



Health Reform Update – Weeks of January 26 and February 2, 2015

CONGRESS

Déjà vu all over again as House votes to repeal Affordable Care Act, offer Republican alternative

The House passed a measure this week to fully repeal the Affordable Care Act (ACA) and direct four committees to develop a replacement that meets Republican ideals.

Reps. Robert Dold (R-IL), John Katko (R-NY), and Bruce Poliquin (R-ME) joined with all House Democrats in opposing the bill. The House has now voted four times to fully repeal the ACA and 56 times to repeal all or part of the law.

Even if it likewise clears the Republican-controlled Senate, H.B. 596 is likely to be purely symbolic given that neither chamber has a veto-proof majority. However, the vote gave 47 new House Republicans the opportunity to record their opposition to the ACA.

H.B. 596 differs from previous versions as it would require Republicans to develop an ACA replacement and not simply recycle a traditional wish list of malpractice reform, interstate health plans, privatized Medicare, and Medicaid block grants (see Update for Week of March 31st). Three House and Senate leaders did unveil the blueprint for such replacement legislation, which would eliminate the ACA's controversial individual/employer mandates and Medicare cost-cutting board, as well as the health insurance Marketplaces and taxes on health plans and device and drug manufacturers. However, the replacement would retain some of the law's framework, including prohibitions against pre-existing condition denials and lifetime benefit caps, allowances for young adults to remain on their parents' group plans, and some revenue-raising measures including the tax on so-called "Cadillac" health plans.

Most notably, the Republican plan would retain the same premium tax credits that conservative groups want the U.S. Supreme Court to strip away from federally-facilitated Marketplace consumers (see Update for Week of January 5th). Although tax credit eligibility would be reduced from 400 percent of the federal poverty level to 300 percent, they would be available for Medicaid enrollees to purchase private coverage, as well as to anyone working for companies that employ less than 100 workers.

The Medicaid expansion under the ACA would also be terminated in favor of Republicans' long-sought proposal to convert Medicaid into a federal block grant program with few if any strings attached.

House Ways and Means chair Fred Upton (R-MI), Senate Finance chair Orrin Hatch (R-UT), and Senator Richard Burr (R-NC) pledged to provide additional details in the coming weeks, although Burr acknowledged it likely would not be voted on until a new President is inaugurated in 2017.

The blueprint garnered little immediate support from Congressional Republicans and House Majority Leader Kevin McCarthy (R) announced that a different group of House members led by Rep. Paul Ryan (R-WI) and Rep. John Kline (R-MN) are crafting their own alternative.

CBO says ACA will cost 20 percent less due to fewer subsidies, Marketplace enrollees

The Congressional Budget Office (CBO) announced last week that expanded health coverage under the Affordable Care Act (ACA) will cost the federal government roughly \$571 billion from 2015-2019, down from the \$710 billion figure it initially projected when the law passed in 2010.



The 20 percent downgrade is due to many factors, led by the continued "slowdown in the growth of health care costs", premiums for ACA-subsidized plans that are lower than expected, and one million fewer consumers enrolling in Marketplaces by 2016 (due to technological impediments). In addition, projections for Medicaid spending per beneficiary are significantly below projections in the 28 states (and the District of Columbia) that are participating in the Medicaid expansion under the ACA, resulting in overall savings despite Medicaid and Children's Health Insurance Program enrollment exceeding expectations (increasing overall projected costs by seven percent).

CBO does expect Marketplace enrollment to "grow rapidly over the next two years [to 25 million] in response to increased outreach by state health agencies and others and to increased awareness of the individual mandate," helping to further reduce the number of uninsured working-age Americans by eight percent through 2017. According to CBO, the majority of the remaining uninsured will be exempt from the individual mandate under the ACA because they will be either undocumented immigrants or fall into the "coverage gap" created by states opting-out of the Medicaid expansion.

From 2016-2025, the federal government is expected to spend \$909 billion in premium tax credits under the ACA and another \$147 billion in cost-sharing subsidies, assuming that roughly 75 percent of Marketplace enrollees qualify for the assistance. Per CBO, these subsidies will average roughly \$5,000 per qualifying enrollee from 2016-2018 and increase to nearly \$8,000 in 2025 (about seven percent lower than initially projected).

CBO acknowledged that 15 percent of subsidy-eligible individuals chose the least generous bronze-level coverage in the Marketplaces during the inaugural open enrollment period and thus did not qualify for the ACA subsidies, which also exceeded their expectations. This caused overall costs to be further downgraded.

Projected revenue from the excise tax on "Cadillac" health plans that goes into effect in 2018 is now expected to be \$149 billion higher than anticipated during the first eight years, also contributing to the lower cost projection. However, proposed repeals or limitations of this tax have attracted some Democratic support in Congress and its ultimate survival remains unclear.

The lower projections for the ACA helped to lower CBO's federal budget deficit projections to the lowest level since 2008.

Kaiser poll shows strong support for Congress, states to protect ACA subsidies

New polling conducted by the Kaiser Family Foundation revealed last week that a strong majority of those surveyed want Congress or state lawmakers to restore premium and cost-sharing subsidies under the Affordable Care Act (ACA) if they are denied to federally-facilitated Marketplace (FFM) consumers by the U.S. Supreme Court later this year.

The high court has scheduled oral arguments on March 4th regarding legal challenges to the FFM subsidies brought nationwide by conservative groups (see Update for Week of January 5th). The court's intervention prior to a split in appellate opinions has worried ACA proponents (see Update for Week of November 10th), since RAND testified before Congress this week that striking down the FFM subsidies would raise FFM premiums by roughly 47 percent and cause a 70 percent decline in FFM enrollment.

The Kaiser survey found that most FFM consumers at risk of losing their subsidies had not heard of the legal challenge and a shocking two-thirds did not even realize their Marketplace was federally-controlled. When informed, nearly two-thirds (64 percent) stated that Congress should act to preserve the FFM subsidies (including 40 percent of Republican respondents) while 59 percent wanted their state to create their own ACA Marketplace in order to keep the subsidies in place (including 51 percent of Republican respondents).



According to the U.S. Department of Health and Human Services (HHS), 87 percent of the seven million consumers signing-up for FFM coverage in 2015 are eligible for the ACA subsidies (see below).

The Republican chairmen of the House Energy and Commerce Committee and House Ways and Means Committee sent a letter this week to HHS and Treasury demanding that they stop “unlawfully and unconstitutionally” issuing the cost-sharing subsidies for those earning 100-250 percent of the federal poverty level. The agencies made over \$2.7 billion in such payments during 2014 despite the lack of any Congressional appropriation by using funds intended to consumer tax refunds.

CBO hikes cost of permanent fix to Medicare physician payment formula

The odds of Congress passing a permanent fix to the current Medicare physician payment formula before a 21 percent cut goes into effect on April 1st became much longer this week after the Congressional Budget Office (CBO) increased the cost of the proposed replacement by \$30.5 billion.

Compromise legislation hammered out by three congressional committees last year had been bogged down by disputes over how to offset the \$144 billion cost that CBO predicted over the next decade (see Update for Week of January 19th). However, CBO now estimates that the same measure will cost \$174.5 billion, albeit with an 11th year added to their budget window.

Congress has been forced to pass 17 separate delays of the sustainable growth rate (SGR) formula since 2003, in order to avoid severe annual cuts of 20-30 percent in Medicare physician reimbursement. The latest patch expires March 31st (see Update for Week of December 8th).

House Ways and Means and Senate Finance leadership stated this week that another temporary extension was almost certain. However, CBO predicted that even a nine-month freeze in current physician payment rates would cost \$6 billion.

The proposed offset for a temporary patch is likely to be a one-year extension of the sequestration cuts for mandatory spending programs such as Medicare (past 2024). They also would extend the Affordable Care Act cuts to disproportionate share hospital payments for indigent care to 2025. These cuts were premised on all states expanding Medicaid under the law so “opt-out” states will suffer the greatest impact from extended DSH reductions.

President's budget fully funds ACA, targets Medicare payment for high-cost drugs

President Obama released his proposed budget this week for fiscal 2016 that cuts the federal deficit by \$1.8 trillion over ten years while fully funding implementation of the Affordable Care Act (ACA) and other critical health care programs. However, it also would strip away \$399 billion in health care funding primarily through cuts in Medicare payments.

The plan is just a starting point and likely to be opposed in large part by the Republican-controlled Congress as it would exceed the spending caps set by the *Budget Control Act of 2011*. The most recent federal spending bill for fiscal 2014-2015 stayed within these caps, avoiding the law's automatic sequester cuts (see Update for Week of January 19th).

The budget plan would extend funding for the state Children's Health Insurance Program (SCHIP) past its September 30th expiration through 2019. The extension was recommended by the Medicaid and Children's Health Insurance Program Payment and Access Commission (see Update for Week of February 17th) and has bipartisan support despite the lack of Congressional action. It would be funded largely through increased tobacco taxes.



The President's budget would also increase FDA funding by six percent while holding funding for Ryan White HIV/AIDS programs constant at \$2.3 billion (with \$900 million allocated for the AIDS Drug Assistance Program).

Stating that the President is "deeply concerned with the rapidly growing prices of specialty and brand name drugs," the budget proposes several changes in Medicare payments for prescription drugs that are intended to lower costs by \$126 billion over ten years.

The most prominent of these proposals is likely to draw the most ire from Republicans, as it would give Medicare Part D authority to negotiate pricing for biologics and other high-cost drugs. The 2003 law creating the Part D program explicitly barred it from negotiating prices directly with drug manufacturers.

President Obama is renewing his earlier proposals to limit the exclusivity period for brand-name biologics to seven years (see Update for Week of March 3rd), as he initially sought in 2009 before Congress expanded the window to 12 years under the new regulatory pathway for biosimilars that was created by the ACA. He now estimates that this change alone would generate \$16 billion in savings over ten years.

The President's budget also would accelerate ACA-mandated discounts on brand-name drugs so that Part D beneficiaries pay the same coinsurance in or out of the coverage gap or "doughnut hole" starting in 2017, instead of 2020.

Other Medicare savings resurrect proposals from the President's earlier budgets (see Update for Week of March 3rd), including banning "pay-to-delay" generic drug settlements (\$10 billion over ten years), expanding Medicaid drug rebates to Part D (\$116 billion over ten years), a move strongly opposed by Republicans, and raising Part B and D premiums for wealthy Medicare enrollees, a proposal that has some bipartisan support (see Update for Week of January 6th). It is now estimated to generate about \$66.4 billion in revenue over the next decade (compared to \$52.8 billion projected in last year's budget).

The President's savings assume that Congress will take action to replace the flawed Medicare physician payment formula. However, any permanent fix seems unlikely for the current year due to the inability of Congress to agree how to offset the \$144 billion price tag (see above).

FEDERAL AGENCIES

Marketplace enrollment for 2015 surpasses initial target

Nearly ten million Americans signed-up for coverage in the federally-facilitated or state-based Marketplaces (SBMs) created by the Affordable Care Act (ACA) through January 30th, according to the most recent figures released by Health and Human Services (HHS).

With only two weeks remaining until the February 15th end of the second open enrollment period, the number of sign-ups have surpassed the 9.1 million projected by the HHS Secretary, which was downgraded from the 12 million initially predicted by the Congressional Budget Office (see above). Roughly 7.5 million consumers have enrolled in the 37 federally-facilitated Marketplaces (FFMs), while another 2.4 million signed-up through SBMs. The majority (58 percent) of FFM enrollees were returning customers while 42 percent enrolled for the first time.

Florida continues to lead all other states with more than 1.4 million enrolled. HHS credits aggressive marketing and outreach for enabling the five south Florida counties with among the nation's highest rates of uninsured (including Miami-Dade at 34.4 percent) to account for one-seventh of the state's total Marketplace enrollment. (One zip code in Hialeah led all others with nearly 12,500 residents



enrolled). Last year's Marketplace leader California is close behind at 1.2 million, while Texas is approaching one million enrollees, exceeding their 2014 total by more than one-third.

Enrollment in other states has surprisingly lagged (see Colorado below). The Washington Healthplanfinder, which enrolled the fourth highest number of consumers in 2014, has reached only 60 percent of its 2015 target.

HHS confirmed that roughly 87 percent of enrollees have qualified for the ACA's premium tax credits, up from 83 percent the year before. However, this assistance could be denied to FFM consumers by the U.S. Supreme Court later this year (see Update for Week of January 19th).

More FFM consumers in 2015 are purchasing silver-level coverage (70 percent compared to 65 percent). The ACA's premium and cost-sharing subsidies are tied to these plans.

Young adult Marketplace enrollment continues to lag

Recent data released by the Department of Health and Human Services (HHS) shows that the share of adults aged 18-34 enrolling in Affordable Care Act (ACA) Marketplaces has remained largely the same as in 2014.

Only 25 percent of last year's Marketplace enrollment were within this coveted less-costly age group, well below the 39-40 percent proportion that insurers insisted was required to ensure the a financially-viable risk pool (see Update for Week of January 13, 2014). This figure has increased to only 26 percent through January 30th.

HHS officials noted that young adult enrollment surged during the end of the inaugural open enrollment period in 2014. A similar surge by the February 15th deadline this year should improve the young adult ratio.

The enrollment of Latino-Americans has also improved so far this year (ten percent compared to seven percent in 2014). This is another key demographic given the traditionally higher rates of uninsured among Latino-Americans.

Medicaid and SCHIP enrollment breaks ten million nationwide

The latest Health and Human Services (HHS) figures on Medicaid and the Children's Health Insurance Program enrollment show that roughly 10.1 million are covered by both programs through last November, representing a 17.5 percent increase since the year prior.

Among the 26 states and the District of Columbia that had expanded Medicaid under the Affordable Care Act (ACA) by that time, enrollment had jumped nearly 25.5 percent from the July-September 2013 baseline just before the opening of the new health insurance Marketplaces. However, Medicaid and SCHIP enrollment still increased by seven percent in "opt-out" states due largely a "woodwork effect" from simplified application and eligibility criteria under the ACA.

IRS will not penalize consumers that fail to promptly repay ACA subsidy overpayments...for now

The Internal Revenue Service (IRS) announced last week that it will not impose late payment penalties on Marketplace consumers who fail to promptly repay premium tax credits to which they were not entitled.

Under the Affordable Care Act (ACA), those earning 100-400 percent of the federal poverty level (FPL) are eligible for the premium tax credits. Most elected to have them paid in advance to their insurer.



The amount of the tax credits averaged about \$3,000 and varied based on reported income for 2014. The amount received is then reconciled against the consumer's actual income recorded on IRS Form 8962 and any overpayment must be repaid.

This repayment is capped at \$2,500 for those earning at or below 400 percent of FPL. However, if a consumer's income increased to more than 400 percent during the year, the entire overpayment must be repaid.

The IRS estimates that 2-4 percent of the nation's 150 million taxpayers (or roughly six million Americans) will be required to repay premium tax credit overpayments for tax year 2014. The agency will let consumers repay these amounts in installments, but they will be assessed interest until the entire balance is paid. However, late penalties will not be applied for 2014 if the amount is not fully repaid by April 15th. The IRS has not indicated that any other tax relief will be provided.

Officials with the Department of Health and Human Services (HHS) had been urged by consumer advocates to create a special enrollment period (SEP) for these six million repayees. Thus far, they have only agreed to consider the issue after the Marketplace enrollment period closes on February 15th.

Senate Finance chairman Orrin Hatch (R) issued a letter last week demanding that the IRS explain the decision to forgo penalties and state whether it will continue to do so in future years.

Medicare to cover testing for HIV/AIDS

The Centers for Medicare and Medicaid Services (CMS) announced this week that it will start covering routine screening tests for the HIV/AIDS virus.

Under the proposed rule, beneficiaries age 15-65 would be able to receive annual HIV screening. Adolescents under 15 and adults over 65 can receive an annual voluntary screening if they have an increased risk for the virus.

Medicare coverage for pregnant women will not change. Women will still receive three voluntary HIV screenings (one when the pregnancy is diagnosed, another when the woman is in her third trimester and a third at labor.)

The AIDS Institute lobbied for the rule change, which it insists will help better identify those who are unaware of their infection (roughly 168,000 of 1.2 million Americans living with HIV/AIDS).

HHS to accelerate Medicare transition to new payment models

The Department of Health and Human Services (HHS) outlined its plan last week to accelerate efforts to transition reimbursement methodologies away from traditional fee-for-service (FFS) and towards value-based payments tied to quality.

The announcement represents the first time the agency set concrete goals for tying a certain portion of Medicare spending to alternative payment models. It also marks a broader shift to focusing on care delivery and payment reform now that the coverage expansion under the Affordable Care Act (ACA) has been fully implemented.

Under the agency's timeline, at least 30 percent of Medicare's FFS payments will go towards alternative payment models by 2016, phasing up to 50 percent by 2018 (when 90 percent of Medicare payments will be linked to some sort of quality metrics). This would be an increase from the 20 percent of provider payments that were made through alternative models in 2014 (which does not include Medicare Advantage or Part D payments).



Alternative payments models include ongoing demonstrations under the ACA, such as those testing accountable care organizations where providers and physicians share in savings for meeting quality and efficiency targets, bundled payments or global budgets, and coordinating care for dual-eligibles through capitated plans.

The American Medical Association and American Hospital Association broadly endorsed the goals set by HHS, which include a new Health Care Payment Learning and Action Network to help the agency work with payers and providers to expand value-based payment. Several of the nation's largest health care systems, insurance plans and employers also announced that they will follow HHS' lead and put 75 percent of their business into value-based payment arrangements by 2020.

STATES

Harvard documents that Marketplace insurers in 12 states are unlawfully limiting drug coverage

A Harvard University study published last week in the *New England Journal of Medicine* confirms that Marketplace insurers in at least a dozen states are employing cost-sharing designs for prescription drugs that unlawfully discriminate against persons with HIV/AIDS.

Researchers with the Harvard School of Public Health initiated the analysis in response to discrimination complaints filed by The AIDS Institute (TAI) and other consumer advocates with the U.S. Department of Health and Human Services (HHS) and Florida Office of Insurance Regulation (OIR). HHS has since issued proposed rules declaring the practice of moving all or most drugs for a given condition into tiers requiring consumers to pay percentage of the drug's cost (or coinsurance) to be in violation of the anti-discrimination provisions of the Affordable Care Act (ACA) (see Update for Week of January 5th). OIR has also entered into consent orders or settlements with three of the four Florida insurers found to be engaging in the same discriminatory practice (see Update for Week of December 15th).

Researchers determined that the same practice is occurring in 12 of the 37 states using the federally-facilitated Marketplace (FFM). They compared the out-of-pocket costs for HIV drugs imposed by insurers in six of these states (Delaware, Florida, Louisiana, Michigan, South Carolina, and Utah) with HIV drug cost-sharing charged by the six most populous FFM states that did not have these insurers in their Marketplace.

The findings showed that 25 percent of the surveyed plans relied on "discriminatory drug tiering" for a commonly-prescribed class of HIV medication called nucleoside reverse-transcriptase inhibitors (NRTIs). Consumers in these tiers paid \$3,000 more on average for these NRTIs (even for generic versions) than consumers in non-discriminatory drug tiers.

The study concluded that these practices were designed to "dissuade those with preexisting conditions such as HIV from enrolling in the plan" and effectively circumvent the goal of the ACA to prevent discrimination against those with pre-existing conditions. It warned that such discrimination could engender a "race to the bottom" in plan designs that try to avoid a large influx of costlier enrollees.

Arkansas

"Private option" alternative to Medicaid expansion survives for another year

Both the House and Senate fast-tracked legislation this week to extend Arkansas' federally-approved alternative to the Medicaid expansion under the Affordable Care Act (ACA), at least through June 2016.

Consistent with the recommendations of new Governor Asa Hutchinson (R) (see Update for Week of January 19th), the measure (S.B. 96) creates a 16-member legislative task force to study



changes or replacements to the “private option” expansion, which requires an annual re-authorization via a three-quarters margin from the legislature. The program survived by only one vote last year and appeared to be in severe jeopardy this session following the election of several conservative lawmakers who campaigned on a pledge to terminate coverage for more than 205,000 Arkansans that have enrolled (see Update for Week of November 3rd).

The “private option” was the first alternative to the ACA Medicaid expansion to receive federal approval (see Update for Week of September 23, 2013). Five states have followed with similar models (see Indiana below).

Medicaid settles consumer lawsuit over rationing of cystic fibrosis drug

Medicaid officials announced this week that they reached a settlement that will resolve a federal lawsuit alleging that it unlawfully denied coverage to cystic fibrosis (CF) patients due solely to cost.

The lawsuit was filed last summer by three patients after Medicaid had denied coverage for two years for the drug Kalydeco, which has an annual wholesale price of \$311,000. According to *The Wall Street Journal*, the drug’s manufacturer (Vertex) had stopped providing free product through its patient assistance program, insisting that it would encourage other Medicaid programs to likewise start rationing care. Several states had already started restricting coverage for costly new Hepatitis C “cures” to only the sickest patients (see Update for Week of July 28th).

As part of the settlement, Arkansas Medicaid agreed to make its eligibility criteria consistent with Food and Drug Administration (FDA) guidelines and maintain the changes for at least two years. All three plaintiffs meet these guidelines, but were denied coverage until their health worsened from taking older medications. Medicaid was also requiring CF patients to prove that Kalydeco was improving their lung function, weight gain, and number of hospitalizations before it approved any renewed prescriptions.

Arkansas Medicaid had already eliminated the onerous requirements that were the subject of the lawsuit in January, after an advisory board recommend that they do so. Under the new policy, patients only have to show improvement in one of these areas or provide other evidence of clinical benefit. The policy may be put to the test this summer when the FDA is expected to approve a combination drug from Vertex that will cover a broader number of CF patients but with less clinical benefit.

State Medicaid programs spent \$28.45 million on Kalydeco in the first half of 2014, representing 24 percent of the drug’s total US sales over that time.

California

Vast majority of Covered California consumers are renewing plans

Covered California officials announced last week that roughly 92 percent of all existing customers have re-enrolled in the Affordable Care Act (ACA) Marketplace for 2015.

Roughly 57.5 percent of consumers allowed their 2014 coverage to simply renew, while the remainder decided to shop for new plan options within the Marketplace. Kaiser Permanente led all participating insurers with a 99 percent retention rate.

Anthem, the nation’s second largest health insurer, continues to control the largest market share within Covered California (at 29 percent). However, its closest competitor, Blue Shield of California, made the surprising decision this year to pull out of 250 most rural zip codes throughout the state, including four entire counties (Alpine, Monterey, Sutter, and Yuba). This has caused a majority of consumers in northern California to be left with only one participating insurer, a move sure to increase premiums if other insurers do not fill the void (see Update for Week of January 19th).



Blue Shield insists that its decision to withdraw was based solely on its inability to find enough health providers willing to accept the low reimbursement levels and narrow provider networks that were required to keep premiums affordable.

Colorado

Technology glitch causes erroneous cancelations of more than 3,600 Marketplace plans

Officials with Connect for Health Colorado acknowledged last week that 3,615 plans that should have been renewed were wrongly canceled due to technology glitches with the online web portal that has prevented another 4,800 consumers from applying.

The oversight board has already approved emergency funding in an effort to fix the software issues, that greatly depressed enrollment during the inaugural open enrollment period last year. The persistent flaws and unexpected costs led the Senate to unanimously pass legislation last week (S.B. 19) authorizing a comprehensive new audit of all Marketplace finances, after a more limited audit identified nearly \$500,000 in questionable payments (see Update for Week of December 8th). Republican backed legislation to also transition the Marketplace back to federal control failed to advance in the Democratically-controlled House.

Connect for Health Colorado will offer retroactive coverage back to January 1st for those whose plans were erroneously canceled. The Marketplace continues to struggle in attracting new customers as roughly 76.5 percent of the 121,650 enrollees through January 15th were renewals, far above the 58 percent average for the 37 federally-facilitated Marketplaces (see above).

Florida

House preemptively refuses to consider ACA-funded Medicaid expansion

For the third consecutive year, a House Speaker has rejected calls for Florida to participate in the Medicaid expansion under the Affordable Care Act (ACA) even before the legislative session begins.

The Republican-controlled Senate passed legislation last year (see Update for Week of March 31st) that would have created a private sector alternative to the Medicaid expansion similar to that federally-approved for six states (see Arkansas and Indiana above). However, the more conservative House chamber refused to consider any alternative that accept federal funds.

New Speaker Steve Crisafulli (R) made clear last week that the position of House leadership remains unchanged and that only more limited state-funded expansions will be debated in 2015. His position appears to leave little room for the alternative plan advanced by a business coalition called “A Healthy Florida Works” that would use ACA matching funds to create a private health insurance Marketplace for the roughly 740,000 Floridians that fall into the coverage gap between current Medicaid eligibility and the threshold for ACA subsidies (see Update for Week of December 15th).

Speaker Crisafulli was reminded by expansion proponents that Florida already accepts \$1 billion in federal funds to operate its Low Income Pool that covers hospital uncompensated care costs. However, he drew a distinction between those funds and the ACA matching funds, which he and other Republicans insist may never materialize.

Indiana

CMS approves Governor's Medicaid expansion alternative based on health savings accounts

Governor Mike Pence (R) and the federal Centers for Medicare and Medicaid Services (CMS) reached a long-sought agreement last week on an alternative to the Medicaid expansion under the Affordable Care Act (ACA).



The approval makes Indiana the 28th state to participate in the ACA expansion (in addition to the District of Columbia). Governor Pence also becomes the tenth Republican governor to do so.

Under the Governor's three-year demonstration plan submitted last year (see Update for Week of June 2nd), up to 350,000 Indianans made Medicaid-eligible by the ACA would be covered under the state's existing Healthy Indiana Plan (HIP), which allowed residents just above standard Medicaid eligibility to make contributions to health savings accounts (HSA) that pay premiums and cost-sharing for private coverage through Medicaid managed care plans. The new plan (HIP 2.0) creates two levels of coverage: HIP Basic for those earning at or below 100 percent of the federal poverty level (FPL), which complies with the essential health benefit package mandated by the ACA, and HIP Plus, which provides broader benefits to those earning above this threshold.

As with the existing HIP, those enrolled in HIP Plus will be required to make monthly contributions of about \$25 to a Personal Wellness and Responsibility (POWER) account, a type of HSA. Premiums will be limited to no more than two percent of income, but can be reduced by participating in wellness programs. They will not be charged additional cost-sharing, unless receiving emergency room services. For those earning less than 95 percent of FPL, cost-sharing will be limited to no more than \$1 per month.

Indiana is the first state in the nation to receive federal approval to "lock out" enrollees above 100 percent of FOPL and deny them coverage for failing to make the required contributions for 60 days. The current HIP allowed the state to locked non-medically frail enrollees for up to 12 months, which CMS reduced to six months.

However, CMS rejected the Governor's effort to require a \$2,500 deductible and removed all work requirements from the Governor's plan, as it did from those submitted by other conservative governors in Pennsylvania, Tennessee, and Utah (see Update for Week of December 1st). Indiana will be allowed only to "encourage" employment through a state-funded incentive program that will not impact coverage or costs for individuals.

CMS will also no longer allow Indiana to cap enrollment, as it did under its existing HIP waiver, nor can premium payments exceed two percent of income.

Governor Pence is rumored to be a potential Presidential candidate in 2016 and promoted his plan as one that embodied "conservative principles" not found in the traditional ACA expansions pursued by other Republican governors that may be also competing for the nomination, including Chris Christie of New Jersey and John Kasich of Ohio. Despite his agreement to accept the ACA matching funds to expand Medicaid, Pence insisted that he still favors a total repeal of the law.

The demonstration waiver already has the approval of the Republican-controlled legislature and went into effect on February 1st. The state share of costs will be partly funded by an assessment on Indiana hospitals, as well as revenue from cigarette taxes.

Maryland

Drug coverage in Marketplace plans is more costly than employer-based plans

A new study from the Partnership to Fight Chronic Disease found last week that prescription drug coverage under the Maryland Health Benefit Exchange is imposing out-of-pocket costs that are so high they are deterring patients from adhering to their medications.

The analysis surveyed cost-sharing designs under silver-level plans offered by Marketplace plans and compared them to a typical employer-sponsored plan in Maryland. It found that on average, Marketplace subscribers with one or more chronic conditions paid 66 percent more for their prescription drugs than those under employer plans. Those with only one chronic condition actually saw the highest average increase of nearly 89 percent.



Researchers also stressed that Marketplace plans in Maryland are failing to include an adequate number of physicians in their networks to ensure access to care.

The study concludes that those with chronic conditions are effectively being discriminated against by the Marketplace plans, in direct violation of the Affordable Care Act. The authors noted that they are working with state Senator Catherine Pugh (D) and Delegate Ariana Kelly (D) on future legislation to prevent this type of discrimination and make it easier for Marketplace consumers to avoid plans that impose the highest out-of-pocket costs for prescription drugs.

Mississippi

Legislation to ban specialty tier coinsurance dies in committee

The House Insurance Committee refused to hear legislation this week that would prohibit health insurers from using specialty tiers that require subscribers pay a percentage cost for prescription drugs.

The bill sponsored by Rep. Alyce Clarke (D) would have declared specialty tiers as contrary to the purpose of health insurance. H.B. 90 also sought to limit prescription drug copayments to no more than 500 percent of the lowest copayment required by the policy for its formulary medications and out-of-pocket drug expenses could not exceed \$1,000 per year for each insured or \$2,000 per insured family.

Ohio

Attorney General sues to block ACA tax on state and local government plans

Attorney General and former U.S. Senator Mike DeWine (R) filed a federal lawsuit last week challenging the constitutionality of the Affordable Care Act (ACA) tax on state and local government health plans.

Four public universities joined the lawsuit in the U.S. District Court for the Southern District of Ohio, which appears to be the first challenge to the tax on self-insured group health plans. The tax funds the ACA's three-year Transitional Reinsurance Program that compensates insurers for exceptional claims in order to keep premiums affordable. It collected \$6.25 million from Ohio government entities last year, which the plaintiffs want the court to return to the state.

Attorney General DeWine insists that there is no precedent for such an "unconstitutional" and "broad-based" tax, a portion of which goes directly into a general fund for the U.S. Department of Treasury and not the reinsurance program.

Pennsylvania

Health committee unanimously approves parity bill for oral cancer drugs

The House Health Committee voted last week to send a bill to the floor that would make Pennsylvania the 35th state to bar insurers from imposing higher cost-sharing on oral anti-cancer medications.

H.B. 60 passed unanimously despite objections from the insurance industry, including complaints that they were being unfairly blamed for high drug costs charged by manufacturers. Consumer advocates strongly back the so-called "parity" measures as a coinsurance of 20 percent or more of the cost of an oral medication can be a prohibitive barrier compared to intravenous chemotherapy, which can cost roughly \$100 per visit.

The bill was sponsored by committee chairman Matt Baker (R), who refused to delay the vote citing the overwhelming House support for a comparable measure last year (which passed with only one dissenting vote). However, that measure stalled in the Senate.



Similar legislation will receive a February 13th committee hearing in Connecticut (S.B. 7), is under consideration in the South Dakota Senate Commerce Committee (S.B. 101), and was approved last week by the Mississippi House (H.B. 953).

South Dakota

Committee advances bill to improve plan transparency for provider networks, drug coverage

The Senate Commerce and Energy Committee unanimously approved legislation this week that would make South Dakota the latest state to increase public transparency of provider networks and prescription drug coverage offered by private health plans.

As with pending legislation in California (see Update for Week of January 19th), S.B. 118 would require provider network lists be published online and updated at least every six months. This includes a description of drug formulary provisions including how to identify whether a specific drug is included, as well the process for requesting an exception to the formulary.

The bill also specifically requires an online explanation of how plan limitations impact enrollees, including information on enrollee financial responsibility for payment of drug coinsurance or other non-covered or out-of-plan services.

Tennessee

Senate panel rejects Governor's Medicaid expansion alternative

The Senate Health Committee voted this week to reject the proposed "private sector" alternative to the Medicaid expansion under the Affordable Care Act (ACA) that had been put forward by Governor Bill Haslam (R).

The Governor had been negotiating the terms of his Insure Tennessee plan for months with the federal Centers for Medicare and Medicaid Services (CMS), based on a similar model the agency recently approved for Indiana (see above). He called a special session this month to secure the needed legislative approval for the plan, which would have used ACA matching funds to provide private Medicaid managed care or employer-sponsored coverage to at least 280,000 Tennesseans earning up to 138 percent of the federal poverty level.

However, Insure Tennessee faced fierce opposition from conservative lawmakers fervently opposed to accepting any federal funds for a Medicaid expansion. Despite the backing from key Republicans, the Tennessee Hospital Association, and a majority of Tennesseans polled, the committee voted 7-4 against the plan.

House Majority Leader Gerald McCormick (R) insists that the plan has the votes to pass "comfortably" in the House. However, the rejection by the Senate panel makes it unlikely that measure will continue to be considered by the House Health Committee, effectively ending the special session.

The lone Democrat on the Senate Health Committee, Jeff Yabro, sparked intense debate on the Insure Tennessee plan by pointing out that 116 of the General Assembly's 132 lawmakers receive government-subsidized health coverage through the state employee health plan (where taxpayer funds pay 80 percent of premium costs).

Attorney General Herbert Slatery (R) had previously confirmed with the Centers for Medicare and Medicaid Services (CMS) this week that Tennessee can opt-out of the Medicaid expansion at any time without penalty. His legal opinion was intended to solidify legislative support for Insure Tennessee. It stressed that states that they can "suspend or terminate the demonstration program" as long as it follows the proper notice and phase-out procedures spelled out in their respective waiver.



The committee also heard from a former CMS Administrator under President George W. Bush, who insisted that Tennessee would be “crazy” not to participate in the Medicaid expansion, as well as former majority leader in the U.S. Senate, Bill Frist, MD (R-TN), who noted that eligibility cuts a decade ago to Tennessee’s existing Medicaid program only served to increase uncompensated care costs for hospitals by 60 percent.