

Health Reform Update – Weeks of January 30, 2012

CONGRESS

DOJ, actuaries stress that individual mandate cannot be severed from rest of ACA

Briefs filed by the Department of Justice (DOJ) this week urged the U.S. Supreme Court to only strike down provisions requiring guaranteed issue and community rating should it find the individual mandate to be unconstitutional.

The mandate under the Affordable Care Act (ACA) requiring individuals to buy health insurance or pay a tax penalty is supported by over two centuries of precedent, dating back to the very first Congress that imposed an analogous mandate on maritime workers (see Update for Week of December 19th). However, the DOJ brief reflects a growing unease that the increasingly conservative high court will ignore judicial precedent, as it did in overturning decades of campaign finance restrictions in 2010. Even though conservative justices would have to void their own precedent in order to overturn the individual mandate, the court clearly signaled that it was willing to consider doing so in devoting an unprecedented three days to oral arguments and agreeing to hear whether the entire law should be struck down if the individual mandate is deemed unconstitutional (see Update for Week of November 14th).

Congressional Democrats deliberately did not include a severability clause in the final version of the ACA in order to pressure courts not to overturn one provision that could wind up jeopardizing all of the consumer protections under the law. However, DOJ pointed out that the lack of a severability clause does not by itself require the court to void the entire law.

DOJ emphasized that the only provisions that are interrelated to the individual mandate are the ban on pre-existing condition denials (i.e. guaranteed issue) and limitation on how much insurers can vary premiums (i.e. community rating). The individual mandate cannot be separated from these provisions, because it ensures that the health insurance risk pool will include sufficient numbers of healthy, less-costly individuals to offset the huge number of sicker, more costly populations that insurers will now be forced to accept (without imposing higher premiums based on health status).

DOJ's position was supported by a separate brief from the non-partisan American Academy of Actuaries, who stressed that consumer costs will skyrocket if the individual mandate from these related consumer protections. Their conclusion was reinforced by a recent Robert Wood Johnson study showing that premiums would rise by at least 25 percent in its absence (see Update for Week of January 9th).

To strike down the entire law would also engender severely "bizarre results" and force millions of Medicare beneficiaries to lose drug discounts and repay the \$250 rebate checks they received in 2010. However, despite this scenario that could result in a political nightmare for both parties, the National Federation of Independent Business, one of the plaintiffs in the case, continues to insist that the whole law must be voided if the individual mandate is found to be an invalid exercise of Congressional authority to regulate interstate commerce.

FEDERAL AGENCIES

Public comments largely critical of HHS punting essential health benefit definition to states

The Department of Health and Human Services (HHS) was flooded this week with questions and concerns regarding its proposal to let state officials define the essential health benefits that all non-employer plans must cover beginning in 2014.

Comments on the HHS guidance bulletin were due January 31st (see Update for Week of December 12th). Although HHS officials have yet to make these comments public, advocacy groups did not hesitate to disseminate them this week.

Few of the commenters were willing to endorse HHS' approach, which many like AARP, Federation of American Hospitals, Plasma Protein Therapeutics Association, National Organization for Rare Disorders American Plasma Users Coalition, and American Cancer Society fear will lead to a "race to the bottom" and "drastically unequal coverage across the states."

The American Hospital Association (AHA) was also one of many who were alarmed by the "disturbing" lack of transparency and public feedback into the process of defining essential health benefits. A group of Republican lawmakers and children's health advocates had warned the agency last week that the guidance bulletin circumvents Congress' intent under the ACA that HHS define essential health benefits through formal rulemaking with public notice and comment (see Update for Weeks of January 16th and 23rd).

HHS officials have insisted that they will still issue essential health benefit regulations later this year. The agency did release a list last week of the kinds of benchmark plans that states can choose from when defining essential health benefits (see article above). However, the list came with the caveat that the examples are for "illustrative purposes" and not an official list of state options.

Using data from www.healthcare.gov, the list includes plans with the three largest enrollments in the small-group market in each state (though total enrollments are not specified.) In addition, it identifies the top three nationally available Federal Employee Health Benefit Program plans, based on enrollment as of March 30th.

OMB reviewing final rule on coordinating Medicaid and SCHIP with new insurance exchanges

Final regulations delineating how Medicaid and the Children's Health Insurance Program will coordinate with the health insurance exchanges required by the Affordable Care Act (ACA) are awaiting approval by the Office of Management and Budget (OMB).

The OMB paperwork clearance is typically the last step before federal regulations are published. These new rules from the Department of Health and Human Services would finalize proposed regulations published last summer (see Update for Week of August 8th).

CMS says higher Medicaid drug rebates, new pricing calculation will save \$17.7 billion

The Centers for Medicare and Medicaid Services (CMS) claim that Medicaid spending on prescription drugs will fall about \$17.7 billion over five years under proposed regulations that shift more of the cost to drugmakers and pharmacies.

The long-awaited rule implements provisions of the Affordable Care Act (ACA) that increase the rebates drugmakers must pay when their products are dispensed to Medicaid patients. Brand-name manufacturers now pay rebates of at least 15 percent on the average price they charge for their medicines, which will rise to 23 percent under the rule. For generic drug manufacturers, rebates would rise from 11 to 13 percent of their average prices.

The rebates also apply to drugs sold by managed-care plans that administer Medicaid benefits. Medicaid payments to pharmacies would additionally be pared by about \$4 billion over five years.

In addition, the new rules will make it easier for all state Medicaid programs to reimburse pharmacies to collect receipts from local pharmacies and reimburse based on what the pharmacies actually paid for the medications. HHS initially approved this model for Alabama, which claimed to cut Medicaid pharmacy spending by six percent in the first year (see Update for Week of July 18th). The agency has since approved similar waivers for Oregon, Idaho, and California.

According to CMS, the new rules would save the federal government \$13.7 billion while states would spend \$4 billion less on Medicaid. (Overall, Medicaid spent about \$26 billion for drugs in 2009 and recouped \$9 billion in rebates.)

The proposed rules are the culmination of a long fight by pharmacy groups to correct what they said are problems involved in using average manufacturer price (AMP) as a method of setting Medicaid payments. A 2006 deficit reduction measure (PL 109-171) authorized CMS to use the AMP model. However, the National Association of Chain Drug Stores (NACDS) and National Community Pharmacists Association successfully blocked an attempt by CMS to implement the AMP method under the 2006 law, insisting that AMP was an improper basis for pharmacy reimbursement as “it is not a price paid in the marketplace but instead is a benchmark to determine manufacturer rebates in the Medicaid program.”

The rules were released only after 25 GOP lawmakers sent a letter to CMS last week complaining about the seven-month delay in OMB granting the required paperwork clearance. NACDS and other pharmacy groups have declined comment until they can thoroughly review the new standards.

Medicare Part D costs, Advantage premiums decline

The Department of Health and Human Services (HHS) revealed this week that Medicare beneficiaries were spared an average of \$604 in prescription drug costs over 2011, thanks to the Affordable Care Act (ACA).

Nearly 3.6 million Part D enrollees saved a total of \$2.1 billion due to the 50 percent discount required of brand-name drug manufacturers under the new law. The additional seven percent discount for generic medications (which increases to 14 percent in 2012) saved 2.8 million enrollees about \$32 million last year.

HHS predicts that Part D enrollees will ultimately save an average of \$4,200 from 2011 to 2021, thanks not only due to reduction in the “doughnut hole”, but also elimination of cost-sharing for certain preventive services and restricted growth in Medicare Advantage premiums. The HHS report noted that average premiums for Medicare Advantage dropped seven percent last year, while enrollment is up ten percent for 2012.

Enrollees in high-deductible plans are more likely to forgo medically necessary care

A new study from the Robert Wood Johnson Foundation concluded this week that families enrolled in high-deductible health plans (HDHPs) are 3-4 times more likely to report forgo needed care.

The study compared 370 families in traditional plans with 208 families with chronic conditions who were enrolled in 2008 in employer-sponsored plans that imposed annual deductibles of \$1,000 to \$6,000. It found a 40 percent probability that adults in HDHPs had forgone care, versus only 15 percent for traditional plans (or 18 percent for children in HDHPs versus five percent for traditional plans).

The results are timely given that recent data from Employee Benefit Research Institute showed that HDHP enrollment is at an all-time high. Previous studies by RAND and the Kaiser Family Foundation also found higher rates of forgone care among HDHP enrollees (see Update for Week of December 12th).

STATES

Alabama

New bill would impose standards of care for bleeding disorders

Senator Cam Ward (R) will introduce S.B. 92 next week, resurrecting previous legislation that will amend state insurance law to provide standards of care for bleeding disorders.

The “Hemophilia Standards of Care Act” would compel pharmacy providers that distribute blood clotting products used at home to meet certain specified conditions. It also requires that health insurers provide certain benefits in their policies for persons with bleeding disorders.

Arizona

Ways and Means chair proposes new limits on health plan out-of-pocket expenses

Senator Rick Murphy (R) introduced legislation this week that would limit health plan cost-sharing and out-of-pocket expenses for prescription drugs. Under S.B. 1401, a corporation with a drug benefit that uses a multi-tiered drug formulary could not classify biologics or plasma-derived prescription drugs to a higher cost tier during the term of the subscriber’s plan contract without 60 days notice.

The measure also requires hospital and medical coverage to apply any cost-sharing or out-of-pocket expenses for prescription drugs to the plan’s overall annual out-of-pocket maximum. This overall maximum cannot exceed a limit to be determined by the legislature.

Senator Murphy is a member of a local hemophilia association and serves as chairman of the powerful Senate Ways and Means Committee.

California

Federal judge again blocks Medi-Cal payment cuts

U.S. District Court Judge Christina Snyder ruled this week that her earlier temporary injunction blocking cuts in Medi-Cal reimbursement rates for pharmacies and managed care plans should be extended to physicians and other providers (see Update for Week of January 2nd).

The Centers for Medicare and Medicaid Services (CMS) approved the across-the-board cut for most health care providers last fall that are retroactive to June 1, 2011, as well as new cost-sharing hikes and service limits for enrollees. However, Judge Snyder is blocking the cuts from going into effect, concluding that CMS did not adequately evaluate whether the severity of the ten percent cut, coming on top of similar reductions in prior years, would restrict access to care for Medi-Cal enrollees.

Federal Medicaid law bars states from cutting reimbursement so severely that it will harm access to care, a nebulous standard that CMS often ignores in order to prevent states from otherwise cutting benefits or eligibility. Medi-Cal providers successfully sued to block an analogous cut in 2009, a decision that is currently being reviewed by the U.S. Supreme Court (see Update for Week of September 26th).

California to run out of cash...again

It what appears to have become an annual ritual, state Controller John Chiang told budget leaders this week that California will again run out of cash and start issuing IOUs if lawmakers do act to prevent the \$3.3 billion shortfall by March 1st.

Chang specifically recommended that lawmakers borrow money and defer or delay other state payments. He blamed the shortfall on court rulings that have repeatedly blocked Medi-Cal spending cuts (see article above), as well as tax revenues are coming in \$2.6 billion below projections.

Governor Jerry Brown (D) and leaders of the Democratically-controlled legislature insisted that a temporary solution will be worked out as early as next week. The Assembly Budget Committee has already approved legislation that would allow the Department of Finance to borrow \$865 million more from special funds in order to fill the general fund shortfall.

Colorado

Bill repealing health benefits exchange defeated by one vote

The Senate Health and Human Services Committee voted down S.B. 53 this week, a Republican-sponsored measure that would have repealed the Colorado Health Benefits Exchange if the U.S. Supreme Court declares any part of the Affordable Care Act (ACA) unconstitutional. The measure failed 5-4 in a straight party-line vote.

Delaware

Bipartisan bill would remove oral cancer drugs from high-coinsurance specialty tiers

A bipartisan bill unveiled last week seeks to add Delaware to the list of states that require health plans to treat oral cancer drugs no different than intravenous medications.

Currently, IV-administered cancer therapies are treated as a medical benefit requiring only a patient copayment. However, most oral cancer drugs fall under the prescription benefit, where patient coinsurance may exceed 25-30 percent of the cost if the drug is moved into a specialty tier.

The "oral parity" bill (H.B. 265) sponsored by Rep. Deborah D. Hudson (R) would eliminate this disparity, so that patients are not forced to pay a percentage of the cost of oral cancer drugs that can cost \$5,000-\$10,000 per month. Similar laws have already been enacted in Washington, D.C., and 15 other states, including New York and New Jersey (see Update for Weeks of January 16th and 23rd).

Florida

NASTAD warns that new jump in ADAP waiting list proves funding crisis has not abated

After a dramatic reduction due to long-awaited federal relief, Florida's waiting list for the AIDS Drug Assistance Program (ADAP) is climbing again.

According to figures compiled by the National Alliance of State and Territorial AIDS Directors (NASTAD), Florida's ADAP had over 4,000 clients on its waiting list last fall, totaling nearly 50 percent of all waiting list cases nationwide. However, \$885 million in federal funding released over several months this fall promptly dropped all waiting list cases by nearly a third (see Update for Week of October 3rd).

Florida's ADAP had dropped all the way to 800 clients in December, but has jumped back up to 1,204 clients, slightly behind Georgia for the most in the nation. However, unlike Georgia whose waiting list continues to decline, Florida's jumped by 95 clients just last month, nearly double the increase of any other state. (Only 12 states still have waiting lists, and only six other states recorded an increase.)

NASTAD warns that the ADAP crisis has simply been masked by the influx of federal relief. The organization emphasizes that "the demand for ADAP has not dwindled and ADAP waiting lists will likely plateau and grow again in the coming months," noting that other ADAPs plan to reinstate waiting lists in 2012 due to limited federal and state funding that fails to meet demand.

However, additional relief is on the way. President Obama announced late last year that he would make \$35 million in additional federal ADAP grants available. The President's proposed budget for fiscal year 2012 seeks an additional \$55 million in ADAP funding (see Update for Week of December 12th), and several leading manufacturers of HIV/AIDS medications have already pledged to expand discounts and rebates through 2013 (see Update for Week of December 19th).

Hawaii

Bill limiting specialty tier coinsurance unanimously clears Senate health committee

The Senate Health Committee voted 5-0 last week to pass legislation that bars the use of specialty tier coinsurance by Hawaii insurers.

In addition to prohibiting private health plans from requiring subscribers to pay a percentage of the cost for specialty drugs, S.B. 2106 would prevent any copayments that exceed \$150 month for a one-month supply. PSI Government Relations had urged the passage of the legislation (see Update for Week of January 16th). Similar measures were considered by 14 states last session, and are currently moving through the legislature in at least Arizona, Indiana, Massachusetts, and Washington (see articles below).

Idaho

Republicans scuttle exchange bill, despite support of Governor, insurers, businesses, and voters

Governor Butch Otter (R) acknowledged this week that the Legislature will be unable to pass legislation authorizing the creation of a state-based health insurance exchange prior to the January 2013 deadline to avoid a federal fallback exchange.

The Governor was one of 11 who have issued executive orders to begin implementing the exchange required by the Affordable Care Act (ACA), in order to circumvent opposition from Republican lawmakers intent on blocking any provision of "Obamacare". However, authorizing legislation is still required to make sufficient progress on exchange implementation necessary to meet the federally-imposed deadline.

Governor Otter was optimistic that authorizing legislation proposed by the Department of Insurance would pass this session (see Update for Week of December 12th), after several key Republicans supported his position that a state exchange is favorable to a federal fallback exchange (see Update for Week of August 22nd). However, Republican leaders instead opted this week to follow the "wait and see" approach adopted by several other Republican-led legislatures, and postponed any action on the exchange until the U.S. Supreme Court rules on ACA constitutionality in June.

Even though he could call the legislature back into special session after the Supreme Court decision, the Governor conceded this week that they could not act in sufficient time to implement the exchange unless the federal government grants a reprieve. Regulations and guidance issued last year by the U.S. Department of Health and Human Services indicated that the agency would be willing to grant extensions past the January 2013 deadline, but only for states that have taken significant steps towards implementation (see Update for Weeks of November 21st and 28th). It is not clear that Idaho would be granted an extension if the legislature waits until next fall to pass authorizing legislation.

Rep. Roy Lacey (D) and fellow Democrats blasted Republican lawmakers for taking such a risk, especially since the exchange has the support not only of a Republican Governor, but the state's insurance and business communities. A recent AARP poll also showed that 73 percent of Idaho voters age 30-64 want the state to create their own exchange versus a mere nine percent that favor a federal fallback exchange.

Illinois

New bill would exclude clotting factor from list of specialty drugs

Senator David Koehler (D) introduced S.B. 3213 this week, which provides that the Department of Healthcare and Family Services shall specifically exclude hemophilia clotting factor from any program requiring a federal waiver in order to limit the pharmacies eligible to dispense specialty drugs. The measure also would bar the Department from including hemophilia clotting factor on a preferred drug list requiring prior approval until 30 days after it submits a report studying the impact of access to care to the House Speaker and Senate President.

Indiana

Health committee passes legislation limiting out-of-pocket costs for prescription drugs

The Senate Committee on Health and Provider Services passed S.B. 335 on January 19th, which would ensure access to life-saving specialty medications by limiting the out-of-pocket costs that individual and small group plans could impose for prescription drugs.

Under the bill, drug copayments or coinsurance may not exceed \$200 for a 30-day supply of one drug, or \$500 for more than one drug. Nor can a plan exclude out-of-pocket cost for covered prescription drugs from applying to the annual out-of-pocket limit for other covered services.

S.B. 335 now moves to the Senate Appropriations Committee. The measure is sponsored by Senator Ron Grooms (R).

Maryland

Governor's exchange bills authorize creation of navigator program

Legislation filed last week at the request of Governor Martin O'Malley (D) would further the design and implementation of the Maryland Health Benefits Exchange.

Maryland was the third state behind California and West Virginia to enact legislation authorizing the creation of an exchange (see Update for Week of April 11th) and the first to complete appointments to its exchange governing board (see Update for Week of May 23rd). However, subsequent legislation is needed to implement additional portions of the exchange, including an ultimate mechanism to ensure the exchange is self-sustaining by 2015 as required by the Affordable Care Act (ACA).

S.B. 238/H.B. 443 closely follows the recommendations of the Exchange Board (see Update for Week of January 2nd). It will require the governing board to establish and implement specific navigator programs for the exchange, and establish criteria determining what entities can serve as a navigator. The ACA requires exchange boards to award grants to "navigators" who can facilitate exchange enrollment and provide "fair and impartial" guidance to consumers on plan options, availability of federal tax credits for exchange premiums and cost-sharing, and questions about grievances, complaints, and appeals.

Proposed rules published last summer by the U.S. Department of Health and Human Service (HHS) gave states significant flexibility in defining who could serve as a navigator, subject to basic federal standards (see Update for Week of August 8th). For example, navigators can include trade, industry, or professional associations, as well as "consumer-focused" non-profit entities. However, a navigator cannot be a health insurance issuer or receive "any consideration directly or indirectly from any health insurance issuer" for enrolling individuals or employers in a particular plan.

The Governor's legislation would ensure that Maryland operate separate exchanges for individual and small group plans, and hire different navigators for each exchange. The Senate Finance Committee has scheduled a February 22nd hearing on S.B. 238. The second public stakeholder meeting on the legislation will be held on February 10th.

Massachusetts

Specialty tier bill finally clears committee

Legislation introduced last session by Senator Anthony Petrucci (D), chair of the Joint Committee on Financial Services, was reported favorably last week by the Joint Committee on Financial Services (see Update for Week of October 10th). S.B. 455 would prohibit insurers from using specialty tiers that require consumers to pay a percentage of the highest-cost prescription drugs. It also bans

prescription drug copayments in which the maximum copay exceeds by more than 500 percent the lowest prescription drug copayment charged by the plan.

Despite similarities, Massachusetts must change state reforms to comply with ACA

The Affordable Care Act (ACA) was largely based on the landmark health reforms enacted by Massachusetts in 2006. As with the ACA, the Massachusetts model requires that everyone obtain health insurance and provides generous tax subsidies to help low-to-moderate income residents do so. Massachusetts also mandates requires that health insurers cover everyone regardless of pre-existing conditions, and created a Commonwealth Connector health insurance exchange.

However, there are key differences between the federal and state models that must be reconciled before the ACA goes fully into effect in 2014. For example, the tax penalty for not purchasing health insurance when affordable is much higher under the Massachusetts plan than the ACA. Commonwealth officials must now decide whether to go with the lower federal penalty or make residents pay both the state and federal penalty.

The Massachusetts model also provides far more generous subsidies than the ACA, but limits subsidies only to those earning up to 300 percent of the federal poverty level, instead of 400 percent under the ACA. Massachusetts regulators must decide whether to seek federal permission to “grandfather” or retain the current 300 percent level, or reduce the amount of subsidies to extend assistance to a greater number of residents.

Another chief concern for Massachusetts is that the mandated Medicaid expansion under the ACA could reduce enrollment in the Commonwealth Connector exchange by a whopping 70 percent, meaning that the exchange will no longer be able to fund itself.

The Massachusetts reforms remain very popular with Commonwealth residents, even if many health care cost controls have yet to be implemented (see Update for Weeks of January 16th and 23rd). However, a new Harris Interactive poll released this week found that most respondents across the nation knew little about the Massachusetts model, apart from the fact that it was similar to the ACA and signed into law by former Governor and Presidential candidate Mitt Romney (R).

Minnesota

Democrats resurrect exchange-authorizing bill as Republicans remain divided

Senator Tony Lourey (D) and Rep. Joe Atkins (D) pledged to introduce measures within one week that will create the health insurance exchange required by the Affordable Care Act (ACA).

The move represents the opening salvo of what is expected to be a bitter battle this session with the Republican-controlled legislature. Governor Mark Dayton (D) became the first Democrat to use an executive order to proceed with implementation, after Republican-sponsored authorizing legislation was blocked last year by “tea party” backed Republicans insisting that an exchange would merely legitimize “Obamacare” (see Update for Week of October 31st)

Opposition has been led by Senator David Hann (R), chair of the Senate Health and Human Services Committee who has already held hearings on possible measures to block any new authorizing legislation and even threatened to sue the Governor if he attempts to proceed on his own (see Update for Week of August 15th). Opposition Republicans also refused to fill any of their seats on the Governor’s task force charged with making recommendations for exchange design. Instead, Hann created his own Republican task force to strategize on how to block an exchange.

Senator Hann also disputed this week that other key Republican lawmakers and constituencies were backing exchange legislation, even though Rep. Mary Franson (R) eliminated Hann-backed language blocking exchange implementation from last summer’s budget compromise (see Update for

Week of July 11th). Hann insisted that the Minnesota Chamber of Commerce and the Minnesota Business Partnership are supportive merely of the exchange concept and not the effort by Governor Dayton to align the state with “Obamacare”.

Governor Dayton has pledged to use the federal exchange grant to ensure Minnesota can at least meet the January 2013 deadline to avoid a federal fallback exchange. However, he and Commerce Commissioner Mike Rothman have repeatedly acknowledged that they will need legislative approval “at some point” to get the exchange operating (see Update for Week of October 31st).

South Carolina

Exchange committee spent less than a third of federal grant before rejecting exchange

The Health Planning Committee charged by Governor Nikki Haley (R) with deciding whether to create a health insurance exchange publicly disclosed this week that it spent less than third of the state’s federal planning grant before recommending that South Carolina not pursue an exchange.

The final spending report required by the U.S. Department of Health and Human Services only fueled the ongoing controversy over e-mails from Governor Haley indicating that she pre-ordained the negative decision to be reached by members she appointed, despite claiming she would use the federal funds to create the exchange required by the Affordable Care Act (ACA (see Update for Week of December 12th). U.S. Senator Tom Harkin (D-IA) has requested an investigation into whether the Governor thus misused the federal planning grant obtained by her predecessor and should return the entire \$1 million (see Update for Week of December 19th).

Governor Haley did not contest that the committee’s conclusion mirrored her initial e-mail directing them to study “how to opt out and how to avoid a federal takeover, NOT create a state exchange.” However, she insists that the members reached their decision independently based on “insufficient federal guidance” about how to proceed.

Governor Haley and Health and Human Services Chairman Tony Keck have elected to simply allow a federal fallback exchange to be operated in South Carolina starting in 2014 (see Update for Week of November 14th).

South Dakota

Legislature set to approve new Medicaid copayments to start in April

The Legislature is set in February to approve a state agency request for a federal waiver that would significantly hike copayments required for certain Medicaid beneficiaries.

The higher copayments are one of 11 recommendations put forth by the Medicaid Solutions Work Group, an assembly of health care providers, lawmakers and state employees assigned with finding savings. However, it would be the first to be implemented in April, if approved by the U.S. Department of Health and Human Services (HHS).

Under the direction of Governor Dennis Daugaard (R), the group also proposed ways the state could better manage care for the highest-cost Medicaid enrollees and restrict non-emergency use of emergency rooms.

Even though the plan would hike pharmacy copayments to the highest amount allowed under federal law (\$1 for generics and \$3.30 for brand name drugs), the group insisted that federal permission was likely given their recent approval of similar copayment hikes by Arizona and California. Neighboring states of Montana also impose similar copayments. However, Utah’s request to boost Medicaid copayments from \$3 to \$6 was rejected last week by HHS.

Texas

Federal government rejects Texas' request to phase-in new insurer payout standards

Texas became the ninth state late last week to be rebuffed in their attempt to phase-in new federal rules limiting health insurer profits.

The Affordable Care Act (ACA) requires all individual and small group plans to spend at least 80 percent of premium revenue on direct medical care (instead of administration and profits). Those that failed to comply in 2011 must issue rebates to consumers this year.

The Texas Department of Insurance (TDI) had sought a federal waiver allowing them to gradually move from 71 percent to 80 percent by 2014. The U.S. Department of Health and Human Services (HHS) has granted similar waivers to six states (Maine, New Hampshire, Kentucky, Nevada, Iowa, and Georgia) that demonstrated that immediate compliance would significantly disrupt their marketplace. However, at the urging of Congressional Democrats from Texas (see Update for Week of January 2nd), HHS found that TDI failed to show that individual and small group plans in Texas either already meet this new medical-loss ratio or are sufficiently profitable to adjust their business practices to do so.

As a result of the rejection, 23 of the 34 Texas health plans subject to the new medical-loss ratio will have to pay an estimated \$476 million in rebates to consumers. Roughly \$90 million is likely to come from Blue Cross and Blue Shield, which spent less than 70 percent of individual health plan premiums on medical care.

Waiver requests for North Carolina and Wisconsin remain pending.

Vermont

New bill creates broader insurance exchange than ACA, limits prescription drug cost-sharing

Comprehensive legislation introduced last week would lay the groundwork for the first phase of the Vermont's landmark single-payer system.

The new law passed last session (H.202) set the state on the path to abolish private insurance and create only a state government payer of health services by 2015 (see Update for Week of May 23rd). H.599 sponsored by Reps. Michael Fisher (D) and Ann Pugh (D) sets forth the ground rules for the health insurance exchange required by the Affordable Care Act (ACA) and also limits subscriber out-of-pocket expenditures for prescription drugs (including high-cost specialty tier drugs) to no more than \$1,000 per individual or \$2,000 per family (while barring any annual limits)

The exchange portion of the bill could prove controversial, as it forces individual and small group plans to only offer coverage in the exchange and includes provisions requiring small employers to only purchase coverage through the exchange. As with S.208 (see Update for Week of January 2nd), it also expands exchange eligibility for small employers to up to 100 employees, which would add an estimated 200,000 exchange enrollees. Competing bills would limit exchange eligibility to only small employers with up to 50 employees (as well as the uninsured), consistent with the ACA standard until 2016.

H.559 would also allow Vermont to offer more "wrap-around" subsidies that extend beyond the federal subsidies offered in the exchange. As with neighboring Massachusetts (see above), Vermont's existing state health plan offers more generous subsidies than the ACA, but only extends subsidies to those earning up to 300 percent of the federal poverty level (as compared to 400 percent under the ACA).

Washington

New bills would limit out-of-pocket expenses for prescription drugs

PSI Government Relations urged the Senate committee on Health and Long-Term Care this week to pass S.B. 6241/H.B. 2435, measures that would limit health plan cost-sharing and out-of-pocket expenses for prescription drugs.

The bills would impose a single out-of-pocket maximum across all health benefits covered by fully-insured health plans. As does the Affordable Care Act (ACA), the cost-sharing under both bills limits mirror those established by the Internal Revenue Service (IRS) for qualified high-deductible health plans (\$5,950 for single coverage, \$11,900 for family coverage). However, the bills are effective in 2013 (one year earlier than the ACA) and apply only to fully-insured plans (instead of all plans as under the ACA).