Health Reform Update – Weeks of February 6, 2012

CONGRESS

House and Senate remain at impasse over Medicare cuts, extension of payroll tax holiday

House and Senate conferees remained deadlocked this week of how to prevent a 27 percent cut in Medicare physician payments next month, as well as the expiration of the payroll tax holiday and enhanced unemployment benefits.

The two-month extension of both measures signed by President Obama ends of February 29th (see Update for Week of January 2nd). However, Democrats and Republicans are still dug into their entrenched positions on how to offset the $150 billion cost of a full year extension.

The Kaiser Family Foundation appeared to throw cold water this week on any broad agreement between the parties—raising Medicare cost-sharing for higher-income beneficiaries. Current law requires Medicare enrollees pay higher Part B and D premiums if they earn more than $85,000 per year (or $170,000 for a couple). This provision affects only about one of every 20 enrollees. However, Kaiser found that proposals by both Democrats and Republicans would require premiums surcharges for those earning as little as $47,000 per year and impact one of every four Medicare enrollees by 2035.

Bipartisan Senate legislation revives debate over broker commissions

Senator Mary Landrieu (D), chair of the Small Business Committee, introduced legislation this week (S.2068) to exempt insurance agent and broker commissions from counting as administrative expenses that are limited by the Affordable Care Act (ACA).

The new medical-loss ratios (MLRs) that went into effect for the 2011 plan year require individual and small group plans to spend no less than 80 percent of premium revenue on medical care instead of administration and profits (or 85 percent for large group plans). The National Association of Health Underwriters led an unsuccessful charge to remove broker fees and commissions from the calculation of administrative expenses under final regulations promulgated by the U.S. Department of Health and Human Services. However, they have picked up the support of several key House and Senate Democrats for legislation that would exclude commissions from the calculation.

The National Association of Insurance Commissioners also voted by a narrow margin last year to encourage Congress to consider legislation exempting brokers from the MLR calculations. However, it stopped short of endorsing specific legislation (see Update for Weeks of November 21st and 28th).

Agents and brokers staunchly object to including commissions under administration, claiming that plans are simply eliminating them in order to meet the new MLRs. A Government Accountability Office report last summer appeared to validate these concerns, concluding that consumer savings under the new MLRs are coming at the expense of cuts in broker fees (see Update for Week of August 29th).

Senator Ben Nelson (D-NE) joined with Senators Johnny Isakson (R-GA) and Lisa Murkowski (R-AK) in immediately cosponsoring S. 2068. An analogous House bill (H.R. 1206) introduced by Rep. Mike Rogers (R-MI) has over 170 cosponsors, including at least 18 Democrats. However, the Senate bill has several modifications intended to boost bipartisan support, including removing commissions only for individual and small group plans (but not large groups). In addition, insurer bonuses paid by to agents who refer a significant amount of business would continue to count as administrative expenses.

Conservative appeals panel says seniors cannot opt-out of Medicare Part A

A three-judge panel for the U.S. District of Columbia Circuit Court of Appeals rejected an attempt by five anti-government plaintiffs to block their automatic enrollment into Medicare Part A.

All citizens who receive Social Security benefits are entitled to Medicare Part A benefits upon turning age 65. However, a group led by former House Majority Leader Dick Armey (R-TX) sought court approval to "opt-out" of Part A because their private health plan coverage limits inpatient hospital benefits for Part A enrollees.

Two conservative justices (appointed by Presidents Reagan and George W. Bush) were sympathetic with the plaintiffs' "desire for better insurance coverage" but affirmed the lower court's dismissal of the case, emphasizing that there is "no statutory avenue….to disclaim their legal entitlement to Part A benefits" once they agreed to accept Social Security benefits. However, the court emphasized that the plaintiffs' remain free to "decline Medicare benefits and [instead] pay out of pocket", though acknowledging that would likely not be to their financial advantage.

A third conservative justice dissented, insisting that the plaintiffs should have the option of returning the Social Security benefits they received if they want to "opt out" of Medicare Part A.

House lawmakers introduce bipartisan legislation creating user fees for generic drugs

A bipartisan group of House lawmakers introduced legislation this week to reduce the backlog of 2,000 generic drug applications at the Food and Drug Administration (FDA).

The Generic Drug and Biosimilar User Fee Act calls on generic drug makers to pay about $1.5 billion over the next five years to fund the federal regulatory review and approval of new drugs. It follows a similar model used for brand-name drugs and medical devices.

The legislation is based on agreements negotiated between the industry and the FDA over the past year. In exchange for the user fees, the FDA will be required to review 90 percent of applications within five years, effectively eliminating the backlog.

The Generic Pharmaceutical Association (GPhA) used a House Energy and Commerce hearing this week to urge lawmakers to promptly pass the critically-needed legislation. It insisted that over the past dozen years, generics have saved the healthcare system more than $1 trillion.

H.R. 3988 was introduced by Reps. Tim Murphy (R-PA), Henry Waxman (D-CA), Frank Pallone (D-NJ) and Joe Pitts (R-PA).

FEDERAL AGENCIES

FDA releases guidance on new regulatory pathway for biosimilars

The Food and Drug Administration (FDA) released long-awaited guidance this week implementing the Biosimilar Price Competition and Innovation Act (BPCI) that was included with the Affordable Care Act (ACA).

The three separate documents detail how the agency will create the regulatory pathway authorized by the ACA for generic versions of biologic drugs that could sell at 25-45 percent lower cost. The new review procedures are expect to engender a plethora of cheaper alternatives to some of the nation's most complicated and expensive drug products.

The guidance gives manufacturers of the "reference product" a 12-year exclusivity period from the date of first licensure, during which another biosimilar product cannot be approved. However, the

FDA can accept and review an application for a biosimilar drug after four years, and the FDA will have ten months to make a decision on whether there is sufficient data to prove the product is safe and effective.

President Obama has sought a seven-year exclusivity period, both during ACA negotiations and in his fiscal year 2012 budget proposal (see Update for Week of February 14, 2011). However, biotech companies have refused to budge on their successful demand for 12-year period.

Biologic drugs are much larger and more complex than pills, because they involve living matter. Agency officials expect there to be some differences between the copycat versions and the original biologic on which the generics are based. However, the FDA will require companies to show that a biosimilar does not have major differences in safety, purity and potency from the reference product.

Although approval will require a very "high bar", biosimilar sponsors may go through fewer hoops than the reference product provided the sponsor can show there are no clinically meaningful differences between the two products. Brand-name manufacturers were disappointed that the FDA did not require full-scale human trials for any biosimilar product, as they sought. However, many of the largest biologic makers (including Merck, Amgen, and Biogen) are already pursuing their own biosimilars.

During a press conference, FDA officials acknowledged that no companies have sent in an application for a biosimilar to be reviewed since passage of the ACA. However, they stressed that the exact studies that will be required for the biosimilar product will still need to be determined on a "case-by-case basis." FDA will use existing data for more than a dozen biosimilars that are already sold overseas, since the European Union already has procedures in place for regulating biosimilar drugs.

Once a product is determined to be biosimilar, a manufacturer could ask the FDA to determine if it is "interchangeable" with the original drug so that patients could switch back and forth between the two versions without problems. Doing so could not only help the company win over patients or physicians, but help the new product become eligible for health insurance coverage.

According to Datamonitor, the worldwide market for biosimilars will jump to $3.7 billion by 2015 (up from only $243 million in 2010), as more than 30 brand-name biologics lose patent exclusivity. The Congressional Budget Office has estimated that the United States could save $25 billion over ten years from the new pathway for biosimilars.

Comments will be accepted for 60 days, once the guidance is published in the *Federal Register*.

Final rules slightly weaken ACA mandate for user-friendly benefit summaries

Final rules released this week by the Centers for Medicare and Medicaid Services (CMS) and two other agencies will ensure that health plan subscribers will receive a four-page summary in "plain English" explaining what limitations or exceptions will apply to their policies.

The "Summary of Benefits and Coverage" (SBC) was required by the Affordable Care Act (ACA). It is intended to allow consumers to make "apples to apples" comparisons of different plans and prevent insurers from burying important coverage details in the fine print of plan documents.

As feared by consumer advocates, the final rules make several concessions to insurers and businesses who insisted that the proposed rules were too onerous and did not allow sufficient time to comply (see Update for Week of January 16th). Chief among these is a delay in the effective date until September 23rd. However, CMS noted that this six-month delay is far less than the 18 months sought by industry lobbyists and was inevitable after CMS missed the March 2011 rulemaking target in the ACA. The head of CMS' Center of Consumer Information and Insurance Oversight (CCIIO) insisted that a September 23rd effective date still gave consumers enough time to make decisions for the 2013 plan year.

The final rules also responded to industry comments by dropping the initial requirements that the summaries include premium and out-of-pocket costs for specific procedures. America's Health Insurance

Plans and other groups claimed that this information would be difficult to summarize, particularly for tiered insurance products, and would likely confuse subscribers. CCIIO agreed and insisted that they could get that information to consumers through "other vehicles".

As expected, the final rules also required insurers to give ballpark cost estimates for maternity and diabetes care—two of the most common covered benefits. CCIIO dropped the recommendation from the National Association of Insurance Commissioners that breast cancer also be included.

However, the new labeling requirements will still apply to all group, and individual plans (including large groups) regardless of whether they are "grandfathered" from other consumer protections. (The U.S. Chamber of Commerce was not able to get CMS to exempt self-insured employers.)

The final rules also continue to require plans to include a uniform glossary of terms in ""plain English" that describe commonly used terms like deductibles and co-payments. Penalties of up to $1,000 per enrollees likewise remain in place.

White House budget will propose greater NIH funding to combat Alzheimer's disease

President Obama proposed this week to increase spending on Alzheimer's research to over $500 million next year as part of a campaign to find effective treatments by 2025.

Under the two-part National Alzheimer's Plan, the National Institutes of Health (NIH) immediately will devote an extra $50 million, on top of the $450 million a year it currently spends for Alzheimer's research. The President will then ask Congress next week to devote an additional $80 million as part of his proposed budget for fiscal year 2013.

According to NIH, more than five million people already have Alzheimer's or related dementias. That number is expected to more than double by 2050 because of the aging population, at an annual cost of more than $1 trillion.

While the Alzheimer's Association immediately praised the move, it insisted that a research investment of up to $2 billion a year was needed to make a real impact. President Harry Johns noted that the federal government spends nearly $3 billion just on research into treatments for HIV-AIDS.

The President's budget will also likely seek to reduce the federal deficit by $3 trillion over the next decade, including nearly $250 billion in Medicare cuts and $72 billion less spending for Medicaid. His plan will largely mirror the one he laid to out to the failed deficit "super committee" last fall, which avoids structural changes to Medicare like raising the eligibility age and instead hikes premiums and cost-sharing for high-income enrollees (see above).

HEALTH CARE COSTS

RAND finds that generics have mitigated the burden of prescription drug costs

A new study released this week by the RAND Corporation concludes that out-of-pocket costs for prescription drugs were significantly mitigated from 2003-2008 by a boom in generic drug usage.

The report shows that over those five years, out-of-pocket prescription costs began to decline, after increase every year from 1999-2003. Researchers relied on expenditure data from Agency for Healthcare Research and Quality to determine that 4.3 percent of Americans under age 65 lived in families during 2003 that spent more than ten percent of their income on prescription drugs. That figure declined to 3.1 percent by 2008, nearing the 2.9 percent of Americans who had such a high financial burden in 1999.

However, researchers emphasized that generic drugs have merely restrained the phenomenal growth in prescription drug costs, which are continuing to rise dramatically. They also note that many Americans are being forced to accept less efficacious generic alternatives due to the increasing prevalence of specialty tier coinsurance, which require plan subscribers to pay a percentage of the cost for the highest-priced drugs.

According to RAND, generic drug utilization jumped from 36 percent of Americans from 1999-2003 to 56 percent by 2008.

Cost-sharing for employer health coverage jumped dramatically over last seven years

A recent study by the Commonwealth Fund shows even consumers are paying far more for employer-provided health coverage than they did in 2003.

Total premiums for employer-sponsored family coverage rose 50 percent from 2003 to 2010 to nearly $14,000 a year. However, workers are shouldering a 63 percent greater share of the total premium during this time (averaging roughly $3,700 in 2010), while the average family deductible nearly doubled to almost $2,000.

According to the Commonwealth Fund, the result has been stagnation or decline in actual take-home pay that has directly hindered the nation's economic recovery. Researchers noted several provisions in the Affordable Care Act that are intended to mitigate this trend, including caps on insurer profits, community rating of premiums, and restrictions on cost-sharing within the new health insurance exchanges. However, they acknowledge that it remains unclear how much these provisions can actually curb the continued growth in out-of-pocket costs.

Low income adults far less likely to have health insurance, access to primary care

A Commonwealth Fund survey released this week confirmed that low-income Americans are less likely to have health insurance and access to primary care than those with higher incomes.

The online survey of over 2,100 adults last summer found that families with annual incomes of less than 133 percent of the federal poverty level (FPL) were the most likely of all income categories to be uninsured (57 percent). A third of respondents in this group also lacked health insurance for at least two years, ten times higher than those who earn more than 400 percent of FPL.

Another 36 percent of adults with incomes between 133 and 249 percent of FPL lacked insurance during 2011, while 23 percent had been uninsured for one year or more.

The study also found that low-income adults were more likely to cite factors other than medical emergencies as reasons for going to the emergency department and less likely to receive critical preventive services like cancer screenings and cholesterol testing. Over a third of those under 250 percent of FPL use the emergency room to get a prescription, double the rate of everyone else.

STATES

<u>Arizona</u>

Insurance committee rejects bill allowing for limited benefit health plans from other states

Legislation that would allow for the sale of limited benefit interstate health plans failed to pass the Senate Banking and Insurance Committee this week.

Sponsored by Health and Human Services chair Nancy Barto (R), the measure (S.B. 1260) would have allowed health insurers from other states to sell plans to Arizonans that did not comply with Arizona

coverage mandates and regulation. Similar measures were enacted last year by several states, including Georgia, Oklahoma, and Wyoming.

California

New caps on insurer profits made permanent

The Office of Administrative Law has made permanent an emergency regulation requiring individual and small group health plans spend at least 80 percent of premium revenue on medical care (and 85 percent for large groups.)

Insurance Commissioner Dave Jones (D) issued the rules last year to implement analogous medical-loss ratio provisions of the Affordable Care Act (ACA). However, the rules differ from the ACA in one respect, as the new standards are applied immediately after a rate is filed with the Department of Insurance instead of after subscribers pay the entire year premium.

Federal government rejects higher Medi-Cal copayments

The Centers for Medicare and Medicaid Services (CMS) has rejected California's proposal to hike Medicaid copayments for physician visits and prescription drugs.

The copayments were part of the budget agreement passed last summer and were projected to save $511 million annually. Under the waiver sought by Governor Jerry Brown (D), most Medi-Cal enrollees would have been required to pay up to $200 for hospital stays, $50 for emergency room care, $5 for physician visits , and $3-5 for certain prescription drugs.

Acting Administrator Marilyn Tavenner emphasized that while CMS has approved higher copays for certain higher-income Medicaid beneficiaries, the breadth and level of copayments sought by California went far beyond the limits set by federal Medicaid law. The agency recently rejected a less severe copayment hike by Utah Medicaid (see Update for Week of January 30th), but approved copayment hikes for Arizona Medicaid (see Update for Week of October 10th).

The Department of Finance pledged to appeal the decision, insisting that it would force California to spend an additional $575 million in the next fiscal year. It also complicates the state's effort to close a $9.2 billion budget deficit.

Delaware

Senate Finance to hear House-passed mini-COBRA bill

The Senate Finance Committee is currently considering legislation (H.B. 170) that would allow qualified individuals who are covered by a small employer plan to continue health benefits for up to nine months after termination of coverage.

This "mini-COBRA" bill was introduced last year by Rep. Bryon Short (D), chair of the Economic Development/Banking/Insurance/Commerce Committee. It unanimously passed the House in January.

Kansas

Blue Cross Blue Shield backs out of Governor's plan to expand Medicaid managed care

The state's largest insurer decided last week that it wants no part of the plan by Governor Sam Brownback (R) to move all Medicaid enrollees into capitated managed care plans this fall.

Blue Cross Blue Shield (BCBS) of Kansas surprised state officials by electing not to submit bids to participate in Medicaid managed care. It insisted that expanding managed care to traditionally-

excluded Medicaid populations required too great a change to their business model to be accomplished in less than one year.

The move by BCBS immediately prompted Rep. Jim Ward (D) and other Democrats to seek legislation requiring annual audits documenting that cost savings could still be achieved without reducing access to care for disabled and elderly Medicaid enrollees who are often the most costly.

Governor Brownback made Medicaid privatization a centerpiece of his plans for reforming state government and projected $2.8 billion in savings under the managed care model (see Update for Week of November 7th). However, federal approval is far from certain, as the Centers for Medicare and Medicaid Services already indicated it will require additional safeguards under a similar Florida waiver to ensure against rationing of care and payment delays that occurred under the state's initial five-county demonstration (see Update for Week of August 1st). However, the agency has already approved broad expansions of managed care in states like California, Kentucky (see below), Louisiana, and Texas.

Kentucky

Governor's Medicaid managed care expansion gets off to a rough start

Medicaid officials faced a barrage of complaints last week about the new Medicaid managed care expansion that went into effect November 1st.

Governor Steve Beshear (D) pushed to move nearly two-thirds Medicaid beneficiaries into managed care as a way to save over $1.3 billion, figures that were hotly disputed by Senate President Dave Williams (R), who failed to unseat Beshear in last fall's election. However, Kentucky's acting Medicaid commissioner acknowledged before the Senate Health and Welfare Committee that the state has face an unexpected level of problems with the program since selecting three Medicaid managed care plans to administer it (see Update for Week of July 11th).

Committee chairwoman Julie Denton (R) was alarmed about reports of delayed payments, lost prescriptions, lack of available doctors, and rationed care—all problems that Georgetown University documented with Florida's earlier Medicaid managed care demonstration (see Update for Week of August 1st). Kentucky Medical Association officials noted that the highest level of complaints related to denials and claims delays for the highest-cost drugs and services.

Lawmakers from both parties lamented the new layers of bureaucracy, noting that providers must now bill four different managed care plans with four new sets of procedures, instead of just billing traditional Medicaid.

Despite access and quality concerns, most states are seeking to transition most Medicaid enrollees into managed care in order to combat rising Medicaid costs. Over two-thirds of all Medicaid enrollees were already moved into managed care by 2010 (see Update for Week of September 12th) and 36 states have since expanded Medicaid managed care (see Update for Week of October 24th).

Illinois

Insurance committee resurrects rate review, medical-loss ratio bills from last session

The House Insurance Committee held a hearing this week on legislation that would create a Health Insurance Rate Review Board to ensure that plan increases are reasonable and justified.

H.B. 289 was introduced last session by Rep. Mary Flowers (D), chair of the Health Care Availability Access Committee. The measure failed to clear committee but was reassigned last week.

The committee also heard new legislation (H.B. 3968) from Insurance chair Monique Davis (D) directing the Director of Insurance to ensure that health plans provide the necessary justification of rate increases set forth by the Affordable Care Act (ACA), before the higher rates are allowed to go into effect.

The hearing included consideration of separate legislation by Rep. Flowers that would require health plans to tell subscribers each year to what extent they complied with the new medical loss ratios required by the ACA. H.B. 2977 was also reassigned after failing to clear committee last session.

Senate takes up specialty tier study resolution passed by House

The Senate Insurance Committee is preparing to hear a resolution calling for the Department of Insurance to study and make determinations about the negative impact of specialty tier coinsurance for the highest-cost prescription drugs.

S.R. 432 sponsored by Senator Linda Holmes (D) is the counterpart to H.R. 450 passed last November by the House.

New York is the only state to have prohibited the use of specialty tiers, though similar measures are being considered in several other states including Arizona, Indiana, Massachusetts, Vermont, and Washington (see Update for Week of January 30th).

Maine

Governor agrees to compromise on "worst in the nation" Medicaid cuts

The Republican-controlled Legislature has reached a compromise with Governor Paul LePage (R) on reimbursement cuts needed to fill a $221 million gap in the Medicaid budget.

The Governor had threatened last week to shut down the entire Department of Health and Human Services if lawmakers blocked his plan to throw over 65,000 people off the Medicaid rolls, in addition to cutting Medicaid payments to hospitals by over $20 million. Republican budget leaders had pushed back at the severity of the cuts, which they deemed the "worst in the nation". However, in the end, Governor LePage backed down from most of his eligibility and benefit cuts after unanimous approval for his proposed drop in Medicaid payment.

Two controversial parts of the Governor's eligibility cuts survived the compromise, namely extended an existing enrollment freeze on Medicaid funding for childless adults and a lower income threshold for parents of Medicaid children. This means that roughly 14,000-16,000 residents will remain on a waiting list for non-categorical Medicaid eligibility. However, lawmakers conceded that was far better than the Governor's alternative of eliminating the eligibility category entirely.

New Jersey

Health committee passes legislation creating health benefit exchange, Basic Health Plan

Legislation creating the health benefit exchange required by the Affordable Care Act (ACA) cleared its first hurdle this week when it passed the Assembly Health and Senior Services Committee.

The measure sponsored by chairman Herb Conaway (D) was strongly supported by consumer advocates like AARP. However, insurers and businesses objected to provisions in A.2171 barring health insurers from serving on the exchange oversight board and allowing the board to negotiate rates and exclude unaffordable plans.

This "active purchaser" model is already in place in Massachusetts, and proposed in several states such as California, Hawaii, and Maryland. However, most states have sought the "clearinghouse" model operating in Utah where any plan that meets the minimum standards in the ACA can participate.

Chairman Conaway, who chairs a National Conference of State Legislatures health reform task force, sought to mollify opposition by insisting that exchange model in his bill (A.2171/S.1319) would create a "middle of the road" active purchaser and not an "aggressive regulator".

Conaway also seeks to exercise the flexibility provided by the ACA to create a Basic Health Plan (BHP) for those earning between 133-200 percent of the federal poverty level. According to the Urban Institute, a BHP would lower average out-of-pocket costs to just under $200 per year, as compared to $1,650 for exchange plans. It also would bring in additional federal funds under the ACA.

Several other states including California, Connecticut and Illinois are considering creating a BHP. However, the California Health Benefit Exchange Board has vigorously opposed doing so in that state, claiming it will significantly reduce the number of exchange participants, making it difficult for the exchange to be self-sustaining by 2015 as required by the ACA (see Update for Week of July 25th).

Oklahoma

New bills codify regulations requiring individual plans to offer child-only coverage

Senators Jim Wilson (D) and Tom Adelson (D) have filed legislation to codify new emergency rules that require individual health plans to write child-only policies.

Oklahoma was one of several states where health insurers completely abandoned the child-only market following the Affordable Care Act's guaranteed issue mandate for children that went into effect for the 2011 plan year (see Update for Week of September 20, 2010). As in states like Arkansas, California, Colorado, Kentucky, Oregon, and Washington, individual health insurers resumed writing child-only policies only after being forced to do so by emergency regulations that restrict enrollment to one or two month window per year.

The Department of Insurance rules signed by Governor Mary Fallin (R) set an initial open enrollment period that concludes February 29th (see Update for Week of January 9th). However, S.B. 1181 (which was modeled after Colorado's new law) would mandate a 30-day open enrollment period every January and July.

Vermont

Governor, lawmakers make small business concessions on exchange-authorizing bill

Governor Shumlin (D) and legislative leaders backtracked this week on plans to immediately require small businesses with up to 100 workers to participate in the new health benefits exchange.

Acknowledging that the exchange "is not the answer to all Vermont's health care problems", the Governor backed off his earlier support for pending legislation that would go well beyond the ACA requirement that the exchange be open to small business with at least 50 employees, at least until 2016 (see Update for Week of January 30th). He also decided to no longer support prohibiting "bronze" plans in the exchange, which are the lowest-cost but lowest-benefit plan offering. Business groups had protested the both provisions, insisting it would lead to higher costs.

The exchange is part of the state's landmark legislation signed last year that abolishes all private insurance and creates a single-payer health care system by 2017 (see Update for Week of May 23rd).

Virginia

Senate follows House lead, delays action on exchange-authorizing bills

The Senate Commerce and Labor subcommittee voted this week to delay action on any exchange-authorizing legislation until after the U.S. Supreme Court resolves the constitutionality of the Affordable Care Act (ACA).

Although the constitutionality of the health insurance exchanges is not at issue, the high court has agreed to consider whether the unconstitutionality of any one provision could strike down the entire law (see Update for Week of January 30th). As a result, both Governor Bob McDonnell (R) and House Speaker William Howell (R) previously decided that Virginia should "wait and see" how the court rules, an approach adopted by several over states like Florida, Missouri, Nebraska, Oklahoma, Ohio, and South Dakota (see Update for Week of January 16th).

However, Labor and Commerce subcommittee chair Jeffrey McWaters (R) and Labor and Commerce chair John Watkins (R) were adamant that Virginia could not afford to gamble that the federal government will extend their January 2013 deadline to avoid a federal fallback exchange if the ACA were upheld. The subcommittee held three extensive meetings on legislation sought by Senator Watkins (S.B. 496) that would move forward with exchange implementation this session. However, in the end, the lack of House support forced them to agree to carryover the legislation until at least a special session next fall.

The industry-backed bill from Senator Watkins was opposed by consumer advocates who favored competing Democratic bills that would create the exchange as a quasi-governmental entity, as recommended last fall by the Governor's Health Reform Initiative Advisory Council (see Update for Week of September 12th). However, Watkins' bill would house the exchange within the State Corporation Commission. West Virginia is the only state thus far that has placed their exchange in a state agency, though Maine is proposing to do so (see Update for Week of October 31st).

Washington

Medicaid to deny all non-medically necessary care in emergency rooms

State Medicaid officials issued new regulations this week that deny payment for any use of emergency rooms by Medicaid enrollees that they deem to be "not medically necessary" as of April 1st.

The Health Care Authority (HCA) had previously sought federal approval to pay for only three non-emergent visits per year. However, a lawsuit brought by the Washington chapter of the American College of Emergency Physicians (ACEP) successfully blocked the service limits, as a state court ruled that HCA failed to get provider input into the list of 700 non-emergent diagnoses drawn up by the agency (see Update for Week of September 26th).

HCA instead moved to a "medically necessary" standard. The agency claims that the federal Centers for Medicare and Medicaid Services advised them that they could so without issuing new rules and going through a formal public notice and comment process.

The rules are part of an effort by Governor Christine Gregoire (D) to cut $664 million from state health care spending in order to fill a $2 billion deficit and rely on charity care to "pick up the slack" (see Update for Week of October 31st).

HCA estimates that eliminating "overuse and abuse" of emergency rooms by Medicaid enrollees will save at least $21 million per year. However, the Washington State Medical Association and other provider groups insist it will only boost uncompensated care costs, as physicians and hospitals will be on the hook for visits not covered by Medicaid.

ACEP called the latest rules "outrageous" as they require Medicaid enrollees to know what their ultimate diagnosis will be before they even enter the emergency room. It claimed that the rules also force emergency providers to either treat Medicaid enrollees with non-emergent conditions for free or refuse them care and risk liability under patient dumping laws should their condition prove to be emergent.