiums in Virginia's health insurance market.

The Virginia Market Stability Group has agreed to study the impact of the new short-term and association health plans allowed by the Trump Administration, which will let consumers purchase lower-cost coverage that does not comply with consumer protections required by the Affordable Care Act (ACA) (see above). However, Secretary of Health and Human Resources Dan Carey acknowledged that the creation of a federally-approved reinsurance program will likely be the "number one and most promising tool" that the Group will evaluate before issuing its final report to the Governor and

legislative budget committees by November 1st, while Commissioner of Insurance Scott White advised group members that reinsurance is likely "the only game in town right now."

Six states (Alaska, Maine, Minnesota, New Jersey, Oregon, and Wisconsin) have already received State Innovation Waivers under the ACA allowing them to create a reinsurance program with federal and state funds, which seek to compensate insurers for exceptional claims similar to the temporary reinsurance payments under the ACA that expired after 2016 (see above). These have or expect to be able to dramatically mitigate premium increases following implementation and Virginia regulators predict it could reduce individual market premiums in the Commonwealth by as much as 15 percent.

The two-year budget plan recently signed by the Governor authorizes the Secretary to apply for a federal waiver to mitigate premium increases. However, the Commissioner concedes the final impact of reinsurance payments are difficult to quantify because the Commonwealth's pending expansion of Medicaid is expected to reduce premiums by 6-10 percent once fully implemented. He noted that proposed rate increases for the 2019 plan year already are reflecting a 1.5-5 percent reduction due solely to legislative approval of the Medicaid expansion (see Update for Week of May 28th). However, he cautioned that the Trump Administration's expansion of non-ACA compliant coverage could siphon healthier consumers out of insurer risk pools and drive-up premiums by as much as 15 percent, as some insurers are already seeking increases of up to 32 percent due to the prevalence of short-term or association health plans and the Congressional repeal of ACA individual mandate penalties (see Update for Week of May 7th).