



Health Reform Update – Week of May 4, 2015

CONGRESS

Senate adopts joint Republican budget that would repeal ACA provisions

The Senate narrowly voted this week to accept a joint Republican budget agreement that would allow the chamber to repeal parts of the Affordable Care Act (ACA) through the budget reconciliation process and impose more than \$430 billion in Medicare cuts over the next decade.

Senate Democrats used reconciliation to enact several key ACA provisions with only a simple majority, instead of the 60-vote margin typically required to overcome a filibuster. Republicans plan to use reconciliation to pass repeals of certain taxes imposed by the ACA, including those on health insurers, “Cadillac” health plans, and medical device companies (see below). However, the budget agreement does not identify how that lost revenue would be offset.

Reconciliation could also be used to replace part of the ACA subsidies for federally-facilitated Marketplace consumers that the U.S. Supreme Court could strike down next month (see below). However, as with repeal bills, President Obama could still veto any measures that link subsidy replacement to the elimination of key ACA provisions like the individual and employer mandates.

The budget plan passed by the Senate assumes that the Court will eliminate the FFM subsidies and the Medicaid expansion under the ACA will be fully repealed. House Republicans did drop their proposal to privatize Medicare by giving enrollees vouchers to purchase private coverage—a controversial centerpiece of three prior budgets (see Update for Week of April 7, 2014). However, President Obama has still pledged to veto the agreement due to the ACA repeal provisions and cuts in Medicare, Medicaid, and other domestic programs like food stamps (see Update for Week of March 23rd).

Congress and the White House must reach a new spending deal by the September 30th end of the federal fiscal year or risk another government shutdown.

Senate Republicans continue to offer contingency plans for federal Marketplace subsidies

Senator Ron Johnson (R-WI) introduced legislation last week that would allow federally-facilitated Marketplace consumers to keep their premium subsidies under the Affordable Care Act (ACA) in the event they are invalidated next month by the U.S. Supreme Court.

The high court held oral arguments earlier this year on whether the ACA statute authorizes the subsidies only for the 15 Marketplaces created by states (see Update for Weeks of March 2nd and 9th). According to the Urban Institute, an adverse ruling could potentially eliminate nearly \$29 million in ACA subsidies that are expected to be issued to 9.3 million FFM consumers for 2016.

Even though the Supreme Court challenge was backed by several conservative think tanks, Republican governors have largely been urging Congress to continue the subsidies through separate legislation if they are struck down (see Update for Weeks of March 2nd and 9th). Senator Johnson’s bill (S.1016) would do so through August 2017, but only if the individual and employer mandates under the ACA are repealed—provisions likely to ensure a Presidential veto.

Senator Ben Sasse (R-NE) has also introduced a bill to phase-down the subsidies over 18 months (see Update for Weeks of March 2nd and 9th), while a separate plan from Senators Orrin Hatch (R-UT), Lamar Alexander (R-TN), and John Barasso (R-WY) would temporarily continue them.



Aetna stated this week that it had assumed FFM subsidies would be retained when it submitted 2016 individual market rates to state regulators. The nation's third largest insurer noted that an adverse Supreme Court decision would force them to recalibrate their premium proposals.

Aetna, Anthem, and UnitedHealthcare all announced in recent weeks that earnings and enrollment estimates for 2015 Marketplace business beat initial estimates. Roughly 85-90 percent of their Marketplace customers currently rely on ACA subsidies.

House bills to repeal ACA taxes on health insurers receive bipartisan support

Six Democrats are among the 218 cosponsors for legislation that would repeal the Affordable Care Act (ACA) tax on health insurers, giving it a bipartisan majority in the House.

H.R. 928 was introduced earlier this year by Reps. Charles Boustany (R-LA) and Kyrsten Sinema (D-AZ). It would eliminate the tax that started at \$8 billion in 2014 but will nearly double to \$14.3 billion by 2019 and increase thereafter based on premium trends. However, lawmakers have to identify how the revenue from the tax will be offset, which the Congressional Budget Office estimates will be \$145 billion through 2024.

Meanwhile, it was House Democrats Joe Courtney (D-CT), Donald Norcross (D-NJ), and Dina Titus (D-NV) that introduced a measure last week to eliminate the 40 percent excise tax on the portion of premiums for employer-sponsored plans that exceed \$10,200 for individuals or \$27,500 for families. This "Cadillac" tax will not take effect until 2018, yet is projected to be one of the ACA's leading revenue raisers. It has drawn the ire of both Democrats and Republicans for "adversely impact[ing] beneficiaries in high-cost areas."

An Internal Revenue Service (IRS) notice earlier this year notes that the agency is considering exempting employers whose workers are mostly engaged in high-risk professions such as construction or mining (see Update for Week of February 23rd). Public comments are being accepted through May 15th.

Senate Republicans demand better oversight, guidance regarding state Marketplace funding

Senators Orrin Hatch (R-UT) and Chuck Grassley (R-IA) asked the Centers for Medicare and Medicaid Services (CMS) this week to clarify how state-based Marketplaces (SBMs) can spend federal exchange establishment grants after a federal audit found that they are being improperly used.

The Affordable Care Act (ACA) required the Marketplaces to be self-sustaining by 2015. This means that the \$5 billion in federal grants can no longer be used for operating expenses as of last January and only can be spent on "design, development, and implementation."

However, the Office of the Inspector General (OIG) for the Department of Health and Human Services (HHS) found last week that states lack clear definition from CMS regarding these categories. Furthermore, nearly half of the 15 SBMs are unable to sustain themselves solely on premium assessments or user fees, due to lower than anticipated enrollment, leading to states to improperly using remaining federal funds or seek additional grants.

CMS officials insist that they will follow OIG's recommendation for clarifying guidance and will seek to recover any misspent funds identified during their own review.

According to Avalere Health, most SBMs are struggling because building the necessary technology infrastructure has been a more challenging and costly task than envisioned. Continued problems with call centers, online web portals, and interface with federal databases have depressed



enrollment in SBMs like Hawaii, Maryland, Massachusetts, Minnesota, Vermont, Nevada, and Oregon—forcing the latter two to already default to the web portal for the federally-facilitated Marketplace (see Update for Week of June 2nd).

Unresolved technical glitches are forcing Hawaii, Minnesota, and Vermont to weigh whether to likewise default to the federal portal. Just this week, the Hawaii legislature also had to pass legislation (S.B. 1028) allowing the Marketplace to sell \$28 million in state-guaranteed debentures to cover its projected deficit through 2022 (see Update for Weeks of April 6th and 13th). The Rhode Island legislature is currently weighing whether to impose a fee on participating Marketplace plans that would increase or decrease based on operating costs for the Marketplace.

One of the most successful Marketplaces in Connecticut has already allowed Maryland to use its software to help rebuild their portal and is offering website and call center assistance to other SBMs (see Update for Weeks of March 17 and 24, 2014). Connecticut is also exploring the feasibility of creating a regional Marketplace with both Rhode Island and Vermont.

Senate Finance seeks to reduce record backlog of Medicare appeals

A Senate Finance Committee last week weighed potential changes to the Medicare appeals process that could reduce backlog of more than 500,000 cases.

Officials with the Centers for Medicare and Medicaid Services (CMS) testified that appeals are currently taking about 547 days to resolve compared to only 95 days in fiscal year 2009. The backlog is due largely due a record number of appeals being submitted (more than 700,000 in fiscal year 2013) while CMS' claims appeal staff has remained constant. As a result, the office is no longer hearing new appeal cases.

President Obama proposed to double the number of appeals staff in his fiscal year 2016 budget. However, Senator Ron Wyden (D) and CMS staff focused instead on the potential of imposing a "refundable filing fee" that would create a disincentive for provider to file claims just to "gam[e] the system." The director for the Medicare appeals office within CMS noted that 51 percent of all claims filed in fiscal year 2015 were submitted by only five organizations.

Other witnesses suggested that CMS change the streamline or eliminate the initial level of appeals, such as by allowing contractors to "triage" claims that involve clinical decisions and automatically advance them to second-level appeals. Increased use of electronic records was also proposed.

FEDERAL AGENCIES

RAND study shows 17 million gained coverage since opening of ACA Marketplaces

A RAND Corporation study published this week in *Health Affairs* concludes that nearly 17 million Americans have gained coverage since the health insurance Marketplaces created by the Affordable Care Act (ACA) opened in October 2013.

The overall number of Americans lacking health insurance plummeted nearly 40 percent from 42.7 million in September 2013 to 25.8 million by the close of the second open enrollment period in February 2015. Roughly 23 million gained coverage during this time while six million lost coverage.

The net increase of 16.9 million is slightly above the Obama Administration estimate last March that found that 14.1 million adults gained coverage since October 2013. A recent Gallup survey found that the uninsured rate for American adults now stands at only 11.9 percent--the lowest recorded figure tracking started in 2008 (see Update for Weeks of April 6th and 13th).



During the time period surveyed, RAND determined that that net enrollment rose by 9.6 million for Medicaid, 11.2 million for Marketplace plans, and eight million for employer-sponsored coverage. Roughly 37 percent of those that signed-up for Marketplaces lacked health coverage in September 2013.

Coverage through non-group plans concurrently decreased by 1.9 million and ten million for Medicare, TRICARE, and other sources.

Consistent with recent findings from the Urban Institute (see Update for Week of March 16th), the RAND study showed that concerns about plan cancellations in the individual market were largely overstated, pointing out that only 600,000 subscribers that initially had non-group coverage became uninsured. According to RAND, “the vast majority of those with individual market insurance in 2013 remained insured in 2015 [suggesting that] even among those who had their individual market policies canceled, most found coverage through an alternative source.”

In addition, researchers found that 80 percent of the 155.8 million with coverage in September 2013 did not change coverage sources during the period surveyed while 47 percent of those who were uninsured in September 2013 remained uninsured.

A separate survey released this week by The Commonwealth Fund showed that these figures can still improve dramatically if the remaining 21 holdout states participate in the Medicaid expansion under the ACA. For example, while the overall rate of uninsured among Latino adults fell by six percent since the Marketplaces opened, it is still more than twice as high as the overall rate and 20 percent higher in non-expansion states (46 percent compared to 26 percent).

The Kaiser Family Foundation released a study last week documenting that the individual insurance market in the United States grew by 46 percent in the first year of the new Marketplaces and by more than 75 percent in six states (Arkansas, Florida, Georgia, Maine, New York and Rhode Island.)

HRSA will shortly release long-sought guidance to improve 340B oversight and transparency

The Office of Management and Budget (OMB) has received new draft guidelines from the Health Resources and Services Administration that will provide some long-sought clarification of definitions and rules governing the Section 340B drug discount program.

The OMB paperwork clearance is the final required step before the rules are formally published with a 60-day public commented period. According to HRSA, the new guidelines will address many policy issues, including eligibility for hospitals and outpatient facilities, a patient definition, and compliance by manufacturers and contract pharmacies.

A Congressional subcommittee had nearly unanimously urged HRSA last month to implement long-standing recommendations from the Department of Health and Human Services Office of Inspector General (HHS OIG) and GAO to not only create a “clear definition” of eligible patients but set increase program transparency and oversight regarding how covered entities are spending program savings (see Update for Week of March 23rd). The agency has been heavily criticized by Congress since 2011 when government audits blamed a lack of oversight for allowing 340B providers to reap “windfall profits” when using discounted 340B drugs to also treat Medicare or private insurance patients (see Update for Weeks of July 1 and 8, 2013).

HRSA insists they have made several efforts to increase program oversight and integrity in response to these criticisms, 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, they have elected to pursue program changes through the forthcoming guidance document instead of formal rulemaking.

HRSA also sent out an email last week stating that it will implement a system later this year to verify the accuracy of 340B ceiling price submitted by drug manufacturers and urging them to voluntarily make “any necessary corrections today [that] will promote the security and integrity of your sensitive pricing data.” The agency has already submitted an Information Collection Request to OMB proposing to collect Average Manufacturer Price, unit rebate amount, package sizes, National Drug Code, period of sale and manufacturer-determined 340B ceiling prices.

The Affordable Care Act requires HRSA to provide access via website to ceiling prices of 340B drugs for the nearly 11,000 participating safety-net providers that receive 340B discounts (totaling about on outpatient drugs used to treat low-income and uninsured patients. It also authorized a forthcoming rule imposing penalties on manufacturers that fail to offer 340B ceiling prices to participating providers.

Safety Net Hospitals for Pharmaceutical Access and other groups have been demanding to see them after 2006 OIG report found that at least 14 percent of 340B purchase improperly exceeded these ceiling prices. HRSA is supposed to keep 340B ceiling price data privileged and not disclose them to participating providers. However, groups representing drugmakers have opposed such disclosures until HRSA issues rules governing how ceiling prices will be calculated and confidentiality maintained.

STATES

CMS warns nine states that uncompensated care funds are contingent on expanding Medicaid

The Centers for Medicare and Medicaid Services confirmed last week that it has officially warned nine states with federal waivers for uncompensated care pools that such funding will not be continued if they do not expand Medicaid pursuant to the Affordable Care Act (ACA).

The move has already resulted in a federal lawsuit filed by Florida Governor Rick Scott (R), whose state’s Low Income Pool (LIP) waiver is set to expire on June 30th (see Update for Weeks of April 6th and 13th). Governor Scott insists that CMS’ refusal to extend the waiver (which provides Florida with more than \$2 billion per year in federal funds) amounts to the same type of “unlawful coercion” that the U.S. Supreme Court sought to prevent when it gave states the discretion to opt-out of the Medicaid expansion without penalty (see Update for Week of June 25, 2012).

Republican governors in Texas and Kansas filed “friend of the court” briefs this week in support of the Florida legislation, after CMS similarly stated that their low income pool funding would not be renewed (in 2016 and 2017 respectively). Arizona, California, Hawaii, Massachusetts, New Mexico, and Tennessee are the other states with separate federal funding waivers for uncompensated care. Florida, Kansas, Tennessee, and Texas are the only states in this group that have not expanded Medicaid.

In its notice, CMS claimed that expanding Medicaid pursuant to the ACA is a more efficient and beneficial route to ensuring access to care than the continued “overreliance on supplemental payments” through the low income pool. The agency stressed that the demonstration waivers creating the programs were by their very nature temporary and not intended to last indefinitely. Such waivers are issued solely at the discretion of the agency and do not create any permanent or long-term entitlement.

Insurer denying premium assistance in 16 Marketplaces to stop selling plans for 2016

The parent company for Assurant Health announced last week that it will stop selling health plans if unable to sell the unit by the end of the year, after the insurer posted operating losses of \$80-90 million for the first quarter of 2015.



Assurant Health, which had a net income of \$54 million prior to the Affordable Care Act (ACA), opted to participate in 16 federally-facilitated or state partnership Marketplaces for 2016. However, it spent just over 30 percent of every premium dollar on administration or profit, well above the 20 percent limit required by the Affordable Care Act (ACA) for individual and small group insurers.

Because Assurant Health was largely unable to meet this medical-loss ratio, it was required to issue significant consumer rebates under the ACA. As a smaller insurer (covering only 967,000 subscribers in 2014), it was unable to spread administrative costs over a large number of subscribers. As a result, its losses were unsustainable despite the increased premium revenue from Marketplace business (up \$300 million from 2013).

In order to compensate, Assurant Health was one of 28 insurers in 23 states that have exercised the discretion granted by the Centers for Medicare and Medicaid Services to refuse third-party premium assistance for Marketplace consumers from charitable groups, even though they are required to accept such assistance from federal and state health programs (see Update for Weeks of March 17 and 24, 2014). PSI has been lobbying CMS and/or Congress to close this loophole, which allows insurers to effectively discriminate against consumers with costly conditions, contrary to the anti-discrimination provisions of the ACA.

Drug pricing transparency bills continue to proliferate despite early failures

The Assembly Health Committee in California rejected a measure last week that would have required that drugmakers report the production costs for specialty drugs costing more than \$10,000 per year. Under A.B. 463, the information that would be furnished to the Office of Statewide Health Planning and Development includes cost data related to acquisitions, clinical trials, marketing, profits, and research and development (see Update for Week of February 23rd). In addition, manufacturers would have to detail the level of financial assistance provided to patients through various third-party programs.

The measure was thought to be the first of its kind in the nation but faced intense industry opposition. Bill sponsor David Chiu (D) has pledged to introduce a revised version next session.

Even though a similar measure also failed in the Oregon legislature (H.B. 3486), other bills seeking to publicize manufacturer costs and profits for specialty drugs have surfaced in states like Massachusetts (S.B. 1048), North Carolina, and Pennsylvania (H.B. 1042).

The Pharmaceutical Research and Manufacturers of America (PhRMA) insists that the data sought by these bills are largely proprietary and not required for any federal or state programs. The chief executive for California Association for Health Plans, which backed Rep. Chiu's bill, acknowledged that some of the pricing information may be unobtainable but insisted that the legislation was needed to for "starting a conversation....about why these drugs are priced so high."

ACA enrollees more satisfied than those with employer-based plans

A new J.D. Power survey of more than 3,000 individuals concluded that those purchasing coverage through the Marketplaces created by the Affordable Care Act (ACA) were slightly more likely to be satisfied with their plan than those with other types of individual health insurance.

Respondents rated satisfaction with their health plans on a scale of one to 1,000. The survey showed that Marketplace received an average of 696 points compared to only 679 for those enrolled in individual coverage through their employer. It also found that plan satisfaction increased by 55 points from 2013 (to an average of 670 in 2014).



The survey revealed that individual consumers in the ten Marketplaces where states are partnering with the federal government reported the greatest satisfaction (an average of 716) compared to a 699 average for the federally-facilitated Marketplace and 683 for state-based Marketplaces.

Researchers found that cost was the single greatest factor influencing consumer satisfaction with their health coverage.

Arizona

Judge grants patients a voice in deciding whether Medicaid expansion plan will survive

A Maricopa County Superior Court judge ruled this week that because patients have a significant stake in the outcome of a constitutional challenge to the state's Medicaid expansion, the court will hear directly from patients before issuing a decision.

The lawsuit is challenging the process the legislature followed in enacting an assessment on hospitals to fund the Medicaid expansion sought by former Governor Jan Brewer (R). The measure passed by a very narrow majority but at least 36 Republican lawmakers insisted the assessment was a tax that instead required a two-thirds supermajority pursuant to the Arizona Constitution (see Update for Week of February 10, 2014).

The Superior Court initially dismissed their claim for lack of standing, arguing that lawmakers are not directly impacted by the program expansion. However, the state Supreme Court reversed that decision and remanded it back to the Superior Court, which has set a July 10th date for oral arguments (see Update for Week of March 16th).

The Arizona Center for Law in the Public Interest applauded the judge's decision to ensure their low-income clients were part of the process. The conservative Goldwater Institute funding the lawsuit had opposed their participation.

California

Health committee passes measure to limit out-of-pocket costs for prescription drugs

The Assembly Health Committee passed the amended version of A.B. 339 last week on a 12-5 vote. The measure would specifically limit cost-sharing to 1/24 of the annual out-of-pocket (OOP) limit applicable to individual coverage for a supply of up to 30 days, similar to last year's version that included a limit of 1/12 of the OOP limit (see Update for Weeks of August 25th and September 1st). It also retains a provision barring plans from placing most or all of the drugs to treat a specific condition on the highest cost tiers of a formulary (see Update for Weeks of April 6th and 13th).

The initial version of the legislation has required simply that cost-sharing for all outpatient prescription drugs to be "reasonable" to ensure access (see Update for Weeks of February 9th and 16th). It now heads to the Appropriations Committee.

The Health Committee unanimously approved two other measures limiting OOP costs (see Update for Weeks of April 6th and 13th). A.B.1305 would ensure that the annual OOP limit under the Affordable Care Act (ACA) for individual coverage (currently \$6,350) be applied to individuals within a family plan, instead of the ACA limit for family coverage (currently \$12,700). A.B. 533 would also protect patient from "surprise" bills from out-of-network physicians treating a patient at an in-network facility.

Bill to expand Medi-Cal to undocumented immigrants on hold after cost estimate

A scaled-back bill to expand Medi-Cal coverage to roughly 1.5 million undocumented immigrants that meet current eligibility criteria has been placed on hold after a legislative fiscal analysis estimated that it would cost from \$175-740 million.



The Senate Appropriations Committee referred S.B. 4 to the suspense file, where measures that cost more than \$50,000 in state general funds are placed until they can be reviewed against the state budget. The bill is a second attempt by Senator Ricardo Lara (D) to expand Medi-Cal coverage to undocumented immigrants. His initial version failed last year after its cost estimate came in at \$1.3 billion.

Senator Lara did remove a provision from last year's bill that increased the cost by offering premium subsidies for undocumented immigrants to purchase private coverage through Covered California. S.B. 4 would still allow them to do so with their own funds if California secures a federal waiver lifting the Affordable Care Act ban on undocumented immigrants purchasing Marketplace coverage.

The price tag for S.B. 4 is so high because federal Medicaid matching funds would not be available for covering undocumented immigrants. However, the actual cost would vary greatly depending on the outcome of federal lawsuits seeking to block President Obama's executive action protecting nearly five million undocumented immigrants from deportation. If President's order is upheld, roughly 900,000 undocumented immigrants would already become Medi-Cal eligible without passing S.B. 4.

Despite the costs, most consumer advocacy groups in the state including Health Access California continued to back the measure, insisting that expanding coverage, especially for preventive care, would greatly reduce uncompensated care and save money for taxpayers. It unanimously cleared the Health committee last month (see Update for Weeks of April 6th and 13th).

State officials declare latest Anthem and Aetna rate hikes "unreasonable"

Insurance Commissioner Dave Jones (D) declared last week that a nearly nine percent average premium increase by Anthem Blue Cross is "unjustified and unreasonable".

The hike applies to "grandfathered" individual health plans that continue to remain exempt from several Affordable Care Act (ACA) standards and went into effect on April 1st. Roughly 4,000 of the 170,000 affected subscribers saw a 25 percent rate hike.

The commissioner stated that Anthem failed to provide actuarial justification for such a dramatic increase, claiming that the insurer was exaggerating its past and future expenses and noting that Anthem has raised premiums on the "grandfathered" plans by more than 26.5 percent over the last two years without providing any extra benefits. His department instead determined that only a 1.5 percent average increase was justified.

Jones directly accused Anthem of trying to unrealistically jack-up rates on "grandfathered" plans in order to force subscribers into Marketplace plans with "with narrower networks and potentially less access to medical providers." However, Anthem insisted that the nearly nine percent average hike was justified due to higher costs for prescription drugs and the number of "specialty drugs [that] are expected to be released in the next year." The insurer also claimed that the risk pool for "grandfathered" plans skews towards older and more costly subscribers, which further warrants higher premiums.

The Department of Managed Health Care also took issue with a 19.2 percent average increase on small group plans imposed April 1st by Aetna, insisting that it did not accurately reflect medical inflation. This is the third time since 2013 that the Commissioner or DMHC has declared an Aetna rate hike to be "unreasonable" or "unsupported" (see Update for Week of December 15th).

Commissioner Jones has crusaded against rate hikes by Anthem and other large insurers that he believes to be "excessive". However, as both an Assemblyman and Insurance Commissioner, he has been unsuccessful in granting his office the authority to reject or modify excessive increases (see Update for Week of November 3rd). As a result, he has used state law and Affordable Care Act (ACA) provisions



to publicly shame insurers for more than \$250 million in premium increases that lacked supporting justification (see Update for Weeks of October 20th and 27th).

Florida

House ends Medicaid expansion negotiations with early adjournment

The House abruptly ended the regular session last week three days early and prior to the adjournment by the Senate, effectively relegating the ongoing debate over Medicaid expansion until a special session.

The move violated the state constitution. However, the Florida Supreme Court refused to act on the petition from the Senate President to force the House to return, claiming that no remedy was available once House members have left town.

Republican leaders in the Senate had been trying to negotiate with the Republican House Speaker on a Medicaid expansion alternative that could clear the House. However, House conservatives remain steadfastly opposed to accepting federal expansion funds, even though Florida will lose \$2.2 billion in federal uncompensated care funds on July 1st if it fails to expand (see Update for Week of April 6th and 13th).

Senate leaders derided the Governor's decision to file a lawsuit trying to force the Obama Administration to extend the demonstration waiver that provides the uncompensated care funding. They also continue to push House members to support the Medicaid expansion alternative that already cleared the Senate (see Update for Week of March 30th).

The stalemate has prevented lawmakers from passing a budget for the fiscal year that starts July 1st. As a result, Governor Scott has already indicated that he will call a special session in June to resolve the impasse. However, House leaders such as Appropriations Committee chair Richard Corcoran (R) insist that they are "not dancing this session...not dancing next session [and] not dancing next summer" and dared Senate leaders to "blow up the process" by insisting on Medicaid expansion.

Nearly all Medicaid HMOs are losing money due to prescription drug spending

An analysis prepared for the Agency for Health Care Administration (AHCA) by the Milliman consulting firm revealed last week that the state greatly underestimated plan costs for moving nearly all Medicaid recipients into managed care.

The transition to managed care concluded last summer (see Update for Weeks of April 28 and May 5, 2014). The spreadsheet released by the agency shows that almost all of the managed care organizations servicing Florida Medicaid enrollees are losing money. The losses totaled more than \$300 million and could reach \$700 million by June 30th. UnitedHealthcare alone accounted for roughly one-third of these losses as of December, while WellCare Health Plans and Sunshine Health Plan also were deep into the red.

The Florida Association of Health Plans attributed the losses largely to higher than expected prescription drug costs. Not only are patients using more drugs than anticipated, the drug costs per patient are also well above predicted levels. For example, drug spending for elderly and disabled Medicaid enrollees averaged nearly \$250 per month from May to December of last year, above the \$198-236 estimate that insurers used to build premiums. This caused plans to spend 97 percent of every premium dollar on medical services and drugs, leaving only three percent instead of the customary ten percent for administration and overhead.



The Association also blamed AHCA's decision to require that plans use the state formulary, in an effort to ease their transition into managed care. They claimed this forced physicians to prescribe costlier brand-name drugs for Medicaid patients even when they prescribe generics for private pay patients.

Louisiana

House and Senate panels reject Medicaid expansion bills for third straight year

For the third year in a row, the House and Senate Health and Welfare committees voted on a largely party-line vote last week to block all Democratic legislation that sought to expand Medicaid pursuant to the Affordable Care Act (ACA).

Senator Ben Nevers (D) and Rep. John Bel Edwards (D) had pushed their Medicaid expansion bills (S.B. 40 and H.C.R. 3) on both fiscal and moral grounds. However, Republican lawmakers would not budge from their refusal to accept the ACA matching funds, despite a \$1.6 billion budget shortfall.

The Senate committee also voted to reject S.B. 10 sponsored by Senator Karen Peterson (D), which would have allowed a voter referendum to decide whether Louisiana should participate in the Medicaid expansion. Only one Republican, Senator Fred Mills, backed the measure.

Insisting that the Medicaid program is "inefficient", Governor Bobby Jindal has steadfastly opposed any form of Medicaid expansion for Louisiana, leaving roughly 250,000 citizens caught in the gap between existing program eligibility and the threshold for ACA Marketplace subsidies (for those earning at least 100 percent of the federal poverty level). The measures had the backing of the state provider, consumer, and business groups and no witnesses testified in person against the measures (the conservative group Americans for Prosperity did register their opposition).

The only Medicaid expansion bill to advance was H.C.R. 75, which allocates a voluntary assessment on Louisiana hospitals to expand Medicaid should a future governor agree to do so. Backed by House Speaker Chuck Kleckley (R), that measure cleared the House Appropriations Committee.

Mississippi

Governor signs parity bill for oral anti-cancer drugs

Governor Phil Bryant (R) signed H.B. 952 last month, making Mississippi one of at least 36 states (including the District of Columbia) requiring that insurance coverage for oral chemotherapy drugs is at least equivalent to coverage for intravenous chemotherapy. A similar bill remains pending in the New Hampshire House (S.B. 137).

Missouri

Governor signs law restoring medical malpractice caps

Governor Jay Nixon (D) signed S.B. 239 into law this week, which creates new limits on monetary damages for medical malpractice lawsuits in place of those that were previously struck down by the Missouri Supreme Court (see Update for the Weeks of July 23 and 30, 2012).

The previous caps of \$350,000 are now set at \$400,000 for personal injury damages and \$700,000 for a catastrophic injury. It also includes a clause to increase the limits by 1.7 percent each year, a provision intended to attract support from Democratic lawmakers. Even though the Congressional Budget Office (CBO) found in 2003 that states with such caps have reduced health care costs by less than two percent, the governor insisted they were needed to avert the "climate of financial uncertainty for health care providers" that resulted by Missouri having no limits for the past three years.

It is not yet clear if the new limits will survive legal challenges, as the high court previously ruled that any restriction on damages violated a plaintiff's constitutional right to a jury trial.



Montana

Governor signs “most conservative” Medicaid expansion alternative into law

Montana is set to become the 29th state to participate in the Medicaid expansion under the Affordable Care Act (ACA) after Governor Steve Bullock (D) signed the *Health and Economic Livelihood Partnership Act* into law last week.

S.B. 405 is a compromise between the traditional expansion sought by the Governor (which the committee already rejected) and a private-sector alternative comparable to the model already federally-approved for six states. A coalition of 13 moderate Republicans joined with Democrats in securing House passage earlier this month despite intense conservative opposition (see Update for Weeks of April 6th and 13th).

The bill was hailed as the “most conservative” of the Medicaid expansion alternatives proposed nationwide. However, it remains unclear whether the plan will secure the necessary federal waiver. In order to attract enough Republican support, the bill includes similar types of work and premium requirements that the Centers for Medicare and Medicaid Services has rejected and removed from waivers sought by states like Pennsylvania, Indiana, and Tennessee (see Update for Weeks of January 26th and February 2nd). This includes automatically disenrolling those who earn from 100-138 percent of the federal poverty level and fail to make timely premium payments.

The measure continues to receive strong support from Montana Health Care Providers and other provider groups, citing studies showing it will boost hospital revenue in the state by nearly \$1 billion in 2022. Montana hospitals incurred nearly \$400 million in uncompensated care costs in 2013 and are slated to lose \$18 million in federal indigent care payments starting in 2017.

The Kaiser Family Foundation estimated this week that the remaining 21 “opt-out” states could reduce their uncompensated care costs by up to \$266 billion over the next ten years if they participated in the Medicaid expansion.

Nevada

Legislation would allow Marketplace board members to have insurer affiliations

The Senate Committee on Commerce, Labor, and Energy is considering House-passed legislation that will remove the existing prohibition on Silver State Health Insurance Exchange board members being affiliated with a health insurer. Under A.B. 86, no more than two of the seven voting members for the Marketplace created pursuant to the Affordable Care Act would be allowed to represent any particular area or expertise. In addition, the Marketplace would no longer be required to be “state-based” after it defaulted to the online web portal for the federally-facilitated Marketplace for the 2015 open enrollment period (see Update for Week of June 2nd).

Pennsylvania

Governor will create ACA Marketplace if necessary to protect ACA subsidies

New Governor Tom Wolf (D) announced last week that Pennsylvania will create its own Marketplace if the U.S. Supreme Court invalidates Affordable Care Act (ACA) subsidies next month.

The high court is currently evaluating whether the text of the ACA statute authorizes subsidies only for Marketplaces created by the states (see Update for Weeks of March 2nd and 9th). Since Pennsylvania is one of 36 states that instead defaulted to the federally-facilitated Marketplace (FFM), converting to a state-based Marketplace would presumably protect the subsidies for roughly 382,000 Pennsylvanians should the Supreme Court deny them to FFM enrollees.



The Governor revealed that he has already submitted a contingency plan to the federal Centers for Medicare and Medicaid Services but stressed that it would not go into effect if the court preserves the subsidies for all Marketplace enrollees.

Washington

Governor signs bill broadening eligibility for prescription drug assistance

Governor Jay Inslee (D) signed legislation last week broadening eligibility for the Prescription Drug Assistance Foundation (see Update for Week of February 23rd).

The foundation was created by the legislature in 2005 as a non-profit corporation that uses donations and other private and public grants (apart from state general funds) to help “qualified uninsured individuals” earning less than 300 percent of the federal poverty level to obtain prescription drugs at little or no cost. Under existing law, “qualified uninsured individual” is defined as a resident lacking health insurance coverage that includes a prescription drug benefit, which can include employer-sponsored coverage, as well as Medicare, Medicaid, or other public programs.

The measure sought by Rep. Marcus Riccelli (D) expands this definition so that the foundation can also assist those also defined as “underinsured”. H.B. 2021 would define “underinsured” as an individual that has prescription drug coverage that is “inadequate for their needs.”

In addition, the definition of health insurance coverage is amended to include coverage in the Marketplace created pursuant to the Affordable Care Act.