



Health Reform Update – Weeks of February 9 and 16, 2015

CONGRESS

Most non-profit cooperatives created by ACA may need to be liquidated

An analysis released this week by Standard and Poor's (S&P) concludes that many of the non-profit Consumer Operated and Oriented Plans (CO-OPs) created with Affordable Care Act (ACA) loans will need to be liquidated as they cannot cover enrollee medical costs.

The study comes on the heels of the Iowa Insurance Commissioner's liquidation of one of the most successful CO-OPs, CoOpportunity Health (see Update for Week of January 19th). The non-profit relied on low premiums to enroll more than 120,000 consumers in Iowa and Nebraska, exponentially above its expectations of only 11,000 enrollees. However, its revenue could not match such unexpected success after Congress rescinded all remaining ACA funding for the CO-OPs (see Update for Weeks of December 24 and 31, 2012).

Although S&P confirmed that CoOpportunity suffered the largest net loss of any CO-OP during the first three quarters of 2014, it found that its 53 percent ratio of debt to remaining funds was near the median for the remaining 23 CO-OPs and 11 actually had worse ratios and may meet a similar fate. Community Health Alliance in Tennessee, which was forced to freeze enrollment last month (see Update for Week of January 12th), has the highest net loss-to-surplus ratio (314 percent) but expects to continue Marketplace participation.

According to S&P, losses for all 24 CO-OPs ranged from \$2.9 million to \$39.8 million over the same time period.

FEDERAL AGENCIES

Late surge causes extensions in Marketplace deadline for certain applicants

The Centers for Medicare and Medicaid Services (CMS) announced last week that consumers who were unable to complete applications for federally-facilitated Marketplaces (FFMs) by the February 15th deadline due of call center wait times or income verification glitches can do so by February 22nd. (Coverage will still be effective starting March 1st.) CMS was unable to estimate how many applicants may ultimately benefit from this one-week extension.

This is the second year in a row that CMS has extended the open enrollment deadline due to technological impediments (see Update for Week of April 7th). As with last year, all state Marketplaces followed CMS' lead and granted similar extensions (see below). Washington's extension for those experiencing technical issues will last until April 17th while Minnesota is creating a special enrollment period (SEP) from March 1st through April 30th for those subject to the Affordable Care Act tax penalty for failing to buy minimum essential coverage they can afford (at least two other states have created a similar SEP). The tax penalty increased in 2015 to \$325 or two percent of income.

CMS announced late this week that it would create a comparable SEP from March 15th through April 30th. To qualify, consumers must self-attest that they did not learn they had to pay the tax penalty until filing their income taxes for 2014 and are not otherwise eligible for FFM coverage. CMS estimated that 10-20 percent of roughly six million taxpayers that were uninsured for some or all of 2014 will qualify for one of the 15 exemptions created by Congress or CMS (see Update for Weeks of April 28th and May 5th). Only 2-4 percent are expected to pay the initial penalty of \$95 per adult or one percent of income.



According to CMS, more than one million consumers selected FFM plans in the last nine days of the enrollment period. The expected late surge caused call center wait times to spike, often exceeding an average of 20 minutes compared to only 2.5 minutes in January. The delays came despite the addition of 14,000 call center employees for the last week of open enrollment and caused about 150,000 applications to remain uncompleted.

Roughly 11.4 million consumers enrolled in Marketplaces during the 2015 open enrollment period (including 8.6 million in FFMs), according to CMS. This far exceeds last year's total of 7.1 million enrollees as well as the Administration's revised target of 9.1 million, and falls just shy of the 12 million that the Congressional Budget Office initially projected for 2015 prior to the failed rollout of the FFM web portal (see Update for Week of November 11, 2013).

However, immigrant advocates were angered at CMS' decision to terminate Marketplace coverage for 200,000 enrollees who were unable to resolve discrepancies in their citizenship status. The agency had already dropped 112,000 enrollees last year on similar grounds (see Update for Weeks of August 25th and September 1st). The National Immigration Law Center has filed a lawsuit against that move, arguing that CMS failed to send requests for verifying documents in languages other than English.

FFM enrollment was dramatically up in several states that underperformed in 2014. Florida's 1.6 million enrollees (including 600,000 new customers) surpassed even last year's overall leader California (see below). Arizona and Georgia saw 70 percent more enrollees in 2015, while sign-ups nearly doubled for Virginia and Wisconsin.

Marketplaces increase reliance on specialty tier coinsurance despite discrimination findings

The Avalere Health consulting firm released a new analysis this week affirming that Marketplace plans are increasingly moving all or most drugs for costly conditions into their highest cost-sharing tier.

The Centers for Medicare and Medicaid Services (CMS), Illinois Insurance Department (see below), and the Florida Office of Insurance Regulation (OIR) have determined that the practice constitutes unlawful discrimination under the Affordable Care Act (see Update for Week of December 1st), as charging consumers a 30-50 percent coinsurance creates such a barrier to access that it effectively circumvents the law's prohibition on pre-existing condition exclusions. OIR has already entered into settlements with three of the four Marketplace insurers identified in a civil rights complaint filed by The AIDS Institute and other consumer groups (see Update for Week of December 15th).

However, Avalere's review of silver-level plan options for 20 drug classes in eight Marketplaces (California, Florida, Georgia, Illinois, New York, North Carolina, Pennsylvania and Texas) found that despite these findings of discrimination, insurers are relying even more heavily on the practice for conditions such as multiple sclerosis (MS), HIV/AIDS, and certain classes of cancer drugs. Avalere specifically found that 51 percent of Marketplace plans are putting all MS agents (including generics) into their highest cost-sharing tier for 2015 (up from 42 percent last year). In addition, the number of Marketplace plans placing protease inhibitors and all available generics for HIV/AIDS have nearly doubled (29 percent compared to 16 percent for 2014).

The AIDS Institute continues to push CMS to enforce the non-discrimination provisions of the ACA against all insurers engaging in this practice, as has the Pharmaceutical Research and Manufacturers of America (PhRMA). However, America's Health Insurance Plans (AHIP) placed the blame entirely on "unsustainable prices of [specialty] medications" and insisted that consumers unable to afford the specialty coinsurance in silver plans should instead select more comprehensive gold or platinum-level options without specialty coinsurance.



To date, CMS has discouraged the practice of moving all drugs for certain conditions into specialty tiers, as part of its Notice of Benefit and Payment Parameters for 2016 (see Update for Week of December 1st). However, the agency has taken no specific enforcement action.

Average Marketplace premiums after tax credits range from \$47-\$172

According to a report issued last week by the Department of Health and Human Services (HHS), roughly 6.5 million of those enrolled in the federally-facilitated Marketplaces (FFMs) qualify for the premium tax credits offered by the Affordable Care Act (ACA).

The credits average about \$268 per enrollee and decreased monthly FFM rates from an average of \$374 to \$105 (or 72 percent). The average monthly premium ranges from a low of \$47 in Mississippi to \$172 in New Jersey, while 80 percent of all FFM enrollees are paying less than \$100.

CMS increases cost estimate for running federally-facilitated Marketplaces

The Centers for Medicare and Medicaid Services (CMS) estimated last week that it will cost roughly \$2.2 billion to operate the federally-facilitated Marketplaces (FFMs) in fiscal year 2016, a 22 percent increase from the current budget year.

Higher user fees are expected to cover the increase, according to CMS officials. The agency should collect \$1.6 billion in revenue from user fees for fiscal 2016, up from \$1.2 billion for fiscal 2015.

The funds come from a general program management account within CMS, which supports a wide array of CMS functions. Congressional Republicans insist that it is “unconstitutional” for CMS to dip into these funds for Affordable Care Act (ACA) implementation and operations, since Congress has blocked appropriations specific to the ACA. They attached provisions to the fiscal 2015 spending resolution demanding that the agency detail how such general accounts are funding ACA functions like Marketplace operations and administration of premium and cost-sharing subsidies (see Update for Weeks of January 26th and February 2nd).

STATE

Small states struggling to fund Marketplaces without federal grants

A report in *POLITICO* this week documented how several smaller state-based Marketplaces (SBMs) are struggling to be self-sustaining since federal exchange establishment grants under the Affordable Care Act (ACA) ended last January.

States such as Hawaii, Rhode Island, and Vermont already had comprehensive state coverage programs in place prior to the Affordable Care Act (ACA), resulting in very low uninsured rates. As a result, Marketplace enrollment and participation has been fairly limited, resulting in low revenue totals from the insurer user fees upon which most other SBMs rely.

Lawmakers are pursuing a number of measures in Hawaii to boost Marketplace viability. For example, S.B. 1338 and H.B. 1467 would expand the Hawaii Health Connector to include large group coverage, broaden the definition of small employer to increase small group participation, and end ACA-deficient transitional policies starting January 1st. S.B. 745 and H.B. 726 would also require any individual health plan insurer with at least a 20 percent market share to participate in the Connector.

The Connector’s director is also asking the legislature for authorization to increase the 3.5 percent user fee, which was set to be consistent with the federally-facilitated Marketplace (FFM), as well as take out \$28 million in bonds. The Connector expects to eventually increase enrollment from 15 to 29



percent of the individual market and 5 to 13 percent of the small group market, shares that could make it financially self-sustaining with a higher user fee.

Several Republican lawmakers in Hawaii and Vermont are proposing to default to the FFM, as was done by SBMs in Nevada and Oregon (see Update for Week of April 21st). However, opponents point out that the transition cost Nevada \$20 million and Oregon \$4-6 million. It would also result in the loss of ACA subsidies for consumers should the U.S. Supreme Court invalidate the subsidies for FFMs later this year (see Update for Weeks of January 26th and February 2nd).

Vermont (like the District of Columbia) already requires all small businesses to purchase coverage through the Marketplace, leading to far higher small group enrollment than any other state. However, even that revenue source has been inadequate to prevent the Marketplace from having to dip into general fund revenues to cover nearly half of its annual budget.

Hawaii and the District led the nation in costs per Marketplace enrollee last year, due to such a limited enrollment pool. However, the District already imposes a one-percent tax on all health insurers to fund the Marketplace, leaving it with little alternative but to increase that fee to sustain operations.

Despite higher than anticipated enrollment, Rhode Island lawmakers are considering imposing a first-time user fee on participating insurers (it is the only SBM without one). With a \$23 million budget that also exceeded estimates, House Health Committee chair Joe McNamara (D) is leaving all options on the table for increasing revenues, including a DC-style tax on all insurers.

California

Marketplace enrollment falls short of 2015 target

Covered California officials extended the February 15th deadline for open enrollment until February 20th, in an effort to reach its 2015 goal of 1.7 million enrollees.

Roughly 1.36 million had signed-up through February 15th and only about 354,000 represented new enrollees. California, which had led the nation in sign-ups for 2014, trailed Florida (which wound up with 1.6 million enrollees) throughout the 2015 open enrollment period (see Update for Weeks of January 26th and February 2nd).

The extension will allow those that already started an application by the original deadline to complete the process via the call center, enrollment counselors, or insurance agents and brokers.

New bill would limit use of specialty tiers, require “reasonable” drug cost-sharing

Assemblyman Richard Gordon (D) introduced legislation this week that would specifically prevent insurers from placing all prescription drugs for certain costly conditions into specialty tiers that require a percentage coinsurance.

The measure differs from Gordon’s previous effort to cap prescription drug cost-sharing that passed the Assembly last session but stalled in the Senate (see Update for Weeks of August 25th and September 1st). A.B. 339 would instead direct the Department of Managed Health Care and Department of Insurance to create by January 1, 2017 a category of “specialty prescription drug[s]” that would be subject to new limitations in the bill. For example, all health plans that cover outpatient prescription drugs would have to cover any medically necessary medication that lacks a therapeutic equivalent, starting January 1, 2016.

Under the bill, the use of the highest-cost tier of a drug formulary would have to be based on clinical guidelines and not the cost. A.B. 339 also would require cost-sharing for all outpatient



prescription drugs to be “reasonable” to ensure access. Insurers must demonstrate to the Insurance Commissioner that the proposed cost-sharing design “will not discourage medication adherence.”

The California Association of Health Plans promptly opposed the bill, insisting that out-of-pocket costs would simply be shifted to higher premiums, without reducing the actual price of the drug. They argued that it would be more beneficial to consumers for lawmakers to require that health plans and drugmakers be more transparent about how specialty drug prices are set.

A report released this week by Avalere Health affirmed that comprehensive information on drug coverage and out-of-pocket costs under Covered California plans for individuals were very difficult to find, particularly for high-cost conditions like HIV/AIDS. The researchers concluded that this lack of transparency often hindered consumers from making informed purchasing decisions.

Lawmakers resurrect bill to ban “skinny” health plans from large employers

Assemblyman Roger Hernandez (D) is resurrecting vetoed legislation from last session that would prevent large employers from offering “skinny” health insurance coverage that fails to meet the minimum essential coverage requirements of the Affordable Care Act (ACA).

The measure introduced this week (A.B. 248) specifically bans employers with 50 or more workers from providing health insurance that covers less than 60 percent of the cost of essential care. It would make limited-benefit or “skinny” coverage in the large group market supplemental to comprehensive coverage.

Governor Jerry Brown (D) vetoed a similar measure last year (see Update for Week of September 22nd).

Florida

Federal refusal to extend Low-Income Pool puts pressure on lawmakers to expand Medicaid

The federal Centers for Medicare and Medicaid Services (CMS) stated this week that it will not approve any extension of the waiver that provides Florida with \$1-2 billion per year in federal funds for safety net providers.

The agency had already signaled its intent to do so when it extended the Low Income Pool (LIP) waiver by only one year last spring, instead of the traditional three-year extension (see Update for Week of April 21st). However, the budget put forward by Governor Rick Scott (R) last month assumed the federal funding would be renewed. As a result, Florida will immediately have a \$1.3 billion deficit in its Medicaid budget should the LIP waiver expire as scheduled on June 30th—a hole that would need to be filled with major reductions from other parts of the budget.

U.S. Senator Bill Nelson (D-FL) and Administration officials acknowledge that the move is an effort by CMS to force lawmakers to participate in the ACA expansion of Medicaid, which would provide Florida with \$51 billion in matching funds over ten years (see Update for Week of April 21st). However, House Speaker Steve Crisafulli (R) has pre-emptively refused to even consider any Medicaid expansion proposal that accepts federal funds (see Update for Weeks of January 26th and February 2nd). Senate offices that met with the Florida Bleeding Disorders Coalition last week stated that they are not likely to advance any Medicaid expansion bills next session so long as the House position remains the same.

New bill would prohibit discrimination in cost-sharing design

Rep. Matt Harrison (R) introduced his *Florida Patient Protection Act* this week, which prohibits health insurance benefit designs from discriminating against consumers based on age, gender, or health status, consistent with the Affordable Care Act (ACA). However, unlike comparable bills in several other



states (see S.F. 349 in Iowa), H.B. 863 adds a specific provision that allows the Florida Office of Insurance Regulation (OIR) to assess a plan's cost-sharing structure for prescription drugs when reviewing whether a plan's benefit design is discriminatory.

The bill also sets minimum network adequacy standards for managed care plans and requires that their prescription drug formularies cover a "broad range of therapeutic options for the treatment of disease states" that should include "at least two products in a therapeutic class." These formularies must be easily accessible on plan websites and updated within 24 hours of any change.

At least three Marketplace insurers have already settled complaints filed with OIR by The AIDS Institute and other consumer groups, documenting that they were moving all or most drugs for a therapeutic class such as HIV/AIDS or Hepatitis C into their highest-cost specialty tiers that require patients to pay 30-40 percent of more of the drug's total cost. Both OIR and the federal Centers for Medicare and Medicaid Services have found this practice to violate the ACA's non-discrimination provisions (see Update for Week of January 5th).

H.B. 863 would direct OIR to hold public hearings on such discrimination complaints. OIR must also report annually on the extent to which it has found drug formulary practices to be discriminatory.

Georgia

Biosimilar substitution bill clears Senate panel without opposition

The Senate Health and Human Services Committee unanimously approved legislation last week that regulates the substitution of biosimilar drugs for their more costly brand-name counterpart.

Sponsored Senator Dean Burke (R), a physician, S.B. 51 would allow pharmacists to give patients a drug that the Food and Drug Administration (FDA) deems to be "interchangeable" with the patient's currently prescribed biologic drug, consistent with the new regulatory pathway created by the Affordable Care Act. However, it would require the pharmacist to first notify the patient's physician and record the substitution.

Groups representing patients with arthritis and cancer testified in support of the legislation, stating that it would improve the critical communication between pharmacist and physician.

Legislation regulating biosimilar substitution has been introduced in at least 18 states starting in 2013. However, they were previously rejected in all but five states as most contained restrictions that were so onerous that they were viewed as creating barriers to competition (see Update for Week of January 19th). Texas is among the handful of legislatures considering more burdensome restrictions this session (S.B. 542).

The FDA is expected to approve the first group of biosimilar drugs later this year (see Update for Week of January 5th).

Illinois

Senator resurrects bill to limit cost-sharing for specialty medications

Senator Linda Holmes (D) introduced S.B. 1359 this week. The measure renews her effort from last session to limit the cost-sharing for specialty medications to \$100 per month for up to a 30-day supply of any single drug (see Update for Week of February 17, 2014). It also would cap annual out-of-pocket expenditures for prescription drugs to no more than 50 percent of the annual cap under the Affordable Care Act (ACA).



Similar to measures introduced in other states, S.B. 1359 requires plans with a tiered formulary for prescription drugs to create an exceptions process that allows enrollees to request an exception. Plans would also be specifically prohibited from placing all drugs in a given class on a specialty tier.

Illinois was one of roughly a dozen states where Marketplace insurers were identified as placing all or most HIV/AIDS drug into specialty tiers (see Update for Week of January 5th). The Illinois Department of Insurance was the first in the nation to warn insurers as early as last May that such a practice violated the ACA's non-discrimination provision and that they would be barred from the state partnership Marketplace if they relied on such cost-sharing designs. The Florida Office of Insurance Regulation and federal Centers for Medicare and Medicaid Services have since made similar findings (see Update for Week of December 15th).

Kentucky

Medicaid expansion slashes uncompensated care by 60 percent during first year

A report released last week by the Deloitte consulting firm concludes that expanding Medicaid under the Affordable Care Act (ACA) has given Kentucky a greater economic boost than anticipated.

Governor Steve Beshear (D) heralded the findings, which showed that the expansion added 12,000 jobs during 2014, including 5,400 in the healthcare sector alone. Deloitte predicted that the total number of new jobs could rise to 40,000 by 2021 thanks to the expansion, bringing the state \$30 billion over eight years.

The figures exceed those initially projected by the Governor in 2013. Governor Beshear had strongly backed the expansion, insisting that Kentucky could not afford to forgo the \$1.6 billion in ACA matching funds that the state would receive in 2014 alone. He stressed that the Deloitte study showed that nearly 44 percent of hospital revenue last year was due to the expansion, which slashed uncompensated care costs by a whopping 60 percent (or \$766 million).

The drop in uncompensated care in Kentucky is far more than other states have experienced, according to a Colorado Hospital Association survey that reported a 32.1 percent decrease in expansion states during the first quarter of 2014. By contrast, charity care increased by 10.5 percent in opt-out states during the same quarter.

The expansion was the primary reason that Kentucky experienced the second-largest uninsured drop in the nation last year (falling to 12 percent from 20 percent the year before). Kentucky's health insurance Marketplace (Kynect) has also been among the nation's most successful, enrolling more than half a million consumers in private coverage for 2015.

Maryland

Marketplace enrollment nearly doubles in year two

Maryland Health Benefit Exchange officials announced this week that 119,096 consumers purchased private plan coverage through the Affordable Care Act (ACA) Marketplace during the 2015 open enrollment period that ended February 15th.

The figure nearly doubles the 63,000 that did so during the inaugural open enrollment period, when the Marketplace web portal was so plagued with technical glitches that the entire software was replaced over the summer with technology from the Connecticut Marketplace (see Update for Week of March 17th and 24th).

A total of 264,245 consumers used the Marketplace to enroll in coverage this year, when accounting for those that were determined eligible for Medicaid. This total was actually higher in year one, when more than 232,000 of the nearly 300,000 that enrolled through the Marketplace were



Medicaid-eligible. Enrollment for 2014 eventually reached 460,000 after an extension was granted by Marketplace officials.

As with the FFM (see above), call centers in Maryland were so overwhelmed from a late surge in applications that more than 8,600 consumers could not get through. As a result, Marketplace officials have granted a two-week extension for those that started an application prior to February 15th.

New bill would prohibit discriminatory cost-sharing designs

Delegate Kevin Kelly (D) introduced H.B. 990 this week, which prohibits qualified health plans participating in the Maryland Health Benefit Exchange from using a benefit design that relies upon discriminatory drug formulary management or medical management practices.

Differential reimbursement rates or cost-sharing for covered benefits is one criterion that the bill directs the Insurance Commissioner to consider when determining whether a drug formulary is discriminatory. In addition, medical management practices could not be applied only to specific diseases or conditions unless they comport with generally-accepted best medical practices among peer-reviewed medical journals or medical specialty societies.

The Health and Government Operations Committee has scheduled a March 12th hearing on the legislation.

Maryland already enacted legislation last year that prohibits health plans from imposing a copayment or coinsurance for covered specialty drugs that exceeds \$150 for up to a 30-day supply, starting January 1, 2016 (see Update for Weeks of April 28th and May 5th).

Oregon

Congress broadens Marketplace investigation after resignation of Governor

Congressional Republicans are using last week's sudden resignation of Oregon's longest-serving governor as justification to broaden a federal investigation into the state's failed health insurance Marketplace.

Severe software flaws left Cover Oregon without any online enrollment capability for the entire 2014 open enrollment period. Governor John Kitzhaber (D) ultimately ordered the Marketplace created pursuant to the Affordable Care Act (ACA) to default to federal control, at least for 2014 (see Update for Week of April 21st).

Both the Government Accountability Office (GAO) and Inspector General for the Department of Health and Human Services (HHS) have been investigating whether Cover Oregon's misuse of federal grants to create the Marketplace led to the failure (see Update for Week of March 10th). However, Republican leaders on the U.S. House Oversight and Government Reform Committee are now demanding email, phone, and other records from the Governor's state and personal accounts relating to Cover Oregon. Since the Governor's resignation resulted from alleged violations of state ethics and procurement laws relating to state employment for his wife, they specifically want to know what connection these violations may have to Cover Oregon's failure.

Oregon Attorney General Ellen Rosenblum (D) has already barred officials from the Governor's office from carrying-out internal directives to destroy these records. The Attorney General is currently seeking civil damages from the lead Cover Oregon contractor, Oracle, for the failed Marketplace (see Update for Week of August 18th). She filed a second lawsuit this week against Oracle for attempting to terminate its contract for the Medicaid enrollment system before a replacement is operational.



The governorship remains under Democratic control after Secretary of State Kate Brown was sworn in this week. Kitzhaber, who had just been re-elected to an unprecedented fourth term, was a former emergency room physician who had made Oregon a pioneer in health reform through experiments to ration Medicaid coverage and transition the state away from fee-for-service reimbursement. However, the Cover Oregon failure had somewhat tarnished his health reform record.

Pennsylvania

New Governor starts replacing Medicaid expansion alternative with traditional ACA expansion

New Governor Tom Wolf (D) followed through last week with his campaign promise to transition the “private sector” Medicaid expansion alternative of his predecessor with a traditional expansion under the Affordable Care Act (ACA).

Former Governor Tom Corbett (R) obtained a federal waiver last year making Pennsylvania one of six states that are allowed to use ACA matching funds to instead cover the 600,000 newly-eligible Medicaid enrollees under private plans (see Update for Weeks of August 25th and September 1st). Starting last December, the state has used these funds to purchase coverage in private Medicaid managed care plans offering a more limited set of benefits, though only a third of the 151,000 that initially applied had actually been enrolled due to technical issues (see Update for Week of January 12th).

Citing the system errors created by Corbett’s “confusing” and “bureaucratic” model, Governor Wolf took the first step towards a traditional expansion by specifically converting three plan options available to enrollees into one. However, the actual conversion of the newly-eligible population into traditional Medicaid coverage will require additional federal approval that is not expected to be received for several months.

The Governor made the conversion a centerpiece of his campaign (see Update for Week of November 3rd). He insists that approval from the Republican-controlled legislature is not needed but will still be sought.

Washington

Marketplace creates special enrollment period after deadline sparks late surge in applications

Officials with the Washington Healthplanfinder created pursuant to the Affordable Care Act (ACA) announced this week that nearly 160,000 residents selected a Qualified Health Plan (QHP) by the February 15th deadline for the second open enrollment period (including more than 66,000 new customers).

However, due to surge in last-minute applications that overwhelmed call centers, the Marketplace created a special enrollment period (SEP) through April 17th for those with uncompleted applications that were started prior to the deadline. Those subject to the individual mandate under the ACA will also be eligible to sign-up for coverage during this SEP.

The Marketplace was one of the more successful in the nation last year, largely due to enrolling high numbers of newly-eligible Medicaid enrollees (see Update for Week of March 10th). However, its 2014 total of 164,000 QHP enrollees was only slightly higher than the 2015 tally.

Wyoming

Medicaid expansion rejected again by both chambers

Proposals to expand Medicaid pursuant to the Affordable Care Act (ACA) appear to be effectively dead for this session after the Senate and House both rejected “private sector” alternatives that had the backing of Governor Matt Mead (R).



This is the second year in a row that conservative lawmakers refused to support any plan that accepted federal dollars. The SHARE plan introduced by Senator Michael Von Flatern (R) (S.F. 129) would have largely followed the expansion alternative recently approved by the Obama Administration for Indiana and Tennessee. However, it failed by a 19-11 margin earlier this month, with opposing senators like Dave Kinskey (R) citing the Administration's refusal to include a work requirement for able-bodied adults. Work requirements have been proposed in waivers sought by conservative governors from Indiana, Pennsylvania, Tennessee, and Utah but stripped out by the Administration (see Update for Weeks of January 26th and February 2nd).

A subsequent effort by Rep. Dan Zwonitzer (R) to expand Medicaid for only two years via a budget amendment was blocked this week in the House by a 41-15 margin. Zwonitzer stressed that participating in the ACA expansion would relieve uncompensated care costs on Wyoming hospitals by \$100 million per year and thus is strongly backed by the Wyoming Hospital Association and Department of Health. However, representatives like Harlan Edwards (R) insisted that the proposal would be equivalent to embracing "socialized medicine."

Similar debates are raging in neighboring Utah and Montana, where Governor-backed expansion alternatives are facing stiff opposition in the more conservative House chambers. The Utah House is meeting behind closed doors this week to decide whether to reject the federally-approved plan by Governor Gary Herbert (R) in favor of a more limited option, even though the measure has the support of Senate Republicans. The Montana House is set to hold a March 6th hearing on the expansion plan put forward by Governor Steve Bullock (D).

North Carolina Governor Pat McCrory (R) stated this week that he would wait to see how the U.S. Supreme Court rules on a challenge to the ACA's premium subsidies for federally-facilitated Marketplaces (see Update for Week of January 5th) before deciding whether to formally submit an expansion proposal to his legislature. Governor McCrory has been negotiating an expansion alternative with the Obama Administration after initially resisting calls to expand.