



Health Reform Update – Weeks of June 8 and 15, 2015

CONGRESS

House votes to repeal medical device tax under ACA

One out of every five House Democrats joined with all of their Republican colleagues this week in voting to repeal the tax on medical device manufacturers imposed by the Affordable Care Act (ACA).

The vote marks the fourth time that the House has sought to repeal the 2.3 percent excise tax (see Update for Week of June 1st). A second measure to repeal the controversial Medicare cost-cutting board (H.R. 1190) also has significant bipartisan support (20 Democratic cosponsors) and is expected to receive a floor vote next week.

The device tax repeal (H.R. 160) now heads to the Senate, despite the estimated cost of \$7.1 billion over ten years, which was not offset. Republicans did propose to offset the Independent Payment Advisory Board repeal by further cutting the ACA fund that covers cost-sharing for certain preventive services.

President Obama has pledged to veto either measure, should it clear the Senate. Neither currently has the supermajority needed to override a veto.

House-passed Medicare Advantage bills include program to encourage lower drug cost-sharing

The House passed four Medicare Advantage (MA) reform bills this week by voice vote, which are intended to “remove many unnecessary bureaucratic burdens” from the private managed care plans.

The *Medicare Advantage Coverage Transparency Act* (H.R. 2505) would require the Department of Health and Human Services (HHS) to submit enrollment data on Medicare Parts A, B, C and D by zip code, congressional district and state. The *Increasing Regulatory Fairness Act* (H.R. 2507) would give plans 60 days to respond to annual pay rules instead of 45 days. The *Seniors' Health Care Plan Protection Act* (H.R. 2582) would prohibit CMS from terminating Medicare contracts for MA plans (until after 2018) just because they received low star ratings.

A additional bill, the *Strengthening Medicare Advantage through Innovation and Transparency for Seniors Act* (H.R. 2570), would create a demonstration program using value-based insurance design that is intended to show how reducing beneficiary cost-sharing on high-value drugs and services can actually increase their use, improve outcomes and lower health spending.

New House and Senate bills would require parity in coverage for oral and IV cancer drugs

Bipartisan legislation was introduced last week in both the House and Senate that would require private health plans covering intravenous cancer drugs to provide equivalent coverage for orally-administered and self-injectable cancer drugs.

H.R. 2739 was sponsored by Representatives Leonard Lance (R-NJ) and Brian Higgins (D-NY), while S. 1566 was sponsored by Senators Mark Kirk (R-IL) and Al Franken (D-MN).

Similar cancer drug parity legislation has already been enacted in at least 36 states including the District of Columbia (see Update for Week of May 4th).

CMS will let states seek extensions to use leftover Marketplace establishment grants

The Centers for Medicare and Medicaid Services (CMS) issued new guidance this week clarifying how states can use the remaining funds from federal exchange establishment grants.

All states but Alaska accepted some form of the federal grants intended to help them create their own health insurance Marketplaces (or exchanges) under the Affordable Care Act (ACA). A dozen states did not seek additional funding beyond the initial grants, while 37 states and the District of Columbia received supplement Level 1 or 2 establishment grants.

The long-awaited frequently asked questions guidance was requested by Senators Orrin Hatch (R-UT) and Chuck Grassley (R-IA) after an audit by the Inspector General for the Department of Health and Human Services warned CMS that state-based Marketplaces were inappropriately channeling establishment grants to operating costs and other improper purposes (see Update for Week of May 4th).

The ACA required state-based Marketplaces to be financially self-sustaining as of January 1st. As a result, the guidance reminds states that any unused funds from establishment grants cannot be used for activities defined as an “ongoing operation”, such as call center operations, hardware and software maintenance, telecommunications and utilities, and rent.

By contrast, appropriate establishment uses include the design, development, and testing of information technology functions, ensuring compliance with data system and program audit policies, and outreach, education, and call center efforts to boost enrollment. Indirect costs that support establishment work, such as salaries, may also be paid for with establishment grant funding. However, all “allowable establishment activities that may be supported with [establishment grant] funds after January 1, 2015...must have been specifically described in a grantee’s approved work plan.”

CMS will allow states that have not used up their Level 1 or 2 grants to request a “no-cost extension” to complete establishment work that was part of their approved work plans under the grant. This would allow establishment work to continue past the one-year project period from the date of the award. According to President Obama’s fiscal year 2016 budget proposal, nearly \$380 million of establishment grants have to be spent by states.

CMS boosts reinsurance payments for extraordinary losses incurred by Marketplace plans

The Centers for Medicare and Medicaid Services announced this week that Marketplace insurers that experienced an exceptional number claims for 2014 will receive additional relief under the Affordable Care Act (ACA) reinsurance program.

The three-year program expires in 2016 and is funded by a \$63 per customer assessment on health insurance premiums. CMS now anticipates that the assessment will raise about \$9.7 billion by November 15th, which is higher than projections and should leave remaining funds for the agency to cover 100 percent of insurer costs above \$45,000 instead of the 80 percent threshold set by earlier regulations (see Update for Week of June 2, 2014). Payments will still be capped at \$250,000.

CMS plans to remit payments to insurers starting in August 2015. However, plans will start receiving reports on June 30th identifying the total amount of reinsurance payments they will receive for the 2014 benefit year.

Several Republican lawmakers including Senator Marco Rubio (R-FL) have insisted that the payments amount to an “insurer bailout” and sought to block funding for the program, which has already



been expanded to compensate insurers for the Administration's decision to extend ACA-deficient plans (see Update for Week of March 10, 2014).

OIG says CMS is poorly managing ACA subsidy payments

A new report issued this week by the Office of the Inspector General (OIG) for Health and Human Services puts the blame squarely on the Centers for Medicare and Medicaid Services (CMS) for inaccuracies in premium and cost-sharing subsidies issued under the Affordable Care Act (ACA).

According to OIG, CMS does not have "effective internal controls" in place to calculate or disperse the subsidies and frequently fails to "follow its guidance for calculating" proper subsidy amounts. It specifically cited CMS' lack of electronic systems that can communicate with state-based Marketplaces and recommended that it install new computer systems and infrastructure that can track and verify individual subsidy payment data, instead of simply relying on data provided by insurers.

CMS agreed with OIG's report and states that they are working to improve their processes.

New 340B rule would fine manufacturers that overcharge for covered drugs

The Health Resources and Services Administration (HRSA) released proposed regulations this week governing the calculation of ceiling prices for discounted outpatient drugs furnished to safety net providers through the Section 340B Drug Pricing Program, as well as the application civil monetary penalties for non-compliant manufacturers.

The rule is only part of the broader regulatory guidance and oversight sought by Congress that is still awaiting the required paperwork clearance by the Office of Management and Budget (see Update for Week of May 4th). Those regulations are expected to be issued by September.

This week's rulemaking provides "precisely defined standards" to calculate ceiling prices by "subtracting the unit rebate amount (URA) from the average manufacturer price (AMP) for the smallest unit of measure." HRSA will then multiply this amount by the drug "package size and case package size." Based on existing guidelines, manufacturers should continue to estimate the 340B ceiling price for the first three quarters a new covered outpatient drug is available and issue refunds or credits to covered entities that purchase the drug above this ceiling "no later than the end of the fourth quarter after the drug is available for sale."

The rule also seeks to implement the ACA penalty of up to \$5,000 each time a manufacturer "knowingly and intentionally" overcharges a covered entity beyond this ceiling price. Despite earlier audits by the Inspector General for the Department of Health and Human Services determining that as much as 14 percent of 340B drug purchases exceeded ceiling prices (see Update for Weeks of July 1 and 8, 2013), HRSA states in the rule that it expects these overcharging penalties to be rarely imposed, given that manufacturers are now being provided with the clearer guidance that OIG recommended.

HRSA estimates that the \$7 billion in annual 340B purchases as of 2013 represent about two percent of the nation's total prescription drug market—or three times more than in 2005. The ACA also expanded the number of providers that can participate in 340B, rising to 2,140 entities by 2014 (or nearly four times more than in 2005).

HRSA will accept public comments on the proposed rule through August 17th.

STATES

Three states win approval to create Marketplaces in order to protect premium subsidies



The Centers for Medicare and Medicaid Services (CMS) announced this week that three states have been “conditionally approved” to create their own state-based Marketplaces (SBM) if the U.S. Supreme Court invalidates Affordable Care Act (ACA) premium subsidies for consumers in federal Marketplaces (see Update for Weeks of March 2nd and 9th).

Two of the states, Arkansas and Delaware, currently operate state-partnership Marketplaces (SPM) where the state assumes only limited Marketplace functions and relies on the federal web portal. The remaining state, Pennsylvania, is a federally-facilitated Marketplace (FFM).

The conditional approval allows Arkansas to start operating its own Small Business Health Options Program (SHOP) Marketplace for small group coverage starting in 2016 and the individual Marketplace in 2017. Governor Asa Hutchinson (R), who assumed office in January, did not block his Democratic predecessor’s plan from last year to shift to full state control. However, it would still require approval from the Republican-controlled legislature that has already passed legislation barring any such transition until the U.S. Supreme Court decides on the validity of FFM subsidies.

Both Delaware and Pennsylvania received conditional approval to run SBMs for individual and small group coverage starting next year, after submitting contingency plans just last month (see Update for Week of May 4th). However, as with Arkansas, a final decision in Pennsylvania rests with the Republican-controlled legislature, which has already been at odds with new Governor Tom Wolf (D) over his decision to convert his predecessor “private sector” alternative to the ACA’s Medicaid expansion into a more traditional expansion (see Update for Weeks of March 2nd and 9th). The Secretary for the Delaware Health and Social Services agency also insists that they have not made a final decision on whether to remain a SPM should the Supreme Court uphold the subsidies.

Mississippi Insurance Commissioner Mike Chaney (R) has submitted a contingency plan to the Governor, Lieutenant Governor, and House Speaker that would also protect the ACA subsidies for that state’s FFM. The plan would funnel federal funding for plans purchase through the Mississippi Comprehensive Health Insurance Risk Pool Association to Marketplace insurers. However, approval from state officials appears unlikely given the steadfast opposition by Governor Phil Bryant (R) to “anything to do with the Affordable Care Act.”

Studies show wide variance in average silver-plan premium increases for 2016

An Avalere Health analysis of preliminary rate proposals in eight states has found that premiums for 50-year old non-smokers in silver-level plans are likely to increase by an average of about 5.8 percent (to \$448 per month), with only a one percent average increase for the second-lowest cost silver plans to which premium and cost-sharing subsidies under the Affordable Care Act (ACA) are tied.

Avalere selected reviewed those states for which all rate filings have been published (CT, DC, MD, MI, OR, VT, VA, and WA), as opposed to CMS which only published proposed increases in federally-facilitated Marketplaces of at least ten percent (see Update for Week of June 1st). Despite the modest average increases, the report did note that there were significant variations among states. For example, the average change for a 50-year old non-smoker in all silver plans ranged from 12 percent increase in Oregon to a 5.3 decrease in Michigan.

However, a separate HealthPocket analysis of 3,800 plans across 45 states found a much higher 12 percent average increase among all silver-level plans. Avalere claimed that the discrepancy in studies is due to the fact that HealthPocket only analyzed rates for major cities and not the entire state.

Both studies stressed that the rate filings are not final and can still be modified in some instances by state regulators. For example, the Oregon Insurance Commissioner actually raised some premiums beyond what was proposed in order to ensure “stability” in the individual market. The commissioner



insisted that Oregon's premiums—among the nation's lowest—were forcing insurers to tap too heavily into reserves in order to cover claims costs that ran \$100 million higher than premium revenue for 2014. As a result, her office forced an eight percent average increase on Kaiser Health Plan of the Northwest, even though it sought a slight decrease. It also raised the average silver-plan premium for a 40-year old from Zoom Health to \$291 per month (a 25 percent increase from the \$233 premium that it proposed).

Overall, the Oregon Insurance Commissioner allowed average silver premiums for 40-year olds to rise by 22 percent for 2016, pending public hearings later this month, in order to ensure “pricing that is much closer to the cost of delivering health care.”

Arizona

Medicaid cancels five percent cut in provider payments

The Arizona Health Care Cost Containment System (AHCCCS) announced last week that it has canceled the five percent cut in Medicaid provider payments that was set to take effect on July 1st.

Governor Doug Ducey (R) has already signed a budget for fiscal year 2016 that includes \$37 million in projected savings from the rate reduction. However, after the cut was intensely opposed by the provider community, AHCCCS officials insisted that it was no longer necessary due to lower-than-expected service utilization among Medicaid enrollees and a prescription drug rebate.

Public comments from 145 providers urged AHCCCS not to implement the cuts, given the more than 340,000 Arizonans that have been added to Medicaid since it was expanded in January 2014 pursuant to the Affordable Care Act. At least 38 Republican lawmakers are plaintiffs in a pending lawsuit challenging the expansion enacted by former Governor Jan Brewer (R) (see Update for Week of May 4th).

Arkansas

Arkansas cancels cost-sharing for poorest in Medicaid expansion

New Governor Asa Hutchinson (R) has canceled plans for the Department of Human Services (DHS) to start imposing cost-sharing changes for the lowest-income enrollees in Arkansas' “private option” alternative to the Medicaid expansion under the Affordable Care Act (ACA).

Arkansas was the first state to receive a federal waiver to use ACA matching funds to cover those made newly-eligible for Medicaid (up to 138 percent of poverty) in the state partnership Marketplace (see Update for Week of March 25, 2013). The federal Centers for Medicare and Medicaid Services (CMS) recently amended the waiver to allow Arkansas to require a \$5 monthly premium for those earning 50-100 percent of poverty and \$10 per month for those earning 100-138 percent of poverty. However, CMS will not allow them to terminate coverage for this population if they fail to make these payments (see Update for Week of January 5th).

According to DHS, roughly 80 percent of the 190,000 “private option” enrollees earn below 100 percent of poverty and were slated to be charged premiums for the first-time starting July 1st. However, the Governor has since waived that requirement for this population. State officials insisted that the decision was based upon legislation enacted last session by the Republican-controlled legislature that created a task force to develop a replacement for the “private option” when its latest reauthorization expires in 2016 (see Update for Weeks of January 26th and February 2nd). A DHS spokesperson stated that “it was not prudent to create this new piece [monthly premiums] for this population if it were just going to change it a year from now.”

Arizona, Indiana, Iowa, and Montana are other states that have also received federal permission to charge minimal premiums on those earning below 100 percent of poverty. Iowa officials stated this week that they have no plans to stop charging those premiums.



California

Budget deal expands Medi-Cal for undocumented children but omits Medi-Cal rate increases



Governor Jerry Brown (D) and state lawmakers reached a \$115.4 billion budget deal this week that is expected to be easily approved by both chambers and signed into law before the July 1st start of the next fiscal year.

The budget plan allocates nearly \$32 billion for health care programs for fiscal 2016, including about \$18 billion for Medi-Cal. Roughly \$40 million of that amount is projected to be spent on an unprecedented expansion of Medi-Cal coverage to about 170,000 undocumented children under age 19 (by no later than next May). The expansion is subsequently expected to cost \$132 million per year.

The legislature recently passed a measure that also extended Medi-Cal to a capped number of adults and allowed them to purchase Covered California coverage with their own funds (see Update for Week of June 1st). However, bill sponsor Senator Ricardo Lara (D) acknowledged that the full expansion would require a “multiyear effort” to implement.

The Governor steadfastly rejected a provision in the budget plan passed earlier in the week by lawmakers (A.B. 93) that would have allocated \$82 million to increase Medi-Cal provider reimbursement rates by five percent. The move was intended to offset the ten percent across-the-board cut in Medi-Cal payment from 2011 that Governor Brown has allowed to stand (for all but dental providers) once they were upheld by federal courts (see Update for Week of May 27, 2013).

The Governor has agreed to call a special legislative session later this year to debate measures to provide at least \$1.1 billion in permanent Medi-Cal funding that would include money for rate increases.

Other health-related provisions in the budget deal include new eligibility requirements for the AIDS Drug Assistance Program (ADAP) and the Office of AIDS Health Insurance Premium Payment program. These changes will consider family size and increase the annual income limit for these programs from \$50,000 (or 447 percent of poverty) to \$58,350 (or 500 percent of poverty).

In addition, the agreement eliminates statutory language adopted during the recession that instituted copayments for emergency room usage for non-emergencies. While this requirement has yet to be approved by the federal government, lawmakers agreed to remove the language so it is not “misused” in future years.

Audit blames erroneous provider directories for lack of Medi-Cal managed care access

A state audit requested by Senator Ricardo Lara (D) confirmed that California is failing to ensure that Medi-Cal enrollees in managed care have the required access to providers.

Inaccuracies in provider directories for 2014 have already resulted in several class-action lawsuits in California for limiting access and forcing enrollees to incur surprise medical bills (see Update for Week of September 29, 2014). The scathing report released this week specifically cited Medi-Cal managed care plans for not correcting provider directories that were riddled with errors, including incorrect telephone numbers and listings for doctors who are no longer part of the plans. Despite prior assurances from the Department of Health Services (DHS) that the provider directories were accurate and up-to-date, the audit found that the directories for three major health plans contained inaccuracies for up to 23 percent of providers. Furthermore, the ombudsman in charge of resolving beneficiary complaints failed to respond to 30-50 percent of calls.

The audit recommended that DHS significantly upgrade its plan oversight and call center capacity, as well as its process for verifying plan data, by September 2015. Since expanding last year pursuant to the Affordable Care Act (ACA), nearly one-third of all Californians are enrolled in Medi-Cal.



Florida

Lawmakers agree to Low Income Pool fix that fills budget deficit, averts shutdown

The Florida House and Senate appear to have resolved a contentious budget debate this week that threatened to shut down the government after June 30th.

The agreement will apply nearly \$400 million in state tax funds towards the Low Income Pool (LIP) that helps cover hospital uncompensated care costs. It will draw down \$600 million in federal matching funds (on top of the \$1 billion already provided) and enable the LIP to continue for one more year at roughly its 2014 funding level of \$2 billion.

The federal government had refused to continue the state's LIP waiver past June 30th unless Florida participated in the Medicaid expansion under the Affordable Care Act, which immediately would have more than filled the budget gap with \$2-4 billion in federal matching funds (see Update for Weeks of May 18th and 25th). The waiver's expiration would have caused Florida to lose more than \$1 billion in federal matching funds, which the House and Governor had relied upon in their fiscal 2016 budget plans.

However, the federal Centers for Medicare and Medicaid Services agreed shortly before the start of the special legislative session to provide \$1 billion through June 2016 and \$600 million through June 2017 before terminating the waiver (see Update for Weeks of May 18th and 25th), allowing state lawmakers to come up with a short-term solution by allocating the \$400 million for this year.

Governor Scott (R) is expected to sign the agreement, even though it rebuffs his plan to raise LIP funds by cutting \$214 million in revenue at some of the state's largest hospitals (see Update for Week of June 1st). The shift in \$400 million from the state budget surplus also forced lawmakers to greatly scale back the scope of the tax cuts sought by the Governor.

A federal judge this week canceled a hearing on the Governor's request for a preliminary injunction against the federal LIP cuts (see Update for Week of May 4th). However, the Governor insists that the lawsuit will continue until a long-term solution is found.

Insurance commissioner requires insurers to limit HIV drug cost-sharing to benchmark plan

The Office of Insurance Regulation (OIR) notified insurers this week it will recommend the removal and decertification of any plan in Florida's federally-facilitated Marketplace (FFM) if it employs a drug formulary that is "discriminatory in benefit design, benefit implementation or medical management techniques."

OIR is taking the action at the direction of the final 2016 Notice of Benefit and Payment Parameters (NBPP) issued by the federal Centers for Medicare and Medicaid Services (CMS). That regulation noted that "placing most or all drugs for a specific condition on a high cost-sharing tier" may be considered to violate the anti-discrimination provision of the Affordable Care Act (ACA) (see Update for Week of February 23rd). This provision was added in response to a civil right complaint filed by The AIDS Institute, which remains pending (see Update for Week of December 1st).

OIR previously determined that such a practice did violate Florida anti-discrimination law as it relates to HIV/AIDS medications and entered into one-year settlement agreements with four insurers that required them to switch from a percentage coinsurance to fixed copayments for most HIV/AIDS drugs (see Update for Week of March 23rd). However, for the purposes of enforcing the NBPP, the agency states that Marketplace plans will be deemed to be "discriminatory" if their tiered formulary for HIV/AIDS medications is not at least as favorable as the state's benchmark plan (the Florida Blue Cross and Blue Shield Blue Options plan for small groups, which currently limits patient co-pays to \$40, \$70, or \$150 per 30-day supply, depending on the medication.)



For each Marketplace plan seeking 2016 certification, OIR will require a signed attestation stating that the insurer does not 1) discourage enrollment of individuals with chronic conditions; 2) place most or all drugs that treat a specific condition on the highest cost tiers; 3) deliver drugs through mail order only; 4) discriminate on the basis of HIV or AIDS; along with several other items relative to prescription medications. However, in instances of non-compliance, OIR can only make a recommendation that CMS not certify the plan for the FFM in 2016.

PSI met with OIR's Deputy Commissioner and Florida Rep. Jose Felix Diaz (R) this week to discuss a similar discriminatory practice by Assurant Health, who is currently refusing to allow Marketplace consumers in Florida and 15 other states to receive premium assistance from charitable organizations. Assurant subsequently has agreed to exit the health insurance market in 2016 (see Update for Week of May 4th).

However, even though the Deputy Commissioner agreed that deliberately making plans unaffordable for persons with pre-existing condition is discriminatory, OIR likely could not compel plans to accept charitable premium assistance without new state legislation or a determination by CMS that it violates the ACA anti-discrimination provision. To date, CMS has granted insurers discretion to deny charitable premium assistance from non-profits, despite agency guidance stating that it only discourages premium assistance from for-profit hospitals (see Update for Weeks of March 17 and 24, 2014).

Maine

U.S. Supreme Court will not allow Governor to cut Medicaid for 19-20 year old adults

The effort by Governor Paul LePage (R) to eliminate Medicaid coverage for more than 6,000 "able-bodied" adults aged 19-20 has been successfully blocked by the courts.

The U.S. Supreme Court declined this week to hear the state's appeal of a unanimous decision by the First U.S. Circuit Court of Appeals upholding the Obama Administration's decision not to provide the required federal approval for the Governor's cuts (see Update for Week of December 1st). The Centers for Medicare and Medicaid Services (CMS) had argued that the "maintenance of effort" provisions of the Affordable Care Act (ACA) prevented states from reducing eligibility levels below 150 percent of the federal poverty level until October 2019.

Governor LePage had sought to end the coverage as part of the Medicaid reforms he instituted during his first term as governor (see Update for Week of June 20, 2011). According to *The Associated Press*, he spent \$53,000 on private lawyers to file the appeal after Maine Attorney General Janet Mills (D) not only refused to do so but filed as an intervenor on behalf of the federal government.

A lower court dismissed the Governor's initial lawsuit that incorrectly claimed the "maintenance of effort" provision was eliminated by the U.S. Supreme Court when it required the ACA Medicaid expansion to be discretionary (see Update for Weeks of August 27 and September 4, 2012).

New York

Assembly passes bill limiting drug formulary changes during enrollment year

The Assembly passed legislation last week that would add a new section to state insurance law limiting changes health plans can make to drug formularies within an enrollment year.

A.7707 specifically prevents plans that cover essential health benefits under the Affordable Care Act (ACA) from removing a prescription drug for its formulary or adding formulary restrictions during the year. If the formulary has multiple coverage tiers that vary cost-sharing, the plan also may not move a drug to a tier with higher cost-sharing within the year, unless a generic equivalent drug is concurrently added to the formulary.



Assemblywoman Crystal People-Stokes (D) sponsored the legislation, which is intended to give Marketplace consumers the assurance that plans “will maintain continuity in coverage for those prescription drugs during the course of the enrollment year” and not cause treatment disruptions or unexpected financial burdens. An identical bill (S.5382) was introduced in the Senate but has not moved.

Senate passage of A.7707 is not clear as Republicans gained control of the chamber this year (see Update for Week of November 3rd).

Oregon

Judge dismisses “frivolous” lawsuit filed by failed Marketplace contractor

A circuit court judge for Multnomah County has dismissed a lawsuit filed by the lead contractor for the failed Cover Oregon Marketplace against advisers to former Governor John Kitzhaber (D).

State officials and Oracle have been embroiled in dueling lawsuits since Governor Kitzhaber was forced to transition the Marketplace to federal control due to severe software flaws and technical snafus that caused Cover Oregon to be without any online enrollment capacity throughout the annual open enrollment period (see Update for Week of June 2nd 2014). Oracle insists that the problems were corrected and Cover Oregon’s web functions were ready to launch in February 2014, but that the Governor chose instead make Oracle a “scapegoat” and scuttle the website for “political reasons.”

Judge Henry Kantor deemed the lawsuit against the Governor’s advisers to be “frivolous”, noting that their private advice to the Governor regarding the website was protected speech and not actionable.

Oracle pledged to appeal and is continuing to pursue a separate lawsuit against state officials for breach of contract. The Oregon Attorney General has sued Oracle for fraud and racketeering, alleging that they were misled by Oracle as to the extent of the technical flaws and did not hire another contractor based on Oracle’s assurances (see Update for Weeks of August 25th and September 1st). A circuit court judge has already denied Oracle’s motion to dismiss the state’s claims against its executives.

Pennsylvania

Governor ensures all CHIP plans meet federal requirements for minimum essential coverage

Governor Tom Wolf (D) announced this week that his administration has ensured that all plans offered under the Children’s Health Insurance Program (CHIP)—including those in which families pay the entire premium—now meet the minimum essential coverage (MEC) requirements of the Affordable Care Act (ACA).

The Governor, who took office in January, noted that families of roughly 3,600 children under full-cost CHIP plans faced tax penalties for 2014 and 2015 because their coverage was not sufficient to meet the ACA’s individual mandate. He sought and obtained hardship waivers from the federal government that allowed the state additional time beyond the February 15th deadline to upgrade their plans and computer systems to meet MEC standards and void any tax penalties. In addition, he assured CHIP families that their premiums will not increase during the current policy year.

CHIP currently provides health coverage to more than 140,000 children under age 19 in Pennsylvania who do not qualify for Medicaid.



Texas

New law authorizes premium assistance for Hemophilia Assistance Program enrollees



Governor Greg Abbott (R) signed H.B. 1038 into law this week, which authorizes the Department of State Health Services (DSHS) to immediately provide insurance premium assistance to persons participating in the existing Hemophilia Assistance Program (HAP).

The HAP provides financial assistance to help purchase blood clotting factor products for adults at least 18 years of age who earn at or below 200 percent of the federal poverty level. It has a cap of \$25,000.

The bill was based on a recommendation from the Texas Bleeding Disorders Advisory Council. They insisted that assisting with health insurance premiums would be a more cost-effective use of the nearly \$325,000 that the legislature allocated to HAP for each of the next two fiscal years. The council also determined that it would enable HAP to serve up to 27 individuals instead of just the four that are currently enrolled.

According to council members, helping applicants obtain insurance coverage would encourage more to apply. Because of the HAP's low cap, many enrollees would benefit for only 1-2 months by financial assistance to purchase clotting factor, thus can benefit longer by adequate health insurance coverage. Premium assistance would also reduce the number of low-income Texans with hemophilia that are without either Medicaid coverage or eligibility for Marketplace subsidies due to Texas' refusal to expand Medicaid under the Affordable Care Act (ACA). Enabling this population to obtain coverage would "lessen the financial impact of uncompensated care on hospital emergency departments."