Health Reform Update – Weeks of April 6 and 13, 2015

CONGRESS

President signs permanent repeal of flawed Medicare physician payment formula

President Obama signed H.R. 2 into law this week only hours before a 21 percent reduction in Medicare physician payments were slated to take effect.

The measure will provide physicians with a 0.5 percent annual increase in Medicare reimbursement for five years while Medicare transitions to incentive-based payments that reward quality (see Update for Week of March 23rd). It would require participating physicians to receive at least 25 percent of their revenue through these Alternative Payment Models by 2019-2020, with the threshold increasing over time.

Congress had passed temporary patches every year since 2003 to avoid the threat of up to 29 percent cuts in physician payment that were being generated each year by a flawed sustainable growth rate (SGR) formula created under the Balanced Budget Act of 1997. There was strong bipartisan support to permanently repeal the formula and it ultimately passed the Senate this week with only eight dissenting votes from the most conservative Senators led by Ted Cruz (R-TX).

The final legislation represents a rare compromise among the two parties. Senate Democrats supported the bill even though it only reauthorized the Children's Health Insurance Program for two years instead of the four years they sought (see Update for Week of March 16th) and further increased Medicare premiums for enrollees earning more than $85,000 per year starting in 2018. Most Senate Republicans backed the measure even though the projected $214 billion cost (over ten years) was only partially offset (see Update for Week of March 23rd).

The Senate rejected all six amendments to the bill in an effort to expedite passage. This includes an amendment by Senator Patty Murray (D-WA) that would have renewed the Affordable Care Act's boost in Medicaid primary care payments that expired last year (see Update for Week of December 8th). Senator John Cornyn (R-TX) also unsuccessfully sought to add an amendment that would repeal the ACA's individual mandate.

Senator Tom Cotton (R-AR) had sought to replace the SGR formula with indefinite 0.5 percent annual increases in physician payments, citing a warning this week from the chief actuary for the Centers for Medicare and Medicaid Services that the new formula will still require additional legislative fixes to avert further cuts in 2025. That is the point at which the five percent annual bonuses that H.R. 2 provides to physicians participating in alternative payment models will expire. The actuary predicts that by 2048, Medicare physician payments will be less under H.R. 2 than they would have been under the current SGR formula.

Appeals court dismisses suit to block ACA subsidies for members of Congress

A three-judge panel for the Seventh U.S. Circuit Court of Appeals has unanimously upheld the dismissal of a lawsuit brought by a U.S. Senator seeking to deprive members and their staff of premium subsidies under the Affordable Care Act (ACA).

A lower court threw out the lawsuit last summer, which was brought by Senator Ron Johnson (R-WI) (see Update for Week of July 21st). It was backed by 38 Republican colleagues but met with derision

by party leaders including Rep. James Sensebrenner (R-WI), who referred to it as a "publicity stunt" (see Update for Week of January 6th).

The suit challenged Office of Personnel Management (OPM) regulations that gave members of Congress and staff subsidies of up to $5,000 a year for individual coverage and $11,000 for families if they purchase gold-level coverage in the Small Business Health Options Program Marketplace for the District of Columbia (see Update for Week of September 30th).

The three judges on the panel (two of whom were appointed by Republican presidents) concurred with the lower court that Senator Johnson lacked standing to challenge rules that conferred a benefit instead of imposing harm. The judges noted that the Senator was free to decline the subsidies if he disagreed with them on ideological grounds. They also concluded that the Senator failed to substantiate his claim that receiving the subsidies caused voters to view him negatively because it forced him to be part of an ACA law that he claims is unconstitutional.

Gallup survey shows uninsured rate hit new record low

The latest Gallup-Healthways Well-Being Index survey of more than 43,500 adults shows that the uninsured rate hit a new record low during the first quarter of 2015.

The adult uninsured rate had peaked at 18 percent in mid-2013, just prior to the opening of the new health insurance Marketplaces. That figure now stands at only 11.9 percent, down a full percentage point from the last quarter of 2014 (see Update for Week of February 23rd).

Gallup attributes most of the decline to the full implementation of the Affordable Care Act (ACA), though researchers note that an improving economy and falling unemployment rate have accelerated the number of Americans gaining health coverage.

The uninsured rate fell at a slightly slower pace during the second open enrollment period that concluded in mid-February (dropping one full percentage point compared to 1.5 percent during the inaugural open enrollment period).

The uninsured rate declined most precipitously among lower-income Americans (earning less than $36,000 per year) and Latino Americans, falling 8.7 and 8.3 percent respectively (since 2013). However, these groups continue to have higher uninsured rates than other demographic groups.

Young adults aged 26-34 saw the largest decline among any age group, falling 7.4 percentage points since 2013.

FEDERAL AGENCIES

Medicare Advantage payment to rise for 2016, instead of initially projected reduction

The Centers for Medicare and Medicaid Services (CMS) revealed this week that Medicare Advantage (MA) payments for 2016 will actually increase by 1.25 percent, instead of the 0.95 percent cut it initially projected (see Update for Week of February 23rd).

The revision is due to changes in its actuarial assessment that are largely based on an assumption that the Senate will pass the Medicare physician payment "fix" already approved by the House (see Update for Week of March 23rd). President Obama is expected to sign that legislation.

CMS also has elected not to pursue proposed changes to the star rating system that provides bonuses to high-ranking MA plans. The agency initially had concerns that the weight given to seven

rating factors are disadvantaging plans that serve large numbers of low-income enrollees. However, it has scrapped plans to halve those weights in response to criticism from most commentators.

CMS notes that the 1.25 percent payment increase will actually translate into a 3.25 percent jump once several over-used codes are eliminated. It claims that these codes made patients appear sicker than they actually were.

The ACA limited the rate of growth in MA payments, which the Government Accountability Office and others found were traditionally excessive. The restricted payment growth has not hurt enrollment, which has continued to climb by about eight percent per year under the ACA to the point where more than one-third of all Medicare enrollees belong to MA plans. It also has not hurt participating insurers, representing more than 40 percent of the annual revenue for UnitedHealthcare and 75 percent for Humana.

However, the Kaiser Family Foundation notes that out-of-pocket (OOP) maximums under MA plans are also increasing. The number of enrollees with OOP limits from $5,001-$6,700 rose from 25 to 41 percent in 2014.

CMS indefinitely extends deadline for grants to upgrade state eligibility and enrollment systems

The Centers for Medicare and Medicaid Services (CMS) published proposed regulations this week that would give state Medicaid programs additional time to obtain more federal funding to update their enrollment and eligibility computer systems.

States had a December 31st deadline to received enhanced federal matching grants that would cover 90 percent of the costs for designing and developing updated systems to meet Affordable Care Act (ACA) standards. The rule would indefinitely extend that deadline and let states continue to receive a matching rate of 75 percent of the costs for maintaining and operating modernized systems.

California and Tennessee were among the 12 states that received warning letters last year for failing to meet earlier deadlines to upgrade enrollment and eligibility systems, resulting in massive backlogs in Medicaid applications and class-action lawsuits (see Update for Week of September 15th). The states complained that the CMS deadlines were “unrealistic”.

CMS estimates that the latest delay will cost the federal government about $3 billion from 2016 through 2025. Public comments are being accepted for 60 days.

CMS issues guidance on new Part B and D reimbursement policies for biosimilar drugs

The Centers for Medicare and Medicaid Services (CMS) issued two guidance documents clarifying how new biosimilar drug products will be reimbursed under Medicare Part B and D.

The Food and Drug Administration approved the first biosimilar product last month under the new regulatory pathway created by the Affordable Care Act and several more biosimilar approvals are expected by the end of the year (see Update for Weeks of March 2nd and 9th). Under Medicare Part B, physician-administered drugs are typically reimbursed using an average sales price (ASP) plus six percent formula. However, because biosimilar copies of brand name drugs should be less costly than their reference product, this would lower reimbursement rates for physicians prescribing biosimilars, giving them less incentive to do so.

As a result, CMS states that Part B will pay the ASP of the biosimilar drug plus an amount equivalent to six percent of the higher-cost reference biologic. Until biosimilars are on the market long enough for an ASP to be established, Part B will also pay 106 percent of the manufacturer’s wholesale

acquisition cost. Lastly, CMS will create separate billing codes to distinguish biosimilars from their reference products. However, this distinguishing identification will not affect reimbursement.

The Part D guidance relates to the current formulary requirement that participating insurers offer at least two distinct drugs in each class. CMS states that it will handle formulary changes involving biosimilars on a case-by-case basis. However, reference biologics and biosimilars "will not be considered as different drugs for the purpose of satisfying the two distinct drugs requirement. Plans must include at least two drugs in each therapeutic category when available."

Even though CMS acknowledges that biosimilars are not generic copies of their reference product, the guidance emphasizes that they are also not so dissimilar that they should be considered a separate drug within a drug class. This means biosimilars could potentially take the place of a reference biologic on a plan formulary. However, CMS indicated that it will address the interchangeability of biologics and biosimilars in later guidance.

HEALTH CARE COSTS

Drug spending sees largest single-year increase since 2001

Specialty drugs and new breakthrough medications approved by the Food and Drug Administration are largely credited for a 13 percent spike in prescription drug costs for 2014. According to the annual report released this week by the IMS Institute for Healthcare Informatics, this represents the largest single-year increase since 2001.

Specialty drug spending constituted one-third of all spending last year, compared to only 23 percent in 2009. Newly-approved drugs accounted for more than five percent, with more than half that amount attributable solely to four therapies approved during the year for Hepatitis C.

Medicaid was the largest driver of retail prescription spending growth in 2014, as the number of prescriptions filled through the program rose 17 percent in 2014, accounting for 70 percent of the overall growth in medication demand. States participating in the Medicaid expansion under the Affordable Care Act filled 25 percent more prescriptions last year, compared to only three percent in opt-out states.

The study noted that the spike in drug costs would have been far greater had not the number of filled prescriptions among commercial insurance subscribers actually declined in 2014. The expiration of patents on certain drugs had a less significant impact on slowing spending growth than in previous years (only $12 billion compared to $29 billion in 2012 and $20 billion in 2013).

STATES

State-based Marketplaces had higher attrition rates from 2014 to 2015

A new study released this week by Avalere Health found that federally-facilitated Marketplaces (FFMs) re-enrolled a higher percentage of 2014 customers and added new customers at a higher rate in 2015 than their state-operated counterparts.

Avalere's review of data from the recent report released by the U.S. Department of Health and Human Service (see Update for Weeks of March 2nd and 9th) revealed an average re-enrollment rate of 78 percent among FFMs, compared with an average of 69 percent among state-based Marketplaces (SBM). New enrollment in FFMs increased at an even more disparate rate from 2014-2015 (61 percent on average compared to only 12 percent for SBMs).

Three states performed exceptionally poorly. California, which led the nation in 2014 enrollment, saw only a one percent overall increase in enrollment for 2015. Washington and Vermont were the only two states where enrollment actually declined (by two and 17 percent respectively).

California also retained only 65 percent of its 2014 enrollees, besting only Hawaii (36 percent), Minnesota (49 percent), and Washington (62 percent). By contrast, Kentucky, North Dakota, and Wyoming all retained more than 90 percent of their enrollees.

The findings were somewhat surprising in light of the fact that SBMs outperformed FFMs during the inaugural open enrollment period (see Update for Week of April 7, 2014). Avalere researchers stated that it was "unclear" why SBMs performed so poorly. However, since there are only 15 SBMs (including the District of Columbia), a handful of struggling states can more dramatically bring down overall averages. Researchers also noted that FFM figures for 2014 were initially depressed by the failed rollout of the web portal (see Update for Week of November 11, 2013) and the dramatic improvement in 2015 enrollment figures for the two largest FFMs in Florida and Texas greatly boosted FFM figures overall.

Arizona

New law prohibits declares "sovereign authority" over Affordable Care Act

Governor Doug Ducey (R) signed legislation this week intended to create roadblocks preventing the state from implementing key provisions of the Affordable Care Act (ACA).

H.B. 2643 prohibits state officials from "using any personnel or financial resources to enforce, administer or cooperate" with the ACA. This specifically includes the creation of a state-based Marketplace (SBM) should the U.S. Supreme Court make consumers in Arizona's federally-facilitated Marketplace (FFM) ineligible for ACA subsidies (see Update for Week of March 2nd and 9th) and bar state employees from serving as enrollment assisters for any Marketplace model.

Among the most prominent of the bill's provisions bans any "funding or aiding in the prosecution of any entity for a violation of the act." This effectively prevents the Department of Insurance (DOI) from investigating or enforcing any violations of federally-mandated health insurance requirements, as required by the ACA.

Regulatory activities that involve the Arizona Health Care Cost Containment System (the state's version of Medicaid) are exempted, meaning that H.B. 2643 would not impact the expansion of Medicaid under Governor Ducey's Republican predecessor. However, that expansion is already being challenged in court by Republican lawmakers (see Update for Week of March 16th).

Bill supporters insist that the "the federal Department of Health and Human Services cannot commandeer the Arizona Department of Insurance to force them or to investigate alleged violations [of the ACA]." However, it remains unclear whether the new law will survive court challenges, as the U.S. Supreme Court has rejected a similar Arizona challenge to the ACA on the basis that the Constitution makes federal law supreme to any conflicting state laws (see Update for Week of March 30th).

Arkansas

Governor signs bill requiring greater transparency for prescription drug costs

Governor Asa Hutchinson (R) signed legislation this week that will give consumers more detailed information about prescription drug costs imposed by plans offered in Arkansas' state partnership Marketplace.

Under S.B. 466, Marketplace plans must post details about coverage benefits and prescription drug costs in a "readily accessible format", starting January 1, 2017. This information must include

coverage exclusions or restrictions, as well as whether the drug is subject to a flat copayment or percentage coinsurance (see Update for Week of March 30th).

The initial version that passed the Senate also included a provision requiring that health plans relying on tiered copayments for prescription drugs notify subscribers at least sixty days in advance of any increase in cost-sharing due to drug formulary changes (see Update for Weeks of March 2nd and 9th). However, this requirement was not included in the final bill.

California

Covered California seeks $200-500 monthly caps on specialty drug costs

The board overseeing Covered California is proposing to cap monthly out-of-pocket costs for specialty drugs at no more than $500 per prescription, starting with the 2016 open enrollment period.

The cap would vary according to metal tier. The $500 cap would apply to consumers in bronze and gold plans, but be lowered to $300 per specialty drug for platinum plans and $200 for silver plans (to which the Affordable Care Act subsidies are tied).

The board would review and modify the caps annually based on usage data and emerging medications. It also would ask insurers to submit reports detailing how the cost-sharing caps on specialty drugs would impact premiums and recommend alternatives.

Insurance Commissioner David Jones (D) argued that the $500 cap was too high, would create barriers to care, and was "discriminatory" for those with chronic or high-cost conditions. He recommended a $200 monthly cap for all metal levels.

The caps are part of changes to prescription drug benefits for participating plans that were approved by the board, which also voted to require at least one drug for a certain condition be included in the lowest drug tier. Plans must define what drugs will be placed in specific pricing tiers (including the highest specialty tier) and post that information online.

However, the board postponed a vote on the drug caps until their May meeting, insisting that more time was needed to evaluate input from consumer advocates and health plans.

Special enrollment period has signed-up more than 18,000 Marketplace consumers

Covered California officials announced this week that more than 18,000 consumers have signed up for coverage through the state-based Marketplace since its special enrollment period (SEP) started on February 23rd.

The SEP was created for individuals who were not aware of the Affordable Care Act (ACA) tax penalty for remaining uninsured until they filed their 2014 federal tax returns. It will allow those individuals to enroll (through April 30th) in Marketplace coverage for 2015, although they will still be subject to the ACA penalty for 2014.

The 18,000 figure for Covered California is half of the 36,000 that have enrolled through the comparable SEP for the federally-facilitated Marketplace, which did not start until March 15th (see Update for Week of March 30th).

According to Covered California officials, up to 600,000 Californians could ultimately be subject to the ACA individual mandate penalty.

Measures to limit out-of-pocket costs headline new legislative session

A package of bills backed by consumer advocates like Health Access California is at the forefront of the legislative session that began this week.

Several measures seek to limit out-of-pocket (OOP) costs and "unmanageable" cost-sharing that creates barriers to care. One of the lead bills, A.B. 339, was promptly amended and referred back to the Assembly Health Committee this week, after being introduced earlier this year. The initial version had required that cost-sharing for all outpatient prescription drugs to be "reasonable" to ensure access (see Update for Weeks of February 9th and 16th). However, the amended version would specifically limit cost-sharing to 1/24 of the annual OOP limit applicable to individual coverage for a supply of up to 30 days, similar to last year's version that included a limit of 1/12 of the OOP limit (see Update for Weeks of August 25th and September 1st). A provision that bars plans from placing most or all of the drugs to treat a specific condition on the highest cost tiers of a formulary remains in the amended version.

A separate bill (A.B. 1305) would ensure that the annual OOP limit under the Affordable Care Act (ACA) for individual coverage (currently $6,350) be applied to individuals within a family plan, instead of the ACA limit for family coverage (currently $12,700). A.B. 533 would also protect patient from "surprise" bills from out-of-network physicians treating a patient at an in-network facility.

A new bill (S.B. 137) would standardize Marketplace provider directories and require greater oversight to ensure accuracy. Several class-action lawsuits have been filed with insurers after consumers unexpectedly incurred out-of-network costs during 2014 due to provider directories that were frequently unavailable, incomplete, or erroneous (see Update for Week of September 29th).

A bill resurrected from last session (A.B. 248) would prohibit the sale of ACA of "junk" coverage to large employers by requiring a minimum actuarial value of 60 percent for large group coverage, comparable to the minimum level required of small group and individual coverage under the ACA (see Update for Week of August 11th).

Democratic lawmakers are also renewing their effort from last session to extend Medi-Cal and Covered California eligibility for certain undocumented immigrants. S.B. 4 cleared the Senate Health Committee, despite lingering concerns over the projected $400-800 million annual cost of covering up to one million undocumented immigrants. Similar concerns scuttled last year's version of the legislation.

The Assembly Committee on Health unanimously approved legislation this week (A.B. 366) that would reverse the ten percent across-the-board cut in Medi-Cal provider reimbursement from 2011 that was recently upheld by the federal courts (see Update for Week of March 30th).

<u>Colorado</u>

Governor signs bill limiting biosimilar substitution

Governor John Hickenlooper (D) signed legislation this week that will limit when less costly biosimilar products approved by the Food and Drug Administration (FDA) can be substituted for a brand-name biologic.

Pharmacy chains had opposed several restrictions in S.B. 71, which they feared would discourage biosimilar substitution (see Update for Weeks of March 2nd and 9th). For example, the bill requires pharmacists to notify the prescribing physician and patient prior to substituting a biosimilar product, even though they can substitute generic copies of other brand-name drugs without doing so.

Similar legislation regulating biosimilar substitution has been introduced in at least 20 states since 2013. However, they were previously rejected in all but five states as most contained restrictions that were so onerous that they were viewed as creating barriers to competition (see Update for Week of January 19th).

The FDA approved the first biosimilar product last month under the regulatory pathway created by the ACA (see Update for Weeks of March 2nd and 9th). However, it has yet to declare it "interchangeable" (see above), which S.B. 71 would require prior to any substitution.

The Georgia legislature sent a similar bill to their Governor this week (S.B. 51), while Louisiana (H.B. 319), Michigan (H.B. 4437), Oregon (S.B. 147), Tennessee (H.B. 572) and Texas (S.B. 542) are among the other legislatures considering comparable legislation (see Update for Weeks of February 9th and 16th). One of two substitution bills in North Carolina (H.195) cleared their House chamber last week.

Connecticut

Proposed commission would recommend improvements in health care access, cost, and quality

The Senate is set to vote on S.B. 15, which would create a Commission on Health Care Policy and Cost Containment as an independent entity not subject to the supervision or control of any executive officer or agency. The commission would be governed by a ten-person board of directors that must include a consumer advocate.

Under S.B. 15, the commission would be charged with making annual reports to the legislature starting in 2017 on underlying factors for trends in health spending and recommendations to increase health system efficiency, reduce provider price variation, increase price transparency, and improve overall cost and quality. The measure also specifically asks the commission to assess the impact of limited and tiered provide networks on the health care payment and delivery system.

As part of this report, the commission would propose health care cost growth goals for the state and ways to "protect patient access to necessary health care services."

Florida

CMS confirms that Florida must expand Medicaid to continue federal indigent care funding

Governor Rick Scott (R) threatened this week to sue the Obama Administration after Centers for Medicare and Medicaid Services (CMS) officials acknowledged that Florida will need to expand Medicaid under the Affordable Care Act (ACA) if it expects to renew a separate demonstration waiver providing the state with $1 billion to fund indigent care.

The issue has created somewhat of a "civil war" among Florida Republicans. Senate Republicans, with the backing of provider, consumer, and business groups, are advancing another Medicaid expansion alternative this session that would provide private coverage in a health insurance exchange (see Update for Week of March 30th). However, as with last year, they are again being rebuffed by the more conservative House that refuses to accept federal ACA matching funds to expand (see Update for Weeks of February 9th and 16th).

By contrast, House Republicans have no objection to accepting federal funds through the Low Income Pool (LIP) waiver. However, CMS has indicated since last year that it would not renew that waiver past the June 30th expiration when it granted only a one-year extension instead of a traditional three-year renewal (see Update for Week of April 21, 2014). State officials have since been fervently negotiating an additional extension, since House Republicans assumed the waiver would be renewed when they passed their budget for fiscal year 2016 (see Update for Weeks of March 2nd and 9th).

The expansion battle is likely to drag past the end of the regular legislative session in May and require a special session. In an effort to resolve the impasse, CMS for the first time formally stated that the agency would not continue to provide separate indigent care funding to Florida when it can receive more than $50 billion over the next decade in ACA matching funds by expanding Medicaid.

House Speaker Steve Crisafulli (R) has remained adamant that "discussions about LIP and Medicaid expansion must be separate" before House Republicans will consider the Senate's expansion plan. Governor Scott went a dramatic step further by accusing the Obama Administration of engaging in a "gun to the head" type of "coercion" that the U.S. Supreme Court declared unlawful when it required that states have the flexibility to opt-out of the Medicaid expansion without penalty (see Update for Week of June 25, 2012). Citing an Urban Institute study, the Governor insisted that the population served by the LIP waiver were different than those earning up to 138 percent of the federal poverty level that would benefit from Medicaid expansion.

However, legal analysts questioned the likelihood that the Governor's promised lawsuit would prevail given that Florida voluntarily signed the one-year waiver extension last year with full knowledge that it would expire on June 30th. Furthermore, unlike the initial version of the ACA, Florida would lose only the supplemental funding under the waiver if it does not participate in the ACA expansion and not all of their federal Medicaid matching funds.

Hawaii

Both chambers pass legislation to expand Marketplace eligibility

The House and Senate have both passed legislation that will enable the Hawaii Health Connector to start offering large group coverage as of January 1, 2017 and no longer allow transitional ACA-deficient plans to be renewed past 2015 (see Update for Weeks of February 9th and 16th). Once reconciled, they are expected to be signed by Governor David Ige (D).

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The Connector is one of only two state-based Marketplaces that were established under the Affordable Care Act (ACA) as an independent non-profit agency (Connect for Health Colorado is the other). However, due to limited insurer participation and a host of administrative and technical flaws, it has struggled mightily.

Hawaii did have the second-lowest uninsured rate in the nation (roughly seven percent) prior to the ACA, thanks to an ERISA-exemption that enabled it to require employer-mandated coverage. It had only about 40,000 uninsured residents that were not eligible for the expanded Medicaid program, meaning that the Connector has the smallest pool of eligible consumers nationwide. According to Kaiser Health News, it consequently spends the most per Marketplace enrollee of any state ($23,899 in 2014).

However, a lack of website functionality and lengthy delays in determining Medicaid eligibility further limited private plan enrollment in the Connector to only about 10,000 individuals for 2014 (see Update for Weeks of August 25th and September 1st) and just over 13,000 for the 2015 open enrollment period. These figures are far below projections causing the two percent premium assessment to bring in too little revenue for the Connector to cover its annual expenses of up to $15 million.

The Connector has thus been unable to be financially self-sustaining by 2015, as required by the ACA. Lawmakers have until May 7th to appropriate an additional $9-10 million to cover these losses. In the event they cannot do so, Governor David Ige (D) has been negotiating with the Obama Administration on partial takeover that would let the federal government temporarily operate some parts of the Connector without converting it to a federally-facilitated Marketplace (FFM), similar to the model used this year in Nevada and Oregon (see Update for Weeks of June 2nd).

However, transitioning even partially to a FFM model carries with it the risk that Connector consumers could lose their ACA subsidies if the U.S. Supreme Court invalidates them for FFMs (see Update for Weeks of March 2nd and 9th). As a result, H.B. 1467 and S.B. 1338 seek to expand the number of eligible consumers for the Connector by allowing large employers to use the small-group Marketplace, discontinuing transitional or "grandmothered" plans one year before the Obama Administration requires all states to do so (see Update for Week of March 3, 2014), and requiring

individuals eligible for COBRA plans to be informed about affordable coverage options through the Connector.

Kaiser Permanente is currently the only insurer selling plans in the small group Marketplace after the Hawaii Medical Service Association exited last summer (see Update for Weeks of August 25th and September 1st). Both insurers continue to participate in the individual Marketplace.

Maryland

Committee rejects bill to prohibit discriminatory cost-sharing designs

The Assembly Health and Government Operations Committee issued an unfavorable report last week on legislation that would prohibit plans participating in the Maryland Health Benefit Exchange from using a benefit design that relies upon discriminatory drug formulary management or medical management practices.

Under both H.B. 990 and its counterpart S.B. 834, differential reimbursement rates or cost-sharing for covered benefits is one criterion that the Insurance Commissioner could consider when determining whether a drug formulary is discriminatory (see Update for Weeks of February 23rd). The latter bill has not moved since a late March committee hearing.

Missouri

Appeals court upholds most of injunction against overly-restrictive navigator law

The Eighth Circuit U.S. Court of Appeals upheld most of a federal injunction this week that prevents Missouri and other states from implementing laws that prevent navigators and enrollment assisters from carrying out their specified duties under the Affordable Care Act (ACA).

A lower court blocked most of the 2013 Missouri law sought by insurance agents and brokers that went so far as to bar ACA assisters from providing any "advice" to Marketplace consumers about the benefits or features of plans offered in or out of the Marketplace (see Update for Weeks of January 20 and 27, 2014). The law even required that if a consumer previously bought a plan through an insurance broker, assisters were required to refer consumers back to that broker.

The Department of Insurance appealed the decision. However, the appellate court concurred that the state could not bar assisters from carrying out those duties that were permitted by final rules issued by the federal Centers for Medicare and Medicaid Services (CMS). This specifically included educating consumers seeking to purchase Marketplace plans about the differences in benefits and costs between Marketplace and non-Marketplace plans—regardless of whether they were previously assisted by agents or brokers (see Update for Weeks of March 17 and 24, 2014).

The appeals court did lift part of the injunction so that Missouri can enforce provisions requiring assisters obtain a state license, pay registration fees, and undergo 30 hours of training. CMS rules finalized after the initial court decision explicitly allow states to impose these types of requirements (see Update for Week of June 2nd).

The case was filed by Jay Angoff, the former Missouri insurance commissioner and former head of the CMS division overseeing the ACA Marketplaces, on behalf of several non-profit plaintiffs included the St. Louis Effort for AIDS (see Update for Weeks of January 20 and 27, 2014).

Montana

Republican legislature approves Medicaid expansion compromise

After a lengthy legislative battle, the Republican-controlled House voted 54-46 this week to advance a Medicaid expansion bill to the desk of Governor Steve Bullock (D).

The floor vote occurred only after 13 moderate Republicans sided with Democrats to use a procedural move allowing them to overcome a defeat by hard line conservatives in the House Human Services Committee.

The Governor is expected to sign S.B. 405, which would make Montana the 29th state to participate in the Medicaid expansion under the Affordable Care Act (ACA). The measure is a compromise between the traditional expansion sought by the Governor (which the committee already rejected) and a private-sector alternative comparable to the model already federally-approved for six states.

S.B. 405 includes sliding-scale premiums and copayments capped at two percent of annual income, limits assets that enrollees can own, and offers voluntary work assessment and training programs (see Update for Week of March 30th). However, it is not immediately clear if the Obama Administration would grant the necessary federal waiver in its current form.

Nebraska

Lawmakers reject Medicaid expansion proposal for third time

The unicameral Senate voted 28-16 this week to move a Medicaid expansion proposal to the bottom of the legislative agenda, effectively killing the measure for this session.

The plan advanced by Senator Kathy Campbell (R), chair of the Health and Human Services Committee, would have created a "private sector" alternative to the traditional expansion under the Affordable Care Act (ACA). Similar to federally-approved alternatives in six other states, L.B. 472 would have used ACA matching funds to cover those earning 100-138 percent of the federal poverty level (FPL) in the federally-facilitated Marketplace, with state covering wrap-around benefits so that coverage is comparable to traditional Medicaid. Those earning 50-99 percent of FPL would be covered in traditional Medicaid.

All enrollees earning from 50-138 percent of FPL would have been required to pay premiums that could not exceed two percent of income. However, these could have been waived for enrollees participating in certain "wellness" behaviors.

According to the Legislature's Fiscal Office, L.B. 472 would have added nearly 80,000 Nebraskans to the Medicaid rolls while actually saving Nebraska $3.5 million for the next fiscal year (due to the federal match and reduced uncompensated care). A University of Nebraska-Kearney study released last week predicted that the Medicaid expansion would result in at least $1 billion in economic benefit to the state, due to fewer medical bankruptcies and less need for insured patients to subsidize the costs of the uninsured.

However, conservative lawmakers as well as Governor Pete Ricketts (R) insisted that expanding Medicaid would only increase the cost burden on the state, noting that the program already accounts for 19 percent of the state budget. Senator Beau McCoy (R) noted that Nebraska has the nation's lowest unemployment rate and should instead focus on providing Medicaid-eligible groups with job training so they can work for companies that offer "quality health insurance".

The legislature has now rejected Medicaid expansion bills in each of the last three sessions.

Texas

Hemophilia Assistance Program lowers minimum age limit

The Department of State Health Services announced this week that as of April 16th, the minimum age for the Hemophilia Assistance Program (HAP) has been lowered from 21 to 18.

HAP helps Texas residents diagnosed with hemophilia and earning at or below 200 percent of the federal poverty level to pay for their blood factor products (providing up to $25,000 per person per year). Applicants must also not be eligible for Medicare, Medicaid, or the Children with Special Health Care Needs (CSHCN) program and have exhausted all drug coverage under private or group health insurance.