

### Health Reform Update – Week of March 18, 2013

#### CONGRESS

##### ***House and Senate approve spending bill that averts government shutdown, but keeps sequester***

The House this week approved the Senate amendments to a continuing spending resolution that will fund the federal government through the September 30<sup>th</sup> end of the fiscal year.

President Obama is expected to sign H.R. 933, which averts the government shutdown that would have occurred if both parties could not reach agreement by March 27<sup>th</sup>. It retains the spending caps imposed by the recent sequester, including the two percent cut in Medicare payment rates slated for April 1<sup>st</sup> (see Update for Week of February 25<sup>th</sup>). The measure also does not include the nearly \$1 billion sought by the President for implementation of the Affordable Care Act (ACA) and cuts an additional \$10 million for the law's new Medicare cost-cutting board (see Update for Week of March 11<sup>th</sup>).

However, the House did agree to the additional \$71 million appropriation the Senate provided for the National Institutes of Health (NIH), as well as \$12.8 million for the Food and Drug Administration (FDA). The FDA is also allowed to spend the \$40 million in user fees it has already collected to conduct drug and device reviews (see Update for Week of March 11<sup>th</sup>).

The House also voted this week to pass the Republican budget put forward by Rep. Paul Ryan (R-WI), which includes his controversial plan to privatize Medicare, gradually raise Medicare eligibility to age 70, and repeal the ACA. It rejected competing alternatives from the conservative Republican Study Committee that would have balanced the budget through more severe cuts and from the House Democratic Caucus that would protect Medicare and Medicaid while replacing the sequester with \$1.8 trillion in deficit reduction over ten years (with \$1.2 trillion coming from new revenues.) The House also rejected the Senate Democratic budget that would also replace the sequester with \$1.8 trillion in deficit reduction, but cut health care programs by \$275 billion (see Update for Week of March 11<sup>th</sup>).

The Senate appeared on the verge at week's end of passing that budget plan, its first in four years. Senate Republican efforts to include an ACA repeal were soundly defeated; however a bipartisan group of Senators did pass a non-binding amendment that would eliminate the law's 2.3 percent annual tax on medical device manufacturers.

Senate Democrats also put forward the Ryan budget in an effort to force vulnerable Republicans to record their support. Five Republican Senators sided with Democrats in rejecting it.

##### ***House Democrats stress that "rate shock" studies must focus on entire ACA, not just age rating***

House Democrats and Centers for Medicare and Medicaid Services officials are fighting back against insurance industry charges that new age-rating bands in the Affordable Care Act (ACA) will result in "rate shock".

Energy and Commerce Republicans latched on to an Oliver Wyman study widely-circulated by America's Health Insurance Plans (AHIP) in claiming that barring insurers from increasing premiums for older subscribers by more than 300 percent would cause rates to jump for by 29 percent for individuals age 21-29 and 19 percent for those age 30-39. When accounting for other factors, rates would increase 42 percent and 31 percent respectively (see Update for Week of January 7<sup>th</sup>).

However, an Oliver Wyman actuary testified at the committee's hearing last week that Republicans were distorting the study's findings. Even though it acknowledges premiums will rise for some younger subscribers as a result of the new 3:1 band, they will not increase overall by the amounts cited by Republicans, and in fact the consultant expects that "most people will see a decrease in the amount of premiums they pay, primarily due to the premium subsidies offered through the ACA."

Ranking member Henry Waxman (D-CA) and Centers for Medicare and Medicaid Services (CMS) officials accused Republicans of looking at the age-rating band in isolation and failing to account for the other affordability provisions of the ACA such as the subsidies and cost-sharing limits. He cited a recent Urban Institute study concluding that AHIP's predictions of "rate shock" for younger subscribers are not likely to materialize due to these other provisions (see Update for Week of March 4<sup>th</sup>).

Actuaries with both Oliver Wyman and Milliman consulting stressed this week that Republican lawmakers were not considering how the new prohibition on gender rating (i.e. barring higher premiums for women) comprises a "significant portion of the total increase" that young Americans will face.

### ***CMS tells Congress that ACA innovations need a year to show results***

The director for the Centers for Medicare and Medicaid Services (CMS) entity overseeing innovation initiatives funded by the Affordable Care Act (ACA) told the Senate Finance Committee this week that demonstration projects to control healthcare costs will need up to a year to produce any results.

Richard Gilfillan, MD testified that the agency is currently testing at least three-dozen care delivery models involving 50,000 healthcare providers and more than one million beneficiaries. He stated that interim results would likely be available within a year and HHS will be able to issue recommendations on payment changes within the next two years. The innovations range from bundled payments that set a fixed rate for care related to a specific medical procedure or condition to patient-centered medical homes, which coordinate comprehensive care through a medical team headed by single physician.

Chairman Max Baucus (D-MT) expressed disbelief and impatience with the delay, insisting that Congress would not be satisfied with "grand goals and platitudes" and needed "quantifiable" results more promptly. Other Finance Democrats stressed that the Congressional Budget Office (CBO) projected that the innovation models should generate a 13 percent return on investment through 2019, followed by "tens of billions of dollars" in savings in the subsequent decade.

Ranking member Orrin Hatch (R-UT) claimed that Gilfillan's Center for Medicare and Medicaid Innovation (CMMI) created by the ACA is suffering from "confusion and a clear lack of focus" by "trying to do too much at one time." Other Finance Republicans questioned the legitimacy of the \$10 billion in ACA funds to fund such efforts, particularly in light of a recent Government Accountability Office report that cited duplication and lack of coordination within certain CMMI programs.

### ***New Medicaid commission recommends continuous enrollment, more permanent funding***

The Medicaid and CHIP Payment and Access Commission (MacPAC) created by the Affordable Care Act (ACA) issued a report to Congress last week recommending that lawmakers reduce the administrative burden on states for frequent changes in Medicaid and Children's health Insurance Program (CHIP) eligibility to occur due to fluctuation in income. The commission urged Congress to limit this "churning" by letting states enroll eligible individuals for a full year in Medicaid or CHIP, regardless of a change in income during the year that would otherwise end their eligibility.

Currently, states have the option of using continuous enrollment for children and adults. The Government Accountability Office (GAO) found in 2012 that 23 states had continuous eligibility policies for children in Medicaid and CHIP and another ten used it for CHIP but not Medicaid. However, the Affordable Care Act (ACA) revised Medicaid and CHIP eligibility requirements when it standardized eligibility by requiring states to use modified adjusted gross income (MAGI) to determine eligibility.

Starting January 1<sup>st</sup>, states will have to request a waiver to continue using continuous enrollment for adults in Medicaid and for CHIP recipients.

A second recommendation calls on Congress to permanently fund Transitional Medical Assistance (TMA) which provides added months of Medicaid coverage to families that might otherwise become ineligible and uninsured because of an increase in income. Congress typically renews the program for one or two years, however MacPAC recommended the funding be made permanent to help states budget for the future with greater certainty, particularly as they decide whether to expand Medicaid under the Affordable Care Act (ACA).

### ***Affordable Care Act understanding remains limited, especially among the uninsured***

On the third anniversary this week of the Affordable Care Act (ACA), the latest Kaiser Family Foundation (KFF) tracking poll shows that the public is still largely unaware of the law's benefits.

The findings shows that opponents of the ACA have proficiently defined negatives about the law, as the more popular a provision was among respondents, the less likely they were to realize it is part of the ACA. For example, 88 percent said they have a favorable view of tax credits to help small businesses buy health coverage, but only 52 percent knew the ACA offers such assistance. By contrast, 74 percent knew the ACA includes the controversial individual mandate, while just 40 percent approve.

The tracking polls continue to find that misinformation about the ACA remains widespread. Nearly 60 percent thought the law includes the "public option" that Democrats dropped from the final ACA legislation, 44 percent believe the law will cut Medicare benefits, and 40 percent actually it creates "death panels" that will ration end-of-life care.

Among uninsured and low-income respondents, at least two-thirds acknowledged they lacked enough information to know how the ACA will benefit them.

## **FEDERAL AGENCIES**

### ***U.S. Supreme Court to hear "pay-to-delay" case next week***

The U.S. Supreme Court will hold oral arguments regarding FTC v. Actavis on March 25<sup>th</sup>, in an effort to ultimately resolve whether patent litigation settlements that delay cheaper generic drug alternatives violate existing federal antitrust law.

Both Republican and Democratic lawmakers have joined with the Federal Trade Commission (FTC) in seeking for over a decade to ban such "pay-to-delay" settlements. According to the FTC, these anti-competitive "sweetheart deals" involved a record 40 different brand-name products in 2012, delaying the introduction of lower-cost generics by an average of 17 months and costing consumers more than \$3.5 billion in inflated prices every year (see Update for Week of January 21<sup>st</sup>).

The U.S. Supreme Court has agreed to resolve a split in appellate courts over whether the agreements are presumptively anti-competitive (see Update for Week of December 3<sup>rd</sup> and 10<sup>th</sup>). Health insurers, drugstore chains, physicians, and consumer groups are backing the FTC's position. However, the Generic Pharmaceutical Association (GPhA) has joined with Teva Pharmaceutical, Merck, Shire, and other brand-name drugmakers to defend the practice, insisting that consumers benefit from the patent settlements, which always allow consumers to gain access to the generic drug before the patent expiration, saving consumers "tens of billions of dollars over the past decade."

GPhA, as well as former FTC official Jeffrey Brennan and his partner at the law firm McDermott Will and Emery, are predicting a "near unanimous" ruling in favor of the drug companies.

***ACA has saved over \$6 billion in Medicare drug costs, provided free preventive care to 105 million***

The Department of Health and Human Services (HHS) used the third anniversary of the Affordable Care Act (ACA) this week to promote the \$6.1 billion that Medicare enrollees have saved due to provisions in the new law reducing the Part D coverage gap. Over 6.3 million enrollees have benefitted from the mandatory drug discounts in this “doughnut hole”, which will continue to be reduced until enrollees will pay the same coinsurance in or outside the coverage gap in 2020.

Agency officials pointed out that concerns about whether reducing the “doughnut hole” would increase drug utilization and Part D spending proved to be unfounded, as the Centers for Medicare and Medicaid Services actuary is projecting a four percent decline in Part D costs for 2014 (see Update for Week of February 18<sup>th</sup>).

HHS also announced that about 71 million Americans in private health insurance plans and 34 million Medicare or Medicare Advantage enrollees have received coverage for at least one free preventive health care service since the law went into effect.

***CMS will shortly issue guidance on brokers, navigator’s role in federal marketplace***

Centers for Medicare and Medicaid Services (CMS) officials notified stakeholders this week that guidance on the role that brokers, agents, and navigators will play in the new federal marketplace will be released in a “couple of weeks.”

The director for the Center for Consumer Information and Insurance Oversight (CCIIO) made a similar pledge at an earlier conference attended by PSI Government Relations (see Update for Weeks of January 28<sup>th</sup> and February 4<sup>th</sup>). However, the agency now faces critical deadlines as plans can start applying for the federal marketplace starting March 28<sup>th</sup>.

A proposed rule on navigators that will help facilitate marketplace enrollment is awaiting final paperwork clearance by the Office of Management and Budget (see Update for Week of March 11<sup>th</sup>). The first grants will be awarded in June although a specific deadline has not been set for bid requests. Navigators will be required to undergo training starting in July, but need not be licensed brokers and cannot recommend or sell particular plans as can brokers.

According to the CCIIO director, the division expects that brokers and agents will be paid by commissions from participating plans. CCIIO will rely as much as possible on state licensing procedures for brokers and agents rather than attempt to duplicate them on the federal level.

The federal marketplace will be scalable for each state. Premium data will not be known before July and a list of qualified health plans will not be published on the [www.healthcare.gov](http://www.healthcare.gov) website until September. Both a call center and revamped website will be launched in June and the new web portal can be previewed by consumers in August. Website information will be available in both English and Spanish, though CCIIO is still considering other languages.

***Proposed rules limit plan waiting periods to 90 days***

Proposed rules issued this week by the Centers for Medicare and Medicaid Services implement Affordable Care Act standards that prohibit health plans from imposing waiting periods of longer than 90 days. These provisions apply to large group plans, as well as individual and small group plans, regardless of whether they are “grandfathered” under the law. Employer plans also cannot require more than 1,200 hours of service and then apply the 90-day waiting period.

### ***Study shows only two percent of plans currently meet essential health benefit standards***

A recent analysis of health plans by the non-partisan Health Pocket website found that just two percent of individual and small group health plans currently provide the coverage necessary to meet the essential health benefits (EHB) required by the Affordable Care Act (ACA) in 2014.

Most of the plans surveyed cover only about three-quarters of the required EHB. However, coverage varied significantly by category and state. While nearly all plans covered categories like ambulatory care, emergency care, and hospitalization, “gaping holes” exist in the remaining seven EHB categories set by statute. Massachusetts, which already has near universal coverage, had the highest percentage of plans covering the full set of EHB (94 percent), while the lowest percentage belonged to Alaska (66 percent).

## **STATES**

### ***CMS will have to enforce ACA market reforms in four states***

At least four conservative-leaning states have informed the Centers for Medicare and Medicaid Services (CMS) that they are either unable or unwilling to enforce the Affordable Care Act (ACA) reforms to the private insurance market.

The director of the Center for Consumer Information and Insurance Oversight (CCIIO) within CMS sent letters this week to the insurance departments in Missouri, Oklahoma, Texas and Wyoming informing them that CCIIO will assume responsibility for enforcing the ACA in their states. However, the division insists that it is continuing to collaborate with these states to find ways that they can continue to fulfill their oversight role.

The enforcement letters come a little more than a month after a Commonwealth Fund report found just 11 states and Washington, DC had started to adjust state laws to prepare for seven major ACA market reforms that take effect January 1<sup>st</sup> (see Update for Weeks of January 28<sup>th</sup> and February 4<sup>th</sup>).

### ***Survey gives 36 states poor scores for health care price transparency***

A report card on price transparency released this week by a health care purchaser consortium gives 29 states a failing grade and another seven states a “D” for allowing health care providers to keep consumers in the dark about the cost of their care.

Only two states in the survey, Massachusetts and New Hampshire, received an “A,” and even they need to improve their laws, according to Catalyst for Payment Reform (which includes General Electric, Wal-Mart, Boeing, and other large purchasers). The report emphasized that the primary driver of high health care costs is that consumers lack the basic cost information needed to make rational purchasing decisions. Without the ability to “comparison shop” on price or quality, cost-containment initiatives like high-deductible health plans will have little effect on overall costs.

### Arkansas

#### ***State officials insist that expanding Medicaid through exchange is cheaper than CBO projects***

The Department of Human Services (DHS) is refuting estimates by the Congressional Budget Office (CBO) that expanding Medicaid through new health insurance exchanges will be more costly than traditional Medicaid.

Arkansas received federal approval last month to use Medicaid expansion funds under the Affordable Care Act (ACA) to instead cover newly-eligible enrollees in the health insurance exchange that will be operated as a federal-state partnership in 2014 (see Update for Week of February 25<sup>th</sup>). However, the move was criticized by many analysts as the CBO projected last summer that it will cost \$9,000 to

cover each newly-eligible Medicaid enrollee an exchange compared to only \$6,000 if the enrollee had been covered by Medicaid as the ACA intended (see Update for Weeks of July 23<sup>rd</sup> and 30<sup>th</sup>).

However, a Manatt, Phelps, and Phillips study commissioned by DHS and the insurance department insist that this “premium assistance option” would be no more than 13-14 percent more costly than a traditional Medicaid expansion, and possibly not more costly at all.

According to the analysis, the annual cost for enrolling newly-Medicaid eligible groups in the exchange is \$5,975 per person, compared to \$5,200 under traditional Medicaid. Furthermore, the authors claim that introducing 250,000 low-income adults into the private exchange market will increase competition and reduce premium prices by about five percent, further reducing the overall cost.

The “premium assistance option” has largely been endorsed by Republican lawmakers that now control the legislature and had resisted expanding the traditional Medicaid program (see Update for Week of November 5<sup>th</sup>). Insurers and providers also welcomed the deal, as it would dramatically boost exchange enrollment, which reimburses more highly than Medicaid. Consumers will incur greater out-of-pocket expenses in the exchange, although Governor Mike Beebe (D) insisted that they and state officials would benefit from not being bounced between Medicaid and an exchange plan whenever income fluctuated (see Update for Week of February 25<sup>th</sup>).

#### Florida

##### ***Senate Republicans unveil private sector alternative to Medicaid expansion***

Senator Joe Negron (R) released his Healthy Florida plan this week as an alternative to expanding Medicaid under the Affordable Care Act (ACA).

S.P.B. 7038 was heard in the Appropriations Committee chaired by Negron. It would use the ACA funds provided for the Medicaid expansion to instead cover more than one million newly-eligibles under the exchange now operated by Florida Healthy Kids Corporation, a non-profit providing sliding-scale private plan coverage to roughly 300,000 children across the state.

The concept is based on a similar alternative that the Obama Administration recently approved in Arkansas (see Update for Week of February 25<sup>th</sup>). Although the Centers for Medicare and Medicaid Services (CMS) indicated that it would be receptive to the idea (see Update for Week of March 11<sup>th</sup>), it is not clear that federal approval could be obtained and Healthy Kids revamped for adults by January 1<sup>st</sup>. Under Senator Negron’s timeline, the Agency for Health Care Administration would submit the plan to CMS no later than June 14<sup>th</sup>. Any substantial changes to the plan by CMS would likely require legislative approval via a special session, since the regular session ends in May.

Healthy Florida would lock-in enrollees after a 90-day tryout period. Each would be provided a health savings account with rewards for healthy behaviors and the funds could be used to pay their cost-sharing or prescription drug costs. Premium and copayment amounts were not specified, however, Healthy Kids premiums run \$15-20 per month while copayments vary from \$5-10.

Plans would also have to spend at least 85 percent of premium revenue on medical care, similar to the medical-loss ratio required of large-group plans under the ACA. The program would automatically be terminated if the promised federal funding ever falls below 90 percent.

Both the House and Senate committees created to make recommendations on implementing the ACA have rejected any traditional Medicaid expansion (see Update for Week of March 11<sup>th</sup>). Senator Negron drew wide praise from Senate Republicans and Democrats, as well as Governor Rick Scott (R), for proposing an alternative instead of just saying “no”. However, House Republican leaders remained adamant that Florida should reject all ACA funds.

#### Kansas

##### ***Senate passes budget bill that bars Medicaid expansion, despite voter support***

The budget bill that passed the Senate this week (H.B. 2143) included an amendment barring the Governor or state agencies from expanding Medicaid under the Affordable Care Act (ACA) without legislative authorization.

Despite his fervent criticism of the ACA, Brownback is one of only a handful of governors that have yet to stake a position on the Medicaid expansion. This likely due to overwhelming support for the expansion from safety net providers whose uncompensated care costs would dramatically rise if the state opted-out. A poll sponsored by the Kansas Hospital Association also found that 62 percent of Kansans support expanding Medicaid.

Kansas has one of the nation's leanest Medicaid programs, as its eligibility is as low as 32 percent of the federal poverty level (FPL) for non-disabled adults with children. According to the Kaiser Family Foundation, 43 percent of working-age Kansans would be left uninsured and without access to the ACA's premium and cost-sharing subsidies if the state does not participate. A Jackson Hewitt study also found that opting-out would increase ACA penalties on Kansas employers by \$16-24 million per year (see Update for Week of March 11<sup>th</sup>).

### ***Senate-passed bill would allow bare-bones interstate health plans, protect broker commissions***

The House Insurance Committee passed a "mandate-lite" bill this week that already cleared the Senate with only one dissenting vote. S.B. 163 would allow insurance companies doing business in Kansas to sell limited-benefit health plans in the individual and small group markets that need not comply with state-mandated benefits. A similar 2011 law enacted in Georgia has failed to attract interests from insurers (see Update for Week of April 9<sup>th</sup>).

The bill would also exclude commissions paid as part of the premium cost for "mandate-lite" plans from all determinations of the new medical-loss ratios required by the Affordable Care Act.

### ***Senate panel approves House-passed bill to lift lifetime limit in state high-risk pool***

H.B. 2312 cleared the Senate Committee on Financial Institutions and Insurance this week after unanimously passing the House earlier this month. The measure would increase the lifetime maximum benefit in the state high-risk insurance pool from \$3 million to \$4 million.

The bill was introduced at the request of the Kansas Health Insurance Association (KHIA), the non-profit organization that operates the pool. KHIA notes that although the lifetime cap was upped from \$2 to \$3 million as recent as 2011, as many as 12 members of the pool will hit that limit in 2013. There were no opponents to the bill at a House hearing last month.

### ***Insurance department will have no say in navigator grants***

A top Department of Insurance official acknowledged this week that Kansas will not play any role in deciding which organizations are awarded federal "navigator" grants to help facilitate enrollment in the new federal marketplace. According to the director of the health insurance division, the Department will not even know who applies as a result of the decision by Governor Sam Brownback (R) to default to full federal control over the health insurance exchange created by the Affordable Care Act (ACA). As a result, grant decisions will be made entirely by the Obama Administration.

Several conservative-leaning states including Georgia, Ohio, and Virginia are advancing legislation to try and retain control over navigator certification (see Update for Week of March 4<sup>th</sup>). However, it is not yet clear to what extent the Obama Administration will allow states that did not apply for partnership exchanges to retain control over specific exchange functions.

### **Michigan**

#### ***Governor rebuffed on plans to expand Medicaid, enter into partnership exchange***

The Department of Community Health budget passed this week by a House Appropriations subcommittee did not include funds for the Medicaid expansion sought by Governor Rick Snyder (R).

The Governor is one of eight Republicans seeking to accept federal funds to expand Medicaid under the Affordable Care Act (ACA). However, subcommittee Republicans insisted that it would need more information about the state share of costs before voting to add nearly 500,000 to Medicaid.

House Republicans had adamantly opposed any ACA implementation prior to the last election, despite Senate Republicans authorizing a state-based exchange that complies with the ACA (see Update for Weeks of November 19<sup>th</sup> and 26<sup>th</sup>). However, the House has since removed their ban on the Governor using more than \$31 million in federal exchange establishment grants (see Update for Week of February 25<sup>th</sup>) and authorized him to enter into a federal-state partnership exchange instead of defaulting to full federal control. Senate Republicans surprisingly rejected that measure this week (H.B. 4111) even though Michigan is one of seven states to already receive federal approval for a partnership exchange.

### ***New law converts ends Blue Cross Blue Shield's status as insurer of last resort***

Governor Rick Snyder (R) signed legislation this week that will allow the state's dominant insurer, Blue Cross Blue Shield of Michigan (BCBSM), to transition into a non-profit mutual insurer.

BCBSM had been exempt from paying state and local taxes as it served as the state's insurer of last resort and provided coverage regardless of pre-existing conditions. However, the Affordable Care Act requires all insurers to provide such guaranteed issue coverage starting January 1<sup>st</sup>.

As a result, S.B. 61 and S.B. 62 removes BCBSM's status as insurer of last resort, requiring them to pay taxes and contributed \$1.56 billion over 18 years into a separate non-profit charged with continuing the insurer's charitable mission. However, Attorney General Bill Scheutte (R) objected to the move, as it allows BCBSM to more easily hike premiums, especially on Medicare supplemental plans.

### Minnesota

#### ***Governor signs "active purchaser" exchange bill into law***

Governor Mark Dayton (D) signed H.F. 5 into law this week, creating a state-based health insurance exchange that complies with the Affordable Care Act (ACA).

Minnesota had already started the process of developing the information technology for the exchange via the Governor's executive order (see Update for Week of October 31, 2011). Republican lawmakers had repeatedly blocked exchange-authorizing legislation before losing control over both chambers past election (see Update for Week of November 5<sup>th</sup>).

Even though several Republicans subsequently warmed to the state retaining control over the exchange, they remained unified in their opposition to the "active purchaser" model selected by the Democratic-sponsored legislation that allows the seven-member exchange board to exclude plans even if they meet minimum federal standards. The Minnesota Chamber of Commerce likewise opposed this provision of H.F. 5, despite supporting the overall measure. Republicans and business groups largely prefer the passive "clearinghouse" model where any plan meeting minimum standards can participate.

Republican lawmakers also questioned whether the exchange could adequately safeguard user privacy and complete the needed technology infrastructure before enrollment begins on October 1<sup>st</sup>. Plans certified as "qualified" have only until May 17<sup>th</sup> to submit premium rates.

The exchange board will include one member representing individual market consumers and another representing public program enrollees. Members cannot be affiliated with health insurers or providers for one year before or during their appointment (see Update for Week of March 4<sup>th</sup>).

An estimated 1.3 million Minnesotans and small businesses are expected to participate in the MNSure exchange, including 300,000 who are now uninsured.

#### New Hampshire

##### ***House blocks Republican bill to prohibit Medicaid expansion***

The House blocked a measure this week sponsored by former speaker Bill O'Brien (R) (H.B. 271) that would have prohibited the state from expanding Medicaid under the Affordable Care Act (ACA).

Governor Maggie Hassan (D) is seeking legislative approval to accept the ACA funding to expand up to 138 percent of the federal poverty level. While her proposal is likely to be approved by the Democratically-controlled House, it is not yet clear that she has the support from a Senate that remains narrowly in Republican hands.

When controlled by Republicans, the House repeatedly sought to block any ACA implementation and successfully banned state creation of a health insurance exchange (see Update for Week of April 30<sup>th</sup>). House Democrats are now trying to lift this ban (see Update for Week of February 25<sup>th</sup>).

#### Tennessee

##### ***Attorney General says bills to block insurers from federal marketplace are unconstitutional***

A legal opinion issued by Attorney General Bob Cooper (D) declared this week that Republican efforts to prevent insurers from participating in the new federal marketplace are unconstitutional.

The measures sponsored by Senator Dolores Gresham (R) (S.B. 666) and Rep. Vance Dennis (R) (H.B. 476) are part of a series of bills backed by conservatives that aim to impede any implementation of the Affordable Care Act (ACA). They succeeded in getting Governor Bill Haslam (R) to back-off his support for a state-based health insurance exchange and instead cede control to the federal government (see Update for Week of February 11<sup>th</sup>).

In the opinion sought by Rep. JoAnne Favors (D), a retired health care administrator, the Attorney General stressed although states can regulate the business of insurance, federal law in this area overrides conflicting state laws due to the U.S. Constitution's supremacy clause.

#### Virginia

##### ***Governor makes Virginia the first state to limit biosimilar substitution***

Governor Bob McDonnell (R) signed legislation this week (H.B. 1422, S.B. 1285) that requires pharmacists notify patients prior to dispensing that they are receiving an interchangeable biosimilar copy of a brand-name drug. Pharmacists must also record the brand-name on the prescription label. The bill also requires that until July 1, 2015 the pharmacist provides the patient with retail cost information for both the prescribed biological product and the interchangeable biosimilar.

The Affordable Care Act created the new regulatory pathway that for the first time will allow such generic copies of high-cost biologic drugs. However, the Generic Pharmaceutical Association has complained that brand-name drug manufacturers have sought legislation in at least 13 states to create similar roadblocks that would frustrate the intent of Congress to bring lower-cost biosimilars to market in 2015 (see Update for Weeks of January 28<sup>th</sup> and February 4<sup>th</sup>).

##### ***Virginia competing with California to be next state approved for dual eligible demonstration***

According to an executive adviser with the Department of Medical Assistance Services (DMAS), Virginia is competing with California to be the fifth state approved for the dual-eligible demonstration created by the Affordable Care Act (ACA).

At least 25 states initially submitted proposals to participate in the demonstration, which allows states to share in the savings from transitioning those covered under both Medicare and Medicaid into capitated managed care plans. The federal Centers for Medicare and Medicaid Services (CMS) has already signed memorandums of understanding (MOUs) with Massachusetts, Washington, Ohio (see Update for Week of December 17<sup>th</sup>), and Illinois (see Update for March 4<sup>th</sup>). California, New York, and Wisconsin are among the states expected to soon be approved.

DMAS is awaiting final CMS edits for their MOU, which would shift roughly 78,000 dual eligible into 2-3 managed care plans available in each of five regions. The demonstration would begin a 60-day "soft launch" on January 1<sup>st</sup> when dual eligibles can enroll before being assigned to plans in the spring and enrolled in the fall.

CMS has slowed approval of the demonstrations, pushing most into 2014 after sharp criticisms from lawmakers, Medicare experts, and hospital groups that it was moving far too quickly to safeguard access and quality (see Update for Weeks of July 23<sup>rd</sup> and 30<sup>th</sup>). The agency is also denying requests to "lock in" dual eligibles into managed care plans so they cannot promptly leave once enrolled.