



Health Reform Update – Week of November 14, 2016

CONGRESS

Republicans gain clear path to repeal Affordable Care Act, but may move slowly

The stunning upset in the Presidential race last week gave Republican lawmakers their first realistic path to achieving their long-sought goal of repealing the Affordable Care Act (ACA).

Republicans had voted more than 60 times to repeal all or part of the ACA since assuming control of the House in 2011 and Senate in 2015. Although their margins narrowed slightly after the elections last week, they still are likely to hold an eight vote margin in the House and four-vote margin in the Senate, enabling them to pass largely the same budget reconciliation bill that was vetoed by President Obama earlier year (H.R. 3762) that would effectively “gut” the ACA by stripping funding for provisions that impact the federal deficit (see Update for Week of January 4th).

Budget reconciliation bills need only 50 votes to pass the Senate and circumvent a filibuster (that requires 60 votes to break). It was the same mechanism used by Democratic lawmakers to enact key provisions of the ACA when they controlled the Senate in 2009.

House Budget Chairman Tom Price (R-GA), an early favorite to become Secretary of the Department of Health and Human Services, confirmed this week that the House was likely to follow the same path and introduce a 2017 budget resolution to H.R. 3762 in early January. The measure would eliminate penalties used to enforce the controversial individual and employer mandates under the ACA (although leaving the mandates themselves intact.) More importantly, it would block funding for all premium and cost-sharing subsidies, which are critical to ensure the affordability of plans for those earning 100-400 percent of the federal poverty level (FPL). In addition, the measure would prevent insurers from receiving any further reinsurance and risk corridor payments that compensate for exceptional claims. A current shortfall in risk corridor payments has already caused most non-profit cooperatives to go out of business and several large insurers to exit ACA Marketplaces (see Update for Week of October 24th).

As with H.R. 3762, the legislation could roll back provisions allowing states to be reimbursed for nearly all of their expenses for expanding Medicaid up to 138 percent of FPL. However, several Congressional Republicans and at least four Republican governors from expansion states are already pushing back against any repeal of the Medicaid expansion (see below).

Other key revenue provisions of the ACA could also be eliminated through reconciliation, including the current tax on medical device manufacturers and excise tax on high-cost “Cadillac” plans. However, Republicans effectively achieved these goals through an omnibus spending bill that President Obama signed last December, which suspended the device tax for 2016 and 2017 while delaying the “Cadillac” tax for two years past its 2018 effective date (see Update for Week of January 4th). Neither was expected to be resumed even under a Democratic administration.

President-elect Trump campaigned on a pledge to repeal the ACA and would be expected to sign the legislation. However, he appeared to recognize that a full repeal would not be possible in the short term without the unlikely support of at least eight Senate Democrats and suggested this week that he may be open to repealing only the more controversial provisions and amending the law where possible.

Rep. Price and other Republican leaders also hinted that any repeal bill would include a “transition period” of up to two years. This is an apparent recognition of the “massive disruption and



chaos in the individual market for health insurance” that groups like the Center for American Progress insisted would immediately result from a rapid repeal of funding measures without removing other market reforms like the guaranteed issue and community rating requirements. Insurance commissioners from both parties warned that the prospect of dumping 22 million newly-uninsured Americans into a market where persons could not be denied coverage or charged substantially more for pre-existing conditions would have “devastating consequences in the disruption to people’s care” and cause a “stampede” of insurers exiting ACA Marketplaces (who have to decide by May 3rd whether to participate for 2018).

The Congressional Budget Office (CBO) score of H.R. 3762 appears to support these counter arguments, warning that repealing ACA subsidies along with mandate penalties and other revenue provisions while retaining the law’s market reforms would not only cost \$550 billion but “result in a less healthy population in the non-group market and correspondingly higher average premiums”. This could cause markets in smaller states to become “unstable”.

In addition to these concerns, Republicans could also gain politically from waiting until 2019. Not only would the delay avoid a potential electoral backlash in the midterms, but Republicans only have to defend eight Senate seats in 2018 from mostly conservative states, giving them a realistic possibility of gaining the 60-seat majority needed to repeal the entire ACA all at once.

Republican leaders acknowledged this week that they lack a suitable replacement plan that would be needed to minimize the uncertainty and chaos that would result from a repeal and the two-year delay would provide time for one to be developed. However, they reiterated that any replacement plan is likely to include the most popular provisions of the ACA, including the guaranteed issue mandate, allowance for young adults to remain on their parent’s group plans, lifetime caps and annual out-of-pocket limits, and subsidies for low-to-middle income Americans to purchase private coverage in a health insurance Marketplace. Previous replacement plans also included the billions in Medicare “savings” that Republican lawmakers had initially attacked as cuts (see Update for Week of June 20th).

The similarity between Obamacare and a likely replacement plan led some critics to question whether the entire repeal debate would simply be an exercise in “removing Obama from Obamacare.” As a result, Rep. Price and other Republican lawmakers insisted that any replacement plan would likely include previous House-passed proposals from Speaker Ryan that would privatize Medicare and block grant Medicaid (see Update for Week of April 7, 2014), as well as the traditional Republican wish list of high risk pools, health savings accounts, and interstate health plans (see Update for Week of May 16th).

The American Medical Association (AMA) was the first of several stakeholders this week to issue statements that “reaffirmed its commitment to health care reform that improves access to care for all patients” and warning against restricting access to insurance under any repeal and replacement plan. The AMA House of Delegates also urged Congress to maintain not only the guaranteed issue requirement, but also the individual and employer mandates under the ACA so that those who can afford insurance “be required to obtain it.”

ACA replacement plans likely to still include penalties for not purchasing health insurance

Republican lawmakers have previously released several “blueprints” for potential replacements to the Affordable Care Act (ACA). While they vary in terms of the protections they would provide for persons with costly medical conditions, each have include some form on penalty for those that do not purchase health insurance they can afford.

The individual mandate under the ACA requires that non-exempt persons pay a tax penalty of \$695 or 2.5 percent of income (capped at the national average price of the lowest-cost bronze tier plan in a given region) if they did not purchase “minimum essential coverage” for 2016. According to the Kaiser Family Foundation, the average household payout for 2016 is expected to be \$969.



The individual mandate was initially proposed by the conservative Heritage Foundation in 1989. It was intended to force individual responsibility by ensuring that healthier and presumably less-costly individuals entered the risk pool instead of creating a “moral hazard” of remaining uninsured until they required treatment, ultimately causing insured individuals to subsidize their care. Republican lawmakers made the individual mandate the centerpiece of their alternative 1993 bill to President Clinton’s proposed employer mandate and it was ultimately enacted by Governor Mitt Romney (R) in Massachusetts in 2006.

However, the mandate’s tax penalties became very controversial when Democrats made it the centerpiece of the ACA in 2010. It consistently polls as the least popular ACA provision and conservative groups unsuccessfully pushed for it to be declared unconstitutional by the U.S. Supreme Court (see Update for Week of June 25, 2012). Since that decision, Republican lawmakers have continued pursuing legislation to either repeal the mandate or greatly limit its impact by broadening the number of exemptions (see Update for Week of October 24th).

Ironically, health economists like Uwe Reinhardt have largely agreed with the insurance industry that the mandate’s tax penalties are far too low to be effective, thus skewing the risk pools in ACA Marketplaces towards sicker and costlier subscribers. The Tax Policy Center notes that a person earning \$100,000 per year would pay a tax penalty of roughly \$2,400 in 2016, which would be below the average premium for the lowest-cost bronze plan of \$2,700 and make the tax penalty a relative “bargain”. By contrast, consumers in Germany’s national health care system can be fined up to \$12,000 for not purchasing affordable coverage while Switzerland imposes fines that are 30-50 percent above the average premium cost.

Studies from the Blue Cross Blue Shield Association and other groups have already shown that ACA Marketplace enrollees have been sicker and more costly than anticipated (see Update for Week of April 18th). Combined with fewer healthy and less costly subscribers than expected, several major insurers have sustained such dramatic losses that have chosen to exit the Marketplaces in coming years (see Update for Week of August 15th).

Due to these concerns, conservative economists largely agree that some form of “soft mandate” is crucial and all of the Republican ACA replacement proposals have and are likely to continue to include a comparable monetary incentive to compel healthier consumers not to forgo health insurance they can afford (especially since they all retain the ban on insurers discriminating against persons with pre-existing conditions.) For example, the blueprint released last summer by House Speaker Paul Ryan (R-WI) would charge subscribers higher premiums if they do not enroll in coverage when they first become eligible (for example, when they age out of their parents’ group coverage at age 26) (see Update for Week of June 20th). Senator Orrin Hatch (R-UT) included a similar provision in his *Patient Care Act*. This is similar to the current mechanism under both Medicare Parts B and D.

Another approach was included in the *Health Empowerment Liberty Plan* advanced last spring by Senator Bill Cassidy (R-LA) and Rep. Pete Sessions (R-TX) would replace the individual mandate with a lump-sum \$2,500 tax credit that citizens can use to purchase health coverage, regardless of whether they currently receive coverage through an employer (see Update for Week of May 16th).

Federal judge rejects first of a dozen lawsuits brought to recover ACA risk corridor payments

A federal judge dismissed a lawsuit last week brought by the non-profit health insurance cooperative Land of Lincoln Health seeking to recover outstanding funds due under the Affordable Care Act (ACA) risk corridor program.

Land of Lincoln was one of 23 Consumer Operated and Oriented Plans (CO-OPs) that were created with ACA start-up loans before Republicans took over Congress and rescinded 90 percent of the remaining funds (see Update for Weeks of December 24 and 31, 2012). As a result, the Centers for Medicare and Medicaid Services (CMS) had no available funds to cover a shortfall in ACA risk corridor



payments that occurred when insurer collections were below expectations, ultimately forcing 16 to suspend or liquidate their operations when low premiums attracted more consumers and costly claims than the CO-OPs could afford to pay (see Update for Week of August 15th).

The risk corridor fund is one of three temporary risk mitigation programs created by ACA. They were meant to stabilize insurance markets during the initial three years of full ACA implementation by compensating insurers that incur an extraordinary number of high-cost claims.

Unlike the reinsurance fund where collections have largely aligned with expectations (see Update for Weeks of February 8th and 15th), the risk corridors program has a \$2.5 billion shortfall forcing insurers to receive only 12.6 percent of the payments they were due for 2014 (see Update for Week of September 28th). As a result, CMS is using all 2015 collections to pay outstanding amounts owed to insurers for 2014 (see Update for Week of September 12th).

In addition to the CO-OP closures, the shortfall and subsequent losses are largely blamed for the decision of several major insurers to exit ACA Marketplaces for 2017 (see Update for Week of August 15th). As a result, at least four of the surviving CO-OPs (including Evergreen Health of Maryland and Health Republic of New Jersey) and eight other insurers are suing CMS to recover their 2014 costs (see Update for Week of August 15th).

The Land of Lincoln lawsuit was the first to be heard in the U.S. District Court of Federal Claims. Land of Lincoln received only \$550,000 in reinsurance payments for 2014 (instead of the \$4.5 million it was due) and is still owed nearly \$69 million for 2015. It initially elected only to serve individual and not small group consumers in 2017 but ultimately was forced into liquidation on July 12th.

In an ominous ruling for all insurers, Judge Charles Lettow (an appointee of President George W. Bush) held last week that the ACA does not impose a binding contract on CMS to pay insurers their designed risk corridor amounts for each year. He agreed with the Department of Justice (DOJ) argument that the ACA only required CMS to pay the full amount owed over the course of the three-year program but that the agency had the flexibility on how much to pay insurers in a given year. Land of Lincoln plans to appeal.

CMS had agreed to negotiate partial payments with the insurers out of a DOJ fund for legal settlements. However, Republican members of Congress insisted that such settlements would “subvert Congressional intent”, as Democrats and Republicans had previously agreed to provisions in budget resolutions that prevents CMS from transferring funds from other accounts whenever there is a shortfall in the risk corridor program (see Update for Week of October 24th).

Land of Lincoln Health had struggled to enroll just under 3,500 subscribers during the first year of Marketplace operations (or four percent of their target), but increased that number to more than 50,000 (or 20 percent of the entire Marketplace in Illinois) after slashing premiums by 20-30 percent (see Update for Week of August 10, 2015). However, the low premiums brought in more subscribers than they could handle with the lower than anticipated risk corridor payments.

21st Century Cures bill may be postponed until next Congress

Republican leaders including Senate Majority Leader Mitch McConnell (R) and House Speaker Paul Ryan (R) quickly issued assurances this week that the *21st Century Cures Act* remained the top priority for the lame-duck session that opened this week, despite the shocking election of Donald Trump that is likely to dramatically alter the Congressional agenda for next year.

The legislation (H.R. 6), which would speed the development of breakthrough drug treatments for rare disorders by removing regulatory obstacles and boosting available funds, overwhelmingly passed the House last year and has strong support from the biopharmaceutical industry (see Update for Weeks of



July 26 and August 3, 2015). The House was expected to pass the revised version sent over by the Senate before the end of the current Congress so long as both parties could reach agreement on how to offset the cost, in particular the \$4 billion in enhanced funding for the National Institutes of Health (NIH) (see Update for Week of October 10th).

However, the measure also includes the “moonshot” initiative for cancer pushed by President Obama, which is now meeting resistance from many House Republicans who do not want to enhance the outgoing’s president legacy and would prefer to wait until the next Congress reconvenes to pass a new version of the legislation that excludes this initiative. If the bill is delayed until next year, it is likely to be included as part of a user fee reauthorization for the Food and Drug Administration.

FEDERAL AGENCIES

Despite repeal threat, Marketplace enrollment surges

The latest data released this week by the Department of Health and Human Services (HHS) shows that more than one million consumers have enrolled in the 39 Affordable Care Act (ACA) Marketplaces operated by the federal government since the latest open enrollment period commenced on November 1st, with nearly a third of that total signing-up in the three days after the election.

As a result, HHS has already met its previous target for the entire open enrollment period, which ends on January 31st (11 days into the Trump Administration).

The pace of enrollment is 53,000 higher than at this point one year ago, despite initial concerns that premium spikes in some Marketplaces would depress participation nationwide. Instead, the very real threat of Republicans repealing the ACA and taking coverage away from roughly 22 million consumers (see above) appears to have given consumers the sense of urgency to enroll that individual mandate penalties did not (about 25 percent of all enrollees are new sign-ups).

Medicare Part B enrollees will see double-digit increases in premiums and deductibles

The Centers for Medicare and Medicaid Services (CMS) announced last week that monthly premiums will increase 12 percent in 2017 for those enrolled in Medicare Part B while the Part B deductible will rise by more than ten percent.

Part B is the program that covers primarily physician and outpatient services, including infusion drugs. The new monthly premium will be \$137, up from \$121.80 this year. On an actuarial basis, the 2017 premium is \$261.90 for enrollees age 65 and older and \$254.20 for those under-65 that are eligible due to disability. The 2017 deductible for Part B will be \$183, up from \$166 this year.

However, because premiums are rising next year by more than the 0.3 percent annual cost-of-living adjustment for Social Security (see Update for Week of October 24th), roughly 70 percent of Part B enrollees that have their premiums automatically deducted from their Social Security benefits will be protected by a “hold-harmless” provision that will limit their monthly premium to \$109. The other 30 percent) will bear the full brunt of the premium hike, although much of this cost will be borne by Medicaid programs since most of this 30 percent are enrollees that are dual-eligible for both Medicare and Medicaid. Those who are enrolling in Medicare for the first time in 2017 as well as those who do not collect Social Security will have to pay the full \$137 Part B premium.



Voters stuck with party lines to give Republicans unprecedented state-level control

This year will go down as the most partisan election in American history as for the first time every state voted the same party's candidates for U.S. Senate and President.

The increasing trend for voters to stick with party line down the ballot was never more evident. Democrats were actually favored to retake the Senate this year as Republicans had to defend three times as many open seats. However, heavy turnout in rural areas of both Pennsylvania and Wisconsin not only tilted the president race in favor of Republican Donald Trump, but allowed incumbent Republicans to gain two unexpected victories in Senate races that prevented the chamber from being tied.

Voters stayed with party lines in state legislative contests as well, allowing Republicans to beat expectations despite Democrats being favored to pick-up seats. For example, Democrats were expected to pick-up several governorships among the 12 gubernatorial races but appear to have actually lost two net seats (including Missouri and Vermont) with one race in North Carolina still undergoing a recount (where the incumbent Republican trails).

Republicans largely maintained the unprecedented control of state legislatures. They appear poised to hold the majority in 66 of the 98 partisan legislative chambers (excluding Nebraska which is non-partisan but effectively controlled by Republicans). In 32 states, they will now control both chambers, the most ever gained by Republicans.

This level of Republican dominance means that if they gain control of only one additional legislature, Republicans would reach the two-thirds majority needed to ratify any constitutional amendments passed by Congress.

Overall, Democrats gained control of four chambers (New Mexico House, Nevada Assembly, Nevada Senate, Washington Senate) and technically control both chambers in 13 states. However, in Washington, one Democratic member is refusing to caucus with Democrats, effectively given Republicans control.

Democratic gains were largely equaled by Republicans, who were able to gain control of three chambers (Kentucky House, Iowa Senate, Minnesota Senate). Although they hold a numeric majority in the Alaska House, the chamber will be governed by a coalition that gives Democrats functional control.

The Connecticut Senate will be split evenly between Democrats and Republicans while undecided races have yet to determine whether the New York Senate will remain tied.

The partisan trend did enable Democrats in California to regain their supermajority in both legislative chambers. The lone-remaining Republican in the Hawaii legislature was also ousted, making it the only state with an entire legislature comprised of only one party.

However, in the end, Democrats will have their lowest-ever presence in state legislatures, having lost 958 seats since the Affordable Care Act was passed in 2010.

Republican lawmakers from Medicaid expansion states push back against repeal

Republican governors and members of Congress from states that have expanded Medicaid quickly expressed reservations this week about Congressional promises to repeal the Medicaid expansion under the Affordable Care Act (ACA) (see above).



Medicaid expansion was one of the provisions of the ACA that Congress sought to repeal through the budget reconciliation process when it passed H.R. 3762 last year (a bill ultimately vetoed by President Obama)(see Update for Week of January 4th). However, more than a quarter of Congressional Republicans come from states that have already expanded Medicaid and accounted for hundreds of millions of dollars in ACA matching funds as part of their budget cycles that often run for two years .

These states, which include the home state for Vice President-elect and current Indiana Governor Mike Pence (R), could immediately face severe budget deficits if the Medicaid expansion were repealed without any transition period. Furthermore, even with the two-year transition proposed this week by House Budget Chairman Tom Price (R-GA) (see above), Congress would have to at least restore the federal disproportionate share payments for indigent care that are being phased out by the ACA so that hospitals do not face enormous uncompensated care costs once the 12 million that have gained coverage through the Medicaid expansion are again uninsured.

There are currently 20 Republicans in the Senate and another 120 in the House who represent the 31 states that expanded Medicaid under the ACA. In just 2014 alone, states that had expanded received more than \$47 billion in ACA matching funds.

Rep. Price along with House Ways and Means chairman Kevin Brady (R-TX) both insisted this week that it was “too early” to know whether Medicaid expansion would again be part of the reconciliation budget bill they plan to pursue in “early January”. However, already several Senators including Steve Daines (R-MT) and Shelly Moore Capito (R-WV) have cautioned them to consider the negative impacts of repealing the Medicaid expansion.

Eleven Republican governors also have a vested interest as they already agreed to expand Medicaid in their states under the ACA. This includes states like Arizona, New Jersey, and Ohio that sought a traditional expansion and those like Arkansas, Indiana, and Michigan that received federal demonstration waivers to use the ACA funds to purchase private coverage for the expansion population in Marketplace or Medicaid managed care plans.

Both Vice President-elect Pence and Arkansas governor Asa Hutchinson (R) suggested this week that in place of repealing the Medicaid expansion, the Trump Administration would more likely grant state additional flexibility to modify their programs to incorporate conservative principles. This includes a requirement that the expansion population must be working full-time or actively searching for work, which the Obama Administration had consistently stripped out of Medicaid expansion alternatives previously sought by states like Arkansas, Indiana, Kentucky, Michigan, Pennsylvania, Utah and most recently New Hampshire (see Update for Week of March 7th). States may also likely be permitted to terminate coverage for enrollees that fail to promptly pay premiums and impose premiums on those earning below poverty--two other frequent proposals from conservative lawmakers that the Obama Administration has opposed (see Update for Week of November 30, 2015).

Kentucky Governor Matt Bevin (R) has already adopted exactly such an approach. Despite winning election in 2015 on a pledge to repeal that state’s existing ACA expansion, political realities forced him to reverse course and seek to convert the traditional expansion into a demonstration program that incorporate those conservative principles (see Update for Week of August 22nd).

California

Voters reject referendum to cap prescription drug prices

Nearly 54 percent of voters rejected a ballot referendum last week that could have prohibited state agencies that run health care programs from paying more for prescription drugs than the lowest price paid to the federal Department of Veteran Affairs (VA).



As recently as September, polls showed that only about 16 percent of surveyed voters in California opposed the *California Drug Price Relief Act*, also called Proposition 61. However, the Pharmaceutical Research and Manufacturers of America poured more than \$109 million into opposing the measure, launching an intense media campaign that shifted nearly all 34 percent of undecided voters into the “no” column (see Update for Week of October 31st).

The primary donor and supporter is the AIDS Healthcare Foundation, which successfully placed a largely identical measure on the ballot for Ohio voters in 2017 (see Update for Week of July 25th). (Unlike Proposition 61, that measure would exempt drug purchased or procured from Medicaid managed programs). The Foundation and other supporters spent more than \$25 million pursuing the referendum, making Proposition 61 the most costly in history according to Ballotpedia.

Supporters (including the California Nurses Association and AARP) claimed that Proposition 61 would save several hundred million dollars a year on the more than \$4 billion that California now spends on medicines for roughly 5-7 million people. However, some advocacy groups representing HIV and Hepatitis C patients (such as Project Inform and the Treatment Action Group) expressed major reservations about whether the referendum takes the “wrong approach” to reducing drug costs, and would actually cause manufacturers to respond to the new caps by simply raising the prices they charge the VA (see Update for Week of July 25th).

These consumer groups also pointed out that rebates and discounts offered by drug manufacturers are typically confidential, making it difficult to determine whether a state agency is paying less than the VA. Because of this lack of transparency, the Legislative Analyst Office in California has already acknowledged that the actual impact of Proposition 61 would be “highly uncertain”.

The VA receives a roughly 24 percent mandatory drug discount under federal law and thus tends to pay the lowest prices. A 2005 report by the Congressional Budget Office showed that the VA paid 42 percent of list price on average for name-brand drugs while Medicaid was paying 51 percent (see Update for Week of July 25th). The gap between the VA and Medicare or private insurers was even larger.

Largest Marketplace insurer says it will stay despite ACA repeal threat

The chief executive officer for Blue Shield of California reiterated this week that it intends to remain in the health insurance Marketplace that the state created pursuant to the Affordable Care Act (ACA), despite the pledge by Congressional Republicans to repeal the ACA next year (see above).

Statements by members of Congress that the ACA would be repealed without an immediate replacement has caused stakeholders to fear a mass exodus of insurers would result. However, the Blue Shield CEO insisted that an “effective transition [should be] workable”, citing discussions with Republican leaders that suggested key ACA provisions such as premium assistance and the Medicaid expansion may be salvaged.

The CEO did not indicate how Blue Shield would response if those provisions were not retained as part an ACA replacement plan. However, he was highly critical of campaign statements from President-elect Trump suggesting that a replacement plan would largely rely on allowing the sale of health insurance policies across state lines, insisting that this “perplexing” proposal would cause a “race to the lowest common denominator” that would simply “push health plans to find the regulatory body or state with the fewest number of regulations”, limit benefit options for consumers, and do little to increase competition.

Blue Shield is raising Covered California premiums by an average of 2017 for next year as it is projected to lose money on Marketplace business this year (after posting profits in both 2014 and 2015.) However, it has retained a 30 percent market share, which leads all insurers in Covered California.



Covered California currently has about 1.4 million enrollees, making it the largest state-based Marketplace in the nation. Medi-Cal is also the nation's largest Medicaid program with more than 13 million enrollees (or roughly a third of all Californians).

A repeal of the ACA would cause 3.5 million that were added to Medi-Cal through the ACA expansion to lose their coverage, and increase the state uninsured population by more than 7.5 million according to the Urban Institute. With the loss of \$15 billion per year in ACA matching funds for the Medicaid expansion as well as the ACA subsidies, Insurance Commissioner David Jones (D) insisted that the state would be unable to continue either Covered California or the Medicaid expansion

Colorado

Single-payer ballot referendum fails to draw significant support

Nearly 80 percent of voters overwhelmingly rejected a ballot referendum last week that would have made Colorado the first state to create a single-payer health care system.

Starting in 2019, Amendment 69 would have substituted ColoradoCare in place of Connect for Health Colorado, the state-based Marketplace created pursuant to the Affordable Care Act (ACA). However, it was doomed in large part by a series of analyses conducted by the Colorado Health Institute, which found that it could not achieve universal coverage for all Coloradans without raising the payroll tax used to finance the system by far more than the ten percent that was initially proposed (see Update for Week of August 15th).

As a result, insurers and business groups that opposed the measure outspent supporters by more than five to one. It failed to gain support from even Governor John Hickenlooper (D) and U.S Senator Michael Bennet (D).

The most prominent support of Amendment 69 was U.S. Senator Bernie Sanders (I-VT). However, similar tax projections likewise scuttled his state's earlier plan to transition to a single-payer system by 2017 (see Update for Week of December 1st 2014).

Georgia

Senator files bill to prevent surprise medical bills for out-of-network care

Senator Renee Untermann (R) prefiled legislation this week that would make Georgia at least the fourth state to limit surprise medical bills from out-of-network providers contracted with an in-network facility.

S.B. 8 would impose requirements on providers to notify patients of all anticipated costs for their care, including any out-of-network charges, and establish a dispute resolution mechanism to limit costs for patients in situations where unanticipated costs were imposed.

California, Connecticut, and Florida have enacted comparable measures into law this year (see Update for Week of September 12th). The New Jersey legislature is advancing its own bill (see Update for Week of October 31st).

New Jersey

Senate committee clears legislation to limit cost-sharing for prescription drugs

Legislation limiting patient cost-sharing for prescription cleared the Senate Commerce Committee this week with only one dissenting vote and now heads to the Budget and Appropriations Committee.

Introduced last winter by Senator Loretta Weinberg (D), S. 814 would require health insurers that cover prescription drugs to limit enrollee cost-sharing to no more than \$100 per month for up to a 30-day



supply of each prescription drug for all but the bronze or catastrophic tiers of coverage. The limit for bronze plans could not exceed \$200 per month for up to a 30-day supply while catastrophic coverage would remain exempt from such limits.

The cost-sharing limits would apply at any point in the benefit design, including before and after any applicable deductible is reached, except for high-deductible health plans.

The identical counterpart (A.2337) unanimously cleared the Assembly Financial Institutions and Insurance Committee last month (see Update for Week of October 10th).

New bill would limit individual health plan coverage to ACA Marketplace

Assemblyman Troy Singleton (D) introduced A.4321 this week, which would require that individual health plans only be offered in New Jersey through the federally-facilitated Marketplace operated pursuant to the Affordable Care Act (ACA). The measure faces a very uncertain future given the pledge by Congressional Republicans to repeal the entire ACA (see above). It was referred to the Financial Institutions and Insurance Committee.

Oregon

Commerce department seeks to stabilize individual health insurance market

Only two days after the presidential election, the Department of Consumer and Business Services (DCBS) released a package of proposals for public comments that would help stabilize the individual health insurance market in Oregon following the departure of several insurers from rural parts of the state.

The proposals that will be considered for legislation when the sessions starts in February focus on spreading risk and fostering competition. For example, the Department would like to re-establish and expand the expiring state reinsurance program that compensates insurers from extraordinary claims. In addition, it would create an additional insurance option for rural consumers now limited only to a single insurer.

Other changes would allow carriers to cap enrollment so that they are more willing to maintain a presence in less competitive regions, similar to caps recently allowed on Minnesota insurers (see Update for Week of August 15th). Carriers would also be required to participate in any region where they have other commercial plan offerings.

Additional provisions intend to create more predictability for insurers include reducing the grace period on late premium payments from 90 to 30 days and making more uniform pricing for services and broker commissions.