



Health Reform Update – Week of March 10, 2014

By Mark Hobraczek

CONGRESS

AMA retracts support for “doc fix” after House attaches five-year delay of individual mandate

The American Medical Association (AMA) took the unusual step this week of reversing its support for the bipartisan deal to permanently replace a failed Medicare physician payment formula after the House passed the bill with a provision that would delay a key provision of the Affordable Care Act (ACA).

The initial version of H.R. 4015 would avoid a 24 percent in Medicare physician payments starting April 1st, as well as cuts of at least 21 percent that would go into effect every year without Congressional intervention (see Update for Week of February 3rd). It had 48 Democratic cosponsors.

House Republicans revolted from that plan after both parties were unable to agree on how to offset the \$121 billion cost over ten years (see Update for Week of March 3rd). As a result, House Ways and Means chair Dave Camp (R-MI) amended the bill to delay enforcement of the ACA’s mandate that everyone must buy minimum essential health coverage that they can afford—a move that the Congressional Budget Office estimated would save \$170 billion over ten years and thus more than offset the cost of the “doc fix”.

However, the same CBO score also found that such a delay would leave 13 more Americans uninsured and force Marketplace premiums to rise 10-20 percent by 2018. CBO’s findings are consistent with similar estimates previously released by the Urban Institute, RAND Corporation, and the Lewin Group, which predicted that repeal the individual mandate would leave nearly eight to 16 million more Americans uninsured and boost premiums from 9-25 percent.

H.R. 4015 ultimately passed the House with only three Democratic votes but even its sponsor Rep. Ron Kind (R-WI) acknowledges it will go nowhere in the Democratically-controlled Senate unless the individual mandate delay is removed.

The AMA, which had sought the “doc fix” for more than a decade, expressed “profound disappointment” that the “strong bipartisan, bicameral” compromise was undone by “partisan approaches to resolve budgetary issues.”

OIG agrees to Congressional request to audit Maryland health insurance Marketplace

Congressman Andy Harris (R-MD) announced this week that the Office of the Inspector General (OIG) for the Department of Health and Human Services has agreed to his request to investigate the flawed rollout of the Maryland Health Connection (MHC).

The announcement came only days after the Government Accountability Office (GAO) agreed to bipartisan requests to audit how federal funds were used for the flawed rollouts in Oregon and other state-based Marketplaces created under the Affordable Care Act. Maryland is expected to be among the other unnamed states examined by GAO (see Update for Week of March 3rd). However, Rep. Harris stressed that OIG investigations are typically more exhaustive and specific since the agency has subpoena power.



The OIG review is likely to begin in a few weeks and run concurrent with an evaluation by Maryland lawmakers that is not expected to conclude until mid-2015. Rep. Harris had asked the OIG to probe how Marketplace contracts were awarded, what internal controls were in place, and "who specifically failed in their responsibilities to safeguard federal taxpayer money." It is not yet clear if the OIG will focus on these questions or expand their investigation to other issues.

Ongoing technological failures led Maryland officials to terminate the contract with its main contractor last month and try and recover some of the expended funds to offset more than \$100 million in cost overruns (see Update for Week of February 17th). MHC disclosed this week that it has only 38,100 residents enrolled in private Marketplace plans through March 1st, well below the initial goal of 150,000 enrollees by March 31st as well as the revised target of 81,000 (see below).

House Republicans demand premium payment figures from Marketplace insurers

Congressional Republicans pressed the Department of Health and Human Services (HHS) this week to release figures on how many enrollees have actually paid plan premiums, insisting that HHS is withholding this detail in order to overinflate their latest enrollment figures (see below).

HHS claims that they do not have any available data to provide. However, directors for state-based Marketplaces in California, Colorado, Connecticut, and New York have reported that 85-95 percent of enrollees have already paid their first monthly premium. Three insurers in California's Marketplace (Aetna, Wellpoint, and Blue Shield) also disclosed that 80-85 percent of their enrollees have done so.

As a result, House Energy and Commerce Committee Republicans sent letters this week to every insurer participating in the federally-facilitated Marketplaces (currently operating in 36 states) demanding figures on how many enrollees have not paid plan premiums. The letter also sought detail on enrollee age and whether they were previously uninsured.

House Republicans and Democrats agree on two tweaks to Affordable Care Act

In an unusual move, House Republicans and Democrats were able to come together on two measures to improve the Affordable Care Act (ACA) this week.

The House passed legislation in a bipartisan voice vote that would broaden the religious exemptions to the law's controversial individual mandate. H.R. 1814 would let individuals go without minimum essential health coverage they can afford if they include sworn statements with their tax returns documenting that their "sincerely held religious beliefs" make them object to medical care and they were not covered under any type of health insurance coverage during the year (including ACA-deficient plans). Under the bill, medical care does not include vaccinations.

Bill sponsor Rep. Aaron Schock (R-IL) acknowledges that H.R. 1814 is "largely aimed" at Christian Scientists, who argued that the current religious exemptions were "just not clear enough" to exempt them from individual mandate tax penalties.

Because H.R. 1814 received a rare two-thirds majority in the House, it is likely to be considered by the Democratically-controlled Senate.

Only one House member dissented on a separate measure exempting those receiving health care from the Veterans Affairs Department or Tricare coverage from the ACA's employer mandate. H.R. 3474 allows employers not to include these veterans, reservists, or military dependents when determining whether they have more than 50 full-time employees and are thus subject to employer mandate penalties for not providing minimum essential coverage.



The employer mandate has been delayed until 2016 for those with 51-100 employees, but only until 2015 for those with more than 100 employees (see Update for Week of February 10th).

Gallup credits ACA for drop in uninsured

About 15.9 percent of American adults are currently uninsured according to the latest Gallup poll of more than 28,000 adults conducted during January and February.

The figure is the lowest that Gallup has recorded since the height of the recession in 2008 and represents a 1.2 percent drop from December 2013 or three million fewer uninsured. Gallup concluded that it is "probably a reasonable hypothesis that the [Affordable Care Act] is having something to do with this drop" since the rate began declining in December once the new health insurance Marketplaces become mostly functional.

It is not yet clear if this downward trend will be permanent, as Gallup notes the uninsured rate had fallen to 16.1 percent in 2011 before jumping back to 18 percent in mid-2013.

A separate Bloomberg News poll of over 1,000 adults from last week found that 64 percent now support either keeping the ACA as is or making only minor changes.

FEDERAL AGENCIES

Acceleration in federal Marketplaces pushes total enrollment above 4.2 million

The Department of Health and Human Services (HHS) announced this week that roughly 943,000 consumers enrolled in private Marketplace plans in February, bringing total enrollment nationwide to more than 4.2 million. The Marketplaces have determined an additional 4.4 million applicants to be eligible for Medicaid or the Children's Health Insurance Program (CHIP).

Even though the February figure for private plans trailed January's reported total of 1.2 million new enrollees, average enrollment per day actually increased during February 32,744 to 33,763. However, despite the continued acceleration, total enrollment is still likely to fall well short of the initial seven million consumers that HHS initially projected for the inaugural open enrollment period as well as the revised estimate of six million enrollees that HHS projected following the flawed rollout of the federally-facilitated Marketplace and several state-based versions (see Update for Week of February 3rd).

HHS officials continue to predict a late surge in enrollment before the March 31st deadline, consistent with prior experience in with the Massachusetts Connector exchange, the Federal Employees Health Benefit Plan (FEHBP), and Medicare Part D (see below). However, Avalere Health consultants concluded that even if 22 percent of enrollees sign-up over the last month as they did under the FEHBP, total Marketplace enrollment will still struggle to break 5.4 million.

Avalere emphasized that the fiscal sustainability of the Marketplaces will depend less on the total size of initial enrollment and more on the mix of the risk pool—meaning that a surge in the enrollment of younger and healthier subscribers is more critical than the final tally. However, the latest figures showed little change in the proportion of young adults signing-up for Marketplace coverage (remaining at roughly 27 percent). The insurance industry has insisted that at least 38-39 percent of Marketplace enrollees need to age 18-34 in order to keep premiums affordable, though Kaiser Family Foundation insist that insurers can make a "small profit" in only one-quarter of the risk pool belong to this age group (see Update for December 16th-January 3rd).



Other demographic data also remain largely unchanged. Women are continuing to enroll at a disproportionately higher rate than men (55 to 45 percent), while 83 percent of enrollees are eligible for the premium tax credits and cost-sharing subsidies offered by the Affordable Care Act (ACA). Enrollees likewise chose plan levels at roughly the same proportion, with 63 percent enrolled in the silver plans to which premium assistance is tied, 18 percent selected the lowest-cost bronze plans, 11 percent went for gold plans, and only six percent sought the most generous but highest-cost platinum plans.

The latest figures showed that nearly 62 percent of total enrollment is from the 36 federally-facilitated Marketplaces (FFMs), a reversal from the first three months of open enrollment when the lack of functionality in the federal web portal kept FFM enrollment below the total for the 15 state-based Marketplaces (SBMs) (see Update for Week of January 13th).

Sign-ups continued to jump among “red states” most opposed to the ACA, with Florida soaring 49 percent in February to 442,000 enrollees or ten percent of the national total (and Mississippi nearly doubling). California continues to represent more than 20 percent of nationwide enrollment, with nearly 924,000 enrolled by March 9th.

While California is 135 percent over HHS’ projected total, four other states have also exceeded their target. According to Avalere Health, Idaho surprisingly is second with 125 percent of projected enrollees signed-up, while Washington (109 percent), Florida (105 percent), and North Carolina (101 percent) are not far behind. Idaho, Florida, and North Carolina all defaulted to the FFM model.

Colorado, Michigan, Montana, New Hampshire, Pennsylvania, and Vermont are other states that are 89-96 percent of the way to their enrollment target. All but Colorado and Vermont are FFM states.

By contrast, several SBMs continue to struggle. Massachusetts is the greatest surprise, since its prior Marketplace was the model for the ACA. However, it shared the same contractor as the FFM model and been unable to adequately upgrade its website (see Update for Week of January 6th), enrolling only 27 percent of those eligible as a result (with a 60 percent increase just in February). The District of Columbia and Hawaii have also performed very poorly, enrolling only 28 and 30 percent respectively.

Maryland and Oregon, two SBMs that are the subject of federal audits (see above), have actually enrolled 47 and 58 percent of their revised targets. While this is well-below the national average of 70 percent, it is significantly above other comparable-sized states like Wisconsin (34 percent), New Jersey (40 percent), and Minnesota (42 percent).

The state with the third-highest number of total enrollees, New York, is only 51 percent of the way to its target, as is Texas, the state with the highest uninsured rate. Each has enrolled just under 300,000 enrollees.

HHS grants third extension of PCIP coverage

The Centers for Medicare and Medicaid Services (CMS) announced late this week that those enrolled in Pre-Existing Condition Insurance Plans (PCIP) can purchase coverage an additional month if they have been unable to enroll in other coverage.

This is the third extension that CMS has granted for the temporary federal high-risk pools that were created by the Affordable Care Act (ACA) as a way to ensure coverage for those with pre-existing conditions before the law’s guaranteed issue went into effect January 1st. CMS initially extended PCIP coverage until January 31st due to the flawed Marketplace rollout (see Update for Week of December 9th), before further extending it to end coincident with the March 31st deadline for Marketplace enrollment (see Update for Week of January 13th).



Under the latest extension, PCIP enrollees can purchase coverage until April 30th, but will have to do so by April 15th to ensure continuous coverage on May 1st.

HHS insists it has no authority to extend open enrollment deadline

The Secretary for the Department of Health and Human Services (HHS) and other Administration officials vehemently insisted this week that the Affordable Care Act (ACA) statute gives them no discretion to extend the deadline for the open enrollment period in the federally-facilitated Marketplaces.

HHS has been under Congressional pressure to do so due to the flawed rollout of the FFM web portal that has hampered total enrollment (see above). Several struggling state-based Marketplaces, including New Mexico, Nevada, and Oregon, are also strongly considering an extension past March 31st and Congressman Kurt Schrader (D-OR) introduced legislation this week that would provide a one-month extension for all states.

It is not clear that HHS is even seeking Congressional approval to delay, as officials repeatedly stressed this week that such deadlines have previously forced a late surge in enrollment under the Massachusetts Connector, Federal Employees Health Program, and Medicare Part D (see above).

The Secretary also told Congress this week that HHS lacks the authority to grant the delay in individual mandate penalties sought by House Republicans (see above).

CMS may boost reinsurance payments for all insurers, not just those extending deficient plans

According to *Inside Health Policy*, the Department of Health and Human Services (HHS) is strongly weighing an industry request to offer health insurers nationwide a two percent bump in allowable administrative costs when calculating reinsurance and risk corridor payments for 2015.

The move is intended to compensate for greater losses that insurers may incur next year due to President Obama's decision to let plans that do not comply with new Affordable Care Act (ACA) standards to remain on the market until 2017 (see Update for Week of March 3rd). HHS had pledged to adjust the payments through the temporary reinsurance program created by the ACA when the President initially extended ACA-deficient plans for one year, a move that many Republican lawmakers have termed an "insurer bailout" (see Update for Week of January 20th and 27th).

HHS had proposed state-specific adjustments to help only those Marketplace plans operating in the 27 states (and District of Columbia) that agreed to extend ACA-deficient plans. However, the Blue Cross and Blue Shield Association and other insurers have lobbied for an across-the-board adjustment for insurers in all states, not just those that have taken advantage of the President's "transitional" policy.

HHS finalized the retroactive adjustment in the state-specific manner it proposed, based on monthly enrollment numbers that Marketplace plans in states with deficient plans send to HHS. However, CMS also stated that it understood that "issuers in all states are experiencing additional administrative costs as a result of transitional issues" and is "carefully analyzing" whether to propose an adjustment for all states in future rulemaking.

The adjustment would apply only to Marketplace premiums for 2014, which were already locked-in before the President's announcement (see Update for Week of November 11th). CMS stressed that Marketplace insurers can adequately adjust their 2015 rates to reflect the transitional policy. The Secretary of HHS acknowledged in Congressional testimony this week that 2015 Marketplace premiums would likely be higher than 2014 as a result.



However, the Congressional Budget Office (CBO) recently concluded that the risk corridors and reinsurance program under the ACA would actually earn the government \$8 billion over the 2015-2017 period, as the \$8 billion it will cost will be more than offset by \$16 billion in user fees and other revenues (see Update for Week of March 3rd)

CMS backs down on controversial Medicare Part D changes

Under pressure from a broad array of lawmakers, pharmaceutical companies, and consumer groups, the Centers for Medicare and Medicaid Services (CMS) agreed this week to temporarily withdraw part of proposed regulations that sought to make several controversial changes to Medicare Part D.

All but four members of the Senate Finance Committee had urged CMS to scrap the rule altogether while the House was prepared to vote this week on legislation that would have barred CMS from finalizing it (see Update for Week of March 3rd). The measure drew the ire of both Republicans and Democrats largely for provisions that would have eliminated three of the six protected drug classes that Congress created under Medicare Part D and did not rule out ultimately dropping all of them. It also would have limited Part D enrollees to two plan options per service area, required all price concessions from pharmacies be reflected in negotiated prices, and mandate that plan sponsors work with “any willing pharmacy.”

CMS agreed to not to pursue any of these four provisions until at least the 2015 plan year, although Administrator Marilyn Tavenner insists they would have better protected enrollees from drug overutilization while providing them with “more meaningful choices” and lower prices through greater transparency and market competition. The agency had estimated the changes would also save \$1.3 billion from 2015-2019.

STATES

Colorado

Marketplace board rejects 21 percent fee hike on participating insurers

The board overseeing Connect for Health has rejected a proposed 21 percent fee hike on participating insurers meant to make the health insurance Marketplace self-sustaining by 2015 as required by the Affordable Care Act.

Executive director Patty Fontneau had sought the hike in user fees to compensate for far lower initial enrollment than anticipated. Connect for Health has enrolled only about 90,000 consumers, which exceeds the lowest range of the target enrollment but is far below the mid-range target of 133,000 enrollees and upper-range target of 204,000 enrollees. New projections now predict only 152,000 over the first two years of the Marketplace, which may force Connect for Health to slash its \$21-26 million budget without higher user fees to make-up for the loss in projected revenue.

Ms. Fontneau also noted that Colorado’s decision to use the discretion granted by the Obama Administration and extend ACA-deficient plans through at least 2014 has also hampered Marketplace enrollment (see Update for Week of November 11th). The insurance commissioner has not decided yet whether to extend the plans until 2017 (see Update for Week of March 3rd).

Florida

Florida launches ACA-deficient health insurance “marketplace”

Florida’s bare bones alternative to the health insurance Marketplaces created by the Affordable Care Act (ACA) opened earlier this month with one vendor offering five coverage options, including a



prescription discount card and bundled discount products that includes vision, dental, telemedicine and prescriptions.

The Florida Health Choices program was authored by U.S. Senator Marco Rubio (D-FL) when he was Speaker of the Florida House of Representatives in 2008. It was promoted as a “free market solution” to the failures of the individual marketplace where coverage was often unattainable for those with pre-existing conditions. The program has already received \$1.5 million in state funding.

The Health Choices web portal was retooled ten months ago after public interest in the program was reported to be ten times more than initially anticipated. Chief Executive Officer Rose Naff sought to ensure that the site could handle at least 30,000 users per day, or 1,000 simultaneous applications.

However, Ms. Naff acknowledges that none of the coverage products offered under Florida Health Choices meet the ACA standards for minimum essential coverage that must be purchased in order to avoid tax penalties under the ACA’s individual mandate. In fact, the benefits are so limited that they cannot even be marketed in Florida using the words insurance, coverage, benefits or premiums.

Instead, Florida Health Choices is intended simply to provide some discounts to the roughly 1.3 million uninsured Floridians that will be caught in the “coverage gap” in Florida because they make too much to qualify for Florida’s very lean Medicaid program but not enough to receive ACA subsidies to buy Marketplace coverage (available to those earning 100-400 percent of poverty). Critics note that this “coverage gap” would not exist if Florida had accepted ACA funds to expand Medicaid to everyone earning up to 138 percent of poverty.

Florida Health Choices will initially offer five types of discount cards from Careington International that cost \$6-25 per month depending on the medical services selected.

Florida Supreme Court overturns “unconstitutional” cap on medical malpractice damages

In a closely-watched decision nationwide, the Florida Supreme Court voted 5-2 to invalidate the state’s \$500,000 limit on medical malpractice awards in wrongful death cases, holding that the cap was an “unconstitutional” response to an “alleged medical malpractice crisis” that unfairly discriminated against “those who are most grievously injured.” (The court did not address the constitutionality of the cap for non-fatal cases.)

The law was sought and signed by Governor Jeb Bush (R) in 2003 at a time when Republican lawmakers nationwide were making medical malpractice reform the centerpiece of their health reform platforms. At least 35 states have enacted similar limits, according to the National Conference of State Legislatures.

Siding with the Congressional Budget Office and other non-partisan entities that have found only a negligible reduction in health care costs from similar caps in other states, the court held that Florida’s cap “has the effect of saving a modest amount for many by imposing devastating costs on a few.” The Florida Medical Association (FMA) decried the ruling, insisting it would lead to skyrocketing premiums and a mass exodus of physicians from the state.

The U.S. 11th Circuit Court of Appeals previously ruled that the Florida cap did not violate the U.S. Constitution, but remanded it to the Florida Supreme Court to consider state issues.

Hawaii

House passes legislation expanding Marketplace user fee to all insurers

The House passed legislation last week that would expand the user fee for insurers participating in the Hawaii Health Connector to all insurers statewide.



The unspecified fee under H.B. 2529 is intended to ensure that the Marketplace created by Hawaii is self-sustaining by 2015 as required by the Affordable Care Act (ACA). State officials testified that the Marketplace has enough money to cover its costs for 2014, but lower than anticipated enrollment due to initial non-functionality of the web portal will limit its revenue for next year (see Update for Week of October 21st). The bill authorizes the Insurance Commissioner to charge the fee through mid-2018.

Expanding the existing user fee is just one part of the broad legislation, which would also create a legislative oversight committee to better monitor the Connector's finances and operations. An initial provision that sought to accomplish this by reclassifying the Connector as a state agency was stripped out of H.B. 2529 after it was pointed out that the legislature cannot legally disband a private, non-profit entity (see Update for Weeks of January 20th and 27th). Lawmakers also feared assuming the financial risk for the Connector's liabilities.

H.B. 2529 further reduces the number of board members for the Connector from 15 to 10 and alters the composition to include consumer and business groups instead of just insurers and state agency employees. A similar bill that removes insurance industry representatives from the board already passed the Senate last month (S.B. 2470).

Indiana

House and Senate pass legislation limiting biosimilar substitution

The House and Senate are sending legislation to Governor Mike Pence (R) that sets limits on when a pharmacist can substitute an interchangeable biosimilar drug for a brand-name biologic. Under S.B. 262, the prescription must state that such substitution is allowed, the patient must be advised, and the subscriber must be notified in ten days.

The Affordable Care Act (ACA) created a first-time regulatory pathway for the approval of generic biosimilars. Although the Food and Drug Administration (FDA) has yet to promulgate implementing regulations, brand-name manufacturers like Amgen and Genentech have promoted legislation in at least 15 states that would impose additional steps such a physician notification before a biosimilar copy can be substituted—restrictions that the FDA Commissioner has criticized as an effort to undermine trust in biosimilar products (see Update for Week of September 3rd). Although five states already enacted comparable industry-backed restrictions (Florida, North Dakota, Oregon, Utah, and Virginia), ten states have rejected them including California (see Update for Week of October 14th).

Similar legislation remains pending in New Jersey (A.2477), Pennsylvania (S.B. 405) (see Update for November 18th–December 6th), and Washington (H.B. 2326).

Louisiana

Marketplace insurers agree to accept premium assistance payments

Three insurers participating in the federally-facilitated health insurance Marketplace operating in Louisiana agreed this week to accept premium assistance payments through the federal Ryan White program for persons with HIV/AIDS.

Blue Cross and Blue Shield (BCBS) of Louisiana, the state's dominant carrier, had planned to stop accepting the payments on March 1st as part of a stated effort to prevent fraud (see Update for Week of February 10th). Two of the three other smaller Marketplace carriers stated that they had no choice but to follow BCBS' lead.

However, a federal court granted a temporary injunction last month after determining that plaintiffs representing persons with HIV/AIDS were likely to prevail on their claims that rejecting the payments would violate the non-discrimination provisions of the Affordable Care Act (see Update for



Week of February 24th). During a hearing on that lawsuit this week, BCBS announced that it would continue to accept the Ryan White premium assistance payments, leading Louisiana Health Cooperative and Vantage Health Plan to do the same.

At least one other out-of-state insurer, Blue Cross and Blue Shield of North Dakota, still plans to reject Ryan White payments. However, the federal Centers for Medicare and Medicaid Services (CMS) has already “encouraged” Marketplace insurers them to accept such payments and is considering amending program rules to require them to do so (see Update for Week of February 10th). CMS also issued recent guidance permitting non-profit foundations to assist with Marketplace premiums (see Update for Week of February 24th).

Maine

Medicaid expansion appears dead as compromise bill falls short of veto-proof majority

A coalition of Democrats and moderate Republicans appear to have come two votes short of passing any form of Medicaid expansion this session.

L.D. 1487 sponsored by Senators Roger Katz (R) and Thomas Saviello (R) would have expanded Medicaid to everyone earning up to 138 percent of the federal poverty level, at least until federal funding under the Affordable Care Act (ACA) starts to phase down in 2016 from 100 to 90 percent. It was bolstered by a state agency analysis projecting that it would save Maine \$3.4 million in just the first year and result in a \$1 billion stimulus to the state economy (see Update for Week of March 3rd). In a major concession to attract Republican support, the measure also would start to move Medicaid enrollees into managed care plans (Maine and Wyoming had been long-time holdouts from managed care).

While L.D. 1487 passed the Senate by a 22-13, it failed to garner the 24 votes needed to override the promised veto from Governor Paul LePage (R), who is running for re-election this fall and adamantly opposed the expansion and most of ACA implementation.

Missouri

House and Senate pass compromise bill to limit oral chemotherapy costs

The House voted overwhelmingly this week to pass legislation limiting out-of-pocket costs for oral anti-cancer medications.

S.B. 668 already received unanimous approval in the Senate. It is expected to be signed by Governor Jay Nixon (D) and take effect on January 1st. Under the bill, individual and small group could not impose more than \$75 per month in out-of-pocket costs after patients have met their deductible.

Rep. Sheila Solon (R) has sought for three years to make Missouri the 29th state to require parity in coverage for oral and intravenous chemotherapy medications, citing examples of patients having to pay exorbitantly higher cost-sharing for oral pills, which are often covered under a plan’s prescription drug benefit instead of medical benefit. This forces patients to frequently have to pay a high coinsurance or percentage of the drug’s cost, since oral chemotherapy is typically placed in a plan’s specialty tier for the highest-cost prescription drugs.

Insurers relied on a consultant study showing that requiring parity between oral and IV medications would increase insurance premiums by an average of 57 cents per month or \$12 million (see Update for Week of January 13th). While proponents argued that this increase was “minimal”, it was enough for many House Republicans to back the alternative of setting an OOP limit at \$75 per month, which Anthem Blue Cross and Blue Shield predicted would only increase premiums by an average of ten cents per month.



Comparable parity legislation cleared the Ohio Senate (S.B. 99) this week. Other measures remain pending in the Arizona Senate (S.B. 1247), the Georgia Senate (H.B. 943), and the Maryland House and Senate (H.B. 625/S.B. 641).

New Mexico

High risk pool premiums to jump 24 percent

Monthly premiums for enrollees in the New Mexico Medical Insurance Pool will increase by nearly 24 percent effective July 1st.

The executive director for the state high-risk pool acknowledged that the hike is due to shrinking enrollment as more previously uninsurable find coverage in the new health insurance Marketplace. Total pool enrollment has shrunk from 10,000 to 8,300 since open enrollment in the Marketplace started October 1st, greatly increasing the per person costs for the pool.

New Mexico was one of many states (including Indiana, New Hampshire, Texas, and Wisconsin) that elected to continue to their state high-risk pools past the January 1st implementation of Affordable Care Act market reforms that include prohibitions on pre-existing condition denials, due to the flawed Marketplace rollout (see Update for November 18th-December 6th).

Oklahoma

Senate passes Medicaid managed care pilot

The Senate narrowly passed a measure this week to establish a demonstration program that would move Medicaid beneficiaries statewide into private managed care plans.

Both Democratic and Republican opponents of S.B. 1495 fear that privatizing Medicaid would erode provider payments, as well as access and quality of care, pointing to similar problems that occurred during Oklahoma's aborted experiment with Medicaid managed care in the mid 1990's, as well as Florida's Medicaid managed care demonstration (see Update for Week of August 1, 2011).

Bill sponsor Senator Kim David (R) was able to persuade enough Republicans that Oklahoma could follow the example of 36 other states that rely on Medicaid managed care. However, it remains unclear whether the S.B. 1495 will likewise clear the House where it is opposed Rep. Doug Cox (R), an emergency room physician and leading lawmaker on health care issues.

Virginia

Medicaid expansion impasse leads to special session, shutdown threat

Governor Terry McAuliffe (D) agreed to House Republican calls this week for a special legislative session but refused to accede to demands that the divisive issue of Medicaid expansion be separated from the state budget.

Former Governor Bob McDonnell (R) had committed Virginia to participating in an alternative to the Medicaid expansion under the Affordable Care Act (ACA) similar to that federally-approved for Arkansas, Michigan, and Iowa, but only if the Obama Administration agreed to certain Medicaid reforms including expanded managed care and higher cost-sharing. However, Republicans that control the House of Delegates dug in against any form of Medicaid expansion once Governor Terry McAuliffe (D) was elected this fall on a pledge to expand Medicaid (see Update for Week of November 11th).

Republicans in the evenly-split Senate (where Democrats hold the tie-breaking vote) had backed a private sector alternative called Marketplace Virginia, which also has the support of the Virginia Chamber of Commerce and most provider and consumer groups. The expansion plan is part of the two-year budget that must be passed by July 1st to avoid a government shutdown.



However, Del. Thomas Davis Rust (R), the lone House Republican to support the Senate budget including Marketplace Virginia, agreed with House leaders insisting that it must be separated from the state budget and receive a stand-alone vote. House Minority Leader David Toscano (D) has agreed to do so only if House Speaker William Howell (R) supports at least some form of Medicaid expansion alternative instead of remaining in a "just say no" position.

Governor McAuliffe set the start of the special session for March 24th, instead of starting it immediately after the regular session as House Republicans had requested.