



Health Reform Update – Weeks of March 2 and 9, 2015

CONGRESS

Key justice casts doubt on Supreme Court challenge to ACA subsidies

The U.S. Supreme Court used oral arguments this week to debate whether roughly 7.7 million consumers in federally-facilitated Marketplaces (FFMs) will be able to continue receiving premium tax credits and cost-sharing subsidies under the Affordable Care Act (ACA).

The Competitive Enterprise Institute filed lawsuits on behalf of individual plaintiffs in Virginia and the Washington, DC against Internal Revenue Service regulations making ACA subsidies available to all consumers in the new health insurance Marketplaces. The suits claimed that the words “established by the state” in one provision relating to the subsidies meant that Congress intended that they only be available to consumers in the 14 states (including DC) that created their own Marketplaces.

Both lower courts immediately dismissed the claims. A three-judge panel for the U.S. Fourth Circuit Court of Appeals unanimously upheld the dismissal, stating that a reading of the ACA “as a whole” led to “only one sensible conclusion” that Congress wanted the subsidies to be available to all Marketplace consumers. However, a three-judge panel from the DC Court of Appeals concluded that the words must be read literally to mean that federally-facilitated Marketplace (FFM) consumers are ineligible for subsidies, as did a lower court in Oklahoma (see Update for Week of July 21st).

The full appellate court in DC court threw out the panel’s contrary decision and was set to hear the case in December (see Update for Weeks of August 25th and September 1st). However, the U.S. Supreme Court surprisingly intervened in the Virginia case (*King v. Burwell*) before the DC appeals court ruled, setting the stage for a decision this June could dramatically limit the affordability of FFM coverage (see Update for Week of November 10th).

All of the lower court decisions followed the political ideology of the judges and oral arguments on the high court largely held to these partisan divisions. Chief Justice John Roberts, the lone conservative justice previously voting to uphold the entire ACA (see Update for Week of June 25, 2012), offered little insight into his leanings on this case. However, conservative Justice Anthony Kennedy suggested he was at least open to switching sides, telling the plaintiffs that “there’s a serious constitutional problem if we adopt your argument.”

Kennedy agreed with liberal Justice Sotomayor that denying subsidies to states defaulting to the FFM would be viewed as unduly trying to coerce states in creating their own Marketplace. This was the same rationale used by both liberal and conservative justices in 2012, when ruling that states must be given the discretion to opt-out of the Medicaid expansion under the ACA without penalty. (The court could adopt a similar remedy by giving FFM states the discretion whether to accept the ACA subsidies).

However, Kennedy was not one of the justices that chose the opt-out remedy in 2012 and instead voted to strike down the entire ACA. As a result, counsel for the government largely avoided this issue.

Roughly 85 percent of FFM consumers currently receive subsidies that averaged \$268 per month last year, reducing monthly premiums by an average of 72 percent (\$374 to \$105). The consulting firm Avalere Health estimated last week that eliminating the subsidies would increase FFM premiums by an average of 255 percent, including a 338 percent jump for the largest Marketplace in Florida and a staggering 779 percent spike in Mississippi (see Update for Week of February 23rd).



Republicans rush to counter potential loss of ACA subsidies

Under pressure from Republican governors fearing an electoral backlash if millions of Marketplace enrollees can no longer afford their coverage, several Senate and House Republicans put forward bills last week that would at least delay or mitigate a U.S. Supreme Court decision stripping premium and cost-sharing subsidies from federally-facilitated Marketplace (FFM) enrollees.

Conservative justices on the court generally acknowledged that eliminating subsidies would dramatically increase premiums, but insisted that Congress would act to fix the statute. Justice Alito even suggested that the court could give Congress up to a year to do so before FFM subsidies would be lost.

The Obama Administration insists they have no “back-up plan” in the event of an adverse decision. However, commentators largely expect that they would try to temporarily transfer funds from other general accounts, re-classify the seven Marketplaces only partly operated by the federal government as a state-based Marketplace, and give FFMs greater incentives to move to state control.

At least six Senate Republicans led by Finance Committee chair Orrin Hatch (R) insisted that “Republicans have a plan to protect these people and create a bridge away from Obamacare.” Although they provide few details, they suggested that FFM enrollees would be allowed to keep the subsidies for a “transitional period of unspecified length” and not have them eliminated “in the middle of the year.”

Freshman Senator Ben Sasse (R-NE) did introduce a bill that would cover 65 percent of the subsidy for the first six months and then phase-down that assistance over 18 months. Other Senators indicated that they would wait for the June court decision before introducing legislation.

House Majority Leader Kevin McCarthy (R-CA) has formed a working group to formulate the House Republican response to an adverse ruling.

Governor Mary Fallin (R-OK) was among the Republican governors urging the court and Congress to protect the subsidies, even though her state attorney general filed one of the successful lower court challenges (see above). However, some of the ACA’s most strident opponents including Governor Bobby Jindal (R-LA) and Senator Ted Cruz (R-TX) blasted Republican plans to extend the subsidies for any length of time, insisting that their elimination would help force a complete ACA repeal.

CBO reduces ACA cost estimate by 11 percent due to lower than expected premium growth

For the second time in three months, the Congressional Budget Office (CBO) has downgraded its projection of Affordable Care Act (ACA) costs over the next ten years.

The latest reduction resulted from a much slower rate of growth in health insurance premiums in than the CBO previously forecast (only 1.8 percent from 2006-2013 compared to five percent from 1998-2005). This will cause the federal government to spend more than \$200 billion less in ACA subsidies (\$849 billion instead of \$1.1 trillion).

CBO did predict that premiums for both employer-based and Marketplace coverage will grow by an 8.5 percent annual average from 2016-2018 as the temporary ACA reinsurance payments to insurers come to an end. In addition, CBO believes Marketplace insurers will not continue to be able to rely on extremely narrow provider networks to maintain low premiums. However, CBO projects only a 6.4 percent average growth in premiums over the entire 2016-2025 period.

Because CBO does not “expect [premium] growth to return to those previously high levels”, they reduced the estimate subsidy cost, which in turn cut the overall ten-year cost estimate for the ACA by \$142 billion (or 11 percent) compared to its earlier projection (see Update for Weeks of January 26th and February 2nd).



Other factors such as a general slowdown in medical inflation and U.S. Supreme Court allowing states to opt-out of the Medicaid expansion (see Update for Week of June 25, 2012) have contributed to CBO already reducing the cost estimate for the ACA by 29 percent since it was enacted in 2010.

CBO also forecast a slower rate of growth in Marketplace enrollment (22 million by 2025 instead of 23 million). Recent figures by the U.S. Department of Health and Human Services shows that the Marketplaces are more than half way towards that target (see below).

FEDERAL AGENCIES

Marketplace enrollment exceeds target but shows little progress with young adults and minorities

The Department of Health and Human Services (HHS) announced this week that nearly 11.7 million consumers have selected or were automatically re-enrolled into plans offered by state and federally-facilitated Marketplaces during the 2015 open enrollment period.

The agency had extended open enrollment by one week until February 22nd to allow applications to be completed if they were started by the initial February 15th deadline but impeded by technical issues (see Update for Weeks of February 9th and 16th). The final tally includes 8.84 million that enrolled in one of 37 federally-facilitated Marketplaces. It is expected to grow slightly during the special enrollment period (SEP) that HHS created from March 15th to April 30th for those unaware that they were subject to tax penalties under the individual mandate prior to February 15th.

According to HHS, about 2.2 million of the 4.2 million customers from 2014 that re-enrolled or were automatically renewed were “active re-enrollees” that compared new plan options in the Marketplace. Roughly 1.2 million of those 2.2 million actually switched plans, a rate that HHS insists surpassed either Medicare Part D or employer-sponsored coverage.

FFM enrollment of those under age 35 increased only slightly for 2015 (from 34 to 35 percent), while sign-ups among critical demographic groups like Latinos remained largely the same (11 percent). However, HHS notes that increasingly more applicants (nearly three million) are refusing to self-identify their ethnicity. Latino enrollment did increase markedly in state Marketplaces like California (see below).

Final Marketplace tally shows more than 85 percent qualify for ACA subsidies

According to Health and Human Services (HHS), more than 85 percent of federally-facilitated Marketplace (FFM) enrollees in 2015 (or 7.7 million consumers) qualify for premium and cost-sharing subsidies offered by the Affordable Care Act (ACA).

The U.S. Supreme Court is currently weighing whether to deny these subsidies for FFM consumers (see above). States like Alaska, Florida, Georgia, Mississippi, North Carolina, Wisconsin, and Wyoming would be the most impacted by an adverse decision, as more than 90 percent of their FFM enrollees are eligible for ACA subsidies.

FFM enrollees tend to rely more heavily on subsidies. Only 78 percent of enrollees in Illinois' state partnership Marketplace and less than two-thirds in state Marketplaces for Colorado, Massachusetts and Vermont qualify for the ACA assistance.

HHS figures show that Florida, California, and Texas were the only states with more than one million enrollees in 2015. The next closest states of North Carolina and Georgia had less than 600,000 enrollees and their combined total failed to match the 1.2 million enrollees in Texas. Despite their size, New York and Illinois had only about 410,000 and 350,000 respectively.



FDA approves first biosimilar under ACA regulatory pathway

The Food and Drug Administration (FDA) approved the first biosimilar product this week under the new regulatory pathway created by the Affordable Care Act (ACA).

The landmark approval of Zarxio (filgrastim) by Novartis provides generic competition to Neupogen by Amgen, which was approved in 1991 to fight infections in cancer patients. It clears the way for 5-10 more biosimilar approvals expected later this year, including several for costly biologic drugs to treat rheumatoid arthritis. However, Zarxio's actual market entry may be delayed by pending litigation and the FDA did not declare it "interchangeable" with the reference product Neupogen, meaning that it cannot be automatically substituted by pharmacists.

Outstanding confusion over labeling requirements for biosimilars should be clarified shortly when the FDA is expected to release long-delayed guidance. At issue is whether brand-name and biosimilar products can share the same non-proprietary name, since they are not chemically-identical (as is the case with chemically-derived generics and their reference product). Industry and some patient groups have lobbied FDA to require a distinct non-proprietary name for each approved biosimilar.

Pharmacy giant CVS predicted this week that the free entry of biosimilars into the market could reduce prices for brand-name biologics by 40-50 percent.

HEALTH CARE COSTS

Hepatitis C drug costs drive greatest overall spending increase in a decade

The annual report on prescription drug spending from Express Scripts attributed a 13 percent spike during 2014 largely due new high-cost "cures" for the Hepatitis C virus (HCV).

The annual increase is the largest record by the pharmacy benefit manager since 2003. It cites the 743 percent jump in HCV drug costs for the "unprecedented and unsustainable rate" of overall drug spending increase, compared to the six percent increase in spending for more common drugs.

Express Scripts concludes that spending on common drugs for conditions like high cholesterol and heart disease is likely to be mitigated by increased generic competition. However, spending for "expensive, highly target therapies" for conditions like HCV and HIV are like to continue experiencing double-digit increases every year.

STATES

Alaska

House again rejects Medicaid expansion

The Republican-controlled House Finance Committee rejected the latest effort by Democrats this week to expand Medicaid pursuant to the Affordable Care Act (ACA).

The Democratic amendment to the state's operating budget would have allowed Alaska to accept \$145 million in ACA matching funds to provide coverage for roughly 40,000 Alaskans earning up to 138 percent of the federal poverty level. It had the support of the Alaska Hospital Association and Alaska Chamber of Commerce, as well as new Governor Bill Walker (I), who included funding for the state share of the expansion in his proposed budget.



The committee stripped out all Medicaid expansion provisions on a straight party-line vote. Several Republican members indicated that they are not opposed to any expansion, just the traditional expansion in the bill sponsored by Rep. Andy Josephson (D) that the Governor has backed. They encouraged Walker to take a lead role in authoring a “private sector” expansion alternative similar to the model federally-approved for six states (see Update for Weeks of January 26th and February 2nd).

Governor Walker can expand Medicaid unilaterally, but would need legislative approval to accept the \$2.1 billion to \$3.7 billion in ACA matching funds that the Lewin Group projects Alaska would receive by 2020 (see Update for Week of December 1st).

Arkansas

Senate passes bill requiring notice for cost-sharing changes on specialty tier drugs

The Senate unanimously passed legislation this week that would require health plans relying on tiered copayments for prescription drugs to notify subscribers at least sixty days in advance of any increase in cost-sharing due to drug formulary changes.

Beginning January 1, 2017, S.B. 466 would also force plans to detail coverage benefits and costs for prescription drugs on their websites in a “readily accessible format”. This information must include coverage exclusions or restrictions, as well as whether the drug is subject to a flat copayment or percentage coinsurance.

California

Marketplace misses target but increases enrollment of young adults and Latinos

Covered California enrolled more than 1.4 million consumers in qualified health plans (QHP) during the second open enrollment period that ended February 22nd, according to a report this week by the U.S. Department of Health and Human Services.

The final tally actually came in below expectations, allowing California to be surpassed by the federally-facilitated Marketplace (FFM) in Florida, which signed-up just short off 1.6 million consumers. Covered California attributes the shortfall to fewer returning customers than they initially projected.

Despite missing its overall target, Covered California did improve enrollment among several key demographics in 2015. For example, Latinos accounted for 37 percent of new customers, up from 31 percent in 2014. California’s uninsured population is disproportionately Latino making enrollment of that demographic critical to the long-term viability of the Marketplace.

Young adults also now represent 34 percent of new enrollees. This is a significant increase from 29 percent in 2014 and approaches the 39-40 percent ratio coveted by participating insurers (see Update for Weeks of January 20 and 27, 2014).

However, enrollment of African-Americans increased only slightly (from three to four percent) and actually fell markedly from 23 to 18 percent of new Asian-American enrollees.

Roughly 88 percent of Covered California enrollees were eligible for ACA subsidies, slightly above the national average (see above) but well-below the 93 percent figure in Florida. Nearly 60 percent of Covered California enrollees selected the silver-level plan to which ACA subsidies are tied.

According to Covered California, only 30 percent of customers self-enrolled through the web portal. By contrast, 43 percent relied upon an insurance agent or broker, while another ten percent were helped by navigators or certified enrollment counselors.

Anthem Blue Cross and Kaiser Permanente led insurers with a 29 percent Marketplace share.



Colorado

Bill requiring comprehensive audit moves forward as Marketplace enrollment continues to lag

The Colorado Insurance Commissioner refused this week to follow the lead of the federally-facilitated Marketplace and most state models by creating a special enrollment period (SEP) for those that were unaware they were subject to individual mandate penalties under the Affordable Care Act (ACA) until filing their 2014 taxes.

The commissioner noted that the SEP could add as much as \$100,000 in costs for Connect for Health Colorado, which is already under fire for more than \$500,000 in questionable payments identified in a limited audit (see Update for Week of December 8th). A measure require a more comprehensive audit of Connect for Health unanimously passed the House Public Health Care and Human Services Committee after clearing the Senate (see Update for Weeks of January 26th and February 2nd) and appears destined for the Governor's desk.

Connect for Health suffered from technological impediments that depressed 2014 enrollment and managed to enroll only 140,327 during the 2015 enrollment period that ended February 15th. They ranked only 24th out of all 51 Marketplaces and were surpassed by less populous states like Alabama, Louisiana, South Carolina, and Utah.

The success of a non-profit insurance cooperative (CO-OPs) in Connect for Health has emerged as another warning sign. Colorado HealthOP used low premiums to garner nearly 40 percent of the Marketplace, surpassing dominant carrier Kaiser Permanente. However, at least two CO-OPs nationwide have either been liquidated or face liquidation after enrolling far more subscribers than they could cover after Congress rescinded all remaining CO-OP funding (see Update for Week of January 19th).

HealthOP has already reported \$23 million in losses for 2014. It offered the lowest-priced plans in nearly every region of the state for 2015, meaning that premiums could increase significantly if they are unable to compete in the Marketplace in 2016.

Standard and Poors warned last month that most CO-OPs created with ACA loans cannot cover subscriber medical costs and may be liquidated (see Update for Weeks of February 9th and 16th).

Biosimilar substitution bill heads to Governor's desk as FDA approves first biosimilar product

The House sent Governor John Hickenlooper (D) legislation this week that would place limits on when biosimilar products approved by the Food and Drug Administration can be substituted for a biologic.

Similar legislation regulating biosimilar substitution has been introduced in at least 18 states starting in 2013. However, they were previously rejected in all but five states as most contained restrictions that were so onerous that they were viewed as creating barriers to competition (see Update for Week of January 19th).

Pharmacy chains opposed several restrictions in S.B. 71, which they fear will likewise discourage biosimilar substitution. For example, it requires pharmacists to notify the prescribing physician and patient prior to substituting a biosimilar product, even though they can substitute generic copies of other brand-name drugs without doing so.

The FDA approved the first biosimilar product this week under the regulatory pathway created by the ACA (see above). However, it has yet to declare it "interchangeable", which S.B. 71 would require prior to any substitution.



Georgia (S.B. 51), Tennessee (H.B. 572), and Texas (S.B. 542) are among the legislatures considering similar bills this session (see Update for Weeks of February 9th and 16th). Two substitution bills were also introduced in North Carolina this week (H.195 and S.197).

Connecticut

Age distribution remains unchanged despite sharp upturn in Marketplace enrollment

Data released this week by AccessHealth CT showed that the age distribution within Connecticut's state-based Marketplace remained largely unchanged from 2014 to 2015 despite a 37 percent increase in enrollment.

The percentage of young adults age 18-34 inched up only slightly from 25 to 25.6 percent, well below the national average and the 39-40 percent threshold coveted by participating insurers (see above). The proportion of the 110,095 private plan consumers in AccessHealth CT that are aged 55-64 also remained constant at 30 percent.

Just over 38 percent of AccessHealth CT customers were new enrollees in 2015 and only 77 percent of all sign-ups were eligible for Affordable Care Act (ACA) subsidies. Both of these figures were also well below national averages.

Total enrollment should increase during the special enrollment period that Connecticut and most states created for those that did not know they were subject to the tax penalty under the ACA's individual mandate prior to the open enrollment deadline (see Update for Week of February 23rd).

Florida

Senate panel passes partial Medicaid expansion, as House opens door ever so slightly

The Senate Health Policy Committee unanimously passed an alternative to the Medicaid expansion under the Affordable Care Act (ACA) that would use federal matching funds to extend coverage to roughly 800,000 Floridians earning from 22-100 percent of the federal poverty level (FPL).

The proposal differs from a similar alternative advanced last session by Senator Joe Negron (R) that cleared the Senate but was rejected by the House (see Update for Week of March 31st). That measure was crafted to secure federal approval by expanded Medicaid coverage to the entire population made eligible under the ACA (those earning up to 138 percent of FPL). S.P.B. 7044 instead limits coverage only to those caught in the "coverage gap" between Florida's bare-bones Medicaid eligibility and the threshold for ACA subsidies at 100 percent of FPL.

Negron's proposal also would have used the ACA funds to purchase private coverage in the existing Florida Healthy Kids Program. Instead, Senate Republicans are now seeking to use the limited-scope Florida Health Choices insurance exchange that has attracted fewer than 50 customers since its inception in 2008, due largely to a lack of ACA subsidies. The newly-eligible population would receive vouchers to purchase Health Choices, charged sliding-scale premiums ranging from \$3-25, and be subjected to work requirements.

Even if S.P.B. 7044 were to pass the House and become law, it appears unlikely to gain the required federal waiver in its current form. The Obama Administration has steadfastly refused to approve partial expansions or work requirements for the six other states with expansion alternatives (see Update for Weeks of January 26th and February 2nd).

House Speaker Steve Crisafulli (R) retreated only slightly from his refusal to consider any Medicaid expansion plans alternatives (see Update for Weeks of January 26th and February 2nd), stating this week that the measures were still a non-starter "for now." However, that is the first caveat that House Republican leaders have offered in two years, likely indicating an acknowledgment that the chamber will



have to consider some form of expansion once safety net hospitals lose \$1 billion in federal funds for indigent care starting in July (see Update for Weeks of February 9th and 16th). The Agency for Health Care Administration Secretary insisted this week that figure was closer to \$2 billion once lost state matching funds are factored in.

Illinois

New bill would supplement managed care payments to account for new specialty drugs

The House Appropriations-Human Services Committee received legislation this week sponsored by Rep. Sara Feigenholtz (D) that would require the Department of Healthcare and Family Services to pay a monthly supplemental payment for high-cost specialty pharmaceuticals and medical treatments (such as the new “curative drugs” for Hepatitis C) covered by managed care organizations.

Under H.B. 3530, payments must be made within 60 days once the Department receives the data from the impacted managed care organization. For drugs or treatments not previously accounted for in capitated rates, the Department shall be responsible for the full cost until clinical coverage guidelines and supplemental capitation payments are in place.

Illinois was one of the first state Medicaid programs to start limiting coverage for new Hepatitis C drugs to those most in need (see Update for Week of July 28th).

Committee amends bill limiting cost-sharing for specialty drugs

The Senate Insurance Committee amended legislation this week that seeks to limit subscriber cost-sharing for specialty medications to \$100 per month for up to a 30-day supply.

Under the initial version of S.B. 1359, the \$100 limit applied to all metal tiers required by the Affordable Care Act (ACA) (see Update for Weeks of February 9th and 16th). However, the amended version would apply the \$100 limit to silver, gold, and platinum coverage, while raising the limit to \$200 for bronze coverage. Catastrophic policies for young adults remain exempt.

The amended bill also retains the annual out-of-pocket limit for all prescription drugs, which is set at 50 percent of the annual out-of-pocket maximum under the ACA Act (\$6,600 for individual coverage in 2015, \$13,200 for families). All plans would still be required to implement a process by which subscribers can request an exemption from the drug formulary.

However, the amendments removed the prohibition on placing all drugs for a given class into a specialty tier. This provision had been sought by consumer advocates in response to a discrimination complaint settled by the Illinois Insurance Commissioner last year and has been included in comparable bills nationwide (see Update for Weeks of February 9th and 16th).

Kansas

Insurance department warns that new bill limiting drug cost-sharing could increase premiums

The Senate Committee on Financial Institutions and Insurance is considering legislation to limit prescription drug costs for subscribers to \$100 per month for up to a 30-day supply, if the plan is required to offer coverage under the four metal tiers created by the Affordable Care Act (ACA). However, similar to pending legislation in Illinois (see above), a higher \$200 limit would apply to those enrolled in the lowest bronze-level coverage. (The monthly limit would not apply to high-deductible health plans).

Under S.B. 202, these limits shall be inclusive of any subscriber’s out-of-pocket spending, including deductibles, copayments, or a percentage coinsurance required for specialty tier drugs. Similar to comparable bills nationwide, S.B. 202 would also that plans create a process for subscribers to request an exception to the plan formulary.



If enacted, the Department of Insurance cautions that S.B. 202 would increase plan premiums for all metal levels. In addition, the difference between amounts that are currently charged and the S.B. 202 limits would be considered mandated health coverage. As a result, if state law mandates insurers cover benefits that are not included in the minimum essential benefits package adopted by Kansas pursuant to the ACA, the state would be required to pay the additional costs for those benefits for those enrolled in the Marketplace. The Department would incur the cost of reviewing all metal level plans available in Kansas as of January 1st.

Minnesota

Marketplace enrollment projection cut by 15 percent

Officials for the MNSure health insurance Marketplace that Minnesota created pursuant to the Affordable Care Act (ACA) unanimously approved a three-year budget plan this week that cuts the target enrollment by nearly 15 percent.

The board now projects that only 130,000 consumers will sign-up for private coverage by 2017 or less than half its initial estimate in 2013. The reduced target caused the board to cut revenue projections by \$3.2 million, forcing spending cuts and a possible increase in the MNSure user fee to fill the shortfall.

Despite the nation's lowest Marketplace premiums for 2014, MNSure currently has only 61,000 enrolled in private coverage, missing their 2015 target of 67,000 (see Update for Week of December 15th). Software flaws and other technological impediments were largely blamed for depressing enrollment in year one, while the departure of the most popular participating insurer PreferredOne increased overall premiums (see Update for Week of January 12th), causing private Marketplace enrollment to increase by only 13,000 from 2014 to 2015. However, board members also credited Minnesota's strong economy for limiting the demand for individual health plans.

Both Republican and Democratic lawmakers are pursuing legislative fixes for MNSure. One sponsored by Rep. Tara Mack (R) would require MNSure to seek a federal waiver making ACA subsidies available to all individual market consumers, not just those enrolling in MNSure. H.F. 5 cleared the House Health and Human Services Reform committee this week but has drawn opposition from the Democratically-controlled Senate for an amendment that would allow insurance brokers and country officials to serve on the MNSure board. It also would prevent MNSure from setting stricter standards for Marketplace plans than non-Marketplace plans, an amendment strongly backed by business groups.

A second bill sponsored by Senator Tony Lourey (D), chair of Senate Finance's Health and Human Services Budget subcommittee, would give state officials more control over MNSure by making it a state agency and eliminating the MNSure board, similar to a measure enacted this week by Oregon (see below). However, S.F. 139/H.F. 1496 is not supported by Governor Mark Dayton (D).

The House Government Operations Committee unanimously approved a third bill this week sponsored by Rep. Phyllis Kahn (D) that would strip MNSure's exemptions from some state technology rules. H.F. 18 would specifically require that state officials give prior approval for MNSure technology projects and divide those costing more than \$1 million into phases. The Legislative Auditor identified the exemptions last month as a critical factor leading to the flawed rollout of the Marketplace.

Missouri

Governor becomes first Democrat to back work requirement for Medicaid expansion plan

Governor Jay Nixon (D) came out this week in favor of requiring new Medicaid enrollees to seek full-time work or pay higher premiums as a condition of expanding Medicaid pursuant to the Affordable Care Act (ACA).



The requirements are popular among conservative governors and lawmakers pushing expansion alternatives that have been federally-approved in six states. However, they have been consistently rejected or curtailed by the federal government (see Update for Weeks of January 26th and February 2nd).

Governor Nixon's compromise was an effort to kick-start expansion bills that have steadfastly hit a brick wall in the Republican-dominated legislature. However, he remains adamant that his support of conservative proposals like the work requirement are conditioned on a full expansion to everyone earning up to 138 percent of the federal poverty level (FPL), and not more limited expansions proposed by conservatives (such as expanding only up to the 100 percent of FPL threshold for ACA subsidies).

The Governor's proposal to automatically refer "able-bodied" adult enrollees to a career center to help them find work closely follows similar federally-approved compromises in Utah, Pennsylvania, and Indiana (see Update for Weeks of January 26th and February 2nd). The Obama Administration has also approved limited sliding-scale premiums on those earning 100-138 percent of FPL, which the Governor also backs for those who do not accept the state help to find work.

The Governor did find some support from Republican Senator Ryan Silvey, who sponsored a similar measure last session that never received a vote. However, Republican leaders like Senator Rob Schaaf bluntly refuse to consider any type of expansion proposal, regardless of the Governor's position. Furthermore, the budget plan approved by the House this week specifically excludes funding for any Medicaid expansion.

Montana

House panel rejects Governor's Medicaid expansion plan

The House Health and Human Services Committee rejected legislation this week that would expand Medicaid for up to 65,000 Montanans pursuant to the Affordable Care Act (ACA).

In a straight party-line vote, Republican leaders not only refused to advance the measure (H.B. 249) but invoked a procedural rule barring its consideration on the House floor without approval of three-fifths of the House. Committee Democrats planned to appeal the limitation to the House Rules Committee, insisting that it constitutes "a clear abuse of power."

More than 200 supporters testified in support of the Medicaid expansion plan put forward by Governor Steve Bullock (D), including AARP, the Montana Chamber of Commerce, and all of the state hospital, physician, and nursing associations. They cited the projected savings of \$6-30 million through fiscal year 2019 that would accrue from accepting the ACA matching funds and reducing the uncompensated care burden on safety-net providers.

By contrast, only 12 witnesses testified against H.B. 249, two of whom were staffers for the conservative group Americans for Prosperity that has opposed similar bills nationwide. Chairman Art Wittich (R) acknowledged the disparity in support, but insisted that "we are not a democracy by decibel" and should not be governed by the loudest voices. Instead, he claimed that the outcome of the mid-term elections last fall gave the Republican majorities a mandate to block the government expansions.

However, other Republicans were quick to propose more limited expansion alternatives favored by conservatives, including a plan advanced by Senator Ed Buttrey (R) that includes sliding-scale premiums and copayments for the expansion population. Governor Bullock has already rejected one alternative plan from Senator Fred Thomas (R) that would exclude all "able-bodied" adults without dependent children from the expansion.

Nevada

Proposed bill would set out-of-pocket limits for prescription drugs



Senator Kelvin Atkinson (D) introduced legislation last week that would limit cost-sharing for prescription drugs to no more than \$50 per prescription per month, or not more than 20 percent of the maximum annual out-of-pocket limit required by the Affordable Care Act (\$6,600 for individual coverage in 2015, \$13,200 for families). These limits must apply regardless of whether the subscriber has met their annual deductible. In addition, insurers must allow subscribers to request a formulary exception.

As with comparable bills pending in several states, insurers would also be prohibited from moving all drugs for a given class into their highest-cost drug tier, in direct response to discrimination complaints filed by consumer advocates with the Obama Administration and several state insurance commissioners (see Update for Weeks of February 9th and 16th).

Oregon

Governor signs bill moving troubled Marketplace under state agency control

New Governor Kate Brown (D) signed S.B. 1 this week, officially abolishing the semi-independent corporation that operated Cover Oregon and folding the troubled health insurance Marketplace into the Department of Consumer and Business Services.

The measure was passed with bipartisan support, as Cover Oregon was so plagued with technological glitches that it was unable to process any online applications during the entire inaugural open enrollment period (see Update for Week of March 10, 2014). Lawmakers stressed that the transition will have little impact on consumers in the short term, since Oregon is currently relying on the web portal for the federally-facilitated Marketplace (see Update for Week of April 21, 2014).

Oracle America, the contractor largely blamed by state officials for the flawed software, has already threatened to seek a court order blocking the legislation from taking effect. Oracle is fighting two lawsuits filed by the state attorney general and insists the transition to state control is an effort by state officials to gain additional legal immunity from Oracle's countersuit (see Update for Week of February 9th).

Pennsylvania

Transition to traditional Medicaid expansion to finish this fall

The Department of Human Services announced this week that the transition from the Healthy PA "private coverage option" to a traditional Medicaid expansion should be done by the end of September.

New Governor Tom Wolf (D) initiated that transition last month (see Update for Week of February 9th). Governor Tom Corbett (R) had made Pennsylvania one of six states to receive a federal waiver to cover those made newly-Medicaid eligible by the Affordable Care Act (ACA) expansion under private Medicaid managed care plans instead of traditional Medicaid (see Update for Week of December 1st). However, the "private coverage option" was beset with enrollment delays and technical impediments since opening last December (see Update for Week of January 12th).

Department officials pledged that the transition would occur without any gaps in coverage for Healthy PA enrollees. The first phase is slated to end April 30th, which is currently streamlining Healthy PA enrollees into one plan instead of several plan options. The state will stop accepting Healthy PA enrollees in April and enroll applicants directly in the existing Medicaid HealthChoices program.

Utah

House panel rejects Medicaid expansion alternative favored by Governor and Senate

House Speaker Greg Hughes (R) reversed course this week and let the Medicaid expansion alternative that Governor Gary Herbert (R) negotiated with the Obama Administration be considered in the House (see Update for Week of February 23rd). However, the measure (S.B. 164) was promptly rejected by a House committee in favor of a narrow alternative favored by conservative lawmakers.



Governor Herbert refused to concede defeat on his Healthy Utah plan, which is one of six federally-approved alternatives to the Medicaid expansion under the Affordable Care Act (ACA). He threatened to call a special session to debate the measure, citing the support of the Republican-controlled Senate, business groups, and state hospital associations that have offered to pay the state share of costs (see Update for Week of February 23rd).

The Governor acknowledged that his two-year pilot plan may require some modifications to address concerns that conservative lawmakers have expressed over the “fiscal sustainability” of Healthy Utah. He also floated the idea of the House approve both his plan and the more narrow alternative, the latter of which would only take effect if Healthy Utah costs exceed projections.

Majority Leader Jim Dunnigan (R) put forward both Healthy Utah and the House version (H.B. 446), which would provide limited benefits to only about 64,000 of those earning up to the ACA threshold for subsidies (100 percent of poverty). H.B. 446 would cost \$56 million in state funds and draw down \$139 million in federal revenues.

By contrast, Healthy Utah would cover the estimated 146,000 Utahns earning up to 138 percent of poverty. It would cost slightly more at \$78 million but bring in far more federal matching funds (\$648 million by 2021).

Governor Herbert stressed that the House version would likely be rejected by the Obama Administration, which has yet to allow partial expansions. However, he insisted that the Administration would allow Healthy Utah enrollment to be capped if needed to control costs, although it has yet to do so for other states.

Wyoming

Legislature passes “short-term” fix for lack of Medicaid expansion

Governor Matt Mead (R) allowed S.F. 145 to become law this week without his signature, providing Wyoming’s 26 hospitals with \$3 million to help cover the costs of uncompensated care.

Republican leaders intended the measure be a “short-term fix” while the debate over participating in the Medicaid expansion under the Affordable Care Act (ACA) drags into next session. However, the Governor used the bill as an outlet to criticize the House and Senate for rejecting any form of Medicaid expansion for the second straight year, despite the support of the Governor, state hospital association, and business groups (see Update for Weeks of February 9th and 16th).

In a letter to the Secretary of State accompanying the bill, Governor Mead noted that the \$3 million would cover only a mere 1.5 percent of uncompensated care costs that Wyoming hospitals will face in 2015. (The Senate had sought to provide \$5 million before the House reduced it to \$1 million, eventually forcing a conference committee compromise.)

The Governor stressed that the legislature must pass some form of expansion legislation next year before the ACA starts phasing-down federal indigent care funds for safety net hospitals starting in 2017. He noted that “nearly \$100 million” in federal income taxes paid by Wyoming residents would have been returned to the state had the legislature approved his Medicaid expansion plan.

Governor signs parity bill for oral anti-cancer drugs

Governor Matt Mead (R) signed legislation last week (S.F. 62) making Wyoming one of at least 35 states (including the District of Columbia) requiring that insurance coverage for oral chemotherapy drugs is at least equivalent to coverage for intravenous chemotherapy. Similar bills have passed both chambers in Mississippi (H.B. 952) and cleared committee in New Hampshire (S.B. 137).