



Health Reform Update – Week of November 30, 2015

CONGRESS

Senate broadens number of ACA provisions to be repealed through reconciliation

The Senate voted 52-47 this week to pass a budget reconciliation bill that would repeal key provisions of the Affordable Care Act (ACA), including the individual and employer mandates as well as taxes on high-cost health plans and medical device manufacturers.

The bill would also eliminate two other key provisions in two years (after the 2016 election). It would end the Medicaid expansion that 30 states and the District of Columbia have already opted to pursue, as well as ACA subsidies for low-to-moderate income consumers to purchase health insurance.

Moderate Republicans Susan Collins (R-ME) and Mark Kirk (R-IL) sided with Senate Democrats in opposing the bill.

Budget reconciliation was a maneuver used by Senate Democrats in 2009 to pass specific provisions in the ACA without the 60-vote majority needed to overcome a filibuster. It is intended to apply only to provisions that impact spending and revenue.

The measure broadens the House reconciliation bill passed last month (H.R. 3762) that cuts but not eliminates the individual mandate penalties and keeps the Medicaid expansion intact (see Update for Weeks of October 5th and 12th). It also includes an amendment that would restore the threshold for the tax deduction for medical expenses back to the pre-ACA level of 7.5 percent, at least for those who have reached age 65.

Even if it passes the House, the repeal measure faces a certain veto from President Obama. However, several Republican leaders acknowledge that the effort is intended to demonstrate what provisions Congress could repeal if a Republican wins the presidency in 2016. In addition, the fact that the tax on high-cost or “Cadillac” plans (that is not effective until 2018) passed as an amendment with only ten dissenting votes is likely to provide momentum for a stand-alone repeal bill that has enough support to override a Presidential veto.

Federal judge allows House challenge to ACA subsidies to proceed without appeal

U.S. District Court judge Rosemary Collyer denied a request last month from the Department of Justice that would let the U.S. Court of Appeals review her decision to grant House members standing to challenge to the Obama Administration’s funding of Affordable Care Act (ACA) cost-sharing subsidies without a specific Congressional appropriation.

Outgoing Speaker of the House John Boehner (R) brought the unprecedented lawsuit that claimed the Administration lacked the constitutional authority to delay the employer mandate and fund ACA subsidies through alternate accounts. Judge Collyer, an appointee of President George W. Bush, dismissed the employer mandate claim but allowed the appropriations challenge to be heard (see Update for Weeks of August 31st and September 7th).

The Department of Justice had sought an appellate court review of that decision (see Update for Weeks of September 14th and 21st) but Judge Collyer insisted that such a challenge was moot because her ruling on the merits of the remaining House claim would be issued long before the appellate court has a chance to rule. She set a deadline of January 18th for all legal filings.



Republicans urge Supreme Court to take up origination clause challenge to ACA

A group of 46 House Republicans and three Senate Republicans filed an amicus brief last week urging the U.S. Supreme Court to intervene in a procedural challenge to the Affordable Care Act (ACA) that was rejected by two lower courts.

The lawsuit was initially brought by the libertarian Pacific Legal Foundation, claiming that the ACA statute is invalid because it did not originate in the House, as the U.S. Constitution requires for bills whose primary purpose is to raise revenue through taxes. A three-judge panel for the U.S. Court of Appeals for the District of Columbia—all appointed by Democratic presidents—rejected their claim last year, holding that because the ACA’s “paramount” purpose is to increase the number of Americans covered by health insurance and not raise revenue, the origination clause could not be applied (see Update for Week of July 28, 2014). The full D.C. Court of Appeals refused to hear the case, forcing the Supreme Court appeal.

The high court is not expected to intervene given that there is no contrary opinion from other appellate courts. However, it takes the support of only four of the nine justices to hear a case and the court has twice surprised pundits by intervening in ACA challenges that it ultimately rejected (see Update for Week of November 3, 2014).

Congressional probe accuses HCV drugmaker of putting profits ahead of patient access

An 18-month probe led by Senate Finance Committee ranking member Ron Wyden (D-OR) and Finance member Charles Grassley (R-IA) concluded this week that the manufacturer of two newly-approved medications for the Hepatitis C virus (HCV) put profits ahead of patient affordability.

The prices set by Gilead Sciences for both Sovaldi and Harvoni drew instant controversy as they approached nearly \$95,000 per course of treatment (or \$1,000 per pill). They immediately strained the budgets of public health care programs as the Congressional investigation found that both Medicare and Medicaid spent more than \$5 billion on Sovaldi and Harvoni, just in 2014. Investigators also found that the \$1 billion that Medicaid programs spent for Sovaldi treated less than 2.4 percent of HCV enrollees.

The investigation claims that “no evidence” exists to support Gilead’s claim that the high prices were driven by the company’s proposed acquisition of Pharmasset, the drug’s first developer, or that the cost of research and development justified the pricing structure. Instead, both Senators stated that Gilead “pursued a calculated scheme for pricing and marketing its hepatitis C drug based on one primary goal, maximizing revenue, regardless of the human consequences.” They insisted that Gilead instead should have focused on broadening the number of eligible patients that could be treated by setting lower medication prices that promote access to care.

Gilead responded with figures showing that more than 600,000 individuals have been treated with either Sovaldi or Harvoni and insisted that current prices are lower than previous regimens due to rebates and discounts. The company also emphasized that the new drugs reduce the duration of therapy to eight weeks, resulting in a one-third reduction in price, and that patient assistance programs are helping “uninsured individuals and those who need financial assistance to access our therapies.”

Pricing for specialty drugs like Sovaldi and Harvoni have been the subject of several hearings in recent weeks. Senator Bernie Sanders (I-VT) re-introduced legislation earlier this fall that would allow the federal government to directly negotiate drug prices for Medicare Part D and require greater pricing transparency (see Update for Weeks of September 14th and 21st) while Senators John McCain (R-AZ) and Grassley resurrected their efforts last week to persuade the Obama Administration to allow medications to be imported from Canada and other countries. The Senate Special Committee on Aging also launched its own investigation into drug pricing earlier this month.



The impact of HCV drugs on Medicaid budgets in particular caused the Centers for Medicare and Medicaid Services to warn states like Illinois and Oregon earlier this month that their efforts to ration care for these drugs only to those most in need (see Update for Week of July 28, 2014) may be “imposing conditions for coverage that may unreasonably restrict access” and that “they have tools available to manage their costs....[and fulfill] their obligation to provide access to these promising [HCV] therapies.”

FEDERAL AGENCIES

CMS weighs whether to require insurers to accept premium assistance from non-profits

The Centers for Medicare and Medicaid Services (CMS) released its annual Notice of Benefit and Payment Parameters (NBPP) rule on November 20th proposing the standards that qualified health plans in federally-facilitated Marketplaces (FFM) must follow for 2017.

The proposed rule specifically responded to comments from PSI and other groups criticizing CMS' refusal to require that Marketplace insurers accept premium assistance from non-profits, as it does for state and federal healthcare programs like the Ryan White HIV/AIDS Program. PSI pointed out that the agency's interim final rule giving insurers such discretion is inconsistent with multiple guidance documents and responses to Congress in which CMS officials insist their concerns about premium assistance skewing Marketplace risk pools relate solely to for-profit assistance and that non-profit assistance is permissible so long as it is from a bona-fide charity (see Update for Week of June 2, 2014).

Since the interim final rule, more than 30 insurers nationwide have refused or pledged to start refusing to accept premium assistance payment from charitable groups like PSI.

In the rule, CMS acknowledged for the first time that it is “considering whether we should expand the list of entities from which issuers are required to accept [premium assistance] payment...to include not-for-profit charitable organizations.” However, CMS stated that it would likely include guardrails intended to minimize risk pool impacts.” These include “limiting assistance to individuals not eligible for other [minimum essential coverage] and requiring assistance until the end of the calendar year.”

Including such a standard within the final NBPP rule would limit its application solely to 2017, increasing the need for a permanent statutory fix. PSI successfully urged Rep. Kevin Cramer (R-ND) to introduce legislation last month that would amend the ACA to require Marketplace insurers accept non-profit assistance in all subsequent years (see Update for Weeks of October 5th and 12th).

Marketplace rule includes changes to network adequacy, OOP limits, and user fees

As part of the Notice of Benefit and Payment Parameters (NBPP) rule released on November 20th, the Centers for Medicare and Medicaid Services (CMS) is proposing to give federally-facilitated Marketplaces (FFMs) the flexibility to set network adequacy standards based on the state in which they operate, so long as they meet minimum standards that the agency will define at a later date. These standards will be based on maximum travel distances for subscribers and the length of time needed to access providers.

The annual rule setting standards for FFM plans for 2017 proposes to use the same open enrollment period as 2016 (November 1st-January 31st), in an effort to more closely align the enrollment period for Medicare Advantage and Part D plans as well as other employer-sponsored coverage. In addition, the agency would assess the same 3.5 percent user fee on participating plans. However, one change would impose a three percent user fee on state-based Marketplaces (Idaho, Hawaii, Nevada, and Oregon) currently defaulting to the federal web portal while retaining control over other Marketplace



functions. For states like Kentucky weighing this option in future years, the three percent user fee is significantly higher than the fee assessed by their Marketplace (see below).

CMS is also proposing to increase maximum limits on annual out-of-pocket (OOP) costs by 13.2 percent. For 2017, this means the individual limit would rise from \$6,850 to \$7,150, while the limit for family coverage would increase from \$13,700 to \$14,300. However, CMS would allow all medical expenses to be included within the OOP limit and not just those incurred in-network.

A separate proposal would require that participating insurers “count the cost sharing charged to the enrollee for certain out-of-network services (provided at an in-network facility) towards the enrollee’s annual limitation on cost sharing” unless the plan provides the subscriber a ten-day notice that out-of-network providers will be providing services at the in-network facility. This is an effort to prevent surprise bills on consumers from out-of-network contractors at in-network facilities, which individual states are being encouraged to also address (see Florida below).

The NBPP also seeks to further standardize plan options offered by Marketplace plans by requiring a uniform \$6,650 annual deductible for all bronze-level plans, which would decrease to \$3,500 for silver plans, and \$1,250 for gold plans.

One change likely to draw insurer opposition is the proposal to allow selective contracting for FFM. Only a handful of state-based Marketplaces (including California, Maryland, and Vermont) opted for this model, which allows the Marketplace board to exclude insurers with higher premiums even if they otherwise meet minimum standards.

CMS commits to “full payment” of risk corridors obligations despite Congressional opposition

The Centers for Medicare and Medicaid Services (CMS) released guidance on November 19th attempting to assure Marketplace insurers that the agency will follow through with its commitment under the Affordable Care Act (ACA) to make “full payment” for all reinsurance and risk corridors payments that are due under the law.

The three-year program was intended to compensate insurers for the costs of extraordinary claims incurred for patients that are sicker and more costly than anticipated. However, the program ran a \$2.5 billion deficit during its first year of operation, forcing CMS to pay eligible insurers only 12.6 percent of the \$2.87 billion they were slated to receive this year (see Update for Week of September 28th).

The guidance emphasizes that prorated payments for 2014 are only temporary as CMS recognizes that “full payment is required” under the ACA and will shift funding from other 2015 and 2016 sources in order to ultimately cover the shortfall. However, Congress has already blocked CMS from using other funds through a rider it attached to last year’s omnibus spending bill (see Update for Week of December 1st 2014). As a result, CMS acknowledges that full funding of the risk corridors program will ultimately require “working with Congress on the necessary funding” despite the opposition from many Republican members of Congress led by Senator Marco Rubio (R-FL) to any future appropriations for risk corridors payments that they regard as an “insurer bailout” (see Update for Week of January 5th).

Marketplace enrollment already doubles enrollment target for 2016

According to the most recent figures from the Department of Health and Human Services (HHS), more than two million consumers have signed-up for coverage in the federally-facilitated Marketplace (FFM) during the first four weeks of the 2016 open enrollment period that started on November 1st.

HHS determined that roughly one-third of these enrollees are first-time customers while the remainder re-enrolled in FFM coverage. This is a decrease from last year, when nearly 50 percent of FFM enrollees were first-time customers.



HHS had lowered its target for 2016 open enrollment to less than one million consumers, or half the total initially projected by the Congressional Budget Office (CBO). This was an apparent acknowledgment by HHS that the remaining uninsured largely belong to “hard-to-reach” populations to may be difficult to enroll, although the agency tried to cast it as a result of greater employment-based coverage due to an improving economy. However, sign-ups during the first few weeks of the 2016 open enrollment period have been about 20 percent greater than the year before.

The FFM portal is currently being used by 38 states, including four that previously created state-based Marketplaces (SBMs). Florida, which led the nation in 2015 enrollment, leads all FFM states with 445,000 sign-ups, nearly doubling the number of enrollees in the next closest state (Texas at 225,000).

Switching plans could lower premiums for federal Marketplace consumers by 15 percent

A new report released in mid-November by the Kaiser Family Foundation found that consumers who select the lowest-cost, silver plan sold through the federally-facilitated Marketplace (FFM) are likely to pay an average of 15 percent more for their premiums in 2016 unless they shop for a new plan.

Roughly two-thirds of consumers purchasing FFM coverage chose silver plans last year and half of those selected the plan with the lowest premium in their region. However, the Kaiser analysis showed the premiums changed for such plans in about three-quarters of the 2,635 counties surveyed, meaning that remaining in the same plan from year to year provides no assurance that a consumer’s premiums will remain the region’s lowest. Researchers found that the variations could be substantial, as individuals living in 16 percent of the surveyed counties could save up to \$500 per month by switching plans.

The Department of Health and Human Services recently reported that returning Marketplace consumers who switched plans within the same metal tier during the 2015 open enrollment period saved an average of nearly \$400 on their 2015 annual premiums (after accounting for ACA subsidies).

Drug prices, record Medicaid growth blamed for turnaround in national health spending

The Centers for Medicare and Medicaid Services (CMS) reported this week that national health care spending rose dramatically last year to 5.3 percent, breaking a five-year trend where health spending grew at a historically low annual average of only 3.7 percent.

CMS analysts blamed the turnaround on the 12 percent jump in prescription drug costs and the coverage expansions implemented in 2014 by the Affordable Care Act (ACA). In particular, CMS cited the introduction of new specialty drugs with unprecedented price tags, such as Hepatitis C virus (HCV) medications Sovaldi and Harvoni that cost nearly \$95,000 for a course of treatment (see above).

However, despite the uptick in health spending, CMS noted that the 5.3 percent increase still exceeded the rate of growth in gross domestic product by only 1.2 percent, a figure that a former HHS official called “remarkably low” given the upward cost pressures created by drug pricing.

A 19.5 percent decline in the nation’s uninsured population during 2014 alone has increased private health insurance spending by 4.4 percent, Medicare spending by 5.5 percent, and Medicaid spending by 11 percent. However, Medicaid spending per enrollee actually fell by two percent in 2014 after climbing by more than four percent the year before, as many of the new enrollees brought in via the ACA’s expansion were children and working-age adults who were less costly to cover than the elderly and disabled populations already in the program.

Medicaid is likely to experience another dramatic increase in spending for 2015 according to a report last month by the Kaiser Family Foundation. It found that Medicaid enrollment jumped by an average of nearly 14 percent in fiscal year 2015 after only an 8.3 percent bump the year prior, as every



state experienced higher enrollment and spending regardless of whether they expanded Medicaid. However, as with the HHS report, Kaiser found that spending per enrollee declined as the average spending increase was 13.9 percent instead of 14 percent in 2014.

Kaiser researchers predicted that the enrollment and spending growth for Medicaid will start to wane in subsequent years due largely to an improving economy, projecting only a four and seven percent increase respectively in fiscal 2016.

HHS suspends requirement to move CHIP children to ACA plans

Health and Human Services (HHS) Secretary Sylvia Mathews Burwell has suspended a provision of the Affordable Care Act (ACA) that requires states to develop policies to automatically shift Children's Health Insurance Program (CHIP) enrollees into Marketplace plans if federal CHIP funding expires as scheduled in 2017 and the children are not eligible for Medicaid.

The suspension was in response to an HHS analysis concluding that Marketplace plans currently do not offer comparable benefits and cost-sharing requirements compared to CHIP plans, as required by the ACA. Because CHIP plans offer more affordable and comprehensive coverage, Burwell stated that the ACA mandate to transfer CHIP enrollees "does not apply".

Federal judge strikes down 340B orphan drug rule for second time

For the second time in a year, a federal judge has struck down regulations by the Health Resources and Services Administration (HRSA) that would require drug manufacturers to sell orphan drugs at discount to 340B providers when they are used either off-label or to treat common conditions.

The Section 340B program requires drugmakers participating in Medicaid to discount outpatient drugs for participating providers. The Pharmaceutical Research and Manufacturers of America has twice sued to block the proposed regulations, which were implemented pursuant to the Affordable Care Act (ACA). Even though the ACA excluded orphan drugs when it expanded access to 340B discounts to cancer centers (as well critical access hospitals and rural facilities), HRSA insisted that the law requires drugmakers to provide the discounts when the orphan drugs are used to treat a condition that is different from the rare disease for which they were approved (see Update for Week of September 30, 2013).

Judge Rudolph Contreras from the U.S. District Court for the District of Columbia blocked the initial HRSA rulemaking on the basis that the agency lacked the authority under the ACA to issue it (see Update for Week of June 9, 2014). However, that decision did not rule on the merits of the regulation, which HRSA tried to salvage by reclassifying it as an "interpretative rule" that it claimed was not a "final agency action" and thus not judicially reviewable (see Update for Week of July 21, 2014).

Judge Contreras ruled last month that such a maneuver was "arbitrary and capricious." He concluded that Congress specifically "intended to exclude all drugs carrying an orphan-designation from 340B Program eligibility for the newly added entities."

Drugmakers had largely ignored the interpretative rule while the case was being litigated.

STATES

Urban Institute find that silver plan premium increases are far less dramatic than initially reported

A new report released last week by the Urban Institute found that average premiums for the lowest cost silver plans in 20 states increased by only 4.3 percent from 2015 to 2016, or far less than the "20 to 40 percent" requested increases that were widely reported by media outlets.



The study surveyed final approved premiums for the three largest rating areas in states including California, Florida, New York, and Pennsylvania. Nine of the 20 states created their own Marketplaces under the Affordable Care Act (ACA) while the rest defaulted to the federally-facilitated Marketplace, which imposes higher user fees on insurers and thus tends to have higher premiums.

Researchers found that the average premium for the lowest-cost silver plan decreased in six states, increased by less than five percent in five other states, and increased 5-10 percent in another five states. Only four states had an average increase of more than ten percent, with the largest increases largely correlated to states that had 2015 premiums well below the national average of \$264 per month.

The states responsible for the most dramatic increases were Oregon (nearly 15 percent), Iowa (just over 17 percent), Minnesota (almost 24.5 percent), and Colorado (at nearly 34 percent). However, the average increase for California and New York came in at less than one percent, while premiums for Florida consumers purchasing the lowest-cost silver plan actually fell by nearly half a percent on average.

Hawaii was not one of the states surveyed by the Urban Institute. However, their Insurance Commissioner approved nearly a 30 percent average rate hike for the state's two individual market carriers (see below).

While the 4.3 percent average increase from 2015-2016 is significantly higher than the 2.9 percent increase that the Urban Institute found from 2014-2015, researchers blamed press reports for exaggerating the extent of this increase by focusing only on proposed rates and not those that were actually approved by state regulators.

The Urban Institute figures for the lowest cost silver plans are lower than the 7.5 percent average rate increase that the Department of Health and Human Services reported earlier this month for the second-lowest cost or "benchmark" silver plans in the federally-facilitated Marketplaces. "Benchmark" plans are the ones to which ACA premium and cost-sharing subsidies are tied.

Alabama

Governor's task force recommends Medicaid expansion

A task force appointed by Governor Robert Bentley (R) recommended earlier this month that the legislature agree upon a plan to expand Medicaid via "an Alabama-driven solution."

The recommendation formally approved by the Alabama Health Care Improvement Task Force cited the "coverage gap" between current Medicaid eligibility limits and the threshold for ACA subsidies as the single, greatest obstacle to improving health outcomes for "hundreds of thousands of Alabamians." It estimated that roughly 290,000 Alabamians could gain Medicaid coverage through the expansion, nearly 64 percent of whom are currently working.

The task force stopped short of calling for the legislature to expand Medicaid under the Affordable Care Act (ACA), a move that is largely viewed as politically toxic in a largely conservative state and has been staunchly opposed by the Governor. However, the recommendation for a state-based alternative was supported by all 30 plus members of the panel (composed of a wide range of state health care providers) and included a discussion (though not a vote) on a 75 cent increase in the cigarette tax to fund the state share of the costs under the ACA.

Governor Bentley indicated that he favored the state-based solution and will work with the legislature to craft such an alternative.

The University of Alabama-Birmingham School of Public Health projected this year that expanding Medicaid under the ACA would bring in \$1.2 billion per year in new state revenues.



Arizona

Meritus becomes latest ACA cooperative to shut down

Executives with Meritus Health Partners announced earlier this month that it will cease operations on December 31st after failing to secure additional financial backing.

The federal Centers for Medicare and Medicaid Services (CMS) had already blocked the Meritus insurance cooperative from offering plans in the federally-facilitated Marketplace (FFM) in Arizona after the state Department of Insurance filed an order of supervision prohibiting the company from issuing new policies or renewing existing ones. As a result, roughly 59,000 Meritus subscribers will have to find new coverage for 2016.

Cooperatives in Michigan, New York, South Carolina, and Utah had recently issued similar announcements, meaning that 12 of the 23 created with Affordable Care Act (ACA) loans have now become insolvent after claims costs outpaced available funding. CMS has refused to bail out insolvent CO-OPs by transferring funds from other sources following Congress' decision to rescind the remaining ACA funding for CO-OPs as part of deficit reduction agreements (see Update for Weeks of December 24 and 31, 2012). The \$2.5 billion shortfall in reinsurance and risk corridors payments was the death blow for several CO-OPs with exceptional claims costs (see Update for Weeks of October 5th and 12th).

Congress has held several hearings in recent weeks to debate how and whether to save the remaining CO-OPs, a handful of which actually led their respective ACA Marketplaces in market share. The Office of Inspector General (OIG) for Health and Human Services (HHS) is also planning additional audits into CO-OP funding after finding earlier this year that 21 of the 23 CO-OPs were already losing money as of last summer and unanticipated early enrollment for at least eight of the 23 outpaced their ability to pay claims (see Update for Week of June 1st).

District of Columbia

Committee holds hearing on bill to limit cost-sharing for specialty drugs

PSI Government Relations and other consumer groups testified last month before the Committee on Business, Consumer, and Regulatory Affairs in support of the Specialty Drug Copayment Limitation Act of 2015 (B21-0032).

The measure introduced earlier this year by councilmembers Mary Cheh (D) and Anita Bonds (D) would limit cost-sharing for specialty drugs to \$150 per month for up to a 30-day supply (see Update for Week of January 19th). It would also allow a health plan to request that a non-preferred drug be covered under the cost-sharing for preferred drugs, if the prescribing physician determines that the preferred drug (for the same condition) would not be as effective or would have adverse effects for the individual.

Florida

Committees advance bills to eliminate five-year ban on KidCare for lawfully-residing children

The Senate Health Policy Committee and Senate Appropriations Health and Human Services Committee both unanimously passed legislation in November that would eliminate the five-year ban for lawfully-residing immigrant children under Florida's Children's Health Insurance Program (CHIP) known as KidCare.

The Agency for Health Care Administration (AHCA) now estimates that the cost of providing free to low-cost coverage to these children under S.B. 248 would be offset by the savings associated with the Emergency Medical Assistance Fund for non-citizens.



As of March 2015, 29 other states have adopted similar measures, including Texas, Ohio, Kentucky, and California. The House companion bill (H.B. 89) is expected to be shortly heard by the Health Innovation Subcommittee.

Advisory board recommends that lawmakers address surprise bills and “family glitch”

The Florida Health Insurance Advisory Board recommended in mid-November that lawmakers pursue additional protections for consumers in the coming legislative session.

The first major recommendation would protect subscribers under preferred provider organizations (PPOs) and certain other network plans from surprise bills for out-of-network care provided by contractors at in-network providers. Florida law currently only protects HMO consumers in such situations. House and Senate bills to correct this disparate treatment were blocked last session by medical groups.

Rep. Carlos Trujillo (R) has already pre-filed legislation for next session (H.B. 221) that would address this situation, but it only applies to emergency care. The board is urging lawmakers to prevent such surprise billing for non-emergency care as well.

The board’s other major recommendation is intended to fix a so-called “family glitch” that prevents family members of a small business employee from receiving Affordable Care Act (ACA) subsidies to help them purchase Marketplace coverage. According to the board, changing the wording of state law would clarify for small businesses that they can buy health insurance policies that cover only an individual employee and not family members. Because family members would not be eligible for the workplace coverage, they would become eligible for the ACA subsidies.

The board had to table an analogous measure for large employers after legal advisors concluded that no state law could be modified to address the “family glitch” in their situation. The Florida Office of Insurance Regulation (OIR) decided to instead inform insurance carriers in writing that large employers should be given the opportunity to buy worker-only coverage so that families can be subsidy-eligible.

An additional report approved by the board documented that the number of individual market policies in Florida jumped by more than 75 percent (to 1.5 million) following full implementation of the ACA in 2014.

Hawaii

Individual health plan consumers to pay an average of 30 percent more in 2016

The governing board for the Hawaii Health Connector voted earlier this month to accelerate the transition of the Marketplace to a state agency.

Despite defaulting to the web portal for the federally-facilitated Marketplace for the 2016 open enrollment period, state officials will retain control over most Marketplace functions (see Update for Week of May 11th). However, the transition to the federal portal has complicated renewals for roughly 30,000 enrollees with 2015 coverage that have to re-enroll by December 15th so that their coverage will remain uninterrupted for 2016. This is because enrollees now need to use federal enrollment assisters and the Special Marketplace Assister line that is part of the federal call center operates five hours ahead of Hawaii’s peak enrollment hours.

These “mitigating circumstances” have forced state officials to start negotiating with CMS on a “contingency plan” in the event all current enrollees cannot renew as required by December 15th. Remaining Connector duties would also transfer more quickly to state agency control, instead of being only one of two states besides Colorado to operate as an entirely independent, non-profit entity (see Update for Weeks of April 6th and 13th).



The Hawaii Insurance Commissioner also acted in late October to dramatically reduce the 49 percent average rate hike sought by the Hawaii Medical Service Association (HMSA) offered by Blue Cross and Blue Shield. HMSA instead will receive only a 27.32 percent average hike for 2016.

However, the Commissioner dramatically increased the hike sought by HMSA's lone competitor in the individual market (in and out of the Marketplace). Kaiser Permanente received a 34.4 percent increase in average individual market premiums despite requesting only an 8.7 percent average hike.

The final rates will result in an overall weighted average rate increase of nearly 30 percent for 2016 consumers in the individual market. As a result, the number of Connector enrollees receiving ACA subsidies is likely to dramatically increase from the 61 percent that qualified in 2015 (for below the national average of about 85 percent).

Kansas

Speaker removes three health committee members due to Medicaid expansion support

House Speaker Ray Merrick (R) removed three moderate Republicans from the Health and Human Services Committee this month due to their support for legislative proposals to expand Medicaid pursuant to the Affordable Care Act (ACA).

Provider groups including the Kansas Hospital Association have accelerated calls for Medicaid expansion in the wake of several rural hospital closures due to the costs of uncompensated care. This has led several Republican opponents of Medicaid expansion to soften their positions, including Senate Vice President Jeff King (R).

However, the more conservative House has steadfastly rejected all Medicaid expansion proposals in recent years (see Update for Week of January 13, 2014). Despite his previous support for a "private sector" expansion alternative (see Update for Week of November 10, 2014), Speaker Merrick stepped up efforts to squash any expansion momentum by removing Rep. Barbara Bollier (R), a retired physician, Rep. Susan Concanon (R), a former medical foundation director, and Rep. Dan Hill (R), a practicing pharmacist. All three favored Medicaid expansion and were considered to be "three of most knowledgeable [members] on health care issues."

Kentucky

Gubernatorial upset threatens to undo state's ACA reforms

Investment manager and Tea Party favorite Matt Bevin (R) handily defeated Attorney General Jack Conway (D) earlier this month in the race to become the next governor of Kentucky. Bevin, who has never held elected office, will become only the state's second Republican governor since 1971 when he assumes office on December 8th.

Governor-elect Bevin (R) ran on a platform to repeal the state's expansion of Medicaid under the Affordable Care Act (ACA). Bevin has also pledged to turn over control of Kynect state-based Marketplace (SBM) to the federal government by reversing the 2012 executive order from Governor Steve Beshear (D) that created Kynect (see Update for Week of July 16, 2012).

Researchers with the Gallup organization credited both the Medicaid expansion and Kynect with reducing the state's uninsured rate from 20.4 percent to nine percent by June 2015, the second steepest decline in the nation since full implementation of the ACA in January 2014 (see Update for Weeks of February 9th and 16th). Roughly 500,000 of the state's 640,000 newly-insured gained coverage for the first time thanks to the reforms.

Governor Beshear urged Governor-elect Bevin this week to reconsider his campaign pledge to undo the successful reforms, citing state-commissioned studies projecting a \$30.1 billion positive



economic impact to Kentucky, including the addition of 12,000 jobs just in 2014. Previous reports from the Deloitte consulting firm showed that the Medicaid expansion slashed uncompensated care costs for Kentucky hospitals by 60 percent during the first year alone (see Update for Weeks of February 9th and 16th). Beshear also pointed out that eliminating federal matching funds for the Medicaid expansion would immediately create a \$300 million hole in the state budget and increase uncompensated care costs to health care providers by \$2.9 billion.

The Governor-elect's plan to switch to the federally-facilitated Marketplace (FFM) would also increase state costs by roughly \$23 million, according to Governor Beshear, and immediately impose higher user fees on consumers (the 3.5 percent user fee for FFM plans far exceeds the one percent fee charged by Kynect). Beshear noted that Kynect consumers would also no longer be served by a local network of consumer representatives, nor would they have one streamlined portal for both Medicaid and qualified health plan coverage.

Since his election, Governor-elect Bevin has backtracked only slightly from his pledge to repeal the Medicaid expansion and Kynect, indicating that he remains open to converting the expansion into a "private sector" alternative similar to the model the Obama Administration has already approved for six states (see Update for Weeks of June 29th and July 6th). However, Bevin insists that the Medicaid eligibility threshold would have to be reduced from the 138 percent of federal poverty level set by the ACA—a move that the Obama Administration has consistently rejected.

Bevin has stated that he would adhere to federal regulations requiring a 12-month notice to consumers before Kynect could be transitioned to FFM status.

Louisiana

Governor-elect promises to expand Medicaid on first day in office

State Rep. John Bel Edwards (D) surprisingly defeated sitting U.S Senator David Vitter (R) earlier this month in the race to replace term-limited Governor Bobby Jindal (R), becoming the first Democratic candidate to win a statewide election in Louisiana since 2008.

Both Governor Jindal and Senator Vitter were staunch opponents of participating in the Medicaid expansion under the Affordable Care Act (ACA) (see Update for Week of May 4th). However, Governor-elect Edwards, who made several efforts to expand Medicaid while a state lawmaker, immediately pledged to issue an executive order upon assuming office in January that would implement a traditional ACA expansion and bring Medicaid coverage to more than 225,000 Louisianans.

The move could make Louisiana the only southern state to participate in the ACA expansion if Kentucky's governor-elect follows through on his pledge to repeal that state's expansion (see above).

Massachusetts

Committee debates measure to limit cost-sharing for prescription drugs

The Joint Committee on Financial Services held a November 17th hearing on S.B. 541, which would limit pre-deductible cost-sharing for prescription drugs to \$100 per 30-day supply and prohibit insurers from placing all drugs in a given class on the highest cost-sharing tier in a tiered formulary. The measure was introduced last spring by Senator Anthony Petrucci (D).

Montana

Approved Medicaid expansion alternative attracts 5,550 enrollees in first week

The federal Centers for Medicare and Medicaid Services (CMS) has approved Montana's request to expand Medicaid under the Affordable Care Act (ACA) through an alternative model already in place in six other states.



The waiver makes Montana the 30th state in the nation (including DC) to expand Medicaid under the ACA. Roughly 5,500 Montanans applied and were approved for coverage (that starts January 1st) during just the first week after the November 3rd approval, representing nearly one-quarter of the total number that Governor Steve Bullock (D) projected would enroll during the first six months.

Under the approved waiver, Medicaid expansion enrollees with incomes above 50 percent of the federal poverty level (FPL) will use a provider network managed by a third party administrator and pay up to two percent of their income in monthly premiums, which will cover copayment obligations. Those earning more than 100 percent of FPL may have their coverage terminated if they fail to pay premiums after a 90-day grace period.

Work requirements and premiums for even lower-income populations were part of the plan passed by the legislature last spring that was touted as the “most conservative” of the Medicaid expansion alternatives enacted by any state (see Update for Weeks of June 29th and July 6th). However, these provisions were stripped out by CMS to make them consistent with other state models (see Update for Weeks of January 26th and February 2nd).

New Jersey

Governor makes New Jersey the 19th state to enact biosimilar substitution legislation

Governor Chris Christie (R) signed A.2477 earlier this month, making New Jersey the latest of 19 states to enact legislation regulating the substitution of generic biosimilars for brand-name biologic drugs.

The measure previously cleared the Assembly with unanimous support (see Update for Weeks of June 29th and July 6th). Unlike early versions of biosimilar substitution legislation that imposed significant notification and record-keeping burdens on pharmacists (see Update for Week of September 2, 2013), the measure simply requires that pharmacists notify a prescribing physician within five business days whenever a biosimilar product is substituted for the reference product, so long as the biosimilar is therapeutically equivalent to the reference product or is designated by the Food and Drug Administration.

Eleven states (including California, Colorado, Georgia, Louisiana, and Washington) as well as Puerto Rico have now enacted legislation similar to the New Jersey bill just this year that reflects a compromise between groups representing brand-name and generic drug makers (see Update for Weeks of June 29th and July 6th). Comparable bills are still pending in Michigan, Missouri, and Pennsylvania.

All but five states had rejected the initial flurry of biosimilar substitution bills in 2013 as they were largely viewed as imposing onerous restrictions that created barriers to competition (see Update for Week of January 19th).

The Food and Drug Administration approved the first biosimilar product this spring 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”, which many of the state bills require prior to substitution (see Update for Weeks of April 6th and 13th).

New Mexico

Finance committee report highlights dramatic post-ACA decline in uncompensated care

The Legislative Finance Committee released a report earlier this month documenting the decline in uncompensated care in New Mexico that has resulted since the full implementation of the Affordable Care Act (ACA) in January 2014.

The Committee’s report concluded that “by all measures, the costs of uncompensated care have dropped.” It determined that the state’s uninsured rate has fallen by 4.1 percent while uncompensated



care as a percent of hospital expenses dropped 12.5 percent and uncompensated care in hospital cost reports dropped 3.6 percent. In addition, applications for reimbursement from the state's Safety Net Care Pool have plummeted by 30.4 percent from 2014 to 2015.