

Health Reform Update – Week of September 19, 2011

CONGRESS

Here we go again....Congress struggles to avert federal government shutdown

Congressional leaders are frantically trying to avert yet another deadline to shut down the federal government after the September 30th end of the federal fiscal year.

The House struggled to finally approve a continuing spending resolution this week, after freshman “tea party” Republicans refused to replenish depleted funds for the Federal Emergency Management Agency (FEMA) without significant spending cuts to other discretionary programs. The measure that was approved (H.R. 2608) honored the annual spending caps allowed by the Budget Control Act of 2011 passed last month (see Update for Week of August 1st), but not before “tea party” Republicans had tried to undo that bipartisan agreement and cut spending to the lower level in the fiscal year 2012 budget passed by the House last spring (see Update for Week of April 4th).

H.R. 2608 would have kept the government operating only until November 18th, close to the Thanksgiving deadline for the new Joint Deficit Reduction Committee to pass recommendations for \$1.2 trillion in new spending cuts or trigger automatic across-the-board reductions. However, the Senate promptly rejected the measure, with Democrats objecting to the refusal of the House to replenish disaster relief funds without offsetting cuts. The Senate will likely have to work through a planned recess next week in order to reach an accord by October 1st.

The Senate Appropriations Committee did manage to pass a fiscal year 2012 spending bill that funds the Department of Health and Human Services at \$70.18 billion, a slightly lower level than fiscal 2011. The measure would increase funding for cash-strapped AIDS Drug Assistance Programs (ADAPs) by \$15 million. However, this limited increase can cover only about 15 percent of the 8,800 applicants on waiting lists in ten states as of September 15th. President Obama had sought a \$55 million increase, while the AIDS Institute insists that a \$106 million increase is needed.

President relies on Medicare/Medicaid cuts, generics savings in his “super committee” proposal

President Obama presented his deficit reduction plan this week to the Joint Select Committee on Deficit Reduction created by the Budget Control Act of 2011 (see Update for Week of August 1st).

The President’s plan includes \$320 billion in cuts for federal health programs, which drew swift opposition from consumer and industry groups. This includes \$248 billion in Medicare cuts over ten years, with more than half coming from drug rebates for “dual eligibles” that pharmaceuticals have long opposed. Medicaid and other health funding also would be cut by about \$72 billion.

The “super committee” is under no obligation to follow the President’s plan. If they fail to agree on recommendations by November 23rd to cut the deficit by at least \$1.2 trillion, automatic cuts would begin that according to the Congressional Budget Office (CBO) would trim \$123 billion in Medicare spending from 2013-2021, while preserving Medicaid and Social Security (see Update for Week of September 12th).

The President’s plan relies solely on Medicare provider changes, significant Part B premium hikes, increased premiums and deductibles for higher-income enrollees starting in 2017, and new premium surcharges on Medigap plans (see below). Most of these changes were previously sought by the President’s debt reduction committee last winter and the Medicare Payment Advisory Commission

(MedPAC). They also overlap with some changes sought by House Majority Leader Eric Cantor (R-VA) in the debt limit negotiations last summer.

However, the President's plan to strengthen the new Independent Payment Advisory Board created under the Affordable Care Act (ACA) drew intense opposition, as Republicans and some Democrats have fought the control it would cede from Congress. The President's proposal to cut preventive care funding under the ACA by \$3.5 billion also stunned consumer groups, as it leaves the prevention and public health fund with less than \$14 billion to provide free annual wellness visits and no-cost preventive services for enrollees.

The Medicaid proposals were also met with strong opposition by state Medicaid directors, who have long objected to a "blended" federal matching rate and limits on how much revenue they can raise from provider taxes.

The President also included two cost-saving measures related to generic drugs that were in his proposed budget for FY2012. The first is the ban long-sought by the Federal Trade Commission on "pay-to-delay" settlements, where generic manufacturers agree to delay introduction of cheaper generic products. The second is a five-year reduction in the 12-year exclusivity period for biologic drugs under the ACA. (President Obama had initially sought the seven-year exclusivity period during ACA negotiations.)

President Obama did not agree to structural changes sought by Republicans and some industry groups, such as raising the Medicare eligibility age or giving enrollees vouchers to use in the more costly and less comprehensive private marketplace.

MedPAC plan to fix Medicare physician payments includes dual eligible rebates, Medigap tax

The Medicare Payment Advisory Commission (MedPAC) released a draft list of proposals this week to offset the cost of overhauling the Medicare physician payment formula.

The sustainable growth rate (SGR) formula would cut Medicare physician payments by 29.5 percent for calendar year 2012. However, it has been delayed 11 times by Congress since being enacted in 1997 (see Update for Weeks of June 27th and July 4th). In its place, MedPAC recommends that Medicare payments to specialists be cut by 5.9 percent for three consecutive years and then frozen for seven more years. Payments to primary care doctors would also be frozen at current levels for ten years.

The Congressional Budget Office (CBO) projects that the substitute formula would cost \$200 billion over ten years. In order to offset the costs, MedPAC recommends that Congress implement prior MedPAC proposals to restructure Medicare payments for hospitals and other providers. Remaining savings would come from proposals by CBO and the HHS Inspector General. These include extending drug rebates to dual eligibles, a new excise tax on Medigap plans (see below), and restructured out-of-pocket charges to low-income Medicare enrollees to encourage the use of generic drugs (see below).

The American Medical Association and specialty physician groups slammed the MedPAC plan, claiming it threatens access to care by widening the 20 percent gap that already exists between Medicare payment and practice expenses. The American Osteopathic Association criticized MedPAC for departing from its longtime position that all physicians deserved annual increases for serving Medicare enrollees.

MedPAC debates how to deal with high-cost enrollees in Part D plans

High-cost Medicare beneficiaries in Part D plans tend to take more prescription drugs, spend more per medication, and use more brand-name drugs than other enrollees, according to data presented at the quarterly meeting this week of the Medicare Payment Advisory Commission (MedPAC).

MedPAC is charged with making non-binding recommendations to Congress on Medicare payment policy. However, its 17 members panel struggled with how to encourage greater use of generic drugs by high-cost enrollees and agreed to revisit the issue during later meetings.

Commissioners noted that low-income Part D enrollees in particular are often “suspicious” about the effectiveness of generics and prefer brand-name products. About 9.7 million people of Part D enrollees receive the low-income subsidy, although the percentage of low-income enrollees varies widely across the nation. Low-income enrollees constitute more than 50 percent of Part D enrollees in several mostly rural states like Alabama, Alaska, Maine, Mississippi, New Hampshire, and Tennessee. However, they represent less than 30 percent of Part D enrollees in the upper Midwest and west-central states.

MedPAC staff documented that overall spending for those who get low-income subsidies or exceed annual out-of-pocket thresholds has grown faster than for other Part D beneficiaries. Spending grew by 34 percent from 2007 and 2011 to a projected \$22 billion for those receiving the low-income subsidy. Costs grew by 60 percent for those who exceeded the out-of-pocket threshold to a projected \$13 billion. By comparison, spending grew at only 11 percent for other Part D enrollees (to \$20 billion.)

Very few Part D enrollees exceed the out of pocket threshold each year (only eight percent in 2009). A majority of that group is low-income. Compared to other Part D enrollees, they also tend to be enrolled in stand-alone drug plans or are institutionalized or disabled. They fill far more prescriptions than the rest of Part D enrollees (111 compared to 41 or an average of nine per month). Each prescription for this group also cost an average of \$110, compared to only \$42 for other Part D enrollees.

Biologics were surprisingly not to blame for this discrepancy, as they were filled by less than ten percent of high-cost enrollees and accounted for just a small share of the drugs they use. MedPAC staff instead found that high-cost enrollees tend to use more brand-name drugs such as antidepressants and diabetic therapy. They attributed some of this trend to slight differences in co-payments for generics and brand-name drugs, especially for dual eligibles with incomes up to the federal poverty level.

NAIC urges “super committee” not to impose higher cost-sharing on Medigap plans

The National Association of Insurance Commissioners (NAIC) sent a letter to Congress this week opposing proposals to impose higher cost-sharing for Medigap plans.

The Joint Deficit Reduction Committee is considering Medicaid reforms from prior debt commissions that were projected by the Congressional Budget Office (CBO) last March to save the government up to \$53 billion in Medicare spending over a decade. CBO found that those with Medigap often use more services, and that higher cost-sharing will reduce over-utilization.

However, the nation’s insurance commissioners warned the so-called “super committee” that Medicare beneficiaries who purchase supplemental coverage are often sicker and require more intensive care. Many are also seniors on fixed incomes who will be faced with unexpected out-of-pocket costs that may cause them to forgo this needed care.

For example, under one proposal analyzed by CBO, subscribers would pay a \$550 Medigap deductible and then half of the next \$4,950 costs not covered by Medicare. This \$3,025 in out-of-pocket costs would be unaffordable for many, especially if it was due to an unexpected change in policy. NAIC thus maintains that increased cost-sharing can only be applied to new Medigap subscribers, as it represents a benefit change that violates federal and state laws for current subscribers.

President Obama's deficit reduction plan (see article above) would discourage “first-dollar” Medigap coverage that requires no cost-sharing (but would not explicitly ban such plans.) The limited cost-sharing he proposed would save \$2.5 billion over ten years and would only apply to new plans.

Generics saved consumers over \$930 billion last decade

Generic drugs saved consumers and the government over \$930 billion during the last decade, according to a new report released this week by Generic Pharmaceutical Association (GPA). At least

\$157 billion of the savings were achieved in the last year alone, with even more savings expected this year as patents expire for 22 brand-name drugs.

The report recommended far greater use of generics under Medicaid, noting that Medicaid's generic usage rate is nearly ten percentage points lower than the national average of 78 percent. It also supports the President's proposal to speed-up the introduction of generic biosimilars (see article above).

However, the report opposes the ban on "pay-to-delay" settlement between generic and brand-name drug manufacturers that has been long-sought by the Federal Trade Commission (FTC). GPA claims that the settlements are actually "pro-competitive" and have allowed 16 of 22 new first-time generic drugs to reach the market this year before the brand-name drug patent expires.

The FTC claims that 30 percent of such patent litigation settlements delay the introduction of generic drugs by an average of 17 months and cost consumers over \$3.5 billion per year (see Update for Week of June 6th).

FEDERAL AGENCIES

HHS awards \$109 million in rate review grants, mostly to states with authority to block increases

The Department of Health and Human Services (HHS) released the second round of federal grants this week to help states strengthen their process for reviewing unreasonable hikes in health insurance premiums.

The \$109 million in new funding under the Affordable Care Act (ACA) will go to 28 states and the District of Columbia. The baseline grant to each state was \$3 million, while 20 states that already require prior approval of rate increases received an extra \$600,000.

The Director of the Center for Consumer Information and Insurance Oversight (CCIIO) that oversees the grant process acknowledged that the agency deliberately skewed grants in favor of those with existing power to reject or modify rate hikes because they face a heavier workload than states lacking that authority. Even though 33 states have some rate review process in place, the National Institute on Money and Politics found last year that only 19 states had "meaningful authority" to restrict rate hikes that are unreasonable (see Update for Week of August 9, 2010).

The first round of \$1 million premium review grants were released last year to 45 states and the District of Columbia. At least two of those states (Florida and Oklahoma) returned their grants after Republican Governors took control.

Along with the latest funding, CCIIO released a report highlighting how selected states have used their initial grants. For example, North Carolina returned roughly \$14 million in unreasonable premiums to consumers while other diverse states like Connecticut, Indiana, Nevada, New Mexico, Oregon, Rhode Island, and Utah have expanded their authority to additional insurance markets, required public hearings, and increased public transparency into the rate review process. Overall, nine states passed legislation strengthening rate review, 29 states hired new staff, 27 states boosted their rate review technology, and 39 created new consumer protections.

America's Health Insurance Plans (AHIP) objected to the fact that some states are sharing a portion of their premium review grants with consumer advocates. For example, the Oregon insurance department will give \$900,000 over three years to the Oregon Public Interest Research Group (PIRG) to represent consumers during public hearings on rate hikes. California will use about \$225,000 to hire a consumer advocate to expand "understanding regarding factors driving rate increases and to promote more accountability within the health care industry." Maine already used \$250,000 of its initial grant to contract with Consumers for Affordable Health Care, a watchdog group based in the state.

AHIP claims that the use of “taxpayer dollars to politicize the premium approval process” undermines the credibility of these consumer groups, especially as they stand to benefit financially from campaigning against premium increases. However, the insurance commissioners defended the funding for consumer groups, insisting that they play a vital role in ensuring public transparency of rate reviews.

AHIP says insurers are unfairly blamed for rate hikes, will share data to prove it

The nation’s largest insurance industry representative, America’s Health Insurance Plans (AHIP), insists that enhanced rate review under the Affordable Care Act (ACA) will “literally do nothing to address the soaring cost of medical care.” AHIP claims that higher hospital, physician, and drug prices are directly to blame for double-digit rate hikes nationwide.

To bolster their argument that they are being unfairly blamed for the health care cost crisis, some of the nation’s largest insurers volunteered this week to release private claims data to academic researchers (without individually identifying data). Aetna, Humana, Kaiser Permanente, and the United Health Group will provide the newly-formed non-profit Health Care Cost Institute with detailed information on more than five billion medical claims that they insist will show that premium increases are merely reflective of health care price inflation.

Humana claimed that “this is the first time that the claims data paid by carriers will be available to produce public reports and for researchers to be able to use the data.” The lack of private market data has long been a source of frustration for researchers who were unable to compare Medicare claims data that tends to remain fixed nationwide with private claims that can vary greatly by geographic market.

HHS releases additional guidance on federal-state exchange partnerships

The Department of Health and Human Services (HHS) released additional guidance this week on how they can partner with states to create new insurance exchanges under the Affordable Care Act.

The federal-state partnership model was first proposed by HHS in proposed rules last summer as a way for states to avoid a federal takeover of their exchange even if they are unable to comply with the January 2013 deadline set by HHS (see Update for Week of July 11th). Only about a dozen states have made significant progress towards exchange implementation, with about a third still in the early stages of planning. Another eleven states have yet to even introduce authorizing legislation.

Under the partnership model, states would have the option to follow a plan-management function, a consumer-assistance function, or both. The first would involve data aggregation, data analysis, and plan oversight. The latter would involve oversight of in-person consumer assistance, management of the consumer navigator program, and education and outreach initiatives.

The guidance was issued concurrent with a meeting this week between state and federal officials to discuss the partnership model. However, the dialogue reportedly turned tense when federal regulators indicated that partnerships technically must be considered federally-run exchanges, making them a tough sell for many conservative governors who want to keep exchanges under state control.

State officials also want a broader range of partnership options apart from the plan-management and consumer-assistance models described above. However, HHS officials insist that would greatly complicate federal oversight.

HHS is accepting public comments on the proposed rule and guidelines through September 28th.

Two new reports find that ACA has sharply reduced uninsured rate among young adults

Two surveys coinciding with this week’s anniversary of the “patient bill of rights” under the Affordable Care Act (ACA) show that the new law is increasingly reducing the uninsured rate among young adults, even though the number of uninsured continues to grow for other age groups.

The National Center for Health Statistics found that the number of uninsured people aged 19-25 dropped sharply from ten million last year to 9.1 million in the first three months of this year.

A separate Gallup survey reported that the share of adults 18-25 without coverage dropped from 28 percent last fall to 24.2 percent by this summer. That drop translates to roughly 1 million or more young adults gaining coverage.

Both surveys attribute the decrease to the ACA provision effective last September 23rd that allows young adults to remain on their parents' health plans until age 26. The provision has proven to be among the most popular consumer protections under the new law, forcing Republicans seeking total repeal to pledge to include an analogous provision in any replacement legislation.

By contrast, Gallup found that the uninsured rate for those aged 26 to 64 rose from 18.1 percent in the fall of last year to 19.9 percent this summer.

Both surveys are in line with previous study results. Mercer consultants found a two percent increase in workplace health plan enrollment as a result of extending coverage to young adults.

Most popular Part D plans will see premium hikes next year

Although average monthly Part D premiums will decline in 2012, the consulting firm Avalere Health projects that premiums for the most popular plans will jump by as much as 14 percent.

Six of the top ten plans are increasing premiums for next year, according to Avalere's annual survey. United Healthcare's 4.7 million Part D enrollees will see a 14 percent increase while Community CCRx Basic, with 1.7 million enrollees, is hiking premiums by four percent.

However, Humana, Coventry and CIGNA are cutting premiums in their top plans by ten percent. As a result of acquisitions, CVS Caremark is poised to overtake Humana for the second highest Part D enrollment. Human's Walmart-Preferred Rx plan continues to be the lowest priced plan on the market, with a \$15.10 monthly premium.

IRS seeks comments on how to determine if employer plans are affordable under the ACA

The Internal Revenue Service (IRS) issued Notice 2011-73 on September 13th requesting public comments on a proposed affordability safe harbor for employers under the shared responsibility provisions of the Affordable Care Act (ACA).

Starting in 2014, the ACA requires employers with 50 or more full-time employees to either offer affordable health coverage to full-time employees or pay an assessment. Employer-sponsored coverage is defined as "affordable" if the employee share of the plan is less than 9.5 percent of their household income for the taxable year.

The IRS earlier sought public comments on this definition under Notice 2011-36. In response, the IRS plans to change this affordability standard to 9.5 percent of an employee's wages for the calendar year. This modification should make it easier for employers, who commented that they generally do not know an employee's household income.

Employers would also be allowed to make "reasonable and necessary adjustments" for pay periods to avoid allowing an employee contribution to exceed 9.5 percent of wages.

This contemplated "safe harbor" would only apply to the "employer mandate" and not affect employee eligibility for federal health insurance premium tax credit. Eligibility for these tax credits will continue to be based on household income.

IRS is still seeking public comments on whether or how wages and employee contribution amounts would need to be determined for those employed for less than a full year, those who move between full-time and part-time status, and situations in which the plan year is not a calendar year.

GAO says 340B discounts provide benefits, but greater federal oversight is needed

The Government Accountability Office issued a report late this week finding that the 340B Drug Pricing Program enables covered safety net providers to lower costs of outpatient drugs and maintain services, although federal oversight continues to be “inadequate”

The 340B program requires drug manufacturers to provide participating safety-net providers with discounts on outpatient drugs. The new study (GAO-11-836) required by the Affordable Care Act (ACA) found that 13 of the 29 providers surveyed were able to generate revenue from the 340B program that exceeded drug-related costs (including acquisition and dispensing) and enabled them to serve more patients at even lower cost. Only ten were unable to do so.

GAO also found that 61 of the 340B stakeholders surveyed reported that manufacturer distribution of drugs at 340B prices did not impact provider access to the drugs.

GAO recommends that the Health Resources and Services Administration (HRSA) that oversees the 340B program strengthen oversight to ensure program participation and compliance. The report pointed out that HRSA primarily relies on “participant self-policing” and only periodically confirms eligibility for all covered entities (which have doubled to nearly 16,500 over the past ten years). HRSA has also never conducted an audit to determine whether program violations have occurred.

INSURERS

WellPoint buys private health insurance exchange to compete with ACA exchanges

The nation’s largest insurer by enrollment announced this week that is buying a private health insurance exchange that will compete for employers with the new state-based exchanges required by the Affordable Care Act (ACA) starting in 2014.

WellPoint along with Blue Cross and Blue Shield of Michigan purchased a 78 percent stake in Bloom Health, a private exchange that offers a menu of health plans to about 20,000 workers from 50 mid-to-large companies in 19 states. WellPoint intends to expand the exchange to all 50 states.

The dominant insurer argues that using such a private exchange would limit an employer’s costs and provide greater consistency than state-run exchanges that are more heavily regulated. WellPoint views their new exchange as a way to “preserve[e] the employer-based market by providing some predictability in health-care costs.” Under the Bloom model, companies pay employees a “defined contribution” or fixed amount to cover a portion of their health care coverage and workers provide the rest based on the plans they select. This allows employers to maintain their tax deduction on the money paid annually into an employee’s health reimbursement account to help cover the cost of insurance.

Employer healthcare costs on track for lowest hike since 1997

Preliminary results from a new survey released this week by Mercer Consulting shows that employer healthcare costs for 2012 are expected to increase at their lowest rate in 15 years.

Although the findings are good news for cash-strapped workers who increasingly bear a greater share of health insurance costs, the projected 5.4 increase next year is still well-above both inflation and wage growth. However, it is far below the nine percent annual increases over much of the past decade.

Mercer attributes cost-shifting by employers for most of the slowdown in health care costs. It notes that employees are also using far less medical care as their disposable income decreases. RAND found earlier this month that skyrocketing medical costs have eaten away and nearly all of employee wage growth since 1999 (see Update for Week of September 12th).

STATES

Arkansas

Insurance commissioner seeks legislative approval to apply for additional exchange grants

Insurance Commissioner Jay Bradford (D) urged lawmakers this week to support his agency's application for additional federal grants to create the health insurance exchange required by the Affordable Care Act (ACA).

Governor Mike Beebe (D) directed the Commissioner not to apply without approval of the Democratically-controlled legislature. Bradford indicated that he was seeking a \$5 million grant before the September 30th deadline. Arkansas received an initial \$1 million federal exchange grant last year.

In a meeting with lawmakers, Bradford asked them to write a letter to the Governor indicating that they approve of applying for the grant, yet are not committing to creating an exchange. Lawmakers were unable to pass authorizing legislation last session and the Governor has refused call from his Surgeon General to open next year's budgetary session to other business (see Update for Week of August 22nd).

The Governor also declined to issue an executive order creating the exchange as did his counterparts in other states (see Rhode Island article below), insisting that lawmakers "live with" their decision to allow a federal takeover of the exchange.

District of Columbia

Federal appellate court hears oral arguments on constitutionality of ACA's individual mandate

The U.S. District of Columbia Circuit Court of Appeals became the latest federal appeals court this week to hear oral arguments on whether Congress can mandate that all Americans buy health insurance or pay a tax penalty.

A lower court judge appointed by President Clinton upheld the individual mandate under the Affordable Care Act (ACA) last February. Judge Gladys Kessler specifically rejected arguments by the conservative American Center for Law and Justice that the individual mandate violates the constitutional rights of five individual plaintiffs who refuse medical care on religious grounds or prefer to pay out-of-pocket for holistic care (see Update for Week of February 21st).

However, the three-judge panel for the D.C. Circuit is controlled by two very conservative judges appointed by Presidents George W. Bush and Ronald Reagan. The third judge was appointed by President Carter.

During oral arguments, the two conservative judges appeared very skeptical that Congress could mandate the purchase of health insurance, echoing the "tea party" line that it would effectively make Congress' Commerce Clause power limitless. However, one of these two conservatives also appeared sympathetic to the findings of the Fourth and Ninth Circuit that the individual mandate could not be challenged until it actually goes into effect in 2014 (see Update for Week of September 5th).

Prior rulings have largely followed the political ideology of the judge, although two Republican-appointed appellate judges in the Sixth and 11th circuits recently broke rank and upheld the mandate, while a Democratic-appointed judge in the 11th circuit struck it down (see Update for Week of August 8th).

Florida

Republicans angered by CMS conditions on Medicaid managed care waiver

Republican lawmakers accused federal regulators this week of “dictating unilateral terms of surrender” by imposing new conditions for approval of Florida’s statewide expansion of Medicaid managed care.

Florida has operated a Medicaid managed care demonstration in five counties under a federal waiver that expired June 30th. The old waiver was temporarily extended while the Centers for Medicare and Medicaid Services (CMS) considered Florida’s plan enacted last spring to move nearly all Medicaid enrollees into capitated managed care plans (see Update for Week of August 1st).

However, CMS officials consistently warned lawmakers and state officials that any new waiver would not be approved without additional safeguards that protect against the access problems that occurred during the initial demonstration. The Urban Institute and Georgetown University’s Health Policy Institute have documented that savings under the demonstration often resulted only by managed care plans skimping on medical care provided to Medicaid enrollees (see Update for Week of April 4th).

Department of Insurance officials notified lawmakers this week that CMS now intends to require managed care plans in at least the original five counties under the demonstration to spend at least 85 percent of 2012 premium revenue on medical care instead of administration and salaries, similar to the medical-loss ratio (MLR) required for large-group plans under the Affordable Care Act (ACA).

The move angered Republican lawmakers, who had replaced a 90 percent MLR from initial drafts of the legislation with a shared savings plan (see Update for Week of May 2nd). The author of the Senate bill and chair of the Appropriations health subcommittee, Senator Joe Negron (R), blasted CMS officials for a “one-sided negotiation” that treats states like “beggars”. He reiterated his earlier calls for Florida to withdraw from Medicaid (a move his fellow Republicans have consistently rejected).

Kansas

Governor under fire for returning federal exchange grant

Both Democrats and Republicans on the House-Senate Health Policy Oversight Committee demanded answers this week on why Governor Sam Brownback (R) returned the state’s \$31.5 million federal grant to implement a health insurance exchange compliant with the Affordable Care Act (ACA).

Lt. Gov. Jeff Colyer (R) stood by the Governor’s decision to return the grant he had supported (see Update for Week of August 8th) and denied accusations that the Governor simply caved into pressure from tea party groups not to implement any part of “Obamacare”. Colyer insisted that the Early Innovator” grant had “too many strings attached” by the federal government and that Kansas should wait to see if the U.S. Supreme Court overturned the entire ACA before expending resources to implement it.

However, Brownback’s own insurance commissioner, Sandy Praeger (R), rejected Colyer’s rationale. Praeger chaired a National Association of Insurance Commissioners task force on exchange implementation and emphasized that the U.S. Department of Health and Human Services has bent over backwards to give states flexibility to “[do] what you want to do” in creating state-specific exchanges.

The commissioner has been the most vocal Republican supporter of the ACA. She served under former Governor Mark Parkinson (D), who was awarded the “early innovator” grant based on his Administration’s proactive efforts to develop the necessary technology infrastructure for a new exchange. Governor Brownback initially supported continuing this initiative and Praeger stressed that her office will proceed despite the Governor’s change of course.

Republicans were equally upset about the Governor returning the grant without consulting with lawmakers. Senator Pete Brungardt (R) regretted that the Governor passed on such a “huge opportunity” and criticized him for acting as if Kansas was a “banana republic” that could simply ignore federal laws.

Commissioner Praeger and several Republican lawmakers also took offense at the Lt. Governor for trying to claim that the exchanges would allow the federal government to determine coverage for costly end-of-life care. Praeger emphasized that such “death panel” claims were flat wrong.

Senator Roger Reitz (R), a physician, also rejected the Colyer’s claims that the Administration would have to dramatically cut Medicaid benefits and may follow the lead of other states to move most or all Medicaid enrollees into managed care (see Update for Week of September 12th). Reitz insisted that cutting services for “people that need our care” was counterproductive and would not save money.

However, the most conservative lawmakers continued to support the Governor’s actions. Rep. Brenda Landwehr (R), the committee vice chair who has led the charge to oppose any part of the ACA, and Rep. Charlotte O’Hara (R) both reiterated their opposition to the federal grant that the Governor received to upgrade the state’s Medicaid information technology system. They fear that the new billing system is simply a precursor to the exchange they oppose (see Update for Week of September 12th).

Louisiana

Transition to Medicaid managed care delayed for third time

The Director of the Department of Health and Hospitals announced this week that the signature health reform of Governor Bobby Jindal (R) would be delayed a third time in order to give patients and providers more time to adjust to the transition of most Medicaid enrollees into managed care.

Initially set to begin last July, the program has been temporarily blocked by a preliminary injunction obtained by Aetna (see Update for Week of September 5th). The latest postponement will move the start date for the new “coordinated care networks” in the New Orleans area from January to February, with a statewide phase-in completed by mid-2012.

Five private insurers have been chosen to manage the networks for two-thirds of the state’s 1.2 million Medicaid recipients. The companies form networks of physicians, hospitals and other medical providers through which care will be delivered.

However, the agency claims that the insurers are not prepared to begin in January, as the court challenge by Aetna (who was not selected) has impeded contract negotiations. Medicaid enrollees that will be transitioned also have yet to decide what network in which to enroll.

The Louisiana Hospital Association acknowledged that hospitals are wary of the program. Physician groups also sought a delay to learn more about the networks before signing contracts.

Massachusetts

Partners reach agreement with Blue Cross and Blue Shield to slow health plan rate hikes

Partners HealthCare System announced this week that they expect to reach agreement with Blue Cross Blue Shield of Massachusetts (BCBSM) to slow the rate of premium increases for tens of thousands of subscribers.

A preliminary understanding calls for Partners hospitals to accept \$80 million less in reimbursements annually for the next three years under a new contract with BCBSM. Employers and individuals who buy Blue Cross insurance covering Partners hospitals would still pay more under the proposed contract. However, projected 5-6 percent annual rate increases for 2012-2014 would be pared to 2-3 percent, for a total savings of about \$240 million during that period.

The contract would also shift how Partners hospitals are reimbursed, giving them budgets for a treatment category rather than fee-for-service. BCBSM has been steadily moving providers to such a “global payment” system under the alternative quality contract it rolled out in 2009. Nine hospitals run by Partners (which include some of the highest-paid hospitals in the Commonwealth) will now join that plan.

Governor Deval Patrick (D) heralded the voluntary cost-savings agreement between the state’s largest hospital network and its biggest health insurer as yet another example of the success of his campaign to reduce health insurance premiums. Earlier this year, health plans voluntarily limited their rate increases to single digits after the Patrick Administration reduced their double-digit increases in 2010 (see Update for Week of February 14th).

The Partners and BCBSM agreement is the latest of several cost-savings initiatives sought by both entities. BCBSM introduced a plan last winter to charge subscribers as much as \$1,000 more when they receive care from one of 15 hospitals that they designate as “high-cost” (see Update for Week of February 7th). At the Governor’s urging, Partners has also reopened existing contracts with other insurers that free-up \$40 million to be used to reduce premiums for small businesses and individuals. The savings would come in the form of lower rate increases rather than refunds.

House Majority Leader Ronald Mariano (D) has filed a bill to compel health plans to cut payments to the most expensive providers and increase them for those that receive the lowest reimbursement. He urged Partners and BCBSM this week to extend their cost-savings plan by at least three years.

Missouri

Republican appointees control appellate panel to hear Eighth Circuit challenge to ACA

The Eighth Circuit U.S. Court of Appeals named the three-judge panel this week that will hear oral arguments in October on a lawsuit challenging the constitutionality of the Affordable Care Act (ACA) mandate that everyone buy health insurance.

The panel features two judges appointed by President George W. Bush (Lavenski Smith and Steven Colloton). A third judge (Kermit Bye) was appointed by President Clinton.

Prior judicial decisions have largely followed the political ideology of the judges. However, two Republican-appointed judges in the Sixth and 11th Circuit broke ranks and recently upheld the individual mandate, while a Democratic-appointed judge in the 11th Circuit declared it unconstitutional (see Update for Week of August 8th).

The panel will consider a lawsuit brought by Lt. Governor Peter Kinder (R) after the Missouri Attorney General initially refused to join the multi-state lawsuit challenging the individual mandate. A lower court dismissed the case, ruling that he and the individual plaintiffs lack standing as they cannot speculate as to whether they would be uninsured and compelled to buy health insurance when the mandate goes into effect in 2014 (see Update for Week of August 22nd). The Fourth Circuit agreed this month that plaintiffs cannot challenge the mandate before they must pay the fine for not having health insurance (see Update for Week of September 5th).

Republican lawmakers force delay in implementing health insurance exchange

Department of Insurance officials backed-off plans this week to start spending a \$21 million federal grant on upgrading the computer technology needed to operate the new health insurance exchange required by the Affordable Care Act (ACA).

Missouri received the grant last month, in addition to the \$1 million initial exchange grant obtained last year by Governor Jay Nixon (D). However, a handful of tea-party backed Republican Senators

remain committed to blocking any provision of “Obamacare” from being implemented and successfully prevented exchange-authorizing legislation from passing last session.

Governor Nixon has already committed the board for the existing Missouri state high-risk pool to oversee the new Show-Me Health Insurance Exchange. The Department of Insurance has also allocated \$13.7 million for consultants to work on the technical aspects of the exchange.

However, the oversight board canceled votes this week on how to use the latest exchange grant after tensions rose during a meeting of the interim Senate committee created to gather public input on whether to create an exchange. Senator Rob Schaaf (R) accused the Nixon Administration of attempting to circumvent legislative approval, with Senator Jane Cunningham (R) warning of a “war” with the legislature if insurance officials proceeded without authorization.

The Republican Senators insist that create a state-run health insurance exchange contradicts the will of Missouri voters who passes a ballot resolution last year barring any state or federal laws from mandating participation in any health care system (see Update for Week of August 2, 2010).

Ohio

Insurance department report claims that individual premiums will soar due to federal reforms

A report released this week by the Department of Insurance (DOI) projects that individual premiums will soar 55-85 percent after full implementation of the ACA, while small group plans will rise 5-15 percent and large group plans by 3-5 percent.

Milliman consulting prepared the analysis for DOI and claimed that the cost increase was “primarily driven by the estimated health status of the new individual health insurance market and the expansion of covered benefits.” Benefit expenses in the individual market are roughly 40 percent less than the small or large group markets because individual plans tends to cover fewer benefits.

Lt. Governor and DOI Director Mary Taylor (R) trumpeted the findings as validation of her prediction that “Obamacare will result in bigger government [and] unsustainable costs.” However, critics point out that Milliman was forced to acknowledge that prior studies have overestimated costs attributable to the ACA by as much as \$1billion (see Update for Week of October 25th).

Oregon

Exchange board begins operations following Senate confirmation

The Senate this week confirmed the nine members of the Health Insurance Exchange Board appointed by Governor John Kitzhaber (D), clearing the way for the board to begin the process of creating the exchange required by the Affordable Care Act (ACA).

The appointments drew some controversy as they included two members of the health insurance industry, the maximum allowed by authorizing legislation (S.B. 99). Oregon is one of only eight states that allow insurers to serve on their exchange oversight board (see Update for Week of August 22nd).

The Board is charged with developing a “business plan” for exchange implementation by the February 1st start of the next legislative session.

Rhode Island

Governor issues executive order authorizing creation of health insurance exchange

Governor Lincoln Chafee (I) issued an executive order this week creating the health insurance exchange required by the Affordable Care Act (ACA) and naming the members of the oversight board to be chaired by former U.S. Attorney Margaret Curran.

The move was applauded by the Rhode Island Commission on Healthcare Reform, as well as House leaders, all of whom had urged the Governor to issue the order after authorizing legislation (S.B. 87) was blocked last session by House Republicans (see Update for Week of July 11th). The Rhode Island Right to Life Committee immediately threatened to block the Governor's order in court.

The executive order has several drawbacks. For example, the failed legislation would have created the exchange as a quasi-public corporation, but since the Governor lacked the authority to do so, he had to create the exchange as a state entity within the Governor's office. The order also expires after he leaves office (although his first term began last January.)

However, the rest of the Governor's order closely followed S.B. 87, as it barred board members from being affiliated with insurers or brokers (who can only participate in an advisory committee.) Two of the 13 members appointed by the Governor also had to represent consumer organizations.

Republican Governors in Alabama, Georgia, Idaho, Indiana, and Mississippi have already issued executive orders creating an insurance exchange after their respective legislatures failed to act last session (see Update for Week of June 6th).

Utah

CMS rejecting key parts of Medicaid reform waiver

Officials with the federal Centers for Medicare and Medicaid Services (CMS) have indicated that they do not support controversial provisions in Utah's Medicaid reform waiver, including those that would impose higher Medicaid cost-sharing, reimburse providers on a capitated basis, and give Medicaid enrollees vouchers for private coverage.

Under the waiver submitted last summer by the Department of Health (DOH), Medicaid enrollees for the first time would be required to pay an annual \$40 deductible and \$15-25 copayment for emergency room visits (see Update for Weeks of June 27th and July 4th). Federal Medicaid law currently limits out-of-pocket expenses to no more than five percent of annual beneficiary income and DOH acknowledges that CMS appears not likely to allow Utah to waive this maximum, at least for pregnant women and children.

The waiver also would allow DOH to ration Medicaid benefits whenever growth in the state's per capita Medicaid costs exceed growth in its general fund.

CMS has already denied a portion of the waiver that would allow certain Utahns to forgo Medicaid in favor of vouchers to purchase private health policies in the existing Utah Health Insurance Exchange. Utah's Premium Partnership for Health Insurance (UPP) already provides low-income working families with state subsidies to purchase coverage in the private marketplace. However, UPP has been plagued by low enrollment blamed on limited subsidies that failed to cover the cost of most private coverage, even under employer-sponsored plans (only 233 people enrolled as of July 31st).

Governor Gary Herbert (R) insisted that he was simply trying to "upgrade" UPP by giving participants access to the state's health insurance exchange. He publicly blasted CMS for their "absurd" rejection that "practically treat[s] Utahns like indentured servants." However, CMS Administrator Donald Berwick notes that the Governor's plan would have locked eligible children out of more affordable coverage in the State Children's Health Insurance Program (CHIP).