Outline for Today

1. Health and Health Reform
   – State government - changing people & views
   – The Patient Protection and Affordable Care Act (ACA, PPACA, "Obamacare")

2. Medicaid & Pharmaceuticals
   – 2014 - What's next
National Conference of State Legislatures

- Works directly for the 50 legislatures in states + territories.
- Every elected legislator (7,383) is an NCSL member.
- Does not take positions on state laws or legislation.
- Works closely with NGA, NAMD.
- Bi-partisan staff and research functions. 120 NCSL staff - health is the largest topic area.
- Takes limited positions on federal issues affecting states. (No position on PPACA, Medicaid expansion, exchange)
- NCSL Foundation for State Legislatures includes 100+ associations, corporations, unions, non-profits. Their members have no voting, decision-making or editorial role with NCSL itself.

The State Legislative & Executive View: Health Issues by the Dozens

- Medicaid
- Insurance/managed care
- Pharmaceuticals
- Long-term Care
- Uninsured
- Health professions
- Health Facilities
- Environmental
- Prevention & wellness
- Public health
- Hospitals
- PPACA
- CHIP
- Payment Reforms/ACOs
- E M S
- Global payments
- Oral health
- Injury prevention
- Mental Health
- Disabilities
- Substance Abuse
- etc. ......
Why Health Reform?

- 50 million uninsured
- Costs
- Health status
- Complexity
- "Sickness" vs. "health" model

... How viable was the status quo?

Health Policy Decision Factors

- Politics
- Political philosophy
- Costs/Benefits and fiscal climate
- Pragmatism
- Federal flexibility
- Interested parties within the state

State policymakers are key players!
State Legislators Speak Out

Representative Greg Wren (R)  
Alabama  
Co-Chair, NCSL Task Force*

"Now that the Supreme Court has ruled and the national elections are over, it’s clear that federal health reform is moving forward. I intend to remain engaged to ensure that we have as much say as possible in my own state’s implementation."

Assemblyman Herb Conaway  
(D) New Jersey  
Co-Chair, NCSL Task Force*

"We face both opportunities and challenges. We look forward to insuring more people and preventing or treating health problems early on. But, we face tight deadlines, complicated rules and uncertainties."

*As co-chairs of NCSL’s Task Force on Federal Health Reform Implementation, they work together with NCSL to promote maximum state flexibility under federal law and regulations.

Health Reform: Tug-of-War
Among Multiple Views & Interests
In 2013, about HALF of state legislators will be freshmen or sophomores!
Party Control Shifts 2010
24 Chambers

Democrat Gains

Republican Gains

Ties

Alabama House & Senate
Colorado House
Indiana House
Iowa House
Louisiana Senate
Maine House & Senate
Michigan House
Minnesota House & Senate
Mississippi House
Montana House
New Hampshire House & Senate
New York Senate
North Carolina House & Senate
Ohio House
Pennsylvania House
Wisconsin Assembly & Senate

Oregon House
Virginia Senate

Party Control Shifts 2012
12 Chambers

Democrat Gains

Republican Gains

Colorado House
Maine House
Maine Senate
Minnesota House
Minnesota Senate
New Hampshire House
New York Senate
Oregon House
Alaska Senate
Arkansas House
Arkansas Senate
Wisconsin Senate
ACA Overview

• Provide health coverage for up to 30 million.
• Add uniform consumer and patient protections and insurance regulation
• Establish Exchanges in every state
• Can expand Medicaid to adult populations, up to 138% FPL - now a choice for states.
• Require and encourage provider payment reforms, especially within Medicaid and Medicare
• Emphasize wellness and prevention

Expanding Coverage Under the Affordable Care Act

Federal Poverty Level

- 400%+
- 139-399% (Subsidies)
- <139% (Medicaid)

266 M Nonelderly

49.1 M Uninsured

* Medicaid also includes other public programs: CHIP, other state programs, Medicare and military-related coverage. The federal poverty level for a family of three in 2012 is $19,090. Numbers may not add to 100 due to rounding.

SOURCE: KOMU Urban Institute analysis of 2011 ASEC Supplement to the CPS. Medicaid, Public modified by NCSL.
Creating State-Based Exchanges

• All 50 states will have a Health Benefit Exchange in operation by Jan. 1, 2014.

• A coordinated marketplace for individuals and small employers to compare and purchase commercial insurance products, with regulations and consumer protections.

• Eligibility coordination: "No wrong door"

<table>
<thead>
<tr>
<th>Health Exchanges</th>
<th>Which will it be?</th>
</tr>
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<tbody>
<tr>
<td>State Exchange</td>
<td>Federal Exchange</td>
</tr>
<tr>
<td></td>
<td>(default)</td>
</tr>
<tr>
<td></td>
<td>Partnership</td>
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<td>(hybrid of the two)</td>
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2013
## Exchanges: State Roles Will Vary

<table>
<thead>
<tr>
<th>State Exchange</th>
<th>Partner Exchange</th>
<th>Federal Exchange</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Develop, operate and manage all functions and components of an exchange</td>
<td>• Plan Management</td>
<td>• Federal government runs all functions of the exchange</td>
</tr>
<tr>
<td>• Meets certain criteria outlined in law, rules, guidance</td>
<td>• Consumer Assistance</td>
<td>• State Role?</td>
</tr>
<tr>
<td>• State needs federal approval</td>
<td>• Both</td>
<td>• State still regulates insurance</td>
</tr>
<tr>
<td></td>
<td>• Feds still running most functions and facilitating exchange.</td>
<td>• States know consumers best…outreach, etc.</td>
</tr>
<tr>
<td></td>
<td>• State needs federal approval</td>
<td>• Integrating Medicaid/Exchange for seamless enrollment.</td>
</tr>
</tbody>
</table>

### Creating a State Exchange

- Exchange or Exchanges
- Authority Structure Governance
- Financial Sustainability
- Hire Staff Contract with Vendors
- Meet Federal Deadlines and Requirements Develop Plans, get them approved
- Role of Navigators
- Selecting/Certifying Carriers
- Marketing and Outreach
- Design and Build User Friendly Call Centers & Websites
- Developing User Friendly Call Centers & Websites

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[Diagram showing the process of creating a state exchange with various interlinked steps.]
Key Dates for Creating Exchanges

- **Submit State Exchange Blueprint**
  - December 14, 2012 (can be ongoing)

- **Submit Partner Exchange Blueprints**
  - February 15, 2013 (can be ongoing)

- **Open Enrollment Begins**
  - October 1, 2013

- **Coverage Begins**
  - January 1, 2014

- **Federal Funding Expires**
  - December 31, 2014
Exchanges: Where States Stand

As of Feb. 1, 2013

State Plans to Partner with Feds
State Plans to Establish State-Run Exchange
State May Have Federal Exchange as Default

*As of Jan.4, 2013, state received conditional approval of blueprint from HHS.
^ State announced intent to partner with the federal government, but has not submitted a blueprint, as of Jan. 4, 2013. Every state has until Feb. 15, 2013 to declare and plan for a federal/state partnership.

ACA Health Insurance Reforms

Examples

Prohibits:
- Preexisting condition exclusions
- Discrimination based on health status
- Dropping people from coverage (*rescinding* coverage)*
- Annual and lifetime* caps on coverage costs

Requires:
- Young adults up to age 26 can be included on Family plans*
- Guaranteed issue/guaranteed renewal
- Premium rate review and rules*
- Lower drug costs in Medicare coverage gap*

*Includes "Early Market Reforms already in operation."
State Implementation Activities (2012)
Insurance Reforms with CCIIO/CMS/HHS

- 42 states have HHS "certified" premium rate review programs for all state insurance markets.
- Medical Loss Ratios = $1.1 billion in consumer and purchaser rebates paid for more than 12.7 million health policies in 2012,
- 3 million young adults (age 19 up to 26) newly insured.
- Preventive care with no co-pays: 32.5 million patients received services. (45 million women eligible)
- 27 states running federally-funded high-risk programs. (PCIP)
- $4.3+ billion federal grants to states (some $ declined)

10 Required "Essential Health Benefits"

- Ambulatory patient services
- Emergency services
- Hospitalization
- Prescription drugs
- Laboratory services
- Mental health and substance use disorder services, including behavioral health treatment (equal to other benefits, or "parity")
- Maternity and newborn care
- Rehabilitative and habilitative services and devices
- Preventive and wellness and chronic disease management
- Pediatric services, including oral and vision care.
The "Individual Mandate"
Required Coverage; multiple definitions

- Requirement for coverage applies to "most taxpayers"
- "Coverage" includes employer, Medicaid, CHIP, Medicare, state-local programs, new exchange-based subsidized insurance, individual purchase, others.
- Categories of exemptions from coverage or fines:
  - Cannot afford coverage (cost too high)
  - Income below the IRS filing threshold
  - Short gaps in coverage; hardship
  - Undocumented, incarcerated or tribe
  - Religious conscience exemption
  - Income below Medicaid expansion level if state does not adopt the expansion

- Non-compliance can mean a fine or "shared responsibility payment" via IRS.
- Maximum annual IRS payment: In 2014 = $95; 2015 = $325; 2016 and beyond = $695 or 2.5% income with inflation increases. (examples only; see full list)
Employer-Based Health Coverage

• **Small Employers (under 50 workers)**
  – No requirement to offer health insurance
  – But Incentives - Premium tax credits up to 50%
  – SHOP “Small Business Health Options Program”
  – CO-OP plans for private, non-profits (24 states; funds cut 2012)

• **Large Employers (50+ workers)**
  – Required to offer health insurance
  – Failure to offer can lead to a $167/mo fee or penalty for each worker (1st 35 workers exempted)
  – 95% of these employers already offer some coverage
Upgraded HIT & Infrastructure

- 47 states have received or requested bonus federal dollars to upgrade their aging Medicaid enrollment systems, also tied to Exchanges.

- Will states and HHS be ready?

PPACA & National Prevention Strategy

Four Strategic Directions
- Healthy and Safe Community Environments.
- Clinical and Community Preventive Services.
- Empowered People.
- Elimination of Health Disparities.

Seven Priority Areas and examples of state actions related to priorities
- Tobacco Free Living - smoke-free laws, programs to reduce youth access to tobacco
- Preventing Drug Abuse and Excessive Alcohol Use - minimum legal drinking age
- Healthy Eating - incentives for retail access to fresh foods, school nutrition standards
- Active Living - complete streets (e.g., sidewalks, bike lanes), school physical education
- Injury and Violence Free Living - seat belt laws, graduated driver's licensing for teens
- Reproductive & Sexual Health - evidence-based STD & teen pregnancy prevention
- Mental and Emotional Well-Being - access to mental health services.
Clinical Preventive Services

• Evidence-based preventive health services insurance coverage in new health plans - no copay (§1001\2713)
• Medicaid incentives - weight loss, lowering cholesterol, improving blood pressure, preventing diabetes and stopping tobacco use (§4108)
• Funding school-based health center grants (§4101)
  Appropriation - $50 million annually, FY 2010 – FY 2013


Challenges & Alternatives to PPACA

• Multiple federal court challenges (March 2010 - June 2012).

• Final result: U.S. Supreme Court upheld all but one provision: Medicaid expansion to 138% of Federal Poverty cannot be mandatory; it is now an option for each state.

• 20 state legislative laws and constitutional amendments passed opposing mandates to offer & to purchase insurance; bar state agency enforcement

• Latest Challenges -2013
  Requirement for employers to offer contraception coverage:
  – 45+ lawsuits filed, business owners or employers and religious leaders objecting on religious freedom grounds
Part 2

MEDICAID and PHARMACEUTICALS
(I) Vern Smith:
Top 3 Issues for Medicaid Now

- **Controlling Spending:**
  - How to control Medicaid spending in the face of ongoing state budget pressure.

- **Improving Care:**
  - Innovations to coordinate and integrate care and improve quality and outcomes for persons with chronic conditions

- **Preparing for Health reform:**
  - Implementation deadlines loom, but political environment is highly uncertain.


(II) Cindy Mann CMS
Medicaid Moving Forward
"A few of the ways we’re seeing a new Medicaid Program"

Delivery System Reform – ICMs and Health Homes

Business Process Improvements – MACPRO and Waiver Templates (1115 and 1915b)

Transparency – 1115 waivers and State Plan Amendments

Source: Cindy Mann CMS Director of Medicaid, 12/6/2012
(III) State Actions per NCSL
ACA Medicaid Related Provisions:

- Medicaid Expansion
- Interoperability with Exchange
- Fraud and Abuse Prevention
- Dual Eligibles
- Home and Community-based Services

NCSL Presentation to legislators by Melissa Hansen, 2/4/2013

Median Medicaid/CHIP Eligibility Thresholds, January 2012

<table>
<thead>
<tr>
<th>Group</th>
<th>Threshold</th>
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</thead>
<tbody>
<tr>
<td>Children</td>
<td>250%</td>
</tr>
<tr>
<td>Pregnant Women</td>
<td>185%</td>
</tr>
<tr>
<td>Working Parents</td>
<td>63%</td>
</tr>
<tr>
<td>Jobless Parents</td>
<td>37%</td>
</tr>
<tr>
<td>Childless Adults</td>
<td>0%</td>
</tr>
</tbody>
</table>

Minimum Medicaid Eligibility under Health Reform - 133% FPL ($25,390 for a family of 3 in 2012)

SOURCE: Based on the results of a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured and the Georgetown University Center for Children and Families, 2012.
Medicaid Eligibility for Working Parents by Income, January 2012

NOTE: The federal poverty line (FPL) for a family of three in 2011 is $18,530 per year. Several states also offer coverage with a benefit package that is more limited than Medicaid to parents at higher income levels through waiver or state-funded coverage.

SOURCE: Based on the results of a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured and the Georgetown University Center for Children and Families, 2012.

Medicaid Enrollment Grew 58% Nationally Last Decade: Wide State Variation

Note: U.S. Medicaid enrollment increased by 19 million, or 58%, from 2000 to 2010.


Health Management Associates - Updates from Vern Smith
% Change in Medicaid Enrollment, FY 1998–FY 2013

Annual growth rate:
-1.8% 0.4% 3.2% 7.5% 5.6% 4.3% 3.2% 0.2% -0.5% 7.8% 7.2% 4.4% 3.2% 2.7%


Note: Enrollment percentage changes from June to June of each year.


Total Medicaid Spending Growth
FY 1996 – FY 2013

Economic Downturn, Enrollment Declines, New Managed Care 1995-1998

Health Care Cost Growth 1998-2000

Strong Economy, Enrollment Declines, New Managed Care 1995-1998

Low Enrollment Growth & Rx Spending for Duals Moved to Part D 2006-2007


Economic Downturn, Slow Recovery, End of Enhanced FMAP 2008-2013


http://www.kff.org/medicaid/8380.cfm
State Policy Actions Implemented in FY 2012 and Adopted for FY 2013

States with Expansions / Enhancements

<table>
<thead>
<tr>
<th></th>
<th>FY 2012</th>
<th>Adopted FY 2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider Payments</td>
<td>33</td>
<td>37</td>
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<tr>
<td>Eligibility Benefits</td>
<td>32</td>
<td>21</td>
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<tr>
<td>Benefits</td>
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<tr>
<td>Long Term Care</td>
<td>19</td>
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<tr>
<td></td>
<td>29</td>
<td>34</td>
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States with Program Restrictions

<table>
<thead>
<tr>
<th></th>
<th>FY 2012</th>
<th>Adopted FY 2013</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>45</td>
<td>42</td>
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<tr>
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<td>8</td>
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<td></td>
<td>36</td>
<td>35</td>
</tr>
</tbody>
</table>

States with Provider Rate Changes

FY 2010 – FY 2013

States with Rate Increases

<table>
<thead>
<tr>
<th></th>
<th>FY 2010</th>
<th>FY 2011</th>
<th>FY 2012</th>
<th>Adopted FY 2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any Provider</td>
<td>36</td>
<td>35</td>
<td>37</td>
<td></td>
</tr>
<tr>
<td>Inpatient Hospital</td>
<td>18</td>
<td>23</td>
<td>12</td>
<td>10</td>
</tr>
<tr>
<td>Physicians</td>
<td>8</td>
<td>6</td>
<td>2</td>
<td>12</td>
</tr>
<tr>
<td>MCOs</td>
<td>22</td>
<td>18</td>
<td>15</td>
<td>17</td>
</tr>
<tr>
<td>Nursing Homes</td>
<td>26</td>
<td>21</td>
<td>23</td>
<td>30</td>
</tr>
</tbody>
</table>

States with Rate Restrictions

<table>
<thead>
<tr>
<th></th>
<th>FY 2010</th>
<th>FY 2011</th>
<th>FY 2012</th>
<th>Adopted FY 2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any Provider</td>
<td>39</td>
<td>39</td>
<td>40</td>
<td></td>
</tr>
<tr>
<td>Inpatient Hospital</td>
<td>33</td>
<td>28</td>
<td>28</td>
<td></td>
</tr>
<tr>
<td>Physicians</td>
<td>20</td>
<td>14</td>
<td>16</td>
<td></td>
</tr>
<tr>
<td>MCOs</td>
<td>10</td>
<td>11</td>
<td>18</td>
<td></td>
</tr>
<tr>
<td>Nursing Homes</td>
<td>25</td>
<td>30</td>
<td>28</td>
<td>20</td>
</tr>
</tbody>
</table>

NOTE: Provider payment restrictions include rate cuts for any provider or freezes for nursing facilities or hospitals.


HEALTH MANAGEMENT ASSOCIATES
States Cutting or Restricting Benefits
FY 2003 – FY 2013

Number of States

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of States</th>
</tr>
</thead>
<tbody>
<tr>
<td>2003</td>
<td>18</td>
</tr>
<tr>
<td>2004</td>
<td>19</td>
</tr>
<tr>
<td>2005</td>
<td>7</td>
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<td>2010</td>
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<td>2012</td>
<td>18</td>
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<td>2013</td>
<td>8</td>
</tr>
</tbody>
</table>


Health Management Associates

States With Eligibility Expansions / Enhancements
FY 2010 – FY 2013

- Total Changes
- Eligibility Standards
- Application and Renewal

NOTE: Past survey results indicate adopted actions are not always implemented.


Health Management Associates
Optional Medicaid Expansion
Starting January 2014

The ACA expands Medicaid to adults aged 19–64 with incomes at or below 138% FPL

States will receive 100% FMAP rates for the newly eligible population from 2014 through 2016

FMAP rates decline gradually, reaching 90 percent in 2020.

Supreme Court did not change the Medicaid provision, but effectively allows states to opt out.

ACA Medicaid Expansion Specifics

Law Established a minimum eligibility level at 133% of Federal Poverty Guidelines (FPL).
( Estimated to add 17 million Americans if used in all 50 states)

Using the required "modified adjusted gross income, (MAGI)" most new enrollees will qualify with incomes up to 138% FPL -- in 2012:
- Individual -- $15,415
- Family of 4 -- $31,809

No asset test, no resource test

New mandatory categories of eligibility
- Childless adults
- Parents
- Former Foster Care Children to age 26

Law, as passed, allowed the DHHS Secretary to "punish" states by withholding regular federal match - BUT
Court Ruling on Medicaid

The Medicaid expansion is a "gun to the head" because the "threatened loss of over 10 percent of a State's overall budget … is economic dragooning that leaves the States with no real option but to acquiesce."

- United States Supreme Court decision, June 28, 2012*

As a result:
Medicaid expansion is now a state choice, that can be made at any time, and that can be terminated at any future time.
If expansion is chosen, must be to the full increased FPL level of 133%/138%

http://www.supremecourt.gov/opinions/11pdf/11-393c3a2.pdf

Post Court: Recent CMS answers

Is there a deadline for expanding Medicaid? (e.g. 2013 or later?)
NO

Can states “partially” expand Medicaid? (e.g. 100% FPL?)
NO

Once expanded, can states rollback? (e.g. after 2016?)
YES

Will there be flexibility in cost sharing and benefit packages.
YES
### And Remaining Medicaid Questions

#### The Woodwork Effect and The Uninsured

- How many of these people WILL enroll?
- What will happen to disproportionate share hospital (DSH) payments?

#### Who will the newly eligible be?

- What are their medical needs?
- What about provider capacity?

#### What other costs will states face?

- Personnel and expertise
- Other program & administrative functions
- Will the enhanced match last?

### Predictions about Medicaid Expansion

The Advisory Board Company and NASUAD

<table>
<thead>
<tr>
<th>No Expansion</th>
<th>Leaning Toward Not Participating</th>
<th>Leaning Toward Participating</th>
<th>“Yes Expansion”</th>
<th>Undecided</th>
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<tbody>
<tr>
<td>Georgia</td>
<td>Iowa</td>
<td>New Hampshire</td>
<td>Colorado</td>
<td>Arizona</td>
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<tr>
<td>Idaho</td>
<td>Indiana (mixed)</td>
<td>New York</td>
<td>Connecticut</td>
<td>Kentucky</td>
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<tr>
<td>Kansas</td>
<td>Kansas (mixed)</td>
<td></td>
<td>Delaware</td>
<td>Main® (mixed)</td>
</tr>
<tr>
<td>Missouri</td>
<td>Nebraska*</td>
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<td>District of</td>
<td>Michigan</td>
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<td>Nebraska</td>
<td>New Jersey</td>
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<td>Columbia*</td>
<td>Montana</td>
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<td>North Dakota</td>
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<td>Hawaii</td>
<td>→N. Carolina</td>
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<td>South Dakota</td>
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<td>West Virginia</td>
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<td>Missouri (mixed)</td>
<td>Wisconsin</td>
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<td>Nevada</td>
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<td>Oregon</td>
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<td>Rhode Island*</td>
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<td>Vermont</td>
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<td>Washington</td>
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</table>

**BOTTOM LINE:** No one really knows yet! (as of Feb 20, 2013) Source: NCSL research
Enhanced FMAP for States

Source: Cindy Mann CMS Director of Medicaid, 12/6/2012
Affordable Insurance Programs (2014): Without Expansion

For non-elderly, non-disabled individuals, based on current median state eligibility

- 400% FPL
- 241% FPL
- 133% FPL
- 100% FPL
- 63% FPL
- 37% FPL

Exchange Subsidies
Medicaid/CHIP Children

Other Adults
Jobless Parents
Working Parents
Pregnant Women

Source: Cindy Mann CMS Director of Medicaid, 12/6/2012

ACA Impacts on Pharmaceuticals

- Medicare Part D Coverage in the gap.
  - 52.5% brand discounts; -21% generics for 2013
  - Since the health care law’s enactment, 6.1 million Medicare beneficiaries have saved over $5.7 billion on prescription drugs. (Sec. Sebelius’ statement, Feb. 7, 2013)

- Involvement from Rx companies in creating ACA
- More focus and decisions by states
- Court battles over contraception coverage
- "Sunshine rules" requiring disclosure of manufacturer payments to providers.
  - Published February 8, 2013
States Imposing New or Higher Copayments
Overall Medicaid -- FY 2003 – FY 2013

Number of States

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<td>2004</td>
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<tr>
<td>2006</td>
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<td>2007</td>
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<td>2008</td>
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</tr>
<tr>
<td>2009</td>
<td>2</td>
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<td>2010</td>
<td>1</td>
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<td>2011</td>
<td>6</td>
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<tr>
<td>2012</td>
<td>8</td>
</tr>
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<td>2013</td>
<td></td>
</tr>
</tbody>
</table>


Medicaid Pharmacy Policy Measures in Place for FYs 2010, 2011 and 2012

<table>
<thead>
<tr>
<th>Policy Measure</th>
<th>FY 2010</th>
<th>FY 2011</th>
<th>FY 2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preferred Drug List</td>
<td></td>
<td></td>
<td>44</td>
</tr>
<tr>
<td>Supplemental Rebates</td>
<td></td>
<td>44</td>
<td>46</td>
</tr>
<tr>
<td>Script limits</td>
<td>16</td>
<td>16</td>
<td>16</td>
</tr>
</tbody>
</table>

**Medicaid Prescription Drug Policy Changes**

**FY 2011 – FY 2013**

<table>
<thead>
<tr>
<th>Category</th>
<th>2011</th>
<th>2012</th>
<th>Adopted 2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Script Limits</td>
<td>1</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>Reduced Dispensing Fee</td>
<td>1</td>
<td>3</td>
<td>8</td>
</tr>
<tr>
<td>Reduce Ingredient Cost</td>
<td>1</td>
<td>6</td>
<td>13</td>
</tr>
<tr>
<td>Reimbursement</td>
<td>6</td>
<td>8</td>
<td></td>
</tr>
<tr>
<td>Seek/Enhance Supplemental Rebates</td>
<td>7</td>
<td>10</td>
<td>11</td>
</tr>
<tr>
<td>New/Expanded Preferred Drug List</td>
<td>10</td>
<td>13</td>
<td></td>
</tr>
<tr>
<td>Specialty Drug Program</td>
<td>5</td>
<td>7</td>
<td>8</td>
</tr>
</tbody>
</table>

Preferred Drug Lists

• The combination of PDLs and Medicaid Supplemental Rebates remain near-universal tools across state programs. PDLs also used for additional (non-Medicaid) programs

• What will be the impact of ACA benchmark plan formularies (in Exchanges & other markets) on brand name and generic drugs? How will this impact access and coverage?

Biologics and Biosimilars – an emerging debate

• In the overall U.S. Rx market, biologics valued at $67 billion in 2010; will be ¼ of all new drugs in clinical trials or FDA approval.
  Source: IMS Health

• "The pharmaceutical industry is in the midst of patent expirations on major blockbuster drugs, resulting in a staggering loss of revenues estimated at $127 billion over the next 5 years."
  Source: www.mondaq.com accessed January 2013
Biologics and Biosimilars, cont.

• PPACA created an abbreviated licensure pathway for drugs that are 'biosimilar to or interchangeable with' already FDA-approved biotech drugs (under the Biologics Price Competition and Innovation (BPCI) Act).
  Source: www.fda.gov
  – Also known by the FDA as "follow-on protein products or follow-on biologics"
  – No FDA-approved biosimilars in the U.S., however, states are proactively addressing the possibility of biosimilars in the market with legislation in eight states as of January 29, 2013 (AR, CO, FL, IN, MS, ND, TX, VA, WA)

• Copied versions of Humira, Rituxan, Enbrel, Herceptin and others, known as biosimilars, are projected to "save consumers more than $300 billion by 2029." www.nutter.com

• Reports estimate biosimilars may cost between 60 and 80 percent of the original drug.
  Source: www.mondaq.com

In summary…

A New Health World for 2014?

• Exchanges in operation in 50 states(?)

• Insurance for individuals & small groups has:
  – Subsidies from 133%-400% of Federal Poverty
  – Equal coverage for pre-existing conditions
  – Guaranteed-issue and renewal
  – Medical loss ratio and rebates
  – Consumer ombudsmen, appeals, “one stop” eligibility coordination

• Medicaid expansion to 138% FPL in xx States?
  – Higher copayments may be imposed

• Court decisions or congressional action?

• Future unscheduled developments?
Special thanks to:

Vern Smith, HMA  Cindy Mann, CMS/HHS

- Melissa Hansen & Martha King, NCSL Health Program
- The Kaiser Commission on Medicaid & Uninsured
  for select graphics & slides.

Thank you!

Questions??

- **NCSL Health Reform**: Information, features and reports
  [www.ncsl.org/healthreform](http://www.ncsl.org/healthreform)
- NCSL Main page [www.ncsl.org](http://www.ncsl.org)
- **KCMU survey of Medicaid officials** in 50 states and
  DC conducted by Health Management Associates, 10/12
  [www.kff.org/medicaid/upload/8380.pdf](http://www.kff.org/medicaid/upload/8380.pdf)

(update: 2/21/2013 9:30 pm)
<table>
<thead>
<tr>
<th>Learning Assessment Questions</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. The Federal health reform law, signed in 2010 is also known as ____________________________</td>
</tr>
<tr>
<td>2. As enacted, eligibility for adults to qualify for Medicaid would increase to _________% of federal poverty guidelines or FPL.</td>
</tr>
<tr>
<td>3. The only section of the ACA to be restricted by the Supreme Court decision in 2012 was ________</td>
</tr>
<tr>
<td>4. Health Benefit Exchanges must be in full operation by what date? __________________</td>
</tr>
<tr>
<td>5. Which employers must offer health insurance to their employees? ___________________</td>
</tr>
<tr>
<td>6. After the Supreme Court ruling, is there a deadline for expanding Medicaid? ____</td>
</tr>
<tr>
<td>7. Can a state that chooses to expand Medicaid later rollback eligibility to their pre-ACA limit? ____</td>
</tr>
<tr>
<td>8. For 2014-2016, How much will the federal government (HHS) reimburse states that expand adult eligibility to 133%/138%? ___________</td>
</tr>
</tbody>
</table>