Health Reform Update – Week of March 16, 2015

CONGRESS

Senate Republican budget includes $403B in Medicare cuts but no voucher plan

Senate Budget Committee chair Mike Enzi (R-WY) released the first Senate Republican budget in nearly decade this week which would repeal the entire Affordable Care Act (ACA) but does not include the Medicare privatization and Medicaid block grant plans that have been the centerpiece of recent House-passed budget plans.

Both the Senate and House budget plans strive to balance the federal budget for the first time since the Clinton Administration. Senate Republicans seek to do so by 2025 through $403 billion in unspecified Medicare cuts over the next ten years and a restrained growth rate in Medicare spending. However, the House plan includes far deeper spending cuts to accelerate the process, including the plan sought by Rep. Paul Ryan (R) to convert Medicare into a "premium support" program where enrollees use vouchers to purchase private coverage after 2023 in a "carefully monitored [health insurance] exchange."

The House plan largely resembles budgets the chamber has passed for the past four years (see Update for Week of April 7th), including earlier proposals to turn Medicaid into lump-sum block grants that states can use without any strings attached. However, Senate Republicans seek simply to allow Medicaid to operate with the flexibility currently available under the Children's Health Insurance Program.

Senator Enzi set a target date of April 15th by which Republican leaders in both chambers can reconcile the proposals into a joint plan. He expects the Senate Finance and Senate Health, Education, Labor and Pensions committees to identify at least $1 billion in Medicare cuts by July 31st, which would be able to pass via the budget reconciliation process that requires only 51 votes. Unlike the House versions, the Senate budget resolution does not specifically allow for reconciliation to be used to repeal ACA provisions, but does appear to provide some flexibility for the Senate to restore ACA subsidies via reconciliation should the U.S. Supreme Court deny them to federally-facilitated Marketplace consumers starting later this year (see Update for Weeks of March 2nd and 9th).

President Obama still has the authority to veto budget measures that pass both chambers and has indicated that he will do so for those that seek to undo or hinder the ACA. His proposed fiscal year 2016 budget also includes nearly $400 billion in health-related cuts that would mostly come from Medicare (see Update for Weeks of January 26th and February 2nd). However, his budget focuses on savings that would be achieved by how Medicare reimburses providers and prescription drugs, including giving Medicare Part D to authority to negotiate drug prices and accelerating ACA-mandated discounts for drugs furnished to enrollees in the Part D coverage gap.

Congress unveils latest bipartisan bill to prevent dramatic cuts in Medicare physician payments

Senate Democrats reacted coolly this week to the latest bipartisan compromise to permanently replace the Sustainable Growth Rate (SGR) formula that annually threatens to impose Medicare physician payment cuts of more than 20 percent.

The measure released by committee leaders in the House and Senate (H.R. 1470) is similar to the bill introduced last year that stalled amid debates over how to offset the projected $174.5 billion cost (see Update for Weeks of January 26th and February 2nd). Committee leaders still have not resolved that issue and included only a concurrent two-year extension of the Children's Health Insurance Program past September 30th, instead of an extension through fiscal year 2019 that was recommended by the

Medicare Payment Advisory Commission and sought by Senate Democratic leaders (see Update for Week of February 17, 2014).

H.R. 1470 would provide physicians with a 0.5 percent annual increase in Medicare reimbursement for five years while Medicare transitions to incentive-based payments that reward quality. It would require participating physicians to receive at least 25 percent of their revenue through these Alternative Payment Models by 2019-2020, with the threshold increasing over time.

Lawmakers are up against the March 31st expiration of the latest delay in the 21 percent payment cut that will automatically take effect absent Congressional action (see Update for Week of December 8th). However, House Budget Committee chair Tom Price (R-GA) has already acknowledged that Congress is likely to pass another short-term "patch" given the complexities of a long-term deal, as it has done 17 times since the SGR was first implemented (see Update for Week of February 23rd).

The bipartisan deal being negotiated in the House would include "means testing" as part of the necessary offsets, which would increase Medicare Part B and D premiums for wealthier enrollees. However, key Senate Democrats including Finance Committee chair Ron Wyden (D-OR) have objected to the proposal, fearing it could erode benefits for all Medicare enrollees.

IPAB repeal continues to attract Democratic support

Reps. Linda Sanchez (D-CA) and Phil Roe (R-TN) introduced legislation earlier this month that would repeal the Independent Payment Advisory Board (IPAB) created by the Affordable Care Act (ACA).

The controversial board of non-elected Presidential appointees would make annual cost-cutting recommendations to Congress whenever Medicare spending exceeds preset targets. These recommendations would be automatically triggered if Congress fails to pass equivalent cuts.

At least 20 House Democrats including the lead Democrat on the Energy and Commerce Committee (Rep. Frank Pallone of New Jersey) have cosponsored previous efforts to repeal the board, which they fear will cede control over Medicare spending away from Congress (see Update for Week of March 5, 2012). The latest measure (H.R. 1190) already has 18 Democrats among the 210 cosponsors (Sanchez took over as Democratic sponsor for Rep. Schwartz (D-PA), who is no longer in Congress.)

The Congressional Budget Office estimated in 2012 that repealing IPAB would cost $3.1 billion over a decade. Offsetting cuts have been an obstacle to other House legislation such as the Medicare physician payment fix (see above) but Reps. Sanchez and Roe noted that Republican leaders have been less concerned about finding equivalent cuts when it comes to repealing part of the ACA.

Department of Health and Human Services (HHS) Secretary Sylvia Mathews Burwell testified earlier this month that the IPAB was not likely to be triggered before 2019 due to historically low growth rates in Medicare spending. HHS has yet to appoint any members to the IPAB and Burwell indicated that she will wait for recommendations from Congress before doing so.

Bipartisan bills would restore FSA eligibility for non-prescription drugs

Rep. Lynn Jenkins (R-KS) introduced legislation earlier this month that would repeal the Affordable Care Act (ACA) provision preventing over-the-counter (OTC) drugs from being reimbursed under health savings accounts, health reimbursement accounts, and flexible spending accounts (FSAs).

FSA plans remain very popular with employees and reinstating OTC drug eligibility consistently garners strong public support. As a result, both H.R. 1270 and its Senate counterpart (S.709) are cosponsored by Democrats (Rep. Ron Kind (D-WI) and Senator Heidi Heitkamp (D-ND)).

A similar measure was passed as part of more comprehensive House legislation in 2012. However, neither Rep. Jenkins nor Senate sponsor Pat Roberts (R-KS) have indicated whether it will be pursued as a stand-alone bill this session. Either measure would require off-setting cuts of roughly $5 billion over ten years.

FEDERAL AGENCIES

HHS says ACA coverage expansion has been greatest in four decades

The Department of Health and Human Services (HHS) announced this week that 16.4 million uninsured Americans have gained coverage since the enactment of Affordable Care Act (ACA).

The figure represents 14.1 million working-age adults, as well as another 2.3 million young adults that gained coverage from the provision allowing them to remain on their parents' group health plans starting with the 2011 plan year. However, HHS did not identify how many of the 14.1 million were enrolled in the new health insurance Marketplaces or Medicaid.

According to the HHS report, the coverage expansion has resulted in the largest reduction in the nation's uninsured rate over the past 40 years. The uninsured rate for working-age adults has fallen from 20.3 to 13.2 percent just since the Marketplaces opened in October 2013.

The HHS figures are similar to those identified last week by the Congressional Budget Office (see Update for Weeks of March 2nd and 9th), which found that the ACA had reduced the number of uninsured under the age of 65 by 17 million (to a total of 35 million).

HHS stressed that the coverage expansion has dramatically reduced ethnic disparities in uninsured rates. For example, the average uninsured rate among African-American adults is now roughly the same as for all adults (13.2 percent) and dropped from 41.8 to 29.5 percent among Latino-Americans.

Urban Institute finds that numbers of individual plan cancellations were overstated

A report issued last week by the Urban Institute concluded that only about 400,000 individual health plan subscribers had their coverage canceled for 2014, far less than the five million that were initially feared.

The political fallout over reports that full Affordable Care Act (ACA) implementation caused most insurers to cancel non-compliant individual policies ultimately forced the Obama Administration to allow state insurance commissioners to continue ACA-deficient plans through 2016, at their discretion (see Update for Weeks of March 17 and 24, 2014). As a result, Urban Institute researchers found that only about 2.2 percent of individual plan subscribers actually lost their coverage, compared to the 19 percent that the Urban Institute reported in a December 2013 survey.

The same Health Reform Monitoring Survey found that only about 0.3 percent of all subscribers in employer-sponsored coverage (or 500,000 people) had their plans canceled instead of being upgraded to ACA standards.

Urban Institute researchers noted that many media outlets including the Associated Press reported that "millions of Americans who buy their own health insurance" were notified by their insurers that their plans would be canceled. However, the survey showed that only about eight percent of individual plan subscribers ever received such a notice.

Study says higher drug utilization within Marketplaces is likely to be temporary

A new report released this week by Prime Therapeutics shows that prescription drug utilization among consumers in the state-based Marketplaces (SBMs) created pursuant to the Affordable Care Act (ACA) was significantly higher than those enrolled in other private plans.

The survey of Blue Cross and Blue Shield (BCBS) plans participating in the 14 SBMs revealed that the average age of SBM consumers was 42.6 years compared to 34.7 years in the private market, with a 13.6 percent difference in the drug utilization rate among SBM consumers (resulting in average medication costs that were $3 higher than the private market).

Prime Therapeutics, the second largest pharmacy benefit manager in the 2014 Marketplaces, stated that the findings confirm "initial expectations that public exchange members would be, on average, older and have more health care needs than our commercially insured members." However, researchers were surprised at the exceptionally high usage of costly HIV and Hepatitis C medications, which respectively accounted for nine and ten percent of all Marketplace drug costs compared to only three and four percent among the private market.

Company officials attributed the higher usage to "significant unmet needs" and expect that this "bubble of sicker-than-average people" will dissipate over time and "start to look more and more like the average U.S. population."

According to Prime Therapeutics (which is owned by several BCBS companies), they were the second-largest pharmacy benefit management company on the exchanges in 2014, behind St. Louis-based Express Scripts.

HEALTH CARE COSTS

Credit agencies to provide more flexibility regarding medical debt

The three major credit reporting agencies agreed to a policy change last week that will help consumers resolve medical debts before they are added as a delinquent account on their credit report.

Equifax, Experian and TransUnion agreed to the changes in order to settle a complaint filed with the New York Attorney General. However, they will apply for consumers nationwide.

The new policy specifically creates a 180-day waiting period before medical debt is added to an individual's credit report, giving consumers time to work with health insurers to determine whether the debts are valid. In addition, the agencies will promptly remove delinquent accounts from credit reports once they are satisfied, unlike other debts that can remain on credit reports for years afterwards.

According to the Consumer Financial Protection Bureau, medical debt accounts for more than half of all collection items on credit reports. Roughly half of all consumers with reported medical debts have otherwise clean credit reports with no history of delinquent accounts.

The move comes as a Centers for Disease Control and Prevention (CDC) report finds that the percentage of "near-poor" families that report difficulty paying their medical bills actually fell precipitously during the six months following full implementation of the Affordable Care Act in 2014.

CDC defines "near poor" as families earning 100-200 percent of the federal poverty level (FPL). It found that 28 percent of those who are under age 65 and belong to "near poor" families were unable to pay certain medical bills during the first half of 2014, compared to just under 33 percent during all of 2013.

The rate of all families having difficulty paying medical bills also fell during this time from 19.4 to 17.8 percent (and 33.2 to 31.2 percent among the uninsured).

Most households lack enough "liquid savings" to pay health insurance deductibles

A Kaiser Family Foundation report released this week warns that only about a third of non-elderly households in the United States have sufficient "liquid savings" to pay the annual mid-range deductible for private health insurance plans.

The study used data from the Federal Reserve to compare liquid financial assets for households with the typical cost-sharing imposed by health plans offered by employers, Affordable Care Act (ACA) Marketplaces, or the individual market. Researchers found that only 32 percent of lower-income households (those earning 100-250 percent of the federal poverty level) have sufficient savings in bank accounts, certificates of deposit, stocks, or other "liquid" resources to cover an annual deductible of $1,200 for individuals or $2,400 for families. Furthermore, only 20 percent can pay deductibles of $2,500 for individuals or $5,000 for families.

Even 62 percent of households with moderate incomes (250-400 percent of poverty) struggle to pay a mid-range deductible, according to the study. Because cost-sharing subsidies under the ACA are only available to those earning 100-250 percent of poverty, researchers warn that this roughly half of this group are likely for forgo needed care if they cannot borrow money to cover their plan cost-sharing.

STATES

Arizona

Court sets date for Medicaid expansion challenge

The Maricopa County Superior Court will hear arguments on July 10th on whether the Arizona's Medicaid expansion under the Affordable Care Act (ACA) was constitutionally enacted.

The Arizona Supreme Court unanimously ruled earlier this year that Republican lawmakers had standing to challenge the expansion (see Update for Week of January 5th). Governor Jan Brewer (R) had strong-armed a budget through the legislature included funding for the expansion, only by following through on her threat to veto all other legislation until a handful of Republicans joined with Democrats to provide a bare majority (see Update for Week of June 10, 2013).

At least 36 Republican lawmakers filed suit, insisting that the hospital assessment used to fund the state's share of the expansion was a tax that required a two-thirds supermajority. However, the Superior Court dismissed their claim for lack of standing, since lawmakers are not directly impacted by the program expansion (see Update for Week of February 10, 2014). The court has now been directed by the Supreme Court to determine the merits of the case.

Governor Brewer was term-limited and new Governor Doug Ducey (R) has yet to indicate whether he will continue to defend the suit. However, he did appoint a vocal critic of the expansion to serve as policy advisor for healthcare and human services (see Update for Week of January 5th).

Arkansas

New law prohibits state control of Marketplace without legislative approval

New Governor Asa Hutchinson (R) signed S.B. 343 this week, which prevents the Arkansas Health Insurance Marketplace from converting to full state control as planned on July 1st absent the approval of the General Assembly.

The Arkansas Marketplace is one of seven that have operated as federal-state partnership since opening in October 2013. State officials are asking the federal government for permission to become a fully state-based Marketplace (SBM) on July 1st, an application that is expected to be approved by the Obama Administration in order to protect against the loss of any ACA subsidies.

The U.S. Supreme Court is presently considering whether to invalidate the subsidies for consumers in federally-facilitated Marketplaces (see Update for Weeks of March 2nd and 9th). It is not yet clear whether such a ruling would likewise apply to state partnership Marketplaces (SPMs) like Arkansas, but converting to a SBM would preserve the subsidies either way.

S.B. 343 effectively puts the decision whether to convert to a SBM in the hands of the General Assembly instead of Governor Hutchinson. It specifically prohibits any conversion to a SBM until after the U.S. Supreme Court rules in June, and then would allow it to occur only with legislative authorization.

Similar legislation is pending in the Tennessee legislature (S.B. 72 and H.B. 61).

California

Lavish spending unrelated to patient care causes Blue Shield to lose non-profit status

The Franchise Tax Board formally revoked the tax-exempt status for Blue Shield of California this week in a move that could force the non-profit insurer to return billions of dollars in back taxes and consumer refunds.

According to the *Los Angeles Times*, the decision set "shock waves" through the health insurance industry in California, as Blue Shield is a dominant insurer in the state with more than 3.4 million consumers, $13.6 billion in annual revenue, and $4.2 billion in reserves. Blue Shield officials stated that the insurer would continue to operate as a non-profit while the decision is being appealed and has no immediate plans to rebate or lower premiums.

The decision followed a lengthy audit by the Franchise Tax Board, which claimed the $4.2 billion reserve fund was more than four times that amount allowed under state law and showed the insurer's intent to operate as a for-profit company. Citing the insurer's decision to purchase $2.5 million skyboxes at new sporting venues instead of using reserves to reduce premiums, the board concluded that Blue Cross was no longer "living up to [the standards] of a charitable mission that deserves tax exemption."

Consumer advocates like Health Access California and Consumer Watchdog praised the move insisting that subscribers should not be subsidizing such lavish spending.

Florida

Second Senate committee approves Medicaid expansion alternative

The Senate Health and Human Services Appropriations subcommittee unanimously approved a plan this week that would provide private health coverage to roughly 800,000 Floridians made eligible for Medicaid under the Affordable Care Act (ACA).

Under S.B. 7044, coverage within the newly-created Florida Health Insurance Affordability Exchange (FHIX) would be available those earning up to 138 percent of the federal poverty level (FPL), instead of just a partial expansion advanced by the Senate Health Policy Committee (see Update for Weeks of March 2nd and 9th). However, those earning above the threshold for ACA subsidies at 100 percent of FPL would be charged a $25 monthly premium, while monthly premiums would range from $3-20 at lower income levels. Cost-sharing would be limited to five percent of annual income. However, those that fail to pay required premiums within 30 days could be moved to inactive status for at least six months unless they can demonstrate "hardship".

FHIX enrollees must be provided a choice of at least two ACA-compliant plans. The FHIX must also include Medicaid managed care, Florida Healthy Kids SCHIP, and employer-sponsored plans.

The model advanced by the subcommittee is similar to the Medicaid expansion alternative the federal government recently approved for Indiana (see Update for Weeks of January 26th and February 2nd), including health savings accounts that can still be accessed by inactive enrollees. The accounts accept state-provided premium credits and allow for contributions from enrollees or third parties.

S.B. 7044 also includes work requirements intended to attract support from the more conservative House that has adamantly opposed any form of ACA expansion. For example, applicants must provide proof of employment, on-the-job training or placement activities or document that they are pursuing educational opportunities at a minimum hourly level. Parents with children under the age of 18 would have a minimum requirement of 20 hours per week, while childless adults would have a minimum requirement of 30 hours per week. However, the federal government has consistently rejected similar work requirements in expansion alternatives sought by Indiana, Pennsylvania, Tennessee, and Utah (see Update for Weeks of January 26th and February 2nd).

The bill includes an automatic termination should the promised federal funding under the ACA not materialize. It explicitly states that "FHIX is not an entitlement and state and federal funding may end at any time."

The conservative group Americans for Prosperity and the National Federation of Independent Business testified against the plan, urging lawmakers to reject any federal matching funds that the ACA provides to expand Medicaid. However, chair Rene Garcia (R) and other Republican lawmakers pointed out that Florida routinely accepts federal funds for health care, education, transportation, and other projects, including roughly $1 billion per year in uncompensated care funding through the Low-Income Program (LIP) that the federal government will not renew after June 30th (see Update for Weeks of February 9th and 16th). Senate Health Policy chair Aaron Bean (R) insisted that S.B. 7044 would give Florida the flexibility it needs to respond to the likely loss of these funds if the federal government does not reverse its decision.

Kansas

Governor softens opposition to Medicaid expansion

Governor Sam Brownback (R) stated last week that he will consider bills that expand Medicaid under the Affordable Care Act (ACA), so long as lawmakers identify a mechanism to fully-fund the state share of costs.

The Governor's remarks to insurance agents contrasted sharply with his adamant stance against any form of expansion during his re-election campaign last fall. Governor Brownback has been under intense pressure from hospitals and other provider groups urging the state's participation in the ACA expansion once the ACA starts phasing-down federal funds for indigent care starting in 2017.

The Governor specifically referenced one of two "private sector" expansion alternatives already pending in the House, which is modeled after alternate plans federally-approved for six states. The measure sponsored by Rep. Tom Sloan (R) would cover the state's share of expansion costs via a levy on Medicaid-participating providers.

A separate measure (H.B. 2319) introduced by the House Appropriations Committee is currently pending in the House Health and Human Services Committee and would expand coverage through unspecified options to roughly 115,000 Kansans earning up to 138 percent of the federal poverty level.

Under the ACA, the federal government is assuming 100 percent of Medicaid expansion costs through 2016. However, this will phase down to 90 percent by 2020, meaning that Kansas will have to eventually assume ten percent of all expansion costs.

Minnesota

Governor proposes taskforce to debate federal control over Marketplace

The House Health and Human Services Reform Committee approved a measure this week on a straight party-line vote that would require the MNSure health insurance Marketplace to transition from state to federal control.

The bill (H.F. 1664) is the latest in a series of Republican-backed measures to alter or eliminate the Marketplace (see Update for Weeks of March 2nd and 9th), which has been beset by software and technological snafus that have limited enrollment despite premiums that continue to rank among the nation's lowest (see Update for Week of January 12th). Governor Mark Dayton (D) tried to head-off the momentum that has gained traction in the Republican-led House by proposing this week to create a task force to study proposed structural changes to MNSure, including a federal takeover.

Senator Tony Lourey (D), who has proposed several measures to increase MNSure oversight, pointed out that moving to a federally-facilitated Marketplace would be out of the question in the short-term as it could dramatically increase MNSure premiums should the U.S. Supreme Court void ACA subsidies for Marketplace insurers in June (see Update for Weeks of March 2nd and 9th). Lourey is already backing a separate bill to create a 26-member Health Care Innovation Task Force to advise the governor and the legislature on innovative strategies to increase access and quality for health coverage within the state (S.F. 1275). It cleared a Senate committee this week.

Montana

Committee approves catastrophic-only alternative to Medicaid expansion

The House Human Services Committee passed H.B. 528 this week on a party-line vote. The legislation sponsored by chair Art Wittich (R) would provide $35 million in state funds to offset some of the uncompensated care costs incurred by hospitals for cancer patients or other catastrophic care. It is intended to serve as a limited alternative to passing some form of Medicaid expansion under the Affordable Care Act (ACA), which the committee rejected earlier this month (see Update for Weeks of March 2nd and 9th).

Governor Steve Bullock (D) and his Medicaid director scoffed at Wittich's alternative, which would require beneficiaries first incur $10,000 of medical debt and would apply to only about 1,600 childless adults earning below poverty (compared to the 65,000 Montanans that would have gained coverage through his Medicaid expansion plan). The panel passed a procedural rule barring any consideration of the Governor's bill (H.B. 349) without a three-fifths supermajority. However, an alternative being drafted by Senator Ed Buttrey (R) based on the federally-approved Indiana model is expected to heard later this month by the committee.

New Hampshire

House Republicans threaten to terminate Medicaid expansion in 2017

The House Finance Committee voted along party lines last week to strip all funding for the Health Protection Program from the budget plan for fiscal year 2016-2017.

New Hampshire is just one of six states with a federally-approved alternative to the Medicaid expansion under the Affordable Care Act (ACA). Its version (the Health Protection Program) was approved last year by the Republican-controlled Senate after a contentious two-year debate and went into effect on August 15th (see Update for Week of September 29th).

The waiver that Governor Maggie Hassan (D) negotiated with the Obama Administration allows the state to ACA matching funds to cover the newly-eligible population in either Medicaid managed care plans or (when cost effective) in private plans offered by the state partnership Marketplace. However, in order to attract sufficient Republican support, the Governor had to include a sunset clause requiring legislative reauthorization after 2016.

Republicans gained control over both chambers last fall (see Update for Week of November 3rd) and House conservatives now appear intent on terminating the expansion, despite its popularity (enrolling nearly 37,000 of the 50,000 residents expected to be eligible). However, the conservative group Americans for Prosperity is heavily lobbying Republican lawmakers to "stop selling tickets on the Titanic", insisting that "expanded Medicaid is a huge disincentive for people to work" and "benefits people who are underserving of charity."

Under the ACA, the expansion is fully-funded by the federal government through 2016, but the federal share starts phasing down to 90 percent from 2017-2020. Governor Hassan projected the state share of costs for 2017 to be $12 million.

Oregon

Senate panel weighs two bills to increase transparency for prescription drug prices

The Senate Health Care Committee is considering two bills that would give consumers more information about prices for prescription drugs.

The first measure (S.B. 891) would require hospitals and health care facilities to post prices for the 100 most common inpatient and 100 most common outpatient services in Oregon. Sponsored by Senators Elizabeth Steiner Hayward (D) and Brian Boquist (R), it would also mandate that facilities list charges billed to insurers and uninsured patients, as well as the amount allowed by various payers. Facilities that fail to timely respond to patient inquiries about billed charges could be subject to sanctions that include license revocation.

A hearing was scheduled this week on a separate bill (S.B. 900) that would require the Oregon Health Authority to post median prices for the 50 most common inpatient procedures and the 100 most common outpatient procedures for hospitals and outpatient clinics. It has the backing of the Oregon Association of Hospitals and Health Systems, which offered to provide subscribers with estimates on out-of-network costs.

The House Health Care Committee heard unrelated legislation this week (H.B. 3486) that would require drug manufacturers with annual wholesale acquisition costs of at least $10,000 (or with wholesale acquisition cost of at least $10,000 per course of treatment) to file annual reports with the Oregon Health Authority on costs associated with prescription drugs for the previous calendar year.

South Dakota

Governor signs drug transparency bill into law

Governor Dennis Daugaard (R) signed S.B. 118 into law last week, which makes South Dakota the latest state to increase public transparency of provider networks and prescription drug coverage offered by private health plans.

As with pending legislation in California (see Update for Week of January 19th), S.B. 118 requires that provider network lists be published online and updated at least every six months. Effective January 1st, plans must also include a description of drug formulary provisions and enrollee financial responsibility, as well the process for requesting an exception to the formulary (see Update for Weeks of January 26th and February 2nd).

West Virginia

Legislature passes bill requiring greater transparency for Marketplace plans

Governor Earl Ray Tomblin (D) signed S.B. 366 into law last week, which will make information about qualified health plans (QHPs) in the state partnership Marketplace to be more publicly accessible.

Sponsored by Senator Ryan Ferris (R), the law requires the Insurance Commissioner to post specific details on the agency website detailing the names of network physicians and providers, all coverage exclusions and restrictions on covered benefits, and information sufficient for consumers to determine whether a specific drug is covered under the plan formulary. Effective June 9th, QHPs must also detail the amount of copayments or percentage coinsurance for which consumers may be responsible (for each item or service), how drug costs will be applied to deductibles, and the out-of-pocket costs that may not be applied to deductibles.