



## Health Reform Update – Week of March 30, 2015

### CONGRESS

#### ***U.S. Supreme Court denies providers the right to sue over illegal Medicaid reimbursements***

The U.S. Supreme Court ruled this week that providers do not have a private right to sue states for failing to keep Medicaid reimbursement rates high enough to ensure access to care.

The 5-4 ruling held that the supremacy clause under U.S. Constitution does not give providers legal recourse to enforce federal Medicaid law when the Centers for Medicare and Medicaid Services fails to do so. Four of the court's conservative justices were joined by liberal justice Stephen Breyer in concluding that the courts were not the proper venue for these rate disputes, as Congress did not explicitly identify such a right and the Constitution "is silent regarding who may enforce federal laws in court." Consistent with concerns expressed in oral arguments (see Update for Week of January 19<sup>th</sup>), the majority opinion argued that it was "judicially unadministrable" to confer an explicit right to sue upon providers.

Conservative justice Anthony Kennedy joined with his four dissenting liberal colleagues in essentially accusing the court of punting on the issue, noting that it has "long held that federal courts may in some circumstances grant injunctive relief against state officers who are violating, or planning to violate, federal law."

The ruling overturns two lower court decisions that ordered Idaho Medicaid to increase provider reimbursement by \$12 million to keep up with medical inflation, instead of continuing to freeze rates at 2006 levels (see Update for Week of September 29<sup>th</sup>). State officials had insisted that their 2006 rates could remain in place so long as they were federally-approved.

Numerous national groups had backed the five Idaho providers that brought the suit, including the American Medical Association and the U.S. Chamber of Commerce, as the case carried broad implications for other states, including California (see below), where the U.S. Supreme Court previously declined to intervene in a similar suit (see Update for Week of May 27, 2013). It also could dictate whether private citizens could sue states when Medicaid payments are inadequate to ensure provider access, as required by federal law.

#### ***U.S. Supreme Court rejects premature challenge to ACA "death panel"***

The U.S. Supreme Court refused to intervene this week in a challenge to the validity of the controversial Independent Payment Advisory Board (IPAB) created by the Affordable Care Act (ACA).

The court's action effectively upheld the decision by the U.S. Ninth Circuit Court of Appeals and lower court to dismiss a lawsuit claiming the 15-member Medicare cost-cutting board was an unconstitutional "death panel" that was vested with an unprecedented and centralized power to cut Medicare costs whenever preset spending targets are exceeded, unless Congress pass equivalent cuts (see Update for Week of August 18, 2014). The litigation was filed by the conservative Goldwater Institute on behalf of an orthopedic surgeon and uninsured patient whom insisted that the automatic cuts would arbitrarily reduce Medicare reimbursement and harm patient care

Lower courts dismissed the IPAB challenge on procedural grounds because the plaintiffs could not show harm since the IPAB has yet to go into effect. The Goldwater Institute pledged to renew the suit once IPAB recommendations are actually triggered.



The lower courts had also rejected plaintiffs' claim that the ACA's individual mandate violated their due process right to "medical autonomy", concluding that an uninsured person can opt to pay a tax penalty under the ACA instead of purchasing unwanted minimum coverage that he or she can afford. They likewise nullified part of the Arizona Health Care Freedom Act—a ballot referendum passed in 2010 that claimed to exempt state residents from tax penalties under the ACA (see Update for Week of November 1, 2010). The panel found that the Act presents a "classic case of preemption" by federal law, which is always supreme to conflicting state laws pursuant to the U.S. Constitution. Several conservative states have passed similar measures, although they were rejected by voters in Colorado and Florida (see Update for Week of November 5, 2012).

## FEDERAL AGENCIES

### ***Federal Marketplace signs up only 36,000 during first part of special enrollment period***

Newly-released figures from the Department of Health and Human Services (HHS) reveal that only 36,000 consumers have signed up for federally-facilitated Marketplace (FFM) coverage during the special enrollment period (SEP) that runs from March 15<sup>th</sup> to April 30<sup>th</sup>.

HHS created the SEP to allow late sign-ups after the February 22<sup>nd</sup> close of the open enrollment period for uninsured Americans that were unaware they would be subject to tax penalties for failing to purchase minimum essential coverage (MEC) until they filed their 2014 federal tax returns (see Update for Weeks of February 9<sup>th</sup> and 16<sup>th</sup>). SEP enrollees would be required to pay these individual mandate penalties under the Affordable Care Act (ACA) but would not have to go without coverage for 2015.

The 36,000 figure is but a fraction of the four million that many analysts projected would be eligible for the SEP. The Treasury Department has already estimated that up to six million Americans would be required to pay the tax penalty for 2014 and a study released this month by the McKinsey consulting firm showed that roughly 40 percent of uninsured Americans are still unaware of the individual mandate.

Under the ACA, the tax penalty for 2014 is the greater of \$95 or one percent of income. However, the penalty for 2015 rises to \$325 or two percent of income.

### ***IRS will not penalize ACA subsidy recipients that have not received correct tax forms***

The Internal Revenue Service (IRS) announced late last week that Marketplace consumers that received subsidies under the Affordable Care Act (ACA) for 2014 will not be penalized for missing the April 15<sup>th</sup> deadline due to incorrect federal income tax forms.

The issue arose in mid-February when officials with the Centers for Medicare and Medicaid Services (CMS) notified Congress that roughly 820,000 federally-facilitated Marketplace (FFM) consumers were sent tax forms that inaccurately stated that amount of the subsidies they were required to refund due to a change in income during 2014. CMS blamed the problem on "software errors" and pledged to promptly send consumers corrected forms (see Update for Week of February 23<sup>rd</sup>).

However, CMS admitted last week that it has yet to send correct tax forms to about 80,000 of those 820,000 consumers. As a result, the IRS will not penalize subsidy recipients who file after April 15<sup>th</sup>.

IRS previously stated that consumers that filed their taxes using the incorrect forms will not be required to refile (see Update for Week of February 23<sup>rd</sup>). It clarified this week that those consumers that received corrected tax forms prior to April 15<sup>th</sup> will be "encouraged" to refile but are not required to do so.

### Alaska

#### ***Governor's Medicaid expansion bill receives prompt approval from House committee***

The House Health and Social Services Committee passed Medicaid expansion legislation this week that was introduced at the request of Governor Bill Walker (I)

Despite the refusal of House Republicans to even consider Democratically-backed expansion legislation (see Update for Week of March 23<sup>rd</sup>), H.B. 148 was promptly approved with only one dissenting vote from Rep. Liz Vazquez (R) who insisted that the measure was being advanced with undue haste.

The bill will be heard next week in the House Finance Committee. The respective Senate committee has yet to hear the Senate counterpart to H.B. 148.

### Arkansas

#### ***Governor reviews legislation to increase transparency for prescription drug costs***

The legislature sent A.B. 466 to Governor Asa Hutchinson (R) this week. If signed, the measure would require qualified health plans operating in the state partnership Marketplace (SBM) to post details about coverage benefits and prescription drug costs in a "readily accessible format", starting January 1, 2017. This information must include coverage exclusions or restrictions, as well as whether the drug is subject to a flat copayment or percentage coinsurance.

The initial version that passed the Senate also included a provision requiring that health plans relying on tiered copayments for prescription drugs notify subscribers at least sixty days in advance of any increase in cost-sharing due to drug formulary changes (see Update for Weeks of March 2<sup>nd</sup> and 9<sup>th</sup>). However, this requirement was not included in the final legislation.

### California

#### ***U.S. Supreme Court decision will not stop legislative efforts to increase Medi-Cal reimbursement***

The California Hospital Association and several Democratic lawmakers insisted this week they will continue to pursue legislation to increase Medi-Cal provider reimbursement rates, despite the U.S. Supreme Court decision denying providers the right to enforce federal laws requiring payment levels be adequate to ensure access to care (see above).

The high court has already allowed ten percent across-the-board payment reductions enacted during the administration of Governor Arnold Schwarzenegger (R) to stand (see Update for Week of May 27, 2013). Assembly and Senate committees have already scheduled hearings on pending legislation (A.B. 366 and S.B. 243) that would prevent further Medi-Cal provider reimbursement cuts for services furnished on or after June 1, 2011. The bills would also align Medi-Cal payment rates with Medicare, increase rates under Medi-Cal managed care plans, and increase payment for certain inpatient services.

#### ***Health committee sets hearing on bill to prevent discriminatory cost-sharing designs***

The Assembly Health Committee has set an April 28<sup>th</sup> hearing on legislation that would specifically prevent insurers from placing all prescription drugs for certain costly conditions into specialty tiers that require a percentage coinsurance.

The consumer group Health Access California, pursued the measure (A.B. 339) that was sponsored by Assemblyman Richard Gordon (D) (see Update for Weeks of February 9<sup>th</sup> and 16<sup>th</sup>).



However, it continues to be opposed by the California Association of Health Plans, which insists that the bill would merely transfer costs back to insurers and consequently increase premiums.

Under the bill, the use of the highest-cost tier of a drug formulary would have to be based on clinical guidelines and not 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.”

#### Connecticut

#### ***Senate to vote on measures increasing Marketplace transparency, prescription drug access***

The Joint Insurance and Real Estate Committee has sent two measures to the floor that give consumers greater information about health plan options under the Affordable Care Act (ACA) Marketplace.

Similar to transparency measures advanced in states like California, Maryland, and Oregon, S.B. 751 would require Marketplace carriers to post accurate and updated directories for their provider networks online (see Update for Week of January 19<sup>th</sup>). It is sponsored by Senator Kevin Kelly (R), the ranking member for the committee, which issued a favorable report earlier this month.

A separate measure introduced by chair Joseph Crisco (D) would require insurers to publish “easily readable and understandable” information on their websites (with links from the Marketplace web portal) detailing the restrictions and out-of-pocket expenses for essential health benefits including prescription drugs. This specifically includes the dollar amount of any copayment or percentage of coinsurance applied to each covered prescription drug.

Senator Crisco initially included a provision in S.B. 24 backed by consumer groups that would prohibit insurers from moving a drug to a higher cost-sharing tier unless at least one therapeutically equivalent drug is available in a preferred or lower cost-sharing tier (see Update for Week of January 5<sup>th</sup>). However, the Connecticut Association of Health Plans and the Insurance Department insisted that such a restriction could create “unintended consequences if carriers are limited in their formulary flexibility.” The Department noted that carriers have already “voluntarily” agreed to provide advance notice to subscribers of any “adverse” formulary change (such as removing a drug or shifting it to a tier that would increase their cost-sharing) and not do so more than twice per year.

As a result, the measure that was unanimously approved by the committee requires only that the Insurance Department evaluate whether insurers are complying with the ACA prohibition against discriminatory benefit and cost-sharing designs and provide information upon request detailing which drugs are placed on specific cost-sharing tiers.

The federal Centers for Medicare and Medicaid Services (CMS) articulated this standard in their final their Notice of Benefit and Payment Parameters (BPP) regulation for 2016, stating that “placing most or all drugs for a specific condition on a high cost-sharing tier” may be considered to violate the ACA anti-discrimination provision (see Update for Week of February 23<sup>rd</sup>). However, CMS only enforces this provision when certifying federally-facilitated Marketplace (FFM) plans, while Connecticut conducts its own certification for its state-based Marketplace.

The Joint Insurance and Real Estate Committee also advanced measures that would require the Insurance Department to hold public hearings on any request by a health insurer to raise premiums by more than ten percent (S.B. 9) and add an insurance producer to the board of directors governing the Marketplace (S.B.12) (see Update for Week of January 5<sup>th</sup>).

#### Florida

#### ***Governor retracts support for Medicaid expansion as federal negotiations stall***



Governor Rick Scott (R) announced this week that he will no longer support Florida's participation in the Medicaid expansion under the Affordable Care Act (ACA).

A Medicaid expansion alternative similar to that federally-approved for Indiana unanimously cleared the Senate Appropriations Committee last week, after receiving the full backing of the Appropriations Health and Human Services subcommittee (see Update for Week of March 16<sup>th</sup>). However, it still faces long odds of clearing the House, where conservative lawmakers remain staunchly opposed "for now" to any plan that accepts federal funds (see Update for Weeks of March 2<sup>nd</sup> and 9<sup>th</sup>).

The federal Centers for Medicare and Medicaid Services (CMS) continues to pressure lawmakers into passing some form of Medicaid expansion by refusing to renew Florida's waiver that provides the state with \$1 billion in uncompensated care funding through the Low Income Program (LIP) (see Update for Weeks of February 9<sup>th</sup> and 16<sup>th</sup>). The Agency for Health Care Administration (AHCA) has been fervently trying to negotiate an extension past the waiver's June 30<sup>th</sup> expiration and accused CMS officials of abandoning negotiations this week when they took a two-week hiatus for the Easter/Passover holiday.

Frustration over the impasse with CMS led the Governor this week to retract his initial support for an ACA expansion, insisting that any future expansion should be linked to CMS' extension of LIP funds. However, the Governor's prior support was not enough to persuade House Republicans to support a Senate-passed expansion alternative last session (see Update for Week of March 31, 2014).

#### Illinois

##### ***House committee passes bill limiting prescription drug cost-sharing by metal tier***

The House Human Services Committee passed H.B. 3605 last week. The measure sponsored by Rep. Jaime Andrade (D) would limit prescription drug cost-sharing for health plans offered at the silver, gold, and platinum levels to \$100, while raising the limit to \$200 for bronze coverage. Catastrophic policies for young adults remain exempt.

H.B. 3605 is essentially the House counterpart to S.B. 1359, which was amended to include the same limits (see Update for Weeks of March 2<sup>nd</sup> and 9<sup>th</sup>). That bill remains pending in the Senate Insurance Committee with an April 24<sup>th</sup> deadline.

Both bills retain the annual out-of-pocket limit for all prescription drugs, which is set at 50 percent of the annual out-of-pocket maximum under the ACA Act (\$6,600 for individual coverage in 2015, \$13,200 for families). All plans would also still be required to implement a process by which subscribers can request an exemption from the drug formulary.

S.B. 1359 was also amended to remove the prohibition on placing all drugs for a given class into a specialty tier. This provision had been sought by consumer advocates in response to a discrimination complaint settled by the Illinois Insurance Commissioner last year and has been included in comparable bills nationwide (see Update for Weeks of February 9<sup>th</sup> and February 16<sup>th</sup>).

#### Minnesota

##### ***House panel approves bill eliminating MinnesotaCare in favor of Marketplace coverage***

Republican leaders appear likely to eliminate the state-subsidized MinnesotaCare program as part of the budget plan to be adopted by the House.

MinnesotaCare is the two-decade old state program that provides subsidies to help those just above Medicaid eligibility purchase private coverage. However, a bill passed last week by the House Government Operations and Election Policy Committee would repeal the entire program and shift all



roughly 100,000 enrollees to the MNSure state-based Marketplace operated pursuant to the Affordable Care Act (ACA).

Bill sponsor Matt Dean (R) insists that the move would save Minnesota \$900 million that could be spent on other health care priorities. However, the measure is opposed by several Republicans including Rep. Dave Baker (R), who operates several restaurants and hotels employing MinnesotaCare enrollees.

Dean's plan would provide an unspecified amount of limited subsidies for former MinnesotaCare enrollees to purchase Marketplace coverage.

#### Missouri

##### ***Senate passes measure to increase asset limits for disabled Medicaid enrollees***

The Republican-controlled Senate passed legislation this week that would slightly expand Medicaid for permanent and totally-disabled claimants.

Disabled claimants currently cannot have more than \$1,000 in assets to qualify for Medicaid if they are single, and no more than \$2,000 if married. S.B. 322 sponsored by Senate President pro tem Tom Dempsey (R) would increase those limits to \$2,000 and \$4,000 respectively starting in fiscal year 2016. They would then increase by \$1,000 and \$2,000 respectively each year until fiscal year 2020, when they will be modified based on cost-of-living adjustments.

Several Republicans including Senator Ryan Silvey (R) used debate over S.B. 322 to advocate for Missouri to participate in the larger Medicaid expansion under the Affordable Care Act (ACA). However, Republican leaders have continued to refuse to consider any expansion proposal that accepts ACA matching funds.

#### North Dakota

##### ***Senate committee advances House-passed oral parity legislation***

The Senate Human Services Committee advanced House-passed legislation this week that would make North Dakota at least the 37<sup>th</sup> state to require health insurer cost-sharing for oral cancer medications to be no greater than those imposed for intravenous chemotherapy. H.B. 1072 is expected to be approved by the full Senate.

##### ***Marketplace enrollment for 2015 hits 130 percent of target***

Recent figures released by the U.S. Department of Health and Human Services (HHS) shows that nearly 18,200 consumers enrolled in qualified health plans (QHPs) through the federally-facilitated Marketplace (FFM) during the 2015 open enrollment period, or more than 130 percent of the state's projected target

More than half (55 percent) were renewing customers, while 86 percent qualified for Affordable Care Act (ACA) subsidies. North Dakota did have the second highest average post-subsidy premium in the nation for 2014 at \$132 per month (trailing only New Jersey at \$148), which was far higher than the \$82 monthly average nationwide. However, pre-subsidy premiums for 2014 closely followed the national average (\$350 compared to \$346).

Despite having the same three FFM carriers in 2015, average premiums did fall by about three percent due to a greater number of plan options being offered (30 compared to 21).

#### Oregon

##### ***House passes bill that would limit discriminatory cost-containment measures by health plans***



The House passed H.B 2468 this week with only one dissenting vote. The legislation introduced at the request of former Governor John Kitzhaber (D) would set new minimum standards for provider networks and includes a provision prohibiting insurers from using affordability or cost containment measures that effectively discriminate against subscribers based on health status (see Update for Week of February 23<sup>rd</sup>). It now moves to the Senate Health Care Committee.

### ***House panel postpones hearing on bill to require insurers accept third-party premium assistance***

The House Health Care Committee has indefinitely postponed an April 6<sup>th</sup> hearing on new legislation that would require insurer to accept third-party payments for health insurance premiums.

The measure sponsored by Rep. Mitch Greenlick (D) (H.B. 3194) responds to the recent refusal by at least seven health insurers operating in 19 states to accept premium assistance for Marketplace plans made by non-profit charitable organizations like PSI. Moda Health, which participates in the Marketplaces for Oregon, Washington, and Alaska, has stated that they may stop allowing such premium assistance starting with the 2016 open enrollment period.

The federal Centers for Medicare and Medicaid Services (CMS) issued an interim final rule last spring that require health plans to accept third-party premium assistance from federal and state health care programs after several insurers in Louisiana started refusing to accept premium payments from the Ryan White HIV/AIDS Program (see Update for Weeks of March 17 and 24, 2014). However, this regulation gave Marketplace insurers the discretion to exclude payments from charitable groups despite assurances from the secretary for the U.S. Department of Health and Human Services that such assistance is consistent with agency rules and guidance (see Update for Week of June 2<sup>nd</sup>).

PSI plans to testify in support of H.B. 3194 and continues to work with advocacy partners in pursuing comparable state and federal legislation, as well as a CMS correction to its interim final rule.

### Tennessee

### ***Senate committee rejects Governor's Medicaid expansion plan for second time***

The Senate Commerce Committee voted 6-2 this week to reject the resurrected and revised Medicaid expansion alternative pursued by Governor Bill Haslam (R), despite the earlier approval by five Republicans on the Senate Health Committee.

All but one Commerce Republican opposed the measure (S.J. R. 93), which would authorize the Governor to secure federal approval to use Affordable Care Act (ACA) matching funds to cover roughly 280,000 adults age 21-64 that would be newly-eligible for Medicaid in employer-sponsored coverage or private Medicaid managed care plans operated by TennCare, the state's fully managed care version of Medicaid. It was modeled on the alternative federally-approved for Indiana that creates health savings accounts with state contributions for enrollees to use to pay plan premiums and cost-sharing (see Update for Weeks of January 26<sup>th</sup> and February 2<sup>nd</sup>). (Those earning below the federal poverty level would pay only pharmacy copays). Enrollees could increase their contributions through certain "healthy behaviors".

The Governor has made several efforts to retool his "market-driven" Insure Tennessee plan since it was rejected by the Senate during a special session earlier this year (see Update for Weeks of January 26<sup>th</sup> and February 2<sup>nd</sup>), including limiting it to a two-year pilot project that requires subsequent reauthorization by the legislature. The Senate Health Committee also amended the plan to soften conservative opposition, including a provision to delay implementation until the U.S. Supreme Court rules on the legality of ACA subsidies in federally-facilitated Marketplaces like Tennessee's. Another amendment required that enrollees failing to pay required premiums would be automatically disenrolled for at least six months.



Senator Doug Overbey (R), the S.J.R. 93 sponsor, stressed the positive economic impact that bringing in \$1.3 billion per year in federal funds would have on Tennessee hospitals. The Tennessee Hospital Association has agreed to cover the \$74 million state share of costs over the two-year pilot program, so it would receive a “lifeline” of \$2.8 billion in federal funds to reduce uncompensated care costs that would otherwise rise by \$7.8 billion over the next decade. Under the ACA, the state share of costs gradually starts to phase-up to a ten percent cap starting in 2016. A provision in the bill would automatically terminate the expansion if state share exceeds the ACA limits.

The Senate rejection makes the prospects for the House counterpart very uncertain. House Budget subcommittee chair Mike Harrison (R) has agreed to back the measure sponsored by Rep. Miller (D) (H.J.R. 90) and insists that Republicans have enough votes to get the measure through the House Insurance and Banking subcommittee.

Although Insure Tennessee has the strong backing of provider, consumer, and business groups, it has been steadfastly opposed by the Americans for Prosperity, the conservative group funding anti-expansion efforts in state legislatures nationwide.

#### Wisconsin

#### ***New bill would provide premium assistance for low-income adults at purchase Marketplace plans***

The Committee on Health is set to hear legislation introduced by Rep. Daniel Riemer (D) that would require the Medicaid program to pay premium and cost-sharing amounts for certain parents or childless adults to purchase qualified health plan (QHP) coverage in the federally-facilitated Marketplace.

A.B. 101 is intended to provide coverage options for those who were previously eligible for the BadgerCare Plus demonstration program that Wisconsin operated via a federal demonstration waiver since 2008. Governor Scott Walker (R) cut eligibility for this program as part of his partial Medicaid expansion plan under the Affordable Care Act that was not federally-approved (see Update for November 18-December 6, 2013). Although the Governor’s plan covered everyone earning up to 100 percent of the federal poverty level (FPL), parents and childless adults earning above that threshold are no longer eligible.

Under A.B. 101, parents and childless adults earning up to 133 percent of FPL who cannot be covered under BadgerCare Plus would receive state-funded premium and cost-sharing assistance to instead purchase Marketplace plans. The bill would make them eligible to enroll throughout the year and not just during designed open enrollment periods.

The premium assistance program would still be subject to federal approval.