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OUTLOOK 2016: Growth of ACA Marketplaces, Viability of Plans Top Issues

The top issues for health insurers in 2016 will be whether the Affordable Care Act marketplaces can grow at a stronger pace and whether they can attract a younger population as the law's penalties for not having qualified coverage sharply increase.

Top Issues for Insurers in 2016

A survey of Bloomberg BNA's Health Insurance Report advisory board members as well as other health-care industry leaders determined that the top 10 health insurance issues for 2016 are:

1. Will the Affordable Care Act marketplaces be able grow at a faster pace than they have been?
2. With many ACA marketplace plans losing money, how viable are the marketplaces?
3. Will issuers ask for sharper increases when they file their 2017 rate requests early in 2016?
4. Will increased penalties in 2016 drive more people, especially younger people, to the marketplaces?
5. What will be the effect of pharmaceutical prices—especially specialty drugs—on health insurance plans?
6. In light of the hit on new plans, what changes will the Department of Health and Human Services make to the ACA premium stabilization programs?
7. What changes will be made on network requirements?
8. Will the government allow health insurance mergers, and if so, what will be the impact?
9. Will insurers be able to create more value?
10. Will the CO-OPs survive?

Another major issue is whether health insurers offering plans in the marketplaces can be profitable. UnitedHealth Group Inc. has threatened to pull back from the marketplaces in 2017, although other major national insurers have indicated they believe the marketplaces are viable.

Other top issues include pharmaceutical prices (especially specialty drugs); whether the government will allow four of the top five national insurers to consolidate into two plans; what changes may be made to the ACA's premium stabilization programs; and whether government-funded CO-OPs set up under the ACA will continue.

The third open enrollment period began Nov. 1, 2015, and continues through Jan. 31.

Uncertainty About Marketplaces

In the third year of the ACA health insurance marketplaces, uncertainty will continue to ''plague'' health insurers as enrollees drop in and out of coverage and premium requests will be ''all over the place,'' Paul Keckley, a managing director of Navigant Consulting Inc.'s health-care practice, told Bloomberg BNA. Keckley is based in Navigant's Chicago office.

''Related to that will be the stability of the individual market at the state level,'' Keckley said. ''It's the riskiest market for insurers, and the law made it riskier.''

Illustrating his contention, Keckley pointed to attempts by about a dozen states to lower the threshold for the ACA's medical loss ratio when the provision was first implemented in 2011.

Under the medical loss ratio requirement insurers must spend at least 80 percent of premiums on medical claims or quality improvements or refund the difference to consumers annually.

The states asking for relief feared the threshold was so high many of the individual plans would leave the risky markets, which are characterized by enrollees who aren't able to obtain insurance through employers.

Individual Market Not 'Attractive, Sustainable.' The combination of the medical loss ratio as well as ACA age bands that limit the amount of additional premiums insurers can charge older, higher-cost enrollees ''makes the individual market not attractive and not sustainable for the insurance industry,'' Keckley said.

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The ACA's premium stabilization programs were intended to solve those problems, Keckley said.

''Had that worked as planned maybe [the individual market] would have been less volatile, but it hasn't,'' he said.

The Department of Health and Human Services has so far paid less than 13 percent of claims filed by insurers for the temporary risk corridor program for 2014, and the permanent risk adjustment program has hit hardest the nonprofit Consumer Operated and Oriented Plans (CO-OPs) set up under the ACA with government funding as well as new, small plans.

The low risk corridor payments contributed to the failure of many of the 23 CO-OPs: 12 have failed and two more have capped enrollment for 2016.

While HHS Secretary Sylvia Mathews Burwell's estimate that about 10 million people will be enrolled in ACA marketplace plans at the end of 2016 is reasonable, Keckley said, ''they keep ratcheting back that number.''

The HHS's estimates are well below Congressional Budget Office estimates that 21 million would be enrolled in the plans by the end of 2016.

''They've discovered that not as many young invincibles are ready to jump into the insurance market,'' Keckley said. ''It's the cost. If you're not getting a tax credit to pay 75 percent of the premium it's going to cost you a couple of hundred dollars a month at the cheapest and most of these kids think they can just take their chances.''

The marketplaces have struggled to attract the broad mix of younger, healthier, low-cost enrollees that are needed to keep premiums low while covering older, higher-cost enrollees.

Increased Penalties. But Benjamin Isgur, who leads the regulatory center of PricewaterhouseCoopers LLP's Health Research Institute (HRI), told Bloomberg BNA that a ''big driver'' for 2016 sign-ups in the marketplaces will be the ACA's increased penalties for not having minimum essential coverage for themselves and their dependents.

For 2016 the penalty rises to $695 per adult and $347.50 per child up to $2,085 for a family, or 2.5 percent of family income, whichever is greater.

A ''big driver'' for 2016 marketplace sign-ups will be the ACA's increased penalties for not having minimum essential coverage for themselves and their dependents.

—Benjamin Isgur, PricewaterhouseCoopers LLC

''Those penalties are something that people are going to take into account much more because they have reached that point where it's a big chunk of money for many individuals and families,'' Isgur said.

In addition, Isgur said, ''providers have become pretty sophisticated in setting people up with navigators and helping people find insurance. It's in their interest that people be signed up.''

The greatest impact on enrollment will be the economy, Howard Wizig, president of technology company Vivius Holdings LLC, told Bloomberg BNA. Increased employment will result in more employer-based insurance, he said.

Premiums Picking Up. Deloitte Consulting LLP estimates ''that we will again see some fairly significant increases'' in exchange premiums when insurers file rate proposals for the 2017 plan year, Gregory Scott, the U.S. health plans sector leader in the Pittsburgh office, told Bloomberg BNA. In prior years the rate proposals have been filed in the early months of the year.

''We expect that many plans will need to get a 10 percent or greater increase in their products in the next premium rate approval cycle in order to hit their financial plans.''

—Gregory Scott, Deloitte Consulting LLP

Deloitte's actuarial practice has conducted premium modeling.

''We expect that many plans will need to get a 10 percent or greater increase in their products in the next premium rate approval cycle in order to hit their financial plans,'' Scott said.

''There are a number of plans that dug themselves a fairly significant pricing hole,'' pricing their products aggressively while ending up with less-healthy enrollees, Scott said.

While plans generally forecast losing money for up to three years when new products are launched, ''plans are generally experiencing more red ink than they have anticipated,'' he said.

Indeed, Standard & Poor's Ratings Services released an article, ''Two Years In, The ACA's Impact On Health Insurer Ratings Remains Limited,'' concluding that, ''with few exceptions, ACA business has been unprofitable for health insurers.''

However, the article said, ''this business is only a small part of the overall commercial health insurance market and is an even smaller part of the privately insured marketplace (which includes managed Medicare and Medicaid).

As we expected, the impact of ACA business on a given health insurer's overall operating performance has typically been tied to the proportion of ACA business in the insurer's total book. This explains the ACA's

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much smaller overall impact on the operating performance of large, national players (Aetna, United, Cigna, and others) than on single-region Blue plans.''

Premiums are driven by underlying health-care costs, known as medical cost trend. The HRI forecasts that medical cost trend for employers will grow 6.5 percent in 2016.

''That number is growing because there are more insured,'' Isgur said. ''Trend is going up but not at the same rates as what we've seen in past years.''

The HHS has touted the marketplaces' relatively low premiums when ACA tax credits are factored in. But for people earning more than 250 percent of the poverty level the subsidies are often not enough to make the plans affordable, and Keckley expects premiums to start rising more sharply as plans file rate proposals for 2017.

The Robert Wood Johnson Foundation and Manatt Health Solutions recently released comprehensive data, ''HIX Compare 2015-2016 Datasets,'' that included information on all plans offered in the health insurance marketplaces in 2015 and 2016.

The data showed that the average overall premiums for a silver tier plan increased 11.3 percent to $296 a month from 2015 to 2016, while premiums for the lowest-cost silver plan increased 12.4 percent to $253 a month.

Cost and Value. In a video posted online by health-care consulting firm Avalere Health, Caroline Pearson, senior vice president of strategy and policy, said the two overarching themes for the health-care industry in 2016 will be cost and value.

Pearson said three main policy themes are emerging: increased price transparency, value-based purchasing and efforts to reduce consumer out-of-pocket costs.

''Health plans are facing increased regulatory pressure around both benefit design and network adequacy while at the same time consumers continue to clamor for lower premiums,'' Pearson said.

''Health plans are responding with a variety of strategies, including business strategies around mergers and acquisitions and policy solutions for things like changing the risk adjusters,'' she said.

Health plans also are continuing to push providers into payment arrangements that are intended to reward value instead of volume. The CMS has set a goal of making 30 percent of Medicare payments through alternative payment models by 2016, which health insurers have called for.

''The question that remains is how those reimbursements will be structured and how we'll measure clinical quality,'' Pearson said.

Health plans, Pearson said, ''need to understand the underlying risk of their enrollees in order to manage financial performance.''

Effect of Drug Costs. ''Insurance folks are really watching specialty drug costs,'' Keckley said. ''That's the biggest single line-item increase,'' accounting for an approximately 12 percent increase in 2015, he said.

''Increases in drug prices and utilization—especially for new specialty pharmaceuticals—will continue to put upward pressure on health insurance plans in 2016.''

—Edith Rosato, Academy of Managed Care Pharmacy

Edith Rosato, chief executive officer of the Academy of Managed Care Pharmacy (AMCP), told Bloomberg BNA, ''Increases in drug prices and utilization—especially for new specialty pharmaceuticals—will continue to put upward pressure on health insurance plans in 2016.''

Health plans working with managed care pharmacists ''must examine the implications of use of these medications in individuals by examining clinical trials and evidence,'' she said.

The AMCP represents pharmacists and others who work in managed care settings, including health plans, pharmacy benefit management companies, consultants, union health plans and large employers.

Wizig said it's ''possible that pharmaceutical manufacturers may pause their price increases in order to avoid more negative publicity between now and the 2016 elections, but eventually they will resume their practice of increasing price.''

Price increases ''have very little impact on demand since drug copayment and coinsurance out of pocket maximums make the patient insensitive to the cost of the drug,'' he said.

One of the most effective tools insurers and pharmacy benefit managers have to reduce prescription drug costs is to restrict drugs they cover on their formularies, Wizig said.

However, ''the use of restrictive networks is a target that politicians use to vilify insurers,'' which limits the ability of insurers to use the tool.

And, while Republican presidential candidates have continued to focus on efforts to repeal and replace the ACA, Democratic candidates, notably Hillary Rodham Clinton, have focused on controlling drug prices.

Premium Stabilization Programs

Many insurers will be pushing the HHS to make changes in the ACA's premium stabilization programs in 2016.

The so-called premium stabilization programs, two temporary programs and one permanent program that intended to protect insurers who cover sicker-than-average enrollees under the law's guaranteed issue requirements, are ''a source of great contempt for the insurance folks,'' and are contributing to pressure to raise premiums more in 2017, Keckley said.

Rate proposals had already been filed when the Centers for Medicare & Medicaid Services issued its report in June 2015 announcing low risk corridor payments.

The premium stabilization programs have ''not worked out as imagined; nor have the policymakers and

the regulators been willing to make some concessions,'' Keckley said.

Indeed, appropriations legislation for 2016 continues a 2015 provision blocking the HHS from using money from sources outside the risk corridor program to finance it. The risk corridor program ends at the end of 2016, while the risk adjustment program is permanent.

Insurers now feel, ''If that's the way it is, jack my premiums up or just suspend plans altogether,'' Keckley said.

He predicted ''some back-room dealing'' as the HHS attempts to ''mitigate any negative distraction'' during the 2016 presidential election in the fall.

Pricing, Market Participation. ''The insurers have been loud and clear that the funding that they thought they were going to get for taking on these higher-risk patients—the more costly newly insured—is not coming to fruition,'' Isgur said. ''It leaves insurers with some interesting questions for the next months—how are they going to price differently, which markets to exit, which to enter, where are new opportunities? Do you continue to make a play for volume and accept some of that risk or make a play for price and exit some of those markets?''

In its proposed Notice of Benefit and Payment Parameters for 2017, the CMS proposed updating 2017 risk adjustment factors to incorporate data on the use of preventive services and prescription drugs and it proposed a lower default risk adjustment charge beginning in 2016 for small issuers in a state's individual and small group markets.

Network Requirements

Expect to hear more debate about narrower networks in the marketplaces as the CMS makes a push for more stringent requirements on health plans in its 2017 benefit and payment parameters proposed rule, which will likely be finalized early in 2016.

Under the ACA, developing more cost-efficient provider networks and drug formularies are among the few methods insurers have for keeping premiums low since the law prescribes a comprehensive set of essential health benefits that must be covered without charging people with health problems higher premiums than healthier people.

''You have a double whammy on the exchange side in that many of these consumers have never had insurance before'' and they're choosing the lowest premiums because they're not familiar with cost sharing, Isgur said.

Out-of-pocket costs for doctors' visits or hospital charges are ''really starting to surprise some of the consumers,'' he said.

Consumer Concerns. Regulators, politicians and advocacy groups ''are listening'' to consumers' concerns about narrow networks, Isgur said.

Whether that will result in major regulatory changes in 2016 is unclear, ''but I think it's certainly on the table,'' he said.

''The federal government is going to have to proceed with caution on this topic,'' Deloitte's Scott said.

Adequate choice and access to providers are important goals, but so are ''having networks composed of high-quality providers, not any willing provider,'' he said.

The HHS is placing greater emphasis on value-based payment arrangements, which ''require health plans to make choices and develop collaborations with specific providers,'' Scott said. ''That sort of partnership that really provides the greatest value-based impact by necessity requires more narrowly defined networks . . . Bigger is not always better.''

Moreover, ''Plans are already struggling with financial performance, even in some cases with some narrow networks,'' Scott said. ''If the government tries to inhibit narrow networks I think that more plans are going to have to take a harder look at whether or how they participate on exchange products.''

Any Willing Provider Requirements. ''Limited networks are among the negotiating levers that insurers may use to lower costs to consumers,'' AMCP's Rosato said. ''Legislative and regulatory efforts on both a federal and state level often make it difficult to implement limited networks through efforts to enact any willing provider laws and regulations.''

Those requirements generally allow for most or all providers in an area to participate in networks under the terms offered to other providers, and the Federal Trade Commission has assessed such laws to restrain a network's ability to offer lower costs, she said.

In the 2017 benefit and payment parameter proposal the CMS proposed allowing states with federally facilitated marketplaces to select their own network adequacy standards.

Alternatively, default time and distance standards would be applied to issuers applying for qualified health plan certification in federally facilitated marketplace states that don't implement a standard that meets HHS qualifications.

Network adequacy requirements are ''a key component'' of the CMS proposed rule, Rosato said. The proposal suggests that plans meet minimum CMS requirements for network adequacy or be subject to additional CMS scrutiny, she said.

''These provisions are vague and confusing,'' she said.

While pharmacy network standards aren't included in the proposed rule, ''organizations that represent health plans and pharmacy benefit management companies will continue to examine these provisions,'' Rosato said.

The Health Benefit Plan Network Access and Adequacy Model Act adopted by the National Association of Insurance Commissioners in November 2015 as a suggested model for states ''recognizes that health benefit plans may limit the size of their networks but establishes safeguards to ensure that the network provides the necessary access and is adequate,'' she said.

More Network Restrictions. The proposed rule means ''HHS is already indicating that it will impose more regulatory restrictions on network arrangements,'' George Strumpf, of EmblemHealth Inc., told Bloomberg BNA. ''HHS intends to nibble at the regulatory margins by proposing additional time and distance standards,'' as well as ''prospective minimum provider-covered person ratios for the specialties with the highest utilization rate for its state,'' he said.

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—GEORGE STRUMPF, EMBLEMHEALTH

The HHS proposal also includes ''new network adequacy standards that address patient cost sharing when an individual receives care from an out-of-network provider'' such as an anesthesiologist or a pathologist in an in-network facility, Strumpf said.

''In response to advocacy demands from providers and consumer groups the insurance industry can expect additional and more intrusive/costly regulations,'' he said.

Politicians and provider groups such as the American Medical Association and the American Hospital Association ''will push for broader networks, since it is an easy concept for the public to understand,'' Vivius's Wizig said. ''In reality such requirements will result in higher prices, because by limiting the ability of the insurer to get providers to 'compete' to be in the provider network, providers will be able to negotiate higher prices.''

Mergers and Acquisitions

Strumpf lists mergers and acquisitions as one of the top issues in the health insurance industry in 2016.

''The five largest insurers have a national market share of at least 83 percent,'' he said. If the proposed mergers are approved between Anthem Inc. and Cigna Corp. and between Aetna Inc. and Humana Inc., the remaining three companies, including UnitedHealth Group Inc., would have a market share ''approaching 85 percent,'' he said.

Local market concentration has been above Department of Justice and Federal Trade Commission recommendations for competitive markets since 2012, Strumpf said.

''Approval of the proposed mergers will consolidate commercial and Medicare Advantage enrollment into a handful of plans who will have significant leverage over providers,'' he said.

Keckley expects ''some tough negotiations'' between the Blue Cross and Blue Shield plans and Anthem ''in how they operate, especially since Cigna is a competitor to many of the Blues.''

Medicare Advantage

Despite a potential negative impact due to increased market consolidation, the outlook for Medicare Advantage in 2016 appears healthy, with continued enrollment and a net increase in plan entry.

Industry eyes will be focused on the CMS as staff prepares policies that attempt to make quality ratings and payment more equitable for MA plans that enroll a higher proportion of beneficiaries who are lower on the socioeconomic scale.

The Market. With the announcement in the April 2015 rate notice that Medicare Advantage rates will rise by an average 1.25 percent in 2016, observers expect the program to have another good year.

In its annual analysis released in mid-December, the Medicare Payment Advisory Commission, which advises Congress on Medicare policy, found that MA enrollment grew 6 percent in 2015, a few percentage points lower than in previous years, but significantly higher than fee-for-service enrollment.

''Since 2006, enrollment has more than doubled and plans project continued growth for 2016,'' MedPAC said.

Ins and Outs. The Kaiser Family Foundation (KFF), in its end-of-year study, said 203 plans that were available in 2015 will be exiting the Medicare Advantage market, and 259 plans will be offered for the first time.

As examples, Cigna has a new zero-premium plan in Kansas City, Mo. In Colorado, Anthem Blue Cross Blue Shield has a new health maintenance organization and a special needs plan for beneficiaries dually eligible for Medicare and Medicaid.

On the West Coast, Stanford Health Care is launching a new plan in Santa Clara County, Calif.

Net Increase. In 2016, 2,001 Medicare Advantage plans will be available for individual enrollment, 56 more than in 2015, KFF said.

''With steady growth and higher payment rates, 2016 will be a good time for health plans to be in the Medicare Advantage business.''

—JOHN GORMAN, HEALTH-CARE CONSULTANT

''With steady growth and higher payment rates, 2016 will be a good time for health plans to be in the Medicare Advantage business,'' John Gorman, a health-care consultant, has said.

Sean Cavanaugh, CMS's deputy administrator and director of the Center for Medicare, characterized the 2016 outlook for the program as bright with a projected 17.4 million enrollees, up by 1 million from 2015.

Tom Kornfield, a vice president at Avalere and a health-care consultant, told Bloomberg BNA that although the exact 2016 enrollment won't be known until February, it appears that plans have weathered ACA cuts well, with a good percentage offering zero-premium plans.

This indicates they were able to tweak their benefit packages to make them more efficient, he said.

MA Concerns. In February, the CMS will release its proposed rate notice for 2017.

Although the agency in December 2015 released underlying numbers that showed a possible increase for 2017, Mara McDermott, a vice president of federal affairs at CAPG, told Bloomberg BNA that the growth numbers indicated in the notice are preliminary. CAPG is a trade association for accountable physician organizations.

She said she's concerned about other factors that could negatively impact rates, such as risk adjustment,

coding intensity and a curtailment of the use of home health risk assessments.

Kornfield, a former CMS staffer, said once final payment rates are unveiled in April it will determine how the agency may alter its policies. A rate increase might lead to a policy initiation that could have a negative impact on overall plan payments.

Consolidation Impact. Others see possible darkening clouds in the MA market created by pending large mergers in the industry.

''The aggregation of this program has really multiplied very quickly,'' Gorman said. With the pending mergers between Aetna and Humana and Anthem and Cigna, other companies in the MA industry will be ''fighting against much bigger entities,'' he said.

The Kaiser Family Foundation said that, while the four firms' products differ from one another, their combined share of the Medicare Advantage market means that the acquisitions could have important implications for the MA program.

Aetna and Humana accounted for 26 percent of MA enrollees in 2015, while Anthem and Cigna accounted for about 6 percent, KFF said.

Market Variation. Kornfield said the impact of merger activity depends on the market. In some cases, fewer plans could mean more negotiating leverage over hospitals.

KFF said that although the average Medicare beneficiary will be able to choose from many plans, in some areas these plans will be offered by just a handful of firms.

UnitedHealthcare, Humana, Blue Cross Blue Shield and its affiliated companies, Kaiser Permanente, Aetna, Cigna and Wellcare accounted for almost three-quarters of MA enrollment in 2015, KFF said.

Regulatory Changes. In the policy arena, Vanessa D. Pawlak, a principal at Ernst & Young LLP, told Bloomberg BNA that ''CMS needs to make sure that plans are not unfairly penalized for enrolling dual eligible and low-income beneficiaries, which has been a challenge for most health insurers nationwide.''

The CMS stated in 2015 that it will ''continue to work diligently'' to address complaints from plans with high enrollment of the low income that they are disadvantaged in receiving bonuses that stem from star quality ratings.

The star ratings on the Medicare Plan Finder website inform beneficiaries about the performance of MA and Part D prescription drug plans, as well as serve as the basis of quality bonus payments for MA organizations that score at least four stars on a one-to-five scale.

Request for Comments. In the last quarter of 2015, the agency released a request for comments on changes to the 2017 star ratings system, including asking about assistance for MA organizations and prescription drug plan sponsors that contend that enrolling a high percentage of low-income enrollees or those who are disabled and under 65 hurts their ability to achieve high star ratings.

The CMS has engaged the National Committee for Quality Assurance and the Pharmacy Quality Alliance to examine measure specifications to determine if changes are needed.

In addition, the IMPACT Act (Pub. L. No. 113-185) instructed the HHS Office of the Assistant Secretary for Planning and Evaluation to conduct a study before October that would examine the effect of individuals' socioeconomic status on quality measures and resource use in Medicare.

Concerns About Underpayments. Also in the last quarter of 2015, the CMS said that, in response to concerns, it has undertaken an evaluation to assess how well its risk adjustment model predicts plan costs for dual eligible and other low income beneficiaries.

Under risk adjustment, the Medicare program reimburses managed care plans based on the health status of their members as well as other demographic factors.

''In recent years, there has been an increased focus among some plans on exclusively serving the dual eligible population and CMS feels it is an appropriate time to revisit the model,'' the agency said.

Rather than looking at all beneficiaries the same, the CMS is considering separate segments for six population groups. These include full benefit dual eligibles, who are eligible for full Medicaid benefits, and beneficiaries who are eligible for partial benefits.

''Our analyses indicate that this revised model would improve predictive performance for aged and disabled full benefit dual, partial benefit dual, and non-dual beneficiaries in the community,'' the CMS said.

Seeking Value in MA. Also during 2016, the CMS will review applications and prepare plans for a new program that will be tested in seven states starting in 2017.

The five-year Medicare Advantage Value-Based Insurance Design, or MA-VBID, is intended to allow plans to offer benefit packages aimed at improving quality of care and reducing costs for beneficiaries with certain conditions.

Applications are due to the CMS on Jan. 8 and participants will be named in March.

''The MA-VBID model will test whether the flexibility to offer clinically-nuanced VBID elements in Medicare Advantage plan benefit designs will lead to higher quality and more cost-efficient care for targeted enrollees,'' the CMS said.

Currently, requirements for uniformity in MA benefit design bar approaches based on health status or other enrollee characteristics.

Value-Based Modifier. Provisions on MA comprise a relatively small percentage of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), which ended the physician sustainable growth rate payment system. However, the law does require the CMS to submit to Congress a study on the feasibility of integrating alternative payment models in Medicare Advantage.

Due July 1, the study would discuss the feasibility of including a value-based modifier and whether such a modifier should be budget neutral.

Congress wants to know ''how we align what is happening in Medicare fee-for-service alternative payment models with what's going on in Medicare Advantage,'' CMS's Cavanaugh said.

The agency will be asking for suggestions from the industry, he said.

MACRA also requires the Government Accountability Office to compare the use of quality measures under fee-for-service Medicare, the Medicare Advantage program and private payer arrangements. It will make rec-

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ommendations on how to reduce the administrative burden involved in applying quality measures.

Part D Drug Program

The new year ushered in a new regulatory requirement for disclosing drug pricing that one pharmacy representative described as huge. Pharmaceutical prices remain the major topic for Medicare beneficiaries, and the CMS will try to ignite interest in medicine counseling programs through a new model that offers a prospective payment for more extensive interventions.

Generic Drug Reimbursement. Starting Jan. 1, Part D drug plan sponsors and their pharmacy benefit managers (PBMs) must offer their network contracted pharmacies regular updates of reimbursement limits for generic drugs.

The change is a ''huge deal'' for drugstores, Susan Pilch, vice president of policy and regulatory affairs at the National Community Pharmacists Association (NCPA), told Bloomberg BNA.

Part D plans will have to disclose the maximum allowable cost (MAC)—the most a plan will reimburse a contracted pharmacy for a generic drug. The disclosure has to be every seven days so pharmacies have current data on the amount of reimbursement they can expect.

NCPA is pleased but waiting to see how it will be carried out by plan sponsors.

Time to Implement. Although the requirement was in a 2014 CMS final rule, implementation wasn't to start until 2016, giving plans time to consider the layout and delivery method for conveying the data to pharmacies.

NCPA said that MAC lists are created by the PBMs, but the methodology to create these lists isn't disclosed.

The PBMs have contended that requiring public disclosure of MACs and MAC methodologies is likely to lead to collusion and higher prices.

NCPA said pharmacists have had to wait at times months to get updates, frequently resulting in reimbursements below acquisition cost for various medications.

The change will also allow accurate updates for beneficiaries who use the CMS's Medicare Plan Finder website, Pilch said.

When pharmacies can't ''determine whether their reimbursement is consistent with their contractual arrangements, the accuracy of the prices displayed in the Medicare Prescription Drug Plan Finder is questionable,'' the rule said.

Data Access. Pilch said NCPA members are waiting to see how the sponsors will offer access to the data and how the CMS enforces the new requirement.

The agency said in the 2014 rule that, despite a request for a requirement that MAC prices be disclosed for easy analysis, it would leave those details up to the parties.

Pilch said plans might utilize ''user friendly'' portals—such as Wisconsin's ForwardHealth Portal that includes interactive Medicaid Maximum Allowable Fee Schedules—or merely a PDF document that's not in real time.

Access 'Outliers.' Another issue that will likely be discussed in 2016 is beneficiary access to Part D preferred cost-sharing pharmacies (PCSP).

Under a PCSP system, enrollees must fill their prescriptions from a subset of network pharmacies to receive lower cost sharing. The CMS has said that such a system may not be beneficial to all of a plan's enrollees depending on where they reside.

An April 2015 study by the agency concluded that while plans' preferred cost-sharing pharmacies met convenient access standards in suburban and rural areas, that wasn't always the case in urban areas.

In a November 2015 memo, the CMS said it would provide drug plan sponsors with an analysis of their 2016 retail pharmacy access and use the data to identify sponsors that the agency considers ''access outliers.''

The CMS also said it will require plans with PCSP networks considered outliers—set at the bottom 10th percentile compared with all Part D plans in a given ''geographic type''—to disclose this in their marketing materials.

The information also would be posted on the agency's website.

The CMS said in the November memo that it will review sponsors' marketing materials to determine if the required PCSP outlier disclaimer was used appropriately.

Plans sponsor identified as outliers that don't use the outlier disclaimer will receive compliance or enforcement actions, the Medicare agency said.

Drug Prices. The backdrop of most conversations about Part D is rising drug prices.

CMS's Cavanaugh said this fall that while total Medicare costs per capita grew by 1 percent, Part D drug benefit costs grew by 8 percent and are forecast to grow by 15 percent in 2016.

The issue is being examined in various government sectors.

HHS Secretary Burwell held a pharmaceutical forum in November 2015 for consumers, providers, employers, manufacturers, health insurance issuers and government representatives on the growing cost of drugs, and particularly the cost of specialty medications.

The goal was to gather information to ''develop innovative purchasing strategies and incorporate value-based and outcomes-based models into purchasing programs in both the public and private sectors.''

Congressional Inquiry. On Capitol Hill, five Democratic senators in mid-December asked acting CMS Administrator Andrew Slavitt about the agency's efforts to contain drug prices.

The questions dealt with how the agency plans to use its Center for Medicare and Medicaid Innovation to ''examine the potential of alternative payment mechanisms,'' including methods to increase the use of generics.

A Kaiser Family Foundation study released in October said the Part D average prescription drug plan premium, weighted by 2015 plan enrollment, will increase by 13 percent.

This marks ''a significant departure from recent years when premiums were essentially flat,'' KFF said. ''Even if a number of beneficiaries switch or are reassigned to lower-premium plans, the average premium increase for 2016 is likely to be the largest since 2009.''

The biggest concern for the Part D program ''for 2016 is the uptick in premiums and deductibles,'' Ernst & Young's Pawlak told Bloomberg BNA. ''This is stem-

ming from high cost specialty drugs and other breakthrough drug costs.''

Out-of-Pocket Costs. Max Richtman, president and CEO of the National Committee to Preserve Social Security and Medicare, told Bloomberg BNA that many beneficiaries will experience an increase in out-of-pocket costs as a result of the spike in prices.

The top 10 stand-alone prescription drug plans are expected to increase premiums in 2016 as a result of increased drug costs, he said.

''Compared to 2015, more prescription drug plan enrollees will pay at least $60 per month in premiums in 2016.''

—Max Richtman, National Committee to Preserve Social Security and Medicare

''Compared to 2015, more prescription drug plan enrollees will pay at least $60 per month in premiums in 2016,'' Richtman said, adding that deductibles are also rising.

KFF said found that about two-thirds of PDPs will charge a deductible in 2016, up from 58 percent in 2015.

''High drug costs can also have a significant impact on the quality of care,'' Richtman said.

Research indicates relatively small changes in monthly costs can cause seniors to delay or discontinue using drugs.

Medication Therapy Management. The CMS will be choosing participants in 2016 for a model intended to control Part D costs through medication therapy management.

The Part D Enhanced Medication Therapy Management model will offer stand-alone prescription drug plans in 11 states the chance to design and implement strategies to improve medication use and care coordination, the agency said.

The five-year model will begin in 2017 in Virginia, Florida, Louisiana, Iowa, Minnesota, Montana, Nebraska, North Dakota, South Dakota, Wyoming and Arizona.

MTM programs target individuals who have multiple chronic diseases, are taking multiple covered Part D drugs and are identified as likely to incur annual costs for covered Part D drugs that exceed a certain threshold.

The Medicare Modernization Act required that every Part D plan offer an MTM program but participation has been much lower than expected, both by enrollees and clinicians.

More Consultations. PDPs participating in the new model could offer enrollees ''higher-touch services, such as more frequent person-to-person consultations'' after transitions of care or other changes in risk status, the CMS said.

Plans have until Jan. 8 to submit applications and the CMS will name the participants in March.

Applicants will be lured with a prospective payment for more extensive MTM interventions beyond a plan's annual Part D bid as well as performance payment, in the form of an increased direct premium subsidy, for plans that successfully reduce expenditures and fulfill other requirements.

By Sara Hansard and Mindy Yochelson

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