



Health Reform Update – Week of May 16, 2016

CONGRESS

Federal judge says CMS cannot fund ACA cost-sharing subsidies without Congressional approval

A federal judge appointed by President George W. Bush gave House Republicans a surprising early victory in their lawsuit seeking to block Affordable Care Act (ACA) cost-sharing subsidies.

Former House Speaker John Boehner (R) filed the lawsuit in 2014 alleging that the Obama Administration acted without the required legislative authority in delaying the employer mandate under the ACA and allocating \$175 billion in cost-sharing subsidies over ten years without a Congressional appropriation (see Update for Week of July 28, 2014). House Republicans had refused to approve any appropriations for the subsidies, which help those earning from 100-250 percent of the federal poverty level afford copayments and deductibles imposed by their Marketplace plans.

Judge Rosemary Collyer with the U.S. District Court for the District of Columbia previously dismissed the initial employer mandate claim (see Update for Weeks of August 31st and September 7th), but sided with House Republicans last week in ruling that the Administration lacked the executive authority to fund the cost-sharing subsidies without legislative approval. However, Judge Collyer refused to actually enjoin the subsidies until the Administration's expected appeal is heard by the appellate court.

The Centers for Medicare and Medicaid Services (CMS) continues to insist that it can use other funding sources to pay for the cost-sharing subsidies, specifically the separate permanent appropriation for premium tax credits authorized by the ACA. Judge Collyer insisted that the ACA must be read literally to conclude that Congress only intended for the premium tax credits to be permanently funded without further legislative approval, but not the cost-sharing subsidies. She rejected the Administration's claim that to conclude otherwise would yield "absurd economic, fiscal and healthcare policy results."

Roughly 56 percent of Marketplace subscribers (or 5.6 million consumers) received the cost-sharing subsidies as June 2015, according to figures provided by CMS.

The Administration is already appealing Judge Collyer's initial rulings in the case that granted standing for lawmakers to sue the executive branch over policy differences calling it an "unprecedented" and "momentous step" (see Update for Weeks of August 31st and September 7th). Judge Collyer herself acknowledged that giving standing to lawmakers in a policy dispute was "rare step" that carried "significant political ramifications".

The Kaiser Family Foundation noted that a legal victory for House Republicans at the appellate level could cause Marketplace premiums to rise, but that insurers were likely to bear the brunt of Congress being able to deny appropriations for cost-sharing subsidies because their existence is guaranteed by the ACA statute. As a result, insurers would likely have to sue CMS for lack of payment, should the agency be unable to fund the subsidies.

Republican lawmakers unveil first ACA replacement bill

Senator Bill Cassidy (R-LA) and Rep. Pete Sessions (R-TX) introduced a long-awaited draft bill this week that represents one Republican plan to eliminate and replace key provisions of the Affordable Care Act (ACA).



The legislation is called the Health Empowerment Liberty Plan or HELP Act. In a significant departure from campaign rhetoric, it does not fully repeal “Obamacare” but instead eliminates several major provisions that conservative lawmakers find most objectionable. This includes the requirement that everyone purchase minimum coverage that they can afford (the individual mandate), the requirement that large employers offer minimum affordable coverage or pay an assessment (the employer mandate), and the minimum essential health benefits that all plans must provide.

In place of the individual mandate, the bill would rely upon a lump-sum \$2,500 tax credit that citizens can use to purchase health coverage, regardless of whether they currently receive coverage through an employer. The HELP Act would not repeal the health insurance Marketplaces created by the Affordable Care Act (ACA), nor the premium and cost-sharing subsidies, but rather “grandfather” existing enrollees and require any new Marketplace enrollees to instead use the \$2,500 tax credit.

A task force created by House Speaker Paul Ryan (R-WI) is expected within the next five weeks to release their own outline of concepts it would like to see in ACA replacement plans. However, the plan put forward by Cassidy and Sessions is the first to offer actual legislation.

Medicare Part B drug payment changes draw fire from Congressional committees

The House Energy and Commerce Committee and Senate Finance Committee held hearings over the past two weeks on the Centers for Medicare and Medicaid Services (CMS) proposal to test new payment methods for drugs paid by Medicare Part B.

The Part B program covers prescriptions furnished in a hospital or physician office, including those that are infused or injectable. The current formula reimburses Part B drugs at the drug’s average sales price (ASP) plus a six percent add-on or dispensing fee. However, CMS proposed earlier this spring to conduct a demonstration project that would change this formula to ASP plus 2.5 percent and add a flat fee of \$16.80 per drug per day. A later phase would test several value-based purchasing strategies such as reference pricing, discounted patient cost-sharing, online decision support tools, and risk-sharing agreements based on outcomes.

CMS believes the new formula and strategies would help rein in costs for Part B drugs by encouraging greater use of lower-cost drugs that are at least as effective. More than two dozen consumers groups, unions, and insurers have backed their plan, including AARP and the Medicare Rights Center. However, more than 1,200 stakeholders submitted public comments prior to the May 9th deadline opposing the demonstration, including Patient Services Inc., due largely to concerns about limiting access to care and the lack of stakeholder input sought or received by CMS in formulating its proposal. Cancer groups in particular have insisted that the new Part B formula fails to “cover the costs of obtaining and providing these complex therapies in the outpatient setting.”

Republicans on the committees remained unanimously against this week and roughly half of the panel’s Democrats joined in their opposition. At least 242 members of Congress have already urged CMS to alter their proposed reimbursement formula, which they insist will “severely harm patient access” for those with rare diseases and other costly conditions.

CMS officials insisted this week that patient groups are receiving “misinformation” about the proposal, which they claim will not reduce the number of drugs currently covered by Part B. The agency’s chief medical officer informed private groups that the agency is actively soliciting input from physicians about whether the new formula will limit patient access, but did not offer an explanation for why such input was not obtained while the proposal was being developed.

House Republicans claim HHS is thwarting investigation into reinsurance payments



Republican leaders on the House Energy and Commerce Committee sent a letter this week to the Department of Health and Human Services (HHS) claiming that agency officials are refusing to cooperate with their investigation into temporary reinsurance payments under the Affordable Care Act (ACA).

Committee chairman Fred Upton (R-MI) along with two subcommittee chairmen are threatening to subpoena agency officials to testify if they do not adequately respond to earlier requests by May 30th. The chairmen are seeking documents relating to HHS' decision to prioritize funds raised from insurance companies for the purpose of making reinsurance payments to individual insurers instead of the Department of Treasury, which the chairmen insists is a "clear violation of federal law".

The reinsurance program ends after 2016. It was intended to provide additional compensation to those insurers incurring exceptional medical costs during the first three years after full ACA implementation. A shortfall in reinsurance funding for 2014 caused eligible insurers to receive only 12 percent of the compensation they were due, causing the liquidation of a dozen non-profit cooperatives created with ACA loans (see Update for Week of November 30th). Highmark filed a federal lawsuit this week to recover \$220 million of the funds it is owed under the ACA program.

FEDERAL AGENCIES

Uninsured rate hit record low in 2015

The latest survey data from the Centers for Disease Control and Prevention (CDC) revealed this week that the national uninsured rate fell to 9.1 percent in 2015, the lowest ever recorded by the agency.

The drop was most precipitous among the 31 states that expanded Medicaid under the Affordable Care Act (ACA), falling from 18.4 percent prior to the ACA's full implementation in 2014 to 9.8 percent last year. Opt-out states experienced a much smaller decrease from 22.7 percent to 17.5 percent.

Despite more than 16.2 million Americans gaining coverage in 2015, the CDC found that 28.6 million still remain uninsured.

A separate study from the Department of Health and Human Services (HHS) found earlier this year that 20 million Americans have gained coverage under the ACA (see Update for Weeks of February 22nd and 29th).

CMS allows struggling CO-OPs to access private capital, further restricts special enrollment

The Centers for Medicare and Medicaid Services (CMS) released an interim final rule last week that intends to help non-profit insurance cooperatives stay afloat, as well as further responds to insurer requests to prevent Marketplace consumers from abusing rules for special enrollment.

A dozen of the 23 Consumer Owned and Operated Plans (CO-OPs) created with Affordable Care Act (ACA) loans were liquidated last year after unanticipated enrollment offset their ability to pay medical claims once CMS failed to provide them the promised level of ACA reinsurance payments (see Update for Week of November 30th). The new regulations follow through on the acting Administrator's intent to let private investors provide CO-OPs with the outside funding needed to fill this shortfall and bolster CO-OP reserves, which was previously prohibited under the terms of the ACA loans to CO-OPs (see Update for Weeks of January 25th and February 1st).

The interim final rule also removes the requirement all CO-OP board directors be elected by its health plan members (effective May 11th), allowing instead for elections by only a majority vote.



The regulations also put new restrictions on how the remaining six qualifying events for special enrollment periods may be used. CMS eliminated several qualifying events earlier this year in an effort to keep insurers that lost money from Marketplace business from exiting the Marketplaces in 2017 (see Update for Weeks of January 11th and 18th).

The six qualifying events include a loss of minimal essential coverage, changes in household size (such as marriage, divorce, child birth, adoption, or death), permanent moves to a new home, changes in eligibility for ACA subsidies, and enrollment errors made by insurers or Marketplaces.

Among the new restrictions that CMS is placing on these events is a requirement that individuals moving to a new home must have ACA-compliant coverage for one or more days in the 60 days preceding the move.

CMS finalizes new standards for Medicaid managed care and CHIP plans

The Centers for Medicaid and Medicare Services (CMS) published the long-awaited mega rule for Medicaid managed care and the Children's Health Insurance Program (CHIP) on May 6th.

The regulations finalize the proposed rules issued last year, which represented the first changes to the Medicaid managed care program since 2003 and are an effort to bring the program in line with Medicaid reforms since that time (see Update for Weeks of May 18th and 25th). They allow managed care plans to be used within CHIP, but impose significantly more regulatory review and oversight of managed care plans in both Medicaid and CHIP, including requiring that plans spend at least 85 percent of their premium revenue on direct patient care (starting in July 2017), instead of administration and profits.

This medical-loss ratio (MLR) is comparable to that required of large group plans under the Affordable Care Act (ACA), although non-compliant plans would not be required to issue the consumer rebates required of the ACA. CMS is seeking to ensure that Medicare Advantage, Medicare Part D plans, Medicaid managed care plans, and large group plans all use the same MLR. Most Medicaid managed care plans do not currently apply MLRs, although some states like Florida were required to implement an MLR as part of the federal demonstration waivers allowing them to move nearly all Medicaid enrollees into managed care plans (see Update for Week of June 17, 2013).

CMS is also establishing first-ever network adequacy standards for Medicaid managed care plans, including time and distance standards for certain types of providers. In addition, Medicaid managed care and CHIP plans will be subject to a quality rating system similar to what CMS has already put in place for private managed care plans under Medicare Advantage.

According to CMS, roughly 80 percent of all Medicaid enrollees are served through managed care plans.

Popularity of low premium Marketplace plans is causing a moderate increase in cost-sharing

A new report from The Commonwealth Fund shows that individual consumers in Affordable Care Act (ACA) Marketplaces experienced "moderate" increases in plan cost-sharing for 2016.

Researchers found that annual deductibles went up by more than ten percent under 2016 plans offered to consumers, while copayments for non-preferred brand name drugs jumped 13.6 percent and annual out-of-pocket limits on higher-tier plans also rose just over seven percent. The only type of cost-sharing that declined was copayments for generic drugs (by 3.2 percent).

The study blamed part of the overall cost-sharing increase on the increasing proliferation of lower-tier bronze and silver plans that offer lower premiums but higher deductibles and copayments.



Access and affordability under Marketplace plans is comparable to private plans

A new study released last week by the Urban Institute found that affordability and access in Marketplace plans is roughly equivalent to non-Marketplace coverage for low-to-moderate income adult enrollees.

Researchers compared the experience of adult Marketplace consumers earning less than 400 percent of the federal poverty level to those enrolled in employer-sponsored coverage or non-Marketplace individual plans. They found that Marketplace consumers reported no more difficulty securing an appointment or finding a new doctor, nor were they more likely to report problems paying medical bills or having high out-of-pocket costs. However, compared to Medicaid enrollees, Marketplace consumers have a higher rate of unmet medical needs due to cost and greater difficulty paying medical bills, although they are able to secure provider appointments more easily.

STATES

Major insurers remain in Marketplaces for 2017, despite UnitedHealthcare and Humana exits

Health insurer Aetna announced last week that it has no plans to exit any of the 15 federally-facilitated Marketplaces in which it currently offers plans to individual consumers.

Although Aetna's decision is not binding until agreements with states are signed in September, analysts largely did not expect Aetna to be swayed by the recent decisions of UnitedHealthcare and Humana to exit most of their Affordable Care Act (ACA) Marketplace due to unanticipated financial losses (see Update for Week of April 18th). While Aetna operated with Marketplace losses of about 3-4 percent for 2015, it saw significant improvements late in the year and is projecting to break even on Marketplace business for 2016. It also is seeking regulatory approval from states to acquire rival Humana.

Aetna is also seeking to expand into the Kansas Marketplace for 2017, filling the void left by UnitedHealthcare's departure.

Other states are also expecting increased competition for 2017 despite the loss of high-profit insurers. For example, insurance giant Wellmark Blue Cross and Blue Shield will start selling individual Marketplace plans in Iowa, where it has sat out for three years despite being the state's dominant insurer. New start-up insurers will also enter the individual Marketplaces in Colorado, Nevada, and Wyoming.

Anthem, the nation's second largest health insurer, announced last month that it has no plans to either add or subtract from the 14 Marketplaces in which it currently operates, even after its merger with CIGNA. Anthem attracted nearly 185,000 more Marketplace consumers than predicted in 2016, due largely due to closures of non-profit cooperatives in states like Colorado, Kentucky, and New York (see Update for Week of November 30th). However, those consumers typically had higher costs than anticipated causing Anthem not to anticipate meeting its 3-5 percent profit margin target until 2018.

Centene, which is merging with HealthNet, also does not anticipate entering additional Marketplaces or exiting the 15 in which it currently participates, despite profiting from Marketplace business during 2015.

Private study shows that Marketplace losses nearly doubled in 2015

A new study released this week by McKinsey and Company found that individual plan insurers participating in Affordable Care Act (ACA) Marketplaces experience greater financial losses in 2015, compared to the inaugural year in 2014.



Researchers concluded that losses nearly doubled from one year to the next, with insurers losing roughly \$2.7 billion in 2015 on profit margins that were nine to eleven percent in the red.

However, McKinsey still expects the Marketplaces to remain financially viable—so long as the ACA premium and cost-sharing subsidies continue to be available to consumers. While it acknowledged that the shortfall in ACA risk corridor and reinsurance payments contributed to some of the losses, it largely laid the blame for most of the financial losses on business decisions by individual insurers. Researchers emphasized that 30 of Marketplace insurers were profitable in 2014, as 45 states had at least one profitable insurer during that first year.

Alabama

Premiums likely to spike as Marketplace left with single insurer for 2017

Blue Cross and Blue Shield (BCBS) of Alabama will be the lone insurer offering plans to individual consumers in the federally-facilitated Marketplace in Alabama for 2017, after Humana announced this week that it would leave the Marketplace at the end of this year.

Humana's move follows UnitedHealthcare's decision last month to also leave the Marketplace in Alabama and at least 26 other states including Florida, Georgia, and New Jersey (see Update for Week of April 18th). Without competition, premiums for BCBS are likely to be substantially higher for 2017 following the trends in other states with single Marketplace carriers. A series of studies conducted by the U.S. Department of Health and Human Services and private groups like Kaiser Family Foundation, the Urban Institute, and Avalere Health have consistently shown a direct correlation between the number of Marketplace insurers and premium levels (see Update for Weeks of July 27 and August 3, 2015).

Alaska

House Republicans continue legal fight against Medicaid expansion

House Republican leaders announced this week that the Legislative Council has appealed the dismissal of their lawsuit against the Medicaid expansion implemented last summer by Governor Bill Walker (I) without legislative authorization.

A Superior Court judge ruled earlier this year that absent a state law prohibiting the expansion, the Governor was required by the federal Social Security Act to provide Medicaid services to the population made newly-eligible by the Affordable Care Act (see Update for Weeks of February 22nd and 29th). It upheld the Governor's application of a rarely-used fiscal maneuver while the legislature was out of session to expand Medicaid last year even though the Legislative Council, which includes both House and Senate members, had insisted that only the legislature has the authority to determine Medicaid eligibility (see Update for Weeks of August 31st and September 7th).

House Republican leaders filed notice with the court that they intend to appeal the decision and substitute the House of Representatives as plaintiffs, despite waning support for the litigation from Senate Republicans included Majority Leader John Coghill (R). Democratic lawmakers insist that an appeal cannot be filed absent legislative authorization, which cannot be granted while the legislature is currently out of session. However, Republicans blocked their efforts to bring the issues to a vote last month.

According to the Department of Health, more than 16,700 Alaskans have gained Medicaid coverage since the expansion went into effect on September 1st.

Arizona

Legislature reverses course and restores SCHIP coverage



Governor Doug Ducey (R) signed S.B. 1457 this week, restoring Kids Care coverage to more than 30,000 children of low-income families that are eligible for Arizona's version of the federal State Children's Health Insurance Program (SCHIP).

The legislature froze all Kids Care enrollment in 2010, making Arizona the only state in the nation to refuse SCHIP enrollment to new children from families earning up to 200 percent of the federal poverty level (FPL) (see Update for Week of April 9, 2012). Senate President Andy Biggs (R) had blocked the reinstatement of enrollment earlier in the week but was forced to back down after five Republican Senators joined with all Senate Democrats to allow S.B. 1457 to receive a floor vote.

Governor Ducey had previously taken no position on the reinstatement and signed the measure without comment. S.B. 1457 will take effect in August, 90 days after the end of the legislative session. However, Arizona must first receive the expected federal approval in order to reinstate enrollment.

California

Covered California premiums may spike in 2017

The proposed budget released last week by Covered California predicts that Marketplace premiums may increase by an average of eight percent for 2017 or double the average increase for the past two years.

Covered California officials attribute the higher premiums due the expiration of the temporary reinsurance program created by the Affordable Care Act (ACA), which compensated insurers with exceptional medical claims for the first three years of full ACA implementation.

As one of the only few states that employ an active purchaser model for their Marketplace (see Update for Week of May 27, 2013), Covered California officials can exclude insurers solely for affordability and negotiate lower rates before premiums are finalized in July. This has allowed Covered California to hold premiums increases at only a four percent average for both 2015 and 2016.

Covered California projects only a two percent growth in enrollment for 2017 to roughly 1.34 million enrollees and 1.52 million enrollees by 2020. However, the state's gradual increase in the minimum wage (to \$15 per hour) is expected to move increasing numbers of Medi-Cal enrollees into Covered California plans.

Georgia

Health committee chair drops opposition to Medicaid expansion

The chair of the Senate Health and Human Services Committee announced this week that she will support an alternative to the Medicaid expansion under the Affordable Care Act (ACA) similar to the federally-approved "private sector" model in place in seven other states.

Senator Renee Unterman (R) cited the closure of many rural hospitals and long waits for patients to see Medicaid providers as factors caused her to drop her long-standing opposition to any Medicaid expansion. She stated that a model similar to Arkansas and Indiana where enrollees pay up to two percent of their income in monthly premiums may have enough support to pass the Senate next year. The Georgia Chamber of Commerce is preparing to submit proposed expansion legislation when lawmakers return in January.

According to the Urban Institute, up to 400,000 Georgians would be eligible for a full expansion to the ACA threshold (183 percent of the federal poverty level). The Georgia Hospital Association insists that ACA matching funds for the expansion could aid the 41 percent of rural hospitals in Georgia that ended 2014 with negative profit margins.



Unterman's counterpart on the House Health and Human Services Committee, Rep. Sharon Cooper (R), agreed to "entertain" the proposal, though she remained skeptical that Medicaid expansion would solve the access problem in rural areas, where five hospitals have closed since 2012. Both chairwomen are backing separate proposals to continue a temporary increase in Medicaid rates for primary care doctors that was first created by the ACA and then extended by 23 states including Georgia using only state funds. Georgia gave primary care doctors an additional \$84 million in 2016 and went further than the ACA by including OB-GYN physicians.

New law requires accurate and update provider network directories

Governor Nathan Deal (R) signed S.B. 302 into law on April 26th. The measure requires health insurers to maintain accurate provider network directories in online and print formats. Online versions must be updated every 30 days.

Iowa

Insurance commissioner files suit over CO-OP liquidation

Insurance Commissioner Nick Gerhart (R) filed a federal lawsuit this week against the Centers for Medicare and Medicaid Services (CMS), arguing that the federal agency has no right to claim "super priority" over other creditors that are owed money from the liquidation of the Consumer Owned and Operated Plan (CO-OP) that was created in Iowa via Affordable Care Act (ACA) loans.

CMS had placed an "administrative hold" on more than \$20 million in payments that it was supposed to make to CoOpportunity Health, claiming that its right to recover funds from the \$146 million in loans to the non-profit cooperative superseded all other creditors. CoOpportunity had used low premiums to attract more than 120,000 subscribers in both Iowa and Nebraska, but incurred more than \$160 million in losses after claims costs far exceed incoming revenue, forcing the Insurance Commissioner to order its liquidation last year (see Update for Week of January 19, 2015).

CoOpportunity was the first of a dozen of the 23 ACA-created CO-OPs to fail (see Update for Week of November 30th).

Maine

Legislature overrides veto of consumer advocacy bill

The Legislature voted last week to override the veto issued by Governor Paul LePage (R) of legislation that would require the Department of Health and Human Services (HHS) to contract with a Maine nonprofit to provide ombudsman services to those enrolled in MaineCare.

L.D. 1498 clarifies existing state law that requires an ombudsman program to help enrollees navigate the state's version of Medicaid as long as non-state funding is available. HHS had contracted with the non-profit Consumers for Affordable Health Care to provide these services using combined federal and private funds. However, HHS eliminated that contract in June 2015.

Maryland

Marketplace has cut number of uninsured but coverage-eligible Marylanders by 40 percent

Maryland Health Connection officials announced this week that the Marketplace created pursuant to the Affordable Care Act (ACA) has reduced the number of Marylanders eligible for private health insurance coverage by 40 percent.



Roughly 240,000 individuals remain uninsured despite being eligible for private Marketplace coverage, compared to an estimated 405,000 that were eligible when the Marketplace first began open enrollment in October 2013. The figures do not include those eligible for Medicaid.

After initial struggles due to technological flaws, Maryland Health Connection experienced one of the fastest growth rates in the nation and now have enrolled more than one million Marylanders in either private Marketplace coverage or Medicaid. Maryland's uninsured rate for African Americans and Latinos has been cut in half and the state ties for ninth nationwide in the proportion of young adults enrolled in private coverage.

Nevada

Marketplace to continue defaulting to federal web portal for 2017

Officials with the Silver State Health Exchange announced this week that the state-based Marketplace (SBMs) created pursuant to the Affordable Care Act (ACA) will continue to default to the federal web portal for 2017.

Nevada is one of three SBMs that are defaulted to the federal web portal after initial technological flaws during the inaugural open enrollment period remaining unresolved (see Update for Week of June 2, 2014). The executive director for the Silver State Health Exchange stated last month that the Marketplace may consider creating its own web portal again for 2018. He acknowledged that the federal government's three percent user fee on states using the federal web portal (see Update for Week of November 30th) may encourage Nevada to pursue private sector alternatives to www.healthcare.gov.

New York

Marketplace insurers seeks average rate hike of more than 17 percent

Health insurers participating in the NY State of Health Marketplace created by the Affordable Care Act (ACA) are seeking to increase individual premiums for 2017 by an average of 17.3 percent and small group premiums by roughly 12 percent.

Average rate hikes are even higher for three participating insurers, including a whopping 45.6 percent average hike for UnitedHealth Group, which made New York one of only eight of the 24 Marketplaces in which the insurer will remain for 2017 (see Update for Week of April 18th). CareConnect Insurance is also seeking a dramatic rate hike of more than 29 percent, followed by the startup Oscar Insurance, which proposed an 18.4 percent average increase.

The insurers blamed increasing medical costs combined with the end of the ACA's temporary reinsurance program for the rate hikes, claiming that subscribers are requiring for more medical care than they anticipated.

The Department of Financial Services has the authority to modify or reject unreasonable increases in premiums and reduced proposed rate hikes for 2016 from 10.4 percent average to 7.1 percent average.

Insurers required to stop rationing HCV drug treatments

Seven health insurers have reached agreements with Attorney General Eric Schneiderman (D) to change their criteria for covering costly medications for the hepatitis C virus (HCV).

The agreements are the result of a year-long investigation by the Attorney General's office, who had requested documents and claims data from 161 commercial health plans and subpoenaed three that were non-responsive (see Update for Weeks of February 22nd and 29th). The investigation revealed a wide discrepancy in how health plans covered the latest advances in HCV treatments, with some



rationing coverage only patient with the most advantage stages of the illness in order to avoid paying for medications like Harvoni that listed for as much as \$94,500 for a 12-week course of treatment. Five of the insurers were found to be denying as many as 30-70 percent of claims for HCV.

The Attorney General found that EmblemHealth and Aetna were the only plans that were consistently providing coverage to patients with all stages of HCV.

The insurers that agreement to amend their coverage criteria include: Affinity Health Plan, Anthem Inc. (and its subsidiary Empire BlueCross BlueShield), Excellus BlueCross BlueShield, HealthNow New York, Independent Health Association., UnitedHealth Group (and its subsidiary Oxford Health Plans), and MVP Health Care. The agreements would end the Attorney General's investigation into their practices.

Each agreement requires the insurer to cover medications for all stages of HCV, including those whose illness resulted from drug or alcohol abuse.

At least 34 states programs nationwide (led by Oregon and Illinois) have started explicitly rationing care to the latest HCV drugs by limiting coverage only to those most severely ill (see Update for Weeks of January 11th and 18th). Washington is among the states facing a class action lawsuit over the practice (see Update for Weeks of February 8th and 15th).

Virginia

Governor vetoes budget provisions barring Medicaid expansion

Governor Terry McAuliffe (D) vetoed a provision of a two-year budget bill this week that attempted to prohibit him from expanding Medicaid under the Affordable Care Act (ACA) without the permission of the Republican-controlled legislature.

The provision was intended to prevent McAuliffe or any subsequent governor from using executive authority or budget maneuvers to circumvent conservative opposition to Medicaid expansion, as Republican, Democrat, and Independent governors have done in states like Ohio, Kentucky, and Alaska (see above). A spokesperson for Governor McAuliffe acknowledged this week that he is still weighing his options to expand Medicaid without legislative approval and fulfill his central campaign pledge (see Update for Week of November 4, 2013).

Speaker William Howell (R) insisted that the governor's veto was invalid and should not be recognized by the House. While governor "enjoys a line-item veto" authority in Virginia, the Speaker argued that per rulings of the Virginia Supreme Court, he cannot "veto conditions attached to appropriations, without vetoing the appropriation as well." (The House clerk refused to record Governor McAuliffe's veto of a similar budget provision in 2014.)