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exclusive reporting on the new health insurance marketplace

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CMS Approves All State SHOP Employee Choice Delay Requests

CMS on Tuesday (June 10) said "yes" to all 18 federally facilitated SHOP exchange states that asked to not implement employee choice in 2015, and confirmed that 14 FF-SHOP states did not ask for a transition so they will move ahead with the model next year.

Inside Health Policy had previously reported that at least 17 states had asked for a delay and 14 had not.

CMS said Tuesday that the 18 states that won't have employee choice in their small business marketplaces next year are: Alabama, Alaska, Arizona, Delaware, Illinois, Kansas, Louisiana, Maine, Michigan, Montana, New Hampshire, New Jersey, North Carolina, Oklahoma, Pennsylvania, South Carolina, South Dakota and West Virginia.

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PhRMA: HHS Can Do More To Ensure Reduced Cost-Sharing For Drugs

A Pharmaceutical Research and Manufacturers of America spokesperson suggests HHS should issue stricter guidelines requiring federal exchange qualified health plans to reduce cost-sharing for enrollees receiving the ACA's cost-sharing subsidies, coming on the heels of a new Avalere Health report finding that plans reduce out-of-pocket costs differently depending on the medical benefit. Avalere says while nearly all cost-sharing reduction plans in the 34 FFE states reduce deductibles and out-of-pocket caps, many plans don't lower cost-sharing for other medical services, such as specialty drugs, and primary care and specialist visits.

PhRMA in a blog post about the report said only slightly more than half of plans for the lowest-income exchange

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Group Says CMS Bid To Expand Non-Formulary Drug Access Falls Short

CMS' final policy requiring federally facilitated exchange plans to decide within 24 hours whether patients facing "exigent" circumstances can access non-formulary drugs may be an empty victory for patients if CMS does nothing to address the cost of the drugs, an official with the National Health Council says. NHC — a coalition of drug makers and patient advocacy groups — is asking CMS to apply to qualified health plans the Medicare Part D policy on cost-sharing for excepted drugs, which requires the excepted drug to be placed in an existing cost-sharing tier and also requires the cost of that drug to count toward consumers' annual out-of-pocket spending limits.

CMS finalized the expedited exceptions process — which requires the 24-hour turnaround for consumers — as part

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GOP Scrutinizes Reinsurance After Employers Complain About Fee Impact

Senate Republicans have renewed their criticism of the administration's implementation of the ACA reinsurance program and worry the program — and its associated fee on group health plans — could be extended after 2016, which one congressional aide says stems from employer concerns that HHS may consider such a move because the agency has unilaterally extended or delayed other parts of the law.

HHS Secretary Sylvia Mathews Burwell, after her confirmation hearing with the Senate Finance Committee, was asked if she feels HHS has the authority to extend the program, and the associated fee on group health plans which funds it, beyond its statutory end date of 2016. Burwell, in her answers to members' questions for the record, dodged

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answering the question and only said that she would work with Congress "on ideas to strengthen and efficiently implement this and other Affordable Care Act programs."

Steve Wojcik, vice president of public policy for the National Business Group on Health, says he has not heard of any efforts to extend the reinsurance fee after 2016, and adds it would be "very alarming" if such a move occurred. Republicans have criticized HHS and other agencies for taking executive actions to delay or extend certain pieces of the law — such as delaying the employer mandate and reporting requirements, delaying employee choice for the SHOP exchanges and allowing for non-ACA compliant plans to be renewed until Oct. 1, 2016. Due to the number of instances in which HHS has acted without legislation, a GOP aide says, employers are concerned the same could be done for the reinsurance program fee.

Reinsurance provides funding to insurers to protect them against high-cost individual market enrollees. Reinsurance and risk corridors are two of the three risk-mitigation programs the ACA outlines to help keep premiums stable, and the two programs are temporary, unlike the permanent risk adjustment program. Both reinsurance and risk corridors are set to terminate after 2016, although reinsurance funding to plans could continue beyond that date if there is any money leftover.

The law sets how much can go out to plans each year in the form of reinsurance contributions: $10 billion this year, $6 billion in 2015 and $4 billion in 2016. The remaining $5 billion of the $25 billion that's set aside for the program goes to the Treasury over the course of those three years, to make up for the $5 billion spent for the Early Retiree Reinsurance Program.

As such, businesses have been able to calculate the exact amount that they will need to pay in the reinsurance fee. Wojcik says that because the law specifies an exact dollar amount to be collected, any change that requires an additional tax on group health plans would require legislation. One of the issues that the group had with the fee from the beginning was that the amount is set regardless of how much the health plans actually need.

One source says even though reinsurance funding could continue after 2016 if the money is not exhausted by then, such a scenario seems unlikely because HHS has said that it would pay all claims above the attachment point and below the reinsurance cap prior to rolling over funds to the following year. America's Health Insurance Plans spokesperson Brendan Buck notes that reinsurance funding can already continue if there is funding available from previous years, and he says the group has not weighed in on any funding issue outside of that.

Because of CMS' transitional rule that allows non-ACA compliant plans to be renewed until Oct. 1, 2016, CMS has lowered the reinsurance attachment point for 2014 to $45,000, which makes it easier for insurers to tap into the funding, something they had sought. CMS also has said that it intends to lower the 2015 attachment point from $70,000 to $45,000, and will do so in regulations outlining the benefit and payment parameters for 2016. But insurers have cited the $4 billion decline in reinsurance funding from this year to next as a factor putting upward pressure on 2015 rates.

Sen. Johnny Isakson (R-GA) also asked Burwell whether she thinks HHS could extend the risk corridors program beyond its three-year timeframe, raising the issue during the Senate health committee's confirmation hearing for Burwell. Burwell said she was not aware of any plans to administratively extend the program beyond 2016.

Sen. John Thune (R-SD) also pressed Burwell during the subsequent Senate Finance hearing about HHS' "selective enforcement" of the ACA and the department's actions that appear to benefit groups that support Democrats. Thune and other Republicans have argued that HHS' decision to carve out self-funded, self-administered plans from the reinsurance fee was designed to appease unions, as those types of plans generally are union plans. He pressed Burwell on whether the exemption of some plans from the fee will increase how much other group plans have to pay, since the statute specifies how much is paid out every year. Burwell said the exemption does apply to some union plans but it doesn't apply to many, and the decision was made in an effort to better implement the law. — *Rachana Dixit Pradhan*

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Exchange Round-Up

Decision Time On SHOP Employee Choice; Congress Probes Access Issues

HHS has a new secretary and one of the first decisions CMS made under Sylvia Mathews Burwell's watch was which federally facilitated SHOP exchange states will not implement the employee choice model next year. CMS said Tuesday (June 10) that all 18 FF-SHOP states that had asked to get around the model have been given approval to delay employee choice until after 2015. The decision affirms *Inside Health Policy's* previous reporting that at least 17 states where the federal government is running the small business marketplace asked for a delay, yet 14 states did not ask for such a waiver so the employee choice landscape in FF-SHOP states will be split next year. Other developments related to exchange income verification and patients' ability to access medical services and drugs are expected this week, with both issues the subject of House hearings.

Sources had anticipated that a large number of FF-SHOP states would ask CMS to not implement employee choice next year. However, Small Business Majority, which strongly backs employee choice, had pushed back against the requests, arguing that most states' reasons to get around employee choice are not strong enough to warrant a delay.

The states that asked for a delay and were given approval, according to CMS, are*:* Alabama, Alaska, Arizona, Delaware, Illinois, Kansas, Louisiana, Maine, Michigan, Montana, New Hampshire, New Jersey, North Carolina, Oklahoma, Pennsylvania, South Carolina, South Dakota and West Virginia. Additionally, an agency spokesperson says that while Idaho did ask for the same employee choice transition, because it is a supported state-based marketplace the Idaho exchange is responsible for the decision.

State insurance departments that confirmed they did not ask for a delay include: Arkansas, Florida, Georgia, Indiana, Iowa, Missouri, Nebraska, North Dakota, Ohio, Tennessee, Texas, Virginia, Wisconsin and Wyoming.

"Small employers have been looking forward to offering more comprehensive health coverage that offers more choices so their employees can choose the plan that works best for them," the Small Business Majority said in advance of CMS' June 10 deadline to approve or deny state requests. "Allowing states to possibly delay the employee choice option from the health marketplaces doesn't do our primary job creators any favors. We urge the administration to be judicious when determining if states can postpone this feature so small employers and their workers can benefit from the same health insurance choices that larger companies have had for years."

Work also continues on the exchanges' back-end systems, and CMS plans to institute a new process later this year in which the agency will calculate the amount of subsidies paid to qualified health plan (QHP) issuers. Even though the new process would move away from the manual system CMS is using now (which relies upon issuer, rather than agency, calculations), it still falls short of the fully automated mechanism that was supposed to already be in place, sources say.

Meanwhile, on Capitol Hill congressional Republicans are diving into exchange-related issues of income verification and access to physicians and prescription drugs. Two House Ways and Means subcommittees on Tuesday morning (June 10) are holding a joint hearing on the exchanges' income verification systems — over which the administration is again facing criticism because of glitches that impact subsidy calculations — and on Thursday (June 12) the House Energy and Commerce health subcommittee will focus on the ACA and access to prescription drugs and physicians.

As the Ways and Means hearing was announced, CMS said that just because roughly 2 million exchange enrollees had data discrepancies on their applications it doesn't mean there's a problem with their enrollment. CMS says that as of the end of May, 1.2 million enrollees had discrepancies with their annual income, 461,000 had citizenship inconsistencies and 505,000 had immigration inconsistencies. The federally facilitated exchange will be sending out notices to all enrollees that have a data inconsistency in their application and the call center will be calling enrollees with issues, a consultant tells *Inside Health Policy*. Those people will have 30 days to respond with the necessary documentation.

Additionally, the source says CMS is giving carriers the option of reaching out to those enrollees to remind them to submit the necessary information to CMS, but carriers will not be told what the exact data discrepancy is due to privacy issues.

Thursday's Energy and Commerce hearing on access to providers and prescriptions comes as the drug industry and patient groups continue to criticize how plans on the exchanges have crafted their drug benefits, arguing that placing certain drugs in tiers with high cost-sharing requirements puts the drugs of reach for patients with serious chronic conditions.

In the states:

Connecticut exchange CEO Kevin Counihan said Friday (June 6) that Access Health CT is working with local police and filing necessary reports to federal and state governments after a backpack was discovered in Hartford containing personal information for roughly 400 people. According to the exchange, the backpack also contained Access Health CT paperwork and it seems that some of the personal information found in the backpack is associated with consumers' accounts. Counihan said the exchange is also working with call center vendor Maximus and outreach teams to address the situation as quickly as possible.

The state's insurance regulator also recently released information about proposed rate changes for 2015.

Connecticut's exchange has four issuers seeking to offer products, up from three this year because UnitedHealthcare has decided to enter the individual exchange. Anthem Health Plans is proposing a 12.5 percent increase and ConnectiCare is requesting an 11.8 percent increase, whereas the Healthy CT CO-OP is asking for a 8.9 percent decrease. The insurance office is taking public comment on the filings until June 23.

The **Maryland** Insurance Administration on Friday released carriers' proposed 2015 rate requests for the individual and small group markets and the state is taking public comment on the filings. According to the state, all of the companies selling plans this year in the two markets have filed to participate again next year and two companies are seeking to participate in the individual market for the first time. Cigna is seeking approval to offer plans for the first time on the individual exchange, and UnitedHealthcare, which is currently offering plans in the small group market, also wants to expand to the individual exchange for 2015.

As has been the case in other states, insurers' rate change requests run the gamut. In the Maryland individual market, CareFirst BlueCross Blue Shield is requesting an average 30.2 percent increase in their 2015 rates, CareFirst BlueChoice has asked for a 22.8 percent increase, and All Savers Insurance requested a 4.8 percent increase. On the other hand, Kaiser is seeking an average 12.1 percent reduction for next year's rates, and Evergreen Health Cooperative is seeking a 10.3 percent reduction. Read more about insurers' rate change requests here.

The **Nevada** exchange says as of May 23, there were 48,711 confirmed enrollments into qualified health plans and 50,900 confirmed enrollments into dental plans, and the number of people who have paid is 35,712 and 30,094, respectively. The exchange — which recently opted to end its contract with lead vendor Xerox because of major problems that came up during the first open enrollment period — instituted a special enrollment period so that consumers could keep signing up until May 31.

Vermont's exchange is inking a contract with Optum to work through a backlog of "change in circumstance" issues, as 10,000 people who have gotten insurance through the exchange are impacted by problems, according to *VT Digger*. According to the news report, the exchange web site does not let consumers notify insurers if they experience one or multiple changes in circumstance, such as a divorce, marriage, birth, or address change. — *Rachana Dixit Pradhan*

CMS Moves On New Process To Get Exchange Subsidies To Insurers

CMS plans to institute a new system later this year for qualified health plan (QHP) issuers to calculate and receive payments of exchange subsidies, moving away from the manual process being used now because healthcare.gov's back-end systems are not complete, but the new process still falls short of the fully automated system that's supposed to be in place. Industry and other sources also tell *Inside Health Policy* that there's no clear date as to when the automated system will be functional.

CMS' effort to get the subsidy payment and reconciliation process working as it should was a topic of significant interest and discussion during a federally facilitated exchange issuer summit that the agency held on May 20, according to sources who attended the meeting or have knowledge about the discussions.

As envisioned, the payment process is supposed to involve CMS automatically issuing "820" payment files to the QHPs, which includes information on advance premium tax credits, cost-sharing reductions and federally facilitated exchange user fees. Any needed payment reconciliations also would take place. But because the exchanges' back-end systems were not — and still aren't — fully built, CMS in December revealed that it would be using a manual process for payment that relies on information from the plans themselves.

The decision was made so that insurers would still get subsidies starting in January, because at the time experts said it was crucial that all carriers — especially smaller insurers and the new Consumer Operated and Oriented Plans — receive subsidy payments on time. But reconciliation of the data was not taking place, and CMS essentially was relying on insurers' estimates on how much they should be getting in subsidy payments until confirmed exchange enrollment data became available.

The newer process for calculating and transmitting subsidy information to the plans would be semi-automated because the insurer would no longer calculate how much they need and then submit that information to CMS for payment. Rather, CMS would do its own calculation and send a file with the data, one industry source says. Another source says a contractor would work with CMS on the calculation but it's not clear which one.

There are still many questions about how the new process would work and CMS is planning to implement the new system in the fall, industry sources say. One industry source says the plan is to have two rounds of data cleanup and reconciliation, and then CMS will use its enrollment data to send member and policy-level data on subsidy payments to the plans going back to January.

It's still not clear when the fully automated system with the 820 forms, part of the exchanges' back-end system, will be instituted, another industry source says.

Under the enrollment and data template that insurers are submitting now to CMS in order to get subsidy payments,

QHP issuers must send issuer identification information, aggregate premium amounts, aggregate advanced payment of premium tax credit and cost-sharing reduction payment amounts, aggregate federal exchange user fee amounts, and the total number of effectuated enrollments. CMS then makes "estimated payments to the payee group on the best available data at the time of submission."

The process takes place on a monthly basis, and CMS recently issued the May through September schedule for the interim payment system.

One industry source says enrollment data — which is transmitted through "834" forms — is also undergoing a reconciliation process with a small number of insurance companies that have closely worked with CMS over the last several months. That reconciliation will be broadened to include more plans in the coming months, the source said.

House Ways and Means Republicans have tried to push HHS to reveal information on how many exchange enrollees have actually paid their premiums, and have justified their request based on the fact that HHS is receiving the aforementioned data from plans. HHS, however, has said that until the automated payment system is completed and CMS is able to access individual enrollment and payment information from 834 forms, the payment information that it is getting from insurers is neither final nor complete.

The big challenge is how the industry and CMS will address all of the payments that have been made so far to make sure that the subsidy levels are accurate, because reconciliation is not taking place now, says an industry source. It's a question of whether that will be done sufficiently for 2014, or if they'll just get things right for 2015.

Consumers could also face large headaches during the tax filing season next year if their subsidy levels were not accurate, and might be forced to pay back any overpayments.

Republicans are also slamming the Obama administration again for not having proper income verification systems in place to ensure that consumers who signed up for exchange plans get accurate subsidy amounts, and the House Ways and Means Committee has scheduled a June 10 hearing on the subject.

Committee Republicans have called on the Treasury Department to stop issuing subsidies until it can verify that individuals' incomes are accurate. Rep. Diane Black (R-TN) on Thursday (June 5) also reintroduced legislation that would require an income verification system to be established before any subsidies are given to reduce consumers' premiums and cost-sharing. The bill passed the House last year but was not taken up by the Senate. — *Rachana Dixit Pradhan*

NORD Pushes Cost-Sharing Limits, Off-Label Reimbursement, Part D Reform

The National Organization for Rare Disorders joins the drug industry in pushing against what it calls insurers' "prohibitive cost sharing structures" as the debate heats up over potential solutions to drug pricing concerns. In a white paper submitted to the House Energy and Commerce Committee recommending ways Congress could spur medical product innovation, the group pegs stemming prohibitive cost-sharing, ensuring reimbursement for off-label uses and creating a protected orphan drug class under Medicare Part D as top priorities.

The House committee is soliciting stakeholder comments as part a recently launched initiative to foster medical product innovation. NORD, in its May 30 white paper, urges lawmakers to focus on insurance practices and federal policies the group says are blocking access to orphan drugs. Echoing recent complaints by the Pharmaceutical Research and Manufacturers of America that insurers' cost -sharing structures are impeding access to drugs, NORD cites high cost-sharing structures within drug plans as one of the major obstacles barring patient access to orphan drugs.

"These prohibitive cost-sharing structures often involve upwards of 40 percent co-insurance on drugs placed on the highest tier within the formulary, also known as the specialty tier," the group says. "These co-insurance requirements require egregious out-of-pocket costs to be paid by the patient on drugs that are extremely expensive in the first place."

NORD said high out-of-pocket costs are an issue when therapies are not part of a plan's formulary, meaning co-pay limits are no longer applicable. Congress must address tiering structures if it wants to ensure patients will have access to innovative drugs, the group says.

An orphan protected class within Part D should also be established, the white paper advocates. NORD said CMS should add the class since there are generally few alternatives to orphan drugs. Providing protection for orphan drugs will ensure that rare disease patients are able to receive live-saving treatments under the Medicare program, the group said.

Further, NORD notes off-label uses to treat rare diseases are not being reimbursed and that the government "severely restricts" what drug companies can say about new research on off-label uses. Congress should seek new policies that permit drug companies to share appropriate information without fear of enforcement action, NORD said.

A court recently overturned Health Resources and Services Administration regulations that would have made orphan drugs used for off-label treatments subject to 340B program discounts.

NORD also calls for Congress to reform the institutional review board system to make it more transparent and apply uniform standards. Plus, the group says HHS should set up a rare disease ombudsman to serve as a point of contact for

rare disease patients and advise the HHS secretary about key issues like access to drugs and out-of-pocket costs.

NORD also calls for reinstatement of the HHS Orphan Products Board established under the Orphan Drug Act in 1983. Re-establishing the board would facilitate greater communication between FDA and the National Institutes of Health as the agencies work through the orphan drug discovery, development and approval process, NORD says. The board could also facilitate dialogue between FDA, NIH, CMS and the Department of Defense.

NORD also recommends Congress help improve clinical trial designs by establishing an office of clinical trial design at the National Center for Advancing Translational Sciences within NIH. Clinical trial design is important and especially important for orphan treatments that need innovative trial designs to accommodate small populations, the group says. NORD suggests sponsors could consult with experts at the new office, but adds that FDA must also be willing to accept the office's recommendations.

"In order to motivate sponsors to consult with this newly established office, the FDA must accept the new office's participation in the trial design during the product development process and consider recommendations from that office when determining its approach to reviewing the application for approval of the drug," the group writes.

Similarly, an office of clinical endpoints should be established at NCATS, NORD says. The office could consult with patient groups and companies and prevent them from investing in research with inappropriate endpoints and biomarkers.

NORD and other groups like the National Health Council have applauded House lawmakers for soliciting feedback from patients on the 21 Century Cures Initiative being lead by E&C Committee Chair Fred Upton (R-MI) and Rep. Diana DeGette (D-CO). The committee is slated to hold a hearing in incentivizing innovation Wednesday (June 11). — *Stephanie Beasley*

States Get OK To Delay Employee Choice . . . begins on page one

Additionally, a spokesperson for the Idaho Department of Insurance confirms that the state asked for a delay in 2015, but a CMS spokesperson says the Idaho exchange is responsible for making the decision because the state is a "supported state-based marketplace" this year.

Employee choice is viewed as one of the main, if not the biggest, consumer benefit of the SHOP exchange because it allows small business employees to have more flexibility to choose their health plans, but many employer groups and insurers have opposed the provision. HHS already delayed employee choice in 2014 for all federally-run SHOP exchanges, and in recent regulations it gave state insurance regulators in those states the option to delay employee choice for an additional year. CMS said that if an FF-SHOP state was asking for a delay, it had to show either that employee choice would result in significant adverse selection that could not be remediated by other ACA programs, or there was insufficient choice among qualified health plans or dental plans.

CMS has reiterated that the delay, if granted, would only be for one year, and HHS wrote in final regulations that it will require employee choice in all SHOPs in 2016 because the ACA requires it and adverse selection worries in the small group market may not play out. But some sources following the issue are skeptical that employee choice will really be implemented across all states even in two years.

State insurance departments that confirmed they did not ask for a delay in 2015 include: Arkansas, Florida, Georgia, Indiana, Iowa, Missouri, Nebraska, North Dakota, Ohio, Tennessee, Texas, Virginia, Wisconsin and Wyoming. CMS says employers in those states can offer employees either all medical plans across a single metal level and all dental plans across a single coverage level, or a single medical plan and a single dental plan.

Sources had anticipated that a large number of FF-SHOP states would ask CMS to not implement employee choice next year. Small Business Majority, in advance of the deadline for CMS to make its decisions, pushed back against states' requests and said HHS should be rigorous in its evaluation before granting any approvals. The group said the reasons most states gave were not strong enough to warrant a delay. — *Rachana Dixit Pradhan*

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Report Offers Dem Governors Options For Improving Medication Adherence

A report prepared for the Democratic Governors Association suggests policy options for getting Medicaid beneficiaries to take their medicine that include managing medication, coordinating prescription refills, allowing more time between refills and generally teaching people why they should do what their doctor tells them. The recommendations primary apply to Medicaid, but they could also apply to state employee health plans and exchange insurance, the report states.

The paper states that it's key to use medication therapy management only on those patients who need it. CMS recently scrapped a proposal to expand MTM in Medicare in part because plans complained that they would lose money if forced to contact enrollees who don't need the service. The medication-adherence coalition Prescriptions for a Healthy America is now working on a legislative proposal aimed at better targeting people who need MTM.

That coalition — which includes pharmaceutical, chain drug store and pharmaceutical benefit manager members — also contributed to the paper prepared for the Democratic governors. That paper says "super user" programs could offer MTM to the approximately 5 percent of beneficiaries who are in those programs. It points out that an evaluation of 14 super-user programs found that teaching medication adherence is a key feature in all of those programs so it's a natural step to go further with MTM. There also are 20 states with MTM programs that others states could look to, according to the paper.

The paper also suggests what it calls "comprehensive medication management," which requires providers to determine whether patients are getting drugs that treat their conditions, that medications do not interact badly with other medications and that patients are able to take their medicine.

"Because of the ongoing interaction between the patient and their CMM provider, this could lead to better improvements in health outcomes than MTM alone," the paper states.

A study of Vermont's comprehensive medication management pilot found that the state saved twice what it spent on the pilot.

So-called medication synchronization also could improve drug adherence, the report states. Filling all of a patient's prescriptions at once would increase the likelihood that they won't miss filling prescriptions. The report also states that pharmacists, prior to filling prescriptions, call patients to ensure the prescriptions are correct, which would give patients the chance to ask about their medications.

Synchronization also could be coupled with longer refills. Most states limit the number of days that medications can be supplied, but the paper argues that allowing longer supplies would reduce dispensing costs and improve adherence rates.

"To maximize favorable outcomes, Democratic Governors could consider synchronizing 90-day prescriptions to the same schedule, further reducing the patient's trips to the pharmacy and providing the opportunity for appointment-based synchronization services," the paper states.—*John Wilkerson*

Advocates Praise Franken Bill That Would Eliminate ACA 'Families Glitch'

Consumer advocates and others are praising the introduction of Senate legislation that would eliminate the ACA's so-called "families glitch," which blocks children and spouses from accessing subsidies on the exchange if one family member is offered affordable self-only coverage through his or her employer. Advocates have long called for the administration to take action to fix the glitch, but this is the first time Congress has stepped in to address the issue.

Sen. Al Franken's (D-MN) Family Coverage Act would allow families that get stuck in the glitch to have access to the subsidies. The bill has 20 co-sponsors and an aide to Franken says a companion bill is expected to be introduced in the House shortly. Consumer advocates hope to help gin up interest among Republicans and have set up meetings on Capitol Hill for the coming weeks, a source with First Focus says.

Still, Franken's aide believes the situation could also be addressed administratively by the IRS and HHS, and said the lawmaker will continue "on all fronts" to get the administration to act.

Currently, if an employee is offered individual coverage that costs less than 9.5 percent of household income and also has an offer of family coverage, that individual and their entire family are not eligible for premium tax credits on the exchange — even if the cost of family coverage exceeds that 9.5 percent threshold. IRS has outlined this position in regulations, but Franken, other Democrats and children's advocates strongly believe the regulations don't accurately reflect congressional intent.

"When we passed the Affordable Care Act, we intended that all working families should get affordable health coverage," Franken said upon introducing the bill, which has yet to be scored by the Congressional Budget Office. "Right now, many children and families in Minnesota and around the country could lose out on coverage because of the way that the Obama administration is misinterpreting the law. My legislation, which is supported by the Small Business Majority, the American Academy of Pediatrics, and many others, would give families access to tax credits if the cost of their family

coverage at work exceeds 9.5 percent of their family income. It fixes an unintended problem with the way the ACA is being implemented that is now preventing families from getting the coverage they need," Franken added.

Employers, however, have argued that IRS' regulatory interpretation is in line with how CBO and Joint Committee on Taxation scored the health reform bill. If the affordability test had been based on family, rather than self-only, coverage, the bill's cost would have been much higher, they note.

The legislation would not alter the employer requirement to offer affordable coverage, nor the worker's ineligibility for credits should that offer not be accepted. The aide to Franken says the bill would, however, reflect the true congressional intent of the provision by allowing families access to the subsidies if the contribution for family coverage exceeds 9.5 percent of household income.

The families glitch has been a major concern for advocates, who say that they've heard from sources in the states about how the glitch has affected people seeking affordable coverage for their families.

"The legislation would fix a glitch that has created a barrier to accessing health coverage for too many families," says Dick Woodruff, vice president of Federal Affairs for the American Cancer Society-Cancer Acton Network. "This bill aims to fulfill the intent of the law by allowing more families to access affordable, meaningful coverage with the help of financial assistance in the health insurance marketplaces," he adds.

This is a technical fix that really needs to happen because it has major real world implications, says Bruce Lesley, president of the children's advocacy group First Focus.

First Focus notes in a press release that the Government Accountability Office has already estimated that if the issue is not fixed, the glitch could deny coverage to 460,000 children. While individual-only employer-sponsored health insurance costs average around $5,400 a year, annual costs for family coverage average $15,000 — nearly triple. Thus children will remain uninsured because the IRS regulatory glitch denies their parents the tax benefit needed to afford coverage for the whole family, the release adds.

"Senator Franken's proposal offers a common-sense solution to a nonsensical problem, and we urge senators to support it," Lesley said. In addition to being thrilled to see the first piece of legislation that addresses the glitch, Lesley tells *Inside Health Policy* that he was pleased it had already garnered so many co-sponsors. While the bill is technically bipartisan because it has two Independent co-sponsors (Sens. Bernie Sanders (VT) and Angus King (ME)), he says his group is hopeful that it can bring on GOP sponsors as well, and has set up meetings for the coming weeks.

Ron Pollack, executive director of Families USA, was also pleased to see the legislation. This is a very sensible proposal that will give hundreds of thousands of families new choices, and that's a positive thing. It's clear that coverage for families is very expensive and the ACA could provide them with an alternative, but the current IRS rule precludes them from having that option.

Asked why he thought it took so long for Congress to act, Pollack pointed out that it is unclear that the bill will be acted upon. However, he says, that fact that the senator is introducing this bill could hasten the day that the matter will be given serious consideration. *— Amy Lotven*

PhRMA Targets Exchange Drug Cost-Sharing . . . begins on page one

enrollees lower cost sharing for medicines on the highest tier. In 10 percent of plans, individuals pay coinsurance of more than 40 percent for drugs on the highest tier.

"The high levels of cost-sharing for medicines and other services in many exchange plans that get additional federal money to provide cost-sharing reduction for the lowest income enrollees suggest that HHS has not, as of yet, provided sufficient guidance to plans to ensure that cost-sharing requirements for these low-income patients is affordable and allows them to access the health care they need," PhRMA spokesperson Allyson Funk told *Inside Health Policy.*

Cost-sharing reductions are available in the exchange for individuals with incomes between 100 percent and 250 percent of the federal poverty level; for 2014, that range is from $11,670 to $29,175 in annual income. When insurers develop silver plans to be offered on the exchanges — silver plans have a standard actuarial value of 70 percent — they must propose cost-sharing plan variations which have actuarial values of 73 percent, 87 percent and 94 percent, respectively.

A person's income will determine which plan variation they are eligible for, with the higher AV level generally translating into coverage that is more comprehensive and has lower out-of-pocket costs. The 94 percent AV level provides the highest amount of cost-sharing assistance to enrollees.

Avalere found that cost-sharing reductions are more frequently applied to multiple benefits in the 94 percent and 87 percent AV plans compared with 73 percent AV plans. Additionally, almost all cost-sharing reduction plans have lower deductibles than the standard silver plans. Yet low-income consumers could face very high coinsurance for drugs on tiers three and four, which the firm says is the least likely area to have reduced cost-sharing.

PhRMA, along with several patient groups including the AIDS Institute and Colon Cancer Alliance, on Wednesday (June 11) will hold an event to highlight new Avalere research on drugs in the exchanges. The AIDS

Institute is also one of two organizations — the other being the National Health Law Program — that have filed a discrimination complaint with HHS' Office of Civil Rights against four Florida QHP issuers because of how those insurers designed their exchange plan prescription drug benefits. The groups say CoventryOne, Cigna, Humana and Preferred Medical are violating the ACA and federal civil rights laws because their plans — specifically the cost-sharing that they have imposed for medications — discriminate against patients with HIV/AIDS.

The Avalere study, which was funded by PhRMA, suggests low-income consumers — people enrolled in the 87 percent and 94 percent AV plans — are likely to face high coinsurance rates for drugs on tiers three and four of their plan formularies. There is a trend among exchange plans to reduce medical deductibles, yet only slightly more than half of the plans alter enrollees' cost-sharing burdens for tier four prescription medications in the 94 percent AV plans. The firm found that a quarter of the 94 percent AV plans had coinsurance rates of 20 percent or more on the specialty drug tier.

One health consultant says the law imposes fairly specific requirements related to out-of-pocket spending for consumers but beyond that HHS essentially lets health plans meet actuarial value requirements however they see fit, though some state-based exchanges are requiring plans to have standardized benefit designs for their CSR plans. Out-of-pocket limits are ending up lower than what is allowed by the law and that will protect consumers, but there was an assumption that the cost-sharing reductions would just apply evenly to all services even though that is not the case, the consultant adds.

In general, plans are taking very different approaches to meeting actuarial value standards that are in the law, the source says. But they are just abiding by the rules they have been given by HHS.

In response to the Avalere study, America's Health Insurance Plans spokesperson Brendan Buck said, "What this study helpfully observes is that consumers have a wide range of plan options, including different cost-sharing arrangements, that allow them to choose the plan that is best for their families' needs. There's one simple reason why the cost of specialty drugs is an increasing challenge to consumers and the entire health care system, and that's the fact that drug makers are setting increasingly exorbitant prices for their medications."

AHIP and PhRMA have been engaged in a heated battle in recent weeks over drug pricing, spurred by the high-price of the breakthrough Hepatitis C drug Sovaldi. Insurers have repeatedly called on drug companies to lower drug prices, but the drug industry has countered that insurers' cost-sharing policies are impeding patient access to needed drugs. — *Rachana Dixit Pradhan*

Senate Confirms Burwell In 78-17 Vote, Following ACA-Centered Debate

The Senate as expected confirmed Sylvia Mathews Burwell as the next HHS secretary in a 78-17 vote Thursday (June 5), following hours of debate during which Democrats touted the benefits of the health law and expressed hope the GOP would pivot from seeking repeal to working on reforms. The reform caucus is growing, while the repeal caucus is shrinking, Sen. Tim Kaine (D-VA) said.

But even those who voted for Burwell made clear that their votes were not to be seen as an endorsement of Obamacare. "No one should misread my vote today as an acknowledgment that all is now right with the world of Obamacare and at HHS, because nothing could be further from the truth, " said Senate Finance ranking member Orrin Hatch (R-UT).

"But, Ms. Burwell has, for her part, acknowledged that problems exist and has committed to doing what she can to fix some of them," he added. Hatch specifically pointed to Burwell's pledge to be responsive to congressional inquiries, as well as her statement that the administration should use "the full extend of the law" to retrieve federal funds from vendors that failed to produce successful state exchanges.

Several other GOP members of Finance also supported the nominee, while two — Sens. John Thune (R-SD) and Pat Roberts (R-KS) — voted no.

Senate Minority Leader Mitch McConnell (R-KY) opposed Burwell and suggested that he would be against any HHS secretary-nominee at this point. The administration should focus on fixing the law rather than "focusing on a new captain of the Titanic," he said. — *Amy Lotven*

CMS Faces Fire From Republicans Over Glitches In Income Verification Systems

CMS on Wednesday (June 4) defended its efforts to verify income and other information provided by consumers who signed up for plans on the exchanges, saying that just because roughly 2 million enrollees had data discrepancies on their applications doesn't mean there's a problem with their enrollment. The move by CMS comes as House Ways and Means Republicans prepare to focus on the federal government's income and insurance verification systems at a June 10 hearing, and as House Energy and Commerce Republicans charged there are at least 4 million inconsistencies on the applications for coverage through the federally facilitated exchange.

CMS says that as of the end of May, 1.2 million enrollees had discrepancies with their annual income, 461,000 had citizenship inconsistencies and 505,000 had immigration inconsistencies. Most issues at this point have been resolved affirmatively or have needed additional documentation and CMS has not needed to terminate a consumer's enrollment,

CMS says. The agency anticipates working through "the majority" of data discrepancies for 2014 applications this summer.

CMS faced criticism last year over the income and employment verification systems it was putting in place for exchange coverage, after a final regulation said that in certain instances the exchanges could rely on individuals' self-attestations about employer-based coverage and income without further verification. Following the criticism, officials subsequently said that 100 percent of the income attestations that came from people seeking subsidized coverage through the federal exchanges would be verified.

But Energy and Commerce Republicans said Wednesday that documents from Serco — the contractor responsible for processing paper applications, verifying consumer information, resolving any conflicts and obtaining missing information — indicate that the exchanges were launched without a system to process inconsistencies in consumers' applications.

Lawmakers sent letters to HHS, Serco, Accenture and CGI on May 19 seeking information about inaccurate subsidy payments, after a *Washington Post* story said more than 1 million people who signed up through the FFE may have received incorrect subsidy amounts. A spokesperson for committee Republicans did not respond to a question about whether all of the 4 million inconsistencies were on applications for people who ultimately signed up for a plan, or whether they also included people who submitted applications but never enrolled.

In response to the story by the *Associated Press*, which first reported that more than 2 million people who signed up for exchange plans have data discrepancies associated with their applications, CMS spokesperson Aaron Albright said: "We are working with consumers every day to make sure individuals and families get the tax credits and coverage they deserve and that no one receives a benefit they shouldn't. Two million consumers are not at risk of losing coverage — they simply need to work with us in good faith to provide additional information that supports their application for coverage and we are working through these cases expeditiously." Albright defended the 2 million figure as the most up-to-date information.

The June 10 Ways and Means hearing will touch on whether the government's procedure to verify income and insurance information is adequate, so that premium tax credits are calculated accurately. Republicans said the hearing will also look at challenges individuals and employers will face during the 2015 tax-filing year because of the ACA's employer reporting requirements — which were supposed to be in effect this year but were delayed until next year by the Treasury Department — and the subsidy recapture process that takes place if an individual is given too much. Witnesses have not yet been announced.

Ways and Means Republicans have asked the Treasury Department to stop issuing ACA subsidies until it can accurately verify individuals' incomes, and GOP senators have voiced worries as well, though they stopped short of making the same request of Treasury. The HHS Inspector General by July 1 is supposed to provide Congress a report on the effectiveness of safeguards for preventing the submission of fraudulent information by people trying to enroll in exchange plans.

House Ways and Means Democrats pushed back against Republican efforts to criticize the ACA, saying the statutory language gives HHS 90 days to resolve any discrepancies with information. In a blog post, CMS Director of Communications Julie Bataille said the typical family of four generated 21 separate pieces of information that required verification, and all were attested to under penalty of perjury. — *Rachana Dixit Pradhan*

Group Seeks Further Tweaks To Expedited Process . . . begins on page one

of a final rule on exchange standards for 2015 and beyond that was released May 19. The agency did not address cost-sharing in the rule, but does indicate that it will do so in future guidance or rulemaking.

The National Health Council is pleased that CMS finalized the expedited process, but has concerns that the agency did nothing to ensure that once a drug is deemed medically necessary a patient will be able to afford it, says NHC Executive Vice President Marc Boutin. A particular biologic drug that works for a patient could cost thousands of dollars, but the patient may be required to cover the full cost — or potentially with a high co-insurance or co-pay. Additionally, any money spent on that non-formulary drug currently would not count toward the patient's annual out-of-pocket spending that the ACA caps, Boutin says.

Qualified health plans currently have an out-of-pocket spending limit of $6,350 for individual and $12,700 for family coverage in 2014. The amount increases to $6,600 for individual coverage and $13,200 for family coverage in 2015.

Boutin says HHS could have said that if a drug has been deemed medically necessary it should be provided on the same cost-sharing level as the preferred brand product, or that must count toward the out-of-pocket maximum. This is the policy under Medicare Part D program, he says, and in the letter the NHC specifically asks that CMS apply the same policy to QHPs.

Regarding the exceptions process, CMS says that an expedited process must be in place for patients who have "exigent" circumstances, which is defined as "when an enrollee is suffering from a health condition that may seriously jeopardize the enrollee's life, health or ability to regain maximum foundation or when an enrollee is undergoing a

treatment course using a non-formulary drug," the agency says. Issuers must be equipped to take such requests in writing, electronically or by telephone.

The enrollee or the prescribing physician seeking the exception must explain that an exigency exists and provide supporting justifications.

CMS also does not require plans to provide the non-formulary drugs during the exceptions review process, although some consumer groups had requested that policy. Lisa Swirsky, a health policy analyst with Consumers Union, says the group had hoped the drugs would be covered pending the resolution of appeal, but the group was pleased to see CMS institute a "consumer-friendly" turnaround time.

The general concern with the exceptions process is that CMS needs to strike a balance of making sure that consumers have access to needed drugs while not "upending" insurers' abilities to use the formulary to restrict drugs that don't offer additional benefits as a way of controlling costs, Swirsky said.

CMS earlier this year backed off a proposal to give exchanges the authority to require that plans cover any non-formulary drug for the first 30 days of coverage. Instead, in its 2015 final letter to exchange plans released in March, the agency merely encouraged plans to cover drugs for the transitional period, and noted at the time that it was considering creating the 24-hour exceptions process.

Insurers in their comments on the proposed rule argued that exceptions processes already exist and said they did not understand why the agency believed it needed additional regulations.

"Rather than promulgating new regulations in an area where CMS already has requirements in place, and where currently the problem appears to be anecdotal, CMS should use its oversight authority to determine the extent of the problem and whether this can be corrected by working with issuers to ensure the current requirements are implemented in an appropriate manner, or if additional regulations are needed," America's Health Insurance Plans wrote. AHIP also pointed out that exchange plan drug formularies are available, so patients prior to enrollment should be able to use the formularies to purchase a plan that best meets their current and expected drug needs. *— Amy Lotven*

News in Brief

E&C Panel To Probe Provider Access At Thursday Hearing On ACA

The House Energy & Commerce health subcommittee will hold a hearing Thursday (June 12) titled "The President's Health Care Law Does Not Equal Health Care Access," according to a committee release. The exact topic of the hearing is unclear, and the committee has yet to announce who is testifying.

However, subcommittee Chair Joe Pitts (R-PA) indicated that Republicans plan to bring up narrow networks. "Among the president's many broken health care promises was the assurance that, 'If you like your doctor, you will be able to keep your doctor,' a promise one of the law's chief architects has admitted would not hold true," Pitts said.

The release cites a news reports that 70 percent of exchange plans offer fewer hospitals and doctors than employer-sponsored group plans or individual market plans that were on the market prior to the law. It also refers to an editorial by Scott Gottlieb, who was a medical adviser at CMS and FDA during the George W. Bush administration, complaining about "the uncertainty around drug costs and coverage" under the health law.

Gottlieb often testifies at congressional hearings.

— John Wilkerson

CBO: 4 Million To Pay $4B In 2016 Due To Individual Mandate Penalty, But Most Uninsured Exempt From Penalties

The Congressional Budget Office estimates that in 2016 about 4 million people will pay roughly $4 billion in individual mandate penalties because they are uninsured, according to a new analysis released Thursday (June 5) that was promptly blasted by Senate Finance Ranking Republican Orrin Hatch (UT). On average, an estimated $5 billion will be collected per year in penalties between 2017 and 2024, CBO said.

The budget office said the estimates are lower than the last time it ran calculations, because about 2 million fewer people will pay the penalty as the number of individuals who will be exempt from the individual mandate has increased. This is partly a result of HHS' expansion of exemptions that consumers can claim and changes in the economic outlook.

CBO says about 30 million nonelderly residents will be uninsured in 2016 but most of them — 23 million — will be exempt from the penalty. Of the remaining 7 million uninsured, CBO anticipates that some will be granted exemptions because of hardship or other reasons.

Hatch said in a statement: "Under the onerous individual mandate alone, millions of Americans are now expected to pay up to $44 billion more in penalties over the next decade for a mismanaged healthcare law that is barely functional. From failed state exchanges to being kicked off their health insurance, American families continue to bear the brunt of bad policy."

— Rachana Dixit Pradhan

Medicaid & CHIP Grow By 1.1 Million In April

Medicaid enrollment continued to increase between March and April, according to CMS' monthly Medicaid and CHIP enrollment report for April, with 1.1 million additional people enrolled in 48 states' Medicaid and CHIP programs. The report, released June 4, says that 6 million more people were enrolled in Medicaid or CHIP in April than in the period right before open enrollment started.

Medicaid programs grew more in states that adopted the

Affordable Care Act expansion, which CMS Medicaid chief Cindy Mann notes in a CMS blog has been the case for months. Enrollment in expansion states rose 15.3 percent compared to enrollment between July and September last year. States that have not expanded Medicaid reported a 3.3 percent increase in enrollment.

The report notes that the data is still preliminary. — *Michelle M. Stein*

HHS To Award $300M To Community Health Centers For Expanded Services

HHS on Tuesday (June 3) announced it will award up $300 million in grants to community health centers to expand primary care capacity to support new patients and also expand services to cover oral, behavioral, pharmacy and vision services for new and existing patients.

Grantees are required to show how they will expand services, either through extended hours or hiring additional providers, and have the option of using the funding to provide the oral, behavioral, pharmacy or vision services.

"Health centers are key to the Affordable Care Act's goal of expanding access to health care," HHS Secretary Kathleen Sebelius said in a statement. "They are critical providers of care and have also been instrumental in linking people to coverage through the Health Insurance Marketplace. Health centers provided enrollment assistance to more than 4.7 million people since last fall."

Health centers are asked to apply for the grants by July 1, and the Health Resources and Services Administration intends to award the funding by September. — *Amy Lotven*

CT Gets New Exchange Plan; Premium Rate Changes Run Gamut

Connecticut's state-based heath exchange now has four issuers seeking to offer products in 2015, up from three carriers this year because UnitedHealth Care has decided to step into the mix. Initial 2015 rate filings show two issuers seeking low double-digit rate increases and the third — Healthy CT, the state's CO-OP — proposing to decrease rates by 8.9 percent.

Last year, Access Health CT had three offerings in the individual market — from Anthem, Healthy CT and ConnectiCare Benefits — all of which are also seeking to offer products for the second year.

Healthy CT, one of the 23 Consumer Operated and Oriented Plans that were established by the ACA, says in its filing that the average 8.9 percent decrease — for plans both inside and outside of the exchange — would affect 7,248 policies. The CO-OP says that because it is new to the market and has no experience on which to base 2015 rates, Milliman developed them manually using data sources and modeling. The company says that while it anticipates a medical trend increase of 5.2 percent, other factors resulted in the downward rate adjustment, including an expected relaxing of consumers demand for services. The company also opted to spread out administrative expenses and fees over a three-year period, instead of one policy year, which results in a lower fee charge per member per month, according to an executive summary of the filings created by the state's department of insurance.

Anthem Health Plans is proposing a 12.5 percent rate increase, which the company says takes into account the medical cost trend — which it estimates at 8.4 percent — as well as several other factors related to the health law, such as new rating rules and taxes and fees. The increases, if approved, would affect 66,200 policies.

Unlike Healthy CT, Anthem does not expect the pent-up demand to decline, instead assuming continued demand for services in the second full year of the ACA.

Anthem also is accounting for the cost of certain over-the-counter drugs obtained with a doctor's prescription that it plans to cover 100 percent.

The company's projections also factor in the expected costs of the Hepatitis C drug Sovaldi, which it expects will be needed for few members, but will still account for large expenses to due the high cost of the drug. The dosage regimen for Sovaldi, which runs 12 weeks, costs $84,000.

ConnectiCare is requesting an 11.8 percent increase which would potentially affect 27,500 policies. The company says that the increase is based on increasing medical costs and greater demand, and estimates a 10.7 percent impact from trend. The company is also accounting for a $14.68 per member per month cost due to fees and taxes.

UnitedHealth Care is entering the exchange for the first time next year. According to the insurance department's executive summary of the filing, United used experience from its affiliated small group carriers to calculate rates. Base premiums, according to filings, range from $382 to $490, depending on the rating area.

The company says that its pricing is projected to meet the federal medical loss ratio of 80 percent for individual plans, and also says that taxes and fees will account for about 7.3 percent of its rate calculation, according to the summary.

The rates are proposed and the filings are open for public comment until June 23. A spokesperson with the department says that exchange small group filings are expected to be posted later this week. — *Amy Lotven*