

Health Reform Update – Week of March 25, 2013

CONGRESS

Senate approves first budget in four years, despite \$275 billion in health care spending cuts

The Senate voted 50-49 last weekend to approve its first budget in four years. The Democratic plan for fiscal year 2014 (S.Con.Res. 8) includes \$275 billion in spending reductions for health care programs, all but \$10 billion of which would come from Medicare. However, it replaces the annual sequester that went into effect on March 1st with a mix of spending cuts and tax revenue (see Update for Week of March 18th).

Senate Democrats agreed to several health-related amendments, including one that would repeal the Affordable Care Act (ACA) tax on medical device manufacturers. Others would reduce the hospital matching rate for the ACA Medicaid expansion, change the law's definition of a full-time employee, and repeal the new \$2,500 limit for flexible spending accounts and its restriction on non-prescription items. Democrats also rebuffed repeated attempts to repeal the entire ACA or other specific provisions, prevent the Obama Administration from using ACA funds to promote the law's benefits, and preclude citizens and legal residents from qualifying for ACA benefits if they initially came to this country illegally.

Four vulnerable Democrats, including Finance chair Max Baucus (D-MT) voted against the measure, as did every Senate Republican. It is likely to die in the House, where Republican leaders have opposed any additional tax revenues apart those it conceded for wealthy Americans as part of the package to avert the "fiscal cliff" (see Update for Weeks of December 24th and 31st). The Democratic plan also contrasts sharply with the House-passed plan that would privatize Medicare and convert Medicaid to lump-sum federal block grants with no strings attached (see Update for Week of March 11th). President Obama is expected to propose his budget next month.

Closure of federal high-risk pools spurs rare recess hearing in House

The House Energy and Commerce health subcommittee will hold a rare hearing during recess next week to highlight Republican lawmaker concerns over the Obama Administration's decision to suspend enrollment in the temporary federal high-risk pools created by the Affordable Care Act (ACA).

The closure of pre-existing condition plan (PCIP) enrollment was intended to ensure that the roughly 135,000 existing enrollees have sufficient funding through the end of this year, when they can move to the new health insurance exchanges or other guaranteed issue coverage. Although the Centers for Medicare and Medicaid Services (CMS) still has half of the \$5 billion allotment available, costs per PCIP enrollee have been far greater than anticipated (see PCIP Update for Week of February 25th).

Speaker John Boehner (R-OH), health subcommittee chairman Joe Pitts (R-PA) and other Republican leaders have largely panned the Administration's decision, insisting that they should instead divert funds from other ACA programs to continue PCIP enrollment, such as the law's Prevention and Public Health Fund that they have continually sought to winnow down in order to offset deficit reduction measures. Although they insist that repealing the full ACA is still their goal, high-risk pools was one area of common ground prior to passage of the ACA, as Republican alternatives to the ACA propose allocating as much as \$25 million to expand the high-risk pools currently operated by states.

FEDERAL AGENCIES

U.S. Supreme Court signals uncertainty in whether to allow "pay-to-delay" drug settlements

Oral arguments held this week failed to clarify if the U.S. Supreme Court will decide whether generic drugmakers can accept patent litigation settlements that require them to delay introduction of cheaper drug alternatives.

The Federal Trade Commission (FTC) has crusaded against the record number of “pay-to-delay” deals that have proliferated in recent years (see Update for Week of January 14th), insisting that they should be declared presumptively in violation of federal antitrust law unless the parties can show they do not harm competition (see Update for Week of March 18th). However, even liberal justices like Sonia Sotomayor stated that they had “difficulty understanding” that the “mere existence” of a payment should automatically be viewed as anti-competitive.

The eight justices (excluding Samuel Alito who recused himself) acknowledge that some payments may protect effective monopolies and violate antitrust law but openly questioned whether it was appropriate for the U.S. Supreme Court to set-up a framework to tell district courts when they are or are not permissible. Conservative justice Antonin Scalia suggested that a legislative fix may be more appropriate, since the dilemma was created by Congress in the first place under the Hatch-Waxman Act (P.L. 98-147) that made it easier for generic drugmakers to bring patent challenges.

The court is expected to issue a decision in June. However, since appellate courts remain split on the legality of such agreements, any decision to simply defer to the courts or Congress will do little to resolve the issue (see Update for Weeks of December 3rd and 10th).

Senators Amy Klobuchar (D) and Chuck Grassley (R) have renewed their long-standing effort to legislatively ban “pay-to-delay” deals (S. 214) (see Update for Week of January 21st). However, similar measures have always been blocked by members of Congress from both parties who represent states with a heavy drug industry presence (see Update for Week of April 23rd).

AHIP wants an extra month for qualified health plan applications in federal marketplace

America's Health Insurance Plans (AHIP) petitioned the Centers for Medicare and Medicaid Services (CMS) this week to extend the time window for plans to apply for the new federal marketplace.

Applications to be a qualified health plan (QHP) are being accepted by CMS from March 28th through April 30th. However, AHIP insists that an additional month is needed for submissions this year because of the volume of initial data and expected technical glitches.

CMS officials have previously signaled that they may be flexible on the deadline, due to the frenetic pace of trying to get the marketplace online in more than half of the states and ready for open enrollment by the October 1st deadline under the ACA. The agency currently plans to review QHP applications from May 1st to June 16th and release results to insurers on June 17th (after which they would have until June 21st to correct deficiencies and resubmit applications.) Final data and recommendations for CMS certification are set to be released by July 31st.

For partnership exchanges, insurers will work with their state to submit all QHP application data. CMS anticipates that most states will choose to use the National Association of Insurance Commissioners' System for Electronic Rate and Form Filing to collect the required data.

HHS to issue timeline on Basic Health Program rules and guidance by April 15th

The Secretary for the Department of Health and Human Services informed Congress this week that the agency will release a timeline by April 15th that specifies when it will finally issue rules and guidance on the Basic Health Plan (BHP) option allowed by the Affordable Care Act (ACA).

The Secretary's assurances were in response to vociferous criticisms by Senator Maria Cantwell (D-WA) of the agency's decision to delay implementation of the voluntary program until 2015 (see Update

for Weeks of January 28th and February 4th). The ACA provides states with additional federal funding should they choose to exercise the BHP option for those earning 133-200 percent of the federal poverty level (FPL) that do not qualify for Medicaid but would still have trouble affording any exchange plan even with the ACA's premium and cost-sharing subsidies.

Senator Cantwell blasted the agency for delaying the program due to a "backlog" of ACA regulations and the need to ensure the new federal marketplace can start enrollment as required by October 1st (see Update for Week of February 11th). She noted that the delay puts states like Iowa, Massachusetts, Minnesota, New York, and Washington in limbo because their existing versions of the BHP that do not comply with ACA standards were scheduled to end before the ACA fully kicks-in.

The Senator has threatened to vote against the pending nomination of acting CMS administrator Marilyn Tavenner to be the permanent administrator (see Update for Weeks of January 28th and February 4th) unless CMS follows through on the Secretary's pledge to release proposed BHP regulations later this year and finalize the rules in early 2014.

Institute of Medicine finds no benefit to varying Medicare payment by region

The Institute of Medicine (IoM) rejected calls this week from lawmakers to reward those states that provide high-quality, low-cost care with higher Medicare reimbursement and punish poorer performing with states with lower payments.

Members of Congress that represent high-quality states first asked IoM to report on geographic payment variations in 2009, after Dartmouth researchers found significant variation in Medicare spending and quality across the country. Previous Dartmouth studies suggested that Medicare spending could drop by as much as 29 percent if the practices of high-quality, low-cost regions were adopted nationwide.

However, IoM stressed that Dartmouth's data did not show any consistent relation between lower Medicare spending and better health outcomes or patient satisfaction, which also vary greatly by provider even within higher performing regions. IoM thus concluded that varying Medicare payments for high or low performing regions "would not give providers the incentive to delivery care more efficiently" and in fact "reward underperforming providers in some regions and penalize those achieving good outcomes" in other regions.

HEALTH CARE COSTS

Health plans are spending little on quality improvement

According to The Commonwealth Fund, health insurers spent less than one percent of premium revenue on quality improvement in 2011, or an average of only \$29 per subscriber.

The report released this week found that nonprofit health plans were more likely to meet the new Affordable Care Act (ACA) requirement that at least 80 percent of premium dollars go to patient care or quality improvement. However, despite this standard, researchers predicted that most insurers will not substantially invest in quality improvement until the healthcare system becomes more transparent as a whole, giving consumers a better sense of the link between plans and outcomes.

Coinsurance in individual market averages 20 percent, though a quarter of consumers pay more

According to a new study by the non-partisan HealthPocket firm, coinsurance for family and individual health plan consumers currently averages 20 percent for the most expensive health services. A full quarter of the nearly 10,000 health plans surveyed applied coinsurance amounts that exceed the 20 percent national average.

The analysis showed that plans with the highest average coinsurance rate (above 40 percent) also had the highest average annual limit on out-of-pocket expenses. The lowest range of up to a ten percent coinsurance rate corresponded to an average out-of-pocket limit of \$4,286 while the highest range of above 40 percent corresponded to an average limit of \$8,825.

STATES

Highest rates of foregone care found in states with tightest Medicaid eligibility

A study published this week in the *New England Journal of Medicine* found that the number of Medicaid enrollees delaying medically-needed care correlates directly to the restrictiveness of Medicaid eligibility in a given state.

Researchers from the Brigham and Women's Hospital found that those with incomes between 67-127 percent of the federal poverty line (FPL) had up to a 16 percent likelihood of delaying care, a figure that jumped to 42 percent among lower income groups. States like Florida and Texas with the lowest Medicaid eligibility levels saw the highest rate of foregone care (roughly 40 percent of the entire adult population in Hidalgo County bordering Mexico). States like Massachusetts with broad Medicaid eligibility had the lowest rates (only 6.5 percent).

The depth of variation among states "surprised" researchers, who noted that the highest rates of foregone care were found among Latinos and those with chronic diseases.

Arkansas

Medicaid expansion alternative would move all adult enrollees to exchange, not just newly-eligible

Arkansas Department of Health Services (DHS) officials released more details this week of their private sector alternative to the Medicaid expansion under the Affordable Care Act (ACA) that has become the model for other conservative-leaning states.

The Obama Administration surprisingly approved the plan to use ACA funds for the expansion to instead cover the newly-eligible population under the private plans offered by the new health insurance exchange that will initially be a federal-state partnership (see Update for Week of February 25th). The Congressional Budget Office (CBO) predicts that exchange coverage will be more costly to the state than expanding Medicaid, though state officials dispute their estimates (see Update for Week of March 18th).

Cost will become a critical issue, as state officials clarified this week that the program will extend to all adult populations under Medicaid, not just those who are newly-eligible. This includes Medicaid-eligible parents with incomes from 0-17 percent of the federal poverty level, who will be moved to private exchange coverage. Those moved from Medicaid to the exchange will be limited to the "silver" plan, the second cheapest category covering roughly 70 percent of costs (before cost-sharing is factored in), although CMS cost-sharing limits for traditional Medicaid enrollees would still apply.

Arkansas acknowledges that it will need to provide wrap-around benefits to ensure the program meets Medicaid coverage requirements, which will require a federal waiver. The length of time needed to obtain a waiver could prevent the program from starting when the partnership exchange opens enrollment on October 1st.

Consumer advocates stress that federal approval was "conditional" and did not allow the state to make the program mandatory for all adult enrollees, which they claim is a "big departure" from the way the plan was initially presented by Governor Mike Beebe (D). Significant pushback from stakeholders could block or delay at least the mandatory enrollment feature as it requires the additional federal waiver.

California

California becomes fifth state approved for dual-eligible demonstration under ACA

The Department of Health Services (DHS) announced this week that they have signed a memorandum of understanding (MOU) with the U.S. Department of Health and Human Services (HHS) to implement a demonstration to integrate care for dually-eligible beneficiaries.

The program will operate under the name CalMediConnect and span eight counties across the state, including the most populous areas in the San Francisco bay area, Los Angeles, and San Diego. However, only 456,000 dual-eligibles will be enrolled in the capitated plans, instead of the 800,000 envisioned in the state budget for fiscal year 2012. The start of the demonstration will be delayed from June until October and counties will phase-in enrollment over 12-15 months.

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 plans. The federal Centers for Medicare and Medicaid Services (CMS) has already signed memorandums of understanding with Massachusetts, Washington, Ohio (see Update for Week of December 17th), and Illinois (see Update for March 4th). New York, Virginia (see Update for Week of March 11th), and Wisconsin are among the states expected to soon be approved.

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 23rd and 30th). In response to the complaints, CMS has been denying requests to “lock-in” enrollees, forcing California and other states to allow them to change plans or leave the demonstration whenever they please.

Milliman study predicts lower premiums for exchange consumers, higher costs for others

A Milliman analysis commissioned by the Covered California health benefits exchange predicted this week that individuals with incomes less than 400 percent of the federal poverty level (FPL) purchasing coverage in the exchange are likely to pay 47-84 percent less in monthly premiums than they currently pay in 2013, thanks to the premium tax credits available under the Affordable Care Act (ACA).

Although premiums may increase by as much as 30 percent for those earning above 400 percent of FPL, Milliman concludes that ACA caps on out-of-pocket costs as well as the more comprehensive package of essential health benefits will limit overall cost increases to an average of 20 percent.

Premium bids from plans are due April 2. Negotiations with bidding plans will take place in April and May with tentative approval of QHPs anticipated around May 15.

Colorado

Exchange board reveals more funding details

The board overseeing the Colorado health benefit exchange released new details this week regarding their plan to ensure the online marketplace is self-sustaining in 2015 as required by the Affordable Care Act (ACA).

The exchange, now named Connect for Health Colorado, will assess a 1.4 percent fee on all policies sold in the exchange and has asked the legislature for permission to charge plans up to \$1.80 per member per month for up to three years to fund start-up costs. That bill also seeks up to \$5 million in state tax credits for insurers that contribute a like amount to the exchange—similar to the mechanism used by Colorado’s pre-existing condition insurance plan (PCIP) that will terminate January 1st.

The board projects that the exchange will cost \$22-24 million per year to operate, but authorizing legislation prevents it from using state tax revenue and federal exchange establishment grants will not be available after November 2014.

The Colorado Association of Health Plans supports the fee and tax credits, as do business groups like the National Federation of Independent Businesses and Colorado Competitive Council.

Florida

Bills seek to make Florida latest state to require parity for oral and IV cancer medications

The Senate and House are advancing legislation that would require individual and group health plans in Florida to provide coverage for oral cancer medications in a manner no less favorable than those provided intravenously or infused. The *Cancer Treatment Fairness Act* would also prohibit plans from increasing or varying the cost-sharing for intravenous or injectable medications, or altering the classification of any medication, in order to comply with the required changes.

Florida insurance law already mandates the coverage of Food and Drug Administration (FDA) approved cancer drugs, as well as medically necessary services to administer those drugs. However, it does not address parity for any co-insurance, deductible, or copayment that may be related to how cancer treatment medicine is delivered.

S.B. 422 and H.B. 301 have both passed three committees and are headed for floor votes. At least 21 states plus the District of Columbia have passed similar parity laws (see Update for Week of January 7th).

Bills to close gap in children's health insurance remain stalled

A proposal by Rep. Gayle Harrell (R) to bridge the gap between when a child loses private health care coverage and is enrolled in the Florida KidCare SCHIP has passed only her Healthy Families committee and appears to have stalled.

Harrell's bill (H.B. 689) would allow children to keep receiving medical treatment until a final SCHIP eligibility decision is made, usually within 45 days. Currently there's no provision in state law to deem a child presumptively eligible while the application is considered, unless the family already qualifies for a program such as food stamps, the Women Infants and Children (WIC) program or Temporary Aid to Needy Families (TANF).

A Senate companion bill (S.B. 548) has yet to be heard in any of the three committees to which it was referred. The sticking point appears to be the bill's fiscal impact, which the House Appropriations committee and Agency for Health Care Administration estimated at \$14.3 million in the next fiscal year (assuming an additional 9,700 children would be covered). Lawmakers also fear that the presumptive eligibility option will encourage parents to misrepresent their income in order to secure at least temporary coverage for their children while the application is pending.

Few states have a higher percentage of uninsured children than Florida. Roughly 579,000 children were uninsured in 2011, including 358,000 low-income children who were eligible for KidCare.

Iowa

Senate Democrats set-up showdown over Medicaid expansion

Democrats that control the Senate approved legislation this week that would add up to 180,000 low-income residents to Medicaid by participating in the Affordable Care Act (ACA) expansion.

S.F. 296 passed on a straight party-line vote and now moves the Republican-controlled House, which is preparing to take up the "Healthy Iowa Plan" alternative advanced by Governor Terry Branstad (R), which would only extend coverage to the roughly 89,000 uninsured Iowans that earn below 100 percent of the federal poverty level (FPL), instead of the 138 percent threshold under the ACA. Senator Jack Hatch (D), chair of the health committee, insisted that the Governor's plan would be more costly as it "limits patient access" for those that fall between 100-138 percent of FPL, requiring them to continue

seeking expensive emergency room treatment for non-urgent conditions. He also emphasized that Senate plan includes an automatic termination should the promised federal funding not materialize.

Governor Branstad reiterated his opposition to the Senate plan this week, despite the lack of any opposition from provider or business groups. He insists that his partial expansion alternative will receive federal approval, although the Centers for Medicare and Medicaid Services (CMS) insist they have no authority issue ACA funds to states that do not fully expand (see Update for Weeks of December 3rd and 10th). Republican governors in Utah and Wisconsin are exploring similar partial expansions (see Update for Week of March 4th).

Maine

Governor seeks full federal payment as condition for participating in Medicaid expansion

The administration for Governor Paul LePage (R) sent a letter last week to the U.S. Department of Health and Human Services (HHS) stating that it would only participate in the Medicaid expansion under the Affordable Care Act (ACA) if HHS assumed all of the costs for the first ten years.

The letter, which also seeks additional freedom from federal Medicaid regulations, comes only one week after the Governor initiated negotiations on a private sector alternative to the expansion, similar to a plan that HHS recently approved for Arkansas (see Update for Week of February 25th). However, the Governor has not indicated whether he would accept an Arkansas-style deal in lieu of his other demands.

The Governor had been one of the first to “opt-out” of the traditional expansion after the U.S. Supreme Court gave states the flexibility to do so without penalty (see Update for Week of June 25th). However, the loss of Republican control over both legislative chambers has compelled the Governor to open the door slightly to participating (see Update for Week of March 11th).

Under the ACA, the federal government only shoulders 100 percent of Medicaid expansion costs through 2016, at which point the federal match phases down to 90 percent for 2020 and subsequent years. Maine’s rationale for demanding the full federal match for ten years centers on the fact that it was one of the few states that previously expanded its Medicaid program to cover childless adults that will be brought in for other states under the ACA expansion. The LePage administration insists Maine is thus effectively “penalized under the ACA” because it will be shouldering costs for those already included under Medicaid, while other states will have all of those costs reimbursed by the federal government. However, a recent analysis from the Kaiser Family Foundation attests that because Maine expanded Medicaid early, it will be one of ten states for whom the amount state funds it spends on Medicaid will actually drop over the next decade (by 3.8 percent) while its federal share of Medicaid costs will rise (by 11.4 percent).

The ACA expansion has broad support, as it is backed by the Maine Hospital Association, the Maine Medical Association, and the Maine Osteopathic Association. A hearing on new Medicaid expansion legislation (L.D. 1066) sponsored by Rep. Linda Sanborn (D) is scheduled for next week.

Maryland

House and Senate pass bills to fund health insurance exchange, expand Medicaid

Governor Martin O’Malley (D) is expected to eventually sign bills passed this week by the House and Senate that will expand Medicaid under the Affordable Care Act (ACA) and fund the new health insurance exchange that complies with the law.

The *Maryland Health Progress Act of 2013* (S.B. 224, H.B. 228) would impose a two percent tax on health insurers in order fund the roughly \$24 million cost of operating the Maryland Health Benefit Exchange in 2015, by which point in time the ACA requires state exchanges to be self-sustaining. The measures also expand Medicaid to 138 percent of the federal poverty level (FPL) for all residents, as the ACA requires in order for a state to receive matching funds for expanding.

Other provisions spell out how enrollees in the state high-risk pool will be transitioned to the exchange once it opens on January 1st. They also determine how much small businesses may contribute to employee health coverage, but emphasize that contributing remains a voluntary decision.

Montana

Republicans block Governor's plan to expand Medicaid, seek study on alternatives

Two Republican-controlled committees voted this week along party lines to reject the Medicaid expansion plan proposed by new Governor Steve Bullock (D).

The Governor had sought to participate in the ACA expansion, which would add roughly 70,000 uninsured Montanans to the Medicaid rolls (see Update for Week of February 25th). However, the House Human Services Committee and Senate Public Health Committee nixed the Governor's proposal in favor of a House-passed bill that would study the alternative expansion plans over the next two years.

The full House rejected an effort by House Minority Leader Chuck Hunter (D) to bring the Human Services committee bill (H.B. 590) to a floor vote. The Human Services committee had considered legislation to give low-income individuals a one-time \$1,000 grant to buy private insurance. However, these provisions were stripped out of the bill that was sent to the floor (H.B. 623).

A University of Montana study found that participating in the ACA expansion would bring in more than \$6 billion in federal funds and create up to 13,000 jobs. However, Republican lawmakers insisted that it was nothing more than an "unwarranted, unaffordable expansion of government health care."

New Mexico

Governor signs legislation creating state-based health insurance exchange under ACA

Governor Susana Martinez (R) signed S.B. 221 into law this week, which creates a state-based health insurance exchange that complies with the Affordable Care Act (ACA).

The Governor was one of only five Republicans supporting a state exchange. However, authorizing legislation was repeatedly put on hold, first by the Governor's veto and then by a dispute with the Attorney General over whether she could unilaterally create the exchange within the existing New Mexico Health Insurance Alliance without any legislation (see Update for Week of February 11th). Democrats also launched an ultimately unsuccessful effort to create an "active purchaser" exchange that selectively contracted with only the most affordable plans, instead of the "clearinghouse" model in S.B. 221 where any plan that meets minimum standards can participate (see Update for Week of March 11th).

Democrats did succeed in adding a consumer representative to the Alliance governing board and limited insurers to only two members. However, the Governor can still appoint six of the 13 board members while her insurance superintendent can break any tie votes.

Over 250,000 New Mexicans are expected to purchase coverage in the exchange by 2020, as nearly 20 percent of the state remains uninsured.

Pennsylvania

Resolution seeks study of specialty tier pricing for high-cost prescription drugs

Senator Bob Mensch (R) introduced a resolution this week that would direct the Legislative Budget and Finance Committee to study the issue of specialty tier prescription drug pricing to determine its impact upon access and patient care in Pennsylvania. S.R. 70 was referred to the Senate Public Health and Welfare Committee.

Tennessee

Governor will only pursue private sector alternative to ACA Medicaid expansion

Governor Bill Haslam (R) announced this week that he will not seek to participate in the Medicaid expansion under the Affordable Care Act (ACA), but will pursue an alternative similar to that which the Obama Administration recently approved for Arkansas (see Update for Week of February 25th).

The ACA expansion had broad support from provider, business, and consumer groups within the state. However, it was widely opposed in the Republican-dominated legislature. Senate Republicans have legislation pending (S.B. 804, H.B. 937) that would block the Governor from expanding Medicaid without their approval, had he sought to do so (see Update for Week of March 11th).

However, Governor Haslam strongly hinted in recent weeks that doing nothing was not an acceptable alternative, given the additional uncompensated care costs that hospitals would have to incur and the higher penalties that would be imposed on businesses whose workers would consequently qualify for premium tax credits under the ACA (see Update for Week of March 18th). He began negotiations with the Obama Administration on a plan to use the federal matching funds for the ACA expansion to instead cover up to 175,000 residents that would become Medicaid eligible in the federal marketplace to be operated in Tennessee.

The Governor's public rejection of the ACA expansion was largely viewed by stakeholders as an effort to gain more leverage in these negotiations. U.S. Senators Lamar Alexander (R-TN) and Bob Corker (R-TN) immediately sent a letter to the U.S. Department of Health and Human Services urging their swift approval of the Governor's proposal, after unsuccessfully introducing amendments to the Senate budget bill (see above) that would expedite the agency's considering of Medicaid waiver requests.

The move received mixed support from stakeholders, as questions persist about whether covering the newly-Medicaid eligible population under private exchange plans will be more costly for states than through traditional Medicaid (see Update for Week of March 18th). However, the private plan alternative has been embraced by several conservative-run states such as Florida, Indiana, Louisiana, and Ohio as more politically palatable than expanding an entitlement program.

A sticking point in the Governor's proposal appears to be his insistence on higher copayments for Medicaid beneficiaries. HHS has been reluctant to allow states to impose Medicaid copayments through waivers that are higher than those permitted under federal law.

Texas

Senate approves Medicaid managed care expansion for disabled and long-term care

The Senate unanimously passed a bill this week that will dramatically expand Medicaid managed care over a seven-year period to eventually include all enrollees, including the disabled and elderly.

S.B. 7 now moves onto the House. An earlier version drew strong opposition from the disabled and long-term care communities, however most including The Arc of Texas appeared satisfied with the amendments, which include pilot programs and studies to first test whether the \$8.5 million in project Medicaid cost-savings over the 2014-15 biennium will adversely impact access and quality of care. Enrollees in Medicaid waiver programs will also be allowed to remain or voluntarily choose to move over to managed care. S.B. 7 also directs the Health and Human Services Commission to develop payment systems based on the quality of care and aimed at reducing preventable errors and improving outcomes.

Medicaid spending for the 25 percent of enrollees who are disabled or in long-term care makes up 58 percent of the Medicaid budget. The bill sponsor, Senator Jane Nelson (R), insists that putting everyone under managed care will correct this imbalance by providing more incentives for efficient care.

Utah**Governor signs bill maximizing premium assistance for Medicaid and SCHIP**

Governor Gary Herbert (R) signed legislation this week that directs the Department of Health to maximize the use of Medicaid and Children's Health Insurance Program funds for assistance in the purchase of private health insurance coverage for Medicaid-eligible and non-Medicaid-eligible individuals.

H.B. 292 has the support of the business groups like the Salt Lake Chamber of Commerce, as it would allow qualifying Utah families to combine state contributions with the premium subsidies offered by the Affordable Care Act (ACA) in order to purchase private insurance coverage.

Consumers advocates like the Utah Health Policy Project (HPP) remained worried that H.B. 292 and other legislation may be precursors to the state rejecting the Medicaid expansion under the ACA. (Governor Herbert is one of only a handful of governors that have to yet take a position on the expansion.) However, legislation (S.B. 195) that would create a 15-member Charity Care Commission to promote a "comprehensive private partner charity care system" for Utah" has yet to be considered (see Update for Week of February 11th).

Virginia**Governor specifies reforms that must be federally-approved prior to expanding Medicaid**

Governor Bob McDonnell (R) sent to the General Assembly this week his proposed amendments for the budget bill that was passed last month (see Update for Week of February 25th).

The changes sought by the Governor to H.B. 1500 provide greater specificity for the Medicaid reforms that must be federally-approved before Virginia agrees to participate in the Medicaid expansion under the Affordable Care Act (ACA). These amendments relate to the dual-eligible demonstration, program integrity, service limits, and service delivery reforms. They also provide \$3 million in funding for the Department of Medical Assistance Services (DMAS) to contract with a private entity to create a centralized customer service call center for Medicaid and SCHIP. The Governor notes that regardless of whether Virginia expands Medicaid, the ACA requires the commonwealth to upgrade its systems so that residents can apply by telephone, a method of application not currently available in Virginia.

The Governor also proposed amendments to H.B. 1900 and S.B. 921 that explicitly bar the federal marketplace that will operate in Virginia starting in 2014 from covering abortion services, even though the President's executive order in March 2010 does likewise. He signed H.B. 2138, which creates a legislative Health Insurance Reform Commission to monitor implementation of the ACA, determine whether Virginia should ultimately operate their own state-based health insurance exchange that complies with the law, and recommended what essential health benefits must be covered by individual and small group plans in and out of the exchange starting in 2014.

The General Assembly can pass or override the Governor's amendments with a simple majority vote once they return on April 3rd.

A poll of nearly 1,100 registered voters in Virginia released this week by Quinnipiac University found them nearly equally split in their support of the Medicaid expansion. Overall 45 percent favor the expansion, while 43 percent oppose.

Specialty Tier Reform Update – Week of March 25, 2013

Pennsylvania

Resolution seeks study of specialty tier pricing for high-cost prescription drugs

Senator Bob Mensch (R) introduced a resolution this week that would direct the Legislative Budget and Finance Committee to study the issue of specialty tier prescription drug pricing to determine its impact upon access and patient care in Pennsylvania. S.R. 70 was referred to the Senate Public Health and Welfare Committee.

Rhode Island

Bill to limit out-of-pocket cost drug costs to federal maximums held for further study

The Senate Health and Human Services committee elected this week to hold S.754 for further study. The measure would require health plans to establish a separate out-of-pocket limit for all prescription drugs (including specialty drugs), equal to the maximum dollar amounts in effect under section 223(b)(2) of the Internal Revenue Code for self-only and family coverage. The out-of-pocket limits must be consistent with the limits prescribed by U.S. Department of Health and Human Services in implementing Section 2715 of the Affordable Care Act.

A hearing on companion legislation (H.5591) is set for April 2nd in the House Corporations Committee (see Specialty Tier Update for Week of February 25th).