



Health Reform Update – Weeks of February 22 and 29, 2016

CONGRESS

Supreme Court strikes down state laws requiring health insurers report claims and pricing data

A shorthanded U.S. Supreme Court ruled this week that federal law pre-empts state laws that require health insurance reporting for self-funded plans.

The decision strikes down a reporting law in Vermont that was similar to those enacted in nearly 20 other states including Illinois, Maryland, New York, and Texas and proposed in at least 22 others. The 2005 law mandated that health insurers to report claims data to the state's all-payer claims database showing how much they paid for specific services, which is then used by lawmakers and regulators to make policy decisions. However, it was challenged by Liberty Mutual Insurance Company, which insisted that having to comply with different regulations in multiple states imposes wasteful administrative costs on insurers and subjects them to a wide range of liability.

Six of the court's justices sided with Liberty Mutual in concluding that the federal Employee Retirement Income Security Act (ERISA) specifically trumped such "novel, inconsistent, and burdensome reporting requirements", at least on self-funded plans which represent about 60 percent of privately insured Americans. The majority held that ERISA requires "a single uniform national scheme for the administration of ERISA plans without interference from laws of the several states." Hawaii is the only state that obtained a waiver from ERISA before it was implemented in 1974.

The court's ruling was the first since the death of Associate Justice Antonin Scalia, leaving the court with only eight justices equally split among conservative and liberal ideologies. A 4-4 split in this case would have resulted in the same outcome as it would have upheld the appellate court's decision to also strike down the Vermont law. However, two of the court's traditionally liberal justices (Stephen Breyer and Elena Kagan) sided with the court's four conservative justices ruling against the states.

The high court also refused this week to hear the latest Affordable Care Act (ACA) challenge filed by a physician and backed by Senator Ted Cruz (R-TX), a presidential candidate. The lawsuit claimed that the ACA violated the Constitution's origination clause, which requires bills whose primary purpose is raising revenue to start in the House. The court previously rejected a similar origination clause challenge (see Update for Weeks of January 11th and 18th).

FEDERAL AGENCIES

CMS retreats on network adequacy standards, punts on third-party premium assistance

The Centers for Medicare and Medicaid Services (CMS) finalized its Notice of Benefit and Payment Parameters (NBPP) this week that set the standards with which federally-facilitated Marketplace (FFM) plans must comply for 2017.

The rule creates voluntary standard cost-sharing designs for bronze, silver, and gold tier plans, adopts proposed changes to the risk adjustment program under the Affordable Care Act (ACA), allows certain non-grandfathered plans to remain non-compliant with the ACA, and sets open enrollment periods and a 1.5 percent user fee for states using the FFM platform. However, it retreats on proposed network



adequacy standards and delays a decision on whether to require plans to accept third-party premium assistance payments from charitable organizations like PSI (see Update for Week of November 30th).

The standardized plan options were widely-supported by consumer groups such as Families USA and The AIDS Institute as they would allow more drugs and services to be covered outside of the deductible and lowered copayments for some drugs in non-bronze plans. Insurers insisted that the standardized plan options would “limit innovation” in plan design and should not be promoted on the web portal (www.healthcare.gov).

The final rule formally sets the open enrollment period from November 1-January 31 for both 2017 and 2018. However, it will shorten to November 1-December 15 in subsequent years.

CMS had proposed last fall to create a network adequacy standard that required states meet certain federally mandated time and distance requirements (see Update for Week of November 30th). However, the agency elected not to finalize that proposal in favor of simply allowing states to adopt a recent model rule published by the National Association of Insurance Commissioners, after several commissioners and insurers sharply criticized CMS for ignoring the model standards. The final rule states that for 2017 the agency will continue to use the “reasonable access” standards that were applied for 2015 and 2016.

However, CMS did finalize their proposal to require that providers provide written notice to subscribers at least 30 days prior to leaving an insurer network and allow those in “active treatment to continue treatment until the treatment is complete or for 90 days (whichever is shorter) at in-network cost-sharing rates.”

CMS modified its proposal to protect against “surprise” billings from out-of-network providers contracted with an in-network facility by requiring that those services be applied to the subscriber’s annual out-of-pocket limit unless the insurer had informed the subscriber within ten days. The agency now will apply this policy only to cost-sharing paid by a subscriber for essential health benefits, but shortened the time frame from ten business days to “the longer of the issuer’s prior authorization timeline...or 48 hours prior to the scheduled service.” However, consumer groups were most critical of CMS’s decision to delay this provision until 2018.

PSI and other consumer groups were also disappointed by CMS’ failure to decide whether to require that FFM insurers accept third-party premium assistance from non-profit charities, as they are required to do for federal and state health care programs (see Update for Week of November 30th). Insurers had submitted comments strongly opposing any expansion of the list of entities to which they must accept premium assistance, insisting that it would destabilize the risk pool in certain markets, resulting in higher premiums. However, at least 33 members of Congress from both parties have cosponsored legislation requiring CMS to do so (H.R. 3742). Thus far, CMS has agreed only to “consider” the issue for future rulemaking.

CMS requires proof of special enrollment period eligibility

The insurance industry praised the announcement last week by the Centers for Medicare and Medicaid Services (CMS) that consumers in federally-facilitated Marketplace plans will now be required to prove their eligibility for the five most commonly used special enrollment periods (SEPs).

Insurers have pressured CMS in recent months to limit the ability of consumers to sign-up for coverage outside of the annual open enrollment periods, insisting that the long list of criteria triggering a SEP and frequent deadline extensions have allowed consumers to largely wait until they get sick to enroll (see Update for Weeks of January 11th and 18th). The industry blames this “moral hazard” for skewing the risk pool towards sicker populations, depressing enrollment, and causing unexpected financial losses.



In response to insurer complaints, CMS previously agreed to eliminate six SEPs and has now agreed to a verification process requiring consumers provide documentation proving that they have permanently moved, had a baby, adopted a child, had a change in marital status, or lost minimum essential coverage. Consumers previously needed only to check a box attesting to one of these life status events and more than one million did so in 2015 alone.

HHS report shows 20 million working-age adults have gained coverage due to the ACA

The latest report from the Department of Health and Human Services (HHS) shows that the Affordable Care Act (ACA) has expanded health insurance coverage to 20 million working-age adults since it was first enacted in 2010, including 6.1 million young adults aged 19-25.

The White House trumpeted the “historic” reduction in the adult uninsured rate (to 11.5 percent) that researchers attributed solely to the ACA after controlling for other trends, factors, and demographic changes. They noted that the uninsured rate for adults age 18-64 fell dramatically across all racial and ethnic groups, including a more than 50 percent drop among both white and black populations (to seven and ten percent respectively), while the rate for Latinos fell by more than 25 percent (to 30.5 percent).

The findings also show that the number of insured working-age adults has climbed by 13.6 percent since the most recent survey last fall showed that 17.6 million had gained coverage (see Update for Weeks of September 14th and 21st).

A separate annual survey by the Centers for Disease Control and Prevention recently showed that only 9.1 percent of all Americans (including children and seniors) remained uninsured during the first nine months of 2015—the lowest level ever recorded by the agency (see Update for Weeks of February 9th and 15th).

HHS beats goal to tie 30 percent of Medicare payments to quality by 2017

The White House announced this week that roughly 30 percent of all Medicare payments are now tied to alternative payment models created by the Affordable Care Act (ACA), nearly one year ahead of the target set by the Department of Health and Human Services (HHS) in January 2015.

The alternative payment models are intended to reward providers based on the quality of care they provide, instead of traditional fee-for-service that rewards quantity and was responsible for 100 percent of Medicare payments prior to the ACA. These new models include the Medicare Shared Savings Program and the new Center for Medicare and Medicaid Innovation.

As a result, the White House claimed that more than ten million Medicare beneficiaries are now receiving better care coordination, access to physicians, and control over the health care decisions, with less duplication of services and tests.

STATES

Six states sue CMS over ACA fees on health insurance providers

Six states filed a federal lawsuit last week alleging that nothing in the Affordable Care Act (ACA) requires them to pay a portion of the fee levied upon Medicaid managed care plans.

The states (Indiana, Kansas, Louisiana, Nebraska, Texas, and Wisconsin) filed the complaint in the U.S. District Court for the Northern District of Texas. It challenges the Health Insurance Provider Fee used in part to fund the premium subsidies under the ACA.



Regulations issued by the Centers for Medicare and Medicaid Services (CMS) require states to pay a portion of the annual assessment to Medicaid managed care organizations, who then pay them to the federal government. States receive some matching funds for these payments but the six plaintiff states claim that they end up losing 54 cents for every dollar paid. The six state plaintiffs are seeking a permanent injunction against the regulations, which they claim go beyond the authority in the ACA.

Texas reportedly spent more than \$210 million in federal and state funds to cover the Health Insurance Provider Fee before it was recently suspended for one year in the omnibus budget bill that also postponed the ACA's medical device industry tax and assessment on high-cost health plans (see Update for Week of January 4th). That suspension will cost the federal government nearly \$14 billion, according to the Congressional Budget Office (CBO).

Alaska

Judge dismisses Medicaid expansion challenge from Republican lawmakers

Superior Court Judge Frank Pfiffner has dismissed the lawsuit brought by Republican lawmakers that challenged the authority of Governor Bill Walker (I) to expand Medicaid via executive order.

The Legislative Council authorized the lawsuit last year after the Governor agreed to participate in the Medicaid expansion under the Affordable Care Act (ACA) without legislative approval, adding more than 10,000 Alaskans (see Update for the Week of July 13th). However, Judge Pfiffner found that absent a state law prohibiting the expansion, the Governor is required by the federal Social Security Act to provide Medicaid services to the population made newly-eligible for Medicaid by the ACA.

Republican leaders immediately pledged to appeal the decision to the Alaska Supreme Court, which they insist is the proper venue for disputes between the legislative and executive branch. However, the high court has already upheld Judge Pfiffner's refusal to grant a temporary injunction blocking the expansion from going into effect (see Update for Weeks of August 31st and September 7th).

Arkansas

Governor rejects plans for state-based Marketplace

Governor Asa Hutchinson (R) recommended this week that Arkansas not follow through on his predecessor's plans to create a state-based Marketplace (SBM) for the individual market.

Former Governor Mike Beebe (D) elected to pursue a state-partnership Marketplace (SPM) for the individual market following the enactment of the Affordable Care Act (ACA), at least until the state could upgrade its technology infrastructure to operate its own SBM starting in January 2017 (see Update for Week of March 25, 2013). Arkansas already operates a SBM for the Small Business Health Options Program (SHOP) under the ACA.

However, Governor Hutchinson stated that the existing partnership with the federal government was working well for individual consumers when he initially delayed the SBM's start date last fall. Arkansas popular "Private Option" alternative to the Medicaid expansion uses ACA funds to purchase coverage in the SPM for nearly 250,000 Arkansans made newly-eligible for Medicaid by the ACA. As a result, the Governor insisted that staying with the existing SPM would minimize any disruption, especially as he plans to implement reforms approved by the federal government (see Update for Weeks of February 8th and 15th).

California

Governor signs bill expanding tax on managed care plans

Governor Jerry Brown (D) signed legislation this week that will spare the state from losing \$1 billion in federal funding by expanding the state tax on managed care plans.



Currently, managed care plans offered in California are subject to the assessment only if the served Medi-Cal enrollees. The cost of this assessment was offset with federal matching funds.

However, the Obama Administration informed California in 2014 that the assessment would need to be eliminated or revised after it expires on June 30th because singling out Medi-Cal managed care plans violates federal law. As a result, lawmakers from both parties voted to approve the Governor's plan to expand the assessment.

Even though the tax now applies to all managed care plans, it will actually reduce the overall liability of insurers by \$106 million while bringing in \$1.4 billion in federal matching funds. This is because the Governor's plan offset the cost of the tax with \$371 million in break on state premiums and corporation taxes.

Connecticut

Committee to hear bills limiting drug cost-sharing, defining pregnancy as qualifying event

The Joint Committee on Insurance and Real Estate has scheduled a March 10th hearing on legislation introduced this week that would limit cost-sharing for prescription drugs to no more than \$100 per 30-day supply.

As with comparable measures in other states, the bill (H.B. 5517) includes an anti-discrimination provision prohibiting insurers from placing all drugs for a given class into the highest cost-sharing tier of a formulary. It would become effective January 1, 2017.

The committee will also hold a hearing on that date to consider legislation (S.B. 370) that would make Connecticut the second state to recognize pregnancy as a qualifying life event allowing for special enrollment. New York is the only state to enact such legislation (see Update for Week of January 4th).

Florida

House unanimously passes bill to expand KidCare for legal immigrants

The House unanimously passed a measure this week that would expand the Florida KidCare program for roughly 17,000 children of legal immigrants.

H.B. 89 sponsored by Rep. Jose Felix Diaz (R) eliminates the current five-year waiting period and allocates nearly \$29 million for the expansion (see Update for Weeks of January 11th and 18th). The Senate is currently considering a similar measure (S.B. 248) that is also expected to pass.

House passes legislation to create greater price transparency for health care consumers

The House overwhelmingly passed legislation this week that would create a state website to let consumers identify the estimated price for an episode of non-urgent treatment prior to seeking care from a physician, hospital, ambulatory surgery center, or medical equipment supplier. Under H.B. 1175, such estimates would have to be posted "in plain language...comprehensible to an ordinary layperson." Providers also would be required to provide patients with a list of anticipated charges within seven business days of a written request (see Update for Weeks of January 11th and 18th).

A Senate counterpart (S.B. 1496) has cleared three committees.

Georgia

Senate committee hears bill that would create "Arkansas-style" Medicaid expansion



The Senate Health Committee held a hearing last week on legislation that would create an alternative to the Medicaid expansion under the Affordable Care Act (ACA) similar to the “Private Option” model federally-approved in Arkansas.

If implemented, the expansion would cover approximately 300,000 Georgians by using ACA matching funds to purchase Marketplace coverage for those made newly-eligible for Medicaid. However, the bill (S.B. 368) also requires enrollees to pay up to five percent of their income for the coverage.

However, it remains very unclear whether Republican lawmakers have sufficient support to pass the legislation as Governor Nathan Deal (R) and the most conservative lawmakers have remained staunchly opposed to any Medicaid expansion alternative. The Governor even signed legislation that prohibits any state entity from spending money to advocate for Medicaid expansion (see Update for Weeks of April 28 and May 5, 2014).

Idaho

House committee blocks funding for Governor’s limited Medicaid expansion

The House State Affairs Committee has refused to introduce a funding bill that was needed to provide \$19 million of the \$30 million in state funds to create the Primary Care Access Program proposed by Governor Butch Otter (R).

The House Health and Welfare Committee had approved the bill (H.484) to create the limited state-funded alternative to the Medicaid expansion under the Affordable Care Act (ACA). It would have funded only basic preventive services for the roughly 78,000 Idahoans caught in the “coverage gap” between Medicaid eligibility and the threshold for ACA subsidies and did not cover acute or emergency care, hospitalizations, or prescription drugs (see Update for Weeks of February 8th and 15th).

However, staunch opposition from conservative lawmakers to any form of expansion caused the necessary funding bill to be blocked on an 8-6 vote. The approval of the State Affairs Committee was needed to access funds from a nationwide tobacco settlement.

House Speaker Scott Bedke acknowledged that the vote effectively kills H.B. 484 for this session but insisted that Republican leaders are still evaluating other options.

Iowa

Feds approve but delay Medicaid managed care transition

The Centers for Medicare and Medicaid Services (CMS) announced last week that it has approved the Iowa’s proposal to transition 560,000 Medicaid fee-for-service enrollees into managed care plans, but further delayed implementation until April 1st.

Governor Terry Branstad (R) had planned to move Medicaid enrollees into four out-of-state health plans starting January 1st (Amerigroup Iowa, AmeriHealth Caritas Iowa, UnitedHealthcare Plan of the River Valley and WellCare). However, CMS agreed with consumer and provider groups that the plan had 16 operational readiness concerns that “would risk serious disruptions in care” including inadequate provider networks that “lack key providers” within a reasonable distance. As a result, it initially delayed the transition until March 1st (see Update for Week of January 4th).

CMS’ approval letter notes that the state’s Medicaid managed care plans had made sufficient progress to proceed (despite lingering concerns from a bipartisan group of state lawmakers) but required an additional 30-day delay to ensure a smooth transition. Enrollees will be able to switch managed care plans through the end of June.



Kentucky

New bill would limit prescription drug coinsurance for plans above the bronze level

Legislation introduced this week by Senator Tom Buford (R) would require Kentucky insurers to offer a percentage of health plans that strictly limit cost-sharing for prescription drugs.

Under S.B. 268, at least 25 percent of plans that cover essential health benefits for each metal tier above the bronze level must limit drug copayments to no more than 1/12 of the maximum annual out-of-pocket limit for an individual subscriber, starting January 1st. Insurers also could not require that subscribers pay coinsurance for any drug that is included on the plan's formulary (or any non-formulary drug that is otherwise included in the plan).

Maine

Republicans tie Medicaid expansion to drug addiction in effort to survive gubernatorial veto

The Joint Health and Human Services Committee deadlocked last week on a bill from last session that would expand Medicaid pursuant to the Affordable Care Act (ACA).

The 6-6 party line vote kept the measure alive for a full Senate vote in the coming weeks. As with the five previous attempts by the legislature to expand Medicaid, Governor Paul LePage (R) has promised to veto it should it again reach his desk.

However, supporters insist that the latest incarnation of Medicaid expansion may have a chance of reaching the two-thirds supermajority needed to override the Governor's expected veto. They note that the bill sponsor is a Republican, Senator Tom Saviello, who is proposing a "private sector" alternative based on the model federally-approved for seven states. This includes neighboring New Hampshire where a majority of Republican lawmakers of backing a two-year reauthorization of the expansion (see Update for Weeks of February 8th and 15th).

In addition, Senator Saviello sought to use the ACA funds that the expansion would bring into Maine to treat the state's ongoing opiate addiction epidemic, a move that gained the bill the support of the Maine Sheriff's Association (in addition to the state's consumer, hospital, and physician groups). He cites an analysis by the Robert Wood Johnson Foundation showing that participating in the ACA expansion enabled states like Colorado, Michigan, and Ohio to save \$5-13 million per year in criminal justice costs, largely by broadening access to substance abuse and mental health treatment for prisoners.

New York

Attorney General launches investigation into coverage for costly HCV drugs

Attorney General Eric Schneiderman (D) announced this week that his office has subpoenaed three health insurers for documentation relating to subscribers that have been denied coverage of costly new drugs used to cure the Hepatitis C virus (HCV).

The subpoenaed insurers (Aetna, CareConnect, Gilead and EmblemHealth) are among the 16 for which Scheiderman has requested details on procedures used to authorize coverage for HCV drugs. However, two of the three subpoenas focused only on the drug Harvoni by Gilead Sciences, which costs nearly \$95,000 for a 12-week course of treatment.

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).



The move by the New York Attorney General comes in the wake of a probe by the U.S. Senate Finance Committee into pricing for both Sovaldi and Harvoni (see Update for Week of November 30th) and continued Senate investigations into specialty drug costs (see Update for Week of January 4th). It also follows the request by the Massachusetts Attorney General last January for Gilead to reconsider its pricing for its two latest HCV drugs Sovaldi and Harvoni.

Oklahoma

House votes to eliminate Medicaid coverage for able-bodied adults under age 65

The House vote along party lines this week to slash Medicaid coverage for all “able-bodied” adults of working age in an effort to fill the state’s \$1.3 billion budget deficit.

The measure (H.B. 2665) now heads to the Senate, where it faces an uncertain fate as it would require the Oklahoma Health Care Authority to first seek a federal waiver that the Obama Administration is unlikely to approve as it would eliminate coverage for at 110,000 adults with annual household incomes below \$9,500, including single parents with dependent children. .

South Dakota

Governor delays debate on Medicaid expansion alternative until special session

Governor Dennis Daugaard (R) decided this week not to pursue his proposed alternative to the Medicaid expansion under the Affordable Care Act (ACA) during the current legislative session.

The Governor had backed an expansion for roughly 55,000 state residents earning up to the eligibility threshold in the ACA (incomes under 138 percent of the federal poverty level). He proposed to use ACA funds to purchase private Marketplace coverage for those made newly-eligible for Medicaid, similar to the model federally-approved for seven states, so long as it did not require the use of additional dollars from the state general fund and the federal government covered 100 percent of the costs for Medicaid-eligible Native Americans covered through the Indian Health Service (see Update for Week of December 7th).

Governor Daugaard received a letter from the U.S. Department of Health and Human Services approving his latter condition, but insisted this week that there was not sufficient time left in the regular session for lawmakers to fully consider his plan. As a result, he plans to call a special session later this year to debate the proposal, a move backed by House Minority Leader Spencer Hawley (D).

Utah

House and Senate committees advance very different Medicaid expansion bills

The Senate Judiciary, Law Enforcement and Criminal Justice Committee surprisingly advanced a bill last week (S.B. 77) with only one dissenting vote that would allow Utah to participate in the traditional Medicaid expansion under the Affordable Care Act (ACA).

The vote was a surprise as it was sponsored by Senate Minority Leader Gene Davis (D) and departed from the previous Senate-passed Healthy Utah plan pursued by Governor Gary Herbert (R) that followed the “private sector” alternative federally-approved for seven other states. It would cover all of the estimated 110, 000 Utahns earning up to 138 percent of the federal poverty level (FPL), the first full expansion bill to clear any legislative committee. However, three of the Republican Senators that backed the bill in the committee acknowledged that their support was largely a signal to the more conservative House that Utah could not afford to “do nothing” for a third year in a row. They conceded that they may not vote in favor of the full expansion bill if it reaches the Senate floor.

House leaders who rejected Healthy Utah last year proposed their own more limited alternative last week (H.B. 487) that would expand coverage only for those 16,000 Utahns caught in the “coverage



gap” between current Medicaid eligibility and the ACA threshold for premium subsidies (starting at 100 percent of FPL). Hospitals have agreed to pay 45 percent of the state’s \$30 million share under the bill sponsored by Majority Leader Jim Dunnigan (R), although disputes over provider assessment led to Healthy Utah receiving only seven House votes last year (see Update for Weeks of October 5th and 12th).

H.B. 487 also quickly cleared committee after several amendments. However, floor passage is far from certain given the warnings this week from House Speaker Greg Hughes (R) that overly optimistic projections about the state’s revenue growth may lead to shortfalls for the upcoming budget year.