



Health Reform Update – Week of January 12, 2015

CONGRESS

Rule change threatens to cut Social Security disability payments by 20 percent

Democratic leaders sent a letter this week to new Senate Majority Leader Mitch McConnell (R-KY) urging the Senate to reject a rules change by House Republicans that threatens to cut Social Security disability payments by 20 percent.

The language at issue was part of the rules the House passed last week that will govern the 114th Congress. It restricts transfers to the Social Security Disability Insurance Trust Fund, which is scheduled to run dry in 2016 if not replenished.

Congress has historically used tax revenue from the Social Security retirement fund to replenish the disability trust fund, most recently in 1994 when it faced little opposition from either party. If Congress does not do so by 2016, payments will automatically be cut by 20 percent across-the-board, resulting in a \$218 reduction in monthly benefits (\$1,146 to \$928 for the average beneficiary, an amount that would be below the federal poverty level).

Current Republican leaders insist that the disability program is “fraud-plagued” despite Government Accountability Office findings in 2013 that only about 0.4 percent of federal disability beneficiaries were receiving improper payments.

Supreme Court declines to review “origination clause” challenge to ACA

The U.S. Supreme Court declined this week to hear the latest legal challenge to provisions of the Affordable Care Act (ACA).

The high court rejected an appeal filed by the Association of American Physicians and Surgeons and the Alliance for Natural Health USA, which was dismissed by two lower courts. The groups had claimed that the various provisions of the ACA including the controversial individual and employer mandates are invalid because they are part of a revenue-raising bill that did not originate in the House as required by the U.S. Constitution.

Legislation creating the ACA statute did originate in the House, but was substantially changed by the Senate before being returned to the House. However, this so-called “origination clause” challenge has failed to succeed in other courts, with the U.S. Court of Appeals for the District of Columbia ruling that it applies only to bills whose primary purpose is to levy taxes and not those enacted for other purposes that “may incidentally create revenue” (see Update for Week of July 28th). Since the ACA’s “paramount” purpose is to increase the number of Americans covered by health insurance and not raise revenue, the court found that the origination clause did not apply.

The individual mandate itself was already declared constitutional by the U.S. Supreme Court (see Update for Week of June 25, 2012). However, the high court surprisingly agreed to hear a challenge to the ACA subsidies provided to federally-facilitated Marketplace consumers, even before a split in appellate decisions arose (see Update for Week of November 10th). Oral arguments in that challenge are scheduled for March 4th (see Update for Week of January 5th).



Senate Republican investigates federal role in collapse of ACA insurance cooperatives

Senator Charles Grassley (R-IA) is demanding that the Centers of Medicare and Medicaid Services (CMS) explain by January 27th why one of the most successful non-profit health insurance cooperatives (CO-OPs) created by Affordable Care Act (ACA) has suspended enrollment for six months.

CoOpportunity Health was second only to Health Republican Insurance in New York in terms of CO-OP enrollment for 2014, signing up roughly 100,000 consumers in Iowa and Nebraska alone. However, the rapid growth “exponentially” exceeded the expected target of only 11,000 enrollees, which according to the Iowa Insurance Commissioner has resulted in “insufficient capitalization, a lack of additional funds [from CMS] and a delay in federal payments for risk mitigation programs.”

CoOpportunity had been awarded \$145 million in start-up loans through the ACA, including \$32.7 million in additional solvency funding that it received last fall. However, Senator Grassley claims that CMS “unexpectedly and without explanation told CoOpportunity it would receive no additional funding” last December, causing its operations to be assumed by the Iowa Division of Insurance.

Grassley insists that a “lack of openness” by CMS has “played a significant part in CoOpportunity’s failure” and questions whether “its process for informing states about assistance decisions” will cause comparable failures in other states. He specifically asks CMS to identify whether it reserved funds for CO-OPs that exceed enrollment expectations and face greater than anticipated costs.

CMS acknowledges that CoOpportunity’s funding request in December was “greater than all the resources that CMS had available” and maintained that the decision to halt enrollment was made solely to protect against the “rapidly deteriorating financial viability” of the CO-OP. Agency officials stressed that it was Congress that rescinded 90 percent of available ACA funding for CO-OP loans in the compromise to avert the so-called “fiscal cliff”, leaving CMS with only the remaining ten percent to use for a contingency fund (see Update for Weeks of December 24 and 31, 2012).

The Tennessee Insurance Commissioner acknowledged this week that enrollment in the Community Health CO-OP in that state has been halted due to similar concerns over its financial viability.

Bills to repeal ACA medical device tax expect to clear House and Senate

Renewed legislation to repeal the Affordable Care Act (ACA) tax on medical device manufacturers appears to be only one Democratic vote short of passage after five Democrats from states with a heavy device manufacturer presence promptly signed-on.

The *Medical Device Access and Innovation Protection Act* (S.149) would repeal the 2.3 percent excise tax retroactive to its January 1, 2013. It has been introduced repeatedly since 2011 but failed to muster the 60 votes needed to break the filibuster in Democratically-controlled Senates.

The measure is expected to reach the 60-vote threshold, as Senator Elizabeth Warren (D-MA) has long opposed the tax but yet to sign-on. A similar bill already has 27 Democratic cosponsors in the House. If both chambers approve their respective versions, it would then be up to President Obama whether to veto a reconciled bill. Neither chamber currently has a veto-proof margin of support.

The House has already passed three anti-ACA measures this session, after a measure exempting volunteer firefighters from the employer mandate unanimously cleared the chamber this week. The other bills also exempted veterans and adjusted the threshold for the employer mandate from employees working 30 hours per week to those working at least a 40 hour work week (see Update for Week of January 5th).

CMS Administrator resigns in wake of controversy over Marketplace enrollment figures

Marilyn Tavenner made a surprise announcement this week that she will resign as Administrator of the Centers for Medicare and Medicaid Services (CMS) at the end of February.

The second highest-ranking CMS official, Andrew Slavitt, will take over as acting Administrator at that time until a new Administrator is confirmed. However, it remains very unclear whether a new Administrator will even be nominated during the remainder of President Obama's second term, given that Republicans now control the Senate and could prevent any confirmation.

Tavenner served only 20 months in her position or just three months longer than her predecessor Donald Berwick, whose recess appointment endured such controversy that he was never confirmed by the Senate (see Update for Weeks of January 28 and February 4, 2013). Prior to Berwick, CMS had been without a permanent Administrator since 2006.

As Administrator, Tavenner was considered "industry-friendly" and highly regarded by lawmakers from both parties (being confirmed with only seven dissenting votes). She had remained largely unscathed by the flawed rollout of the federally-facilitated Marketplace (FFM) in 2013 and was widely praised for successfully revamping the web portal (see Update for Week of November 11, 2013). Most of the political fallout instead fell on Health and Human Services Secretary Kathleen Sebelius, who resigned last year (see Update for Week of April 7th).

However, Tavenner endured her own controversy last fall when the agency was forced to acknowledge that it had improperly included enrollees in dental-only plans in Marketplace enrollment tallies. Tavenner also faced criticism for Marketplace regulations that many consumer advocates complained were too lenient on insurers and drugmakers.

As with Tavenner, acting Administrator Slavitt comes from the health care industry, having served as an executive at one of the contractors (Optum) that helped design the FFM web portal.

Marketplace enrollment slows after surge before first deadline

The Department of Health and Human Services (HHS) announced this week that nearly 6.8 million consumers have either selected a plan or been automatically renewed for coverage in the 37 federally-facilitated Marketplaces (FFM) since the second open enrollment period commenced on November 15th, roughly 87 percent of whom are eligible for premium or cost-sharing subsidies under the Affordable Care Act (ACA).

The figure includes individuals who selected health plans and those who automatically were re-enrolled in their current or similar plans, but does not reflect how many have paid their first month's premiums. More than 163,000 signed up during the first full week in January, exceeding weekly totals over the holidays but still below the surge that occurred just before the December 15th deadline for coverage effective January 1st (see Update for Week of December 15th).

Despite the slowdown, the FFMs remain on target to meet their goal of 9.1 million enrollees by the February 15th close of open enrollment. The agency trumpeted the fact that waiting times for call centers have plummeted since enrollment opened, falling to a mere six seconds compared to the more than seven minute average during the entire period.



The weekly report was the first to break down FFM enrollment by state, revealing that Florida far away leads all FFMs and state-based Marketplaces (SBMs) with nearly 1.2 million residents newly signed-up or reenrolled since November 15th.

Several FFMs that struggled during the inaugural open enrollment period have seen dramatic improvements, led by Wyoming with 42 percent more enrollees. Nebraska, North Dakota, and Oklahoma also have seen enrollment growth of at least 30 percent. However, Iowa and Ohio continue to experience lagging enrollment rates, as does Nevada, which converted from a SBM to FFM last year after persistent technical glitches hampered enrollment (see Update for Week of June 2nd).

HHS used the report to highlight expanded outreach efforts to the Latino community that have resulted in slightly higher enrollment rates during the second open enrollment period (eight percent compared to seven percent during the same point in time last year). The reported cited upgrades to the Spanish language version of www.healthcare.gov, as well as more than 600 events held by Spanish-speaking enrollment assisters. Similar efforts have similarly increased Latino enrollment in the largest SBM in California (see below).

Study confirms variation in Marketplace premiums correlates to competition

A Kaiser Family Foundation (KFF) analysis of 2015 premiums for coverage offered in Affordable Care Act (ACA) Marketplaces confirmed this week that despite only modest gains in average increases, wide variation continues to exist among different regions of the country depending on the level of insurer competition (see Update for Week of December 1st).

The study found that Alaska has the highest monthly premiums for the lowest-cost silver tier plans sold in the Marketplaces. A 40-year old will pay \$488 for that coverage in any part of the state or 80 percent more than the \$269 nationwide median. This finding is consistent with other studies, attributing the presence of only two Marketplace insurers for increasing premiums by 30-40 percent (see Update for Week of November 10th).

Other rural areas with only 1-2 participating insurers predictably followed close behind, with counties in Wyoming, Nevada, Vermont, southern Mississippi, upstate New York, and inland California rounding out the ten most expensive premiums (\$401-\$459 per month for a 40-year old).

By contrast, 12 competing insurers have lowered the same premiums for Maricopa County in Arizona (including metro Phoenix) by 15 percent to only \$166. Albuquerque, NM, Tucson, AZ, Louisville, KY, and Pittsburgh, PA were only slightly higher (\$167-70) with western Pennsylvania, Knoxville and Memphis metro areas in Tennessee, and the Minneapolis-St. Paul area rounding out the ten least costly areas. All of these regions had five or more Marketplace insurers.

According to KFF, the three-fold gap between the highest and lowest premiums is consistent with the differential for 2014, when consumers in Colorado mountain regions paid \$483 per month for the same coverage while those in Minneapolis-St. Paul paid only \$154. Efforts by Colorado regulators to redraw rating areas lowered premiums in those counties (see Update for Week of June 2nd), while premiums increased in Minnesota after the lowest-priced insurer pulled out of the Marketplace (see Update for Week of September 15th).

HEALTH CARE COSTS

Survey finds that medical debt declined for first time in a decade, except in non-expansion states

The Commonwealth Fund released a new study this week showing that the number of Americans experiencing financial distress from medical bills has declined for the first time in a decade.



The biannual survey found that the percentage of Americans that were in medical debt fell to 35 percent in 2014 from a high of 41 percent in 2012. Fewer respondents were also avoiding physician visits due to cost.

Researchers were unable to quantify the specific impact that full implementation of the Affordable Care Act in 2014 had on the decline, but stated that there was likely some correlation.

The Consumer Financial Protection Bureau previously estimated that more than 20 percent of all Americans have a medical debt listed as a delinquent payment on credit reports. The agency identified medical debt as the leading cause of personal bankruptcies.

Related research from The Commonwealth Fund also found this week that people living in states that have refused to participate in the Medicaid expansion under the Affordable Care Act (ACA) are far more likely to continue to experience medical debt or be uninsured.

The survey showed that in opt-out states, roughly 35 percent of adults earning less than 100 percent of the federal poverty level remain uninsured after the ACA was fully implemented last January. By contrast, only 19 percent are still uninsured in expansion states.

STATES

California

Governor's budget includes funding for high-cost drugs, but not undocumented immigrants

The proposed fiscal year 2015-16 budget released last week by Governor Jerry Brown (D) allocates about \$300 million for high-cost drugs, including expensive medication to treat the hepatitis C virus (HCV). However, the Governor acknowledges that this will not be sufficient to cover all HCV enrollees in Medi-Cal, the AIDS Drug Assistance Program, or other state health care programs.

Several states led by Oregon and Illinois have already developed policies to explicitly ration new HCV treatments that can cost more than \$1,000 per pill and bust through existing Medicaid budgets, leaving little funding for other treatments (see Update for Week of July 28th). Medi-Cal has yet to decide whether to follow suit and limit coverage of Sovaldi, Harvoni, or other new HCV medications only to those most seriously ill.

The budget also proposes to renew for another five years the "Bridge to Reform" Section 1115 federal demonstration waiver that California used to expand Medicaid coverage in 2010, prior to full implementation of the Affordable Care Act last year. The initial five-year, \$10 billion waiver included \$2.9 billion for expanding coverage, \$3.3 billion for improving safety net hospitals and \$3.9 billion for uncompensated care. Under the renewal, the Governor intends to focus on strengthening primary care, avoiding unnecessary institutionalization, and using Medi-Cal to test new ways of providing services.

The Governor's budget will make \$14.3 billion available to continue expanding Medicaid for everyone earning up to 138 percent of poverty, an additional \$150 million to help support Medicaid eligibility determinations, and \$240 million to finish upgrading the state's automatic eligibility system so it no longer needs to rely on county workers to complete manual eligibility reviews. Roughly 3.3 million additional residents are expected to enroll in Medi-Cal by the end of fiscal 2016 for a total 12.2 million people (or 32 percent of the state's population).

Despite the support of several Democratic lawmakers, Governor Brown elected not to broaden Med-Cal eligibility to include undocumented state residents that are protected from deportation under the



recent executive action issued by President Obama (see Update for Week of December 8th). Neither Medi-Cal nor Covered California currently allow for coverage of undocumented immigrants.

Boost in Latino enrollment pushes Covered California near 2015 target

Covered California announced this week that nearly 228,800 consumers have enrolled in qualified health plans during the second open enrollment period that started November 15th, while an additional 304,500 have been determined eligible for coverage.

Despite a slowdown in the pace of sign-ups over the holidays, Covered California officials stated that the Marketplace remains on track to meet its target of 500,000 new consumers by the close of the open enrollment period on February 15th. Another roughly 467,000 consumers have enrolled in Medi-Cal since November 15th.

Even though Covered California led the nation with more than 1.2 million enrollees during 2014, Latino enrollment lagged far behind expectations (see Update for Week of April 7th). Because uninsured rates remain the highest among this population, enrolling them in coverage is critical to the financial viability of the Marketplace.

Covered California's executive director insisted this week that 28 percent of new enrollees for 2015 coverage identify as Latino, a far greater showing than during the midpoint of the inaugural open enrollment period and consistent with the sign-up rate during the late enrollment surge last spring (see Update for Week of March 31st). Increased Spanish language advertising and in-person assistance has been credited for the upturn, as well as an emphasis on assuring applicants that residency information about family members will not be shared with federal immigration authorities (see Update for Weeks of January 20 and 27, 2014).

The director insisted that Latino enrollment will continue to climb as nearly half of the 311,000 consumers that have been determined to be eligible but yet to select a plan also identify as Latino.

Covered California rejects United Healthgroup's attempt to sell policies statewide

The board overseeing Covered California adopted new rules this week that seek to reward insurers that participated during the inaugural open enrollment period and punish those that waited until year two to join.

The move specifically targets insurance giant UnitedHealth Group, which exited California's individual insurance market in 2013 shortly before the new Affordable Care Act (ACA) Marketplace. After staying out of most Marketplaces last year, UnitedHealth Group has joined nearly two dozen for 2015 and sought to offer Covered California plans statewide.

However, the new rules prevent UnitedHealth or other new entrants from doing so before 2017, instead limiting the insurer to only five of the state's 19 rating areas for this plan year—most of which are in rural areas with three or fewer competing insurers. Covered California's executive director insisted that insurers that were in California's individual market in 2012 should not be allowed to undercut rival insurers who patiently endured technological glitches that caused enrollment to be lower than expected during the first few months after the Marketplace was rolled out in October 2013.

The move was opposed by Insurance Commissioner David Jones (D), who urged Covered California to instead allow for maximum choice and competition statewide in order to keep premiums affordable and broaden provider networks. Jones' office has already issued emergency regulations to limit the increasing reliance on narrow networks by Covered California insurers (see Update for Week of January 5th).



Insurance commissioner urges Covered California to delay private plan cancellations

Insurance Commissioner Dave Jones (D) urged Covered California this week to delay planned coverage cancellations for 95,000 consumers that have been determined to be eligible for Medi-Cal, the state Medicaid program.

The cancellations resulted due to a change in subscriber income. However, because Covered California must rely on tax returns when subscribers do not provide other verifying documents, these determinations are often susceptible to mistakes since 2013 returns are the most recent available.

Jones recommends that Covered California change their cancellation process, which he insists violates state law that permits cancelled coverage only for non-payment of premiums or change in service area. Even though Medi-Cal coverage immediately starts upon cancellation, Jones instead argues that subscribers should be allowed to remain in their private Marketplace plans until any discrepancies are resolved, as opposed to being bumped back and forth between Covered California and Medi-Cal when erroneous eligibility determinations are confirmed, similar to the process in place for other states.

Colorado

Board approves \$322,000 fix to Marketplace enrollment system

The board of directors overseeing Connect for Health Colorado agreed this week to spend an additional \$322,000 through February to resolve stalled applications for the online Marketplace.

The emergency expenditure was in response to 1,900 reports of outstanding technical problems with the web portal, which had hit as many as 4,800 earlier in the open enrollment period that started November 15th. More than 20 types of system failures have prevented applicants from completing online applications, particularly for those qualifying for premium tax credits or cost-sharing subsidies.

The lead contractor CGI insisted that the glitches are due not being furnished a full list of system requirements. However, CGI is the same contractor responsible for the flawed rollout of the federally-facilitated Marketplace and several state-based versions (see Update for Week of March 10th).

Despite the lingering software issues, Connect for Health Colorado has still been able to enroll more than 121,000 consumers in medical/dental coverage. However, only about 23,000 of this amount are new customers.

It is not yet clear whether the stalled applications will result in the February 15th deadline for open enrollment being extended.

Florida

Federal judge says low Medicaid reimbursement for children is unlawful rationing of care

A federal judge held late last month that Florida's Medicaid reimbursement prior to transitioning to full managed care was so low that it violated federal law.

Judge Adalberto Jordan with the U.S. 11th Circuit Court of Appeals found that Medicaid reimbursement in the state for pediatricians and other specialists were kept at an artificially low level that exacerbated a physician shortage and led to "rationing of care" by denying a third of the state's Medicaid children any form of preventive care. He also determined that Medicaid children were often switched from one Medicaid provider to another "without their parents' knowledge or consent."

Agency for Health Care Administration (AHCA) officials were quick to point out that the judge's ruling was based on data from 2005 to 2011 and not on the current Statewide Medicaid Managed Care program that has since moved nearly all Medicaid enrollees into private managed care plans under a



federal waiver (see Update for Week of August 1, 2011). AHCA insisted that the waiver program was “cost-effective” and a “success.”

Judge Jordan, who was appointed by President Obama, will decide at a future hearing what resolution may be necessary.

Idaho

Governor asks for hearings on taskforce recommendations to expand Medicaid

Governor Butch Otter (R) used his State of the State address this week to urge lawmakers to hold hearings on whether to expand Medicaid pursuant to the Affordable Care Act (ACA).

The Governor’s own Medicaid Redesign Workgroup has twice recommended that Idaho participate in the ACA expansion, calling it a “no brainer” given the level of federal funding provided by the ACA. Without the expansion, roughly 104,000 state residents are caught in the gap between restrictive Medicaid eligibility levels and the threshold for ACA premium tax credits that starts with those earning at least 100 percent of the federal poverty level.

Governor Otter did not specifically advocate for the expansion. However, he previously made Idaho one of the few Republican-led states to create its own health insurance Marketplace under the ACA, insisting that it was imperative for Idaho to retain “state control” of its own insurance market (see Update for Week of November 10, 2014).

House Speaker Scott Bedke (R) indicated that lawmakers were likely to “honor [the Governor’s] request” for hearings. However, most Republican leaders including Senate President pro tem Brent Hill (R) remain adamantly opposed to any traditional expansion.

The legislature has thus far refused to consider even a private-sector alternative to the Medicaid expansion similar to the model federally-approved for five states. The Medicaid Redesign Workgroup has essentially recommended that Idaho pursue such a model (see Update for Weeks of December 3 and 10, 2012), which was backed by Governor Otter (see Update for Week of March 11, 2013).

New Hampshire

Senate Majority Leader introduces oral cancer parity legislation

Senate Majority Leader Jeb Bradley (R) introduced S.B. 137 last week, which would make New Hampshire one of more than 30 states to limit cost-sharing for oral anti-cancer medications to the amount required for intravenously-administered treatments. It was referred to the Commerce Committee.

Pennsylvania

Medicaid expansion alternative hampered by delays

The Department of Human Services (DHS) acknowledged this week that only 55,000 of the roughly 151,000 applicants for January 1st coverage in Healthy Pennsylvania have actually been enrolled.

The delays have largely resulted from system errors that have often enrolled applicants in the wrong type of private coverage. Healthy Pennsylvania is the Medicaid expansion alternative that outgoing Governor Tom Corbett (R) negotiated with the Obama Administration and places those made newly-eligible by the Affordable Care Act (ACA) expansion into Medicaid managed care plans with more limited sets of benefits (see Update for Weeks of August 25th and September 1st).

Officials working for Governor-elect Tom Wolf (D) blamed many of the delays on Healthy Pennsylvania personnel asking for more detailed “optional” information on applicant income and assets than the federal waiver requires. Wolf’s team used the resulting “chaos” as justification for the Governor-



elect to “un-complicate” the process by converting the alternative waiver into a traditional expansion under the ACA. However, the Governor-elect may ultimately need the approval of a Republican-controlled legislature to do so (see Update for Week of November 3rd).

Roughly 600,000 Pennsylvanians are expected to be eligible for either Healthy Pennsylvania or a traditional expansion.

Tennessee

Governor’s Medicaid expansion alternative lacks votes despite support of Republican leaders

House Majority Leader Gerald McCormick (R) acknowledged this week that the House currently lacks enough votes to pass the Medicaid expansion alternative proposed by Governor Bill Haslam (R).

The Governor will call a special session on February 2nd for lawmakers to debate his Insure Tennessee plan, which uses federal matching funds provided by the Affordable Care Act (ACA) to subsidize employer-sponsored coverage for adults age 21-64 that earn up to 138 percent of the federal poverty level. Other enrollees can use state contributions to health savings accounts to pay new cost-sharing obligations for traditional Medicaid benefits (see Update for Week of January 5th).

Rep. McCormick, as well as Lt. Governor Ron Ramsey (R), and other key Republicans are backing the Governor’s proposal. However, House Senate Majority Leaders Mark Norris (R) and House Republican Caucus chair Glen Casada (R) are either questioning or opposing the plan. (House Speaker Beth Harwell (R) remains non-committal).

Governor Haslam is continuing to negotiate the terms of the proposal from the federal Centers for Medicare and Medicaid Services, which must issue a waiver to let Tennessee receive ACA funds for an alternative to the traditional expansion. However, even with a federal waiver, the Governor will ultimately need the support of both the House and Senate to proceed.

Texas

Governor-elect will not support any ACA expansion of Medicaid

A spokesperson for Governor-elect Greg Abbott (R) scuttled rumors this week that his Administration would support a private-sector alternative to the Medicaid expansion under the Affordable Care Act (ACA), similar to the model federally-approved for five states.

Abbott’s spokesperson insisted that the Governor-elect was “surprised” by local media reports interpreting his request for information about Utah’s Medicaid expansion alternative as an indication that he intended to issue a similar proposal to the Texas legislature. Instead, the spokesperson clarified that any limited expansion proposed by the Governor-elect will use state-only funds and not accept any federal funding for expanding Medicaid that does not come in the form of a lump-sum block grant with no strings attached.

Vermont

After shelving single-payer, Governor seeks \$90 million payroll tax to pay for other health reforms

Only one month after shelving Vermont’s plan to move to a single-payer health care system, Governor Peter Shumlin (D) proposed a new payroll tax this week that would increase Medicaid reimbursement and help Marketplace consumers afford their premiums.

The 0.7 percent payroll tax is but a fraction of the 11 percent payroll tax that the Governor estimated would be needed for single-payer reforms, in addition to a 9.5 percent premium assessment on individuals (see Update for Week of December 1st). However, it would be sufficient to raise more than \$90 million per year.



Under the Governor's budget plan, two-thirds of the new revenue would increase provider reimbursement rates under Medicaid. Governor Shumlin insists that the increased payments will cause a "dollar-for-dollar" reduction in private insurance premiums by lessening the need for them to increase premiums by 15-20 percent to cover the 40-60 percent of costs that Medicaid does not pay. As a result, the Governor argues that the payroll tax would be effectively "cost-neutral" for employer by reducing their health plan costs. It will also bring in \$100 million per year in additional federal matching funds.

Governor Shumlin also proposes to double an existing premium assistance program that helps workers afford coverage in the health insurance Marketplace that Vermont operates pursuant to the Affordable Care Act. Its annual budget would increase from \$4 million to \$8 million.

Virginia

New bill would limit specialty tier cost-sharing to \$100 per month

Delegate Jennifer McClellan (D) introduced legislation this week that would prohibit cost-sharing obligations for a specialty tier drug from exceeding \$100 per month for a 30-day supply. The limit shall apply regardless of whether any deductible has been satisfied.

Similar to legislation introduced in Kentucky, H.B. 1948 would let subscribers request an exception to the tiered cost-sharing structure and prohibit insurers from placing all drugs of the same class within a specialty tier (see Update for Week of January 5th). The latter is a practice that has been discouraged by the federal Centers for Medicare and Medicaid Services in response to civil rights complaints filed by consumer advocates (see Update for Week of December 15th).