



Health Reform Update – Week of March 23, 2015

CONGRESS

President threatens to veto Republican budgets passed by House and Senate

The House and Senate passed competing budget plans this week that would repeal the Affordable Care Act (ACA) and balance the federal budget through dramatic cuts in health spending.

Key differences in the two budgets for fiscal year 2016 will need to be reconciled after the Easter recess. However, President Obama has already pledged to veto any final resolution that includes ACA repeals and neither chamber advanced their version with a veto-proof majority.

The Senate budget resolution (S.Con.Res. 11), which passed 52-46 without any Democratic support, would balance the budget over ten years with \$5.1 trillion in federal spending cuts, including \$430 billion from Medicare. The House plan (H.Con.Res. 27) would do so in nine years with even greater cuts (\$5.5 trillion), while transitioning Medicare into a “premium support” program that provides vouchers for enrollees to purchase private coverage in a health insurance exchange.

The Senate version does not include the “premium support” model favored by House conservatives, but does include their past proposal to convert Medicaid into a lump-sum block grant to states with few strings attached (see Update for Week of April 7th).

The resolutions differ in how to pass measures through the budget reconciliation process with only a bare majority. Reconciliation was used to enact key provisions of the ACA in 2010 and Republican leaders are seeking to undo those provisions through the same process. However, the House instructions go further than the Senate version in targeting non-ACA programs such as food stamps.

Both resolutions stay within the statutory caps on discretionary spending imposed by the *Budget Control Act of 2011*, although they do seek to increase the limit on defense spending.

All but 35 of the hundreds of proposed amendments to the Senate resolution were rejected. However, Senator Patty Murray (D-WA) did garner surprising approval (with the backing of six Republicans) for a provision requiring workers to receive up to seven days of paid sick leave per year.

Senate delays action on House-passed repeal of Medicare physician payment formula

The House passed a permanent fix to Medicare physician payments this week that would avert the 21 percent reimbursement cut slated to take effect on April 1st.

The measure (H.R. 2) passed with the support of 180 Democrats and is expected to likewise received broad bipartisan support in the Senate, despite protests that it includes only a two-year extension of Children’s Health Insurance Program (CHIP) funding instead of the preferred four-year extension until 2019 (see Update for Week of March 16th).

Although Senate passage is likely, it is not a given. Some Democratic leaders object to means-testing provisions that would gradually increase Medicare Part B premiums on enrollees earning more than \$85,000 per year by \$10 from 2018-2025 (Part D premiums for upper-income enrollees would also increase). Abortion restriction on community health center funding is likely to be another sticking point for Democrats, as is a prohibition on Medigap plans covering Part B deductibles (starting in 2020).



Several Senate Republicans also continue to object to the fact that the House plan offsets only \$73 billion of the \$214 billion projected cost over ten years.

President Obama indicated that he will likely sign the legislation that has the strong backing of the American Medical Association and other physician groups. The Senate failed to take action before leaving for the Easter recess, meaning that it will not be enacted before the latest temporary patch expires. However, the Centers for Medicare and Medicaid Services (CMS) has informed lawmakers that they actually have a two-week “cushion” to pass the legislation, since electronic claims are not paid until at least 14 calendar days after they are received.

The Sustainable Growth Rate (SGR) formula has been delayed 17 times by Congress since its creation in 1997, in order to avoid the dramatic cuts in Medicare physician reimbursement that would result. In its place, H.R. 2 would provide physicians with a 0.5 percent annual increase in Medicare reimbursement for five years while Medicare transitions to incentive-based payments that reward quality. It would require participating physicians to receive at least 25 percent of their revenue through these Alternative Payment Models by 2019-2020, with the threshold increasing over time.

GAO says ACA subsidies are responsible for five percent expansion in coverage

A Government Accountability Office (GAO) report released this week concluded that the premium tax credits offered under the Affordable Care Act (ACA) have directly resulted in at least a five percent increase in insurance coverage since their inception in January 2014.

The report, which was based on data from state insurance departments, the U.S. Department of Health and Human Services, and 11 private research groups, determined that the tax credits reduced health insurance premiums by 76 percent from 2013 to 2014 (reducing the average monthly premium from \$346 to \$264 per month).

Meanwhile, a separate report from The Commonwealth Fund showed that the ACA’s medical-loss ratios (MLRs) that cap insurer profits have saved consumers roughly \$5 billion from 2011-2013. Consumers received more than \$1 billion in premium rebates for insurers that went over these caps in 2011, but only \$325 million in 2013, showing that insurers are increasingly spending more on patient care and less on administration and profit as a result of the MLRs.

House committee urges greater oversight and transparency for 340B drug discount program

The following article is intended to explain structural challenges faced by the 340B drug discount program in helping patients to access and afford needed prescriptions. It is an overview of why certain proposals are being debated by lawmakers and regulators and not an endorsement of any specific reform.

The House Energy and Commerce Health subcommittee convened a long-awaited hearing this week to debate potential reforms to the Section 340B drug pricing program, the first review of the program in nearly ten years.

Created in 1992, the 340B program requires most drug manufacturers to provide nearly 11,000 participating safety-net providers with deep discounts (totaling about \$3.8 billion in 2013) on outpatient drugs used to treat low-income and uninsured patients. However, hospitals are not prevented from using the discounted drugs to also treat patients covered by Medicare or private insurance.

As a result, the Health Resources and Services Administration (HRSA) that administers 340B has been widely criticized by lawmakers after government audits from 2011 blamed a lack of oversight and transparency for allowing 340B providers to reap “windfall profits” on the higher reimbursement. They claim this is effectively converting 340B’s mission from serving vulnerable populations to creating a profit



center for the provider (see Update for Weeks of July 1 and 8, 2013). The Government Accountability Office (GAO) noted that 340B providers and manufacturers were essentially allowed to “police themselves and ensure their own compliance” and that HRSA had failed to perform any of the audits authorized by Congress (see Update for Week of September 19, 2011).

A recent study by researchers from the University of Chicago and Sloan Kettering Memorial Cancer Center appeared to validate profiteering criticisms by documenting that those registered for the 340B program in 2004 or later served communities that were wealthier and have higher rates of health insurance (see Update for Weeks of October 6th and 13th). An earlier report produced by the pharmaceutical industry insisted that clinical decision-making by hospitals was being “skewed by efforts to take advantage of the 340B discount” (see Update for Week of February 11, 2013).

Lawmakers cited other studies affirming this trend, including a white paper by Avalere Health revealing that two-thirds of 340B participating providers provide less charity care than the average United States hospitals, while charity care represents less than one percent of total costs for roughly 25 percent of 340B providers. Such a nominal amount of charity care contrasts starkly with a dramatic rise in 340 drug purchases from \$1.1 billion in 1997 to more than \$7 billion by 2013.

Hospital groups created their own website to rebut these conclusions (www.340Bfacts.com). They insist that these studies fail to note that 340B providers furnish “over twice as much care to Medicaid and low-income Medicare patients and almost twice as much uncompensated care.”

Despite these protestations, nearly of all the subcommittee members urged HRSA this week to issue rules and guidance that implement the recommendations of the Department of Health and Human Services Office of Inspector General (HHS OIG) and GAO. This includes a “clear definition” of eligible patients and greater clarity regarding how covered entities spend program savings—both of which are lacking under the existing statute.

HRSA insists they have made several efforts to increase program oversight and integrity in response to these recommendations, but are limited in the scope of what they can do. They cited a recent court ruling invalidating HRSA rules requiring drugmakers to provide mandatory 340B discounts for orphan drugs when used for non-orphan indications—rulemaking that continues to face legal challenges brought by the Pharmaceutical Research and Manufacturers of America (see Update for Weeks of October 20th and 27th).

As a result, subcommittee members largely agreed that Congressional action was needed to expand HRSA’s authority to increase oversight through rulemaking and guidance documents. This included a proposal by Rep. Gene Green (D-TX) to authorize HRSA oversight over orphan drugs.

Despite its current limitations, HRSA deputy administrator Diana Espinosa testified that the agency is moving forward with proposed rules later this year to detail how 340B ceiling prices should be calculated, civil monetary penalties imposed on non-compliant manufacturers, and administrative dispute resolution processes implemented. HRSA will also issue new guidance clarifying hospital eligibility requirements and the definition of a 340B patient.

Resurrected bill to prohibit specialty tier coinsurance still has bipartisan support

Reps. David B. McKinley (R-WV) and Lois Capps (D-CA) renewed earlier legislation this week to limit out-of-pocket costs for specialty drug consumers.

H.R. 1600 would prohibit the use of specialty tier coinsurance, which has become especially prevalent under the Marketplaces created pursuant to the Affordable Care Act (ACA (see Update for Weeks of February 9th and 16th)). Plans have increasingly used the cost-control mechanism to force subscribers to pay up to 50 percent of the cost for specialty drugs, an amount that can create a barrier to



care for those needing medications that cost several thousands of dollars or more per month. The legislation would instead require insurers to use fixed monthly copayments for specialty drugs.

Previous versions of H.R. 1600 in 2013 and 2014 have garnered as many as 142 cosponsors from both parties. The most recent incarnation already has 50 cosponsors.

Supporters of the legislation including the American College of Rheumatology have insisted that the use of specialty tier coinsurance is “discriminatory” and at least two state insurance commissioners (in Illinois and Florida) have already acted to prevent insurers from placing all or most drugs for a specific condition into a specialty tier (see Update for Weeks of February 9th and 16th). PSI Government Relations has also testified in support of the legislation.

Opponents such as America’s Health Insurance Plans insist that outlawing specialty tier coinsurance without addressing the cost of specialty drugs will only force insurers to increase premiums.

FEDERAL AGENCIES

Aetna agrees to limit HIV drug cost-sharing nationwide

Aetna has responded to a discrimination complaint by limiting their use of specialty tier coinsurance to contain costs for HIV/AIDS drugs.

The AIDS Institute (TAI) and National Health Law Program (NHeLP) had filed a complaint last year with the civil rights office for the U.S. Department of Health and Human Service alleging that the practice of placing most or all HIV/AIDS drugs (including generics) into specialty tiers violates the anti-discrimination provisions of the Affordable Care Act (ACA) (see Update for Week of June 2nd). The complaint identified four insurers including Aetna that were charging subscribers in Florida’s Marketplace up to 50 percent of the total cost for HIV/AIDS drugs, a practice that TAI and NHeLP documented can often create an affordability barrier to care.

Although HHS has yet to formally act on the complaint, it use rulemaking to concur that moving all or most drugs for a class of costly medications could be unlawful discrimination (see Update for Week of December 1st). Insurance commissioners in Illinois and Florida have also taken action to curb the practice (see Update for Weeks of February 9th and 16th).

As a result, Aetna agreed this week to move all but one HIV drug (an injectable fusion inhibitor) from specialty tiers into to either a generic or non-preferred brand tier, effective June 1st. This policy applies to all Marketplace plans nationwide (including those offered through Aetna’s subsidiary Coventry). The move will lower out-of-pocket costs for HIV/AIDS drugs from a roughly \$1,000 per month coinsurance to fixed post-deductible copayments of \$5-100.

Aetna had already settled the complaint TAI filed with the Florida Office of Insurance Regulation (OIR) by lowering the cost of four brand-name HIV/AIDS drugs to \$200 per month and moving generic HIV/AIDS drugs to the generic tier (see Update for Week of December 1st).

TAI praised the new nationwide policy but stressed that Aetna only committed to leave it in place for individual Marketplace plans through 2016. Aetna’s Florida settlement also expires after one year.

Despite proposed legislation in several states seeking to curb the use of specialty tier coinsurance, Marketplace insurers increasingly are relying upon the practice. Avalere Health documented earlier this year that the proportion of bronze and silver-level plans charging consumers more than 30 percent of the cost of specialty drugs increased by 14 percent from 2014 to 2015 (see Update for Weeks of February 9th and 16th).



Kaiser study shows half of those receiving ACA subsidies were overpaid by nearly \$800

The Kaiser Family Foundation released a new report this week showing that roughly half of all households receiving Affordable Care Act (ACA) subsidies are being required to refund some or all of premium tax credits when they file their federal income taxes for 2014.

The ACA made the tax credits available to those earning from 100-400 percent of the federal poverty level (FPL). Most elected to make the tax credits “advanceable”, which immediately reduced their premiums but required them to refund any portion to which they were no longer entitled should their projected household income increase during the year.

The Kaiser study estimates that subsidy recipients that underestimated their income will owe the Internal Revenue Service (IRS) an average of \$794 for 2014. However, 45 percent of subsidy recipients will receive an average refund of \$773 because their income for 2014 was overestimated.

H&R Block had previously found that about 52 percent of early tax filers were being required to return an average of \$530 in overpaid subsidies, which decreased their tax refund by approximately 17 percent (see Update for Week of February 23rd).

Administration finalizes rules on employer-sponsored wraparound benefits

The departments of Health and Human Services (HHS), Treasury, and Labor finalized rules last week 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 final rule makes only a handful of changes from the proposed rule sought by labor unions and retailers last year (see Update for Week of January 5th). These include increasing the dollar limit for “wraparound” coverage from \$2,500 to either “the maximum permitted annual salary reduction towards a health flexible spending account ... or [15 percent] of the cost of coverage under the primary plan.”

As with the proposed rule, group health plan sponsors have the option to 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.

The final rule still creates two pilot programs. The first allows wraparound benefits only for multi-state plans offered in the Marketplace. The second allows 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.

Both pilots would provide excepted benefits to coverage first offered no later than December 31, 2018 (one year later than the proposed rule). They 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 still meet several requirements. 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, “wraparound” coverage cannot exclude anyone based on health status or income.

Kaiser says uncompensated care costs falling twice as fast in Medicaid expansion states

Uncompensated care costs for hospitals in states that expanded Medicaid pursuant to the Affordable Care Act (ACA) fell nearly twice as fast as opt-out states, according to a new report released this week by the Department of Health and Human Services (HHS).

The study found that the 22 remaining opt-states experienced only a \$2.4 billion decline in uncompensated care due to the lower uninsured rates resulting from the ACA. However, expansion states saw an even more dramatic decline of \$5 billion.

HHS data shows that nearly 70 million Americans were enrolled in Medicaid and the Children's Health Insurance Program as of January 2014, an increase of more than 19 percent since the opening of the ACA Marketplaces in October 2013. However, an unrelated analysis released by the Centers for Disease Control and Prevention showed that only 69 percent of physicians nationwide are willing to treat Medicaid patients, a rate that falls as low as 38.7 and 54.2 percent in highly-populated states like New Jersey and California.

Study shows physicians have not been overwhelmed with sicker patients post-ACA

A report released this week by the Robert Wood Johnson Foundation found that physician practices have not been overwhelmed by sicker and more costly patients since full implementation of the Affordable Care Act (ACA), contrary to claims from insurers and ACA critics.

According to researchers, the proportion of new patient visits at primary-care providers increased by only 0.3 percentage points between 2013 and 2014. Furthermore, the analysis showed "no evidence" that new cases were "significantly more complex."

Despite a 4.5 percent increase in new patient assessments over the same time, the study concludes that this "rise in new patients is not of a magnitude that would cripple the delivery system."

Alaska

New Governor unveils Medicaid expansion legislation

The respective Health and Social Services committees for the House and Senate have scheduled hearings on bills introduced at the request of Governor Bill Walker (I) that will allow Alaska to participate in the Medicaid expansion under the Affordable Care Act (ACA) (H.B. 148 and S.B. 78).

The newly-elected Governor had been unable to secure legislative approval to expand Medicaid through his proposed budget (see Update for Weeks of March 2nd and 9th). As a result, he is proposing stand-alone legislation since the House Health and Social Services Committee refused to hear the traditional expansion legislation backed by the Governor that was introduced last January by Sen. Andy Josephson (D)(H.B. 18).

The Governor's versions would use a provider tax to partially fund the state share of expansion, which the Affordable Care Act (ACA) limits to ten percent in 2020 and subsequent years. It also includes an automatic termination clause should the state share rise above ten percent.

Arkansas

Senate fails to freeze Medicaid expansion



The Senate narrowly blocked an effort to freeze enrollment in the popular “private option” to the Medicaid expansion under the Affordable Care Act (ACA).

More than 205,000 Arkansans have already enrolled in the program, which was the first expansion alternative to receive federal approval (see Update for Week of March 25, 2013). However, many conservative lawmakers have continually sought to eliminate the “private option” since Republicans took control over both chambers and the governorship last fall (see Update for Week of November 3rd).

New Governor Asa Hutchinson (R) was only able to secure a one year extension of the “private option” while a legislative task force comes up with acceptable alternatives (see Update for Weeks of January 26th and February 2nd). The proposal to freeze enrollment in the interim failed by only one vote after the Governor stressed that it would receive the required federal approval.

Colorado

Insurance division to discontinue ACA-deficient plans in 2016

The Division of Insurance (DOI) announced this week that all non-grandfathered health plans for individuals and for small employers that do not meet Affordable Care Act (ACA) will not be allowed to continue into 2016.

The Obama Administration granted all state insurance commissioners the discretion to continue ACA-deficient individual and small group plans through 2016, in response to the political fallout over the apparent mass cancellations of individual plans prior to full implementation of the ACA in January 2014 (see Update for Week of March 3, 2014). However, DOI elected to do so only through 2015 and insists that no additional time is necessary.

A DOI survey of Colorado carriers found that as of the end of 2014, 189,779 consumers will have their ACA-deficient plans discontinued next year by DOI’s decision. Nearly 75,000 of this amount are individual plan subscribers.

A study released last week by The Urban Institute found that reports of mass cancellations were “overstated” and that only about 2.2 percent of individual plan subscribers actually lost coverage (see Update for Week of March 16th).

Connecticut

Anthem Blue Cross and Blue Shield is no longer Marketplace leader

Data released this week by the Connecticut Insurance Department revealed that the state’s largest insurer Anthem Blue Cross and Blue Shield is no longer the dominant carrier in the state-based Marketplace created pursuant to the Affordable Care Act (ACA).

ConnectiCare Benefits captured more than 42 percent of the nearly 111,000 enrollees during the 2015 open enrollment period for AccessHealth CT, narrowly beating out Anthem, which held a 39.8 percent Marketplace share. The non-profit insurance cooperative created with ACA loans (HealthyCT) increased its Marketplace share 3.2 percent to 15.6 percent, while newcomer UnitedHealthcare signed-up only two percent of AccessHealth CT consumers despite its name recognition and size.

Maryland

Marketplace must repay more than \$28 million in improper expenses

The U.S. Department of Health and Human Services (HHS) is ordering the Maryland Health Benefit Exchange to repay \$28.4 million in federal exchange establishment grants that were misallocated during the failed rollout of the Marketplace in 2013.



The year-long audit by the Office of Inspector General was conducted at the behest of Congressman Andy Harris (R-MD) (see Update for Week of March 10, 2014). It showed no criminal wrongdoing or fraud, but did blame a lack of proper oversight and internal controls for allowing the Marketplace to claim federal reimbursement for projected enrollment that never materialized.

Software failures and feuding contractors caused Marketplace enrollment to be less than half of the initial target for the inaugural open enrollment period, yet state officials continued to report erroneously higher figures to HHS in an effort to recoup federal reimbursement that was based on Marketplace sign-ups. Auditors found that state officials never corrected the record with HHS to reflect their actual enrollment in year one.

State Marketplaces received higher reimbursement for private plan sign-ups versus Medicaid enrollees. As a result, the inflated private plan figures enabled Maryland to obtain \$28.4 million in federal funds to which they were not entitled.

HHS is requiring that Maryland return the entire amount and apply for the amount that is actually due based on accurate enrollment figures. However, the office of new Governor Larry Hogan (R) has declined to indicate whether they will do so.

One of the Marketplace contractors, the non-partisan Hilltop Institute, acknowledges providing HHS with out-of-date enrollment data that inaccurately inflated actual private plan enrollment from about 70,000 to 150,000.

A separate state-level audit remains ongoing.

Massachusetts

New bill would limit out-of-pocket costs for prescription drugs

Legislation limiting out-of-pocket costs for specialty drugs and other prescription medications was referred in mid-March to the Joint Committee on Financial Services. Sponsored by Rep. Marjorie Decker (D), H.828 would require separate out-of-pocket limits for prescription drugs that cannot exceed the minimum annual deductible for high-deductible health plans set by the federal Internal Revenue Code. The limitation would apply to individual and group plans, including health maintenance organizations.

Montana

Medicaid expansion “compromise” passes Senate but faces stiff House opposition

Seven Republicans joined with all Senate Democrats this week in passing legislation that would expand Medicaid pursuant to the Affordable Care Act (ACA).

Despite the bipartisan support, the measure (S.B. 405) still faces long odds in the more conservative House, where Republican members have sought for the past two sessions to block any expansion bills that accept ACA funding.

Bill sponsor Senator Ed Buttrely (R) sought to soften conservative opposition by requiring enrollees to pay sliding-scale premiums and copayments capped at two percent of annual income. It also limits assets that enrollees can own and offers voluntary work assessment and training programs. The provisions are viewed as a “compromise” from the traditional expansion plan sought by Governor Steve Bullock (D) that was already rejected by the House (see Update for Week of March 2nd and 9th).

Several House conservatives are already seeking stricter mandatory work requirements. However, comparable provisions in waivers sought by Indiana, Pennsylvania, Tennessee, Utah, and Wyoming have already been rejected by the Obama Administration (see Update for Weeks of February 9th and 16th).



Senator Buttrey was able to thwart several Senate Republican amendments that would have limited the expansion to only those earning 100 percent of the federal poverty level (FPL), the threshold for ACA subsidies. However, he warned that such partial expansion amendments may resurface in the House, calling them “poison pills” since the federal government has consistently refused to approve waivers that do not fully expand to 138 percent of FPL as a pre-condition to receiving ACA matching funds (see Update for Weeks of August 6 and 13, 2012).

The House Human Services Committee, which rejected the Governor’s plan, has tried to stem some of the criticism it faced for failing to expand Medicaid by passing a limited state-funded alternative that only covers catastrophic care (H.B. 528)(see Update for Week of March 16th).

Nevada

Marketplace enrollment doubles after switch to federal control

The latest figures from the Nevada Division of Insurance show that nearly 73,600 consumers enrolled in private Marketplace plans during the 2015 open enrollment period, which more than doubles last year’s tally when the Marketplace was under full state control.

The Silver State Health Insurance Exchange was so beset by software and technical issues during the inaugural open enrollment period that state officials ultimately opted to default to federal control (see Update for Week of June 2nd), resulting in the dramatic improvement in enrollment. However, the state has retained key Marketplace responsibilities, such as plan certification, rate approval, and Medicaid eligibility determinations while the federal government is handling online enrollment. Nevada’s Marketplace thus remains classified as a state-based Marketplace, meaning that ACA subsidies will still be available to consumers even if the U.S. Supreme Court invalidates them for the federally-facilitated Marketplace in June (see Update for Weeks of March 2nd and 9th).

Nevada is also the only state in the nation where consumers can purchase individual market coverage outside of the Marketplace year-round (although carriers can impose a waiting period of up to 90 days). However, ACA subsidies are only available to those purchasing Marketplace coverage during open or special enrollment periods.

Bronze-level premiums among the four Marketplace carriers in Nevada average \$227 per month, which is below the national average of \$249. Competition from the Nevada Health CO-OP created with ACA loans has been credited with helping to keep premiums affordable, as they garnered a surprising 37 percent of Marketplace consumers in 2014.

Ohio

New bill would limit specialty tier cost-sharing, discrimination

Senator Capri Cafaro (D), ranking member on the Joint Medicaid Committee, introduced S.B 135 this week, which would limit cost-sharing for specialty drugs to no more than \$150 for a 30-day supply. The legislation includes provisions comparable to specialty drug bills being heard in other states this session in that they require an exceptions process for specialty drugs not listed on a preferred drug formulary and prohibit all drugs in a given class from being placed on a specialty tier (see Update for Weeks of March 9th and 16th).

South Dakota

Governor signs parity bill for oral anti-cancer drugs

Governor Dennis Daugaard (R) signed S.B. 101 earlier this month. The legislation makes South Dakota one of at least 36 states to require oral anti-cancer medications be covered no less favorably than



intravenous chemotherapy (see Update for Week of March 2nd and 9th). It specifically prohibits plans from increase cost-sharing for cancer medications unless the increase is applied to all benefits.

Marketplace premiums fall as enrollment rises, despite absence of dominant carrier

The latest figures from the Division of Insurance and U.S. Department of Health and Human Services (HHS) shows that enrollment in the federally-facilitated Marketplace (FFM) operated in South Dakota increased by 63 percent during the 2015 open enrollment period.

The increase is likely due to 21 percent decrease in Marketplace premiums, which had been among the nation's highest (averaging \$298 per month for bronze coverage compared to \$249 nationwide). Although South Dakota did not add any Marketplace carriers for 2015, the three that participate added several plan options, including those that significantly lower out-of-pocket costs.

Premiums are expected to fall again for 2016 when the dominant carrier Wellmark Blue Cross Blue Shield (controlling 73 percent of the market) enters the Marketplace for the first time.

More than 21,000 consumers are now enrolled in private Marketplace plans, 86 percent of whom qualified for ACA subsidies (down from 89 percent in 2015). More than half (53 percent) were renewing customers.

Proposals by Governor Dennis Daugaard (R) to expand Medicaid only to the eligibility level for ACA subsidies (100 percent of poverty) have twice been rejected by the Obama Administration, as the ACA requires states to expand to 138 percent to receive expansion matching funds. The Governor has thus far refused to consider a full expansion, even though 26,000 South Dakotans are currently caught in the "coverage gap" between current Medicaid eligibility and the ACA subsidy threshold.