



Health Reform Update – Weeks of February 8 and 15, 2016

CONGRESS

Republicans pre-emptively reject President's plan to cut Medicare spending, curb drug prices

President Obama submitted his \$4.1 trillion budget proposal last week for fiscal year 2017, which seeks to reduce Medicare spending by more than \$470 billion over the next ten years, while reducing prescription drug costs for both Medicare and Medicaid.

The proposals are largely symbolic and intended to frame the debate in an election year as Senate Budget Committee chair Mike Enzi (R-WY) and other Republican leaders took the unprecedented step of refusing to grant a hearing on the President's budget before it was even received. However, even in a non-election year, members of both parties are likely to oppose several of the President's Medicare targets, including his plan to increase cost-sharing burdens by increasing the Part B deductible in years 2020, 2022, and 2024 by \$25 for new enrollees. In addition, income-related premiums would expand for both Part B and D so that individuals with incomes down to \$45,600 would be forced to pay higher premiums (generating \$41.2 billion in "savings" over ten years).

The President repeated calls from his earlier budgets to allow Medicare to negotiate Part D drug prices with manufacturers and also ensure that Medicare receives the same rebates as Medicaid for brand name and generic drugs provided to beneficiaries who receive the Part D Low-Income Subsidy (see Update for Weeks of January 26 and February 2, 2015). He also seeks to "close" the Part D coverage gap by limiting beneficiary coinsurance to 25 percent by 2018 or two years earlier than currently scheduled under the Affordable Care Act (ACA).

Even if Congress would approve the President's cuts, Medicare spending would still jump from nearly \$600 billion in 2017 to \$1 trillion by fiscal 2026, due to the aging of the "baby boomer" population that has already started to swell Medicare rolls.

As with prior years, the President proposed no changes to Social Security payments though he would have increased the Social Security Administration budget by 7.5 percent to help continue to reduce the backlog of claims for the agency's disability programs.

The budget would save an estimated \$5.8 billion over the next decade by creating a negotiating pool through which state Medicaid programs could use their combined bargaining power to leverage greater discounts on prescription drugs. It sought to specifically allow CMS and state Medicaid programs to partner with a private sector contractor to negotiate supplemental drug rebates.

Managed care plans that cover Medicaid and State Children's Health Insurance Program enrollees would also be subject to the same medical-loss ratio that the ACA currently applies to large group plans, which would require plans spend at least 85 percent of premium revenue on medical care or issue consumer rebates. According to the President, that provision alone could generate \$23.5 billion in savings over ten years.

Other provisions targeting drug costs include the President's repeated call to prohibit "pay-to-delay" settlements between brand-name and generic drugmakers, as the Federal Trade Commission (FTC) has sought for a decade. Although such agreements have been halved since the U.S. Supreme



Court ruled they could be subject to antitrust scrutiny, the court has allowed them to continue if the FTC is unable to prove an adverse competitive impact (see Update for Weeks of January 11th and 18th).

The President also still seeks to reduce the exclusivity period for brand-name biologic drugs to seven years, down from the 12 years afforded to manufacturers under the ACA (see Update for Week of March 3, 2014). A 12-nation trade deal that the President submitted to Congress last fall would reduce the exclusivity period down to five years (see Update for Weeks of October 5th and 12th).

Among the first time provisions relating to drug costs are the President's call to give the Department of Health and Human Services (HHS) greater authority to require public disclosure of manufacturer drug costs, including the portion allocated to research and development. Senate Democrats are seeking to include comparable transparency provisions as part of the Senate's counterpart bills to the House-passed *21st Century Cures Act* (see Update for Weeks of January 11th and 18th). Similar transparency bills have proliferated at the state level, though most have faced intense opposition from manufacturer groups and failed to advance through initial committees.

The President also takes-up calls at the state level to standardize billing documents and eliminate surprise out-of-network charges that consumers often face when receiving care from contracted personnel at in-network facilities (see Update for Weeks of January 25th and February 1st).

As expected, the budget would give states that have yet to expand Medicaid under the ACA the same three years of full federal funding that expansion states received, should they ultimately decide to participate. However, since the ACA set the full funding period only from 2014-2016, this change would require unlikely Congressional approval (see Update for Weeks of January 11th and 18th).

The budget also includes the President's previously announced effort to scale back the threshold for the ACA tax on high-cost health plans (see Update for Weeks of January 25th and February 1st). Previous legislation signed by the President delayed the 40 percent "Cadillac" tax by two years until 2020, due to increasing support from Democrats for a full repeal (see Update for Week of January 4th).

FEDERAL AGENCIES

Medicare enrollees have received an average drug discount of nearly \$19.50 thanks to ACA

The Department of Health and Human Services (HHS) announced last week that "nearly 10.7 million Medicare beneficiaries have received discounts over \$20.8 billion on prescription drugs" since the enactment of the Affordable Care Act (ACA). The discounts average \$1,945 per beneficiary or more than double the average discount of \$941 in 2014.

HHS further noted that roughly 39.2 million beneficiaries took advantage of free preventative services in 2015, or 200,000 more than the year prior. The ACA requires that certain preventive care be provided without beneficiary cost-sharing.

ACA reinsurance payments align with expectations, unlike risk corridors shortfall

The Centers for Medicare and Medicaid Services (CMS) announced this week that Marketplace plans will receive \$7.7 billion in reinsurance payments for the 2015 benefit year.

The reinsurance fund is one of three temporary risk mitigation programs created by the Affordable Care Act (ACA). It is meant to stabilize insurance markets during the initial three years of full ACA implementation by compensating insurers that incur an extraordinary number of high-cost claims. For 2015, the threshold for extraordinary claims is \$45,000 and the reinsurance cap is \$250,000.



The reinsurance program is funded through the \$27 per covered life contributions made by participating insurers and had a \$1.7 billion surplus in 2014 that rolled over to this year. This allowed CMS to reimburse plans at a 100 percent coinsurance rate instead of the 80 percent initially intended.

The \$7.7 billion for 2015 aligns with CMS expectations, unlike the \$2.5 billion shortfall in the related risk corridors program that resulted in eligible Marketplace insurers receiving only about 12 percent of the payments they were due for 2014 (see Update for Week of September 28th). That shortfall has directly led to the closures of many non-profit insurance cooperatives (see Update for Week of November 30th) and is causing some of the nation's largest health insurers like UnitedHealthcare to reconsider whether to continue Marketplace participation (see below).

CMS creates special enrollment period for failure to reconcile 2014 tax credits

The Centers for Medicare and Medicaid Services (CMS) announced last week that it has created a new special enrollment period (SEP) for individuals who did not enroll in Marketplace coverage for 2016 because the federal web portal (www.healthcare.gov) determined them to be ineligible for Affordable Care Act (ACA) subsidies based on their failure to file 2014 federal tax returns and reconcile prior premium tax credits that were advanced to them.

Individuals can only take advantage of this new SEP if they file their 2014 tax return, reconcile any tax credits received for that year, and complete an online attestation. Eligible individuals must not currently be enrolled in Marketplace coverage but able to show they attempted to enroll. The SEP runs only from February 1st to March 31st.

The move runs contrary to CMS' earlier efforts to assuage insurer concerns about adverse risk selection by eliminating six SEPs that insurers insist were being abused by consumers waiting until they got sick to enroll (see Update for Week of January 11th and 18th).

STATES

CDC survey shows eight states are mostly responsible for 37 percent decline in uninsured rate

The latest National Health Interview Survey released this week by the Centers for Disease Control and Prevention (CDC) show that the nation's uninsured rate declined to 9.1 percent over the first nine months of 2015, a 37 percent drop from the period just before the opening of the Affordable Care Act (ACA) health insurance Marketplaces in 2013.

The declines were considered "statistically-significant" in eight states led by Kentucky at 6.5 percent. Despite such a pronounced coverage gain, Kentucky's new governor is attempting to dismantle both the health insurance Marketplace and Medicaid expansion that engendered it (see below).

Arizona surprisingly had the second-greatest drop at 5.9 percent, followed by New York at 5.6 percent. The other five with significant drops were California, Colorado, Florida, Illinois, and Michigan.

Florida was the only state with a statistically-significant decline that did not expand Medicaid under the ACA. Among all 31 states expanding Medicaid, the uninsured rate fell a whopping 46 percent compared to only 24 percent in opt-out states.

Uninsured rates fell by amounts that were not considered statistically-significant in ten other states (Georgia, Idaho, Indiana, Louisiana, Mississippi, New Hampshire, New Mexico, North Carolina, Oklahoma, and Rhode Island). Only four of these states have expanded Medicaid, although Louisiana is expected to do so this summer (see Update for Week of January 4th).



Moda Health returns to individual market in Alaska and Oregon

Moda Health Plan (MHP) announced this week that they will return to the individual health insurance markets in Alaska and Oregon, only two weeks after each state's insurance department had issued supervision orders barring them from selling or renewing policies (see Update for Weeks of January 25th and February 1st).

Moda had incurred more than \$58 million in losses in 2015, forcing its capital reserves to shrink to the point where it was no longer financially viable. The insurer largely blamed the losses on the shortfall in ACA risk corridor payments for insurers with an exceptional number of costly claims (see Update for Week of November 30th). As a condition of re-entry, the Alaska Division of Insurance is requiring Moda to sell a portion of the risk corridor payments owed to them by the federal government, as well as sell assets and set aside at least \$15 million to protect subscribers should the insurer fail (a comparable measure was not required in Oregon since that state has the authority to seize insurer assets).

Moda's return was critical to the individual market in Alaska, which had only one remaining insurer (Premera Blue Cross and Blue Shield). It is the third largest insurer in Oregon's individual market, which has nine other participating insurers.

Alabama

Medicaid managed care waiver receives federal approval

Governor Robert Bentley (R) announced this week that the federal Centers for Medicare and Medicaid Services (CMS) has approved his request for a Section 1115 demonstration waiver that would allow Alabama Medicaid to move more than 60 percent of enrollees (including children, aged, blind, and the disabled who are not receiving long-term care) into private managed care plans delivered through hospital and provider-led entities called Regional Care Organizations (RCOs).

Under the new structure set to launch in October, Medicaid will contract directly with RCOs established in five regions at an established cost for services. Alabama will receive \$328 million in federal funds over three years to transition to the new RCO delivery system, including start-up costs and provider payments. However, the state must demonstrate that more pregnant women and children receive recommended checkups, and that fewer patients are admitted to hospitals.

Arkansas

Governor claims federal approval for most proposed reforms to Medicaid expansion alternative

Governor Asa Hutchinson (R) announced this week that federal officials have agreed to most of his requested changes to the demonstration waiver allowing Arkansas to use Affordable Care Act (ACA) funds to purchase private Marketplace coverage those that the law makes newly-eligible for Medicaid.

Arkansas was the first of seven states that have obtained a federal waiver to create a "private sector" alternative to the ACA's Medicaid expansion (see Update for Week of September 25, 2013). However, the waiver first secured by Governor Mike Beebe (D) in 2013 has met with stiff opposition from conservative lawmakers that have since gained control of the governorship and legislature. The "private option" in Arkansas survived by only one vote last year and conservatives insisted that it would not be reauthorized this year if reforms were not implemented that would increase enrollee cost-sharing, impose "work encouragement" requirements, move lower-income enrollees into traditional Medicaid, and terminate those that fail to pay premiums (see Update for Weeks of January 26 and February 4, 2015).

According to Governor Hutchinson, the Secretary for the U.S. Department of Health and Human Services "accepts the framework" for such reforms (which he calls Arkansas Works), claiming that she rejected only the proposed fee on enrollees with substantial assets. A statement from Secretary Burwell was more cautiously worded, stating only that the changes were "innovative" and warranted further



discussion, although some provisions “push the bounds of what is allowable under federal Medicaid law and raise concerns about potential adverse impacts on beneficiaries.”

The Governor plans to call for special session in April to secure legislative approval for the changes that are ultimately approved by HHS (see Update for Week of January 4th). The demonstration waiver will automatically expire at the end of 2016 without the annual legislative reauthorization, which requires a three-fourths majority from both chambers. If not reauthorized, the termination of the “private option” would eliminate coverage for roughly 250,000 Arkansans and create a \$100 million hole in next year’s state budget.

California

Anthem no longer leads in Marketplace enrollment due to increase competition

While insurer-specific enrollment data will not be released until later this month, Covered California officials disclosed this week that Blue Shield of California gained the largest market share for the 2016 open enrollment period, surpassing the 30 percent market share that Anthem Blue Cross has held since the health insurance Marketplace first opened in 2013.

Anthem Blue Cross had previously acknowledged that enrollment in Covered California (and 13 other Marketplaces in which it participates) has run 30 percent lower than the insurer’s projections for 2016, due largely to lower premiums charged by an increasing number of competitors. Covered California officials documented that the number of consumers signing-up for Marketplace plans offered by competitors apart from the “Big 4” of Anthem, Blue Shield, Kaiser Permanente, and HealthNet has nearly tripled from 2015. However, two newcomers that were expected to dramatically boost competition (UnitedHealthcare and Oscar) barely made a dent with only several thousand enrollees each.

Both UnitedHealthcare and Oscar blamed Covered California’s decision to restrict their plan offerings to only to a handful of counties. However, insurance agents and brokers pointed out that each insurer offered plans with extremely narrow provider networks, leading consumers to show more interests in higher-priced plans with broader networks.

Connecticut

UnitedHealthcare prevented from eliminating broker commissions on Marketplace plans

The Insurance Department announced this week that UnitedHealthcare cannot stop paying broker commissions for 2016 Marketplace plans, although they will be permitted to cut them by half.

UnitedHealthcare had paid agents and brokers a \$20 commission for selling their Marketplace plans. However, larger than projected losses during the insurer’s first year participating in the Marketplaces has forced the insurer to implement several cost containment measures for 2016, including refusing to accept premium assistance from charitable groups like PSI (see Update for Weeks of January 25th and February 1st).

The Department’s decision barred UnitedHealthcare from eliminating the commissions altogether because they were included as part of the insurer’s rate filing for 2016. However, Department officials acknowledged they could not stop insurers from removing all commissions as part of their 2017 rate filings. In the interim, the Department is allowing UnitedHealthcare to halve its commissions to \$10.

The other three insurers participating in the Access Health CT Marketplace (Anthem Blue Cross and Blue Shield, ConnectiCare and HealthyCT) insist that they do not intend to eliminate agent and broker commissions. Marketplace officials openly worry that cutting commissions will depress total enrollment, as 40 percent of Marketplace business currently comes through agents and brokers.



Access Health CT officials warned that eliminating commissions is part of a national trend of insurers trying to cut costs by avoid sicker and more costly patients. Covered California officials are currently weighing a proposal to mandate participating pay such commissioners during both open and special enrollment periods in an effort to ensure costlier patients are not diverted to other plans by agents and brokers.

UnitedHealthcare typically had the highest-priced plans in the Access Health CT Marketplace and consequently garnered only a 1.6 percent market share during the 2016 open enrollment period. The nation's largest insurer had suggested that they may pull out of all two dozen Marketplaces entirely for at least 2017, if losses do not substantially improve this year (see Update for Week of November 30th).

Florida

Humana enters into consent order prohibiting discriminatory cost-sharing for HIV/AIDS drugs

The Office of Insurance Regulation (OIR) announced this week that has fined Humana \$500,000 for failing to cooperate with an investigation that started in 2014 regarding its practice of moving all or most HIV/AIDS drugs into specialty insurance tiers that impose a 40-50 percent coinsurance.

As part of its approval of Aetna's acquisition of Humana, OIR required Humana to enter into a consent order in which it agreed to "maintain procedures to ensure that it does not by effect or design treat people living with HIV/AIDS less favorably than any other condition." In a response to a civil rights complaint filed by The AIDS Institute (see Update for Week of June 2, 2014), OIR had conducted a market investigation of drug formularies to see if they violated state law prohibiting discrimination against HIV/AIDS patients. It concluded that the specialty tier practices of four insurers in Florida's federally-facilitated Marketplace (including both Aetna and Humana) did constitute discrimination and entered into one-year settlement agreements requiring them to switch from a percentage coinsurance to fixed copayments for most HIV drugs (see Update for Week of March 23, 2015).

OIR subsequently used the authority granted by federal regulations to recommend that insurers not be federally-certified for Marketplace participation if their tiered formulary for HIV drugs is not at least as favorable as the state's benchmark plan (see Update for Week of June 8 and 15, 2015). Florida's benchmark plan is the Florida Blue Cross and Blue Shield Blue Options plan for small groups, which currently limits patient co-pays to no more than \$150 per 30-day supply, depending on the medication.

OIR also found that Humana had directly impeded agency examiners by improperly claiming the investigation was a civil action not making company records freely available. In addition to the fine, Humana was required to agree to such records will be accessible to investigators so they can determine if future practices discriminate against persons with HIV/AIDS. The consent order will specifically remain in force even if Aetna's acquisition of Humana does not receive final approval from the Attorney General.

The AIDS Institute noted this week that despite the settlement agreements, discriminatory practices continue to adversely impact other patient populations. For example, both Aetna and Humana are continuing to place nearly all costly Hepatitis B and C drugs onto specialty tiers that impose a post-deductible 40-50 percent coinsurance.

PSI Government Relations also met with Florida lawmakers last week to notify them that both Aetna and UnitedHealthcare are currently refusing to accept premium assistance from charitable organizations in an effort to circumvent the Affordable Care Act's anti-discrimination provisions and create financial barriers to care for high-cost subscribers.

Idaho

Idaho leads all state-based Marketplaces in per capita enrollment, low establishment costs



Officials with Your Health Idaho announced this week that more than 102,350 consumers signed up for qualified health plans offered by the Marketplace during the 2016 open enrollment period that ended January 31st, a five percent increase in enrollment from 2015.

The figures are the highest ever recorded by Your Health Idaho, which switched from federal to state control for the 2015 open enrollment period (see Update for Week of June 23, 2014). According to data provided by the U.S. Department of Health and Human Services, Your Health Idaho led all state-based Marketplaces in per capita enrollment, and trailed only the federally-facilitated Marketplace in Florida in that category. State officials also emphasized that Your Health Idaho had the lowest establishment costs of any of the 14 other states (including the District of Columbia) that created their own Marketplaces under the Affordable Care Act.

House committee passes Governor's narrow alternative to Medicaid expansion

The House Health and Welfare Committee advanced a bill this week that could create the Idaho Primary Care Access Program. The program proposed by Governor Butch Otter (R) would provide basic preventive services to roughly 78,000 Idahoans caught in the "coverage gap" between Medicaid eligibility and the threshold for Affordable Care Act (ACA) subsidies.

The Senate Health and Welfare Committee recently held the first ever hearing on Medicaid expansion legislation but refused to vote on a Democratic-backed bill that would have accepted ACA funds for a traditional expansion (see Update for Weeks of January 25th and February 1st). By contrast, the Governor's plan under H.484 would apply only to those in "coverage gap" and allocate just \$30 million per year in state funding to primary care providers to furnish solely preventive care. It would not cover acute or emergency care, nor hospitalizations or prescription drugs (see Update for Week of December 7th) and would require beneficiaries to share in the costs.

Kansas

House and Senate leaders block votes on Medicaid expansion bills

The House and Senate held separate votes this week to defeat amendments to budget bills that would have allowed Kansas to expand Medicaid under the Affordable Care Act (ACA).

Rep. Jim Ward (D) brought the House amendment, which was easily blocked by an 85-37 chamber vote after the Rules Committee determined that the state cost would not offset by spending cuts. Under the ACA, the federal government will pay the full share of expansion costs through this year, while states will pay five percent of the costs starting in 2017, which phases up to ten percent for 2020 and subsequent years.

The Senate had previously blocked a budget amendment by Senator Mary Pilcher Cook (R) that was meant to give fellow Republicans the opportunity to record a vote against Medicaid expansion during this election year. However, Senator Pilcher Cook could still provide that opportunity by granting a hearing on Medicaid expansion legislation in her Public Health and Welfare Committee (S.B. 372) that was drafted by the Kansas Hospital Association (see Update for Weeks of January 25th and February 1st).

Kentucky

Former Governor launches campaign to save ACA Marketplace, Medicaid expansion

Former Governor Steve Beshear (D) launched a new 501(c)(4) organization last week that will campaign against the current governor's plan to dismantle the state's Affordable Care Act (ACA) health insurance Marketplace and Medicaid expansion.

The term-limited governor was replaced this year by Governor Matt Bevin (R), who has already started the process to let the federal government assume control over the Kynect state-based



Marketplace created by Governor Beshear. Although Bevin has retreated from this campaign pledge to terminate the Medicaid expansion, he has created a committee to develop a proposed waiver that would allow Kentucky to become the eighth state with a “private sector” alternative to the full ACA expansion.

Former governor Beshear has estimated that defaulting to federal control over Kynect will cost the state \$23 million, including the cost of building a new system that will send and accept application transfers from Medicaid/SCHIP to the web portal for the federally-facilitated Marketplace. These state costs cannot be offset with the remaining \$57.5 million federal establishment grant that Beshear received from the Obama Administration.

Beshear also insists that the transition will also result in higher user fees for participating plans (3.5 percent under the federal model compared to only one percent under Kynect), thus increasing premiums for subscribers (see Update for Week of January 11th). In addition, Kynect subscribers 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).

Maryland

Marketplace enrollment improves dramatically among minorities, young adults

Officials with the Maryland Health Benefit Exchange (MHBE) announced this week that total enrollment in qualified health plans exceed 162,000 consumers for the 2016 open enrollment period that ended February 5th.

The 33 percent increase in enrollment from 2015 was the third-fastest growth rate in the country (following only Minnesota and Massachusetts) and exceeded MHBE’s projection of 150,000 sign-ups. Upgrades to the flawed software and technological infrastructure that plagued the Marketplace during its first two open enrollment periods were largely credited for the enrollment gains (see Update for Weeks of March 17 and 24, 2014). However, expanded marketing and outreach efforts targeting harder-to-reach uninsured populations also proved fruitful, as the number of Latino sign-ups surged by 244 percent and 37 percent for African-Americans.

The MHBE also had the fifth-highest ratio of young adult enrollments at 29 percent, a nearly 7.5 percent gain from 2015 and slightly above the national average of 27 percent.

New Hampshire

House gives initial approval to two-year reauthorization of Medicaid expansion alternative

The Republican-controlled House overwhelmingly voted this week to reauthorize the state’s Medicaid expansion alternative for two additional years after several controversial changes were blocked.

H.B. 1696 will still have to be reapproved by the full House chamber after being reviewed by the Finance Committee. However, the refusal of the House to approve amendments that would have effectively scuttled the expansion appeared to clear the way for ultimate approval by the Senate, as most of the opposition to the expansion rested in the more conservative House chamber.

New Hampshire is one of seven states that have received federal approval to use Affordable Care Act (ACA) matching funds to purchase private coverage for those that the law makes newly-eligible for Medicaid (see Update for Week of November 30th). However, the federal waiver will expire at the end of 2016 without legislative reauthorization.

Even if H.B. 1696 ultimately passes the House, it is likely to again be modified by Senate or the federal government as it includes a requirement that enrollees work 30 hours per week or be enrolled in job training or higher education programs (see Update for Weeks of January 25th and February 1st). The



Obama Administration has consistently rejected similar work requirements proposed by other states, though it has approved incentives to “encourage” work (see Update for Week of November 30th).

Vermont

State seeks federal waiver allowing it to avoid creating small business Marketplace portal

State officials posted a draft request for a federal waiver that would let Vermont forego the required establishment of an online infrastructure for the Small Business Health Options Program (SHOP) Marketplace required by the Affordable Care Act (ACA).

Under Section 1132 of the ACA, states can receive waivers starting in 2017 allowing them to opt-out of certain ACA requirements so long as their alternative reforms provide a comparable increase in coverage without imposing additional cost. Vermont’s proposed waiver would allow the state to maintain its current system where small business employees enroll directly through insurers instead of being forced to use the Vermont Health Connect (VHC) web portal. Employers would retain the ability to offer their employees any qualified health plan (QHP) and insurers would continue to be responsible for all employer and employee notices, premium processing, and reporting enrollment data. VHC would also still certify QHPs, determine small business tax credit eligibility, and operate an appeals process.

Washington

Lawsuit challenges Medicaid rationing of costly Hepatitis C drugs

A class action lawsuit filed this week against the Washington Health Care Authority (HCA) seeks to change a policy that allows Medicaid to ration the coverage of costly hepatitis C medications.

Nearly 3,600 Medicaid enrollees are infected with the hepatitis C virus (HCV) and take medications that could potentially cure their illness yet be denied from them by Medicaid. The plaintiffs represented in part by Columbia Legal Services and the Center for Health Law and Policy Innovation at Harvard Law School insist that such explicit rationing of care is illegal. Several similar lawsuits have been filed in states like Oregon and Illinois that promptly applied similar policies limiting coverage only to the most severe form of liver fibrosis after several new HCV “cures” were approved (such as Harvoni from Gilead Sciences) that carried a price tag of nearly \$95,000 for just a 12-week course of treatment.

Washington’s Medicaid Director informed Congress last fall that states were simply not capable of footing such a bill, as it would cost Washington \$242 million this year just to provide the HCV drugs to high-risk patients. To extend that coverage to all patients would cost nearly three times more than the nearly \$1 billion budget for 2016.

Two similar class-action lawsuits in Washington were filed late last month against private insurers Group Health Cooperative and Bridge-Span, a subsidiary of Regence BlueShield. Bridge-Span promptly revised its policy to allow coverage for all HCV patients, regardless of liver-fibrosis stage. Group Health has agreed to “consider” lesser forms of liver fibrosis but not to cover all stages.

The lawsuits note that rationing of HCV drugs based on severity of illness are also “no longer supported by best medical practice” as both the American Association for the Study of Liver Diseases and the Infectious Diseases Society of America have updated their guidelines to recommend that drugs such as Harvoni should be used to treat all patients with HCV, “including mild liver disease.”