Health Reform Update – Week of October 10, 2016

CONGRESS

GAO validates Republican complaints about ACA reinsurance payments

The Government Accountability Office (GAO) concluded last week that the Department of Health and Human Services (HHS) is violating the requirements of the Affordable Care Act (ACA) in how its distributes payments under the health insurance reform law's Transitional Reinsurance Program.

The reinsurance payments are intended to compensate insurers that incur an exceptional number of high-cost claims in a given year. It is funded by an assessment on all health insurers, including those sold outside of the Marketplaces and those that are self-insured.

Under the ACA, the assessment should have raised $12 billion in 2014, $8 billion in 2015 and $5 billion for this year (before it expires). Insurers with exceptional claims were scheduled to get back $10 billion, $6 billion, and $4 billion in each of those years respectively, with $2 billion due to the Treasury in both 2014 and 2015 and an additional $1 billion to be deposited for 2016.

However, the actual 2014 revenue from the assessment was well below the expected amount, forcing insurers to receive only a fraction of the amount they were due under the ACA (see Update or Week of September 28, 2015). HHS acknowledges that the ACA requires full payment to insurers and has been diverting funds from other programs in an effort to cover the shortfall (see Update for Week of November 30th), while giving insurers priority over the Treasury Department for the remaining funds (see Update for Week of May 16th). As a result, Treasury has received only about $500 million in residual reinsurance payments from HHS.

Republican leaders in both the Senate and House have held several hearings this year on the reinsurance payments, which they term an "insurer bailout". They allege that HHS has been refusing to cooperate with the investigations (see Update for Week of May 16th) and sought not only the GAO opinion but legislation that would slash the HHS budget by half if the Treasury Department does not receive the $5 billion in reinsurance payments it is due under the ACA.

HHS promptly responded that it "strongly disagrees" with GAO's opinion that "the agency is not authorized to prioritize collections in this manner" and must "collect and deposit amounts for the Treasury, regardless of whether its collections fall short of the amounts specified in statute for reinsurance payments." Agency officials claim that by providing proper public notice of how to distribute the payments, it complied with the ACA, especially since no public comments were submitted that objected to HHS' proposed plan.

As an independent watchdog of Congress, GAO has no authority to enforce its interpretation of the ACA. However, the language in the GAO report largely mirrors the recent conclusion of a federal district court that HHS also violated the ACA in funding cost-sharing subsidies from other sources when Congress expressly did not appropriate money for the subsidies (see Update for Week of May 16th). HHS is currently appealing that decision.

Analysts with the Kaiser Family Foundation note that the shortfall in reinsurance payments is largely blamed for the staggering financial losses that have forced some of the nation's largest insurers to exit the ACA Marketplaces (see Update for Week of August 15th). They stress that had HHS not prioritized the residual funding in favor of insurers, even more insurers would have left the Marketplaces

in 2017, with the lower level of competition likely resulting in even higher premiums and out-of-pocket costs for consumers.

House passes bill to exempt failed CO-OP consumers from individual mandate penalty

Despite a promised veto from President Obama, the House passed legislation before the fall recess that would temporarily exempt individuals from tax penalties under the Affordable Care Act (ACA) if they were enrolled in a Consumer Operated and Oriented Plan (CO-OP) that closed mid-year.

Only five of the 23 CO-OPs are continuing to operate following substantial Marketplace losses that caused most to collapse (see below). The losses were largely attributable to the CO-OPs use of low premiums to attract far more consumers than they could handle, as well as a shortfall in ACA reinsurance that failed to promptly compensate them from an unexpected influx of high-cost subscribers (see Update for Week of November 30th) and a flawed ACA risk corridor formula that forced them to pay up to 28 percent of their revenues to dominant carriers (see Update for Week of August 15th).

According to the Joint Committee on Taxation (JCT), roughly 725,000 individuals had purchased coverage from one of the failed CO-OPs (see Update for Week of September 12th). The legislation (H.R. 954) would specifically exempt these consumers that lost coverage mid-year from the ACA mandate that they purchase minimum essential coverage (MEC) they can afford (or pay a tax penalty of $695 or 2.5 percent of income for 2016). It would be retroactive, providing an exemption from any penalties incurred in 2014, 2015, or 2016.

House Democrats were united in their opposition to the bill, which they insist would undermine the individual mandate and ignore the hardship exemption already in place for those for whom purchasing MEC would cost more than 9.5 percent of their income (see Update for Week of December 1, 2014).

Republican leaders seek to pass 21st Century Cures bill in lame duck session

Senate leaders reaffirmed their commitment before the fall recess began earlier this month to pass a version of the *21st Century Cures Act* (H.R. 6) in the lame duck session that will start after the November elections.

The House overwhelmingly passed its bill last year that would speed the development of breakthrough cures for rare disorders by removing regulatory obstacles and providing enhanced funding, primarily to the National Institutes of Health (NIH) (see Update for Weeks of July 26 and August 3, 2015). (It includes the "moonshot" initiative for cancer chaired by Vice President Biden.) However, negotiation have stalled in the Senate Health Education and Labor Committee as Chairman Lamar Alexander (R-TN) sought to split the comprehensive package into 19 smaller bills (see Update for Weeks of January 11th and 18th).

Congress is widely expected some version of the legislation before the session ends, given the broad support for the package from both parties and the biopharmaceutical industry.

As usual, the primary sticking point among Republican and Democratic Senators remains how to offset the cost of the legislation, in particular the enhanced NIH funding. Among the more widely debated offsets are a provision that would prevent brand pharmaceutical companies from barring generic makers' access to samples of drugs.

The latest Senate negotiations have greatly reduced the amount of additional funding for NIH from the $8.75 billion over five years included in H.R. 6 to only $4 billion over the same time period. Funding for the FDA has also been cut from $500 million in H.R. 6 to $300 million.

House Speaker Paul Ryan (R-WI) has thus far agreed to allow a floor vote on a version of H.R. 6 that would include the Senate changes, before sending it over the Senate for final passage.

President signs extension and expansion of expiring pediatric cures program

President Obama signed an extension of the Pediatric Rare Disease Priority Review Voucher Program last month that also expands the pediatric rare disease definition to include those with symptoms that emerge any time before 18 years of age.

The program created by Congress in 2012 was set to expire September 30th but under S.1878 has been extended to the end of 2016. A pending bill sponsored by Senators Johnny Isakson (R-GA) and Bob Casey (D-PA) (H.R. 1537) would extend it another five years and has already passed the Senate Health Education Labor and Pensions Committee. However, a similar extension is also include in the *21st Century Cures Act* that will be considered during the lame-duck session of the current Congress that starts in November (see above).

Under the program, drugmakers that receive Food and Drug Administration approval for new treatments to treat rare pediatric diseases would be rewarded with a voucher that can accelerate the agency's review of a separate product for any illness (by requiring a six-month instead of ten-month review). The drug company can either keep or sell this voucher.

Senate leaders had sought to pass the five-year extension of the program before the fall recess started last month. However, Senators Elizabeth Warren (D-MA) and Bernie Sanders (I-VT) blocked those efforts until the Senate could reach agreement on the additional funding sought by the Cures Act for the National Institutes of Health.

The FDA has opposed the priority review voucher program, insisting that it has not proved to increase the development of drugs for rare pediatric diseases. The agency also insists that the program hinders their ability to set priorities because staff must provide priority reviews of new drugs that would not otherwise qualify.

FEDERAL AGENCIES

Medicare Advantage premiums fall by four percent for 2017

The Centers for Medicare and Medicaid Services (CMS) announced late last month that average monthly premiums for Medicare Advantage plans will actually decline next year by $1.19.

The roughly four percent drop will bring the average premiums to $31.40 for those enrolled in the plans that provide coverage for benefits not covered by traditional Medicare. Despite provisions of the Affordable Care Act (ACA) that restrained the growth rate in Medicare Advantage spending, plan enrollment has jumped by 60 percent since the ACA was passed in 2010 to nearly 18.5 million, or almost a third of all Medicare enrollees.

Standard and Poor's predicts five-year stability in Marketplace enrollment

A new study published this week by Standard and Poor's projects that sign-ups for Affordable Care Act (ACA) Marketplaces are likely to be flat or decline for the 2017 open enrollment period that starts on November 1st.

The analysis predicts that 11.7-13.3 million consumers will enroll in Marketplace coverage during the next open enrollment period, compared to 12.7 million for 2016. The results are likely to heighten concern among insurers weighing whether to follow the lead of UnitedHealthcare, Aetna, Humana, and

other insurers that have already withdrawn from Marketplace participation due to lower than expected numbers of younger and presumably healthier enrollees (see Update for Week of August 15th).

However, Standard and Poor's researchers stressed that the "significant slowdown" that they project over the next two years should not signal "game over" for the Marketplaces, as they also "expect a five-year path to stability in the [Marketplace] business." They predict that the federal government will make necessary regulatory changes "to improve marketplace rules" and moderate premium increases beyond 2017, both of which will "likely bring growth back to the marketplace in future years."

STATES

UnitedHealth subsidiary exits remaining ACA Marketplaces

The nation's largest health insurer, UnitedHealth Group, is continuing its retreat from the health insurance Marketplaces created by the Affordable Care Act (ACA).

UnitedHealth announced last spring that it was withdrawing from nearly all of the 34 Marketplaces in which it participated in 2015 and 2016 (see Update for Week of April 18th). Its subsidiary, Harken Health Insurance, had initially sought to expand its level of Marketplace participation but previously canceled plans to offer new coverage in south Florida counties (see Update for Week of August 22nd). It has now also decided to no longer offer individual plan coverage in the Georgia or Illinois Marketplaces, the only Marketplaces in which it participated for 2016 (offering coverage via a managed care model for consumers in the Atlanta and Chicago metropolitan areas). Harken officials insisted that the move was necessitated by "significant operating losses".

Another smaller insurer Arise Health Plan also announced last week that it will exit the ACA Marketplace in Wisconsin for 2017.

The departures of major insurers like UnitedHealth, Aetna, and Humana means that only a single insurer (Blue Cross and Blue Shield) will be participating in the Marketplaces for five states next year (Alabama, Alaska, Oklahoma, South Carolina, and Wyoming). In addition, Blue Cross and Blue Shield will be the lone insurer participating in the majority of counties for several other states like Florida, Georgia, North Carolina, and Tennessee (see Update for Week of August 22nd).

<u>Arizona</u>

CMS rejects part of Governor's plan to modernize Medicaid

Governor Doug Ducey (R) received federal approval last week for part of his plan to "modernize" the Medicaid program.

Arizona was the last state to agree to participate in Medicaid and did not do so until 1982 when it created the Arizona Health Care Cost Containment System (AHCCCS), a fully managed care version of Medicaid that has been operated under several federal Medicaid demonstration waivers. The latest renewal extends the program through September 2021 and will allow AHCCCS enrollees to contribute to health savings accounts for services not covered by Medicaid.

However, the federal Centers for Medicare and Medicaid Services (CMS) rejected several provisions of the Governor's plan favored by conservative lawmakers that would have imposed a job search requirement, five-year limit on Medicaid benefits, and premiums for those earning less than the federal poverty level. CMS has consistently blocked these provisions in other states (see Update for Weeks of January 25th and February 1st) insisting that they "undermine access to care and do not support the objectives of the [Medicaid] program."

California

New laws protect consumers from surprise medical bills, rate hikes

Governor Jerry Brown (D) signed legislation this week that seeks to protect consumers from incurring out-of-network charges from services rendered by ancillary providers at an in-network provider.

A.B. 72 had been sought by consumer groups for nearly a decade and passed both chambers by nearly unanimous margins after similar legislation failed last session by only three votes (see Update for Week of September 12th). Starting in 2017, it requires insurers to pay out-of-network providers 125 percent of the amount Medicare pays for the service of the insurer's average contracted rate. Florida and Connecticut enacted similar measures earlier this year (see Update for Week of April 18th).

Governor Brown also signed S.B. 908 into law, which will require insurers to notify subscribers in writing at least 60 days before a rate hike deemed "unreasonable" by the Department of Insurance. Insurers were previously only required to post this notice online.

Colorado

Individual market consumers will see 20 percent average hike in premiums

The Division of Insurance announced late last month that it has approved a 20.4 percent average increase in monthly premiums for the individual health insurance market in 2017 (compared to only 2.1 percent for the small group market).

The rate hikes range from a slight decrease of 0.5 percent for Denver Health Medical Plan all the way up to a staggering 46.2 percent increase for Golden Rule Insurance Company (which was six percent higher than the insurer sought). The largest individual health insurers (Kaiser Foundation Health Plan and Anthem Blue Cross and Blue Shield) received increases closer to the overall average while CIGNA subscribers will see a 9.5 percent increase on average.

Due to the departures of several major carriers from the health insurance Marketplace that Colorado operates pursuant to the Affordable Care Act (ACA), individual consumers in 14 of the state's 64 counties will have only one Marketplace option from which to choose for 2017.

District of Columbia

Marketplace premium increases to decline for 2017 as ACA cuts uninsured rate in half

The DC Health Benefit Exchange Authority (DCHBX) announced last week that average premiums for individual DC Health Link consumers will increase by an average of 7.27 percent.

The figure is slightly below the last year's average making DC Health Link one of the few Affordable Care Act (ACA) Marketplaces not facing higher premium increases for 2017. The Marketplace is also one of only a handful to have the same participating insurers as 2016, with Aetna, CareFirst Blue Cross Blue Shield, Kaiser Permanente, and even UnitedHealthcare returning. Aetna and UnitedHealthcare are withdrawing next year from most of their other Marketplaces (see Update for Week of August 15th).

DCHBX also released the findings of a survey commissioned by the Authority showing that more than 25,500 previously uninsured residents gained coverage through DC Health Link in 2016 alone, resulting in a 50 percent reduction in the District of Columbia's uninsured rate since full implementation of the ACA. Roughly 25 percent of all individual DC Health Link consumers in 2016 were previously uninsured, while more than half (53 percent) of those determined eligible for Medicaid lacked prior coverage.

Premiums for those participating in the small group version of the Marketplace will increase by only by a mere 0.36 percent average for 2017. The survey showed that about 40 percent of the small businesses enrolled in DC Health Link did not previously offer health insurance to their employees.

Hawaii

State regulators approved 30 percent average premium increase for Marketplace consumers

The Department of Commerce and Consumer Affairs announced this week that premiums for individual consumers in Hawaii's Affordable Care Act (ACA) Marketplace will increase by an average of 30 percent for 2017.

Premiums for the Hawaii Medical Services Association will jump by the highest amount (a 35 percent average) while Kaiser Permanente subscribers will see a 25.9 percent average increase. These are the only two Marketplace carriers for 2017 and they jointly serve roughly 41,000 subscribers.

Kentucky

CMS approves Marketplace transition to federal control

The federal Centers for Medicare and Medicaid Services (CMS) approved Kentucky's request this week to convert its state-based Marketplace (SBM) created pursuant to the Affordable Care Act (ACA) into a SMB that uses the federal web platform (SBM-FP) at www.healthcare.gov.

New Governor Matt Bevin (R) had pledged not only to terminate the state's participation in the Medicaid expansion under the ACA, but to dismantle the SBM created by his predecessor Steve Beshear (D), who had used his executive authority to make Kentucky the lone southern state to implement either part of the ACA (see Update for Week of January 4th). Governor Bevin has since slightly retreated from both positions and agreed to several federal approval for private-sector alternative to the Medicaid expansion (see Update for Week of August 22nd) as well as simply allowing the current SBM to be run through the federal web platform, similar to the arrangement already approved for six other states (Arkansas, Hawaii, Idaho, New Mexico, Nevada, and Oregon).

Former Governor Beshear had launched an advocacy organization committed to saving both the Medicaid expansion and the SBM (see Update for Weeks of February 8th and 15th). He insists 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 (see Update for Week of January 11th).

CMS acknowledged in its approval letter that many Kynect consumers are now likely to "experience a waiting period while their application is transferred and processed" from the SBM to the federal web portal, instead of the "fast, accurate determinations for coverage" that could have been made through the Kynect alone.

In addition, CMS is increasing the 1.5 percent user fee charged to participating Kynect insurers up to the three percent fee it charges SBMs using the federal web platform (see Update for Week of September 12th). Former Governor Beshear emphasized that this will result in higher premiums for Kynect consumers.

Beshear also noted that Governor Bevin's termination of the state-run advertising campaign to promote Kynect already caused overall enrollment to drop by 12 percent from 2015 to 2016.

Only three carriers will be participating in Kynect for 2017 after Aetna, Baptist Health, and UnitedHealthcare decided earlier this year to withdraw (see Update for Week of April 18th). Aetna elected to abruptly withdraw from the ten counties in which it offered Marketplace coverage after the Department of Insurance granted the insurer only a 5.6 percent average premium increase for next year (see Update

for Week of August 15th), well below average increases for Anthem Blue Cross Blue Shield (22.9 percent), CareSource Kentucky (29.3 percent), and Humana (31 percent). (CareSource's average increase was actually nearly nine percent higher than the carrier had proposed).

Maryland

Non-profit CO-OP will convert to for-profit status in order to remain financially solvent

The governing board for Evergreen Health approved a plan this week to convert the non-profit insurance cooperative into a for-profit entity, in an effort to ensure its financial survival.

Evergreen is one of 23 Consumer Operated and Oriented Plans (CO-OPs) that were created with Affordable Care Act (ACA) loans. However, 17 others have already collapsed or being ordered to cease operations due to financial insolvency since last year, due largely to a shortfall in ACA reinsurance payments for insurers with exceptional claims.

However, it is the related risk corridors program under the ACA that threatens to force the closure of Evergreen Health. The three-year program was meant to stabilize Marketplace premiums by making insurers with healthier and less costly risk pools compensate those that took on sicker and more costly subscribers. It has created bizarre results where Evergreen is now obligated to pay Maryland's dominant carrier CareFirst Blue Cross and Blue Shield more than $22 million or 26 percent of its total premium revenue for 2015 (see Update for Week of June 20th).

Evergreen was the first of the surviving CO-OPs to sue the federal government in an effort to block these payments, which is preventing Evergreen from otherwise turning a 2-3 percent profit (see Update for Week of August 15th). If approved as expected by state and federal regulators, it will also become the first to convert to for-profit status in an effort to stay solvent.

Evergreen officials insisted the transition would appear seamless to its 38,000 subscribers, about 8.000 of whom purchased Evergreen coverage through the ACA Marketplace. Consumers will continue to receive the same ID cards and Evergreen will remain part of the Marketplace. The CO-OP has also obtained a temporary loan to continue operations while the plan transitions to a group of private equity investors (whose identity will not be disclosed until a public hearing next month.)

Minnesota

Individual market insurers allowed to cap enrollment after premiums jump by up to 67 percent

The Department of Commerce released final approved premiums last week for the individual market, revealing a dramatic spike of 50-67 percent in the amounts that individual consumers will pay next year.

The increases are sharp contrast to the small group market, where premium increases range from a one percent decrease up to a high of only 18 percent. Commerce officials blamed premium spikes on the top 1.79 percent of individual consumers who had claims expenses exceeding $100,000 last year, emphasizing that if they were "removed from the market….average claims would have dropped 45 percent."

The spikes caused the agency to let insurers cap the number of enrollees that they will accept next year, in response to the sudden departure of dominant insurer Blue Cross and Blue Shield (BCBS) of Minnesota (see Update for Week of August 15th) and likelihood that sicker and more costly insurers from BCBS will largely be assumed by the remaining individual market insurers (BCBS controlled 40 percent of the individual market in Minnesota). Despite questions about whether the caps violate the Affordable Care Act (ACA) guaranteed issue mandate, all but one insurer (Blue Plus HMO) has already announced plans to implement them.

The actions by the Commerce Department have led to calls from state lawmakers and the Minneapolis Star Tribune editorial board for Minnesota to implement a state reinsurance program that would help offset insurer costs for exceptional claims. They specifically pointed to the reinsurance program that the Republican legislature in Alaska passed earlier this year that limited average premium increases in that state to only about seven percent for next year (see Update for Week of July 18th), noting that the $55 million cost in Alaska would be well within the $731 million surplus in the revenues brought in by Minnesota's tax on medical providers.

Nebraska

Blue Cross and Blue Shield withdraws from ACA Marketplace citing losses

Blue Cross Blue Shield (BCBS) of Nebraska, the state's dominant insurer, announced late last month that it would exit the Affordable Care Act (ACA) Marketplace for 2017 but would return in subsequent years if Congress makes needed changes to the health insurance reform law.

BCBS officials claimed that the insurer has lost $140 million on Marketplace policies since 2014, even though they cover only 20,000 of BCBS' 750,000 overall subscribers. The insurer insists that the losses could have reached as much of $250 million if they participated in 2017, since the ACA's temporary reinsurance program will no longer offset costs for exceptional claims and the insurer is paying out $1.56 in claims for every dollar brought in through Marketplace plans.

BCBS repeated calls for a newly-elected President and Congress to amend the ACA in order to extend the reinsurance program and broaden the age-rating band that now prohibit insurers from charging older consumers premiums that are more than three times as higher as younger subscribers.

Rep. Brad Ashford (D-NE) stated that he hoped that nationwide Marketplace departures by major insurers such as BCBS, UnitedHealthcare, Humana, and Aetna would compel Congress to act. However, Governor Pete Ricketts (R) and all Republican members of Nebraska's Congressional delegation insisted that the departures prove that "Obamacare is a failure and can't be fixed."

According to the Department of Insurance, the departure by BCBS leaves only Aetna and Medica as participating Marketplace insurers for 2017 and reduces the number of plan options available to consumers by about one-third. However, Aetna abruptly quit 11 other Marketplaces last summer after the U.S. Department of Justice blocked its merger with Humana (see Update for Week of August 15th). It has elected to remain only in Nebraska, Delaware, Iowa, and Virginia.

UnitedHealthcare had already decided to exit the Nebraska ACA Marketplace earlier this year (see Update for Week of April 18th).

New Jersey

Bill limiting prescription drug cost-sharing clears first committee

The Assembly Financial Institutions and Insurance Committee favorably reported legislation this week that would limit cost-sharing for prescription drugs.

A.2337 (and its identical counterpart S.814) are resurrected legislation from last session that were reintroduced earlier this year. Under the current bills, health insurers that cover prescription drugs would have to limit enrollee cost-sharing to no more than $100 per month for up to a 30-day supply of each prescription drug for all but the bronze or catastrophic tiers of coverage. The limit for bronze plans could not exceed $200 per month for up to a 30-day supply while catastrophic coverage would remain exempt from such limits.

The cost-sharing limits would apply at any point in the benefit design, including before and after any applicable deductible is reached, except for high-deductible health plans.

New York

Marketplace participation to remain steady for 2017

NY State of Health announced this week that participation in the Affordable Care Act (ACA) Marketplace that New York created for individual consumers will remain largely steady for 2017.

WellCare was the only 2016 insurer that elected to leave the Marketplace. The remaining 14 include not only three Blue Cross/Blue Shield carriers but also UnitedHealthcare, which is staying in New York's Marketplace despite withdrawing from 31 others (see Update for Week of April 18th).

NY State of Health is one of only two ACA Marketplaces (besides MNSure in Minnesota) that offers the basic health plan option created by the ACA for those earning from 138-200 percent of the federal poverty level (see Update for Weeks of August 17 and 24, 2015). This population can purchase this Essential Plan coverage next year from the same plans for $20 per month with no deductibles.

Basic health plan states receive additional federal funding under the ACA while the federal government saves money because it has to pay only 95 percent of the amount of ACA subsidies that basic health plan enrollees would have received had they remained in the Marketplace. NY State of Health officials stress that coverage is comparable to Marketplace plans but come with much lower premiums and cost-sharing. They predicted that a person earning $20,000 a year who uses moderate health care services will pay only about $730 per year in premiums and cost-sharing under the Essential Plan, as compared to $1,830 if they were enrolled in the Marketplace (see Update for Weeks of August 17th and 24th).

NY State of Health officials also revealed this week that New York has cut its uninsured rate in half (from ten to five percent) since full implementation of the ACA in 2014.

Oklahoma

Sole Marketplace insurer dramatically hikes average premiums

The lone insurer participating in the Affordable Care Act (ACA) Marketplace for individual consumers has proposed a 76 percent average premium increase for 2017.

The rate hikes submitted by Blue Cross and Blue Shield (BCBS) of Oklahoma range from 58 percent to 96 percent. BCBS officials insist that the staggering increases are needed to compensate for lower than expected enrollment of younger and often less costly subscribers. However, analysts cite the lack of competition in the Marketplace and the ability of individual market insurers to hike premiums indiscriminately as the state is one of only three without any regulatory process for reviewing or modifying rate hikes (see Update for Week of July 18th).

Oklahoma is one of five states with only one participating Marketplace insurer for 2017 (see above).

Pennsylvania

Senate committee to hear legislation limiting specialty drug cost-sharing

The Senate Banking and Insurance Committee has scheduled an October 25th hearing on legislation that would limit annual out-of-pocket costs for specialty drugs.

S.B. 841 introduced last year by Senator Bob Mensch (R) seeks to explicitly limit cost-sharing charges for a specialty tier prescription drug to not more than $100 per month for a 30-day supply (or an aggregate cost for all specialty tier drugs of no more than $200 per month)(see Update for Weeks of May 18 and 25, 2015). However, the specific dollar limits may be changed following the committee's mark-up.

A separate provision of the bill bars health plans from place all prescription drugs of the same class in a specialty tier. This provision may also not survive as comparable prohibitions have been stripped out of legislation in several states including Connecticut, Louisiana, and Oregon (see Update for Week of May 11, 2015) even though such a practice was determined to be discriminatory by the insurance commissioners in Florida and Illinois, as well as the federal Centers for Medicare and Medicaid Services (see Update for Week of February 23, 2015).

New lawmakers introduces standards of care bill for bleeding disorders

Rep. Nick Miccarelli (R), a member of the House Appropriations Committee, introduced legislation last month that would require health insurers to provide benefits and health care services to individuals with severe bleeding disorders.

The Hemophilia Standards of Care Act (H.B. 2364) would prevent pharmacies from making substitutions of blood clotting products without the prior approval of the treating physician, as well as require insurers to cover all FDA-approved brands of blood clotting products and include them under their drug formularies. Subscribers would also be assured the choice of at least three full service home care providers.

Rhode Island

Governor signs law requiring plan notification of changes in prescription drug cost-sharing

Governor Gina Raimondo (D) signed S. 2294 into law late last month. The measure requires that health insurers give subscribers at least a 30-day notice before implementing any changes to the preferred or tiered cost-sharing status of a coverage prescription drug. However, drugs deemed unsafe may be removed from a plan formulary without any notice.