



Health Reform Update – Week of January 19, 2015

CONGRESS

Medicare physician payment fix stalled over old debates on offset

The House Energy and Commerce health subcommittee held a two-day hearing last week to consider proposals to permanently fix to the Medicare physician payment formula.

Congress has postponed the sustainable growth rate (SGR) formula 17 times since it was first enacted in 1997, in order to avoid payment cuts of at least 20 percent. The latest extension expires March 31st (see Update for Week of December 8th).

Measures to permanently repeal and replace the formula (H.R. 4015, S. 2000) were backed by members of both parties last year (see Update for Week of March 10th). However, Republicans and Democrats remain at an impasse over how to offset the cost, which the Congressional Budget Office (CBO) now estimates at \$144 billion over ten years (see Update for Week of December 8th).

House Republican leaders refuse to bring any permanent fix to the floor without offsetting budget cuts. They also want to include increased Medicare premiums for wealthy enrollees, a concept backed by the American Medical Association and President Obama, although Democrats and AARP oppose some proposals that would raise premiums for enrollees earning as little as \$40,000 per year. House Democrats are instead largely seeking to use war savings to offset the cost.

Rep. Michael Burgess (R-TX) was among a handful of subcommittee Republicans suggesting that war savings may be used to pay for part of the total cost. However, there remains disagreement over how much money actually remains in the Overseas Contingency Operations fund.

New Senate bill would repeal individual mandate

The new Senate majority has officially targeted the controversial individual mandate under the Affordable Care Act (ACA) for repeal.

Under Republican control, the House has voted more than 50 times to repeal all or part of the ACA, including several efforts to repeal the law's requirement that everyone must purchase minimum essential coverage that they can afford. It passed legislation last spring to at least delay the penalties under the individual mandate (see Update for Week of March 10th), a measure that is also likely to be resurrected this session.

Previous individual mandate bills were all denied floor votes in the Democratically-controlled Senate after the mandate's constitutionality was upheld by the U.S. Supreme Court (see Update for Week of June 25, 2012). However, S.203 introduced by Senate Finance Committee chairman Orrin Hatch (R-UT) may be the first bill repealing the individual mandate to reach the floor if it can marshal the six Democratic backers needed for the 60-vote majority to overcome a filibuster.

President Obama has already promised to veto any repeal of the individual mandate, which is the lynchpin to the other market reforms under the ACA. Without a mechanism to ensure younger and healthier subscribers enter the risk pool, ACA provisions requiring insurers accept everyone regardless of pre-existing conditions and limit differential premiums would cause rates to spiral upwards. The Congressional Budget Office has already estimated that delaying individual mandate penalties would increase premiums 10-20 percent by 2018 (see Update for Week of March 10th).



For those who do not qualify for one of the 15 exemptions (see Update for Weeks of April 28th and May 5th), the tax penalty for not complying with the individual mandate increased for 2015 to two percent of income or \$325 per person, whichever is higher.

FEDERAL AGENCIES

U.S. Supreme Court remains split on whether providers can sue to increase Medicaid payment

Justices on the U.S. Supreme Court appear to still be divided over whether providers have the legal right to force Medicaid reimbursement rates to keep pace with medical inflation.

The high court heard oral arguments this week in the case of Armstrong v. Exceptional Child Center. Both the U.S. Ninth Circuit Court of Appeals and a lower court had ordered Idaho Medicaid to update their rates from 2006 levels after five providers brought suit against them in 2009 (see Update for Week of September 29th). However, the Idaho Attorney General insists that neither the state nor federal constitutions give private parties the right to enforce federal Medicaid funding laws against states.

Conservative justices Antonin Scalia and Samuel Alito suggested that the courts were not the proper venue for rate disputes, claiming that Congress would have explicitly included such a right into federal Medicaid law if that were its intent. They insisted that the role of ensuring Medicaid payments are adequate rests with the Centers for Medicare and Medicaid Services (CMS).

By contrast, liberal Justices Sonia Sotomayor and Elena Kagan seemed to side with the plaintiffs in pointing out that providers have no other actual recourse but the courts to rectify low reimbursement levels that threaten access, noting the reluctance of CMS to enforce federal Medicaid rules on California or Idaho. Counsel for the provider plaintiffs pointed out that CMS has never once cut off Medicaid funding for non-compliant states. However, Chief Justice John Roberts questioned the “practical significance:” of letting providers challenge rates in court, insisting that “[t]he effect ... will be putting the setting of budget priorities in the hands of dozens of different federal judges.”

The high court previously voted 5-4 to stay out of such disputes, remanding a similar appeal from California health providers back to the Ninth Circuit, which held that states should have “wide discretion” to set Medicaid payments in refusing to block a ten percent Medi-Cal rate cut (see Update for Week of February 20, 2012). The court’s decision is expected to be issued in June.

Deadline for February 1st coverage causes surge in Marketplace enrollment

Enrollment in federally-facilitated Marketplaces (FFMs) jumped last week due to the January 15th deadline for February 1st coverage. More than 400,250 selected coverage in one of the 37 FFMs, far above the enrollment for each of the previous three weeks which topped out at only 163,050 (see Update for Week of January 12th).

The total number of FFM sign-ups for the second enrollment period that started November 15th is now almost 7.2 million people. This figure includes those automatically re-enrolled but does not identify the portion that have actually paid their first month’s premium. Enrollment for both FFMs and state-based Marketplaces is expected to top the 9.1 million target set by the Health and Human Services Secretary once the predicted surge occurs before the final deadline of February 15th.

Florida continues to outpace all other FFMs or SBMs, with nearly 1.3 million consumers selecting a plan. Texas is the only other state approaching one million.



OMB confirms no sequester this year

The Office of Management and Budget (OMB) confirmed this week that across-the-board budget cuts will not be triggered for fiscal year 2015.

The sequester was created by the *Budget Control Act of 2011* and went into effect in 2013 after a Congressional “supercommittee” was unable to agree on equivalent cuts (see Update for Week of February 25, 2013). However, the “cromnibus” spending plan passed by the lame duck Congress in December stayed within the discretionary spending caps, negating the need for the automatic cuts this year (see Update for Week of December 8th).

OIG confirms that CMS did not properly vet Marketplace contractors

A new report from the Department of Health and Human Services (HHS) Office of Inspector General (OIG) has determined that the Centers for Medicare and Medicaid Services (CMS) “did not perform thorough reviews of contractor past performance when awarding two key contracts” for designing and operating the health insurance Marketplaces created by the Affordable Care Act (ACA).

The OIG findings confirm problems that *The Washington Post* first highlighted last year with the lead contractor hired by CMS. The OIG initiated its investigation after CGI Federal was fired by CMS following the failed rollout of the federally-facilitated Marketplace (FFM) (see Update for Week of January 6, 2014) and similarly removed from several glitch-plagued state-based Marketplaces (see Update for Week of February 17, 2014).

The report blamed CMS for failing to follow standard contracting requirements and best practices in awarding FFM contracts, including provisions that limited the number of competing bids and allowed the federal government to assume the responsibility for cost increases. In addition, OIG criticized the agency for not appointing anyone to oversee and coordinate the projects for 33 different contractors that helped build the FFM web portal.

CMS agreed to all of the OIG’s recommendations, which included calls to revise its acquisition guidance to ensure that contractors are adequately vetted assign project coordinators for any future and complex information technology contracts.

STATES

Temporary ACA hike in Medicaid physician payments increased patient access

A temporary boost in Medicaid primary care physician reimbursement under the Affordable Care Act (ACA) has directly increased the availability of physician appointments for enrollees, according to a new study released this week by the Urban Institute and University of Pennsylvania.

The two-year increase made Medicaid physician payments equivalent to Medicare but officially expired on December 31st. It was available to primary care doctors in all states, regardless of whether their state participated in the ACA Medicaid expansion.

According to researchers, the availability of primary care appointments rose by nearly eight points in the ten states surveyed compared to only a single percent among privately insured patients. New Jersey, Pennsylvania, Illinois, and Texas received the greatest increase in Medicaid reimbursement (since their payment levels were the lowest) and consequently saw the largest increase in appointment availability (more than ten percent).



The study did not evaluate whether the pay raise led more doctors to participate in Medicaid. However, the Medicaid expansion in 27 states (at the time of the study) has caused Medicaid rolls to increase by nearly ten million people nationwide.

Republicans blocked a Democratic effort in Congress to extend the temporary increase for another two years (see Update for Week of December 8th). As a result, 14 states have already decided to continue the increase with state-only funds (24 states have reverted back to pre-ACA levels for Medicaid primary care reimbursement). Legislation introduced late last week in Connecticut (H.B. 5493) and Indiana (H.B. 1254) seeks to make those states the latest to preserve the payment increase.

The Urban Institute previously found that the temporary bump under the ACA increased Medicaid primary care payments by an average of 73 percent nationwide (see Update for Week of July 28th). It also warned that without the increase, primary care reimbursement will fall by more than 50 percent in large states like California, New York, New Jersey, Illinois, and Pennsylvania whose Medicaid populations have grown significantly due to the ACA expansion.

Arkansas

New Arkansas governor wants to keep Medicaid expansion, for now

New Governor Asa Hutchinson (R) called on the legislature this week to retain Arkansas' "private option" to the Medicaid expansion under the Affordable Care Act (ACA), at least through 2016.

Arkansas was the first state to gain federal approval for an alternative to the Medicaid expansion (see Update for Week of September 23, 2013). The waiver sought by Governor Don Beebe (D) successfully mollified some Republican opposition to expanding a government-program by using the ACA matching funds to instead purchase private plan coverage in the state partnership Marketplace (SPM). However, Republicans have since assumed full control of the legislature and gained enough votes (75 percent) to terminate the expansion this session, should they so choose (see Update for Week of November 3rd).

Governor Hutchinson did not favor stripping coverage from more than 205,000 Arkansans that have become insured as a result of the expansion. However, he acknowledged that "the phrase 'private option' itself has become politically toxic" and did recommend creating a legislative task force to study how the federal waiver may be changed once it expires on December 31, 2016. Senator Jim Hendren (R), the chair of the State and Public School Life and Health Insurance Task Force, promptly introduced S.B. 96 to create a 16-member task force to develop an alternative plan for 2017.

California

Judge orders Medi-Cal to provide temporary benefits to applicants stuck in backlog

An Alameda County Superior Court judge ordered the Medi-Cal program this week to grant temporary coverage to applicants that have not received an eligibility decision within the 45-day period required by federal law.

California was cited last summer for a nation-leading backlog of more than 900,000 applicants (see Update for Week of July 14th) after technology upgrades were not completed before a surge of applications followed the program's expansion under the Affordable Care Act (ACA). Although the state has since pared down the number of applications exceeding the 45-day window to only 34,000 (see Update for Week of December 8th), consumer advocates led by the National Health Law Program (NHeLP) filed suit seeking to require Medi-Cal to make temporary coverage available to those awaiting a determination (see Update for Week of September 15th).

The court agreed and ordered Medi-Cal to grant temporary benefits to any applicants that appeared to qualify for Medicaid prior to December 1st based on available but unverified information on



income or citizenship. Other applicants must get notices that they have a right to a hearing on their application.

NHeLP had already prevailed in a similar class action filed in Tennessee, where Medicaid was ordered to honor any request for a hearing from an applicant that has waited more than 45 days (see Update for Week of August 25th and September 1st).

New bill would require greater Marketplace transparency for provider networks

With the backing of three consumer groups, Senator Ed Hernandez (D) introduced legislation this week that would force health plans to update their provider lists weekly and make them more widely available online to prospective consumers.

The measure is in direct response to complaints and class actions lawsuits filed against Covered California plans, which were found by the Department of Managed Health Care to have deliberately misled consumers about the narrow scope of their networks during the inaugural open enrollment period (see Update for Week of December 1st). Despite the problems, Covered California plans have only increased their reliance on narrow provider networks for 2015 (see Update for Week of September 29th).

The bill (S.B. 137) would require insurers to update and publish online provider lists weekly, post online whether in-network physicians are accepting new patients, and publicize what languages are spoken by in-network providers. It is supported by Consumers Union, Health Access, and the California Pan-Ethnic Health Network. The California Association of Health Plans has also stated that they are willing to work with lawmakers on the bill when it is heard by the Senate Health Committee in April.

Colorado

Senator renews effort to place restrictions on biosimilar drug substitution

Senator Cheri Jahn (D), vice chair of the Business, Labor, and Technology Committee, resurrected legislation last week (S.B. 71) that would let pharmacists substitute less costly biosimilar copies of brand-name biologics only if the prescribing physician is notified.

Similar legislation was introduced in more than 18 states including Colorado in 2013 with the backing of biotech manufacturers like Amgen and Genentech, but rejected by most legislatures after they were denounced by the Food and Drug Administration and generic drug groups, arguing that they were intended simply to create barriers to competition (see Update for Week of September 9, 2013). However, at least five states have already enacted some type of biosimilar restrictions and Georgia is among the list of states that are pursuing comparable bills this session. A bill in Hawaii (H.B. 254) would take a slightly different approach by establishing a workgroup that would recommend to the legislature how the state should regulate biosimilars.

The regulatory pathway allowing for biosimilar approval was created by the Affordable Care Act (ACA). However, the FDA is still developing rules and guidance governing the process. The first biosimilar is expected to reach the market this year after an FDA advisory panel unanimously recommended its approval earlier this month (see Update for Week of January 5th).

Connecticut

New bills would increase Marketplace transparency, state control over user fees

Senator Kevin Kelly (R), the ranking member of the Insurance and Real Estate Committee, introduced several bills this week that would increase transparency and state control over the health insurance Marketplace created pursuant to the Affordable Care Act (ACA).



Similar to a Democratically-backed measure in California (see above), S.B. 751 would require Marketplace carriers to post accurate and updated directories for their provider networks online. S.B. 753 would require public hearings and prior legislative approval for any assessments and user fees that the Marketplace oversight board wants to impose on participating carriers, while S.B. 754 would set limits on any such assessments and fees.

District of Columbia

New bill would limit cost-sharing for specialty drugs to \$150 per month

Councilmembers Mary Cheh (D) and Anita Bonds (D) introduced legislation this week that would limit cost-sharing for specialty drugs to \$150 per month for up to a 30-day supply. The bill (B21-0032) also would allow a health plan to request that a non-preferred drug be covered under the cost-sharing for preferred drugs, if the prescribing physician determines that the preferred drug (for the same condition) would not be as effective or would have adverse effects for the individual. According to the bill, non-preferred drugs are specialty drug formulary classifications that are subject to limits on eligibility for coverage or impose higher cost-sharing amounts than preferred specialty drugs.

Iowa

Insurance commissioner to liquidate overwhelmed non-profit cooperative

Insurance Commissioner Nick Gerhart (R) announced this week that he will seek a court order to liquidate CoOpportunity Health effective February 28th.

CoOpportunity Health is one 23 non-profit health insurance cooperatives (CO-OP) created by Affordable Care Act (ACA) loans. It enrolled nearly 120,000 consumers in Iowa and Nebraska during its first year in operation, far exceeding projections of only 11,000 enrollees (see Update for Week of January 12th).

However, the success of CoOpportunity Health became its downfall as expenses far outstripped the amount of federal funding available after Congress rescinded the remaining CO-OP funding allocated by the ACA in the bipartisan compromise to avert the so-called "fiscal cliff" (see Update for Weeks of December 24 and 31, 2012). Senator Charles Grassley (R-IA) has already demanded an explanation as to why the Centers for Medicare and Medicaid Services (CMS) denied a request for emergency relief (see Update for Week of January 12th).

The commissioner stressed that with less cash on hand than medical claims it needed to cover, his office had no choice but to seek liquidation since the CO-OP had no expected infusion of new funding until the second half of 2015. While special insurance-guarantee funds will pay outstanding claims, Gerhart urged all remaining customers to switch carriers by February 15th to avoid any gap in coverage.

The liquidation would leave the federally-facilitated Marketplace in Iowa with only one carrier for most of the state (Coventry Health) and two smaller participants in selected counties (Avera Health Plans and Gunderson Health Plan). The loss of a key competitor is very likely to correlate to higher premiums for consumers.

Dominant insurer Wellmark Blue Cross and Blue Shield already sells more than 75 percent of individual health plans in Iowa but has yet to participate in the Marketplace. Without their presence, a survey by The Commonwealth Fund last month found that Iowa is one of only ten states experiencing a double-digit average increase in Marketplace premiums for benchmark silver-level plans (see Update for Week of January 5th). Iowa's 11 percent average rate hike from 2014 contrasts dramatically with the zero percent average increase nationwide for benchmark plans, a differential attributed largely to limited competition (see Update for Week of January 12th).



Despite the failure of CoOpportunity Health, nearly 35,000 consumers had selected Marketplace plans during the 2015 open enrollment period, already topping the roughly 30,000 that signed-up during the inaugural open enrollment period in 2014.

Oklahoma

New bill would limit specialty tier coinsurance to no more than \$200 per month

Rep. Emily Virgin (D) introduced H.B. 1504 this week, which would limit cost-sharing for certain prescription and specialty drugs to \$100 per month for a 30-day supply or \$200 in aggregate per month. As with similar legislation in other states, the measure allows subscribers to request an exception to the tiered cost-sharing structure and prohibits plans from placing all drugs for a given class on a specialty tier (see Update for Week of January 12th).

Vermont

New bill would increase state premium and cost-sharing assistance for Marketplace enrollees

Rep. Paul Poirier (I) introduced legislation this week that would increase the premium and cost-sharing assistance that Vermont provides to qualified health plan (QHP) subscribers in the Affordable Care Act (ACA) Marketplace.

Vermont already supplements the premium tax credits and cost-sharing subsidies provided by the ACA. However, the bill (H.24) would broaden eligibility for the state premium assistance from those earning at or below 300 percent of the federal poverty level (FPL) to 400 percent of FPL, consistent with the ACA threshold. H.24 also would increase eligibility for cost-sharing subsidies from those earning at or below 200 percent of FPL to 400 percent of FPL, or much higher than the 250 percent of FPL threshold under the ACA.

The measure was referred to the House Committee on Health Care.

Virginia

Senator introduces companion to specialty tier legislation

Senator Rosalyn Dance (D) introduced S.B. 1394 this week, which is the companion legislation to H.B. 1948 introduced by Delegate Jennifer McClellan (D) (see Update for Week of January 12th). Both measures would limit cost-sharing obligations for a specialty tier drug to no more than \$100 per month for a 30-day supply, allow subscribers to request an exception to the tiered cost-sharing structure, and prohibit insurers from placing all drugs of the same class within a specialty tier.

Both measures will be heard in their respective committees on Commerce and Labor.

West Virginia

New bill would require evaluations of discriminatory benefit designs under Marketplace plans

Delegate Eric Householder (R) introduced legislation this week that would require the Insurance Commissioner and the West Virginia Health Benefit Exchange to publish details of provider networks for plans offered in the health insurance Marketplace created by the Affordable Care Act (ACA).

H.B. 2215 would specifically let consumers review online the names of all providers and specialists in each network. In addition, the respective websites must identify any coverage exclusions for each category of benefits covered by Marketplace plans, as well as any restrictions on the use or quantity of covered items or services.

The bill also requires that the commissioner and Marketplace provide a description of how prescription drugs are included or excluded from plan deductibles, including an identification of all out-of-



pocket costs that consumers may incur. This includes the “specific dollar amount of any copay or percentage coinsurance for each item or service.”

The online directories must also enable consumers to determine whether a specific drug is included within plan formularies, as well as any clinical prerequisites or prior authorization required.

An additional section of H.B. 2215 would compel the commissioner to report each year to the governor, legislature, and public on whether the essential health benefit packages offered by Marketplace plans employed any “discriminatory practices” and how such practices may have been corrected. It specifically requires the commissioner to assess whether plans “impermissibly impose clinical prerequisites by limiting care available to those who are sicker, or who have a shorter life expectancy.”

Imposing differential reimbursement rates or cost-sharing for covered benefits like prescription drugs is one example of such an impermissible pre-requisite. The Centers for Medicare and Medicaid Services (CMS) and Florida Office of Insurance Regulation have already identified apply specialty tier coinsurance to all drugs for a specific medical condition as an example of unlawful discrimination under the ACA (see Update for Week of January 12th).

The ACA Marketplace in West Virginia is currently operated as a state-federal partnership. Separate legislation introduced this week by Delegate Joe Ellington (R) (H.B. 2216) would prevent any governor from transition the Marketplace to full state control without legislative approval.

West Virginia’s Marketplace is also the only one in the nation with just a single participating insurer. Highmark increased its Marketplace plan options from 12 to 14 for 2015, but increased premiums by average of 6.7 percent, compared to the zero percent net average increase nationwide (see Update for Week of January 12th).

However, West Virginia was the second most successful state in the nation last year (next to Oregon) in increasing enrollment in Medicaid and the State Children’s Health Insurance Program (SCHIP). By September of 2014, it had enrolled nearly all of those made eligible for Medicaid by the ACA expansion. Roughly 27 percent of all West Virginians are now enrolled in Medicaid or SCHIP.

Wyoming

Committee seeks to draw high-risk pool to a close

The Joint Labor, Health and Social Services Interim Committee unanimously passed S.F. 64 this week, which gives the Insurance Commissioner authority to terminate coverage in the state high-risk pool on or after July 1st for any enrollee that has “reasonable access to health insurance”, so long as they receive 90 days prior notice.

Wyoming is among only a handful of states that have continued to operate their high-risk pools for persons with pre-existing conditions well past the Affordable Care Act (ACA) guaranteed issue mandate, which went into effect in January 2014. S.F. 64 would continue this pool only for those that are unable to be covered under another plan at a “reasonable expense”.