



Health Reform Update – Week of November 10, 2014

CONGRESS

Appeals court will wait for U.S. Supreme Court ruling on federal Marketplace subsidies

The District of Columbia U.S. Court of Appeals has agreed to delay its review of a challenge to the validity of Affordable Care Act (ACA) subsidies for consumers in federally-facilitated Marketplaces.

The full DC court was expected to hear the case on December 17th, after throwing out a decision by a three-judge panel that invalidated the subsidies (see Update for Weeks of August 25th and September 1st). Two of the three judges on that panel (both Republican appointees) had ruled that the text of the ACA authorizes premium and cost-sharing subsidies only for state-based Marketplaces (see Update for Week of July 21st).

The Fourth Circuit U.S. Court of Appeals unanimously concluded to the contrary, insisting that such an interpretation was absurd when the provision at issue was not pulled out of context from the entire statute (see Update for Week of August 11th). However, the U.S. Supreme Court made the surprise move last week to review the Fourth Circuit decision, even before the District of Columbia appellate court had a chance to rule (see Update for Week of November 3rd).

The Tenth Circuit U.S. Court of Appeals is expected to likewise delay their pending review of a lower court decision also invalidating the subsidies (see Update for Week of September 29th).

Republican budget will not back-off ACA repeal or efforts to transform Medicare and Medicaid

Senior House aides indicated this week that Republican leaders are preparing a budget plan for next year that will include a full repeal of the Affordable Care Act (ACA), as well as renewed proposals to transform Medicare into a voucher program and convert Medicaid into lump-sum block grants.

All three of the measures have been passed by the House at least three times since 2011 (see Update for Week of March 11, 2013). However, with the Senate now under Republican control, it could now reach the President's desk with only six Democratic votes, forcing him to issue a high-profile veto that Republicans could use a campaign issue for 2016.

As with prior Republican budgets, the latest version would again retain the \$716 billion in Medicare "cuts" under the Affordable Care Act (ACA). This includes restrictions on the rate of payment growth for private Medicare Advantage plans, which Republican lawmakers had campaigned against, arguing that they would reduce benefits.

The total 2015 budget plan would cut more than \$5 trillion in federal government spending over the next decade, with \$861 billion coming from the Medicare and Medicaid transformations.

Once it clears the House as expected, the Senate could pass most of the budget through the reconciliation process requiring only 51 votes. However, the necessary budget resolution would require 60 votes to break a Senate filibuster, thus requiring the support of at least six Senate Democrats.

As a result, several Republican leaders continued to call this week for piecemeal measures to attack the ACA, including those that previously had some bipartisan support (see Update for Week of November 3rd). However, many of the vulnerable centrist Democrats that supported specific repeal



measures will no longer serve in the next Congress, severely limiting the number of potential crossover votes that Republicans can recruit.

One new Senate Democrat that Republicans are targeting is Rep. Gary Peters (D-MI). However, as a House member he previously opposed a version of the most likely Republican bill to be enacted (H.R. 2575), which would increase the threshold for a full-time employee under the ACA's employer mandate from 30 to 40 hours per week (see Update for Week of February 24th). However, Senator-elect Peters did vote with Republicans to weaken penalties on individuals and employers that do not comply with the ACA's minimum essential coverage requirements.

Senators Joe Manchin (D-WV), Heidi Heitkamp (D-ND), and Joe Donnelly (D-IN) are other centrist "red state" Democrats that will be vulnerable in coming elections and may be willing to side with Republicans on certain ACA modifications. Manchin is often considered to be the most conservative of Senate Democrats and is rumored to be weighing a party switch.

MedPAC debates altering Medicare Part B drug payments to avoid "perverse" incentives

Members of the Medicare Payment Advisory Commission (MedPAC) agreed this week that the drug reimbursement methodology under Medicare Part B creates a "perverse incentive" for providers to use more costly medications and debated various structural reforms to address the problem.

Measures that the panel considered recommending to Congress included consolidating payment codes for Part B drugs, paying a flat fee to physicians for managing Part B medications, and replacing the current average sales price (ASP) formula with bundling options used in a recent pilot demonstration by UnitedHealthcare. Part B covers infusion drugs, such as clotting factor products for bleeding disorders.

Under the current ASP formula, if the ASP of a Part B drug is \$100 a physician would receive an additional six percent (or \$106) from Medicare, regardless of the price the physician actually pays for the medication. Thus, physicians make more money by using costlier drugs.

The commissioners debated but appeared to disfavor reimbursing physicians an average weighted sales price for all drugs available for a specific condition (plus the six percent), concluding that it would effectively punish physicians for prescribing the higher-priced drug when it was clinically appropriate. Part B enrollees that wanted the costlier drug would also incur higher out-of-pocket costs.

As a result, the commissioners leaned towards recommending that providers receive a flat fee for Part B medication management, and MedPAC staff would present research on this option at the next panel meeting in December.

The commissioners were "intrigued" by a pilot done by UnitedHealthcare, in which the insurer bundled payments for oncology drugs, reimbursing at ASP plus zero percent and including a flat per-episode fee instead of the current drug add-on. MedPAC staff found that while drug utilization under this experiment increased, hospital admissions declined significantly resulting in savings of \$33 million (with providers sharing in \$11 million of that amount). At least one commissioner suggested that such an approach could be implemented through the accountable care organization demonstration being operated pursuant to the Affordable Care Act.

FEDERAL AGENCIES

HHS lowers short-term estimate of Marketplace enrollment, but still expects 25 million by 2017



The Department of Health and Human Services (HHS) announced this week that an estimated nine million to 9.9 million consumers will be enrolled in Marketplace plans by the end of the second open enrollment period on February 15th.

The figures represent the number of consumers HHS projects will enroll or re-enroll and pay their premiums. However, it is well below the 13 million consumers that the Congressional Budget Office (CBO) predicted last spring would be enrolled for 2015. Currently, roughly 7.1 million consumers are enrolled and are paying premiums for Marketplace plans.

HHS officials say that they downgraded the CBO estimate in the short-term because they expect that enrollment will take an additional 1-2 years to “ramp up” to CBO’s projections of 25 million Marketplace enrollees by 2017. HHS still expects to hit the latter benchmark.

According to HHS, the longer “ramp up” is due to “mixed evidence” regarding anticipated shifts from employer-sponsored coverage and off-Marketplace individual coverage into the Marketplace, as well as slower enrollment growth curves experienced during the early implementation of Medicare Part D and the Children’s Health Insurance Program (CHIP). HHS notes that extending “CBO’s ramp-up from three years to 4-5 years” is more consistent with Part D and CHIP and would lower the enrollment estimate to nine to 9.9 million.

HHS officials expect an 83 percent retention rate for the 7.1 million consumers enrolled as of October 2014, meaning that 5.9 million will renew Marketplace plans and carry over into 2015. However, they acknowledge that the fluidity of the individual market makes it difficult to ascertain how many will stay in individual plans for a full year.

HRSA withdraws sweeping new “mega-rule” on 340B drug pricing

In a surprise move, the Health Resources and Services Administration (HRSA) withdrew its long-awaited “mega-rule” clarifying vague eligibility and transparency requirements for the federal Section 340B Drug Pricing Program.

The sweeping new proposed regulations were awaiting final paperwork clearance at the Office of Management and Budget (OMB) and were expected to be published imminently after being delayed past their June 2014 target date (see Update for Week of July 21st). They were to be the first comprehensive set of regulations for the 340B program, which has been largely operated for 22 years on different sets of regulatory guidance.

The “mega-rule” was intended to address frequent criticism from Congress and the Government Accountability Office in recent years that HRSA lacks adequate oversight to ensure safety net providers receiving the discounts are not reaping improper windfalls and that manufacturers are providing the best prices for the drugs (see Update for Weeks of July 1 and 8, 2013). RAND has also concluded that lack of clear directives from HRSA has caused “increasingly divergent views on the program’s purpose and the role it should play in supporting safety net providers” (see Update for Week of August 11th).

However, HRSA has belatedly decided that disputes about the role and direction of the 340B program can better be resolved through additional agency guidance documents instead of one “mega rule.” HRSA officials announced that the first set of guidance will be issued early next year and address many of the issues that were to be clarified by the proposed regulations.

Earlier this year, a federal court ruled that HRSA lacked the statutory authority to issue regulations pursuant to the Affordable Care Act (ACA) that would extend mandatory 340B discounts for orphan drugs to non-orphan indications (see Update for Week of July 21st). HRSA had issued an “interpretive” rule to circumvent that injunction (see Update for Weeks of October 20th and 27th), which does not appear to be withdrawn along with the “mega rule”.



It is not clear what impact the court decision had on HRSA's decision to abandon the "mega-rule". However, the agency did acknowledge that it wanted to issue directives solely on areas where they have "explicit" authority from Congress, including civil monetary penalties for drugmakers that violate 340B rules, the calculation of 340B ceiling prices, and the administrative dispute resolution process.

Study predicts that sales growth for orphan drugs will outpace other products

A report released this week by EvaluatePharma predicts that global sales for orphan drugs will grow more than twice as fast by 2020 as those for non-orphan drugs.

The projection is based largely on lower cost for clinical trial and higher prices at launch. Phase III trial costs for orphan drugs are roughly half that of non-orphan products, while the expected return on investment is more than two times as high.

EvaluatePharma projects that orphan drug sales will reach an annual growth rate of nearly 11 percent in 2020, compared with only about four percent for non-orphan drugs. Total sales of orphan products are expected to grow from \$97 million in 2014 to \$176 billion by 2020, representing 19 percent of the total global share of prescription sales.

The Food and Drug Administration (FDA) granted a record 260 orphan drug designations in 2013, while orphan drug designations in Europe and Japan both declined by 17 percent, according to the study.

HEALTH CARE COSTS

Out-of-pocket costs for insured adults at highest point in a decade

The Commonwealth Fund released a new survey this week of more than 2,750 working age adults with health insurance showing that out-of-pocket (OOP) costs are at the highest level recorded in the past ten years.

More than 20 percent of those surveyed reported spending at least five percent of their income to cover OOP costs for their health plan and 13 percent spent ten percent or more. OOP costs were highest for those with the lowest incomes, with 41 percent of those earning below 100 percent of the federal poverty level (FPL) spending at least five percent of their income on OOP costs (and 31 percent spending ten percent or more).

Researchers documented that cost-sharing has risen dramatically for individual subscribers in employer-sponsored plans, averaging \$1,217 in 2014 compared to \$584 just eight years ago. The number of employer plan subscribers with deductibles of at least \$1,000 has doubled over that time to more than 20 percent.

About three out of five privately-insured respondents to the survey reported having difficulty affording their deductibles, and 40 percent acknowledged delaying needed care as a result. The latter figure rises to nearly 50 percent for those earning less than 100 percent of FPL.

A *Modern Healthcare* review of plans options for the federally-facilitated Marketplaces operated under the Affordable Care Act found that 60-80 percent are "high-deductible plans" per Internal Revenue Service regulations, as they impose annual deductibles of at least \$1,300 for individuals and \$2,600 for families. New data from Mercer Consulting also shows that 75 percent of employers are expected to offer employees a high-deductible plan combined with a health-savings account next year, while 20 percent will offer only those types of plans.



Overall Marketplace premiums to increase by six percent average, but fall in major cities

PricewaterhouseCoopers (PwC) released their updated analysis of rate filings for 43 states and the District of Columbia this week, showing that individual Marketplace premiums for 2015 will increase in those states by an average of only 5.6 percent.

This figure is less than half of what the annual increases experienced in the individual market prior to passage of the Affordable Care Act (ACA). Furthermore, the average increase falls down to 3.5 percent for the seven states (CO, MD, NY, OH, OR, RI, VT) and DC that have finalized individual market rates in and out of the Marketplaces created by the ACA.

Among these seven states (and DC), the average monthly premium (across all metal tiers and ages) comes out to about \$344 compared \$381 for those in all 43 reporting states (and DC). These amounts will be lower for the roughly 83 percent of Marketplace consumers that qualify for ACA subsidies.

PwC emphasized that actual rates will vary markedly across and within states, ranging from a 22 percent decrease to a 35 percent increase.

The Kaiser Family Foundation also updated their earlier analysis this week of Marketplace premiums in major cities (see Update for Weeks of August 25th and September 1st), finding that among the 48 now analyzed, average premiums will actually fall by 0.2 percent due to the increased competition found in metropolitan areas. However, Kaiser also stressed that it found wide variations nationwide. For example, average premiums will rise by 28 percent in Anchorage and 18 percent in Minneapolis, while fall by 24 percent in Jackson, MS and 15.6 percent in Denver.

Kaiser also pointed out that decreases will mostly be found in higher end plans, as premiums for the lowest cost bronze tier plans will see a 2.3 percent increase on average.

An unrelated Urban Institute review of premiums for 17 states and DC showed that consumers will pay no more than five percent more for silver tier coverage next year due largely to high competition in urban areas, and in many cases will see a reduction. The second-lowest cost silver tier or “benchmark” plan is the one to which ACA premium tax credits are tied.

An initial Wakely Consulting survey of premiums posted this week on www.healthcare.gov for 34 of the 36 federally-facilitated Marketplaces (FFMs) showed that benchmark plans in the largest county will drop precipitously in several states. For example, Mississippi consumers will see a 25 percent decline in Hinds County (including the capital of Jackson) to \$410 per month for a 40-year old, thanks to the expanded statewide competition (see Update for Week of September 15th). The benchmark plans in the largest counties for Arizona, New Hampshire, and Pennsylvania will also see a double-digit decline, while seven other FFM states are expecting single-digit decreases.

By contrast, consumers in Anchorage will see benchmark rates spike by 28 percent, consistent with Kaiser’s findings and earlier state insurance department figures (see Update for Week of September 8th). However, the \$381 average benchmark premium for a 40-year old will still be lower than comparable premiums for the largest counties in states like Mississippi (see above) and Wyoming. Kansas is the only other FFM state expecting a double-digit jump in benchmark premiums for its largest county (up 13 percent to \$203 for a 40-year old). Benchmark rates will increase by single digits for the largest counties in 16 FFM states.



Despite the wide variation among states, the overall benchmark premium among the largest county for all states will remain unchanged at a national weighted average of \$251 per month.

Loss of DSH payments could close 225 hospitals in states refusing to expand Medicaid

Researchers from Tulane University and the Georgia Health Policy Center published a new study this week showing that 225 of the nation's most vulnerable hospitals are likely to close or drastically cut indigent care services over the next decade if they continue to refuse to expand Medicaid pursuant to the Affordable Care Act (ACA).

Roughly \$35.1 billion in federal disproportionate share (DSH) payments for indigent care will start being phased out in 2017, as Congress initially anticipated that all states would be expanding Medicaid under the ACA for everyone earning up to 138 percent of the federal poverty level (FPL). However, the U.S. Supreme Court decision allowing states to opt-out of the expansion meant that millions would be ineligible for Medicaid for the ACA subsidies to help purchase Marketplace coverage, which are not available to those earning less than 100 percent of FPL.

The study found that up to 30 million Americans will be caught in this coverage gap for the 22 states currently not participating in the Medicaid expansion. However, safety net hospitals will no longer be receiving the same level of DSH payments after 2016 for treating exceptional numbers of these uninsured patients, forcing them to potentially lose millions of dollars in these opt-out states.

Researchers analyzed more than 2,100 acute care hospitals nationwide and identified 551 that are "highly dependent" on DSH payments, including 225 that are in "weak financial shape" and not likely to survive if they are forced to incur higher uncompensated care costs.

The report also noted that at least two states (Florida and Texas) have state funding programs for indigent care through federal demonstration waivers that are set to expire before 2017. The Centers for Medicare and Medicaid Services (CMS) has hinted that they may not renew these indigent care waivers unless each state participates in some form of the ACA expansion of Medicaid.

A separate study by Florida Legal Services warned that a single hospital in Florida's largest county (Jackson Health System in Miami-Dade) stands to lose up to \$570 million per year if Florida's Low-Income Program (LIP) funding was not renewed and another \$75 million per year once federal DSH payments are phased out—a potentially crippling blow for a hospital system that already incurs \$85 million in annual uncompensated care costs. Other Miami-Dade hospitals could lose a combined \$60 million per year while hospitals in nearby Broward, Palm Beach, and Monroe Counties could together lose more than \$500 million per year.

The Florida Legal Services report stressed that the \$5 billion that Florida would annually receive in ACA matching funds would far offset the state's loss of \$240 million per year in federal DSH funds and \$1.8 billion in LIP funds.

The future loss this critical funding has caused many Florida Senate Republicans led by Senators Joe Negron and Rene Garcia to continue pushing for legislation that would create a "private sector" alternative to the ACA expansion similar to the model federally-approved for five states. However, the more conservative Republicans in the House remain adamant that they will not accept any ACA funds to expand Medicaid (see Update for Week of November 3rd).

California

Covered California expects 43 percent enrollment bump in 2015, despite decline in Medi-Cal



Covered California officials estimated this week that enrollment in health insurance through the individual Marketplace created pursuant to the Affordable Care Act (ACA) will increase by 43 percent during the second open enrollment period that starts November 15th.

More than 1.2 million consumers used Covered California to enroll in health coverage during the initial six-month open enrollment period, by far the most of any state. Officials project that 500,000 more individuals will enroll during the upcoming three-month period

California's participation in the Medicaid expansion under the ACA has added 2.7 million enrollees since October 2013, an increase of 31 percent. California now has 11.3 million residents in Medi-Cal, or roughly 30 percent of the entire state population.

Medi-Cal enrollment figures are expected to drop by roughly 2.5 million over the coming months as enrollees decide not to renew for a variety of reasons, including declining unemployment numbers. Less than 60 percent of Medi-Cal enrollees are renewing coverage, less than the 70 percent rate Medi-Cal experienced in previous years.

Delaware

Marketplace announces modest premium increases, new plan options

The Department of Health and Social Services revealed this week that it has approved an across-the-board rate hike of 3.99 percent for individual health plans offered in the state-partnership Marketplace that Delaware operates pursuant to the Affordable Care Act (ACA). Rates will increase by 3.6 percent for small group Marketplace plans.

State officials stressed that the modest increases are but a fraction of the double-digit rate hikes in the individual and small group market before the ACA was enacted. In addition, the 3.99 percent increase is well below the 5.6 percent national average found by PricewaterhouseCoopers (see above).

The rate announcement comes as good news to most Marketplace consumers in Delaware. Obama Administration figures showed that average post-subsidy Marketplace premiums in Delaware were the third-highest in the nation to very limited competition (Highmark dominates more than 83 percent of the Marketplace). According to the Government Accountability Office, Delaware was one of only seven states that offered only 11-25 plan options in their Marketplace (see Update for Week of September 29th).

Delaware has still been able to enroll about 21,750 consumers into individual Marketplace plans (see Update for Week of August 18th). This exceeded the federal target of 8,000 but was well below Delaware's goal of enrolling 35,000 of the state's 90,000 uninsured residents into private Marketplace plans during year one.

The Obama Administration certified 23 individual Marketplace plans for next year (up from 19 in 2014) and 16 small group plans (up from 11). As with 2014, only one platinum plan will be offered (see Update for Week of August 18th). The individual version of the ChooseHealth Delaware Marketplace will have essentially the same three participating insurers for 2015 and Highmark will remain the only insurer serving the small group version.

Florida

CIGNA settles with insurance commissioner over HIV drug discrimination

The Office of Insurance Regulation (OIR) announced this week that CIGNA has agreed to reduce the out-of-pocket costs that Floridians must pay for HIV medications, settling a discrimination complaint filed last spring by The AIDS Institute (TAI) and National Health Law Program (NHeLP).



The two advocacy groups filed a similar discrimination complaint with the U.S. Department of Health and Human Services (HHS), documenting that four Marketplace insurers including CIGNA were moving all drugs for costly conditions like HIV or Hepatitis C into specialty tiers that require consumers pay 40-50 percent or more of the drug's total cost (see Update for Week of June 2nd). They insisted that these practices violate the non-discrimination provisions of the Affordable Care Act (ACA), which ban health plans from discriminating based on health status or discouraging enrollment of those with significant health needs.

Under the terms of the consent order, CIGNA will avoid litigation by setting a \$200 per month limit on the amount that consumers must pay for commonly prescribed HIV drugs like Atripla, Complera, Stribild and Fuzeon. CIGNA will also place all generic HIV drugs into a lower cost "generic" tier, and eliminate the 30-day supply limit, as well as other burdensome prior authorization and step therapy requirements for these drugs.

The consent order also requires CIGNA to meet with TAI, NHeLP, and the AIDS Healthcare Foundation to address HIV drug affordability and access issues (although none of the groups are parties to the order).

TAI praised the settlement as "progress" but insisted that it did not go far enough. For example, some widely-prescribed drugs like Truvada were not included in the list of drugs with a \$200 co-payment. TAI also stressed that the settlement applies only to CIGNA's Marketplace plans in Florida and did not end HHS' investigation into similar practices by other Florida insurers or in other states like Illinois.

One of the three other insurers that TAI's complaint identified in Florida (Preferred Medical) indicated that they were likely to make changes in 2015 that would distribute HIV drugs more broadly across several cost-sharing tiers. However, Coventry and Humana have yet to respond.

Idaho

Idaho becomes first GOP-controlled state to create its own ACA Marketplace

Idaho became the only state this week to move from a federally-facilitated to a state-based Marketplace for 2015, as well as the lone state fully under Republican control to create their own Marketplace under the Affordable Care Act (ACA).

Governor Butch Otter (R) fought for approval to use the \$35 million federal grant he obtained to build the Marketplace, despite the resistance of conservative lawmakers to any ACA implementation. However, the Governor convinced a majority of the Republican-dominated legislature that it was in the state's best interest to control their own Marketplace instead of allowing the federal government to do so (see Update for Week of March 11, 2013).

Idaho defaulted to federal control during 2014 only because the legislative authorization for a state-based Marketplace (SBM) came too late in 2013 for the state to design and test its own information technology infrastructure (see Update for Week of August 12, 2013). The flawed rollout of the federally-facilitated Marketplaces (FFM) convinced lawmakers that creating their own version was the better option.

The delay allowed Idaho to proceed at a slower pace and allow consumers to start window-shopping for 2015 plans six weeks before the November 15th start of the second open enrollment period. This feature has already drawn interest from more than 50,000 consumers.

The FFM failures did not deter more than 76,000 consumers from enrolling in Idaho's FFM during the first year, which represented more than 125 percent of their initial projected total as of March 2014—a performance exceeded only by California (see Update for Week of March 10th). Idaho officials expect the Marketplace to ultimately enroll up to 165,000 consumers.



Idaho's decision to move to a state control could result in a huge positive impact for consumers if the U.S. Supreme Court invalidates ACA subsidies for FFM consumers (see Update for Week of November 3rd). More than 80 percent of consumers in Idaho's initial FFM were eligible for the premium tax credits.

In addition, the state version of the Marketplace will charge insurers only a 1.5 percent fee to fund operations instead of the 3.5 percent surcharge imposed while the Marketplace was under federal control. Savings from this lower fee are expected to at least partly be passed on to consumers.

The state's dominant health insurer, Blue Cross of Idaho, supported the transition to state control and provided input into the new Marketplace design. Blue Cross will be joined in the SBM by the same three insurers that participated in last year's FFM, as well as new non-profit cooperative (Mountain Health Co-Op) that was created with ACA loans and garnered more than 12,000 consumers last year in Montana's FFM (see Update for Week of June 23rd). The Co-Op is offering most of the lowest-priced options in the new SBM.

The five health plans will offer a total of 198 plan options, or 52 more than were available in the last year's FFM.

The New Mexico Marketplace will also transition to full state control, but not until 2016 (see Update for Week of July 28th). Two state-based Marketplaces (Nevada and Oregon) were forced to default to the FFM web portal at least for 2015 due to persistent software flaws (see Update for Week of June 2nd). However, officials in each state emphasized this week that they are still designated as state-based Marketplaces by the federal Centers for Medicare and Medicaid Services and thus would not be adversely impacted by a U.S. Supreme Court decision terminating ACA subsidies for FFMs (see Update for Week of November 3rd).

Iowa

Medicaid expansion cuts uninsured burden for hospitals by nearly half

The Iowa Hospital Association (IHA) reported this week that the Iowa's Medicaid expansion has already cut the number of uninsured hospitalizations by 46 percent during its first six months. In addition, it has reduced charity care costs by 18.5 percent (or \$32.5 million), as well as lowered overall hospital admissions and emergency room use by 4.4 and one percent respectively.

IHA had pushed vigorously for newly re-elected Governor Terry Branstad (R) to make Iowa the fifth state to receive federal approval for a "private sector" alternative to the Medicaid expansion under the Affordable Care Act (see Update for Week of December 9th). The Governor's Iowa health and Wellness Plan went into effect on January 1st and used ACA matching funds to already purchase Marketplace coverage for 110,000 previously uninsured Iowans.

The Heritage Foundation and other expansion opponents did not dispute IHA's figures. They instead insisted that expanding Medicaid was not the best route to covering the uninsured population and criticized the Obama Administration for not requiring those made newly-eligible to hold full-time jobs if they are working age and "able-bodied". Republican governors in Michigan, Pennsylvania, and Utah were unable to put such work requirements in their comparable alternative plans, although all of them (including Iowa) offer enrollees state help to find a job (see Update for Weeks of October 20th and 27th).

Kansas

Election results do not deter hospital association from pushing Medicaid expansion alternative

The Kansas Hospital Association (KHA) insisted this week that it will continue to move forward and press state officials to participate in the Medicaid expansion under the Affordable Care Act (ACA),



despite last week's election results that decreased the odds of any form of expansion clearing the legislature.

Governor Sam Brownback (R) had refused to consider both the traditional expansion and any of the "private sector" alternatives that have been federally-approved for five states and the Republican-dominated legislature had barred any expansion through June 2015 (see Update for Week of January 13th). House Minority Leader Paul Davis (D) had pledged to seek a "private sector" alternative if elected, given that it had the support of several Republican lawmakers including House Speaker Ray Merrick (R). However, Rep. Davis not only failed to prevail over Brownback but Democrats narrowly lost several House seats to conservative challengers that promised to block any expansion in the future.

Despite the setback, KHA remained undeterred in its determination to persuade the legislature to expand before 2017, when federal disproportionate share payments for treating indigent patients start to be phased out (see above). KHA cited an Urban Institute study showing that Kansas stood to lose more than \$2.6 billion in federal funds from 2013-2022 if they fail to participate.

The plan backed by KHA would use these federal matching funds provided by the ACA to instead cover those newly-eligible for Medicaid in existing Medicaid managed care plans under KanCare. Governor Brownback has already transitioned most Medicaid enrollees into these private KanCare plans, so KHA insists that such a model would be the best fit for the state.

New York

Marketplace premiums to rise by 4.5 percent average or half of pre-ACA increases

The Department of Financial Services (DFS) revealed this week that average 2015 premiums will rise by 4.5 percent for the individual Marketplace created pursuant to the Affordable Care Act (ACA) and 6.7 percent for the small group version.

State officials stressed that the rate increases are less than the national average of nearly six percent (for individuals) reported by PricewaterhouseCoopers (see above) and 50 percent below the average premium hikes in the individual and small group markets before the ACA was enacted. In addition, copayment and deductibles for the Marketplace will remain flat.

Monthly premiums for individual NY State of Health plans will range from \$131 for MVP Health's catastrophic plan in the Rochester area to \$1,207 for Oxford-OHP's platinum plan in New York City, the Hudson Valley, and Long Island. Premiums double for couples and will be 2.85 times higher for families.

DFS officials used their authority as an "active purchaser" to reduce proposed rates for both Marketplaces by more than half (see Update for Week of September 8th).

NY State of Health will have 16 participating insurers offering individual coverage for 2015, second only to the 17 offering plans in Michigan's federally-facilitated Marketplace. Only one insurer dropped out from last year (American Progressive) while insurer giant Wellcare is being added—a move expected to greatly increase competition and put downward pressure on rates.

Nine insurers will participate in the small group version of NY State of Health. EmblemHealth will be replacing Oxford Health Plan, the only insurer to leave.

More than 370,600 New Yorkers enrolled in private NY State of Health plans last year, while an additional 590,000 used the Marketplace to sign-up for Medicaid or the Children's Health Insurance Program (CHIP).

NY State of Health officials insist that the Marketplace web portal is operating smoothly this year after initial glitches at the start of the inaugural open enrollment period took several weeks to be



corrected. Page load times are now averaging only 2.5 seconds and the website has been upgraded for 2015 to include a tax credit calculator and Spanish-language version.

A Harris poll of 250 individual NY State of Health consumers conducted for the New York State Health Foundation found last month that 92 percent were satisfied with their coverage with 84 percent already using it to obtain medical care. However, nearly 25 percent did report some difficulty getting physicians to accept them as a new patient.

Ohio

Medicaid expansion buttressed by \$470 million lower cost for entire program

The Office of Health Transformation for newly re-elected Governor John Kasich (R) announced this week that the total cost of the Medicaid program in the current two-year state budget is expected to be \$470 million less than initially anticipated.

The Governor's office largely attributed the lower costs to a decline in traditional Medicaid enrollment following the January expansion of Medicaid pursuant to the Affordable Care Act. The decrease was likely due to an improving state economy, which increased household incomes to the point where applicants either qualified through the expansion (for those earning up to 138 percent of poverty) or now made too much to be Medicaid-eligible.

Enrollment of newly-eligible through the Medicaid expansion has already exceeded estimates by more than 100,000 (see Update for Week of November 3rd). The prospects of securing the required annual reauthorization from the legislature could be buttressed by the unanticipated savings—\$350 million of which represents the state's share.

Texas

Governor's medical board recommends Medicaid expansion

A board of medical professionals appointed by Governor Rick Perry (R) recommended this week that Texas participate in some form of the Medicaid expansion under the Affordable Care Act (ACA).

Stating that it was "unacceptable" to leave one-quarter of state residents uninsured, the 15-member Texas Institute of Health Care Quality and Efficiency urged the legislature to let the commissioner of the Health and Human Services Commission (HHSC) negotiate a "private sector" alternative to the expansion similar the model that has been federally-approved for five states and proposed by at least three others (see Wyoming below). Under legislation passed during the last session in 2013, the commissioner is currently prohibited from doing so without legislative approval.

More than one million Texans currently fall into a "coverage gap" as they are ineligible for Texas' bare-bones Medicaid program but earn below 100 percent of the federal poverty level—the threshold for ACA subsidies to purchase Marketplace coverage. Both Republican and Democratic lawmakers proposed legislation last session that would have created a "private sector" alternative using ACA matching funds to cover the newly-eligible population in the federally-facilitated Marketplace (FFM). However, Republican leaders in both chambers have steadfastly opposed any alternative that accepts federal funds, as has outgoing Governor Perry. Governor-elect and current Attorney General Greg Abbott (R) has also shown no inclination to expand, insisting that it would "bankrupt" Texas.

The board is comprised of executives from some of the state's leading hospitals (including Baylor Scott and White Health System) that stand to lose millions in uncompensated care if Texas continues to opt-out after federal indigent care funds start phasing out in 2017 (see above). However, its recommendations are not binding on lawmakers or state officials.



Wyoming

Governor to release details of Medicaid expansion alternative, claims federal approval is near

Newly re-elected Governor Matt Mead (R) announced this week that he is nearing agreement with the Obama Administration on a Medicaid expansion alternative similar to that federally-approved for five states.

The waiver proposed by the Governor would allow Wyoming to ensure that the newly-eligible population has some “skin in the game” by requiring premiums and deductibles across-the-board, as well as a “workforce development” requirement. Governor Mead did not release specific details other than to insist that the cost-sharing and work provisions go beyond those that Centers for Medicare and Medicaid Services (CMS) officials have approved for other states.

The governors of Pennsylvania and Utah had to recently relax similar work search requirements in order to secure federal approval for their plans (see Update for Weeks of October 20th and 27th). In addition, CMS previously allowed only nominal premiums for Medicaid enrollees earning more than 100 percent of the federal poverty level.

Governor Mead has directed the Department of Health (DOH) to release a report in the coming weeks detailing his Medicaid expansion discussions with CMS. DOH and the Wyoming Hospital Association have backed the alternative, issuing studies showing Wyoming would save \$50-200 million per year from participating in some form of the Affordable Care Act (ACA) expansion (see Update for Week of August 18th).

Mead’s proposal ultimately requires legislative approval as the Republican-controlled legislature blocked state officials earlier this year from accepting federal funds for any expansion. They also rejected a similar “private sector” alternative (see Update for Week of February 10th). However, they did allow the Governor to continue negotiating with CMS and will consider any federally-approved proposal when the Joint Interim Labor, Health and Social Services Committee next meets in mid-December.