PATIENT SERVICES INCORPORATED

Health Reform Update – Week of October 29, 2018

CONGRESS

Kaiser finds that individual mandate repeal and "junk" plans are increasing 2019 premiums by 16 percent

An analysis of nationwide rate filings released last week by the Kaiser Family Foundation found that "benchmark" premiums in most Affordable Care Act (ACA) Marketplaces will be 16 percent higher next year than they would be without Congressional and regulatory actions to weaken the ACA.

KFF had previously determined that average premiums for "benchmark" plans are expected to actually decrease next year by 1.5 percent (see Update for Week of October 15th). ("Benchmark" plans are the silver-tier plans selected by most enrollees because they are tied to the ACA premium tax credits). However, the new analysis concludes that premiums would be far more dramatically lower if not for Congress' repeal of the ACA individual mandate tax penalty for 2019 (see Update for Week of December 18th), the Administration's elimination of ACA cost-sharing reductions (CSRs), and final regulations removing limits on short-term and association health plans that provide limited benefits and do not comply with key consumer protections under the ACA (see Update for Week of August 13th).

Researchers specifically determined that the combination of repealing the individual mandate penalty and expanding the use of so-called "junk" insurance will increase 2019 "benchmark" premiums by an average of six percent. KFF added this increase to ten percent jump in "benchmark" premiums previously that the Congressional Budget Office (CBO) previously attributed to the Administration's decision to eliminate reimbursement for CSRs that insurers still must statutorily provide (see Update for Week of November 13, 2017).

The KFF analysis did not include Marketplaces in states that already implemented their own counterpart to the ACA's individual mandate (i.e. Massachusetts, New Jersey, and the District of Columbia). It also excluded New York, which prohibits insurers from loading an individual mandate surcharge on top of their 2019 premiums.

Researchers concluded that absent the adverse actions by the Trump Administration, average "benchmark" premiums would be falling by 17.5 percent next year (to an average of $427 per month for a 40-year old consumer) due to the fact that state regulators allowed insurers to dramatically increase 2018 premiums by far more than was necessary to account for the uncertainty over if and how the Administration and Congress would repeal all or most of the ACA. As a result, most insurers are profiting to such an extent that they would have to pay sizeable consumer rebates under the ACA's medical-loss ratios (which cap insurer profits and overhead at 20 percent of premium revenue) if they imposed additional increases for 2019.

FEDERAL AGENCIES

CMS credits increased competition for lowering premiums for most federal Marketplace consumers

The Centers for Medicare and Medicaid Services (CMS) released a report shortly before the November 1st start of the open enrollment period showing that average premiums will likely be lower next year for most consumers in one of the 39 states defaulting to the federally-facilitated Marketplace (FFM) under the Affordable Care Act (ACA).

According to the report, the average premium for a 27-year-old non-smoker for the second-lowest cost or "benchmark" silver-tier plan will be two percent lower in 2019. "Benchmark" premiums are typically selected by more than 60 percent of Marketplace consumers as they are tied to the ACA premium tax credits. As a result of the premium decline, the federal government is likely to pay three percent less in premium tax credits.

CMS credits an increased number of insurers participating in the Marketplaces for driving down premiums. For 2019, 57 percent of those currently enrolled in FFMs will have at least three plans from which to choose (up from 44 percent this year). Roughly 20 percent will be limited to only one FFM insurer (down from 29 percent a year ago). CMS notes that this includes the entire states of Alaska, Delaware, Mississippi, Nebraska, and Wyoming. However, this is an improvement from 2018 when eight states had only one participating insurer statewide.

As a result of the ACA's premium tax credits, CMS stressed that 80 percent of FFM consumers will be able to purchase coverage for $75 or less.

Trump Administration guidance relaxes or removes restrictions for states to receive ACA waivers

The Departments of Health and Human Services (HHS) and Treasury released new guidance last week intended to make it easier for states to seek and receive State Innovation Waivers allowing them to opt-out of key provisions under the Affordable Care Act (ACA).

Since 2017, Section 1332 of the ACA has allowed states to seek federal waivers to implement their own health reforms so long as they were budget neutral, provide comparable levels of coverage to the parts of the ACA that they would supplant, and authorized by their legislatures. Eight states have already received approved State Innovation Waivers, with most using them to create reinsurance programs that compensate insurers with exceptional claims (see Update for Week of August 27th). At least 35 states have passed or are considering legislation authorizing a State Innovation Waiver.

Under the new guidance, HHS and the Treasury are relaxing or eliminating the guardrails placed on these waivers by the Obama Administration, so that state agencies can now pursue these waivers without authorizing legislation. In addition, states would be allowed to reduce or limit coverage to specific populations and offer coverage that does not comply with the ACA so long as ACA-compliant coverage remains available.

These renamed State Relief and Empowerment Waivers are intended to give states the flexibility and authority to offer the association health plans (AHPs) and short-term coverage approved by the Trump Administration in recently finalized regulations (see Update for Week of August 13th). These lower cost limited-benefit plans need not comply with most of the consumer protections mandated by the ACA and states could receive waivers allowing consumers to purchase them with ACA premium tax credits.

Consistent with the Notice of Benefit and Payment Parameters (NBPP) that HHS recently finalized for 2019 Marketplace plans (see Update for Week of April 16th), states receiving Section 1332 waivers will no longer be bound by the ten essential health benefits (EHB) categories set by the ACA but "will now be able to choose from the 50 EHB-benchmark plans used for the 2017 plan year [or] build their own set of benefits that could potentially become their EHB-benchmark plan."

The guidance specifically states that HHS and Treasury will favor waiver requests that expand private health insurance coverage (such as AHPs and short-term coverage). Conversely, it discourages states from seeking waivers that promote more progressive reforms, such creating options for consumers to buy-in to Medicare or Medicaid or experimenting with single-payer health systems.

The guidance drew swift criticism from consumer and provider groups, many of whom feared it could represent the Administration's most effective tool to weaken the ACA. They warned that the prevalence of non-compliant plans would essentially segment the individual health insurance market into two different risk pools, with healthier and lower-cost consumers migrating into the lower-cost "junk" coverage while ACA-compliant plans are left to serve to sicker and higher-cost populations. This would translate into dramatically higher premiums for the latter.

Proposed rule would let employers provide workers with HRAs to purchase individual market coverage

Proposed regulations issued last week by the Departments of Health and Human Services (HHS), Treasury, and Labor would let employers provide workers with health reimbursement arrangements (HRAs) that could be used to purchase health insurance in the individual market.

The departments insist that the rule would increase the options for employers to comply with the employer mandate under the Affordable Care Act (ACA) while giving employees lower-cost coverage choices. Under current regulations promulgated during the Obama Administration, HRAs can be used to purchase individual coverage but would not satisfy the employer mandate, which requires employers to provide minimum essential coverage or pay an annual per employee assessment.

The proposed rule would also allow Medicare enrollees to use HRAs to pay for Part B or D premiums. However, the departments are asking the public to comment on whether HRAs could also be used to purchase short-term health plans that do not comply with ACA standards. The Trump Administration recently extended the limit on short-term health plans from 90 to 364 days (see Update for Week of August 13th).

In order to mitigate acknowledged concerns about adverse selection (i.e. effectively creating separate risk pools for healthier and sicker consumers), the proposed rule specifically requires employers to offer either an HRA or a traditional health plan, instead of giving employees a choice between the two plans. The offer must also be uniform among all classes of employee.

The departments expect that the proposed changes would result in 10.7 million additional HRA consumers for the individual health insurance market, while group plan enrollment would fall by 6.8 million.

Federal court will not block new regulations expanding use of short-term health plans

A federal judge appointed by President George W. Bush indicated this week that he would not grant the preliminary injunction that insurers sought in order to block the Trump Administration's expansion of short-term health plans that do not comply with the Affordable Care Act (ACA).

Final regulations that went into effect on October 1st allowed non-compliant health plans to last for up to 364 days, instead of the 90-day limit imposed by the Obama Administration (see Update for Week of August 13th). They can also be annually renewed for up to three years.

Insurer, provider, and consumer groups insist that allowing a plethora of lower-cost "junk" plans with very limited benefits will siphon away healthier and lower-cost consumers from the risk pools for 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). However, Judge Richard Leon with the U.S. District Court for the District of Columbia stated that consumers should have this lower-cost available to them until data is available that can prove the risk pools are being harmed.

The judge urged the plaintiffs to withdraw their request for preliminary injunction and seek a trial on the merits of their complaint, which could be heard in early 2019.

MACPAC urges Trump Administration to pause approvals for Medicaid work requirements

The Medicaid and CHIP Payment and Access Commission (MACPAC) sent a letter this week to the Secretary for the Department of Health and Human Services (HHS) urging him to not to approve any new Medicaid work requirements for states until the agency can develop adequate means to evaluate the adverse impact of mass disenrollment.

Advisors on the Commission, which was created pursuant to the Affordable Care Act (ACA), expressed alarm that nearly 8,500 enrollees have already been dropped from Arkansas Medicaid after that state implemented its new work requirements on June 1st (see Update for Week of August 13th). With another 12,000 enrollees at risk of losing coverage through the end of the calendar year (if they fail to provide the required documentation for three months), MACPAC urged HHS to immediately halt Arkansas' removals due to its wholesale lack of any method to track whether those who lose coverage are able to obtain other insurance or are simply increasing uncompensated care costs for hospitals and other safety-net providers.

MACPAC insisted that HHS should not approve federal waivers sought by at least ten states seeking to impose work requirements, or let previously-approved states move forward without first requiring them to gather baseline data, create control groups, and develop specific operational plans for ensuring enrollees are aware of the requirements and contact those who have been disenrolled. It noted that under the waivers HHS has already approved, states are not required to submit interim evaluations for two years.

The Urban Institute also voiced concerns about the Medicaid work requirements in Arkansas after survey results showed the vast majority of impacted enrollees were not aware they had been implemented and nearly 20 percent lacked the Internet access needed to submit the required documentation through the online web portal, the only means the state made available for enrollees to comply.

The U.S. District Court for the District of Columbia has already barred Kentucky from implementing its Medicaid work requirements, concluding that HHS' approval of its waiver was "arbitrary" and "capricious" unless it first adequately evaluates the impact of eliminating coverage for an estimated 95,000 Medicaid enrollees (see Update for Week of June 25th). The same court is currently considering an analogous challenge to Arkansas' Medicaid work requirements (see Update for Week of August 13th). Federally-approved work requirements for Medicaid programs in Indiana and New Hampshire are scheduled to go into effect on January 1st (see Update for Week of May 7th).

HRSA reverses delay of final rule imposing fines on Section 340B safety-net providers

The Health Resources and Services Administration (HRSA) issued a Notice of Proposed Rulemaking (NPRM) this week reversing a prior delay in implementation of final regulations that would punish drug manufacturers who overcharge safety-net providers participating in the Section 340B Drug Pricing Program.

The so-called "ceiling price rule" had been delayed five times by the agency, leading to a lawsuit filed in September by the American Hospital Association and other trade groups demanding its implementation. It has been strongly opposed by the Pharmaceutical Research and Manufacturers of America (PhRMA), which sought the delays on the basis that complying would be "disruptive" given the "substantive questions that have been raised" about eligibility requirements, oversight, and lack of clear definitions (see Update for Week of August 14th).

The rule was first proposed by the Obama Administration in 2015 and would penalize manufacturers for "knowingly and intentionally" charging a participating provider more than the ceiling price for a covered outpatient drug. The rule calculates the ceiling price essentially by subtracting a drug's Unit Rebate Amount from the Average Manufacturer Price (AMP). . For a new 340B drug, the ceiling price will be calculated as the wholesale acquisition cost (WAC) of the drug, less the appropriate rebate percentage, until the AMP is known to the manufacturer.

HRSA subsequently decided under the Trump Administration to delay the initial March 2017 effective date for the rule in order to consider "alternative and supplemental regulatory provisions." The agency most recently set implementation for July 1, 2019 (see Update for Week of May 7th), but would move that date up by six months under the NPRM.

The Centers for Medicare and Medicaid Services (CMS) issued a separate final rule this week governing the Hospital Outpatient Prospective Payment System (OPPS) for Medicare, which would extend 340B payment policies to hospital outpatient departments,

STATES

Georgia

Average premiums to increase by less than four percent as Anthem returns to metro counties

The Department of Insurance announced this week that individual plan consumers in the Affordable Care Act (ACA) Marketplace that the federal government operates for Georgia will see overall premiums increase next year by just under four percent on average and only 0.3 percent for the popular "benchmark" silver-tier plans upon which the ACA premium tax credits are based.

The limited increase is a dramatic departure from 2018, when Marketplace consumers in Georgia faced a 57 percent average spike in premiums—by far the highest increase in the nation (see Update for Week of November 6, 2017). Anthem Blue Cross Blue Shield had decided to exit the entire Marketplace in 2018, due to uncertainty over the fate of the ACA, but negotiated an agreement with Insurance Commissioner Ralph Hudgens (R) to remain just in 85 of the state's 159 counties that would otherwise have no participating insurers (see Update for Week of May 15, 2017). (Anthem was also the only insurer offering coverage in 96 rural counties for 2017).

The Department attributed the far lower premiums to increased competition, especially Anthem's decision to re-enter 31 of the urban northern Georgia counties they abandoned for 2018. This include the Atlanta metro area (except for Clayton and Rockdale counties). However, Anthem will leave 41 of the 85 rural counties they covered in 2018, as Ambetter has agreed to expand into those areas.

All four Marketplace insurers from 2018 have agreed to participate next year. Anthem premiums will actually decline by an average of 0.3 percent after being reduced from the 2.2 percent rate hike they sought. However, other insurers will receive significant bumps, including a 14.7 percent average premium increase for Kaiser Health Plan, ten percent for Alliant, and 8.8 percent for Ambetter (which was actually increased from their requested 7.7 percent hike).

Kaiser received the greatest increase because they were the only insurer that did not build the cost of the ACA cost-sharing reductions that were terminated by the Trump Administration into their 2018 premiums (see Update for Week of November 13, 2017). Kaiser will include these costs for 2019, but only for silver-tier plans to which the CSRs were tied. The other three insurers are likewise adopting this "silver-loading" approach. (Indiana, Mississippi, and West Virginia where "silver-loading" is not allowed for 2019 and the cost of CSRs are being spread across all ACA-compliant plans).

New York

State regulators grant Marketplace insurers only one-third of average premium increase requests

Final premiums for the open enrollment period that started this week show that the NY State of Health Marketplace will continue to have robust competition for 2019 with 12 participating insurers, none of whom control more than a third of the Marketplace.

Premium increases will average 8.6 percent, which is far above the 1.5 percent average decrease for plans within the federally-facilitated Marketplace (FFM). However, because the state-based Marketplace in New York has wide authority to modify or reject excessive rate hikes, the increase is only about a third of the 24 percent average hike initially sought by insurers (see Update for Week of May 28th).

In their initial rate filings, insurers noted that their increases were largely due to the loss of the ACA's individual mandate for the 2019 plan year and would have been 50 percent lower without the repeal of the tax penalty for not buying

health insurance you can afford (see Update for Week of May 28th). However, the Superintendent for the Department of Financial Services (DFS) insisted this his agency would ensure that insurers do not use "the Trump Administration's many efforts to sabotage affordable and comprehensive healthcare coverage…as a cover for excessive premium increases."

As a result, DFS reduced the average rate hike sought by the dominant carrier, Fidelis Care (owned by Centene) by nearly two-thirds (from 38.6 percent to 13.7 percent). Fidelis currently enrolls 30.4 percent of NY State of Health consumers.

Oscar Health Plan, the second largest insurer in terms of market share (15.4 percent), saw their average rate hike slashed by more than half (from 25.2 percent to 11 percent). The average increase for Excellus Health Plan (which controls 8.2 percent of the Marketplace) was also cut by in half (from 8.2 percent to 4.6 percent), while Emblem Health Insurance Plan of Greater New York went from 31.5 percent to only 17 percent (Emblem has an 8.4 percent market share).

Empire HealthChoice HMO (which controls nearly eight percent of the Marketplace) had their entire 24 percent average rate hike rejected, while UnitedHealthcare of New York (2.1 percent market share) retained only 1.5 percent of their 23.6 percent average rate hike request and Independent Health Benefits Corporation received only 0.6 percent of their 21.3 percent average request.

Two NY State of Health insurers will actually decrease average premiums for 2019. These are Capital District Physicians' Health Plan (1.7 percent market share), whose 5.1 percent average rate hike was reduced to a 1.9 percent decline, and HealthNow New York (a combination of Blue Cross Blue Shield plans for western and northeastern New York), whose 3.2 percent average decrease was approved as filed. (HealthNow has a 2.2 percent market share).

New York is the only state besides Minnesota electing to participate in the Basic Health Plan option under the ACA (see Update for Weeks of May 29 and June 5, 2017). Called the Essential Plan, it provides the state with enhanced federal matching funds for those earning up 138-200 percent of the federal poverty level in separate plans from the Marketplace that provide coverage with no deductibles, limited copayments, and premiums of no more than $20 per month. For 2019, 15 insurers will participate in the Essential Plan, enrolling nearly 700,000 enrollees (or 40 percent of all Marketplace consumers).

New York, California, and the District of Columbia are the only SBMs that have adhered to the 12-week open enrollment period that all Marketplaces used prior to 2018 (see Update for Week of October 1st). Enrollment in NY State of Health will continue through January 31st. (Essential Plan enrollment continues year-round).

According to the U.S. Census Bureau, New York is one of only three states to experience continued improvements in their uninsured rate in 2017 (see Update for Week of September 10th).

North Carolina

Trump Administration lets Medicaid transition to managed care, but rejects work requirements

The federal Centers for Medicare and Medicaid Services (CMS) partially approved the Section 1115 demonstration waiver sought by North Carolina to move nearly all of its Medicaid population in managed care plans.

The Medicaid Reform Demonstration was revised by Governor Roy Cooper (D) after he assumed office last year from his Republican predecessor. It makes North Carolina to first state to create a pilot project with its Medicaid managed care delivery system that will tailor specific packages of enhanced case management services specific to high-need Medicaid enrollees (using $650 million in federal funds through 2024).

Governor Cooper had included provisions allowing Medicaid to impose work requirements on those made newly-eligible by any future expansion of Medicaid under the Affordable Care Act (ACA), as well as charging those earning at

least 50 percent of the federal poverty level with premiums equal to two percent of income. However, CMS rejected these provisions because the legislature failed to pass any legislation authorizing the expansion.

Dominant insurer cuts Marketplace premiums by four percent due to increased competition

Final premiums approved by the Department of Insurance (DOI) show that increased competition will slightly lower what Affordable Care Act (ACA) Marketplace for 2019.

Blue Cross Blue Shield (BCBS) of North Carolina and CIGNA will both return to the Marketplace next year, but Ambetter (Centene) will enter the Marketplace for two populous continues (Durham and Wake). Consumers in Chatham, Johnston, Nash, and Orange counties will be able to choose from either BCBS or CIGNA, but BCBS will be the lone insurer in every other county.

As a result of Ambetter's entry, the dominant insurer BCBS (with more than 475,000 enrollees) will actually decrease premiums by an average of 4.1 percent. BCBS' rate filing noted that they would be seeking an even greater decrease if not for "Destabilizing Federal Health Policy", which it identified as the repeal of tax penalty for the ACA's individual mandate and the expansion of short-term health plans (see above).

CIGNA voluntarily reduced the 3.6 percent average increase they initially proposed down to only 0.4 percent. Combined with BCBS, this resulted in a 1.4 percent average drop in 2019 "benchmark" premiums for Marketplace consumers. "Benchmark" plans are second-lowest cost silver-tier plans to which the ACA's premium tax credits are tied, causing them to be selected by more than 60 percent of Marketplace consumers.

Pennsylvania

Governor blocks new work requirements for "able-bodied" Medicaid enrollees

Governor Tom Wolf (D) vetoed legislation last week that would have imposed new work requirements on "able-bodied" Medicaid enrollees.

The governor, who is up for re-election next week, stated that H.B. 2138 "increases costs, creates unnecessary delays and confusion, penalizes individuals who need healthcare, and terminates health coverage for those who need it the most." He also vetoed similar legislation in 2017.

The latest legislation would have required that Medicaid recipients work at least 20 hours a week or perform 12 job training-related tasks each week. It would have exempted pregnant mothers, high school students, those over 65, those receiving disability benefits and a number of other groups of people who couldn't reasonably be expected to work.

Comparable Medicaid work requirements have already been approved by the Trump Administration in Arkansas (see above), Indiana, Kentucky, New Hampshire, and Wisconsin (see below), with at least nine other states pursuing or preparing to pursue them. Arkansas was the first to go into effect after consumer advocates Kentucky's approval was invalidated by a federal court in the District of Columbia, which found that neither the state nor the federal government adequately considered that up to 95,000 enrollees would lose coverage (see Update for Week of June 25th). A similar legal challenge involving Arkansas' approval is pending before the same judge (see Update for Week of August 13th).

H.B. 2138 was opposed by national and state hemophilia organizations, as well as other major consumer groups.

Wisconsin

Trump Administration approves Medicaid work requirements, premiums

The federal Centers for Medicare and Medicaid Services (CMS) made Wisconsin the fifth state to receive federal approval to impose work requirements and higher premiums on "able-bodied" adults enrolled in Medicaid.

Unlike the four other states, Wisconsin sought to apply the work requirements to an existing Section 1115 demonstration waiver, allowing them to go into effect after the current waiver expires on December 31st. Wisconsin is one of 16 states that continue to refuse to participate in the Medicaid expansion under the Affordable Care Act (ACA), in which states accept federal matching funds to cover at least 90 percent of the cost of providing Medicaid to everyone earning up to 138 percent of the federal poverty level (FPL). Instead, the state received a demonstration waiver from the Obama Administration in 2014 allowing it provide Medicaid-comparable benefits to non-pregnant, nondisabled, non-elderly childless adults with incomes at or below 100 percent of FPL. According to CMS, more than 178,000 individuals were receiving coverage under the BadgerCare Reform demonstration as of June 30th, with the federal government covering only 40 percent of the costs.

The waiver extensions allows Wisconsin to continue BadgerCare Reform for five more years while requiring childless adults enrolled in the program to participate in and timely document 80 hours per month of community engagement activities if they are aged 19-49. Qualifying activities include employment, job training, community service, or enrollment in an allowable work program.

Those who have been enrolled in the program but have not met the work requirements for 48 aggregate months will be disenrolled and ineligible to re-apply for six months. They can enroll in Medicaid during this lock-out period, if they are eligible.

In addition to the work requirement, BadgerCare Reform enrollees earning 50-100 percent of FPL can now be charged premiums of up to $8 per month and locked-out of coverage for up to six months for failure to comply. Non-emergency use of emergency departments will also require $8 copayments.

CMS acknowledges that the work requirements will result coverage losses but did not provide an estimate. This is likely in response to a federal court invalidating CMS' approval of Medicaid work requirements in Kentucky, concluding that CMS failed to adequately consider the projected loss in coverage for up to 95,000 enrollees (see Update for Week of June 25th). A similar lawsuit against Arkansas' Medicaid work requirements remains pending before the same judge (see Update for Week of August 13th).

The Medicaid and CHIP Payment and Access Commission (MACPAC) had urged CMS not to approve any pending waivers for Medicaid work requirements until it can develop adequate methods to evaluate whether those who lose coverage are able to obtain insurance from other sources (see above).

CMS rejected Wisconsin's request to require all Medicaid enrollees submit to drug testing. However, the new waiver still includes a controversial provision allowing the state to demand intrusive information from Medicaid enrollees about lifestyle behaviors such as drug and tobacco use, diet and exercise habits, and use of seatbelts. CMS will allow Wisconsin to impose the maximum premiums on those deemed to be engaging in "unhealthy" behaviors.

The ultimate fate of the waiver will likely rest on the outcome of the gubernatorial election next week. Incumbent Scott Walker (R) is a proponent of the Medicaid work requirements but faces a tough challenge from the state superintendent for education Tony Evers (D) who opposes them. If elected, Evers would have the authority to modify or withdraw any part of the waiver.