Health Reform Update – Weeks of March 17 and 24, 2014

CONGRESS

House surreptitiously passes one-year "doc fix" patch

Republican leaders in the House successfully passed a one-year delay this week in the 24 percent cut in Medicare physician payments slated to take effect on April 1st. It is expected to pass the Senate.

Conservative members that opposed a temporary patch were upset that H.R. 4302 passed through a voice vote with many members not in the chamber. They had previously scuttled a bipartisan compromise on a permanent "doc fix" by attaching an offset that delayed the controversial individual mandate under the Affordable Care Act (ACA)—a non-starter in the Democratically-controlled Senate (see Update for Week of March 10th). Congress has been unable to agree on a permanent fix for over a decade and been forced to pass 17 temporary patches to avert the annual 21-30 percent payment cuts since the sustainable growth rate formula was enacted in 1997.

The latest one-year patch offset the $15.8 billion cost of the delay through cuts that largely avoided the hot-button issue of ACA implementation. H.R. 4302 modifies the timing of planned Medicare cuts under the ongoing budget sequester (see Update for Week of February 25, 2013). It also grants Medicare physicians a 0.5 percent increase through the end of 2014 and extends the delay in the scheduled phase-down in Medicaid disproportionate share payments for hospitals that serve large numbers of indigent patients until fiscal year 2017.

Hospitals in states electing not to expand Medicaid under the ACA would face sharply higher uncompensated care costs had the phase-down gone into effect as planned for 2014. However, the three-month patch that expires March 31st already delayed that phase-down until fiscal year 2016 (see Update for Week of December 9th).

The offsets do include a repeal of one ACA provision, namely section 1302(c) which caps deductibles for small group plans at $2,000 for individual coverage or $4,000 for family policies starting last January. Even though the Centers for Medicare and Medicaid Services will allow plans to exceed the statutory cap when there is no other reasonable way to provide an actuarial value at a given tier of coverage, such a waiver applies only for three years and can be modified or rescinded at any time (see Update for Week of February 18, 2013). As a result, the House bill would drop the cap as a matter of law.

The American Medical Association and the American College of Surgeons urged the Senate to reject the temporary patch and focus instead on a permanent fix. The Congressional Budget Office also found that the bill would increase spending by $14 billion over the next two years and that almost $11 billion of projected savings would not be realized until 2024.

Vulnerable Senate Democrats offer ACA fixes

A group of centrist Senate Democrats facing tough re-election bids this year or beyond called this week for a series of measures to fix or strengthen the Affordable Care Act (ACA).

In an op-ed piece published in *Politico*, Senators Mark Warner (D-VA), Mark Begich (D-AK), Mary Landrieu (D-LA), Heidi Heitkamp (D-ND) Joe Manchin (D-WV), and Angus King (I-ME) (who caucuses with Democrats) called for Congress to support Republican-backed proposals to exempt all businesses with less than 100 workers from the law's employer mandate and expand the ability of health insurers to

sell policies across state lines. However, they also urged Congress to heed Democratic calls to restore the start-up funds for non-profit health insurance cooperatives that were stripped from the ACA by the bipartisan compromise to avert the "fiscal cliff" (see below).

Other proposals to strengthen the ACA include passing Senator Begich's bill that would allow for "copper" level plans in and out of the Marketplace, which offer lower premiums than the lowest-level "bronze" plans currently offered, but impose higher out-of-pocket costs (see Update for November 18th – December 6th). The lawmakers also seek to broaden the small business tax credits available under the ACA and create another permanent path to enroll in Marketplace plans other than www.healthcare.gov.

New bill would create incentives to seek new approvals for old biologics

A bipartisan House bill introduced this week by Reps. Joaquin Castro (D-TX) and Randy Forbes (R-VA) would grant companies additional patent protections for repurposed biological products.

The *Independent Innovator and Repurposing Act* (H.R. 4287) would allow sponsors of biologic drugs to apply for a five-year extension of the term of their original product if it was approved by the Food and Drug Administration (FDA) for a new use and the sponsor is not affiliated with (or the same as) the original sponsor of the product.

Such an approach is already being advanced within industry and government, as companies share their compound libraries with one another and work with the National Center for Advancing Translational Science (NCATS) to screen potentially useful compounds. However, H.R. 4287 would differ by focusing on already-approved products and not those that are discarded. It would also apply retroactively to all products approved in the last ten years that meet the bill's terms.

The Affordable Care Act (ACA) created a regulatory pathway to approve generic biosimilar copies of approved biologics. However, the FDA has yet to issue implementing regulations (see Update for Week of September 3rd).

FEDERAL AGENCIES

HHS will extend Marketplace enrollment deadline for "special circumstances"

The Department of Health and Human Services (HHS) issued long-rumored guidance this week that will give consumers that started but failed to complete applications through the federal web portal extra time to enroll in the federal Marketplaces created by the Affordable Care Act (ACA).

HHS had been adamant that the March 31st deadline for open enrollment would not be delayed, in an effort to nudge procrastinators to enroll (see Update for Week of March 10th). However, they previously hinted at a limited extension at least for those with "special circumstances" similar to its extension of the December 15th deadline for January 1st coverage (see Update for December 16h-January 3rd).

Republican lawmakers criticized HHS for relying on the "honor system" by agreeing to grant the extension for consumers that simply check a blue box on www.healthcare.gov claiming that they started the process to enroll before the deadline but were unable to finish. HHS will not seek to verify the accuracy of these claims.

The HHS guidance did not specify how long of an extension that would be granted, though it is largely expected to be until April 15th since that the middle of the month was typically the deadline for coverage starting the first of the following month.

CMS will process paper applications received by April 7th "to capture those consumers who were 'in line' with paper applications."

The extension applies only to the 36 states relying on the federal marketplace. However, several other state-based marketplaces have granted similar extensions (see below) including Maryland, Minnesota, Nevada, and Oregon.

Marketplace enrollment exceeds revised CBO forecast of six million, may reach initial target

The Centers for Medicare and Medicaid Services (CMS) announced that the expected late surge in Marketplace enrollment enabled it to meet the Congressional Budget Office's revised forecast of at least six million consumers four days prior to the March 31st end of the inaugural open enrollment period, while a flood of subsequent applicants may actually hit or pass the initial target of seven million enrollees despite the flawed rollout last fall.

CMS has long-insisted that based on prior experience with similar Marketplaces such as the Massachusetts Health Connector, Medicare Part D, and the Federal Employees Health Benefit Plan (FEHBP), many consumers would wait until the open enrollment deadline approached before enrolling (see Update for Week of November 11th). However, the scope of the late surge has far surpassed the 5.4 million total ultimately projected by Avalere Health (see Update for Week of March 10th), as more than two million consumers have already enrolled in March, or nearly the same total that signed-up in February and March combined.

The Congressional Budget Office (CBO) had initially forecast that seven million consumers would enroll in the Marketplaces during the first open enrollment period. However, the projection was reduced by one million after the flawed rollout of the web portal for the 36 federally-facilitated Marketplaces, and persistent glitches in several state-based models. CBO has yet to reduce their projection of 13 million enrollees by 2015 and 22 million by 2016.

Enrollment continues to vary greatly by state, with the most successful state and federal Marketplaces witnessing huge surges in enrollment just before the deadline, while struggling state and federal Marketplaces like Arkansas, Maryland (see below), Massachusetts, and Oregon (see below) continue to lag far behind projections. California remains far and away the leading state in overall enrollment with more than 1.2 million consumers, nearly 80,000 of whom signed-up in the last week before the deadline.

Vermont continues to lead in enrolling the highest percentage of eligible applicants (54 percent), while South Dakota has enrolled just six percent of those that qualify for a Marketplace plan.

Republican lawmakers continued this week to insist that the Obama Administration was "cooking" the enrollment numbers, pointing to the fact that they are not providing data on how many enrollees have actually paid their first month's premium (see Update for Week of March 10th), although the Health and Human Services Secretary later estimated that 80-90 percent have done so. They also have claimed that most new enrollees were not previously uninsured, although a RAND survey of insurers released this week claimed that about one-third of Marketplace enrollees lacked prior coverage (see below).

RAND concludes that ACA has expanded coverage to more than 9.5 million previously uninsured

The RAND Corporation concluded this week that the Marketplaces, Medicaid expansion, simplified Medicaid applications, and other Affordable Care Act (ACA) provisions have actually extended coverage to 9.5 million uninsured overall—4.5 million of which were enrolled into Medicaid.

RAND's poll of 3,300 working-age adults also estimated that the nationwide uninsured rate has dropped from nearly 21 percent last fall to about 16.5 percent by March 22nd, consistent with similar survey results from Gallup (see Update for Week of March 10th).

State officials and insurers are reporting a similar flood of previously uninsured applicants, either to the Marketplaces or Medicaid. New York and Kentucky report that 70-75 percent of Marketplace and Medicaid applicants did not have prior coverage, while Nevada and Tennessee are among the other states witnessing a similar pattern.

Health Net and Blue Shield of California, two of the state's largest insurers, expect to substantially increase their customer base "beyond our projections", as does Florida Blue. Independence Blue Cross in Pennsylvania and its New Jersey subsidiary AmeriHealth are reporting 200-700 percent increases. Blue Cross Blue Shield of Minnesota attributes 90 percent of its growth to its participation in that state's Marketplace, despite continued glitches that have hampered enrollment. Even Wellmark Blue Cross and Blue Shield is witnessing significant customer growth in states like Iowa and South Dakota where it elected not to participate in the Marketplace.

Marketplace surge occurred without most subsidy-eligible applicants enrolling

Kaiser Family Foundation (KFF) released a new study this week confirming that premium subsidies offered under the Affordable Care Act (ACA) continue to vary widely by state. However, it further documents that overall Marketplace enrollment could be much higher than predicted targets if even half of those that are subsidy-eligible choose to apply.

The figures provided as of March 1st (before the late surge in enrollment detailed above) show that 83 percent of all Marketplace enrollees qualify for the subsidies available to those earning 100-400 percent of the federal poverty level (FPL). This proportion is consistent with earlier figures (see Update for Week of February 10th), as is the disparity nationwide that ranges from a low of 13 percent and 35 percent in the District of Columbia and Hawaii respectively up to 92 percent and 93 percent in Wyoming and Mississippi. (KFF noted that DC figures are lowered because members of Congress and their staff must use their Marketplace but are excluded from the ACA subsidies).

However, the study also shows that nearly four out of every five subsidy-eligible consumers have not applied for Marketplace coverage. Only 21 percent of those eligible have actually enrolled, but this rate drops down to only ten percent in states like Iowa, New Mexico, North Dakota, Oklahoma, and South Dakota—several of whom have some of the nation's highest uninsured rates.

KFF points out that the highest rate of subsidy-eligible enrollment belongs to states that created their own Marketplaces and devoted additional resources to marketing and outreach. This includes Vermont, where half of all subsidy-eligible consumers have enrolled, Rhode Island (41 percent), California (40 percent), Connecticut (39 percent), and Washington (32 percent). These states are not coincidentally among the best-performing Marketplaces overall (see Update for Week of March 10th).

KFF estimates that more than $10 billion in subsidies will be issued nationwide, with more than half that amount going to consumers in only five states (California, Florida, New York, North Carolina, and Texas). California consumers alone will receive more than $2.3 billion in subsidies.

The average subsidy is expected to total roughly $2,890 per person, ranging from a low of $1,350 in DC and $1,780 in Utah to a high of $4,370 in Mississippi and $4,980 in Wyoming. KFF notes that subsidy amounts will tend to be lowest in Marketplaces that have the lowest premiums, since subsidies are tied to the premium offered by the second-lowest cost silver plan. As a result, subsidies will predictably be highest in states with greater numbers of older enrollees since they can be charged up to three times more than younger subscribers under the ACA.

CMS formally requires Marketplace plans to accept Ryan White premium assistance payments

The Centers for Medicare and Medicaid Services (CMS) published an interim final rule in the March 19th *Federal Register* that requires all qualified health plans (QHP) in Affordable Care Act (ACA) Marketplaces to accept premium and cost-sharing payments made by the Ryan White HIV/AIDS program on behalf of QHP enrollees.

CMS had already issued guidance that "encouraged" QHPs to accept such payments and indicated that it would likely clarify through rulemaking that the non-discrimination provisions of the ACA required them to do so (see Update for Week of February 10th).

The move was in direct response to the refusal of three insurers in the Louisiana Marketplace to accept such payments due to "fraud" concerns. The three have since reversed their policy after a federal court issued a temporary injunction against them (see Update for Week of March 10th.) However, at least one other insurer (Blue Cross and Blue Shield of North Dakota) had continued to refuse the payments.

CMS used the rule to emphasize that their November guidance "discouraging" premium assistance payment from hospitals and other commercial entities does not apply to Ryan White payments. The agency clarified last month that non-profit foundations like PSI also can assist with QHP premiums and cost-sharing (see Update for Week of February 24th).

Consumer advocates complain that broader network standards don't go far enough

The Centers for Medicare and Medicaid Services (CMS) issued new standards last week for provider networks used by Marketplace plans in 2015, in response to a flood of consumer complaints about the narrow networks offered in 2014.

Previous studies found that up to 70 percent of Marketplace plans narrowed their provider networks in order to offer more attractive premiums for 2014, forcing CMS to already give consumers the flexibility to switch to broader network plans for this year (see Update for Week of February 10th).

In the proposed rule, the agency formally acknowledged that Marketplace enrollees "with certain complex medical conditions…are having trouble accessing in a timely fashion clinically appropriate prescription drugs." In response, CMS stated that it would more closely scrutinize qualified health plans (QHPs) offered in the federally-facilitated Marketplaces to ensure "reasonable access", and rely less on evaluations from state insurance regulators and private accreditation firms.

The new proposed standards largely follow those the agency outlined in a letter to stakeholders earlier this year (see Update for Week of February 3rd). They would generally require QHPs to have contracts with at least 30 percent of "essential community providers" in their service area (up from 20 percent in 2014). This includes community health centers, clinics for people with HIV/AIDS, children's hospitals, and hemophilia treatment centers (HTCs).

QHPs also would have to give CMS an advance list of all in-network providers and facilities when seeking certification. Those that fail to comply would be excluded from participation. CMS has decided to implement this requirement for 2015 despite previous statements indicated that it may be delayed until CMS had the technological capability to do so.

CMS will also "encourage" QHPs to "temporarily cover non-formulary drugs… as if they were on the issuer's formulary during the first 30 days of coverage."

The rule also states that QHPs must not discriminate against people with "significant health needs" and that "in the future, CMS may require that states performing plan management functions provide details regarding their respective nondiscrimination review process." To enforce that standard,

CMS will analyze co-payments charged for prescription drugs, hospital stays, and specialist visits, and it may challenge any QHP that requires "prior authorization" for an unusually large number of drugs used to treat a particular condition. However, this change does not address whether QHPs can put all formulary drugs to treat certain conditions like HIV/AIDS into specialty tiers requiring higher coinsurance, a practice The AIDS Institute (TAI) and other groups are fighting in Florida (see Update for Week of December 9th).

As with the February letter, providers and consumer advocates largely criticized the proposed standards as "nowhere near adequate" and urged CMS to require QHPs to contract with every essential provider in their service areas, including HIV/AIDS clinics, children's hospitals, and 340B safety net providers. TAI stated that they "continue to be disappointed [that] the Administration is not enforcing the [ACA] non-discrimination provisions."

However, the U.S. Chamber of Commerce claimed the new standards were a "regulatory power grab" while America's Health Insurance Plans insisted that they would cause 2015 premiums to rise.

CMS seeks to prevent states from passing navigator rules intended to obstruct the ACA

Proposed rules issued last week by the Centers for Medicare and Medicaid Services (CMS) take aim at laws/regulations enacted or pending in more than 20 states that hinder navigators, in-person assisters (IPAs), and certified application counselors (CACs) from helping to facilitate enrollment in the Affordable Care Act (ACA) Marketplaces.

CMS used the rule to define examples of restrictive navigator requirements that would be preempted by the ACA. For example, CMS proposes to prohibit any state defaulting to the federally-facilitated Marketplace (FFM) from imposing additional standards that prevent the application of federal standards. For example, an individual or entity that meets all federal standards to serve as a navigator, IPA, or CAC cannot be deemed ineligible by any FFM state.

The rule specifically states that mandatory conditions such as fingerprinting, background checks, or additional training are permissible. However, a state cannot set deadlines for compliance that make it "impossible any individual or entity approved by [CMS] to comply on a timely basis, despite good faith efforts." CMS adds that state rules that require navigators, IPAs, or CACs to refer consumers to agents or brokers that might not give consumers impartial advice would also be preempted, as would rules preventing those entities from working with all of the persons to whom they are required by the ACA to assist. This provision appears targeted at states like Georgia, where proposed H.B. 707 would prevent state-funded entities like the University of Georgia from using federal grants to serve as a navigator (see Update for Week of March 3rd), or Florida, which administratively tried to prevent navigators or other assisters from entering the property of state or county health departments to do their jobs (see Update for Week of September 23rd).

CMS also spells out that states cannot bar any entity from serving as a navigator just because its principal place of business is not located in the state. However, they do have to maintain a physical presence in their service area.

The proposed rule specifically trumps any state requirement barring navigators or other assisters from helping employers or employees with plans sold in the small employer "SHOP" marketplaces unless they are licensed insurance agents or brokers.

A federal court recently struck down a Missouri law that would have prevented navigators and other assisters "from providing information about health insurance altogether." It concluded that states defaulting to the FFM gave up their right to enact any state requirements that go beyond the minimum federal standards for navigators and enrollment assisters (see Update for Weeks of January 20th and 27th) though the proposed rule does not go quite that far.

It is not yet clear what impact the CMS rule and court decision will have on pending navigator legislation like H.B. 707 in Georgia (passed the House), H.B. 2508 in Arizona (passed committee), or H.B. 3286 in Oklahoma (passed committee this week).

CMS to adjust allowable administrative costs for insurers due to flawed Marketplace rollout

The Centers for Medicare and Medicaid Services (CMS) announced that as part of a comprehensive proposed rule issued last week it would adjust the medical-loss ratios mandated by the Affordable Care Act (ACA) in order to offset increased costs insurers must incur as a result of the flawed Marketplace rollout and three-year extension of plans that are not ACA-compliant (see Update for Week of March 3rd).

Adjusting the MLRs is one of the "premium stabilization policies" sought by CMS to keep Marketplace rates from rising dramatically for 2015. The MLRs required individual or small group plans to spend no more than 80 percent of premium revenue on direct medical care instead of administration and profit (or 85 percent for large group plans). While the proposed rule does not change these thresholds, it would allow plans to request a two-percent increase in the MLR limit for administrative costs and profit due to additional information technology costs caused by Marketplace glitches and the increased call center volumes and manual paper processing that resulted.

America's Health Insurance Plans indicated that it would not take a formal position on the proposal until CMS provides more guidance on how it will adjust allowable administrative costs in these situations.

Rep. Diane Black (R-TN) and several other Republican lawmakers accused the Administration of allowing insurers to keep additional profit solely to avoid an "October surprise" when proposed Marketplace premiums for 2015 are announced one month before the mid-term elections. Rep. Black asked the Secretary for the Department of Health and Human Services to commit to reversing the MLR adjustments after 2015.

CMS says ACA has saved Medicare enrollees $9.9 billion in prescription drug costs

The Centers for Medicare and Medicaid Services (CMS) used the fourth anniversary of the Affordable Care Act (ACA) last week to promote the fact that more than 7.9 million Medicare enrollees have saved roughly $9.9 billion in prescription drugs costs as a result of the law. The savings work out to an average of $1,265 per enrollee or $911 per enrollee just in 2013 alone.

Starting in 2011, the ACA gradually started winnowing down the coverage gap under Medicare Part D. For 2014, enrollees are receiving a 53 discount on brand-name drugs within this so-called "doughnut hole" and a 28 percent discount on generic drugs. This discount will continue to increase until 2020 when enrollees will pay the same coinsurance in or out of the "doughnut hole".

CMS also stressed that the number of Medicare enrollees receiving preventive services without cost-sharing continues to increase each year, rising to roughly 37.2 million enrollees in 2013 (compared to 34.1 million in 2012). The agency noted that before the ACA, enrollees undergoing preventive services like colorectal cancer screening could be subject to as much as $160 in cost-sharing.

STATES

Most state-based Marketplaces are extending enrollment deadlines

Most of the 15 state-based Marketplaces have largely followed the two-week extension that the Obama Administration granted last week for applicants that sought to enroll online before March 31st but were unable to do so due to technological issues (see above).

Connecticut and Rhode Island refused to grant any extension, while Washington offered to do so only on a "case-by-case" basis. However, California, Colorado, Kentucky, Maryland, Minnesota, New York, Vermont and DC largely followed the extension allowed for the federal marketplace, while Nevada, Massachusetts, and Oregon were granted longer extensions as detailed below:

- After initially refusing to allow an extension, Covered California's website became so overwhelmed with over 50,000 applications per day that they chose to allow those who were unable to enroll online to go through the call center, enrollment counselor, county office, or insurance agent by April 15th.
- Maryland residents have until April 15th, as long as they call or message a hotline prior to that date to indicate that they experienced issues while trying to enroll before March 31st.
- Massachusetts was already granted a federal extension until June 30th allowing residents that faced technical problems enrolling via the web portal to either keep their current coverage or enroll in temporary plans. They are seeking an additional extension until September.
- Nevada Health Link has extended open enrollment for 60 days or until May 30th for nearly 300,000 consumers that they claim were unable to enroll online.
- Covered Oregon was granted a federal waiver to extend open enrollment for everyone until April 30th since they have had no online enrollment capability since October 1st.

ACA delivers mixed results in promoting greater competition among health insurers

A new study by the Kaiser Family Foundation (KFF) shows that competition in the health insurance marketplace for individual plans has increased in some states as a result of the Affordable Care Act (ACA) but waned in others.

Researchers acknowledge that their initial study is based on "limited" data from only seven states (CA, CT, MN, NV, NY, RI, and WA) and is not representative of the nation as a whole. It found that the individual plan market in California and New York "appear to be noticeably more competitive than their 2012 individual markets as a whole" but that Connecticut and Washington were less competitive.

The study found New York's ACA Marketplace to be the most competitive compared to the six other states and credited new entrants brought into the individual market by the Marketplace with moving the state's overall market from "moderately concentrated" to "unconcentrated". New York is one of five states that followed the "active purchaser" model for its Marketplace. However, KFF notes that despite being able to selectively contract with only 16 carriers and exclude other qualified insurers, the Marketplace has remained very competitive as seven of those carriers hold more than a five percent market share.

California, which also went with the "active purchaser" model, moved from a "highly concentrated" to a "moderately concentrated" individual market. Although the state's dominant insurers all continue to hold more than a 30 percent share of California's ACA Marketplace, KFF points out that the state's largest carrier (Anthem Blue Cross) controls only 30 percent of the ACA Marketplace compared to 47 percent of the individual market in 2012.

The study did note that in Minnesota the state's fifth largest carrier was able to garner more than 60 percent of the ACA Marketplace by offering the nation's lowest average premiums, despite the presence of the state's dominant insurer Blue Cross and Blue Shield, which could muster only a 24 percent market share. However, researchers questioned whether smaller carriers could continue to rely on low premiums to beat traditionally dominant carriers, since PreferredOne was able to do so by

severely limiting the provider network available to subscribers and new federal rules will require broader networks for 2015 (see above).

KFF acknowledges that its initial data hold little insight into long-term trends as many large health insurers that opted out of Marketplaces for 2014 have already pledged to participate in 2015. Connecticut, Kentucky, Iowa, New Hampshire, Rhode Island, and South Dakota are among the states already expecting additional Marketplace entrants next year.

Most insurance cooperatives are thriving in ACA Marketplaces

The 23 non-profit health insurance cooperatives created by the Affordable Care Act (ACA) have enrolled more than 300,000 consumers in Marketplaces nationwide and garnered substantial market share in several states, according to trade groups representing them.

The most successful Consumer Operated and Oriented Plan (CO-OP) has been Community Health Options in Maine, which remarkably holds an 80 percent share of that state's federally-facilitated Marketplace (FFM) despite the presence of the Maine's dominant insurer Blue Cross and Blue Shield.

CO-OPs have also attained a substantial foothold in the ACA Marketplaces for New York, Iowa, Nebraska, Colorado, Kentucky, Wisconsin, South Carolina, Utah, Montana, Nevada and New Mexico. For example, Republican Insurance of New York ranks second to only Empire Blue Cross and Blue Shield in New York's Marketplace, while CoOportunity has enrolled about 54,000 consumers in Iowa's Marketplace, or nearly 500 percent more than initially projected.

According to the McKinsey and Co. consulting firm, the success of CO-OPs is directly attributable to the fact that they have "emerged as price leaders" offering more than a third of the lowest-premium plans offered in ACA Marketplaces. Those that have not been successful, such as the CO-OPs in Michigan and Tennessee, initially overpriced their plans so that they were more costly than well-known competitors. Vermont denied an insurance license to its CO-OP, insisting that its enrollment projections were "unrealistic" due to proposed rates that were not competitive. Other CO-OPs in states like Maryland, Massachusetts, and Oregon have been hampered by the continued technological glitches that have greatly restricted online enrollment (see Update for Week of March 3rd).

A group of Senate Democrats are using the success of CO-OPs to urge Congress to restore $2.3 billion in funding for start-up loans that were stripped out of the ACA by the bipartisan compromise to avert the "fiscal cliff" (see Update for Weeks of December 24 and 31, 2012). The move prevented CO-OPs that had yet to apply from being started, limiting participation to only 23 states.

The Centers for Medicare and Medicaid Services (CMS) does have a $253 million "contingency fund" that it is using to for "oversight and assistance" of CO-OPs, as well as to provide $113 million to allow CO-OPs in Montana, Massachusetts, and Kentucky to expand into neighboring states of Idaho, New Hampshire and West Virginia next year.

<u>California</u>

Governor signs bill ensuring continuity of care for those with canceled plans

Governor Jerry Brown (D) signed A.B. 369 on March 20th, which immediately ensures continuity of care for those with acute or chronic conditions whose individual health plans were canceled due to the Affordable Care Act (ACA).

Despite requiring a two-thirds vote, A.B. 369 unanimously cleared both chambers. It allows about 900,000 Californians whose individual coverage was terminated from December 1, 2013 to March 31, 2014 to complete treatment with their existing provider if they have a specified condition like cancer or any terminal illness, even if that provider is not in the network for their new plan.

Indiana

Indiana becomes sixth state to enact biosimilar substitution law

Governor Mike Pence (R) signed legislation on March 25th making Indiana the sixth state to set limits on when a pharmacist can substitute an interchangeable biosimilar drug for a brand-name biologic (see Update for Week of March 10th).

Under S.B. 262, the prescription must state that such substitution is allowed, the patient must be advised, and the subscriber must be notified in ten days. Although five other states already enacted comparable industry-backed restrictions (Florida, North Dakota, Oregon, Utah, and Virginia), ten states have rejected them including California (see Update for Week of October 14th). Similar legislation remains pending in New Jersey (A.2477), Pennsylvania (S.B. 405) (see Update for November 18th–December 6th), and Washington (H.B. 2326).

The Affordable Care Act (ACA) created a first-time regulatory pathway for the approval of generic biosimilars. However, biosimilars are not expected to be approved before 2015 as the Food and Drug Administration has yet to promulgate implementing regulations (see Update for Week of September 3rd).

Maryland

Marketplace board to scuttle web portal in favor of Connecticut model

The board overseeing the Maryland Health Connection acknowledged this week that the glitch-plagued website for the Affordable Care Act (ACA) Marketplace is beyond repair and will have to be replaced.

State officials have been under pressure for months by even Democratic members of Congress to abandon the web portal, whose technological flaws have severely hampered enrollment in Maryland and resulted in federal audits of the $122.5 million in federal grants used to build the failed infrastructure (see Update for Week of March 10th). However, instead of defaulting to the overhauled federal model as expected, the board instead is planning to use the website technology implemented by Connecticut, a very successful state-based Marketplace.

As of March 15th, less than 45,000 consumers have enrolled in Maryland Health Connection, far below the 150,000 initially projected or the revised 81,000 estimate after the web portal flaws were revealed (see Update for Week of March 10th).

House and Senate pass bills to limit out-of-pocket costs for specialty drugs

The Senate Finance Committee unanimously voted last week to clear legislation that would cap out-of-pocket costs for specialty tier drugs.

H.B. 761 has already unanimously passed the House on March 17th and if passed by the Senate and signed into law it would prohibit health plans from imposing a copayment or coinsurance for covered specialty drugs that exceeds $150 for up to a 30-day supply (adjusted for medical care inflation), starting January 1, 2016. The same limit was enacted last year in Delaware (see Update for July 15th-August 2nd).

The accompanying fiscal note attests that specialty drugs in Maryland can cost more than $10,000 for a month's supply, including Incivek for hepatitis C that costs roughly $16,000 per month. It cites industry figures showing that specialty drugs accounted for 25 percent of all prescription drug expenditures in 2012 (but only one percent of prescriptions filled) leading insurers to charge subscribers up to 50 percent of the cost of the specialty drug.

The state's dominant insurers Care First Blue Cross and Blue Shield and Kaiser Permanente testified in support of H.B. 761.

The House Health and Government Operations will hold an April 1st hearing on companion legislation (S.B. 874) that unanimously passed the Senate on March 19th.

Nebraska

Medicaid expansion alternative narrowly defeated

A bill that would allow Nebraska to participate in a "private sector" alternative to the Medicaid expansion under the Affordable Care Act (ACA) fell six votes short this week on the needed majority to end debate and proceed to floor vote.

L.B. 887 sponsored by Jeremy Nordquist (D) largely followed the alternative model that the Obama Administration has already approved for Arkansas, Iowa, and Michigan, as those earning 100-138 percent of poverty would be covered through the ACA Marketplace instead of Medicaid (see Update for Week of January 6th). Roughly 54,000 Nebraskans would gain Medicaid or Marketplace coverage overall at a cost to the state of $62 million for the first six years. However, Nebraska would receive more than $2.2 billion in federal matching funds.

New Hampshire

Medicaid expansion alternative becomes law

Governor Maggie Hassan (D) has signed legislation passed last week by the House that would make New Hampshire the 27th state agreeing to participate in the Medicaid expansion under the Affordable Care Act (ACA).

S.B. 413 cleared its main obstacle earlier this month when it passed the Republican-controlled Senate (see Update for Week of March 3rd). It is a "private sector" alternative that largely follows the model already federally-approved for Arkansas, Iowa, and Michigan (see Update for Week of January 6th). However, instead of using ACA funds to cover the newly-eligible population in the state partnership Marketplace, about 12,000 adults earning up to 138 percent of the federal poverty level would be covered instead starting July 1st through an existing state program that subsidizes employer-based coverage. Another 38,000 would be covered first through Medicaid managed care plans and then transition to private Marketplace plans when federal funding starts to phase down from 100 percent to 90 percent.

The state must obtain federal waivers for each stage of the expansion. It will sunset in 2017 without additional legislative approval.

Oregon

Governor cleans house following failure of Marketplace website

Governor John Kitzhaber (D) has removed state officials responsible for the failed rollout of the Covered Oregon Marketplace, which lacked any online capacity for the entire open enrollment period.

The removals include the Oregon Health Authority director, as well as the chief operating officer and chief information officer for Cover Oregon. The management structure for the Cover Oregon board will also be overhauled while the Governor awaits a report from outside information technology experts on whether the web portal can be repaired or the state should default to the federally-facilitated Marketplace (FFM). He also pledged other procurement reforms including a review of contracting practices that were largely blamed for failing to assess any penalties on Oracle Corporation, which still got paid despite a non-functional product (see Update for Week of March 3rd).

The removal of the OHA director and Governor's closest health reform ally was intended to thwart political fallout from the failure of the $200 million Marketplace that was expected to be a national model. Instead, Cover Oregon is now the focus of two separate federal audits that threaten to derail what had been expected to be an easy re-election bid by the Governor (see Update for Week of March 10th).

Governor Kitzhaber did receive some good news last week when the Obama Administration approved his request to extend the open enrollment period for 30 days due to the lack of online enrollment (see above). The Administration will also let small businesses in every state qualify for ACA tax credits without having to apply for coverage through their Marketplace—so long as they sign-up for non-Marketplace coverage that is at least equivalent to the level of coverage offered inside the Marketplace. Members of Oregon's Congressional delegation led the push for the change.

Virginia

Governor signs bill imposing notice requirement for specialty tier coinsurance

Governor Terry McAuliffe (D) signed legislation on March 24th that requires insurers or health maintenance organizations using a prescription drug formulary to give subscribers at least 30 days prior written notice whenever a formulary drug is moved to a tier with higher cost-sharing requirements (see Update for Week of February 3rd).

Earlier versions of H.B. 308/S.B. 201 had set the notice requirement at 60 days (see Update for Week of January 6th).

Wisconsin

Assembly amends Senate bill requiring parity in oral and IV cancer drugs

The Assembly watered down a Senate-passed measure last week that would have prevented health plans covering both oral and intravenous chemotherapy from imposing a higher cost-sharing on the former.

S.B. 300 cleared the Senate on March 18th with only two dissenting votes. However, the measure was promptly modified by the Assembly, where nearly half of Republicans had initially refused to take a position. The amended version that must now go back to the Senate states that a plan is in compliance with the parity requirements if it limits copayments to no more than $100 for a 30-day supply of the oral cancer medication (adjusted for inflation starting in 2016).

At least 29 other states including neighboring Illinois, Iowa, and Minnesota have enacted parity legislation, although California and Missouri (see Update for Week of March 10th) have done so by placing similar caps on out-of-pocket costs ($200 for a 30-day supply in California, $75 in Missouri). If the amended version clears the Senate, Governor Scott Walker (R) has indicated that he will sign it.