Health Reform Update –Week of June 2, 2014

CONGRESS

New HHS Secretary praised for responsiveness to Republican queries on ACA

In a rare show of bipartisan support, Sylvia Mathews Burwell was confirmed this week by the Senate to serve as the next Secretary for the Department of Health and Human Services (HHS) with only 17 dissenting votes. She becomes the first non-governor to head the agency in over 14 years.

Burwell's confirmation comes just over a year after she was unanimously confirmed as Office of Management and Budget (OMB) Director just over a year ago. She has also served as chief of staff for the Department of Treasury Secretary and has headed two private foundations.

Despite the continued rancor over implementation of the Affordable Care Act (ACA), she won praise from several key Republicans for her responsiveness to Senate Finance Committee queries, including concerns about prescription drug benefits under Marketplace plans, the adequacy of provider networks within the Marketplaces, and HHS efforts to mitigate against any steep premium hikes for 2015 (see below). During confirmation hearings, Burwell pledged to support a permanent Medicare physician payment fix and avoid overall payment cuts that would be automatically triggered by the controversial Independent Payment Advisory Board created by the ACA (though she opposes it repeal).

Burwell also specifically committed the agency to using the "full extent of the law" to recover any federal grants that were misspent by states that were unable to create functioning state-based Marketplaces under the ACA (see Update for Weeks of April 28th and May 5th).

PSI will immediately be working with Ms. Burwell on formally clarifying that non-profit charitable organizations can continue to assist with premiums and cost-sharing for Marketplace plans (see below).

CBO lowers estimate of Americans that will pay individual mandate penalty

The Congressional Budget Office (CBO) predicted this week that only four million of the 30 million that are expected to remain uninsured in 2016 will actually be subject to the tax penalty under the Affordable Care Act (ACA) for not buying minimum essential coverage that they can afford.

The 13 percent figure is lower than CBO's 2012 estimate, which had predicated six million would be subject to the controversial "individual mandate". CBO reduced its estimate after the Centers for Medicare and Medicaid Services (CMS) broadened the number of exemptions to the mandate. A total of 23 million Americans are expected to qualify for an exemption.

Overall, the federal government is projected to collect $4 billion from individual mandate penalties in 2016, followed by $5 billion every year through 2024.

CBO says it will no longer provide ACA cost estimates

Senator Ron Johnson (R-WI) introduced legislation this week requiring the Congressional Budget Office (CBO) to continue its annual cost estimates of the Affordable Care Act (ACA) after the non-partisan scorekeeper insisted it was no longer possible to do so.

The measure (S.2446) is based on a prior amendment from Senator Johnson that was adopted by the Senate Budget Committee as part of a fiscal 2014 budget resolution in March 2013. Even if

enacted, CBO claims that such estimates simply cannot isolate the incremental effects of the ACA on existing federal programs and the federal tax code. However, CBO is still estimating the fluctuating costs of the insurance provisions of the law, which include health insurance subsidies, the Medicaid expansion in participating states, and the individual mandate.

House Republicans target income verification glitches for two million Marketplace enrollees

The Centers for Medicare and Medicaid Services (CMS) acknowledged last week that the applications for nearly two million enrollees in federally-facilitated Marketplaces (FFMs) contain "data discrepancies" but insisted that such inconsistencies are not automatically indicative of problems with their enrollment.

According to CMS, roughly 1.2 million enrollees had discrepancies with their annual income through the end of May, while another 461,000 had citizenship inconsistencies and 505,000 had immigration inconsistencies. The agency claims that most issues have already been resolved by obtaining additional information and no consumers have had their enrollment terminated as a result.

Republican leaders on the House Ways and Means Committee insist that the figure is at least twice as high as the two million cited by CMS and scheduled a hearing next week to examine the discrepancies. They also sent letters to CMS and relevant contractors on May 19th demanding greater detail on how many enrollees received inaccurate subsidy payments, after *The Washington Post* reported that Internal Revenue Service (IRS) filings showed this figure exceeded one million individuals.

The article claimed that the IRS still lacks the technical capability to verify that the income amounts reported by enrollees are correct because the necessary infrastructure has yet to be built and is not slated to start development until this summer. Ways and Means leaders have asked the Department of Treasury to stop issuing any premium subsidies under the ACA until an accurate income verification system is in place and the HHS Inspector General completes its assessment of the agency's safeguards by July 1st.

Ways and Means Democrats noted that the ACA gives HHS 90 days to resolve such data discrepancies.

FEDERAL AGENCIES

HHS confirms that non-profits can assist with Marketplace premiums and cost-sharing

Outgoing Secretary Kathleen Sebelius responded to queries from the American Hospital Association and other groups last week by re-affirming that non-profit premium assistance for Marketplace plans is consistent with rules and guidance issued by the Department of Health and Human Services (HHS).

The Secretary's response was necessitated by conflicting statements made by the Centers for Medicare and Medicaid Services (CMS) since last fall. While CMS guidance documents appeared to "discourage" the payment of premiums and cost-sharing by for-profit groups, they consistently permitted such assistance from non-profit charitable organizations like PSI (see Update for Week of February 24th).

However, a provision in an interim final rule published on March 19th appeared to grant Marketplace insurers discretion to exclude premium assistance from charitable groups, while clarifying that it must accept such assistance only from state or federal programs (like Ryan White HIV/AIDS payments) (see Update for Weeks of March 17th and 24th).

CMS has subsequently been inundated with public comments from PSI and other consumer groups urging the agency to correct this provision. Senators David Vitter (R-LA) and Rep. Bill Cassidy (R-LA) also recently sent a letter urging CMS to clearly exempt non-profit charitable groups from any premium assistance prohibitions after several insurers in the Louisiana Marketplace began denying third-party payments in an effort to effectively circumvent the ACA's ban on pre-existing condition insurance denials (see Update for Week of March 10th). PSI has been working with other offices to sign-on to a comparable letter from Rep. Cedric Richmond (D-LA) that similarly points out that excluding premium assistance from non-profits would contradict existing CMS policy for Medicare.

OIG targets manufacturer patient assistance programs run by independent charities

The Office of the Inspector General (OIG) for the Department of Health and Human Services announced last month that it will "closely scrutinize" manufacturer patient assistance programs (PAPs) run by independent charities to ensure they are "sufficiently independent" from donors such as pharmaceutical manufacturers.

In its May 21st Supplemental Special Advisory Bulletin, OIG reiterates its earlier 2005 guidance warning that a "charity [cannot act] as a conduit for a drug manufacturer to induce the prescription of its drugs, Federal health care programs and their beneficiaries." However, the OIG affirms its support for "properly structured PAPs [that] can help Federal health care program beneficiaries" with prohibitive prescription drug cost-sharing.

To avoid any confusion or interruption in patient care, OIG is reaching out to charities that have already received favorable advisory opinions to ensure they are consistent with OIG's expanded guidance. OIG specifically cautions that narrow disease funds for a specific stage or complication or disease will be subject to greater OIG scrutiny than broader funds earmarked for conditions like cancer or diabetes. The OIG is also concerned about limiting assistance only to "expensive or specialty drugs" or a "subset or available products, rather than all products approved by the Food and Drug Administration (FDA) for treatment of the disease state(s) covered by the fund."

The bulletin reiterates that OIG disapproves of any effort by charities to give donors specific data allowing them to correlate donation amounts with how frequently PAP recipients use particular products or the volume of PAP-supported products.

HIV/AIDS advocates file HHS complaint alleging Marketplace discrimination

The AIDS Institute (TAI) and National Health Law Program filed a complaint last week with the Office of Civil Rights for the Department of Health and Human Services (HHS) alleging that several Marketplace insurers in Florida and Illinois are unlawfully discriminating against persons with HIV/AIDS.

TAI had brought the issue to the attention of HHS last fall, after it discovered that several insurers in the federally-facilitated Marketplace (FFM) operated in Florida were moving all HIV/AIDS drugs into specialty tiers that impose the highest-levels of cost-sharing, averaging 40 percent of the total drug cost for the lowest-level bronze and silver level plans (see Update for Week of December 9th). For example, Humana's two silver-level plans place all HIV/AIDS drugs (including generics) into its highest fifth tier, which requires enrollees pay 40-50 percent of the drug's total cost after a $1,500 deductible.

In addition to Humana, the complaint cites CoventryOne, Cigna, and Preferred Medical for violating the anti-discrimination provisions of the Affordable Care Act (ACA) by making drugs for specific costly conditions like HIV/AIDS so costly that patients are unable to access them. TAI points out that such practices effectively circumvent the new ban on pre-existing condition exclusions under the ACA.

The complaint also follows a directive from the Illinois Department of Insurance Director Andrew Boron, who recently warned insurers that the "[ACA] prohibition on discrimination applies equally to all

health conditions, including but not limited to individuals with HIV/AIDS." He urged insurers to stick to recommendations from HHS when it comes to offering affordable drug regimens to treat HIV/AIDS.

The insurers mentioned in the Florida complaint defended their plans and pricing in statements to *Healthline.* Coventry, a subsidiary of Aetna, claimed that their practices follow all HHS requirements and provides sufficient access to care for HIV/AIDS patients. Humana insisted that the ACA's new cap on out-of-pocket expenses would still ensure access to specialty drugs, even if the up-front costs for the patient ranged from 32-50 percent of the total drug costs.

CMS acknowledges that it not do any "outlier tests" on rates and cost-sharing for the 2014 certification process, but would do so in 2015. However, TAI insists that these tests would be inadequate to detect the discriminatory practices documented in the complaint.

PSI Government Relations has worked with TAI in bringing this issue to the attention of Florida's congressional delegation.

CMS finalizes standards for 2015 Marketplace enrollment

The Centers for Medicare and Medicaid Services (CMS) has finalized standards for the 2015 open enrollment period that increase reinsurance payments to insurers for extraordinary losses, curtail the ability of states to engage in navigator suppression, allow an additional delay in the small business Marketplace, and create an expedited exceptions process for prescription drugs.

Consistent with earlier proposals (see Update for Week of March 10th), the May 27th final rules lower the threshold for reinsurance payments from $70,000 in consumer claims to only $45,000 in order to compensate insurers for the Administration's decision to extend ACA-deficient plans for two years (see Update for Week of March 3rd). They also increase the cap on administrative costs from 20 percent of revenues to 22 percent and will allow insurers to collect up to a five percent profit instead of only three percent. However, insurance industry comments insisted that these two percent increases will not be sufficient to prevent "rate shock" for 2015 (see below).

HHS notes that while such payments will remain "budget neutral", the agency will use "other sources of funding….in the unlikely event of a shortfall for the 2015 program year."

Consistent with the proposed regulation (see Update for Weeks of March 17th and 24th), the final rules also make clear that CMS will "pre-empt" all or part of any state law that seeks to prevent navigators and other assisters from carrying out their duties set forth by the ACA. While CMS will allow states to require that navigators pass background checks, obtain a license, or complete additional state training, it will not permit state laws that require navigators refer all consumers to insurance brokers or agents for help choosing a Marketplace plan or preventing those entities from working with all of the persons for whom they are required by the ACA to assist.

The final rules also allow states to further delay offering employee choice in their Small Business Health Options Program (SHOP) under certain conditions (see Update for Week of March 3rd). The employee choice requirement was already delayed until 2015 for FFMs. State-based Marketplaces (SBMs) had the option to delay until 2015, although a handful elected to implement it this year.

However, any FFM or SBM can postpone the employee choice requirement an additional year if the state insurance commissioner submits a written recommendation explaining that delay is in the best interests of small employers, employees, and dependents, given the likelihood that it would lead to higher premiums due to adverse selection. For FFM SHOPs, this recommendation had to be submitted by June 2nd and 11 states did so (Alabama, Alaska, Arizona, Kansas, Louisiana, Maine, New Hampshire, North Carolina, Oklahoma, Pennsylvania, and South Carolina.)

Under the final rules, all non-grandfathered individual and small group plans must now include an expedited exceptions process as part of their provision of prescription drug benefits. When an exceptions request is based on "exigent circumstances," the rules require an issuer to respond no later than 24 hours after receipt. The rules define such circumstances as those where an enrollee is suffering from a health condition that could have significant consequences on their life, health, or ability to regain maximum function or when the enrollee is under a course of treatment with a non-formulary drug.

Drugs approved through this exceptions process must continue to be covered throughout the related exigency. However, CMS will address how insurers should treat cost-sharing for drugs approved through the exceptions process in future rulemaking.

CMS used the final rule to respond to comments from brokers and consumer advocates urging the agency to creating additional special enrollment periods (SEPs) so that certain consumers can sign-up for Marketplace plans outside of open enrollment periods. Groups like the National Association of Health Underwriters and Families USA would like those experiencing a dramatic change in provider networks or mid-year increase in income in states not participating in the Medicaid expansion to qualify for an SEP, among a long list of other proposed qualifying life events. CMS stated that it would consider these proposals but stressed that the agency has already issued recent guidance creating SEPs for those transitioning off COBRA continuation coverage and those whose non-calendar year individual insurance policies are up for renewal (see Update for Weeks of April 28th and May 5th).

IRS will penalize employers that dump health coverage in lieu of tax-free contributions

The Internal Revenue Service (IRS) ruled last month that employers cannot give workers tax-free contributions to purchase Marketplace coverage in lieu of providing employee health benefits.

Employers remain free to decide that paying the assessments under the Affordable Care Act (ACA) for failing to provide minimum essential coverage (MEC) is more affordable or advantageous for them than provide employee health benefits. However, the guidance clarifies that giving employees tax-free contributions to reimburse employees for their Marketplace premiums and cost-sharing would create an “employer payment plan” under IRS Notice 2013-54 that are essentially considered to be group health plans to do not comply with minimum ACA standards. As a result, this arrangement would subject employers to an additional excise tax of $100 per day for each employee.

The guidance does not restrict employers from instead reimbursing employees by increasing their taxable wages.

STATES

Proposed Marketplace premiums for 2015 show mostly modest increases but wide variation

Proposed premiums submitted by insurers seeking to participate in Affordable Care Act (ACA) Marketplaces for 2015 are line with the low double digit rate hikes projected by analysts like J.P. Morgan, though they vary widely by state and within states.

Proposed rates must be submitted by June 27th and then approved by either the U.S. Department of Health and Human Services (HHS) for federally-facilitated Marketplaces (FFMs) or state insurance commissioners for state-based Marketplaces (SBMs).

Rate hikes submitted by insurers for Ohio’s FFMs averaged 13 percent for the individual market (to $374 from $332 in 2014 not including ACA subsidies) and 11 percent for the small group market. About five percent of that amount was attributed to an increase in the ACA’s tax on insurer premiums that takes effect for 2015. However, insurers did not seek increases for a skewed risk pool, as many analysts

had initially feared following the Obama Administration's decision to extend ACA-deficient plans for two years (see Update for Week of March 3rd), mitigating the likelihood of any steep increases of more than 20 percent.

The Ohio increase is comparable to Virginia 11.7 percent average increase under proposed rates filed thus far. The Virginia Health Plan Association stated that rate hikes were consistent with the pre-ACA market and moderated by higher than anticipated Marketplace enrollment, including roughly 1,400 individuals previously covered under the state AIDS Drug Assistance Program (ADAP).

State-based Marketplaces in Connecticut, Kentucky, Maryland, and Washington are seeing similar average increases while the state with the only non-functional website (Oregon) will not have any increases above five percent with one insurer (Providence Health Plan) actually seeking to cut rates by an average of 16 percent based on its predictions of lower medical costs.

However, "outliers" from some dominant insurers have attracted attention from ACA critics. For example, CareFirst Blue Cross and Blue Shield (BCBS) is seeking to hike individual premiums in the Marketplace by 23-30 percent, even though two other insurers in the Marketplace (Kaiser and Evergreen Health Corporation) are proposing to lower rates by10-12 percent.

Anthem Blue Cross in Connecticut also drew the ire of that state's Healthcare Advocate, who demanded a public hearing after Anthem proposed a 12.5 percent average increase based largely on an assumption that sicker patients would enter the risk pool in 2015. The Healthcare Advocate noted Anthem's own filing attributed two-thirds of the increase to rising medical costs (including the introduction of an $84,000 per year Hepatitis C drug) even though its Marketplace competitor HealthyCT is planning to drop rates by nearly nine percent on average. She also contends that the rate hikes do not reflect the increased competition for 2015, as United Healthcare will enter the Marketplace and Connecticare will add a platinum-level option that was not available from any Marketplace insurers in 2014 (see Update for Week of November 11th).

Medicaid enrollment surge leads to application backlog

New Medicaid enrollments surged to six million by the end of April according to the most recent figures reported by the Department of Health and Human Services (HHS), with 1.1 million enrolling during April alone.

The 26 are participating in the Medicaid expansion under the ACA experienced a 15.3 percent growth rate, compared to only 3.3 percent in opt-out states. Nevada, Oregon and West Virginia were among the states with especially pronounced jumps in Medicaid enrollment.

However, HHS also acknowledged that more than 1.7 million applicants have remained in limbo for as long as eight months as states have been unable to process the large number of applications. California has had a persistent backlog this year (see Update for Week of April 28th and May 5th) with nearly 900,000 still unprocessed as of early June. Illinois is next with 283,000, while even opt-out states like North Carolina and Georgia have 170,000 and 100,000 backlogged applications respectively.

The reasons for the problems include technological glitches that prevented the federally-facilitated Marketplace (FFM) from transferring data on applicants to state Medicaid agencies and many states' inability to handle an enrollment surge because of inadequate staffing or their own software flaws. However, HHS points out that not all states have been affected, with three of the largest (New York, Texas, and Florida) reporting little or no backlog.

HHS acknowledges that Alaska, Kansas, and Maine are still unable to receive applications transferred through the FFM. However, all other states have had such capability since May.

California

Covered California creates special enrollment period for COBRA enrollees

Covered California announced last week that it launched a two-month special enrollment period (SEP) for those enrolled in COBRA continuation coverage that want to transition to a Marketplace plan.

Because those electing to continue their employer-based coverage following termination of their employment must pay the full amount of their premium, Covered California officials have been actively promoting Marketplace plans as a less costly option. However, Covered California director Peter Lee acknowledges that the website was "confusing" for many COBRA enrollees and that officials were more focused on reaching out to those without any insurance during open enrollment.

As a result, COBRA enrollees that did not switch to a Marketplace plan under Covered California through the inaugural open enrollment period can still enroll through July 15th by selecting the "other 'qualifying life events'" option. They also can enroll thorough a broker or enrollment counselor.

The Obama Administration recently created a similar SEP for COBRA enrollees under federally-facilitated Marketplaces (see Update for Weeks of April 28th and May 5th). These SEPs are separate from the SEP that the U.S. Department of Labor already requires once COBRA coverage is exhausted.

Covered California officials predict that the SEP could impact nearly 300,000 Californians receiving COBRA benefits.

Health measures continue to advance before June 30th end of session

The Senate passed several health-related bills last week, which must now clear the Assembly before the June 30th end of the legislative session.

The measure includes S.B. 964, which would broaden minimum standards for provider networks in Covered California. S.B. 964 would go beyond earlier efforts by the Obama Administration to ensure that insurers participating in Affordable Care Act (ACA) Marketplaces are not relying on unreasonably narrow provider networks to lower premiums (see Update for Weeks of March 17th and 24th).

The Senate also passed S.B. 1100, which would provide continuity of care protections for consumers who change their individual coverage, including Marketplace plans offered through Covered California. Other Senate-passed measures would remove any waiting period for those with pre-existing conditions (S.B. 1034), instead of the 90-day waiting periods permitted by the ACA (see Update for Week of February 17th), make health plans responsible for tracking out-of-pocket costs for in-network providers and reimbursing consumers when they exceed their out-of-pocket limit (S.B. 1176), and mandate rate review for premium increases on large group plans that exceed five percent (S.B. 1182). The ACA currently makes individual and small-group plans justify any double-digit rate increase (see Update for Week of August 29, 2011).

The Assembly also passed several health-related measures that must now be acted upon by the Senate. This includes legislation that would prohibit costs-sharing for any single prescription from exceeding 1/12 of the annual out-of-pocket limits set by the ACA (A.B. 1917), which will effectively spread out the cost-sharing for the highest tier specialty drugs over a full year instead of forcing consumers to pay all at once. A.B. 2088 also would help consumers avoid "junk" health coverage by making limited benefit plans supplemental to essential health benefits offered by employer-based plans, essentially extending the comparable protection that California already requires for "junk" coverage in the individual and small group markets.

Colorado

Feds approved Colorado plan to lower nation's highest premiums for rural resort areas

The Centers for Medicare and Medicaid Services (CMS) has approved Colorado's plan to consolidate several geographic rating areas used to determine premiums for its Affordable Care Act (ACA) Marketplace.

The plan proposed by the Division of Insurance was intended to reduce Marketplace premiums in mountain and resort areas that were the highest in the nation (see Update for Weeks of April 28th and May 5th). It will combine four rural areas into two large rating areas, while retaining the seven urban rating areas. By placing pricey mountain resorts intro the same rating area as the state's 21 western counties, the Insurance Commissioner hopes to slash premiums in resort areas by 4-8 percent while acknowledging that premiums may rise 4-6 percent for other consumers in rural parts of the rating area.

The Kaiser Family Foundation had found earlier this year that a 40-year old in resort counties of Garfield, Eagle, Pitkin and Summit would pay $483 a month compared to only $280 for a comparable person living in Denver.

In addition to the rate relief plan, Governor John Hickenlooper (D) also signed legislation this week creating the Colorado Commission on Affordable Health Care charged with making recommendations by November 15th on how to control health care costs for consumers. S.B. 187 requires that two of the 12 voting members on the commission must be consumer representatives.

Illinois

Specialty tier legislation introduced in House

Rep. Jaime Andrade (D) introduced legislation last week that would amend the Illinois Insurance Code to ensure that any required cost-sharing for specialty tier drugs does not exceed $100 per month for up to a 30-day supply of any single drug. H.B. 6277 would also limit a beneficiary's annual out-of-pocket expenditures for prescription drugs to no more than 50 percent of the out-of-pocket limits under the Affordable Care Act (ACA).

Comparable companion legislation remains in Senate committee (see Update for Week of February 17th). Both measures provide that plans covering prescription drugs through a tiered formulary must implement a process to allow enrollees to request an exception to the tiered cost-sharing structure. They explicitly would prohibit plans from placing all drugs in a given class on a specialty tier, a practice that resulted in a recent discrimination complaint in both Illinois and Florida (see above).

Indiana

Governor alters his Medicaid expansion alternative relying on health savings accounts

Governor Mike Pence (R) has agreed to alter portions of his controversial Medicaid expansion alternative in an effort to secure federal approval.

Indiana is seeking to become the 28th state (including the District of Columbia) to participate in some form of the Medicaid expansion under the Affordable Care Act (ACA). Three states (Arkansas, Iowa, and Michigan) have already received federal approval for a private-sector alternative that uses ACA matching funds to instead purchase Marketplace coverage for those made newly-eligible under Medicaid (see Update for Week of January 6th).

Governor Pence's proposal is different from these models as newly-eligible residents would instead be enrolled in a health savings account (HSAs) to pay for their medical costs, similar to the Healthy Indiana demonstration project operated in Indiana since 2008 (see Update for Week of February 25, 2013). The HSAs would come with a steep $2,500 deductible with required sliding scale contributions that start at $3 per month for those earning $214 per month and rise to $25 per month for those earning

$93-1,342 per month. (The Governor emphasizes that these contributions are slightly lower than those previously required for Healthy Indiana participants.)

Enrollees that put money into their HSAs will have no other costs apart from a $25 copayment for non-urgent use of emergency rooms that is waived if enrollees first call a referral hotline. However, those earning below the federal poverty level (FPL) that do not make contributions would be shifted into a less generous plan with more limited prescription drug benefits and higher copayments.

Among the more controversial parts of the Governor's plan is the elimination of benefits for those earning from 100-138 percent of FPL (the upper end of the ACA expansion) who do not make contributions. Another provision would require non-disabled beneficiaries that working less than 20 hours per week to be referred to the state's job training and job search programs. However, the Governor did remove two of the most controversial provisions from his plan that limited benefits and maintained a waiting list.

Starting in 2016, the Governor's plan would allow consumers to use ACA matching funds to instead buy private coverage through their jobs. Consumers can choose between get coverage through the state Healthy Indiana program, or putting a state contribution toward the cost of insurance provided by their employers.

Louisiana
Specialty tier bill sent to Governor

The legislature sent S.B. 165 to Governor Bobby Jindal (R) last week after it unanimously passed the House and previously cleared the Senate with only one dissenting vote (see Update for Weeks of April 28th and May 4th). If signed, the measure would limit coinsurance or copayments applied to drugs on a specialty tier to not more than $150 per month for each specialty drug or up to a 30-day supply of any single drug.

Nevada
Nevada reverts to federally-facilitated Marketplace for 2015

The board of directors for the Silver State Health Exchange has voted to sever ties with its website contractor Xerox and default to the federally-facilitated Marketplace (FFM) for at least one year.

Nevada becomes the fourth state to abort efforts to create its own state-based Marketplace pursuant to the Affordable Care Act (ACA) (see Update for Week of April 28th and May 4th). Maryland and Massachusetts will try to fix their flawed web portals with technology from other states, while Nevada and Oregon will revert back to the federal model.

Nevada's website was plagued with over 1,500 technical glitches that Xerox had been unable to correct. Xerox has only been paid $12 million of its $75 million contract and the board has already been forced to award an additional $1.5 million to Deloitte consulting to fix several persistent flaws. It expects to spend $30-40 million to ultimately rebuild the software.

State officials, Nevada Health Link, and Xerox all face a class action lawsuit from at least 40 Marketplace consumers (see Update for Week of April 7th).

According to Nevada Health Link officials, only 35,712 consumers enrolled in the Marketplace plans through May 23rd or less than a third of its initial estimates (see Update for Week of April 7th).

New Hampshire
Five insurers now slated to participate in ACA Marketplace for 2015

The Insurance Department announced this week that Assurant Health and Maine Community Health Options are seeking to participate in New Hampshire's state partnership Marketplace for 2015.

New Hampshire and West Virginia were the only states that had only one dominant participant in their Affordable Care Act (ACA) Marketplace for 2014. Harvard Pilgrim and Minuteman Health have already sought to participate for next year (see Update for Week of January 6th).

If approved, Maine Community Health Options would give the New Hampshire Marketplace two non-profit cooperatives created by the ACA. It already garnered 80 percent of the market in Maine's Marketplace, despite insurance giant Anthem Blue Cross being its only competition (see Update for Week of February 24th). However, it will only offer plans in five New Hampshire counties next year.

Anthem Blue Cross came under heavy criticism last year for relying on severely limited provider networks to keep Marketplace premiums affordable (see Update for Week of September 16th). As a result, Assurant (which currently participates in 41 ACA Marketplaces) specifically will offer plans in the New Hampshire Marketplace that that include far broader provider networks.

The Marketplace in West Virginia also added an insurer as neighboring Kentucky Health Cooperative received approval from the state insurance commissioner last week to offer plans for 2015.

Oklahoma

Oklahoma ends state high-risk pool

Governor Mary Fallin (R) signed H.B. 3282 this week, which repeals the Health Insurance High Risk Pool Act. Effective June 1st, policies will cease to be offered while all existing policies will terminate on December 31st.

Virginia

Hopes for Medicaid expansion compromise fade as Democrats lose Senate majority

Senator Philip Puckett (D) accepted a Republican offer this week to resign his Senate seat in exchange for a position on the state tobacco commission and a confirmed judgeship for his daughter. The shocking move sent the Senate into turmoil as Republicans now hold a 20-19 majority and the ability to block any Medicaid expansion compromise pursued by several Republican Senators including Emmett Hanger (R).

The Senate had passed a budget plan when Democrats held the tiebreaking vote that included a private-sector alternative to the Medicaid expansion similar to the model federally-approved for Arkansas, Iowa, and Michigan (see Update for Week of April 7th). Despite the backing of at least three moderate Senate Republicans, the plan was blocked in the Republican-controlled House, forcing lawmakers into a stalemate since Senate Democratic leaders have refused to separate the Medicaid expansion from the budget.

It is not immediately clear if the loss of a Senate majority will resolve the budget impasse before the government shuts down on June 30th. Newly-elected Governor Terry McAuliffe (D), who had made Medicaid expansion a centerpiece of his campaign (see Update for Week of November 11th), called the inducements that procured Senator Puckett's resignation "unacceptable".