Health Reform Update – Weeks of January 11 and 18, 2016

CONGRESS

Supreme Court refuses to hear ACA challenge based on origination clause

The U.S. Supreme Court refused this week to intervene in the latest procedural challenge to the Affordable Care Act (ACA) that was rejected by two lower courts.

The lawsuit was initially brought by the libertarian Pacific Legal Foundation, claiming that the ACA statute is invalid because it did not originate in the House, as the U.S. Constitution requires for bills whose primary purpose is to raise revenue through taxes. A three-judge panel for the U.S. Court of Appeals for the District of Columbia rejected their claim, holding that because the ACA's "paramount" purpose is to increase the number of Americans covered by health insurance and not raise revenue, the origination clause could not be applied (see Update for Week of July 28, 2014). The full D.C. Court of Appeals refused to hear the case, forcing the Supreme Court appeal.

A group of 49 House and Senate Republicans had urged the Supreme Court to reverse the ruling (see Update for Week of December 7th). However, the high court frequently declines to intervene in cases when there is not a split in appellate opinions.

The Supreme Court has agreed to hear a challenge to the ACA's preventive services mandate brought by a group of Catholic nuns objecting to its application to contraceptives.

President's budget to expand incentives for states refusing to expand Medicaid

White House officials confirmed last week that President Obama will seek to sweeten the pot for the 19 states that are still opting-out of the Medicaid expansion under the Affordable Care Act (ACA).

When a Democratic Congress passed the ACA, it offered to pay 100 percent of state expenses through 2016, phasing down to 90 percent in 2020 and subsequent years. With the addition of Louisiana (see below), 31 states and the District of Columbia have accepted the offer before the 100 percent share starts declining next year.

Conservative lawmakers in the 19 states that have opted-out have been under intense pressure from provider groups to accept the ACA funding and expand Medicaid in order to dramatically reduce costs of uncompensated care. As a result, the President will propose to "indefinitely" give opt-out states the same three-years of full federal funding that participating states had from 2014-2016. The extended 100 percent share will be part of his fiscal year 2017 budget scheduled to be released on February 9th.

However, such a proposal will need Congressional approval, which the National Association of Medicaid Directors acknowledged this week is unlikely given the partisan make-up of the current Congress that recently voted to repeal key provisions of the ACA (see Update for Week of January 4th).

Senate committee to break-up House-passed "cures" bill

The chairman of the Senate Health, Education, Labor and Pensions (HELP) Committee announced this week that the panel intends to break-up the *21st Century Cures Act* into separate bills.

The House overwhelmingly passed the expansive bill (H.R. 6) last summer (see Update for Weeks of June 29th and July 6th). It is intended to facilitate the development of breakthrough cures for rare disorders by removing regulatory obstacles and providing enhanced funding, primarily to the National Institutes of Health (NIH).

However, HELP chairman Lamar Alexander (R-TN) has always favored a scaled back version of the legislation given the difficulties in forming any bipartisan consensus about how to fund the initiatives, causing the House-passed package to be stalled in committee (see Update for Week of July 20th). Breaking up the larger bill into smaller pieces is intended to facilitate passage of at least the more popular provisions.

The committee will hold three mark-ups over the next several months to consider measures that would expedite the Food and Drug Administration approval of breakthrough products and clinical trials through NIH. The first is scheduled for February 9th, during which seven bipartisan bills will be heard.

MedPAC recommends ten percent rate cut for Part B drugs furnished to 340B providers

Commissioners on the Medicare Payment Advisory Commission's (MedPAC) voted this week to approve a controversial recommendation that would reduce payment rates by ten percent of the Average Sales Price (ASP) for Medicare Part B drugs furnished to safety net providers participating in the federal 340B drug discount program.

The recommendation, which will be part of MedPAC's March report to Congress, was opposed by three commissioners with hospital backgrounds. They sided with the American Hospital Association and other provider and physician groups who argued that the cuts served only to benefit the pharmaceutical industry and moved MedPAC into an arena that was not part of their designated mission.

However, the other 14 commissioners continued to cite concerns about the 340B program unintentionally spurring hospital acquisitions of physician practices and thus increasing costs for Medicare (see Update for Week of December 7th). In addition, they were persuaded by briefing materials concluding that 340B hospitals were not sufficiently using drug savings to expand community services. This includes an Avalere Health study showing that 40 percent of 340B hospitals provided less than the national median share of uncompensated care (see Update for Week of March 23rd),

Members of Congress have increasingly called for greater oversight and accountability for the 340B program since federal auditors claimed in 2011 that participating providers were reaping "windfall profits" when using discounted 340B drugs to also treat Medicare or private insurance patients (see Update for Weeks of July 1 and 8, 2013). A Government Accountability Office report earlier this year found that Medicare Part B drug spending was substantially higher per beneficiary at 340B hospitals than at non-participating hospitals and recommended that Congress consider eliminating financial incentives for 340B providers to overprescribe (see Update for Weeks of June 29th and July 6th).

FEDERAL AGENCIES

Average premiums increase by nine percent for federal Marketplace consumers

The latest figures released by the Department of Health and Human Services (HHS) shows that the average 2016 premium for consumers in the federally-facilitated Marketplace (FFM) increased to $408 as of December 26th, an increase of nearly nine percent from 2015.

The press release from HHS largely emphasized that the average premium tax credit received by 83 percent of FFM enrollees has also increased by 9.7 percent to $294 (or 72 percent of the pre-credit premium), meaning that the average share of premiums that enrollees pay is only $113—a 7.6 percent

increase from a year ago. According to HHS, nearly 60 percent of FFM enrollees can still purchase a plan that charges premiums of less than $50 per month after tax credits are reflected.

The report also stressed that the 60 percent of returning FFM customers who switched plans saved an average of $43 per month on their premiums.

With only two weeks left in the 2016 open enrollment period, more than 8.8 million FFM consumers had their coverage renewed or signed-up through the FFM portal (with more than 1.3 million entering through the Spanish language version). The FFM portal is currently being used in 38 states.

Florida continues to far outpace other FFM states with more than 1.6 million enrollees. Texas is the only other FFM state with more than one million (signing-up 1.1 million through January 16th). North Carolina is third with just under 570,000 enrollees followed by Georgia with nearly 536,000.

Among metropolitan areas, Miami-Fort Lauderdale signed-up nearly 600,000 FFM consumers, well ahead of the nearly 405,000 enrollees in Atlanta and 341,000 in Dallas-Fort Worth.

Another 2.5 million enrollees have signed-up through the state-based Marketplaces in 12 states and the District of Columbia.

CMS eliminates six special enrollment periods in response to insurer complaints

The Centers for Medicare and Medicaid Services (CMS) announced this week that it will eliminate six of the more than 30 special enrollment periods (SEPs) that allow consumers to enroll in qualified health plans (QHPs) outside of the annual open enrollment period.

CMS officials acknowledge the move is in response to pressure from Marketplace insurers, who believe SEPs are creating a "moral hazard" by letting many consumers wait until they are sick to purchase coverage. America's Health Insurance Plans and the Blue Cross and Blue Shield Association had insisted that SEPs were being "easily gamed" by consumers that tend to utilize more health services. They argued that the SEPs thus limited enrollment below their initial projections, which purportedly caused insurers like UnitedHealthCare to lose more than $720 million on Marketplace business, forcing it to re-evaluate whether to continue participating in roughly two dozen Marketplaces for 2017.

A recent survey of Connecticut insurers by Wakely Consulting Group appeared to validate these concerns as it showed that special enrollment subscribers had "significantly higher health care costs" and were more likely to drop coverage within three months. These results persuaded the state-based Marketplace in Connecticut to also tighten its rules on special enrollment.

SEPs that CMS has deemed no longer necessary include those that allowed consumers to enroll if a redundant or duplicate policy (or system error) resulted in inaccurate premium tax credits, an error was made in the treatment of Social Security Income for tax dependents, Marketplace errors delayed the processing of applications for those below the income eligibility level for tax credits, or those eligible or enrolled in COBRA who were not informed of their coverage options. The SEP for consumers previously enrolled in the temporary Pre-Existing Condition Health Insurance Program (PCIP) high-risk pools prior to 2014 will also be eliminated.

CMS previously terminated the SEP that had been created for those not aware they were subjected to individual mandate penalties under the Affordable Care Act until filing their taxes (see Update for Week of December 7th).

The announcement also clarifies that the currently available SEP for those who have permanently changed their residence "cannot be used for a short-term or temporary move where the consumer doesn't

plan to stay in their new location, including situations in which a consumer is admitted to a hospital for treatment in a different area."

The agency notes that it may issue additional guidance if other needed modifications or clarifications of SEPs are determined to be necessary. The announcement does not impact the traditional SEPs that are available to most health insurance consumers for major life changes such as marriage, divorce, the birth of adoption of a child, or the loss of minimum essential coverage. However, CMS officials stated that the most frequently used SEPs such as those for losing MEC and permanently relocating will be "under the microscope" to determine whether they are being abused.

Insurer participation in ACA Marketplaces remains stable for 2016

An analysis of 17 state-based Marketplaces (SBMs) released this week by The Commonwealth Fund finds that the number of participating insurers has remained largely stable or increased for 2016 despite the failure of most of the non-profit cooperatives created by the Affordable Care Act (see below).

The study found that nine of the 17 SBMs (which include states like Hawaii, Idaho, Nevada, and Oregon that are defaulting to the federal web portal) are experiencing no net change in the number of participating insurers for 2016 while three are experiencing a net gain. Five SBMs saw a slight decline, due to either a cooperative liquidation or a decision by a small insurer named Assurant Health to exit the individual market entirely (see Update for Weeks of June 8th and 15th). However, researchers stress that the number of Marketplace insurers increased dramatically from 2014 to 2015 (see Update for Week of September 22, 2014) and every other insurer that waited until 2015 to enter the Marketplaces decided to remain for 2016.

The Commonwealth Fund noted that the Obama Administration previously reported similar rates of participation within the federally-facilitated Marketplace. However, they specifically credited additional rules imposed by several SBMs for fostering additional competition. For example, California limits future participation for insurers that leaves the Marketplace. Maryland requires insurers to participate in the Marketplace if they want to offer non-Marketplace plans for individual market consumers.

CMS seeks to recoup funds from failed CO-OPs

The acting Administrator for the Centers for Medicare and Medicaid Services informed the Senate Finance Committee this week that the agency is working with the Department of Justice to recover $1.17 billion in Affordable Care Act (ACA) loans to non-profit health insurance cooperatives that ultimately failed.

The ACA initially provided $2.4 billion in start-up loans that were used to create the Consumer Operated and Oriented Plans (CO-OPs) in 23 states before the remaining funding was rescinded by Congress as part of bipartisan deficit reduction agreements (see Update for Weeks of December 24 and 31, 2012). Several CO-OPs used low premiums to attract far more Marketplace consumers than they anticipated and without any additional funding from CMS were unable to rely on premium revenue to pay claims. The Inspector General for the Department of Health and Human Services (HHS) found last year that only one was profitable (see Update for Week of December 7th) while at least 12 have already been liquidated or announced they will close (see Update for Week of November 30th).

Administrator Andy Slaviitt acknowledged that it is unlikely that CMS can recover most of the start-up loans. He did reveal that CMS would conduct a financial audit of the remaining CO-OPs after the 2016 open enrollment period and meet in March with each plan to ensure they can continue to meet their claims obligations despite the $2.5 billion deficit in the ACA reinsurance and risk corridors program that is causing insurers with exceptional claims in 2014 to receive only about 12.6 percent of the amount that CMS is obligated to compensate them (see Update for Week of November 30th). This shortfall directly contributed to the decision of several CO-OPs to terminate their operations.

CMS will be issuing forthcoming guidance to help CO-OPs attract private investors and merger partners. Consumers from failed CO-OPs will still be allowed to enroll in other coverage during a special enrollment period (SEP), even though CMS is eliminating other SEPs (see above).

Officials with the Evergreen Health CO-OP in Maryland urged CMS to cap the amount that CO-OPs have to pay into the ACA risk adjustment program at two percent of revenues, instead of the 15 percent or more that they are currently paying. He insisted that the lack of a cap benefits larger insurers with established capital and limits the ability of start-ups to compete through lower premiums.

Senate Finance Democrats blamed partisan politics for the demise of the 12 CO-OPs, as well as federal rules limiting the marketing and outreach efforts they can undertake. Republicans instead claimed the failures were largely due to a lack of oversight by CMS.

IRS says 1.4 million households failed to properly account for ACA subsidies

The Internal Revenue Service (IRS) disclosed last week that about 1.4 million households or 30 percent of those receiving advanceable premium tax credits under the Affordable Care Act (ACA) during 2014 failed to accurately reflect that amount on their federal tax returns.

IRS officials found that of the roughly 316,000 households that failed to file any tax return for 2014 were likely to be low-income individuals that typically are not required to file tax returns and did not realize that accepting ACA subsidies now required them to do so. Another 976,000 households did not submit the new Form 8692 that is required to reconcile tax credits with actual income during the year and determine if subsidy recipients were overpaid. The remaining 147,000 households requested an extension from IRS to file this form yet never did so.

The agency emphasized that the 1.4 million households failing to accurately reflect their subsidy amounts technically forgo the option to have their subsidies “advanceable”. This means they will no longer be paid by IRS directly to the insurer. Instead, the subsidies will be “refundable” meaning the consumer pays the entire premium upfront and has the tax credit refunded to them when they file their federal tax return.

However, IRS officials stated that due to first-year confusion about the process the agency is likely to only terminate advanceable tax credits for recipients who failed to file any 2014 return.

Gallup survey shows uninsured rate plateaued in 2015

The share of uninsured adults remained essentially the same nationwide during 2015, according to the latest Gallup-Healthways polling data released this week.

The telephone survey of nearly 43,000 adults conducted over the last three months of 2015 showed that 11.9 percent remained uninsured, a figure that was largely unchanged since January 2015 despite a brief drop to 11.4 percent from April to June. The increase in late 2015 was the first climb in the uninsured rate that Gallup recorded since full implementation of the Affordable Care Act (ACA) in 2014.

Gallup researchers concluded that the results appear to validate “concerns that similarly large reductions may not be possible in the future because the remaining uninsured are harder to reach or less inclined to become insured." However, researchers still predict another decline in the uninsured rate during the first three months of 2016 due to a “strong open enrollment period” that ends January 31st, although they acknowledge they are unsure whether the decline will be significant.

Previous Gallup surveys have shown that the uninsured rate for working-age adults dipped to 11.7 percent during the first half of 2015, which is a one-third reduction from 2013 (see Update for Week

of August 10th). Surveys completed by the Centers for Disease Control and Prevention (CDC) found that the overall uninsured rate fell to 9.2 percent nationwide by March 2015, which is the lowest level ever recorded by the agency.

Uninsured rate among Latino children hits record low

A new report released this week by the Georgetown University Health Policy Institute and National Council of La Raza show that the uninsured rate among Latino children fell to the lowest level ever recorded in 2014, even though it remains disproportionately higher than other populations.

Roughly 300,000 Latino children gained coverage during the first year of full implementation of the Affordable Care Act (ACA), dropping the uninsured rate among this group by two full percentage points (to 9.7 percent). This is a steeper decline than among all children, whose uninsured rate fell from 7.1 percent to six percent.

Researchers note that much of the gain among Latino children occurred in states that expanded Medicaid, particularly California. Nationwide, the uninsured rate among Latino children averaged only seven percent in expansion states compared to 13.7 percent in opt-out states. The uninsured rate among Latino children in two of these opt-out states (Georgia and Texas) broke 15 percent, while Arizona and Florida were slightly below average at 12.7 and 12.1 percent respectively.

According to the report, Latino children represented 39.5 percent of the nation's uninsured children in 2014 even though they constitute only 24.4 percent of all children under age 18. More than 30 percent of all uninsured Latino children reside in the state of Texas.

Supreme Court ruling cuts number of "pay-to-delay" drug settlements by nearly half

The Federal Trade Commission (FTC) released new figures this week showing that the number of "pay-to-delay" patient litigation settlements between brand-name and generic drugmakers have been cut by nearly half since the U.S. Supreme Court ruled they could be anti-competitive and subject to antitrust scrutiny.

The FTC had crusaded for nearly a decade to declare the settlement agreements "presumptively illegal" unless the parties could demonstrate no adverse impact on competition (see Update for Week of March 25, 2013). The agency insists such settlements cost consumers $3.5 billion per year in higher drug prices and delays entry of lower-cost generic competitors by an average of 17 months.

Although the Supreme Court agreed that the agreements could unlawfully hinder competition, five of the nine justices decided instead to put the burden on the FTC to prove on a case-by-case basis that the settlements restrict competition (see Update for Week of June 17, 2013). However, according to the FTC, this "partial victory" was sufficient to cut the number of "pay-to-delay" settlements to 21 in federal fiscal year 2014, down from a record high of 40 in 2012.

STATES

Florida

House Speaker backs bills to eliminate KidCare waiting period for legal immigrants

House Speaker Steve Crisafulli (R) called last week for Republican lawmakers to support long-sought legislation that would eliminate the waiting period that prevents children of legal immigrants from being eligible for Children's Health Insurance Program (CHIP) coverage for five years.

Rep. Jose Felix Diaz (R), chair of the House Regulatory Affairs Committee, has championed the removal of the waiting period for four years. His bill this session (H.B. 89) is also being pursued in the Senate by Health and Human Services Appropriations chair Rene Garcia (R) via S.B. 248.

Both sponsors acknowledged that an "anti-immigrant" sentiment could still impede passage of the legislation, but insisted that the Speaker's support for the "good bill" was a critical step forward. However, the price tag (estimated at $1.7 million in state revenue for an additional 17,000 children) remains an obstacle for many Republican lawmakers.

Senate committee advances price transparency legislation

Health committees in the Senate and House passed legislation this week that seeks to make consumers better purchasers of health care.

The measures (S.B. 1486 and H.B. 1175) would create a state website that lets consumers identify the price for an episode of non-urgent treatment prior to seeking care from a physician, hospital, ambulatory surgery center, or medical equipment supplier. Such estimates should be posted "in plain language…comprehensible to an ordinary layperson." Providers also must provide patients with a list of anticipated charges within seven business days of a written request.

The senior policy adviser for Senate President Andy Gardiner (R) stated this week that the website would be built by the non-profit Health Care Cost Institute at a state cost of $2.7 million.

The measures unanimously cleared the Senate Health Policy Committee and House Select Committee on Affordable Health Care Access. They now move on to their respective appropriation committees.

Passage came shortly after lawmakers received a final report from Governor's Commission on Healthcare and Hospital Funding, which wrapped up eight months of hearings on hospital payment issues by recommending that the legislature give consumers the ability to make educated purchasing decisions by requiring providers to given them advance information on costs. The lack of price transparency is frequently cited by economists as a primary reason why market-based reforms often do not succeed in lowering health care costs as "the laws of supply and demand don't apply to the health industry".

The Commission agreed with this finding, concluding that ""healthcare as an industry does not currently fit the definition of a free-market system." Senator Ron Bradley (R) concurred, insisting that his bill (S.B. 1496) "will create for the first time an actual marketplace" and pushing for penalties against hospitals that overcharge consumers and assert confidentiality over the amounts they are actually paid for specific services. Provisions in the bill would allow consumers to receive assistance from the state's Insurance Consumer Advocate in appealing charges they believe were billed unfairly.

Transparency bills in states like Colorado (H.B. 1102), New York (S.B. 5338), and Virginia (S.B. 487/H.B. 1113) would go a step further by requiring drug manufacturers to report certain wholesale acquisition costs. Democratic lawmakers in California backed-off efforts to resurrect comparable legislation from last year (A.B. 463) when it became evident that it lacked the needed ten votes to clear the Assembly Health Committee.

House committee approves legislation limiting "surprise" out-of-network bills

The House Insurance and Banking subcommittee cleared legislation last week (H.B. 221) backed by the Insurance Consumer Advocate within the Department of Financial Services that would prohibit "surprise" medical bills from out-of-network providers contracted with an in-network facility. The measure would apply only for non-emergency services.

Comparable bills have proliferated in state legislature over the past year after New York enacted the nation's most comprehensive prohibition last spring against surprise out-of-network bills for both emergency and non-emergency services. The Pennsylvania Insurance Commissioner is encouraging the legislature in her state to enact a similar prohibition that would limit subscriber costs to in-network rates.

According to the Kaiser Family Foundation, nearly seven out of ten consumers with unaffordable out-of-network bills were not informed that their provider was out of their plan's network at the point of service.

Kentucky

New Governor seeks federal approval to dismantle ACA Marketplace

New Governor Matt Bevin (R) notified the Obama Administration last week that he plans to follow-through on campaign promises to dismantle the Kynect health insurance Marketplace that his predecessor created pursuant to the Affordable Care Act (ACA).

Kentucky is one of only 12 states that created their own Marketplace instead of defaulting to the federally-facilitated model. It was also one of the most successful, avoiding many of the technological glitches and software failures forced other state-based Marketplaces to default to the federal web portal.

The change will not take effect until the 2017 open enrollment period. However, it will cost Kentucky around $23 million to transition to the federal model and result in higher user fees for Kynect insurers (3.5 percent under the federal model compared to only one percent under Kynect). Former Governor Steve Beshear (D) pointed out last month that this will result in higher premiums for Kynect subscribers, who will also no longer be served by a local network of consumer representatives nor have one streamlined portal for both Medicaid and qualified health plan coverage (see Update for Week of November 30th).

Governor Bevin insisted that it was a "redundancy" for Kentucky to operate its own Marketplace and objected to Governor Beshear creating Kynect via an executive order without legislative support (see Update for Week of July 16, 2012).

The new Governor has backtracked from his pledge to likewise terminate the Medicaid expansion authorized by Beshear. He instead will issue a proposal by mid-2016 to replace the traditional expansion with a federally-approved "private sector" alternative that is favored by conservative lawmakers (see Update for Week of January 4th).

Minnesota

Governor's task force recommends that Minnesota stay with state-based Marketplace

The Health Care Financing Task Force created last year by Governor Mark Dayton (D) has rejected a proposal from Republican lawmakers to transition the MNSure health insurance Marketplace from state to federal control.

MNSure has been beset by software and technical failures that have depressed enrollment far below expectations despite premiums that have been among the nation's lowest (see Update for Week of January 12, 2015). The persistent problems forced state officials to weigh whether to follow the lead of similarly-plagued state-based Marketplaces in Hawaii, Nevada, and Oregon and simply default to the federal web portal (see Update for Week of March 16th).

The Republican-controlled House passed legislation last session that would require a switch to federal control, forcing the Governor to create the 29-member task force to study the issue. However, the panel voted largely along party lines to recommend that the Marketplace remain fully under state control

given the cost of transitioning to the federal portal, although it also recommended that MNSure undergo a full performance audit following the 2016 open enrollment period.

The Task Force also urged the legislature to expand the eligibility criteria for MinnesotaCare, the state-funded program for roughly 120,000 "working poor" that provides basic coverage for those ineligible for either Medicaid or employer-sponsored coverage. The recommendation to raise the maximum eligibility from 200 percent of the federal poverty level to 275 percent would add an estimated 41,200 Minnesotans to the program. MinnesotaCare is funded through a provider tax that is set to expire in 2019 and would require federal approval to renew and expand.

Nebraska

Bipartisan group of lawmakers propose Arkansas-style Medicaid expansion alternative

After three previous attempts to expand Medicaid have failed in the unicameral legislature, a bipartisan group of lawmakers unveiled a new bill this week that would largely mirror the "private option" alternative that was first federally-approved for Arkansas.

The measure introduced by Senator John McCollister (R) and backed by 16 other Republican and Democratic Senators (L.B. 1032) would use federal matching funds under the Affordable Care Act to purchase private Marketplace coverage for the majority of an estimated 77,000 newly Medicaid-eligible adults. The medically frail would remain in Medicaid while the state would provide premium assistance for those adults eligible for employer-sponsored coverage.

The bill proposes to assess premiums up to two percent of income on those earning more than 50 percent of the federal poverty level, although that threshold may need to be raised to 100 percent to secure federal approval for the necessary waiver. The expansion would automatically terminate if the minimum federal share of costs ever dips below the 90 percent level required by the ACA.

According to Senator McCollister, an ACA opponent, the Medicaid expansion would be good for Nebraska businesses because "a healthier population…should result in greater productivity." The Senator cited a University of Nebraska at Kearney study commissioned last year by the Nebraska Hospital Association, which predicted that the expansion would bring in $2.1 billion over the first five years and result in a net gain of $1 billion in economic benefit to the state. This includes the elimination of so-called "silent taxes" paid through higher premiums to cover the cost of the uninsured, a reduction in medical related bankruptcies, and increased consumer spending.

The measure has the backing of Appropriations Committee chair Health Mello (D) but is staunchly opposed by Governor Pete Ricketts (R) and several conservative lawmakers that are opposed to any form of expansion. A very similar measure sponsored last session by Health and Human Services Committee chair Kathy Campbell (R) received only 16 votes (see Update for Weeks of April 6th and 13th).

Virginia

Democratic lawmakers introduce scaled-down bills to limit discriminatory cost-sharing

Senator Rosalyn Dance (D) and Delegate Jennifer McClellan (D) introduced legislation at the start of the legislative session last week that would prohibit health insurers from placing prescription drugs on their highest cost-sharing tier unless at least one prescription drug that is in the same therapeutic class and is a medically appropriate alternative treatment for a given condition is available on a lower cost-sharing tier. The bills (S.B. 442 and H.B. 702) are more limited than the versions both lawmakers sponsored last year that also would have limited cost-sharing obligations for a specialty tier drug to no more than $100 per month for a 30-day supply (see Update for Week of January 19, 2015).

Wyoming

Lawmakers continue to reject Governor's plans to expand Medicaid

For the third year in a row, House conservatives have rejected a request from Governor Matt Mead (R) to expand Medicaid pursuant to the Affordable Care Act (ACA).

As part of his proposed budget, the Governor had asked the legislature to pass a "private sector" Medicaid expansion alternative similar to that federally-approved for seven states including neighboring Montana (see Update for Week of December 7th). He emphasized that projections from the Department of Health show that the state's budget shortfall due to falling oil and gas prices could be largely filled with the $268 million that participating in the Affordable Care Act (ACA) expansion would bring to the state.

However, conservative lawmakers in both chambers have steadfastly opposed any form of Medicaid expansion that accepts federal dollars, including similar private sector alternatives that the Governor proposed last year (see Update for Weeks of February 2nd and 9th). As a result, the Joint Appropriations Committee quickly rejected the Governor's proposal this week. Only a two-thirds majority of the full legislature can override the committee's rejection.