



Health Reform Update – Week of January 5, 2015

CONGRESS

House votes to increase threshold under employer mandate

The 114th Congress convened this week with Republicans in control of both legislative chambers for the first time since 2006. Republican leaders wasted little time in resurrecting stalled legislation from last session that would alter, impede, or repeal certain provisions of the Affordable Care Act (ACA).

Raising the threshold for applying the employer mandate was their first priority. As of January 1st, employers with at least 100 workers must provide minimum essential coverage to at least 70 percent of employees that work 30 or more hours per week, or pay a per employee assessment. The mandate has been delayed until 2016 for those with at least 50 workers (see Update for Week of February 10th), a move that resulted in an unprecedented federal lawsuit by House leaders (see Update for Week of December 1st).

Twelve House Democrats joined with every Republican in passing H.R. 30 this week, which would increase the threshold from 30 to 40 hours per week. A similar measure (H.R. 2575) passed the House last year with the support of 18 Democrats in competitive races (see Update for Week of March 31st), seven of whom did not return to the new Congress.

The Senate Health, Education, Labor, and Pensions Committee will hold a hearing on the measure on January 22nd. Newly-installed Majority Leader Mitch McConnell (R-KY) pledged that the Republican-controlled Senate would bring the measure to a floor vote, where it currently has the backing of two conservative Democrats (Joe Manchin of West Virginia and Joe Donnelly of Indiana). However, it will need the support of additional Democrats to gain the 60 votes necessary to overcome a filibuster.

Passage is far from certain as the Congressional Budget Office projected this week that H.R. 30 would increase the federal budget deficit by \$53.2 billion over the next ten years as one million fewer Americans will receive employer-sponsored coverage, pushing half of those individuals into government programs and leaving the other half uninsured.

For these reasons, President Obama has pledged to veto the measure. H.R. 30 fell well short of veto-proof majority needed in the House, but Republicans are hoping that pressure from business groups may force him to reconsider.

Republican leaders largely dismissed the CBO estimate, using it as further justification to replace Doug Elmendorf as director for the non-partisan agency. Elmendorf had been generally praised by members of both parties, but recently drew the ire of Republicans for repeatedly downgrading CBO's initial cost estimates for the ACA. Elmendorf was appointed by a Democratic Congress and his rumored replacements all work or formerly worked for Republican members or conservative think tanks.

The new House unanimously passed a related measure this week (H.R. 22), which automatically excludes employees with health coverage through the departments of Defense or Veterans Affairs from the employer mandate calculations. A similar measure passed with only one dissenting vote last year but was never considered in the Democratically-controlled Senate.

While CBO also estimated that H.R. 22 would increase the deficit (by \$858 million over 11 years), it is not expected to increase the number of uninsured Americans as would H.R. 30.



Republicans renew push to repeal ACA insurer “bailout”

Senator Marco Rubio (R-FL) and Rep. Andy Harris (R-MD) promptly reintroduced stalled legislation this week, which would fully repeal the three-year reinsurance and risk corridor program under the Affordable Care Act (ACA)

The *Obamacare Taxpayer Bailout Prevention Act* (S.123/H.R. 221) would halt ACA payments to insurers that incur exceptional numbers of costly claims from 2014-2016. This program, which has the strong backing of America’s Health Insurance Plans, was intended to mitigate risk and prevent “rate shocks” that could result from shifting large number of subscribers with pre-existing conditions into the risk pools for private Marketplace plans.

However, Senator Rubio has been among the handful of Republicans insisting that such payments constitute an insurer “bailout” intended to “protect the profits of the insurance companies that helped write ObamaCare.” The measures were originally introduced in late 2013 (S.1726/H.R. 3541) after the Administration broadened the thresholds for the \$25 billion program to account for greater numbers of individuals being allowed to remain in ACA-deficient plans (see Update for Weeks of January 20th and 27th).

Other anti-ACA measures that were resurrected this week include S.16, legislation introduced by Senator David Vitter (R-LA) to prevent members of Congress and their staff from receiving subsidized Marketplace coverage (see Updates for Weeks of October 6th and 13th). Senator Vitter is also seeking to apply the federal anti-kickback statute to private Marketplace plans (S.97), contrary to the stated intent of the Department of Health and Human Services (see Update for Week of June 2nd).

Latest Gallup poll finds uninsured rate hits new record low

The latest survey from Gallup, Inc. found that the percentage of all adults that lack health insurance dropped to an average of 12.9 percent in the fourth quarter of 2014, the lowest since Gallup first started tracking uninsured rates in 2008.

The latest result is 0.5 percent lower than the third quarter of 2014 and 4.2 percent below the uninsured rate before the new health insurance Marketplaces began offering coverage pursuant to the Affordable Care Act (ACA). The rate for adults aged 18-64 fell from 20.8 percent in the fourth quarter of 2013 to 15.5 percent for the same period in 2014.

The results mesh with earlier findings from the Centers for Disease Control and Prevention, which found last fall that the rate of uninsured for adults under age 65 stood at the lowest level the agency has recorded since it first tracked such data in 1997 (see Update for Week of September 15th).

Gallup’s findings showed that African-Americans experienced the largest drop in uninsured (seven percent), while those earning less than \$36,000 per year were close behind (6.9 points). Latinos continued to have the nation’s highest uninsured rate (32.4 percent), despite a decline of 6.3 percent over the past year.

Young adults aged 18-25 saw a 6.1 percent drop from the last quarter of 2013 to the same period in 2014, while the rate for those aged 35-65 fell by 5.3 percent. Only two percent of those over age 65 remain uninsured, the same percentage as before the ACA.

Gallup predicts a further decline in the uninsured rate for 2015 as additional states expand Medicaid, as well as the impact of large employers with at least 100 workers being required as of January 1st to offer coverage to at least 70 percent of their workforce or pay fines (see above).



HHS reports that 2015 Marketplace enrollment has broken seven million

At least 7.1 million consumers have enrolled in Marketplace coverage since the 2015 open enrollment period started on November 15th, according to figures released by the Department of Health and Human Services (HHS) last week.

The data includes new sign-ups, those actively re-enrolling in a plan, and 2014 customers that allowed their coverage to automatically renew. It reflects enrollment in both federally-facilitated Marketplaces (FFMs) and state-based Marketplaces (SBMs) as of January 2nd.

The vast majority (6.6 million) have enrolled via one of the 37 FFMs. More than 8.4 million have submitted applications through the FFM, with roughly 35 percent of all FFM users using the Spanish-language interface (CuidadoDeSalud.gov). The figures pale in comparison to the mere 106,000 consumers that selected FFM coverage during the first month of 2014 open enrollment, when technological glitches severely impaired the web portal and delayed the start of the Spanish-language version (see Update for Week of November 11, 2013).

According to HHS, more than two-thirds of FFM enrollees for 2015 have selected silver-level plans to which the ACA premium subsidies are tied. About 87 percent of FFM consumers have qualified for premium subsidies (or up to 94 percent in states like Florida), higher than the comparable figure for 2014 (see Update for Week of March 31st). However, these subsidies will be lost if the U.S. Supreme Court rules they were not intended by the ACA following oral arguments now set for March 4th (see Update for Week of November 3rd).

RAND Corporation estimated this week that invalidating the ACA subsidies for FFM consumers would lower enrollment in all ACA-compliant plans (in and out of the Marketplace) by 70 percent (or 9.6 million people) in FFM states. This would cause premiums in the ACA-compliant individual market to spike by 47 percent in FFM states (or a \$1,610 annual increase for a 40-year old nonsmoker purchasing a silver-level plan).

Despite increased marketing and outreach efforts targeting young adults and Latinos, their participation rates have remained largely the same as last year. Young adults aged 18-34 represent only 24 percent of 2015 enrollment, slightly down from the final tally for 2014 but higher than the 23 percent figure for the first three months of the inaugural open enrollment period. Latino enrollment is slightly higher than that three-month period last year (eight percent compared to seven percent), while African-American enrollment is below last year 11 percent instead of 14 percent).

The Mississippi FFM had the highest percentage of new consumers at 58 percent, while FFMs in Alaska, Maine and North Dakota lagged at the rear with only 39 percent.

In stark contrast to the inaugural open enrollment period, FFM enrollment far outweighs SBM enrollment, with Florida leading all states by a wide margin (enrolling more than 673,250 by December 18th). California, which led all states last year with more than 1.4 million enrolled, added only 144,000 Marketplace consumers by December 15th, while New York signed-up 83,100 through December 20th.

Some SBMs are performing better than year one. Washington is already half-way to its 2015 enrollment goal with 107,000 enrollees by the end of December. States such as Maryland and Massachusetts that were plagued with technological glitches until their web portal software was replaced last summer have already exceeded their 2014 totals.



The HHS Secretary insisted that the figures show that overall Marketplace enrollment is likely to exceed the agency's target of 9.1 million consumers by the February 15th end of open enrollment.

CMS will investigate discriminatory drug plans

According to the *New York Times*, the Centers for Medicare and Medicaid Services (CMS) has agreed to investigate whether certain Marketplace plans are unlawfully discriminating against enrollees with costly illnesses like HIV/AIDS by moving all drugs for their condition into specialty tiers that impose unaffordable cost-sharing levels.

The investigation responds directly to a civil rights complaint filed with the agency by The AIDS Institute and other consumer groups last spring (see Update for Week of June 2nd). The complaint alleged that "discriminatory benefit designs" used by a handful of Marketplace insurers in states like Florida and Illinois violated the anti-discrimination provisions of the Affordable Care Act (ACA) by effectively barring access to care for certain pre-existing conditions. Three Florida insurers have already limited or moved away from specialty tier coinsurance in order to settle a similar complaint filed by TIA with that state's Office of Insurance Regulation (see Update for Week of December 15th).

Advocates were pleased that CMS already agreed in a recent proposed rule that plac[ing] most or all drugs that treat a specific condition on the highest cost tiers [can] effectively discriminate against, or discourage enrollment by, individuals who have those chronic conditions" (see Update for Week of December 1st). The agency has further committed to challenging any benefit restrictions such as arbitrary age limits that are not rooted in "clinically indicated, reasonable medical management practices."

As part of its investigation, CMS reportedly will inspect benefit designs offered by FFM insurers. It will calculate "estimated out-of-pocket costs associated with standard treatment protocols for specific medical conditions using nationally recognized clinical guidelines", which are likely to include HIV/AIDS, bipolar disorder, diabetes, rheumatoid arthritis, and schizophrenia.

However, the agency's 2016 plan certification guidance (see below) emphasizes that the enforcement against discriminatory benefit designs remains largely a state regulatory decision. The letter does encourage states to prevent issuers from placing all medications that treat a specific condition on their highest-cost drug tiers.

CMS issues plan certification guidance to federally-facilitated Marketplaces

The Centers for Medicare and Medicaid Services (CMS) released draft guidance in late December clarifying plan certification requirements for federally-facilitated Marketplaces (FFMs) during the 2016 open enrollment period.

Several FFMs where states have been allowed to retain control over certain plan management functions may diverge from the requirements set forth by CMS, but all of the other states that continue to default fully or partly to the FFM must comply. The letter sets the initial window for qualified health plan (QHP) applications from March 16th to April 15th of this year, with final certification to be completed from August 17th to September 15th. The open enrollment period for 2016 is set to begin on October 1st (as opposed to November 15th for this year).

For 2016, CMS will continue to rely on a "reasonable access" standard to "identify networks that fail to provide access without unreasonable delay." In its certification and re-certification review, CMS will focus "most closely on those areas which have historically raised network adequacy concerns," such as hospital systems, mental health facilities, and oncology and primary care providers.



CMS expects to apply the same heightened adequacy standard as 2015, which requires QHPs to contract with at least 30 percent of available essential community providers in each plan's service area (see Update for Weeks of March 17th and 24th).

If CMS determines that a QHP network is inadequate, it will notify the issuer and request that the problem is addressed by either adding providers or submitting a justification explaining how "reasonable access" will be provided. The agency notes that it continues to receive input from the National Association of Insurance Commissioners on appropriate standards for network adequacy.

Proposed rule gives employers the option of providing wraparound coverage for individual plans

The departments of Health and Human Services (HHS), Treasury, and Labor issued proposed rules last month that would amend the definition of "excepted benefits" to allow limited wraparound coverage for individual plans offered in and out of the Affordable Care Act (ACA) Marketplaces.

The change comes in response to public comments submitted by unions and retailers in response to prior rulemaking. The rule specifically would give group health plan sponsors the option provide wraparound benefits that supplement those provided under individual health insurance purchased by the employee. They are intended to help employees who cannot afford their employer coverage or do not have access to comprehensive benefits through an employer plan.

Two pilot programs would be created under the rule. The first would allow wraparound benefits only for multi-state plans offered in the Marketplace. The second would allow wraparound benefits for part-time workers who otherwise qualify for flexible spending accounts (FSA) and enroll in an individual market plan. However, under both options, wraparound coverage can only provide benefits that are not likely to be included as essential health benefits mandated by the ACA.

If finalized, both pilots would provide excepted benefits to coverage first offered no later than December 31, 2017. It would end either three years after the day wraparound coverage is first offered or the date when the last collective bargaining agreement relating to the plan ends after the day wraparound coverage is first offered (whichever is later).

Wraparound benefits must meet several requirements outlined in the proposed rule. First, individual plans are not eligible if they grandfathered or transitional plans that remain exempt from ACA consumer protections (see Update for Week of March 3rd). Second, the wraparound coverage must offer "meaningful benefits" beyond just cost-sharing. Furthermore, the annual cost of coverage per employee and any covered dependents cannot exceed \$2,500 (the maximum annual contribution for health FSAs). The others relate to non-discrimination based on pre-existing condition, health status, and income.

HHS proposes changes to required benefit summaries

The Department of Health and Human Services (HHS) issued proposed rules in late December to streamline the summary of benefits and coverage (SBC) required for Marketplace plans under the Affordable Care Act (ACA) in an effort to make them more "user friendly".

The template requirements were first finalized by HHS in 2012. The upgrades include new information designed to let consumers better understand cost-sharing charges for both emergency and non-emergency situations, and are based on input receiving during months of consumer testing. Most of the changes are designed to reduce unnecessary duplication and reduce the summaries from four to 2.5 double-sided pages.

Comments are due through February 22nd. If finalized, the new summaries would be implemented on or after September 1st.



Late surge brings FDA approvals to 18-year high, biosimilars may lead to higher total for 2015

At late surge in drug approvals by the Food and Drug Administration (FDA) brought the 2014 total to 41, the highest level since 1996 and a 52 percent increase from 2013.

New treatments for rare diseases made up nearly 40 percent of 2014 approvals, the highest number recorded since passage of the *Orphan Drug Act* in 1983. The agency expedited a number of reviews this year, with 11 approvals coming through the breakthrough therapy pathway created by Congress in 2012. As a result, median approval times were significantly reduced from 7.9 months to 6.5 months (see Update for Week of December 15th).

The new approval pathway that the Affordable Care Act (ACA) created for generic copies of high-cost biologics may lead to even more approvals in 2015. The FDA's Oncologic Drug Advisory Committee unanimously recommended just this week that the agency approve the first biosimilar product under this pathway, agreeing that the biosimilar filgrastim (manufactured by Sandoz) has "no meaningful clinical difference" from the reference product Neupogen (manufactured by Amgen).

The FDA has until March to decide on the application and disputes over naming, labeling, and interchangeability still need to be resolved absent pending agency guidance. If Sandoz receives approval and prevails in patent litigation filed by Amgen, the market entrance of the first biosimilar is expedited to facilitate pending applications for biosimilar copies of the popular Remicade drug for rheumatoid arthritis and pegfilgrastim (which stimulates the growth of white blood cells).

HEALTH CARE COSTS

Employees continue to pay more for health insurance, despite spending slowdown

The Commonwealth Fund reported this week that consumers are continuing to spend more out-of-pocket for employer-based health coverage despite a slowdown in medical inflation and premium growth.

In every state, employee contributions towards their health insurance costs amounted to a higher share of state median income in 2013 than they did only a decade ago, with workers in 15 states experiencing at least a 100 percent increase. Nationwide, the average employee contribution represented 9.6 percent of median income for those under age 65, compared to 8.4 percent in 2010 and only 5.3 percent in 2003.

No state had an average per-person deductible of more than \$1,000 in 2003. However, researchers found that only three states and the District of Columbia had lower average per-person deductibles by 2013.

The report stressed that health care cost growth has actually declined over the last four years of the decade, falling from an average of 5.1 percent before the 2010 enactment of the Affordable Care Act down to 4.1 percent from 2010-2013. Premiums likewise have grown more slowly, increasing by 5.9 percent per year since 2010, compared to the annual 7.2 percent growth rate from 2003-2010.

However, stagnant wages over the decade have caused premium growth to outpace income growth across the board. In all but 13 states and the District of Columbia, employee health insurance costs accounted for 20 percent or more of the state median income, compared to only two states (New Mexico and West Virginia) in 2003.

Those living in southern states faced the high cost burden, with Floridians spending 12.4 percent of their income for employer-based coverage and Texans spending 12.3 percent (Hawaii had the lowest



at six percent). Average premiums were 25-28 percent of the median income in seven states: Alaska, Arkansas, Kentucky, Nevada, New Mexico, Texas, and West Virginia.

STATES

Marketplace premiums remain stable nationwide

The Commonwealth Fund released a new analysis last week from the University of Chicago showing that Marketplace premiums for individual benchmark plans in 2015 remain constant nationwide, despite double-digit increases in ten states and the District of Columbia. (Benchmark plans are the second lowest-cost silver plans to which premium subsidies are tied).

Researchers called the zero increase “unprecedented”, citing routine double-digit increases in average premiums in the years before the Affordable Care Act (ACA) was passed. It noted that the double-digit hikes in some states were offset by average declines in 14 others. Average deductibles for the benchmark plans increased by only one percent.

The study attributes increased competition from 50 new carriers for holding premiums in check, consistent with the conclusions from earlier studies (see Update for Week of December 1st). It noted that the largest average increase of 31 percent occurred in Alaska, where only two insurers are participating in the Marketplace (see Update for Week of September 8th). By contrast, new entrants in Virginia forced Optima Health to drop a silver-plan option charging \$2,000 per month or more than seven times the average premium in Virginia. That decision was largely credited for causing a 56 percent decline in average Marketplace premiums for that state.

Researchers also attributed lower premiums to the \$25 billion reinsurance and risk corridors program under the ACA, which new Congressional legislation seeks to eliminate (see above). The study directly credits such “risk stabilization programs” for “the increase in insurer participations [that] helps to contain costs.”

Arkansas and Iowa receive more leeway for Medicaid expansion waivers

The Centers for Medicare and Medicaid Services (CMS) notified Arkansas and Iowa officials this week that they have approved amendments to existing waivers allowing them to operate “private sector” alternatives to the Medicaid expansion under the Affordable Care Act (ACA).

The states were the first to experiment with an alternative model that used ACA matching funds to purchase private Marketplace coverage for those made newly-eligible for Medicaid. The amendments will now make both states the first to be able to impose cost-sharing on enrollees earning less than the federal poverty level (FPL) even though CMS had repeatedly rejected similar proposals for other states. Iowa will also be allowed to continue not offering any non-emergency transportation services, despite objections from consumer advocates.

The cost-sharing in Arkansas is part of that state’s move to incorporate health savings accounts, similar to those proposed by states like Indiana and Tennessee (see below). Arkansas will contribute \$10-25 per month to enrollee accounts for those earning 100-138 percent of FPL.

Both Arkansas and Iowa can now charge up to a \$5 monthly copayment for those earning 50-100 percent of FPL (and up to \$10 for those from 100-138 percent of FPL). However, CMS will not allow them to terminate coverage for this population if they fail to make monthly copayments.



Arkansas will be allowed to refuse medical services for those earning 100-138 percent of FPL if they do not make the required copayments. Iowa can terminate coverage for this population if they fail to pay their premium for 90 days (as well as pursue debt collection).

Iowa already imposed premiums on the 100-138 percent of FPL group. Data from the first year showed that only about 13,000 of the 120,000 enrollees in this population took advantage of the wellness programs that negated any premium.

The Arkansas expansion may be in jeopardy after Republican electoral gains last fall (see Update for Week of November 3rd). It requires an annual reauthorization and survived last year by only one vote (see Update for Week of March 3rd).

Arizona

Supreme Court says lawmakers can sue to block Medicaid expansion

The Arizona Supreme Court unanimously ruled this week that the legislature's legal challenge to the state's Medicaid expansion under the Affordable Care Act (ACA) can move forward.

The high-court overruled the earlier dismissal by the Maricopa County Superior Court, which concluded that the 36 Republican lawmakers filing the suit lacked standing, since they were not directly impacted by the program expansion (see Update for Week of February 10th). The case is now remanded back to the Superior Court to decide whether the funding mechanism created for the expansion violates the state constitution.

Governor Jan Brewer (R) was only the second Republican governor to push for a traditional ACA expansion, which restored Medicaid coverage for nearly 240,000 Arizonans and added another 57,000 (see Update for Week of January 14, 2013). Her proposed budget paid for the expansion through a hospital assessment, which the Arizona Hospital and Healthcare Association strongly favored as an alternative to losing hundreds of millions per year in uncompensated care. The Medicaid program estimated that the \$75 million levy was outweighed by \$108 million in savings just during the first six months of 2014 (see Update for Week of September 9, 2013).

The Governor's expansion bill gained only a very narrow majority in the legislature despite intense opposition from conservative lawmakers, which insisted that any tax required a two-thirds supermajority to be enacted. She ultimately prevailed only by following through on her promise to veto all other legislation until the Medicaid expansion was passed (see Update for Week of June 10, 2013).

It is not yet clear whether incoming Governor Doug Ducey (R) will defend the expansion as fervently as Governor Brewer. During his campaign, he supported the right of the lawmakers to "have their day in court" but did not indicate whether he would seek to terminate the Medicaid expansion once elected. However, he appointed a vocal critic of the expansion to serve as policy advisor for healthcare and human services.

California

Emergency regulations address narrow provider networks

The Department of Insurance (DOI) issued emergency rules this week intended to broaden the provider networks offered under Covered California plans.

The rules are in response to findings by the Department of Managed Health Care that Anthem Blue Cross and other insurers in the Affordable Care Act (ACA) Marketplace deliberately misled subscribers about the narrow scope of the provider networks and inaccuracies in their provider directories. Several class action lawsuits over the narrow networks have been filed by consumer



advocates, alleging that the concealment resulted in dramatically higher out-of-pocket costs for subscribers (see Update for Week of September 22nd)

Despite the lawsuits, Covered California insurers have only increased their reliance on narrow provider networks for 2015 (see Update for Week of September 29th). As a result, the emergency regulation specifically imposes new standards for minimum numbers of providers and waiting times for appointments. In addition to requiring accurate directories, it also requires that insurers provide out-of-network care for the same price as in-network care whenever the network has insufficient numbers of providers. Insurers must also report any changes in networks to DOI.

Governor Jerry Brown (D) has already signed legislation (S.B. 964) that will expand state monitoring and enforcement of existing rules for network adequacy in 2015 (see Update for Week of September 22nd).

According to Insurance Commissioner David Jones (D), his office has the authority to ban non-complaint insurers from selling any policies in California next year.

Connecticut

New bills to limit specialty tier coinsurance, change Marketplace structure, increase rate review

Senator Joseph Crisco (D), the chair of the Joint Insurance and Real Estate Committee, filed a flurry of health insurance bills this week at the outset of the 2015 legislative session, all of which will be heard by his committee.

The first measure (S.B. 7) would make Connecticut at least the 31st state to require parity in health insurance coverage of oral anti-cancer medications and those that are intravenously-administered.

Another measure (S.B. 24) by Senator Crisco would prohibit health insurers from creating drug formularies that place a prescription drug in a non-preferred or higher cost-sharing tier unless at least one therapeutically equivalent drug is available in a preferred or lower cost-sharing tier. Insurers also could not make mid-year changes to their drug formularies and must provide consumers with information to more easily compare health plan options.

Other measures include S.B. 9, which would require that the Insurance Department hold public hearings on any request by a health insurer to raise premiums by more than ten percent. S.B. 11 would require the health insurance Marketplace that Connecticut operates pursuant to the Affordable Care Act (ACA) to act as an “active purchaser” and exclude qualified health plans that do not negotiate affordable premiums, instead of the “clearinghouse” model that accepts any qualified health plan meeting ACA standards. S.B. 12 would add an insurance producer to the board of directors governing the Marketplace.

Kentucky

Bills limiting specialty tier coinsurance are introduced in both chambers

Senator Tom Buford (R) introduced companion legislation this week to House measures (H.B. 99, H.B. 146) that would limit copayments or coinsurance for drugs subject to a tiered formulary to no more than \$100 per month for up to a 30-day supply or \$200 per month in the aggregate. All of the measures would allow subscribers to request an exception to the tiered cost-sharing structure and prohibit them from placing all drugs of the same class within a specialty tier (see Update for Week of December 15th). The latter is a practice that has been discouraged by the federal Centers for Medicare and Medicaid Services in response to civil rights complaints filed by consumer advocates (see above).

Minnesota

CMS increases federal grants for Marketplace to upgrade web systems



The Centers for Medicare and Medicaid Services (CMS) announced late last month that the MNSure Marketplace created pursuant to the Affordable Care Act (ACA) would receive a 22 percent upward adjustment to their federal exchange establishment grant.

The \$34 million in new funding is intended to accelerate the information technology development of the MNSure web portal, which has been plagued with software glitches since being implemented in October 2013. MNSure officials announced that they specifically would streamline the premium invoicing process for MinnesotaCare, create a navigator/broker portal, and increase support for critical “back office” functions such as data transmission to insurance carriers and federal partners. It is also expected to use the money to enhance consumer assistance and outreach.

MNSure’s total federal investment is now just over \$189 million, making it the fourth most affordable state-based marketplace (SBM) in the country according to state officials. MNSure is also the only SBM that determines eligibility for qualified health plans, Medicaid, and a state basic health plan, meaning that its technology needs are greater than other state or federal Marketplaces.

Under the ACA, CMS is authorized to adjust an existing grant by up to 25 percent in order to facilitate completion of projects and has done so for ten of the other 14 SBMs.

Despite lingering glitches, MNSure has already enrolled 83,865 residents in some form of health coverage since the 2015 open enrollment period opened, including more than 41,700 in Marketplace plans. These numbers far exceed totals from a year ago and already approach MNSure’s 2015 target of 67,000 in private plan enrollment. As of May 2014, enrolment gains had already reduced Minnesota’s uninsured rate to 4.9 percent, the lowest in state history (see Update for Week of December 15th).

Ohio

Physicians urge governor to cover loss of Medicaid primary care payments under ACA

The Ohio Medical Association is heavily lobbying Governor John Kasich (R) to restore \$630 million in Medicaid reimbursement for primary care physicians that was lost when the temporary payment bump under the Affordable Care Act (ACA) expired on January 1st.

Medicaid physician reimbursement for primary care immediately fell in the state by 43 percent (from \$71.09 per visit to \$40.38) once Medicaid payments were no longer required to equal Medicare. Medicaid patients make up one of every four Ohioans and nearly 40 percent of Ohio physicians have already pledged to stop seeing Medicaid patients are cut back dramatically, unless the funding is restored at the state level.

Just over 10,000 primary care physicians received the temporary enhancement, which the OMA argues was vital to accommodating the 16 percent increase in the Medicaid rolls via the Governor’s decision to circumvent legislative opposition and participate in the ACA’s Medicaid expansion.

Governor Kasich, an expected contender for the Republican Presidential nomination in 2016, has not ruled out seeking supplemental funding, even though he must also protect funding for the expansion that was approved via a state control board (see Update for Week of October 14th). However, the cost of the expansion is expected to be \$470 million less than initially projected over the next two years (see Update for Week of November 10th).

President Obama, Senator Sherrod Brown (D-OH), and leading Democrats had pushed Congress to extend the enhanced physician fees for an additional two years as part of the fiscal year 2016 spending bill, but were rebuffed by House conservatives (see Update for Week of December 8th). Only six states (and the District of Columbia) have moved to provide supplemental funding, at least temporarily, although the largest state of California has decided not to do so despite Medicaid primary care reimbursement of only \$18.10 per visit. The Urban Institute has estimated that Medicaid payments for primary care would



drop by about 43 percent nationwide, but up to 59 percent in states like California that have exceptionally low reimbursement levels.

Tennessee

Governor releases more details for his Medicaid expansion alternative

Governor Bill Haslam (R) released further details this week of his alternative to the Medicaid expansion under the Affordable Care Act (ACA) and announced that he would call a special session in February for the legislature to approve or reject the proposal.

Under the Insure Tennessee plan, roughly 200,000 Tennesseans would gain Medicaid coverage. Children and those aged 19-20 years would still get coverage through traditional Medicaid. However, those aged 21-64 would be required to choose between the Healthy Incentives plan, which imposes new cost-sharing requirements on traditional Medicaid benefits, or a health savings account option that rewards enrollees for healthy behavior. The latter would charge a \$20 monthly premium and variable copayments for those earning above the poverty level, and make minimum state contributions to the accounts that enrollees could use to pay their cost-sharing.

A separate premium assistance option called the Volunteer Plan would subsidize employer-provided insurance for the working poor, so long as the employer agreed to cover at least half of the premium cost.

The Governor obtained a commitment from the state hospital association to support a higher provider tax in order to avoid increasing existing state obligations.

The Insure Tennessee plan must still obtain the required federal waiver. However, officials with the federal Centers for Medicare and Medicaid Services (CMS) disclosed this week that they largely supported the broad strokes outlined by the Governor.