



## Health Reform Update – Week of February 23, 2015

### CONGRESS

#### ***HHS denies having contingency plan should FFM subsidies be invalidated***

Department of Health and Human Services (HHS) Secretary Sylvia Mathews Burwell claimed before Congress this week that the Obama Administration has not developed a contingency plan in the event the U.S. Supreme Court invalidates Affordable Care Act (ACA) subsidies for federally-facilitated Marketplace enrollees (FFM).

The decision expected in June could strip the premium tax credits from roughly 87 percent of the 8.8 million FFM enrollees (see below) and raise monthly premiums by an average of 225 percent, according to the latest analysis by Avalere Health released this week. Nine states including the largest FFM in Florida (see below) could see premiums spike by more than 300 percent, while Avalere projects a staggering 779 percent jump for Mississippi.

Although the legal challenge was funded by the Competitive Enterprise Institute and other conservative groups, Republican governors this week lobbied Congress to reinstate the subsidies in the event they are invalidated, fearing an electoral backlash if they are unable to secure legislative approval to protect the subsidies by transitioning their Marketplace to state control (see Florida below). Recent polling by the Kaiser Family Foundation showed nearly two-thirds of respondents want the subsidies to remain in place (see Update for Weeks of January 26<sup>th</sup> and February 2<sup>nd</sup>).

The U.S. Supreme Court has scheduled oral arguments on the case for March 4<sup>th</sup> (see Update for Week of January 5<sup>th</sup>). Should the subsidies be invalidated, the HHS Secretary insists that there are “no administrative actions that could...undo the massive damage to our health care system that would be caused.” House Republicans accused the Secretary of trying pressure the Supreme Court or Congress to protect the subsidies by refusing to disclose a viable back-up plan.

#### ***House investigates inaccuracies in tax forms for 820,000 federal Marketplace consumers***

A House Oversight and Government Reform subcommittee held a hearing this week demanding answers from the Centers for Medicare and Medicaid Services (CMS) to why roughly 820,000 federally-facilitated Marketplace (FFM) consumers received tax forms that contained inaccurate information about the amount of Affordable Care Act (ACA) subsidies that they may be required to refund.

During the subcommittee hearing this week, the new chief executive officer for the Marketplace was blasted by members of both parties for not being forthcoming enough with details about the software errors that led to the inaccurate tax forms. Kevin Counihan, who oversaw Connecticut's state-based Marketplace until last fall, pledged that CMS would send out corrected forms next week and contact affected consumers through calls, emails, and letters.

Eligible consumers that received advanceable premium tax credits for 2014 must repay a portion of the subsidy if their income increased during the year. According an analysis by H&R Block, about 52 percent of those that already filed their federal income tax returns are being required to return an average of \$530, which decreased their tax refund by approximately 17 percent. However, roughly one-third are receiving an average of 11 percent in higher refunds (or \$365) because they overestimated their income.

Internal Revenue Service (IRS) officials decided this week not to penalize consumers that filed incorrectly based upon inaccuracies in their tax forms. These filers will not be required to amend their



returns and the IRS “will not pursue the collection of any additional taxes from these individuals.” The IRS will allow those who would receive a larger refund from filing an amended return to do so.

Less than ten percent of tax filers have already submitted their returns. CMS already moved last week to create a special enrollment period through April 30<sup>th</sup> for those filers that attest they were unaware that they may be subjected to tax penalties under the individual mandate until they prepared their returns (see Update for Weeks of February 9<sup>th</sup> and 16<sup>th</sup>).

### ***Senate Republicans criticize proposed IRS guidance on “Cadillac” health plan tax***

Republican leader on the Senate Finance and Judiciary committees attacked the Internal Revenue Service (IRS) this week for suggesting that labor unions should be exempt from the Affordable Care Act (ACA) tax on high-cost health plans that goes into effect in 2019.

IRS released its first guidance this week on the 40 percent excise tax on so-called “Cadillac” plans, which had been proposed for decades by both conservative and progressive economists as a means to discourage the overutilization of care under exceptionally-generous health coverage. The agency specifically is seeking comments by May 15<sup>th</sup> on the threshold for defining high-cost plans, as well as input on whether the tax should be applied to employer-sponsored coverage.

The guidance floated several proposals, including excluding coverage for “high-risk” occupations from the tax, as well as limited-scope vision and dental coverage. However, it was the implication that some “high-risk” occupations are largely affiliated with labor unions that drew the ire of Finance chair Orrin Hatch (R-UT) and Judiciary chair Charles Grassley (R-IA), who accused the IRS of trying to cater to “the president’s political supporters.”

Both Senators sent a letter to the Department of Treasury Secretary demand details on how many of the “high-risk” employee categories identified in the guidance are “unionized”. Officials with the AFL-CIO and American Federal of State, County, and Municipal Employees have fervently opposed the excise tax, referring to it as a “stupid mistake”. However, it is projected to be one of the ACA’s largest sources of revenue once implemented.

### ***Republican plan to extend CHIP funding would pare-down coverage for higher-income families***

House and Senate Republicans released their proposal this week to overhaul and extend funding for the Children’s Health Insurance Program (CHIP), which is currently set to expire in September absent Congressional action.

The move comes only about two weeks after House and Senate Democrats introduced their own plans to extend funding through federal fiscal year 2019 (H.R. 919 and S.522) following the release of the President’s budget proposals (see Update for Weeks of January 26<sup>th</sup> and February 2<sup>nd</sup>). However, the Republican plan would eliminate the 23 percent increase in CHIP matching rates included in both Democratic bills, citing Congressional Budget Office (CBO) analyses showing that the resulting \$10 billion spending increase would not necessarily result in a corresponding coverage gain.

Republican leaders are also seeking to eliminate the “maintenance of effort” provision of the Affordable Care Act (ACA), which would allow states to start revising eligibility standards in October 2015 instead of extending the prohibition against eligibility changes until 2019. They also would eliminate the requirement that states cover Medicaid children aged 6-18 with family incomes from 100-133 percent of the federal poverty level (FPL), cut funding for families earning more than 250 percent of FPL, and eliminate the requirement entirely for those above 300 percent of FPL.



Other Republican provisions would allow for waiting periods and ensure that state-funded health care programs providing coverage equivalent to CHIP satisfies the ACA requirement for minimum essential coverage (thus avoiding tax penalties under the individual mandate).

Republicans on the House Energy and Commerce Health subcommittee have stated their intent to pass more SCHIP costs onto consumers as a condition of any extension (see Update for Week of December 8<sup>th</sup>). Several expressed concerns that CHIP payments are actually “subsidizing the upper middle-class” instead of its original intent to help the most vulnerable of children. However, the Medicaid and CHIP Payment and Access Commission and Government Accountability Office have disputed such claims, noting that roughly 90 percent of SCHIP families have incomes less than 200 percent of FPL.

### ***House leaders eyeing 4-6 month patch for Medicare physician payment cuts***

House Budget Committee chair Tom Price (R-GA) stated this week that a permanent repeal and replacement of the Medicare physician payment formula is unlikely to be passed by the March 31<sup>st</sup> expiration for the latest extension of the 20-30 percent cuts.

The House passed a bipartisan measure last year to replace the flawed formula (H.R. 4015, S.2000), which has been postponed every year by Congress since its enactment (see Update for Week of December 8<sup>th</sup>). However, the measure continues to be bogged down over debates on how to offset the sizeable cost, which the Congressional Budget Office (CBO) now pegs at \$174.5 billion from 2015-2025 (see Update for Weeks of January 26<sup>th</sup> and February 2<sup>nd</sup>).

Rep. Price indicated that House leaders are working on a 4-6 month temporary extension that would give them time to formulate a permanent fix that could be attached to legislation extending funding for the Children’s Health Insurance Program, which expires September 30<sup>th</sup> (see above). Health and Human Services Secretary Sylvia Burwell stressed this week that a permanent repeal remains a priority of the Administration, even if another short-term patch is needed.

A temporary extension would still require offsetting cuts, which Price did not identify.

### ***Democrats push legislation to protect and increase NIH funding***

Several House Democrats are backing legislation introduced last week that would make funding for the National Institutes of Health (NIH) no longer subject to the annual budget process.

The *Permanent Investment in Health Research Act* (H.R. 777) would designate NIH medical research funding as non-discretionary spending, thereby removing it from the caps on discretionary spending put in place by the *Budget Control Act* (see Update for Week of August 1, 2011). It would effectively treat NIH funding the same way as programs like Social Security, Medicare, and Medicaid.

Primary sponsors Kathy Castor (D-FL) and G.K. Butterfield (D-NC) insisted that “funding for medical research is too essential to be subjected to political squabbles”, citing the nearly annual threats of shutdowns and dramatic cuts. They pointed out that NIH funding peaked in 2010 at \$31.2 billion but has already been slashed down to \$30.6 billion by 2014 as a result of annual spending compromises.

Separate legislation introduced by Democratic members including Rep. Castor (H.R. 744) would increase medical research funding for NIH partly by mandating that drugmakers reinvest a small percentage of profits into the agency as part of any fraud and abuse settlements entered into with the federal government. A Senate counterpart (S.320) was introduced last month by Senator Elizabeth Warren (D-MA). Bill sponsors estimate that such a requirement would have resulted in a 20 percent increase in NIH funding had it been in place over the past five years.

### ***Federal Marketplace enrollment exceeds 8.8 million for 2015 open enrollment period***

The Department of Health and Human Services (HHS) announced that about 200,000 consumers signed-up for coverage through the federally-facilitated Marketplace (FFM) during the one-week extension of the open enrollment period that ended February 22<sup>nd</sup>.

The additional enrollees were those that had started applications prior to the initial February 15<sup>th</sup> deadline but were prevented from completing them due to technical issues (see Update for Weeks of February 9<sup>th</sup> and 16<sup>th</sup>). They bring the final FFM tally for the 2015 open enrollment period to more than 8.8 million consumers. According to HHS figures, roughly 53 percent of sign-ups were new consumers while the remainder represents renewals.

HHS is currently operating the FFM for 37 states. All of the 14 state-based Marketplaces (SBMs) have issued similar deadlines. Both the FFM and many SBMs have already created a special enrollment period (SEP) for those unaware that they are subject to individual mandate penalties until filing their 2014 federal income taxes (see Update for Weeks of February 9<sup>th</sup> and 16<sup>th</sup>).

HHS officials stated that the number of FFM consumers actually dropped from coverage for failing to verify their immigration status totaled around 90,000, instead of the 200,000 initially estimated (see Update for Weeks of February 9<sup>th</sup> and 16<sup>th</sup>).

The agency also revealed that enrollment in Medicaid and the Children's Health Insurance Program (CHIP) continues to rise steadily, increasing by nearly 0.8 percent in December, nearly the same increase that occurred in each of the previous three months. Overall, Medicaid and CHIP has increased by 10.8 million enrollees (or 18.6 percent) since the Affordable Care Act (ACA) Marketplaces opened in October 2013.

Kentucky experienced the largest growth (nearly 76.9 percent) while Vermont (70.7 percent), Nevada (64.9 percent), and Oregon (64.6 percent) also saw dramatic increases. Overall, states participating in the Medicaid expansion under the ACA saw a roughly 27 percent average increase while opt-out states increased by only an average of 7.3 percent.

### ***Open enrollment period will start three weeks earlier in 2016***

Final rules for qualified health plans (QHPs) published last week by the Centers for Medicare and Medicaid Services (CMS) have moved-up the open enrollment period for 2016 coverage.

Open enrollment ran from November 15<sup>th</sup> to February 15<sup>th</sup> for 2015 coverage. CMS had proposed last fall to shorten the open enrollment window for 2016 to only ten weeks and move it up to October 1, 2015 – December 15, 2015. However, the final Notice of Benefit and Payment Parameters rule (see below) decided on a 12-week window from November 1, 2015 – January 31, 2016 to avoid burdens cited by commentators.

### ***CMS finalizes Marketplace rule for 2016, including provision on discriminatory cost-sharing***

The Centers for Medicare and Medicaid Services (CMS) finalized their Notice of Benefit and Payment Parameters (BPP) regulation late last week, which address issues affecting qualified health plans (QHP) for 2016.

Under the final rule, proposed changes to the temporary reinsurance program created by the Affordable Care Act (ACA) remain intact (see Update for Week of December 1<sup>st</sup>). The reinsurance



payments compensate QHPs incurring exceptional claims. Instead of reimbursing QHPs for half the costs of annual claims beyond \$70,000, this previous threshold will now be pared down to \$45,000.

The BPP rule also requires QHPs to pay an annual tax of \$27 per enrollee in 2016, as well as continuing the existing user fee, which comes out to 3.5 percent of premiums. CMS will pay half of insurer costs for patients that incur more than \$90,000 in costs (up to a cap).

Other key changes require QHPs to “publish an up-to-date, accurate, and complete list of all covered drugs on its formulary drug list, including any tiering structure and any restrictions on the manner in which a drug can be obtained.” In response to consumer complaints about difficulties finding what drugs are covered under Marketplace formularies, the rule requires these details to be “easily accessible to plan enrollees, prospective enrollees, the state, the Marketplace, HHS, OPM, and the general public.”

The final rule also directs QHPs to notify consumers how to request exceptions for drugs not listed on plan formularies and adds a requirement for external review of exception denials. CMS also stipulates that cost-sharing for drugs obtained through the exceptions process must count towards the plan’s annual cost-sharing limits

The final rule likewise retains the provision sought by consumer advocates warning QHPs that “specific practices may be considered discriminatory, including restricting services based on age when the service may be appropriate for all ages, and **placing most or all drugs for a specific condition on a high cost-sharing tier** [emphasis added].” CMS states that such “impermissible benefit designs” will be considered by the agency when deciding whether to certify QHPs for the federally-facilitated Marketplace (FFM), and that CMS encourages state-based Marketplaces to do the same.

This provision is in direct response to a discrimination complaint filed by The AIDS Institute (TAI) with the Office of Civil Rights for the Department of Health and Human Services. The complaint documented that several Marketplace insurers in Florida and Illinois starting moving all or most drugs to treat HIV/AIDS or Hepatitis C into specialty tiers that required consumers pay a coinsurance of 40-50 percent of the drug cost (see Update for Week of June 2<sup>nd</sup>). The insurance commissioners in both Florida and Illinois have since taken enforcement action against such practices (see Update for Weeks of February 9<sup>th</sup> and 16<sup>th</sup>).

CMS will also “identify QHPs that are outliers based on an unusually large number of drugs subject to prior authorization and/or step therapy requirements in a particular USP category and class.” This review will include an analysis of the “availability of covered drugs recommended by nationally-recognized clinical guidelines” for treating bipolar disorder, diabetes, rheumatoid arthritis, and schizophrenia to “ensure that issuers are offering a sufficient number and type of drugs needed to effectively treat these conditions and....are not restricting access through lack of coverage and inappropriate use of utilization management techniques.” The final rule suggests that HIV/AIDS drugs may be considered in future reviews.

The BPP rule also sets the 2016 annual out-of-pocket limit at \$6,850 for individuals and \$13,700 for family coverage.

### ***ACA has saved Medicare enrollees \$15 billion in prescription drug costs, per HHS***

The Department of Health and Human Services (HHS) announced this week that Medicare enrollees have saved a total of \$15 billion on prescription drugs since the Affordable Care Act (ACA) was first enacted.

According to HHS, nearly 5.1 million enrollees saved \$4.8 billion just in 2014, which averages to \$941 per enrollee. These figures are higher than 2013, when 4.3 million saved \$3.9 billion, for a per enrollee average of \$911.



Medicare Part D enrollees who enter the coverage gap or “doughnut hole” during 2015 will now receive brand-name drug discounts of 55 percent and 35 percent for generics.

HHS also noted that enrollees are increasingly taking advantage of wellness exams and other preventive services provided without cost-sharing under the ACA. Roughly 39 million enrollees (including those enrolled in Medicare Advantage) took advantage of at least one free preventive service in 2014, up from 37.2 million in 2013.

### ***CMS proposes to cut in Medicare Advantage rates by nearly one percent***

The Centers for Medicare and Medicaid Services (CMS) issued proposed rules late last week that would cut reimbursement rates for Medicare Advantage (MA) plans by 0.95 percent in 2016.

The proposed reduction, which must be finalized by April 6<sup>th</sup>, is less than half of the 1.9 percent sought by CMS for 2015, which was fiercely opposed by the participating private insurers. CMS ultimately reversed the cut in favor of a slight increase (0.4 percent), in response to pressure from Congressional Democrats in competitive election races (see Update for Week of April 7<sup>th</sup>).

Roughly one-third of Medicare beneficiaries choose to enroll in MA plans, which provide secondary benefits not covered under traditional Medicare, like hearing aids and eyeglasses. Under MA, physicians are reimbursed based on a risk-adjusted, per-person payment formula that is annually updated by Medicare. Prior to the Affordable Care Act (ACA), MA plans were paid about 14 percent more than traditional Medicare.

However, the Congressional Budget Office (CBO), Medicare Payment Advisory Commission (MedPAC), and other entities had long-recommended that Congress curb these “overpayments” to MA plans and bring MA reimbursement more in line to traditional Medicare. As a result, Congress lowered the rate of MA payment growth through the ACA and used the \$156 billion in “savings” to fund other ACA provisions such the premium tax credits for mid-to-low income Americans to purchase Marketplace coverage (see Update for Week of February 7, 2011).

CMS officials stressed in media reports that the 0.95 percent reduction will actually lead to higher overall payment growth once combined with adjustments in plan risk scores. MA plans that score high on quality measures also receive higher payments. However, the proposed rule cuts the weight of seven of these quality measures in half, stating that they appear to disadvantage plans that cover beneficiaries enrolled in both Medicare and Medicaid.

As with new rules for Marketplace plans (see above), the new rules require MA plans to increase the accessibility and accuracy of their provider directories.

The proposed rules also adjust the model for Part D premiums in 2016 to more quickly factor in new treatments for the Hepatitis C virus (HCV) that can cost nearly \$100,000 for a 12-week course of treatment. CMS typically adjusts prospective rates by a person-level risk factor, but this is the first time it has ever done so for HCV. Analysts largely expect Part D premiums to increase as a result.

## **STATES**

### ***Gallup survey shows uninsured rate continues to fall to record low levels***

According to Gallup polls, the percentage of Americans lacking health insurance fell from 17.3 to 13.8 percent during 2014, reaching the lowest level recorded by the organization since it started tracking uninsured rates in 2007.



The latest results continue to show even more precipitous drops in states that expanded Medicaid under the Affordable Care Act (ACA) and/or created their own health insurance Marketplace (see Update for Week of January 5<sup>th</sup>). These states saw a 4.8 percent decline, while the uninsured rate in states that did one or neither fell by only 2.7 percent.

The largest decline of 11 percent occurred in Arkansas, which was the first state to seek and receive federal approval for a “private sector” alternative to the Medicaid expansion (see Update for Week of March 25, 2013). Declines in Kentucky, Oregon, and Washington followed close behind.

### California

#### ***Kaiser Permanente backtracks on decision to move HIV/AIDS drugs into specialty tiers***

Kaiser Permanente became the latest insurer this week to stop moving most or all drugs for HIV/AIDS into specialty tiers that require a percentage coinsurance.

The insurer had put a new policy into effect starting January 1<sup>st</sup> that shifted medications for chronic conditions like HIV/AIDS into their highest tier that forced subscribers to pay 20 percent of the drug’s cost instead of a fixed copayment amount. Similar moves by insurers in at least 12 other states have sparked a backlash from consumer advocates, as well as several complaints with state regulators arguing that the practice violates the non-discrimination provisions of the Affordable Care Act (ACA) and is effectively a means to circumvent the law’s prohibition on pre-existing condition denials (see Update for Week of January 5<sup>th</sup>).

Insurance commissioners in at least two states (Florida and Illinois) have already taken enforcement action to curtail the practice (see Update for Weeks of February 9<sup>th</sup> and 16<sup>th</sup>), while the federal Centers for Medicare and Medicaid Services (CMS) has finalized rules that would allow it to deny certification to Marketplace insurers that rely in such discriminatory cost-sharing designs (see below).

In response, Kaiser announced that it would return to fixed copayments for brand-name HIV drugs, as well as refund coinsurance to some subscribers that purchase the applicable drugs during January. The insurer also agreed to work with Covered California and other insurers on alternative cost-sharing designs for specialty drugs.

However, Kaiser has yet to revert to fixed copayments for other drugs moved into specialty tiers according to the *San Francisco Chronicle*, nor did it indicate an intent to do so.

The Assembly is currently considering legislation (A.B. 339) that would require specialty tier placement to be based on clinical guidelines and impose only “reasonable” cost-sharing that does “not discourage medication adherence” (see Update for Weeks of February 9<sup>th</sup> and 16<sup>th</sup>).

#### ***New bill would increase transparency for prescription drug costs***

Assemblyman David Chiu (D) introduced A.B. 463 this week, which would require drugmakers to report the production costs for drug therapies costing more than \$10,000 per year.

Under the bill, the information that would be furnished to the Office of Statewide Health Planning and Development includes cost data related to acquisitions, clinical trials, marketing, profits, and research and development. In addition, manufacturers would have to detail the level of financial assistance provided to patients through various third-party programs.

The agency would submit the data to the legislature in an annual report, as well as post it online.



Florida

***New bill would protect ACA subsidies for nearly 1.5 million Floridians***

Senator Darren Soto (D) introduced legislation this week that would protect Affordable Care Act (ACA) subsidies for nearly 1.5 million Floridians enrolled in the federally-facilitated Marketplace (FFM).

S.B. 1498 specifically would create a state-based Marketplace so the premium and cost-sharing assistance under the ACA would continue to flow in the event the U.S. Supreme Court strips them from FFM consumers in June (see above). Florida became the nation's largest Marketplace this year with more than 1.6 million enrollees, 93 percent of whom received an average monthly subsidy of \$297.

The bill estimates that an adverse Supreme Court decision would deny a projected \$4.75 billion in both premium tax credits and cost-sharing subsidies to Florida consumers. A new analysis from Avalere Health predicted this week that FFM premiums in Florida would spike by an average of 338 percent if the subsidies were struck down. Only four FFM states (Mississippi, Alaska, Georgia, and Maine) would see a greater increase.

Hawaii

***Committees advance bill that would exclude bronze coverage from Marketplace***

The House Consumer Protection and Commerce Committee passed H.B. 727 this week with only one dissenting vote, which would require that a "qualified health plan" under the Hawaii Health Connector include only coverage options deemed to be at the silver, gold, or platinum level. The House Health Committee already passed the measure unanimously, but not before amending the initial version, which required the Marketplace plans be at least at the gold level.

Maine

***Federal court declares Maine drug importation law unconstitutional***

The U.S. District Court for the District of Maine ruled this week that a new state law allowing for the importation of drug products from certain other countries is pre-empted by federal law.

The Pharmaceutical Research and Manufacturers of America (PhRMA) led the court challenge to Maine's 2013 law that let residents access prescription drugs from licensed retail pharmacies in countries like Canada, England, Australia, and New Zealand. Although a lower court deemed that PhRMA lacked standing, it did allow Maine pharmacists and trade associations to pursue their claims that such a law pre-empts the prohibition on drug importation under the federal *Food, Drug, and Cosmetic (FDC) Act*.

Judge Nancy Torreson (appointed by President Obama) agreed that the Maine law extends beyond the regulation of pharmacies and pharmacists within Maine and into "the traditionally federal spheres of foreign commerce and affairs." As a result, since the FDC Act pre-empts conflicting state law, she declared Maine's program invalid under the supremacy clause of the U.S Constitution.

The judge noted that both the FDC Act and the *Medicare Modernization Act (MMA) of 2003* establish a clear "Congressional intent to tightly control prescription drug importation." As a result, all states are effectively unable to encroach into the "field of importation of pharmaceuticals from foreign countries" without Congressional consent. (She did not address the Food and Drug Administration's sporadic enforcement of this prohibition.)

The chief sponsor of the Maine law, Senator Troy Jackson (D), urged the plaintiffs to appeal. However, they have yet to indicate whether they will do so.

Several members of Congress including Senators John McCain (R-AZ) and Amy Klobuchar (D-MN) as well as Reps. Keith Ellison (D-MN) and Dana Rohrabacher (R-CA) have tried for years to amend







the FDC Act to allow for drug importation from licensed pharmacies abroad, but stiff industry opposition caused it to be excluded from the Affordable Care Act and MMA (see Update for December 16, 2013-January 3, 2014). The McCain/Klobuchar legislation this session (S.122) would allow for such importation, but only from Canada.

At least a dozen states including Illinois, Kansas, and Montana have considered similar drug importation measures in recent years, but only Maine's was actually enacted.

#### Maryland

#### ***Senator files counterpart to House bill prohibiting discriminatory cost-sharing designs***

Senator Catherine Pugh (D) introduced S.B. 834 this week, which is the counterpart to H.B. 990 introduced the week prior.

Both bills would prevent the Maryland Health Benefit Exchange from using a benefit design that relies upon discriminatory drug formulary management or medical management practices. Differential reimbursement rates or cost-sharing for covered benefits is one criterion that the bills direct the Insurance Commissioner to consider when determining whether a drug formulary is discriminatory (see Update for Weeks of February 9<sup>th</sup> and 16<sup>th</sup>).

#### Minnesota

#### ***New bill would sets new transparency and disclosure requirements for prescription drugs***

Rep. Tony Albright (R) introduced H.F. 1060 last week, which sets new transparency and disclosure requirements for prescription drugs. The measure will be heard in the Health and Human Services Reform Committee.

H.F. 1060 still allows health plans to expand formularies or reduce prescription drug cost-sharing during a plan year. They also can move a drug to any benefit category that reduces cost-sharing for subscribers. However, the plan can only remove a brand-name drug approved by the Food and Drug Administration or increase enrollee cost-sharing for the drug only if it adds an "A-rated generic or multisource brand name equivalent at a lower cost" to the formulary and provides a 60-day notice to prescribers, pharmacists, and affected enrollees.

The bill requires that any enrollee cost-sharing be consistent with any cost-sharing that the plan charges for non-formulary drugs under a medication exceptions process.

Plans must likewise establish and maintain a transition process of at least 60 days to prevent gaps in drug coverage for both new and continuing enrollees with ongoing prescription drug needs who are affected by changes in formulary drug availability.

#### Nebraska

#### ***Legislature weighs "Medicaid redesign" bill to close coverage gap***

Senator Kathy Campbell (D) introduced L.B. 472 this week in the unicameral legislature, which would allow Nebraska to design a "state-specific" plan to expand Medicaid only for those caught in the coverage gap between current Medicaid eligibility and the threshold for Affordable Care Act (ACA) subsidies at 100 percent of federal poverty level (FPL).

Conservative opposition has scuttled prior attempts over the past two years to approve Nebraska's participation in the ACA expansion of Medicaid. New Governor Pete Ricketts (R) is adamantly opposed to any form of expansion, making even the more limited expansion sought by Senator Campbell a long-shot.



The measure would direct Nebraska to seek a federal waiver for an alternative model similar to that federally-approved for six states. However, instead of covering all those earning up to 138 percent of FPL, it would be limited to 100 percent. In order to mollify conservative opposition, it would require those earning 50-100 percent of FPL to pay premiums equal to two percent of income and also “redesign” the Medicaid program to encourage greater efficiency.

The federal Centers for Medicare and Medicaid Services (CMS) has consistently rejected partial expansions (see Update for Weeks of August 6 and 13, 2012), as well as premiums on those earning below 100 percent of FPL (see Update for Weeks of January 26<sup>th</sup> and February 2<sup>nd</sup>).

#### Oregon

##### ***New bills would limit discriminatory cost-sharing for prescription drugs***

The House Health Care Committee introduced legislation last week that would require health plans in Oregon to limit cost-sharing for prescription drugs to no more than \$100 for a 30-day supply. H.B. 2951 also would prohibit deductibles for drug coverage and require drug cost-sharing to apply to any other plan deductible.

Similar to measures being advanced in several other states, the bill specifically would bar insurers from moving all drugs within a therapeutic or pharmacological class into the highest cost-sharing tier. It likewise requires the insurer to create an exception process for the coverage of drugs not on a formulary or preferred drug list.

Separate legislation sought by former Governor John Kitzhaber (D) prior to his resignation (see Update for Weeks of February 9<sup>th</sup> and 16<sup>th</sup>) sets new minimum standards for provider networks and includes a provision prohibiting insurers from using affordability or cost containment measures that effectively discriminate against subscribers based on health status (H.B. 2468). It was heard last week in the Department of Commerce and Business Services.

#### Rhode Island

##### ***New bill would require 60-day notice for cost-sharing changes to formulary drugs***

Rep. Arthur Corvese (D) introduced H.5599 this week, which would require that all insurers give at least a 60-day notice to subscribers, prescribers, pharmacists, and network pharmacies whenever they remove a prescription drug from the plan formulary. The same notice must be issued if the plan makes any change in the preferred or tiered cost-sharing status of a covered drug. It will be heard in the House Corporations Committee.

#### Utah

##### ***House rejects Medicaid expansion alternative advanced by Governor and Senate***

The Republican-controlled Senate voted 17-11 this week to pass the private sector alternative to the Medicaid expansion under the Affordable Care Act (ACA) that Governor Gary Herbert (R) negotiated with the Obama Administration (see Update for Week of December 1<sup>st</sup>). However, the measure (S.B. 164) currently appears to be dead after House Speaker Greg Hughes (R) promptly refused to have it considered by the House, which he insists does not have the votes to approve it.

Governor Herbert criticized the Speaker’s refusal to even debate his Healthy Utah plan in the House, which was laden with provisions intend to mollify opposition from the chambers most ardent conservatives, including an automatic two-year expiration. However, Speaker Hughes had insisted that the plan must include higher premiums on those made newly-eligible as well as a work requirement, both of which were eliminated by the Obama Administration.



Speaker Hughes also refused to consider a more limited expansion plan that remains pending in the Senate (S.B. 153), which could cover only the medically frail. However, the Speaker acknowledged that “doing nothing is not an option” and suggested that Governor Herbert go back and extract additional concessions and flexibility from the Administration.

Senate Republicans that likewise opposed the concept of expanding Medicaid urged the House “plug [their] noses” and move forward on S.B. 164 so that roughly 63,000 adults are not left in the coverage gap between current Utah Medicaid eligibility and the threshold for ACA subsidies that starts at 100 percent of the federal poverty level. They stressed that Utah would forgo nearly \$900 million in ACA matching funds over the next 18 months by failing to expand.

Utah hospital associations have also offered to pay for the portion of expansion costs to be assumed by the state once the federal government share drops from 100 to 90 percent after 2016. However, a similar offer by Tennessee hospitals was not enough to persuade conservative lawmakers to pass a similar expansion alternative in that state (see Update for Week of January 26<sup>th</sup> and February 2<sup>nd</sup>).

Utah currently becomes the fourth state after Florida (see Update for Week of March 31<sup>st</sup>), Tennessee, and Wyoming (see Update for Weeks of February 9<sup>th</sup> and 16<sup>th</sup>) where conservative lawmakers have rejected a Medicaid expansion alternative backed by their Republican governor.

#### Virginia

##### ***House and Senate reject Medicaid expansion***

House and Senate passed a revised fiscal year 2016 budget this week after negotiators rejected the proposal by Governor Terry McAuliffe (D) to expand Medicaid under the Affordable Care Act (ACA), but agreed to accept some of his other health care spending priorities, including medical and prescription drug benefits for those with severe mental illness.

The prompt agreement contrasted with last year’s bitter standoff over Medicaid expansion that threatened to shut down the government and was resolved only when the Senate shifted to Republican control (see Update for Week of September 15<sup>th</sup>). Governor McAuliffe, who had campaigned on a pledge to expand Medicaid, made only a symbolic pitch this year, having already abandoned plans to try and expand via an executive order (see Update for Week of September 8<sup>th</sup>).

#### Washington

##### ***House committee advances bill broadening eligibility for prescription drug assistance***

The House Health Care and Wellness Committee passed legislation this week that would broaden eligibility for the Prescription Drug Assistance Foundation.

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

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