



## Health Reform Update – Week of December 8, 2014

### CONGRESS

#### ***House spending bill extends current funding levels, averts government shutdown***

The House narrowly passed a “cromnibus” spending package this week (H.R. 83) that will fund the federal government through fiscal year 2015. If passed by the Senate and enacted, it is expected to avert any likelihood of a government shutdown until next fall.

Many of the usual partisan spending fights were mitigated by the budget agreement last winter that capped total discretionary spending for both fiscal 2014 and 2015 at \$1.014 trillion (see Update for Week of January 6<sup>th</sup>). The House agreed to retain these caps, as well as the ongoing budget sequester that came out of the 2011 stalemate over the debt limit (see Update for Week of August 1, 2011).

However, the package does include severe cuts to the Internal Revenue Service (IRS), which stands to lose \$346 million over concerns about the agency’s role in enforcing provisions under the Affordable Care Act (ACA) as well as partisan debates over whether the agency unfairly targeted conservative groups.

Funding for other federal agencies including the Department of Health and Human Services (HHS) remains relatively flat for fiscal 2015 (although funding is doubled for initiatives to combat Medicare and Medicaid fraud.) The federal Ryan White HIV/AIDS Program will also receive the same \$2.3 billion that it did in fiscal 2014 and \$900 million is again allocated for its AIDS Drug Assistance Program.

House appropriators emphasized that the package includes no new funding for ACA implementation. It also rescinds \$10 million from the Independent Payment Advisory Board that House Republicans have long-sought to eliminate and includes a controversial provision barring HHS from transferring any additional funds to the three-year reinsurance and risk corridors program that offsets losses for health insurers with exceptional claims (see Update for Week of December 1<sup>st</sup>).

House Republicans have decried the reinsurance payments as an “insurer bailout” and sought to eliminate them as part of annual deficit reduction negotiations (see Update for Weeks of January 20<sup>th</sup> and 27<sup>th</sup>), with Senator Marco Rubio (R-FL) promising to bring repeal legislation in the next Congress. America’s Health Insurance Plans (AHIP) criticized the move this week, insisting that the payments were vital to ensuring affordable premiums and adequate insurer participation in the Marketplaces.

HHS officials had previously indicated that they would tap into other accounts if needed to continue the reinsurance payments until 2016. If enacted, the provision would presumably prevent them from doing so, forcing the program to use only the funds it brings in through Marketplace user fees.

A measure to permanently exempt expatriate health plans from the ACA’s individual and employer mandates (H.R. 4414) is also attached to the “cromnibus” package after it passed the House earlier this year but was blocked by the Senate (see Update for Weeks of April 28<sup>th</sup> and May 5<sup>th</sup>).

#### ***Permanent “doc fix” will have to wait for new Congress***

Congress failed to include a permanent fix to the Medicare physician payment formula as part of the “cromnibus” spending package passed this week (see above), effectively relegating it to next session.



There remains bipartisan support for Congress to finally address the issue, instead of simply passing a 17<sup>th</sup> temporary delay in the annual cuts before the latest extension expires on March 31<sup>st</sup>. Several House and Senate committees did agree on a framework for a permanent fix earlier this year (H.R. 4015, S. 2000), but leaders from both parties have been unable to decide how to offset the cost estimate (see Update for Week of February 3<sup>rd</sup>), which the Congressional Budget Office recently increased to \$144 billion over ten years.

### ***Spending bill fails to extend ACA increase in Medicaid reimbursement for primary care physicians***

Consumer and provider groups were highly critical of Congress for failing to extend any temporary increase in Medicaid reimbursement for primary care physicians as part of the “cromnibus” spending bill passed this week (see above).

The two-year increase to Medicare rates was authorized by the Affordable Care Act (ACA) but expires December 31<sup>st</sup>. Only six states and the District of Columbia plan to use state funds in 2015 to sustain the ACA increase, two of which (Alabama and Mississippi) are headed by Republican governors that oppose the ACA and refuse to expand Medicaid (see Update for Week of July 28<sup>th</sup>).

An Urban Institute study previously found that the ACA effectively increased Medicaid primary care rates by an average of 73 percent nationwide. It also warned that allowing the increase to expire will reduce primary care reimbursement by more than 50 percent in large states like California, New York, New Jersey, Illinois, and Pennsylvania that have or are about to expand Medicaid under the ACA.

Legislation backed by Senate Democrats to extend the primary care increase by another two years and expand the types of eligible physicians (S.2694) is strongly opposed by most Republican lawmakers, who previously sought to limit the increase in order to offset the cost of a permanent Medicare “doc fix” (see Update for Week of December 9<sup>th</sup>).

### ***Senate Republicans require all staff to purchase subsidized coverage in DC SHOP Marketplace***

The Senate Republican Conference adopted a resolution this week urging all staffers to purchase coverage through the small group Marketplace for the District of Columbia.

Office of Personnel Management (OPM) regulations required all members of Congress and staff to use the District’s Marketplace if they wish to continue receiving subsidized coverage (see Update for Week of September 30, 2013). However, leadership and committee offices received an exception allowing them to continue subsidized coverage through the Federal Employees Health Benefit Program.

The non-binding resolution proposed by Senator David Vitter (R-LA) calls on offices to reject that exemption and designate all staff as “official” so that they fall under the OPM rule. It also challenges Senate Democrats to pass an analogous resolution.

Senators Vitter and Ron Johnson (R-WI) have led a separate effort to block the OPM rule, even filing a federal lawsuit that was recently dismissed (see Update for Week of July 21<sup>st</sup>). However, a second lawsuit filed by Judicial Watch seeks to invalidate the rule on the basis that Congress cannot be designated a small business (see Update for Weeks of October 6<sup>th</sup> and 13<sup>th</sup>).

### ***House Republicans weigh passing more SCHIP costs onto consumers***

Members of the House Energy and Commerce Health Subcommittee voiced bipartisan support last week for extending federal funding for the State Children’s Health Insurance Program (SCHIP) past its expiration on September 30, 2015. However, several Republican members indicated that they may condition their support on additional measures to pass greater costs onto SCHIP parents.



About 8.4 million people remained covered under SCHIP, which the Affordable Care Act (ACA) extended through 2019. However, Congress funded the program only through fiscal year 2015, meaning that states would exhaust all funds by early in fiscal 2016 if no further appropriations are made.

Earlier this year, the Medicaid and CHIP Payment and Access Commission (MACPAC) recommended at least a two-year extension of the program, while consumer advocates are largely seeking a full extension through 2019. However, the ACA allows the federal matching rate for states to be boosted in fiscal 2016 from 70 to 93 percent of SCHIP costs, if the program is extended. While Republican subcommittee leaders supported “extend[ing] funding for this program in some fashion,” they also made clear that such a substantial jump in the federal share of costs was not likely to be approved.

Republicans on the panel also expressed concerns that SCHIP payments were actually “subsidizing the upper middle-class” instead of its original intent to help the most vulnerable of children. However, representatives from MACPAC and the Government Accountability Office disputed these claims, insisting that roughly 90 percent of SCHIP families have incomes that are less than twice the federal poverty level (FPL).

Rep. Renee Ellmers (R) was among the Republican lawmakers suggesting that a potential compromise would extend SCHIP funding but increase the program’s cap on out-of-pocket costs at five percent of income.

Officials with the Congressional Research Services (CRS) informed the subcommittee that if Congress let funding lapse next year, states would still be required under the ACA to cover children under the same eligibility guidelines through 2019, but would have to do so through alternatives like Marketplace plans that have higher cost-sharing. Roughly 50 percent of SCHIP enrollees would also be in states whose SCHIP matching rate would automatically fall to the lower Medicaid share (averaging 57 percent instead of 70 percent).

## FEDERAL AGENCIES

### ***Marketplace enrollment for 2015 is outperforming first-month totals from year one***

The Department of Health and Human Services (HHS) announced this week that 618,548 individuals used the federally-facilitated Marketplace (FFM) to enroll in coverage from November 29<sup>th</sup> through December 5<sup>th</sup>— a 33 percent increase from the first week of the 2015 open enrollment period that brings the three-week total to more than 1.38 million consumers.

More than 644,000 (or 48 percent) were new customers, while the remainder re-enrolled in a new or different plan from 2014. Combined with the 183,000 from state-based Marketplaces (excluding Idaho, New York, and Rhode Island), the total puts the Marketplaces on track to “far exceed” HHS’ projection of nine million total enrollees by 2015 (on top of the 7 million that enrolled during 2014), with some estimates pegging the final tally near the 13 million initially estimated by the Congressional Budget Office.

Marketplace web portals have performed far better than during the initial weeks of the inaugural open enrollment period, when severe technological glitches impeded sign-ups nationwide (see Update for Week of November 11, 2013). California (see below), Colorado (see below), Maryland (see below), Massachusetts, and Vermont are among the state-based Marketplaces that appear to have corrected persistent online failures to already far outperform the first-month performance in year one.

### ***Most Marketplace plans have out-of-pocket caps below ACA limits***

An Avalere Health analysis of most 2015 Marketplace plans revealed this week that the majority offer lower annual caps on out-of-pocket (OOP) spending than the Affordable Care Act (ACA) requires.



The Avalere review found 74 percent of OOP limits for silver-level plans are below the ACA maximum of \$6,600 for individuals and \$13,200 for families. The average cap for individuals will instead be \$5,853.

OOP limits are predictably higher for less generous bronze-level plans, which average \$6,381 for individuals. However, 71 percent of OOP caps in bronze plans were still under the ACA maximum.

By contrast, 98 percent of OOP caps were below the ACA maximum for the most generous platinum-level plans (for an average limit of \$2,245), compared to 94 percent (and a \$4,458 average limit) for gold-level plans.

The average maximum limits did not vary much from 2014, when they were \$6,330 for bronze, \$5,877 for silver, \$4,443 for gold, and \$2,795 for platinum.

The Avalere analysis included all 37 federally-facilitated Marketplaces as well as state-based Marketplaces in California and New York.

Avalere did acknowledge that deductibles for these Marketplaces will increase by an average of seven percent for silver-level plans (to \$2,658) and rise for other metal tiers as well.

### ***Urban Institute finds 30 percent drop in uninsured rate in first full year of Marketplace enrollment***

The Urban Institute documented this week that the number of uninsured non-elderly adults has fallen by about 30 percent during the first 12 months since the new health insurance Marketplaces were opened pursuant to the Affordable Care Act (ACA).

The survey of 7,500 non-elderly adults incorporated results of other groups to conclude that more than ten million working age Americans have gained coverage through September, dropping the nation's uninsured rate to 12.4 percent. Surprisingly, the Urban Institute found that the declines were equally dramatic among states participating in the ACA's Medicaid expansion (from 15 to 10.2 percent) and those opting-out (20.1 to 15.1 percent).

### ***Competition for ACA's non-profit cooperatives draws complaints from dominant insurers***

According to the National Alliance of State Health CO-OPs (NASHCO), low premiums offered by the non-profit insurance cooperatives (CO-OPs) created by the Affordable Care Act (ACA) are gaining a foothold in several state and federal Marketplaces. However, they are also drawing complaints from dominant insurers that insist it is "unfair" to compete with insurers receiving low-interest federal loans.

Roughly 450,000 consumers have enrolled in CO-OPs operated in 26 states. The overall numbers are below the 575,000 initially projected for 2014 because Congress eliminated the ACA loans as part of deficit reduction measures before CO-OPs could be established in every state (see Update for Weeks of December 24 and 31, 2012).

However, CO-OPs have already drawn substantial market share in states like Iowa, Maine, Montana, Nebraska, and Wisconsin (see Update for Week of June 9<sup>th</sup>) and according to NASHCO are offering the lowest 2015 premiums for silver-level plans in all or most of Arizona, Connecticut, Colorado, Idaho, Illinois, Maine, Maryland, New Mexico and New Jersey,

At least six CO-OPs have actually lowered their premiums from 2014, with Land of Lincoln Health in Illinois slashing premiums by an average of 20-30 percent, HealthyCT cutting rates an 8.5 percent average, and CO-OPs in Arizona, Colorado, Illinois, Maryland, New Jersey, and Oregon following suit with smaller cuts. The competition has caused several Blue Cross plans and America's Health Insurance



Plans to urge Congress to eliminate the program, arguing the CO-OPs are becoming “very disruptive to the market” and “competing unfairly” with “unsustainable” premiums that will not generate enough revenue to pay claims over the long run. They insist that the CO-OPs could not meet state solvency requirements or federal medical-loss ratio standards without the start-up loans that do not need to be paid back to the federal government for five years.

Researchers at the Georgetown University Health Policy Institute acknowledge that CO-OPs may have difficulty sustaining the low premiums, especially if their enrollment is so much higher than expected that it breaks their budgets. However, they point out that in the short-term CO-OPs are having exactly the effect intended by the ACA, which was to force dominant carriers to offer more competitive premiums.

However, Republican lawmakers have noted that the majority of CO-OPs did not meet initial enrollment targets for 2014, despite the surprising success of several CO-OPs in smaller states (see Update for Week of June 9<sup>th</sup>).

### ***HHS proposed rule allows workers in substandard coverage to receive ACA tax credits***

The Department of Health and Human Services (HHS) issued proposed rules last month clarifying that employer-sponsored health plans that exclude “substantial coverage for inpatient hospital and physician services” do not meet the Affordable Care Act (ACA) requirement of minimum essential coverage (MEC).

Once effective, the law’s employer mandate requires employers with at least 50 workers offer plans that cover at least 60 percent of average health care expenses. Employers that fail to provide this level of MEC must pay a per employee assessment.

HHS provides an online actuarial value calculator to determine if plans meet this standard. However, consumer advocates have complained that the calculator allows employers a “loophole” for less-costly plans with substandard coverage that exclude key benefits like hospitalization.

Both HHS and the Department of Treasury issued notice on November 4<sup>th</sup> clarifying that large employer plans that do not offer “substantial coverage for inpatient hospitalization services” do not comply with the MEC standard. However, the notice acknowledged that many employers had already started enrolling workers in substandard plans for 2015, effectively given them a temporary exemption before the employer mandate kicks in on January 1<sup>st</sup> for those with at least 100 employees (see Update for Week of February 10<sup>th</sup>).

As a result, the proposed rules will allow workers in these plans to receive premium tax credits to purchase a Marketplace plan for 2015, even if their coverage otherwise meets the ACA’s affordability standards. The rules stress that no large employer will be able to meet the MEC standard for 2016 without including “substantial coverage for inpatient hospitalization”.

### ***Obama Administration warns employers not to dump sicker workers into Marketplace plans***

The departments of Health and Human Services (HHS), Labor, and Treasury warned employers last month not to encourage sick workers to drop company health plans and buy coverage in the health insurance Marketplaces created by the Affordable Care Act (ACA).

Insurance brokers and agents have been advising employers that they could save hundreds of thousands of dollars per employee by shifting workers with high-cost medical conditions into Marketplace coverage and simply paying the per employee penalty imposed by the ACA’s employer mandate. Some employers have even offered workers financial incentives to do so.



The agencies have been formulating a response to this practice since last spring and determined that such a practice constitutes unlawful discrimination under the Public Health Service Act and Health Insurance Portability and Accountability Act. However, nothing prevents workers from voluntarily electing to forgo employer coverage in lieu of Marketplace plans, although they will be ineligible for ACA subsidies if their employer coverage meets the ACA standard for affordability.

### ***OPM proposes to delay statewide requirement for multistate plans offered in ACA Marketplaces***

The Office of Personnel Management (OPM) proposed last month to eliminate the requirement that multi-state health plans be offered statewide in every Marketplace operated pursuant to the Affordable Care Act (ACA).

Congress required that OPM contract with at least two multistate health plans (at least one of which is a non-profit) for each Marketplace. However, OPM's initial rulemaking phased-in this requirement through 2017 so that only 31 states had multistate plans in 2014 and 36 will do so next year (see Update for Week of February 25, 2013).

Blue Cross and Blue Shield was the only insurer to participate in 2014. Most of the multistate plans they offered were able to operate statewide but OPM decided that the structural barriers to doing so in a handful of states were not likely to change.

OPM is also seeking to further delay the statutory requirement that multistate plans be offered in both the individual and small group Marketplaces. It also proposes to give multistate plans more flexibility in benefit packages, either by allowing insurers to vary their benchmark plan by state or letting them choose from two types of plans in each state.

Under the proposed rules, OPM would begin collecting an annual user fee from multistate plans that will not exceed 0.2 percent of premiums. The agency will also create a new multistate program advisory board that would include representatives of enrolled consumers.

OPM states that more than 371,000 Marketplace consumers have already enrolled in the roughly 150 multistate plan options available to them in 2014.

### ***Proposed rule makes major changes to Accountable Care Organization demonstration***

The Centers for Medicare and Medicaid Services (CMS) is proposing to make major changes to the Medicare shared savings demonstration created by the Affordable Care Act (ACA).

The demonstration created accountable care organizations (ACOs) that allow hospitals and physicians to share in Medicare savings if they collaborate to offer higher quality Medicare services at lower cost by limiting duplicative tests, needless procedures, and other inefficiencies caused by Medicare's fragmented payment system for medical care (see Update for Week of March 28, 2011). Final rules issued in 2011 already relaxed some initial standards, including exemptions for financial penalties for ACOs that fail to meet savings targets and reducing the number of required measurements to ensure ACOs are not saving money simply by skimping on care (see Update for Week of October 17, 2011).

Proposed rules issued last by month by CMS would now allow so-called "two-sided risk ACOs" that can earn higher savings but also incur penalties to operate without the risk of penalties for another three years. CMS is trying to entice more ACOs to participate in the two-sided risk model by increasing the bonuses and relaxing program rules, such as making it easier for them to meet targets by comparing them only to providers in their region (instead of nationwide). The rules would also gradually make the targets less dependent on past ACO performance. However, the trade-off is that "one-sided risk ACOs" will have their amount of potential savings reduced.



CMS acknowledges the changes resulted from complaints by ACOs, two-thirds of whom had pledged to stop participating if the demonstration forced them to adopt the two-sided risk model that imposes penalties.

### ***OIG finds flaws in provider directories for Medicaid managed care networks***

Audit findings released this week by the Office of Inspector General (OIG) for the Department of Health and Human Services (HHS) found that 35 percent of the private Medicaid managed care plans surveyed are providing inaccurate information about in-network providers, while another 16 percent were either not participating in Medicaid managed care or not accepting new patients.

According to the OIG, the lack of correct information is creating obstacles to care for Medicaid managed care enrollees seeking to find physicians or hospitals that will accept them. More than half of the 1,800 primary care doctors or specialists contacted by the OIG were either not at the location listed in the health plan's directory or refused to treat Medicaid enrollees.

Even among providers that agreed to accept Medicaid managed care enrollees, the median wait time for an appointment was two weeks while more than 25 percent of providers required a wait of at least one month.

The results caused OIG to question whether plan networks are broad enough to accommodate the 9.1 million new Medicaid enrollees since the Affordable Care Act (ACA) expansion went into effect January 1<sup>st</sup> for most states, much less the millions more that will enroll in future years..

They also provide ammunition for complaints from consumer advocates about the narrowing of provider networks in both Medicaid managed care and Marketplace plans. Anthem Blue Cross and Blue Shield of California both face class action lawsuits from consumer groups for their failure to provide accurate provider directories for Covered California plans. State officials concluded last month that the omissions and errors were often deliberate and violated state law.

The Administrator for the Centers for Medicare and Medicaid Services (CMS) agreed to implement OIG's three recommendations relating to provider directory data furnished by Medicaid managed care networks, including greater federal oversight.

The audit was the OIG's second report on Medicaid managed care this fall. The other found that lack of federal oversight was resulting in very disparate access to covered services under Medicaid managed care plans (see Update for Week of September 22<sup>nd</sup>).

## **HEALTH CARE COSTS**

### ***Hepatitis C medications drive 11.7 percent increase in total drug spending***

A new report from the IMS Institute for Healthcare Informatics predicts that spending on prescription drugs will spike by 11.7 percent for 2014, pushing national totals to more than \$375 billion.

The double-digit hike is a dramatic change from the modest 3.6 percent average increase over the past few years. The high cost of three new Hepatitis C treatments leads IMS' list of cited reasons for the jump (accounting for \$8 billion of the \$40 billion in projected drug spending), along with fewer expirations in drug patents compared to prior years.

The report projects only a 7-9 percent increase for 2015 and a return to a 3-5 percent increase for 2016 as the impact of these new drugs begins to wane and less costly biosimilar products start receiving FDA approval under the regulatory pathway created by the Affordable Care Act (see below).



A separate report from AARP found that the price for 227 brand-name drugs increased by an average of 12.0 percent last year, well above the 1.5 percent rate of inflation. According to AARP, the average cost of a regularly-used brand-name drug is roughly \$3,000.

### ***Employee share of health care costs has nearly doubled in past decade***

A new report released this week by The Commonwealth Fund documents that the share of health insurance costs borne by employees in employer-sponsored plans has increased by 93 percent from 2003-2013.

According to the study, workers contributed \$1,170 towards their premiums in 2013 compared to only \$606 in 2003, while the average deductibles soared 150 percent over that time (from \$518 to \$1,273). The number of workers subject to deductibles also grew from 52 to 81 percent, just within the last year.

The report did find that the rate of growth in plan premiums has slowed to just over four percent since the advent of the Affordable Care Act, compared to more than five percent from 2003-2010.

## **STATES**

### ***Brand-name and generic drugmakers agree on model biosimilar substitution legislation***

Manufacturers of brand-name biologics reached agreement this week with the Generic Pharmaceutical Association on model state legislation for biosimilar substitution.

Amgen and Genentech led the biotech industry in lobbying state legislatures for legislation that would make it more difficult for biosimilar products to be substituted for the brand-name biologic, just as the Food and Drug Administration (FDA) began drafting regulations to implement the new biosimilar approval pathway created by the Affordable Care Act (ACA) (see Update for Week of September 3, 2013). Eight states did pass legislation temporarily limiting the situations in which biosimilars could be substituted, which included provisions requiring pharmacists to notify physicians and patients before filling the substitute product. However, only one state (North Dakota) passed restrictions that were as burdensome as the industry proposed and at least 12 states rejected the legislation outright (see Update for Weeks of June 30<sup>th</sup> and July 1<sup>st</sup>).

Due to this limited success, representatives of the both the biotech and generic drug industries agreed on model legislation that they can jointly propose to state lawmakers. The compromise closely follows a Massachusetts law enacted last year (see Update for Weeks of June 30<sup>th</sup> and July 7<sup>th</sup>), which allows pharmacies to automatically substitute biosimilars but also requires them to notify physicians and patients, as well as maintain electronic records of the communications. Physicians would not have the authority initially sought by the biotech industry to prohibit any substitutions of a biosimilar product.

The FDA has yet to approve a biosimilar under the new approval pathway though several applications remain pending (see Update for Week of July 28<sup>th</sup>).

### California

#### ***Covered California enrollment outpaces 2014, but some technical glitches remain***

Covered California officials announced this week that nearly 300,000 consumers have applied and been found eligible for either Medi-Cal or qualified health plan (QHP) coverage since the second open enrollment period for the health insurance Marketplace opened on November 15<sup>th</sup>.



Through December 3<sup>rd</sup>, nearly 130,240 of those applicants were for QHP coverage, far exceeding the 105,000 that enrolled during the entire month of October 2013, when the Marketplace first opened. At this pace, Covered California should exceed its projection of 500,000 new enrollees by the February 15<sup>th</sup> end of open enrollment.

According to Covered California, nearly 49,000 first-time consumers have already selected a QHP plan, compared to only 31,000 during the first month of the inaugural open enrollment period.

California led the nation with more than 1.2 million QHP enrollees during the inaugural open enrollment period for the Marketplaces created by the Affordable Care Act (ACA), despite many of the same software and technological flaws that plagued most state-based Marketplaces (SBMs) and the FFM during the opening months (see Update for Week of April 7<sup>th</sup>). Several of those glitches resurfaced during the past few weeks, including website failures and long waits for call center representatives. However, Covered California officials insisted that the problems were far less frequent or severe than last year.

More than 160,550 of the new consumers were eligible for Medi-Cal, which has already added at least 2.2 million new enrollees over the past year due to California's participation in the Medicaid expansion under the ACA. Roughly 30 percent of all Californians are now enrolled in Medi-Cal.

### ***Backlog of Medi-Cal applications pared down from 900,000 to 34,000***

The director of California's Medicaid program announced this week that the backlog of Medi-Cal applications is down to roughly 34,000, compared to the high of more than 900,000 last summer (see Update for Week of June 2<sup>nd</sup>). However, he cautioned that additional progress could be stalled by the high pace of new applications since the open enrollment period reopened November 15<sup>th</sup> (see above).

Consumer advocate groups are suing the state to force hearings on backlogged applications that have been pending for more than ten months. Medi-Cal officials agreed this week to a request from lawyers for the plaintiffs to give applicants "preliminary coverage" if it appears they are likely eligible for coverage but caught in the backlog. However, these temporary benefits will only be available for those who were identified by December 1<sup>st</sup> and not to subsequent applicants.

Technology shortcomings are the main cause of the backlog in California, as computer systems lacked an automated process to identify and get rid of duplicate applications, as well as updated self-service portals that can catch errors. California was one of at least 13 states that were warned by the federal Centers for Medicare and Medicaid Services last summer to promptly address their backlogs, which violate the enrollment guidelines under the Affordable Care Act (see Update for Week of July 14<sup>th</sup>).

A Tennessee federal court already issued an injunction ordering that state to hold eligibility hearings for any applicant delayed over 45 days (see Update for Weeks of August 25<sup>th</sup> and September 1<sup>st</sup>). A similar injunction hearing is set for mid-December in the Alameda County Superior Court.

### ***Governor may expand Medi-Cal to cover undocumented immigrants***

The top policy aide to Governor Jerry Brown (D) indicated last week that he is considering expanding Medi-Cal coverage to undocumented state residents that are protected from deportation under the recent executive action issued by President Obama.

Uninsured rates among Latinos remain exceptionally high in California as many were reluctant last year to apply for either Medi-Cal or private plan coverage through the new Covered California Marketplace due to fears that the information furnished in their application could expose undocumented family members to deportation (see Update for Weeks of January 20<sup>th</sup> and 27<sup>th</sup>). The Governor's office cited these fears as a potential justification for changing Medi-Cal eligibility rules, which currently bar



coverage for undocumented immigrants. However, it also stressed that the cost of such an expansion will be a primary factor in the Governor's decision.

Undocumented immigrants are not eligible for private plan coverage through any state or federal Marketplace created pursuant to the Affordable Care Act (ACA). The President's executive action did not confer any federal benefits (including Marketplace coverage) on undocumented immigrants and the Governor could not change ACA Marketplace eligibility standards without federal authorization.

However, allowing undocumented immigrants to enroll in Medi-Cal is an option that has the support of several key Democratic lawmakers. Senator Ricardo Lara (D) has already reintroduced legislation (S.B. 4) that extend Medi-Cal coverage to all remaining uninsured earning up to 138 percent of the federal poverty level, regardless of immigration status. The new chair of the Assembly Health Committee has also backed the move.

#### Colorado

#### ***Legislative committee recommends greater Marketplace oversight after scathing audit***

The Legislative Audit Committee voted unanimously to advance legislation next session that would expand state oversight of the health insurance Marketplace that Colorado is operating pursuant to the Affordable Care Act (ACA).

The measure follows on the heels of a scathing state audit concluding that Connect for Health Colorado has mismanaged federal grants to create the Marketplace. It found that the lack of adequate financial controls for the non-profit, independent entity resulted in nearly \$489,000 of questionable payments to vendors and service providers and \$32 million worth of problems with procedure or documentation in exchange payments and contracts.

The state auditor noted that in one case a \$350,000 vendor contract had ballooned to \$3.5 million without the required board approval for the increase. Furthermore, the auditor was unable to determine whether vendors were engaged in direct lobbying activities in violation of the ACA because of poor recordkeeping.

The new measure will largely mirror one sponsored last session by Rep. Dan Nordberg (R) that cleared the House with only one dissenting vote but was blocked by Democrats on the Senate Health and Human Services Committee. H.B. 1257 would have authorized a far more comprehensive audit of Connect for Health Colorado's overall performance, including background checks and personnel management, but was opposed by the Connect for Health CEO, citing multiple federal audits and the need for staff to be devoted to improving enrollment.

Connect for Health officials insisted this week that new contract management and payment processes have been put in place in response to the initial audit and that any lobbying activities by vendors were not paid for with federal funds and thus permitted.

According to *The Denver Post*, Senator Irene Aguilar (D), the chair of the Senate committee that killed H.B. 1257 last session, states that she will not oppose an expanded audit next session.

Despite the controversy, Connect for Health Colorado has been able to enroll nearly 25,000 consumers in the first three weeks of the second open enrollment period, roughly doubling its performance during the first three weeks of the inaugural period when the Marketplace was beset with technological glitches. However, only one-third of the 25,000 are new consumers with the others renewing coverage from 2014.

#### Maryland

#### ***Marketplace enrolls nearly 52,000 since start of open enrollment***



Officials with Maryland Health Connection (MHC) announced this week that nearly 37,000 consumers have selected private plan coverage from November 15<sup>th</sup> – December 8<sup>th</sup>, with another 28,325 using the Marketplace web portal to enroll in Medicaid.

The figures show that roughly one-quarter of 2014 consumers that need to re-enroll in qualified health plans (QHP) by December 18<sup>th</sup> in order to continue coverage into 2015 have already done so. However, Marketplace officials are urging all 2014 consumers to shop around for new plans,

State officials trumpeted the performance of the redesigned website, which imported the software from Connecticut's successful Marketplace after persistent technological failures severely impeded MHC enrollment during the inaugural open enrollment period (see Update for Weeks of March 17<sup>th</sup> and 24<sup>th</sup>). The rebuild cost taxpayers \$40 million (see Update for Week of August 18<sup>th</sup>), but the MHC director insisted this week that the improvement was "night and day", resulting in enrollment numbers that are 29 times higher than the comparable period last year.

Maryland fired its initial Marketplace contractor Noridian Healthcare Solutions (see Update for Week of February 10<sup>th</sup>), but the Marketplace remains the subject of federal investigations and a separate state audit to determine if federal establishment grants were misused by state officials or Noridian (see Update for Weeks of March 10<sup>th</sup>).

#### Michigan

##### ***Dual-eligible demonstration under ACA delayed for two months***

The Department of Community Health announced late last month that the start date for its Affordable Care Act (ACA) demonstration to improve care coordination for Michigan's 220,000 dual-eligibles will be delayed from January 1<sup>st</sup> to March 1<sup>st</sup>.

Michigan is one of 12 states to receive federal approval to move those eligible for both Medicare and Medicaid into capitated managed care plans. Enrollment in the demonstration will now start in February 2015 and the program will run for an additional year through December 2018.

Over the first six months, the demonstration will launch in two phases across four regions of the state. Those that fail to choose a plan will be automatically enrolled. However, dual-eligibles can still opt-out and elect to stay in traditional Medicare, Medicare Advantage, or a Part D prescription drug plan (see Update for Week of March 31<sup>st</sup>).

Under the terms of the waiver, the state and the federal government are projecting one percent lower costs in the first year and two percent in the second.

#### Oregon

##### ***Oregon to use Marketplace infrastructure from Kentucky***

Cover Oregon officials acknowledged this week that only about ten percent of previous qualified health plan (QHP) consumers have re-enrolled for 2015 since the new open enrollment period started on November 15<sup>th</sup>.

Oregon is one of only two states (besides Nevada) that were forced to default back to the federally-facilitated Marketplace after a failed effort to create its own state-based Marketplace (SBM) pursuant to the Affordable Care Act (see Update for Weeks of April 28<sup>th</sup> and May 5<sup>th</sup>). The wholesale transition meant that all QHP consumers from 2014 must re-enroll in Cover Oregon through the FFM portal by December 15<sup>th</sup> or incur a break in coverage starting in January. However, as of November 30<sup>th</sup> only about 7,200 of Cover Oregon's 77,000 QHP consumers have done so.



The spectacular failure of Cover Oregon's web portal severely impeded enrollment as the SBM was unable to complete any online applications during its entire existence (see Update for Week of April 21<sup>st</sup>). Cover Oregon now faces multiple federal and state audits and remains embroiled in dueling litigation with its former lead contractor, Oracle Inc. (see Update for Week of August 18<sup>th</sup>).

Cover Oregon insurers are urging state officials to provide them with some certainty before they set 2016 premiums next summer. In response, Governor John Kitzhaber (D) and leading lawmakers have formulated a proposal to transfer Cover Oregon from an independent entity into the Department of Consumer and Business Services (DCBS), a move that would give the state greater oversight and control over the development of a new state-based web portal.

The state's leading insurer, Regence Blue Cross and Blue Shield, backs the transition to DCBS, as long as the Division of Insurance (which approves their rates) has no oversight over Marketplace operations. Regence is also urging Cover Oregon to quickly revert back to a new state-based web portal in order to avoid any risk of losing ACA premium tax credits if the U.S. Supreme Court invalidates them for FFM consumers (see Update for Week of November 3<sup>rd</sup>).

As a result, Cover Oregon announced this week that it will use the existing software for Kentucky's state-based Marketplace to build its own web portal. Maryland recently made a similar move, electing to import software from Connecticut instead of defaulting back to the FFM (see above).

#### Pennsylvania

#### ***Nearly 27,000 households have applied for new Medicaid expansion alternative***

State officials announced that nearly 27,000 households (or an estimated 49,000 individuals) applied for coverage through the Healthy Pennsylvania alternative to the Medicaid expansion under the Affordable Care Act (ACA) during the first ten days since enrollment started on December 1<sup>st</sup>.

Up to 600,000 Pennsylvanians are expected to ultimately enroll in the program, which was created by outgoing Governor Tom Corbett (R). Pennsylvania is one of only five states that the Obama Administration has allowed to redirect ACA matching funds towards the purchase of private Marketplace coverage for the newly-eligible population (see Update for Week of October 20<sup>th</sup> and 27<sup>th</sup>). However, the long-term fate of Healthy Pennsylvania will be decided in the next legislative session, where Governor-elect Tom Wolf (D) is expected to try and persuade Republicans that control both chambers to convert the expansion alternative into a traditional expansion under the ACA, which the Government Accountability Office and Congressional Budget Office have found to be less costly (see Update for Week of September 29<sup>th</sup>).