



## Health Reform Update – Week of December 1, 2014

### CONGRESS

#### ***House Republicans file lawsuit challenging ACA employer mandate delay, cost-sharing subsidies***

House Republicans filed their long-promised lawsuit last month against the Obama Administration for delaying implementation of the employer mandate under the Affordable Care Act (ACA).

The House authorized the unprecedented federal litigation last summer (see Update for Week of July 28<sup>th</sup>). However, the actual filing was delayed after the first two private legal teams hired by the House Speaker backed out of the case.

House Speaker John Boehner initially stated that the suit would focus on the employer mandate that was delayed until 2016 for those with 51-100 employees and until 2015 for those with more than 100 employees (see Update for Week of February 10<sup>th</sup>). However, the complaint filed last month also included a surprise challenge to the cost-sharing subsidies under the ACA, the funding for which has never been formally authorized by Congress. The Department of Health and Human Services has instead been funding the subsidies from a general account within the Department of Treasury, which are expected to total \$178 billion through 2024.

The complaint is largely expected to be dismissed for lack of standing unless House members can show they are directly injured by the delay. However, it fulfills a campaign pledge to challenge the Administration's traditionally broad discretion to implement or enforce laws via executive actions.

#### ***Republicans seek Supreme Court review of legal challenge to Medicare cost-cutting board***

A group of 24 House Republicans were joined this week by Senator Tom Coburn (R-OK) in a "friend of the court" brief urging the U.S. Supreme Court to review a federal appellate court decision that upheld the constitutionality of the Independent Payment Advisory Board (IPAB) created by the Affordable Care Act (ACA).

Although the controversial Medicare cost-cutting board has yet to go into effect, 26 Democrats have signed-on to legislation seeking its full repeal (H.R. 351), because it would effectively cede authority away from Congress, giving the 15 political appointees on the panel the ability to recommend Medicare payment cuts whenever spending exceeds preset targets (see Update for Week of March 19, 2012). These cuts would automatically go into effect if Congress fails to pass equivalent reductions.

Because the panel has yet to even be appointed, the U.S. Ninth Circuit Court of Appeals concluded that constitutional challenge brought by the conservative Goldwater Institute was premature (see Update for Week of August 18<sup>th</sup>). However, Republican lawmakers are asking the Supreme Court to immediately intervene as it did in the dispute over ACA subsidies in the federally-facilitated Marketplace (see Update for Week of November 3<sup>rd</sup>), arguing that the IPAB is already in effect since the ACA delegates the panel's authority to the Department of Health and Human Services (HHS) Secretary until IPAB members are seated.

#### ***Democratic lawmakers seek to expand Medicaid rebates for generics in response to price spikes***

Senator Bernie Sanders (I-VT) and Rep. Elijah Cummings (D-MD) introduced companion bills last month that would require generic drugmakers to pay Medicaid rebates whenever prices for their products rise faster than inflation.



The legislation (S.2948, H.R. 5748) responds to unexpected spikes in generic drug prices that have been the subject of Congressional inquiries (see Update for Weeks of October 6<sup>th</sup> and 13<sup>th</sup>). It would effectively extend to generics the existing Medicaid rebate that brand-name drugmakers must provide in the same situation. However, it would not impact the standard Medicaid drug rebate for both generic and brand-name drugmakers (which were increased by the Affordable Care Act).

According to the Congressional Budget Office (CBO), the legislation would save Medicaid \$500 million over ten years.

The investigation spearheaded by Senator Sanders and Rep. Cummings found that about half of generic drugs increased in price from July 2013 to July 2014, while ten percent of generics more than doubled in price. A Senate Subcommittee on Primary Health and Aging hearing this week (chaired by Senator Sanders) found that prices for some of the ten generic drugs studied by the panel have spiked by nearly 8,000 percent

### ***House passes first major legislation since ADA to widen federal help for disabled***

In a rare show of bipartisan support, the House approved legislation this week with only 17 dissenting votes that would allow as many as 54 million disabled Americans to open tax-free bank accounts that can pay for health care and other expenses.

The Senate is expected to likewise pass the *Achieving a Better Life Experience (ABLE) Act*. It had been introduced repeatedly since 2006 but faced some opposition from conservative groups that deemed it a "decisive step in expanding the welfare state."

H.R. 647 is modeled after tax-free college savings accounts and would amend the federal tax code to allow states to create the ABLE accounts. Those already receiving federal disability benefits and those diagnosed with a disability by age 26 that results in "marked and severe functional limitations" would be able to qualify for the accounts, which allow families to deposit up to \$14,000 annually to pay for long-term needs. Contributions would be in after-tax dollars but earnings would grow tax-free.

A key to the program is that federal disability beneficiaries can keep their eligibility so long as ABLE account savings do not exceed \$100,000, instead of the current asset limit of \$2,000 for individuals receiving Supplemental Security Income (SSI). Medicaid coverage would continue no matter how much money is deposited in the accounts.

The \$2 billion cost over ten years is currently being offset with other spending cuts or revenue increases, such as higher property levies on tax-delinquent Medicare providers and adjusting caps on worker's compensation. Some lawmakers are objecting to these offsets while the conservative Heritage Foundation is lobbying against lifting the \$2,000 SSI asset limit.

### ***New House bill would extend exclusivity for non-orphan drugs that treat orphan indications***

A new bill introduced last month would grant existing drugs or biologics an additional six months of marketing exclusivity if the manufacturer demonstrates that it treats or prevents a rare disease.

The *Orphan Product Extensions Now Accelerating Cures and Treatments Act* appears to loosely follow the existing Food and Drug Administration (FDA) policy for pediatric products. As with this pediatric exclusivity provision, FDA would be permitted to extend a drug's exclusivity period by six months if a product not initially approved as an orphan drug later meets such approval criteria. However, unlike the pediatric provisions, the subsequent approval would have to be for an entirely new indication, and not just a rare subset of the existing population. In addition, FDA would not have to issue a written request for a company to be eligible for the added exclusivity.



H.R. 5750 does not set a limit on the number of six-month extensions a product can receive, although FDA may create such a limitation in subsequent rulemaking.

## FEDERAL AGENCIES

### ***Specialty tier coinsurance becomes more prevalent for Part D and Marketplace plans***

Two new studies from the consulting firm Avalere Health revealed that the use of specialty tier coinsurance to control insurer spending on high-cost drugs has dramatically increased for consumers in both Medicare Part D and Affordable Care Act (ACA) Marketplace plans.

About two-thirds of Part D plans will make consumers pay at least 30 percent of the total cost of their drugs, a whopping 106 percent increase from 2014 when only 32 percent of Part D plans did so. Overall, 11.1 million Part D subscribers will be enrolled in plans with at least two coinsurance tiers, up more than 73 percent from 6.4 million in 2014.

In addition, Avalere found that all Part D plans will include a fourth tier reserved for the highest-cost specialty drugs, compared to only ten percent of plans that used a specialty tier just two years ago.

Lower-end Marketplace plans will also continue to rely heavily on drug coinsurance, according to Avalere's review, which found that the share of silver-level plans that charge enrollees at least a 30 percent coinsurance will jump from 27 to 41 percent for 2015. (Two-thirds of all Marketplace enrollees selected silver plans last year, since they are tied to the premium and cost-sharing subsidies offered under the ACA.)

In addition, the share of plans requiring coinsurance for specialty medications will range from 91 percent for the least-costly bronze plans, compared to 66 percent for the most generous and costly platinum level coverage.

Avalere attributed increased competition among Marketplace plans (see Update for Week of September 22<sup>nd</sup>) to the desire of most insurers to keep premiums as low as possible and rely upon less-visible coinsurance to control drug costs.

### ***Kaiser finds that competition is restraining federal Marketplace premiums for silver-level plans***

The latest report on federally-facilitated Marketplace (FFM) premiums released this week by the Department of Health and Human Services (HHS) shows that premiums for second-lowest cost silver plan will rise for 2015 by only two percent on average.

According to a new analysis from Kaiser Health News (KHN), the modest increase is largely due to the 25 percent surge in participating FFM insurers cited by HHS, which found that more than 90 percent of FFM consumers will now have three or more insurers from which to choose, compared to only 70 percent last year. In addition, the average number of health plans per county will rise from 30 to 40.

A KHN survey of only the lowest-cost silver plans for a 40-year old in the 35 states that will be all or partly controlled by the federal government in 2015 further showed that competition is directly restraining FFM premiums for hundreds of counties and lowering them for those counties where new entrants are offering the least-costly plan options.

Silver plans are by far the most popular choice among consumers since the premium tax credits are tied to the second-lowest cost or "benchmark" silver plan in each state. KHN found that the number of silver plans has increased for two-thirds of counties, with premiums rising by only an average of one



percent in counties that are adding at least one new Marketplace insurer for 2015. This one percent increase contrasts starkly with the seven percent average rate hike in counties where the number of insurers is declining or remaining the same.

For all FFM, premiums are climbing for the lowest-cost silver plan by only three percent on average (to \$273 per month). But the opposite is true for counties with a new entrant undercutting competition, as the average premiums falls three percent to the national average of \$284 per month in counties where that new carrier is offering the cheapest plan.

For example, Clark and Harrison counties in southern Indiana had only one FFM insurer last year, but competition from four new insurers for 2015 is lowering premiums for a 40 –year old by an average of 25 percent (to \$197 per month). Parts of southwest Georgia had the second most expensive average premiums last year when they were served by only Blue Cross and Blue Shield, but competition from three new carriers (including Coventry Health Care) is forcing premiums down by an average of 21 percent for all ages (to \$363 for a 40-year old).

UnitedHealthcare, which joined only four Marketplaces last year but is now participating in 23, is offering the cheapest silver plan in nine percent of FFM counties, by far the highest of any company. According to KHN, UnitedHealthcare’s entrance is directly responsible for a 28 percent average decrease in three Mississippi counties that had only a monopoly FFM insurer for 2014.

KHN cautions that competition is not a guarantee of lower FFM premiums in all instances, as they are rising by an average of 11 percent in 48 counties in which Human is offering the lowest-cost silver plan. The Chattanooga, TN market is also seeing an average hike of one percent even though the number of participating insurers has doubled.

### ***Renewals are half of Marketplace enrollment, though most can lower premium by switching plans***

The Department of Health and Human Services (HHS) announced this week that roughly 765,000 consumers selected health plans in federally-facilitated Marketplaces (FFM) by November 28<sup>th</sup>.

Roughly half of this number represents new subscribers, while the rest are returning consumers from last year. However, HHS was not able to determine how many renewing customers switched coverage or remained in their existing plan, nor did they identify how many paid their first month premium.

HHS emphasized that less than six percent of the 6.7 million current FFM enrollees have renewed their coverage. The FFM will automatically renew those who fail to do so by December 15<sup>th</sup> (see Update for Weeks of August 25<sup>th</sup> and September 1<sup>st</sup>).

HHS officials also stressed that more than 70 percent of returning customers should be able to lower monthly premiums by shopping around for new plans. Those enrolled in silver plans could save an average of \$492 per year just by selecting a different silver plan, while 79 percent of all consumers can find a plan among all metal tiers that costs less than \$100 per month after ACA subsidies are reflected.

The primary reason for the price differentials is the fact that the premium tax credits are increasing by only two percent on average, compared to a five percent average increase in the monthly premiums for the lowest-cost silver plans. As a result, consumers that do not switch could find that plan premiums are increasing more than their tax credits.

### ***IRS relaxes individual mandate rules for residents of non-expansion states***

The Internal Revenue Service (IRS) issued new guidance on November 21<sup>st</sup> that broadens eligibility for the “hardship exemption” to the controversial individual mandate under the Affordable Care Act (ACA).



Prior to the guidance, those living in non-expansion states and earning below 133 percent of the federal poverty level (FPL) were required to be rejected for Medicaid and then apply to their respective ACA Marketplace in order to be exempt from the mandate to buy minimum essential coverage they can afford. However, they can now simply declare on their tax return that they lived in a non-expansion state at some point during 2014 in order to qualify for the exemption.

Those who lived in a state like Michigan or Pennsylvania that did not expand Medicaid until the middle or latter half of 2014 (see Update for Weeks of October 20<sup>th</sup> and 27<sup>th</sup>) also specifically can qualify, according to the IRS.

The guidance also clarified the rules for other exemptions. For example, families can use the combined cost of two or more self-only employer plans to qualify for the affordability exemption (eight percent of annual income). Anyone below the tax filing threshold yet files taxes can also meet the exemption, but only if they are not claimed as a dependent by another tax filer. Likewise, those who purchase coverage in or out of the Marketplace but had a brief gap in coverage to due to timing issue can use the tax return to apply for the exemption.

### ***Proposed rule enhances ACA reinsurance payments for insurers with more costly subscribers***

The Centers for Medicare and Medicaid Services (CMS) released broad proposed regulations late last month that boost reinsurance payments for insurers with exception claims, shorten subsequent open enrollment periods from October 1<sup>st</sup> to December 15<sup>th</sup>, require monthly updates to provider directories for Marketplace insurers, and let Marketplace consumers request that they be auto-renewed in lower cost plans.

The primary change under the Notice of Benefit and Payment Parameters (BPP) rule would lower the threshold to invoke payments under the reinsurance program created by the Affordable Care Act (ACA). Instead of currently reimbursing insurers for half the costs of annual claims beyond \$70,000, that level will now be pared down to \$45,000.

However, the BPP rule also proposes that insurers pay an annual tax of \$27 per enrollee in 2016 as well as a user fee that comes out to 3.5 percent of premiums. For that plan year, CMS offers to pay half of insurer costs for patients that incur more than \$90,000 in costs (up to a cap).

### ***CMS includes prescription drug access provisions in reinsurance regulations***

Consumer advocates were largely pleased by a provision in a comprehensive proposed rule on Affordable Care Act (ACA) reinsurance payments (see above) that are intended to improve patient access to prescription drugs.

The AIDS Institute (TAI) praised language that appeared to respond to a discrimination complaint they filed with the Office of Civil Rights for the Department of Health and Human Services. The complaint documented that several Marketplace insurers in Florida and Illinois starting moving all or most drugs to treat HIV/AIDS or Hepatitis C into specialty tiers that required consumers pay a coinsurance of 40-50 percent of the drug cost (see Update for Week of June 2<sup>nd</sup>). TAI insisted that this practice violated the anti-discrimination provisions of the ACA and were pleased that the proposed rule at least cautioned insurers that “plac[ing] most or all drugs that treat a specific condition on the highest cost tiers [can] effectively discriminate against, or discourage enrollment by, individuals who have those chronic conditions.”

CMS also proposed to require that insurers create a pharmacy and therapeutics committee of experts that consider new drug and treatment guidelines on a quarterly basis, or in the alternative adopt a



coverage standard that relies on the American Hospital Formulary Service instead of a more narrow compendium called the United States Pharmacopeia,

Responding to consumer complaints about difficulties finding what drugs are covered under Marketplace formularies, CMS is seeking to require that insurers put their formularies on their public websites and no longer require that consumers create an account or submit a policy number in order to browse them. The information would have to be regularly updated and linked to the plan's summary of benefits and coverage.

The regulations also include detailed procedures on how consumers can request exceptions for drugs not listed on plan formularies and add a requirement for external review of exception denials. CMS seeks to require that cost-sharing for drugs obtained through the exceptions process must count towards the plan's annual cost-sharing limits

### ***Drugmaker prevails in first pay-to-delay verdict since Supreme Court ruling***

A jury sided this week with AstraZeneca in the first "pay-to-delay" verdict since the U.S. Supreme Court ruled that settlements between brand-name and generic drugmakers can be subject to federal antitrust laws if they are "anti-competitive".

The case in the U.S. District Court for the District of Massachusetts centered on a \$1 billion patent litigation settlement that Ranbaxy Labs received from AstraZeneca to delay its market entry of a generic competitor to the Nexium heartburn tablet. Several purchaser groups had claimed that this payment was sufficiently "large and unjustified" to meet the Supreme Court's standard for an antitrust violation (see Update for Week of June 17, 2013). However, the jury concluded the plaintiff's failed to produce "compelling evidence" that they were directly harmed by the settlement, even though it agreed that the amount was otherwise "large and unjustified".

Although a significant victory, the ultimate impact of the verdict is not yet clear. It is likely to be appealed and AstraZeneca still faces two similar lawsuits in Pennsylvania courts. The Federal Trade Commission (FTC), which brought the Supreme Court case, is also still pursuing "pay-to-delay" challenges against drugmaker AbbVie over generic competition to its testosterone gel.

The FTC has campaigned for more than a decade to presumptively ban all "pay-to-delay" settlements, arguing that they artificially inflate drug costs by more than \$3.5 billion per year.

## **HEALTH CARE COSTS**

### ***National health spending at lowest level since 1960***

A report released this week by the Centers for Medicare and Medicaid Services (CMS) found that national health spending grew by only 3.6 percent in 2013, the lowest annual increase since the agency began tracking such data in 1960.

The finding is the latest to affirm that health spending remains at historically low rates since consumers dramatically cut their use of health care services during the 2007-2009 recession. However, the actuary's office predicted that the growth rate may accelerate as the national economy picks up steam. It previously credited the ACA for reducing consumer out-of-pocket spending in 2014, but similarly warned that such reduction may be a "historical aberration" and not a permanent shift (see Update for Weeks of August 25<sup>th</sup> and September 1<sup>st</sup>).

Overall, the rate of health spending fell 0.5 percent from 2012 while the total spending remained at 17.4 percent of gross domestic product (GDP), the same as it has since 2009. Medicare spending



declined from four to 3.4 percent, which CMS did attribute partly to ACA changes including a restrained rate of growth for Medicare Advantage payments (7.8 percent instead of 10.6 percent) as well as the ongoing budget sequester (cutting reimbursement by two percent). The transition of high numbers of younger and healthier “baby boomers” into Medicare is also credited with keeping Medicare per-enrollee spending relatively flat.

By contrast, Medicaid spending increased more dramatically from 2012 (four percent) to 2013 (six percent). This was largely due to a 2.7 percent jump in enrollment (the first acceleration since 2009), thanks to several states getting a head start on the ACA Medicaid expansion.

Private insurance premiums also grew at a slower rate in 2013 (2.8 percent compared to four percent in 2012) due to increases in consumer cost-sharing, as well as the ACA’s profit caps and enhanced rate review provisions. Private health plan enrollment increased for the third straight year (by 0.7 percent) to 190 million subscribers of 60 percent of Americans.

According to CMS, prescription drug spending continues to be the dominant driver of national health spending (see below), with new specialty drugs leading the list of reasons that retail drug spending jumped 2.5 percent compared to only 0.5 percent in 2012.

## STATES

### Alaska

#### ***New independent Governor supports Medicaid expansion, but legislative approval uncertain***

Governor-elect Bill Walker (I) pledged last week to urge the legislature to expand Medicaid under the Affordable Care Act (ACA) after he was finally declared the victor in last month’s election.

Walker’s election made Alaska one of only two states (with Pennsylvania) where a Republican incumbent was unseated. He had campaigned on a pledge to expand Medicaid for up to 41,000 Alaskans—a contrast to his predecessor Sean Parnell (R) who had repeatedly rebuffed expansion efforts by the Alaska Chamber of Commerce and Alaska Hospital Association until he was satisfied that the promised ACA matching funds would materialize (see Update for Weeks of January 20<sup>th</sup> and 27<sup>th</sup>).

While Governor-elect Walker could expand Medicaid on his own authority, he needs approval from the Republican-controlled legislature to accept the needed federal matching funds. Several key Republicans had supported earlier Medicaid expansion bills given that Lewin Group studies commissioned by state officials showed it would bring Alaska \$2.1 billion to \$3.7 billion in ACA matching funds by 2020. While Walker has pledged a bipartisan approach (he is a former Republican that was elected with a Democratic running mate), his independent campaign railed against the legislature, making it very unclear whether he can now persuade a majority of either chamber to back either a traditional expansion or “private sector” alternative federally-approved for five other states.

### California

#### ***Agency concludes that narrow provider directories for Covered California violated state law***

The Department of Managed Health Care issued a new report last month concluding that both Anthem Blue Cross and Blue Shield of California violated state law by misleading consumers about the size of their provider networks offered in Covered California plans.

The two insurers are already facing class-action lawsuits alleging not only that their posted provider directories were erroneous, but that the insurers intentionally did not notify subscribers about the errors until it was too late for them to switch plans for 2014. In addition, the lawsuit against Anthem claims



that the insurer deliberately did not inform subscribers that Covered California plans did not offer out-of-network coverage in four of the state's largest counties.

The DMHC report follows a five-month investigation into consumer complaints about the narrow networks that Covered California insurers used to keep premiums affordable during the inaugural open enrollment period for the Marketplace created pursuant to the Affordable Care Act (ACA).

The investigation also found that more than 25 percent of the providers listed in the Anthem and Blue Shield directories were actually not accepting Covered California subscribers or no longer in the location identified in the directories.

DMHC acknowledges that both insurers have since taken "corrective action" to address all but three violations of the state's Health and Safety Code relating to provider directories. According to the *Los Angeles Times*, DMHC will follow-up in six months to evaluate whether all violations have been corrected and has not yet decided whether to impose the penalties sought by consumer groups like Health Access California.

Blue Shield officials insisted that the report "exaggerates the severity of the issues and understates the extent of our corrections." Both Anthem and Blue Shield insisted that their surveys showed more than 90 percent of their providers are contracted to accepted Covered California subscribers.

#### Florida

#### ***Coventry joins CIGNA in settling discrimination complaint over HIV drug coinsurance***

Coventry Health Care (an Aetna subsidiary) has settled a discrimination complaint filed by consumer advocates over the insurer's coverage of HIV/AIDS medications in the health insurance Marketplace operated in Florida pursuant to the Affordable Care Act (ACA).

The terms of the agreement closely follows a similar settlement that CIGNA entered into last month with the Florida Office of Insurance Regulation (see Update for Week of November 10<sup>th</sup>). Instead of placing all HIV/AIDS medications into specialty tiers require enrollees to pay 40-50 percent of the drug's total cost, both insurers have agreed to cap out-of-pocket expenses for four widely-prescribed drugs (Atripla, Complera, Stribild, and Fuzeon) to \$200 per month for Marketplace plans offered in 2015. They also will move generic HIV drugs from specialty tiers into lower tiers with fixed copayments.

Two other insurers named in the complaint (Preferred Medical and Humana) are still considering their options.

The Florida is separate from the one filed by The AIDS Institute (TAI) and National Health Law (NhELP) Program with the Office of Civil Rights for the U.S. Department of Health and Human Services (see Update for Week of June 2<sup>nd</sup>). This complaint remains pending even though proposed federal regulations now discourage the practice (see above). Both TAI and NhELP stressed that the settlements also apply on to Florida and neither CIGNA nor Coventry have yet to apply the new standards to HIV drugs in other states.

#### ***Non-ACA health insurance exchange to start selling ACA Marketplace plans***

Florida's little-used alternative to the health insurance Marketplace created by the Affordable Care Act (ACA) announced this week that it will start selling ACA Marketplace plans despite opposition from many Republican lawmakers.

According to chief executive officer for Florida Health Choices, negotiations should be finalized over the next few weeks with the four insurers that have agreed to offer Marketplace plans. Health





Choices, which was the brainchild of U.S. Senator Marco Rubio (R) when he served as Florida House Speaker, currently sells only limited-benefit or discount coverage that does not comply with the ACA. However, only 49 consumers have purchase Health Choices coverage since its inception in 2008.

CEO Rose Naff hopes that by opening Health Choices up to Marketplace plans, it can attract up to 1,000 consumers, but conceded that she would “be happy if we got 100.” However, consumers using Health Choices will not have access to any of the premium tax credits or cost-sharing subsidies available under the ACA, making their products more expensive than the ACA Marketplace for those earning from 100-400 percent of poverty.

A spokesperson for Senator Rubio criticized the decision, as did other state Republicans. However, Governor Rick Scott (R) declined to state whether he supports opening up Health Choices.

The Health Choices board of directors still must approve allocating \$130,000 from its \$800,000 annual budget to advertise the new ACA Marketplace plans.

### Illinois

#### ***Legislature fails to approve transition to state-based Marketplace***

The House blocked a floor vote on H.B. 3227 before the close of the veto session, effectively killing efforts to authorize the \$270 million needed for Illinois to create its own health insurance Marketplace pursuant to the Affordable Care Act (ACA).

Illinois has operated a state partnership Marketplace (SPM) with the federal government since the Marketplaces opened in October 2013. However, outgoing Governor Pat Quinn (D) and Democratic lawmakers had intended to transition to full state control by 2015, an effort that has taken on greater urgency since the U.S. Supreme Court announced that it will review whether to invalidate ACA subsidies for consumers in Marketplaces controlled fully or partly by the federal government (see Update for Week of November 3<sup>rd</sup>).

Creating a state-based Marketplace (SBM) would have ensured that Illinois could protect the ACA subsidies for nearly one million SPM consumers that received them in 2014, regardless of the Supreme Court decision. However, state officials needed legislative approval to spend the \$270 million they requested from the federal government to build the technology infrastructure needed for their own SBM.

The Obama Administration is ending federal assistance to SBMs after this year, meaning that Illinois will now have to fund the entire \$270 million from state revenues, as considerable obstacle given the state's dire budget crisis. The transition from a Democratic to Republican governor in 2015 could also alter political support for a fully state-run Marketplace (see Update for Week of November 3<sup>rd</sup>).

House Majority Leader Barbara Flynn Currie (D) and other Democratic lawmakers are urging the Obama Administration to extend the deadline for federal Marketplace assistance in the event legislative authorization is granted next session.

### Indiana

#### ***Obama Administration extends Healthy Indiana as Medicaid expansion awaits final decision***

The Centers for Medicare and Medicaid Services (CMS) announced last month that they need additional time to evaluate the Medicaid expansion alternative submitted last summer by Governor Mike Pence (R) and are extending the existing Healthy Indiana demonstration program by one year while outstanding issues are resolved.

The Governor's plan would expand Healthy Indiana to include everyone earning up to 138 percent of the federal poverty level, which has provided coverage since 2007 through health savings



accounts (HSAs) and high deductible plans to adults with incomes under 100 percent of FPL that were not eligible for Indiana Medicaid.

CMS has largely agreed to the concept of the proposal, which would add roughly 350,000 state residents to Healthy Indiana's current enrollment of 60,000. However, negotiations have become bogged down over the Governor's insistence that some of the newly-eligible (those earning 100-138 percent of FPL) should lose coverage if they fail to contribute to the HSAs—a major change from Healthy Indiana's current federal waiver (see Update for Week of June 2<sup>nd</sup>).

The Governor has already had to scale back provisions limiting benefits for those below 100 percent of FPL that fail to make HSA contributions, as well as workforce requirements similar to those removed by CMS from proposals submitted by Republican governors Pennsylvania and Utah (see Update for Weeks of October 20<sup>th</sup> and 27<sup>th</sup>). However, he has insisted on imposing a \$2,500 deductible and sliding scale premiums of up to \$25 per month, which are higher than CMS typically has allowed for certain low-income populations, noting that they are lower than the costs charged for existing Healthy Indiana enrollees.

#### Maine

#### ***Federal appeals court blocks Governor's cuts in Medicaid eligibility***

The First Circuit U.S. Court of Appeals has blocked the effort by newly re-elected Governor Paul LePage (R) to eliminate Medicaid coverage for all "able-bodied" 19 and 20 year old enrollees.

A unanimous three-judge panel of Republican and Democratic nominees upheld the determination by the federal Centers for Medicare and Medicaid Services (CMS) that the cuts violate the "maintenance of effort" provisions of the Affordable Care Act (ACA) preventing eligibility reductions for those earning less than 150 percent of the federal poverty level until October 2019.

The Governor's budget for 2012 had sought to save \$3.7 million by eliminating the coverage for about 6,000 Mainers that fit within that age group and were not disabled. He insisted that the "maintenance of effort" provision was "not sufficiently tailored to any constitutional purpose" and brought the lawsuit over the objections of his Democratic Attorney General.

However, the panel ruled that the "maintenance of effort" provision does serve "the legitimate purpose of ensuring that children do not lose health insurance as the country transitions from the pre-ACA Medicaid regime to the post-ACA Medicaid regime." Department of Health and Human Services Commissioner Mary Mayhew indicated the state was likely to petition the U.S. Supreme Court for review, insisting that the ruling "obstruct[s] the will of the public" by not letting Maine prioritize "welfare funds...toward the elderly, disabled and truly needy."

A lower court dismissed the Governor's initial lawsuit that incorrectly claimed the "maintenance of effort" provision was eliminated by the U.S. Supreme Court when it required the ACA Medicaid expansion to be discretionary (see Update for Weeks of August 27 and September 4, 2012). It also required that Medicaid coverage for 19 and 20 year olds be continued during the appeal process. That injunction remains in place should the state appeal.

#### Minnesota

#### ***Republicans seek "realistic" Marketplace changes after winning control of House chamber***

House Republicans that will control the chamber starting next month are targeting changes to the structure of the MNSure health insurance Marketplace created pursuant to the Affordable Care Act (ACA) as part of the legislative agenda outlined last week.



Their top priorities include adding an insurance company representative to the seven-member board overseeing MNSure, as well as one representing county governments, which were forced to manually process thousands of applications during software failures that plagued the Marketplace during the inaugural open enrollment period. In addition, Republican leaders are seeking to move the independent entity back into a state government agency in order to gain more budgetary control.

Both moves are viewed as an effort to reach bipartisan compromise, as Democrats (which still control the Senate and governorship) have signaled they would be open to restructuring MNSure governance. Republican leaders have thus far tried to tamp down calls from more conservative members to repeal or block funding for MNSure, with House Speaker Kurt Daudt (R) and new House Regulatory Reform committee chair Joe Hoppe (R) advocating for “realistic” fixes that can clear both chambers.

#### Montana

##### ***Governor unveils SCHIP-based alternative to Medicaid expansion***

Governor Steve Bullock (D) unveiled his plan last week to expand Medicaid under the Affordable Care Act (ACA) for nearly 70,000 Montanans.

The Governor’s plan largely follows the “private sector” alternative already federally-approved for five states. These models typically use ACA matching funds to purchase private Marketplace coverage for the newly-eligible population. However, similar to a Republican proposal rejected last year by the Florida House (see Update for Week of March 31<sup>st</sup>), Governor Bullock would instead provide coverage through private insurers contracted with the State Children’s Health Insurance Program (SCHIP).

Even if the Governor’s proposal is approved by the federal Centers for Medicare and Medicaid Services (CMS), passage by the Republican-controlled legislature remains in doubt after it narrowly rejected a traditional expansion last year (see Update for Week of April 22, 2013). Governor Bullock included several Medicaid payment and delivery reforms to his plan (including case management for the chronically-ill) in an effort to attract Republican support, as well as a fraud and abuse reporting system and automatic termination provisions should federal funding fall below the levels stipulated in the ACA.

The plan has the backing of the state’s largest hospitals, which cited a Colorado Hospital Association study showing it would dramatically reduce their uncompensated care costs based on the early experience in other expansion states.

#### Utah

##### ***Lawmakers skeptical that Governor’s Medicaid expansion alternative can pass***

Republicans heading the legislature’s Health Reform Task Force balked at several of the final details of the Medicaid expansion alternative laid out this week by Governor Gary Herbert (R).

The Governor has been negotiating with the Centers for Medicare and Medicaid Services (CMS) on the terms of waiver that would allow Utah to use federal ACA funds for the Medicaid expansions to instead purchase coverage for the newly-eligible population (up to 138 percent of poverty) in the state’s federally-facilitated Marketplace (FFM). His Healthy Utah model would largely follow the one that CMS has already approved for Arkansas, Iowa, Michigan, and Pennsylvania.

However, lawmakers were surprised this week to learn that the state’s share of the expansion cost would rise from \$4.6 million in 2016 to \$80-90 million by 2020 or 40 percent higher than the Governor initially projected. The increase is largely due a higher number of estimated enrollees, 63,000 of whom fall into the “coverage gap” between current Medicaid eligibility (49 percent of poverty) and ACA subsidy eligibility (100 percent of poverty).



Under the terms of the three-year demonstration waiver, Healthy Utah would only receive the full ACA match (100 percent through 2016 phasing down to 90 percent in 2020 and thereafter) if they cover the entire newly-eligible population. The federal share will fall to 70 percent if the legislature limits coverage only to those in the coverage gap (49-100 percent of poverty).

Lawmakers were also discouraged that the Governor was unable to secure much of the “greater flexibility” from CMS that he had sought, including higher copayments. CMS also eliminated the Governor’s requirement that able-bodied recipients by actively seeking full-time work, as it did with similar requirements in proposals advanced by Indiana (see below) and Pennsylvania (see Update for Weeks of October 20<sup>th</sup> and 27<sup>th</sup>). Instead, enrollees must accept job training and work search assistance from the state (see Update for Week of September 8<sup>th</sup>).

As a result, incoming Speaker of the House Greg Hughes (R) insisted that the legislature was going to require further changes to the waiver before granting their approval. House Majority Leader Jim Dunnigan (R) has already sketched out three far less generous alternatives to be debated by the Task Force next session. However, a fourth option would essentially tack on a sunset provision to the Governor’s plan so that anyone earning from 100-138 percent of poverty would automatically become full FFM enrollees should the promised level of federal funding not materialize.

Healthy Utah continues to have the support of Salt Lake Chamber of Commerce and other business groups, as well as large hospital systems like the University of Utah

#### Washington

#### ***Marketplace consumers experience déjà vu as technical glitches shut down web portal***

Officials overseeing the Washington Healthplanfinder acknowledged last week that roughly 6,000 subscribers had their coverage inadvertently canceled due to system errors during the first two weeks of open enrollment for 2015.

The automated cancellation impacted both new and renewing consumers and were part of a series of technical glitches that forced the web portal for the state-based Marketplace to shut down on the second day of open enrollment, including “stuck” applications and inaccurate premium and subsidy calculations. State officials hired Deloitte to resolve outstanding glitches by last August, which have caused intermittent enrollment problems since last fall despite the overall success of the Marketplace (see Update for Week of July 28<sup>th</sup>).

#### Wyoming

#### ***Governor proposes traditional Medicaid expansion with copayments***

Newly re-elected Governor Matt Mead (R) releases his long-awaited plan this week to expand Medicaid under the Affordable Care Act (ACA) for roughly 18,000 state residents.

Governor Mead considered but ultimately rejected a “private sector” alternative similar to the model federally-approved for five states and proposed in neighboring Montana (see above), in which ACA matching funds are used to purchase Marketplace coverage for the newly-eligible population. The Governor cited concerns that such an alternative could be significantly more costly, based on the initial experience in Arkansas (see Update for Week of September 8<sup>th</sup>) and the fact that Marketplace plans in Wyoming are among the most expensive in the nation due to its high proportion of older enrollees (see Update for Weeks of March 17<sup>th</sup> and 24<sup>th</sup>).

As with most of the other 11 Republican governors backing some form of expansion, Governor Mead proposed to increase copayments on the upper end of the newly-eligible population more steeply than the federal Centers for Medicare and Medicaid Services (CMS) has previously allowed (see Update for Weeks of October 20<sup>th</sup> and 27<sup>th</sup>). Under his plan, those earning 100-138 percent of the federal poverty



level (FPL) would be forced to pay \$20-50 month for coverage, depending on their household size and income. The Governor would also impose nominal copayments (but not premiums) on those below 100 percent of FPL.

Even if Governor Mead can secure federal approval for his plan, it faces stiff opposition in the Republican-dominated legislature, which rejected both a traditional expansion and “private sector” alternative earlier this year (see Update for Week of February 10<sup>th</sup>). However, it did authorize the Governor to negotiate a Wyoming-specific alternative with CMS, which the Joint Interim Labor, Health and Social Services Committee will consider starting this month (see Update for Week of November 10<sup>th</sup>).