

Health Reform Update – Week of August 8, 2011

CONGRESS

11th Circuit panel strikes down individual mandate, upholds remaining ACA provisions

A three-judge panel for the U.S. 11th Circuit Court of Appeals held this week that the Affordable Care Act (ACA) mandate that everyone buy health insurance was unconstitutional.

The ruling evens the score in appellate decisions at one apiece. The Sixth Circuit Court of Appeals upheld the individual mandate last month, with conservative justice Jeffrey Sutton unexpectedly siding with the majority (see Update for Week of June 27th and July 4th).

The 11th Circuit's decision was expected, as all three judges from the most conservative appellate court expressed skepticism during oral arguments that Congress could use its traditionally-broad constitutional authority to regulate interstate commerce in order to mandate the lifetime purchase of health insurance (see Update for Week of June 6th). Two of the three judges were appointed to the bench by Republican Presidents and past decisions have typically followed partisan ideology, with the exception of Judge Sutton.

The split 2-1 decision was surprising only in that it did not follow these predicted divisions. Chief Judge Dubina, a staunch conservative appointed by President George W. Bush, wrote the opinion, which was expected given past decisions and the strident ACA opposition of his daughter, Congresswoman Martha Roby (R-AL), who has advocated for "abolish[ing] the IRS" agency that would enforce the individual mandate. However, Dubina was unexpectedly joined by Judge Frank Hull, a Clinton-appointee who became the first Democrat to rule against the mandate.

Judges Dubina and Hull held that the individual mandate was "woefully overinclusive" because it "represents a wholly novel and potentially unbounded assertion of congressional authority" that mandates the purchase of a product throughout "their entire lives".

In a surprise dissent, Judge Stanley Marcus accused the panel of willfully ignoring nearly two centuries of Commerce Clause precedent by invalidating the mandate. He noted that the courts consistently have broadened the Clause to the point where it "is now generally accepted as having afforded Congress the authority to create rules regulating large areas of our national economy." Judge Marcus is a Republican named to the lower court by President Reagan, and appointed as a compromise nominee to the 11th Circuit by President Clinton.

Despite disagreeing with the ruling, the Obama Administration was encouraged that all three judges over-ruled the decision by the lower court in the Florida panhandle to use the unconstitutionality of one provision to strike down the entire law (see Update for Week of January 31st). As a result, the U.S. Supreme Court is now expected to focus on whether the individual mandate is constitutional, and leave the remainder of the ACA intact.

The 11th Circuit decision is the most prominent of the challenges to the ACA, as it was joined by 26 state attorneys general and the National Federation of Independent Business. The Sixth Circuit decision was appealed last week to the U.S. Supreme Court (see Update for Week of August 1st). A Fourth Circuit panel is expected to rule shortly, with the Ninth and D.C. circuits to issue decisions this fall.

Verdict mixed on ability of “super committee” appointees to compromise on debt reductions

House and Senate leaders named the 12 members this week that will form the Joint Select Committee on Deficit Reduction created by the debt reduction compromise signed by President Obama (see Update for Week of August 1st).

At first blush the appointments appear to limit the ability of the so-called “super committee” to reach a consensus on a package of spending cuts or revenue increases that will further reduce the deficit by at least \$1.5 trillion (after an initial \$917 billion cut through yet to be determined spending caps). At least seven members of the committee must agree on recommended cuts to be sent to Congress by November 23rd. However, Democratic leaders appointed six lawmakers that pledged to protect entitlements and increase revenues while all six Republican appointees have already signed pledges to not raise taxes under any circumstances. They also omitted all members of the bipartisan and more moderate “Gang of Six” that previously worked in the Senate to try and forge compromise.

If the committee cannot reach a consensus, or if Congress fails to pass their recommendations, across-the-board spending reductions for 2012 will be automatically triggered. These automatic cuts could cut Medicare payments by two percent and put certain Affordable Care Act (ACA) funds at risk, although Medicare benefits, all of Medicaid and Social Security, and key ACA provisions remain exempt (see Update for Week of August 1st).

Despite the concern about the deep partisan divide on the committee, several lawmakers and their aides expressed optimism that the “all-star” make-up of the committee could lead to a consensus. House and Senate leaders did cater to their base by appointing members at the far left and right of their parties that are “dug in” to entrenched ideological divisions. This includes “tea party” backed conservatives like Rep. Jeb Hensarling (R-TX) and Senator Pat Toomey (R-PA), as well as liberal members like Rep. James Clyburn (D-SC) and Rep. Xavier Becerra (D-CA).

However, Congressional veterans stress that the committee only needs one “dealmaker” in order to get the simple majority needed to pass recommendations. They note that stalwarts like Senate Finance Committee chair Max Baucus (D-MT) and House Ways and Means Committee chair Dave Camp (R-MI) in particular have shown a willingness in the past to compromise on critical legislation and even worked together on President Obama’s debt commission last winter (despite both opposing its recommendations). Even Senator Toomey, despite his leadership of the ultra-conservative and anti-tax Club for Growth, indicated during the debt ceiling debate that he may be willing to support some limited revenue increase through tax reforms (though he ruled out any increase in tax rates).

The remaining members include Senators Patty Murray (D-WA), John Kerry (D-MA), Jon Kyl (R-AZ), and Rob Portman (R-OH) and Representatives Chris Van Hollen (D-MD) and Fred Upton (R-MI), chair of the House Ways and Means Committee.

Drop in nation’s credit rating could compel “super committee” to cut entitlements

The unprecedented drop in the nation’s credit rating by Standard and Poor’s (S&P) could provide the new “super committee” that extra incentive needed to pursue politically-risky entitlement cuts and tax reform, according to an article this week in *The New York Times*.

S&P reclassified the U.S. credit rating from AAA to AA-plus despite the budget agreement reached last week by Congress (see Update for Week of August 1st). It cited the deep partisan conflict in Congress as likely to prevent the spending cuts and revenue increase needed to ensure the nation’s “long-term financial stability”. The credit rating agency specifically urged cuts to entitlement programs, concluding the “only minor changes on Medicare” contained in last week’s compromise will do little to avert future debt crises.

While AA-plus is a slight downgrade from which countries like Canada and Japan have quickly rebounded, it caused wild fluctuations this week in the financial markets and political embarrassment for

the Administration and Congress who immediately fought to assign blame. However, both Democratic and Republican lawmakers and staff speculated that S&P's signal that partisan politics has deep ramifications for the economy may actually spur the "super committee" to reach a more substantial compromise.

The other major credit rating agency, Moody's, indicated this week that it may likewise downgrade the nation's credit rating. Individual states could also be subject to downgrades.

House Republicans not giving up on investigating annual limit waivers by HHS

House Republicans threatened this week to use a "compulsory process" if the Department of Health and Human Services (HHS) does not voluntarily turn over more documents about its process for granting annual waivers from the new annual benefit limits required by the Affordable Care Act (ACA).

The chairman of the House Oversight and Government Reform Committee, Darrell Issa (R-CA), repeated his demands from earlier hearings that HHS fully explain the process for determining what entity will receive waivers, as well as produce copies of every waiver request. In a letter to HHS, Rep. Issa specifically doubted the agency's assertion last month that it had always intended to stop issuing new waivers this September (see Update for Week of June 20th). Issa noted that HHS memos from September 2010 indicate that the agency planned to require a new waiver application every year, as opposed to the three-year extension HHS ultimately provided.

HHS has issued more than 1,500 waivers allowing "mini med" plans to temporarily continue to offer limited benefit plans that do not comply with the annual limit restrictions that went into effect for plan years starting on or after last September 23rd. The Obama Administration feared that many of the employers and unions offering these plans were more likely to quit offering coverage instead of immediately upgrading their plans to comply with the new annual limits (see Updates for Week of September 6th and September 27th).

Avalere study says new Medicaid enrollees under ACA will be sicker and more costly

Avalere Health released a new study this week predicting that Americans who will gain insurance coverage through the expansion of the Medicaid program in 2014 will be sicker and more costly than current Medicaid enrollees. As a result, projections may underestimate the actual costs of the Medicaid expansion.

The consulting group based its conclusion on survey results showing that 61 percent of current Medicaid enrollees report that they are in excellent or very good health, as compared to only 51 percent for low-income and uninsured Americans. Researchers also found that while uninsured people experience chronic illnesses at roughly the same rate as Medicaid enrollees, their conditions are more likely to be left untreated or undertreated, resulting in more severe and costly illnesses once they are enrolled under a safety-net insurance plan. They noted that past studies have shown that uninsured people enrolling for the first time in Medicare initially consume more health care services than do those who were previously insured.

Avalere's findings conflict somewhat with other studies. The Public Policy Institute of California concluded this week that the uninsured in California were "relatively young" and healthier than the state's massive Medicaid population. More than half of California's uninsured are between age 19 and 40, and the vast majority are employed in full or part time job that fail to offer health benefits.

The chief actuary for the Centers for Medicare and Medicaid Services also recently predicted that overall health spending should remain fairly constant despite the expansion of coverage to 32 million Americans under the Affordable Care Act (ACA), as most of the newly-insured will be "younger and healthier" individuals who tend to use less intensive health services (see Update for Week of July 25th).

FEDERAL AGENCIES

Second set of exchange regulations focus on eligibility and enrollment, premium subsidies

The Department of Health and Human Services (HHS) and the Treasury Department issued the second set of proposed regulations this week governing the new health insurance exchanges authorized by the Affordable Care Act (ACA).

The latest rulemaking complements the initial Exchange proposed rule and Premium Stabilization proposed rule published last month (see Update for Week of July 11th). It will be published in the August 17th *Federal Register* and allow 75 days for public comment, during which time the agencies will conduct an “aggressive outreach campaign” that includes holding public forums in six cities.

The first of the new set of proposed rules, titled Exchange Eligibility and Employer Standards, sets new guidelines to facilitate the creation of the eligibility and enrollment system for the new exchanges. These guidelines clarify how eligible uninsured individuals and those working for small businesses can apply for and enroll in the private plans offered through the exchange. It creates a “consumer friendly” process where exchanges must consider whether applicants are eligible for all available programs, so that consumers do not have to guess at which programs they should apply.

The second proposed rule was issued by the Department of Treasury and outlines how an estimated 20 million Americans with incomes up to 400 percent of the federal poverty level (FPL) will get income tax credits to help offset the cost of exchange plans. It explains how the Internal Revenue Service (IRS) will determine the proper amount of the subsidy and then pay that amount in advance directly to the insurance company (in an effort to assist with limited cash flow for many middle-income Americans). The rule emphasizes that because tax credits are tied to premiums, older Americans who pay higher premiums will receive a greater tax credit.

Those who become eligible for smaller subsidies or become ineligible for subsidies due to an increase in income throughout the year will have to repay any excess subsidies they received to the IRS, subject to yearly caps set forth in the ACA. These caps prevent enrollees from unexpected and burdensome repayments at year’s end and range from \$600-\$2500 for married taxpayers, depending on income (or \$300-\$1,250 for single taxpayers). These caps were increased by Republican lawmakers as part of the bipartisan spending compromise signed by President Obama earlier this year (see Update for Week of April 4th).

The third proposed rule creates a “seamless” enrollment process that coordinates exchange enrollment with Medicaid or the State Children’s Health Insurance Program (SCHIP) for eligible applicants. Changes in income throughout the year mean that individuals may “churn” between Medicaid and subsidized coverage through an exchange. The coordinated enrollment process is designed to make that process run as smoothly as possible.

HHS will issue additional proposed rules on related matters such as appeals notices, presumptive eligibility, and the default model that will be used in states that refuse or fail to timely create an exchange.

HHS releases additional round of exchange implementation grants to 13 states

The Department of Health and Human Services (HHS) announced this week that thirteen states and the District of Columbia will split \$185 million in federal grants to help establish the new health insurance exchanges authorized by the Affordable Care Act.

The agency initially awarded \$1 million in Exchange Establishment grants last summer to every state except Alaska (as well as four territories). Three states (Indiana, Rhode Island, and Washington) received supplemental funding last spring, while seven additional states received substantial Early Innovator grants as a reward for taking the lead in developing the technology needed to operate the

exchanges (see Update for Week of February 14th) Florida, Oklahoma, and Kansas (see article below) have returned all or part of their grants to appease “tea party” opposition to implementing any provision of the ACA, and none of these states received the additional grants this week by HHS.

The latest round of grant funding was given instead to states that applied before June 30th and have taken significant steps towards implementing an exchange, regardless of whether their state has yet to pass authorizing legislation. The single largest grant (\$38 million) went to California, the first state to pass an exchange-authorizing law last fall. The second state to pass authorizing legislation, Maryland, receiving the second-highest grant (\$27 million). The remaining states (CT, DC, IL, KY, MN, MO, MS, NV, NY, NC, OR, and WV) are at widely varying stages of exchange implementation. Both Mississippi and Missouri received over \$20 million, despite joining multi-state litigation challenging the constitutionality of other provisions of the ACA.

Applications for the next round of exchange grants are due September 30th. California, Colorado, and Hawaii are among the states that have already applied or plan to apply.

Walgreen's to offer coverage in “lucrative” health insurance exchanges

Several media outlets including CNN reported this week that country's largest drugstore chain plans to begin selling health insurance starting this fall.

Though Walgreen's has yet to release any details, the chain apparently is developing a "variety of [health] plans with different price ranges and coverage levels." They apparently are motivated by the potentially “lucrative” market created in 2014 by the new health insurance exchanges authorized by the Affordable Care Act (ACA).

Walgreen's already operates more than 350 in-store "take care clinics" that provide affordable basic health care services like flu shots and vaccinations. The chain has never before offered health insurance. However, CNN claims that retailers, financial services providers, and even a “large payroll processor” are trying to “muscle” their way into the exchange market.

CMS to help enroll low-income seniors for Medicare Part D subsidies

The Centers for Medicare and Medicaid Services (CMS) announced this week that it will renew its marketing and outreach efforts to enroll more eligible Medicare Part D enrollees in the Low-Income Subsidy Program.

The agency estimates that up to two million enrollees may be eligible but have yet to enroll. The low-income subsidies pay up to \$2.50 for generic drugs and \$6.30 for each brand-name drug. To qualify, enrollees must have incomes less than \$16,335 a year (\$22,065 for married couples) and have resources limited to \$12,640 (\$25,260 for couples), excluding one home and one car.

Changes in Social Security Administration rules last year should make it easier to qualify. The agency no longer counts life insurance policies as a resource for eligibility purposes. Nor does it count, financial assistance received from family and friends to help pay for household expenses like food, mortgages, rent, and utilities.

GAO report says Medicare is most wasteful federal program

Medicare accounted for about 40 percent of wasteful federal spending in fiscal year 2010, according to a report released this week by the Government Accountability Office (GAO). While this figure accounts already tops a list of 70 different federal programs, it is likely to be even higher since GAO did not account for Medicare prescription drug payments.

The investigation found that about \$48 billion of the \$516 billion in Medicare payments to health care providers in 2010 were improper. Medicare's traditional fee-for-service program accounted for about \$34.3 billion of the wasteful spending, while the rest was attributed to Medicare Advantage.

Previously documented wasteful spending for Medicare Advantage was one of the primary reasons that Democratic lawmakers sought to dramatically curb the growth in Medicare Advantage payments under the Affordable Care Act (ACA).

The Inspector General for the Department of Health and Human Services (HHS) emphasized that much of the wasteful spending was likely not related to fraud, and were caused by incorrect coding, eligibility errors, or insufficient documentation.

STATES

Kaiser study shows that ACA will narrow wide state variation in individual premiums

The Kaiser Family Foundation published a new study this week showing that individual premiums average \$215 per month nationwide, but vary widely among states.

States with the lowest average monthly premiums were Alabama (\$136), California (\$157), Arkansas (\$163), Idaho (\$167) and Delaware (\$169). The highest average rates were found in Vermont and Massachusetts (\$400), as well as Rhode Island, New York, and New Jersey (\$244 to \$364).

The study notes that many factors play into the varying rates. These include variations in the cost of living, health care costs, the age distribution in a state, how effectively plans control costs, the benefits offered by plans and patient cost sharing.

The authors notes that the Affordable Care Act (ACA) should significantly narrow this variation, as it requires that individual plans cover a standard set of benefits, use defined tiers of cost sharing, limit age rating bands, no longer base denials on pre-existing conditions, and accept everyone regardless of health status. However, "premiums will likely continue to vary considerably due to differences in the cost of living in general and health care."

Report says states not doing enough to fight cancer, expand access to care

The American Cancer Society's Cancer Action Network (ACS CAN) released a new report this week at the annual convention for the National Conference of State Legislatures (NCSL) warning that most states are passing up key opportunities to control health care costs and expand access to treatment for costly illnesses like cancer.

The study criticized states for failing to expand access to overall health care, noting that only seven provide Medicaid coverage to adults without dependent children, while less than a quarter have passed legislation to create the new health insurance exchanges under the Affordable Care Act .

ACS CAN also specifically tracked legislative action in five areas related to cancer. These include funding for cancer screenings, laws requiring coverage for screenings, tobacco taxes, and anti-smoking initiatives. Delaware was the only state to meet ACS CAN's benchmarks in every category, and only three states (Hawaii, Maine, and New Jersey) met the group's goals in four of the five areas. The group singled-out Alabama, Florida, Idaho, Mississippi, Oklahoma, South Carolina, and Tennessee as states that are deficient in every one of these five areas.

Arizona

Superior Court becomes latest to allow Governor's Medicaid enrollment cuts

A Maricopa County Superior Court judge refused this week to block cuts to the state Medicaid program, saying a voter-approved law requiring health coverage for Arizonans below the poverty level does not force the Legislature to provide funding for it.

The ruling by Judge Mark Brain means an enrollment cap for childless adults under the Arizona Health Care Cost Containment System (AHCCCS) will remain in place, eliminating an estimated 110,000 enrollees in the coming year and freezing out an untold number of low-income Arizonans.

The Arizona Center for Law in the Public Interest represents those denied health care since the freeze was imposed July 8th and had filed suit arguing that it violates Proposition 204 passed by voters in 2000, and as well as a state constitutional amendment passed by voters in 1998 to prevent legislative meddling with ballot measures.

Judge Brain said the Voter Protection Act only prohibits the Legislature from amending or repealing voter-approved laws or diverting funds, but cannot compel them to take a specific policy action such as appropriating funds for certain projects.

Governor Jan Brewer (R) successfully passed more than \$500 million in spending cuts for AHCCCS in order to balance the state's record budget deficit earlier this year. She also obtained federal approval last month to cap enrollment for adults without dependent children, for savings estimated at \$190 million (see Update for Weeks of June 27th and July 4th).

The Center will Appeal to the Arizona Supreme Court, which has declined to intervene in related appeals. The Center argues that Judge Brain's decision effectively repeals the law that voters approved.

Roughly 250,000 people are covered under Proposition 204's coverage expansion, including about 6,100 people with serious mental illness, 1,200 with HIV/AIDS and 1,500 young adults poised to age out of Medicaid coverage for children. Those three groups are largely exempted from the freeze.

AHCCCS is awaiting federal approval for a raft of other reductions, including freezing enrollment for some low-income parents, eliminating, imposing mandatory copayments, eliminating emergency services for immigrants, and requiring AHCCCS patients to re-enroll every six months instead of annually.

Colorado

Exchange board elects one of only two consumer representatives to be chairperson

The Executive Director for the Colorado Coalition for the Medically Underserved was named this week as chairperson of the newly-created Colorado Health Insurance Exchange Board.

Gretchen Hammer was one of only two consumer advocates serving on the board. The other, hemophilia advocate Nathan Wilkes, withdrew his name for consideration as chair in order to serve on the by-laws committee.

Hammer prevailed in a 7-2 vote over Anthem Blue Cross and Blue Shield CEO Robert Ruiz for the leadership position. The Board has been beset by controversy over conflicts of interest since being named last month, as four of the nine members represent health insurers. Consumer groups have demanded the resignation of a fifth member, Eric Grossman, who heads a company that formerly contracted with the insurers. The exchange-authorizing legislation, S.B. 200, prohibits more than four of the Board's members from representing insurance industry interests (see Update for Week of July 11th).

The remainder of the Board's third meeting this week focused on a presentation of potential exchange designs by Wakely Consulting, and lessons learned by the first state to create an exchange (Massachusetts) and reports from technical working groups about exchange operations.

Indiana

Governor removes his ban on Healthy Indiana enrollment due to ACA

Indiana's health insurance program for low-income, childless adults will enroll up to 8,000 residents already on its waiting list and accept new applications for any remaining open slots, so long as applicants can provide proof of continued eligibility.

Childless adults age 19-64 may be eligible for the Healthy Indiana plan if they are uninsured for at least six months, ineligible for Medicaid or employer-based coverage, and earn less than \$21,780 a year. The novel demonstration plan created in 2008 through a federal waiver requires enrollees to contribute up to five percent of their income to health savings accounts used to pay their medical expenses. The state also pays into the account and covers all medical costs that exceed \$1,100 a year.

Governor Mitch Daniels (R) has trumpeted the bipartisan legislation creating the plan, which has used cigarette taxes and other state revenues to enroll over 42,000 residents. However, the Governor halted all enrollment immediately upon passage of the Affordable Care Act, in order to protest the fact that the new law does not permit these types of state health plans to continue after the mandate Medicaid expansion and health insurance exchanges begin in 2014.

However, the Governor agreed this week to start filling any slots that open up in the Healthy Indiana program due to disenrollment. Though he insists the state has no funds to expand enrollment, he said that he would like Healthy Indiana to serve as many residents as possible in order to help convince the Obama Administration to let it remain in effect after 2014.

Governor Daniels has repeatedly insisted that eliminating Healthy Indiana will increase state Medicaid spending after 2014, despite projections to the contrary from the Urban Institute, Congressional Budget Office, and other entities showing that states will financially benefit from the federal funding provided by the ACA for the mandated Medicaid expansion.

Iowa

Governor to lead health committee for nation's governors, protect states from "Obamacare"

Iowa Governor Terry Branstad (R) will join neighboring Governor Dave Heineman (R) of Nebraska in this year's leadership for the National Governors Association (NGA).

Both Branstad and Heineman are fervent opponents of the new federal health insurance reforms who signed their states on to the multistate lawsuit challenging the constitutionality of "Obamacare" (see article above). Heineman was elected last month to serve as the organization's President, while Democrat Jack Markell (D) of Delaware serves a vice-chair (see Update for Week of July 18th). Governor Branstad will head the NGA's Health and Human Services Committee.

Governor Branstad promptly declared that he will be an advocate to protect states against the "burdensome, monstrous new program that President Obama is forcing [on us]."

Kansas

Governor returns "early innovator" exchange grant he supported as recently as last month

Governor Sam Brownback (R) became the second Republican Governor this week to return the federal "early innovator" exchange grant obtained by his Democratic predecessor.

Seven states received the grants, which were designed to reward those states that took the lead in building the information technology systems needed to operate the new state-based health insurance exchanges authorized by the Affordable Care Act (ACA) (see Update for Week of February 14th).

Oklahoma received the largest grant (\$54.6 million). However, Governor Mary Fallin (R) returned it in the face of “tea party” opposition to implementing any provision of “Obamacare”, despite her ardent support for exchange-authorizing legislation that failed (see Update for Week of April 11th).

Despite his strident opposition to the new federal reforms, Governor Brownback also pledged through last month to continue the implementation projects advanced by his predecessor Mark Parkinson (D). The Governor had specifically endorsed the exchange concept and signed orders accepting the grant and directing state agencies to move forward.

However, local “tea party” groups ultimately persuaded the Governor to return the \$31.5 million grant in order to maintain “maximum flexibility” in the design of the exchange, including the nearly \$600,000 the state has already spent on implementation. One of these organizations, November Patriots, has threatened that “the grassroots will explode again” if the Governor followed the lead of Oklahoma Governor Fallin and created an exchange with only state or private funds.

The Governor’s decision was criticized by several Republican lawmakers and his own Insurance Commissioner, Sandy Praeger (R), who headed a key National Association of Insurance Commissioner task force developing model guidance for exchange implementation. Praeger, one of the few Republican supports of the new federal law, insisted that the lack of federal funding would make exchange implementation far more difficult, but that exchange work groups would continue to proceed. Rep. Bob Bethell (R), chair of the Aging and Long Term Care Committee, blasted the Governor for having “circumvented” the will of the Joint Health Policy Oversight Committee, which voted last year to use the federal funds to create the exchange.

It is not yet clear if an eventual exchange created by Kansas will even comply with ACA standards. Republican Governors in Alaska, Oklahoma, and Wisconsin have already stated that they will only proceed with a more limited exchange that does not include the consumer protections required by the new federal law.

Maine

Governor’s exchange advisory committee lacks consumer representation

Governor Paul LePage (R) announced this week that former House Minority Leader Joe Bruno (R), a vocal “Obamacare” critic, will lead the new advisory committee he created to recommend how to create a health insurance exchange authorized by the Affordable Care Act (ACA)

The Governor’s remaining appointments also drew heavy criticism from Maine Democrats as they lack any consumer representation. All but one of the nine-member Advisory Committee on Maine’s Health Insurance is an executive or lobbyist for health insurers, hospitals, or small businesses. The lone exception is the chairperson for Maine’s Indian Tribal-State Commission.

However, Bruno insisted that despite the committee’s slant it would seek to fully implement the provisions of the ACA, as it is “the law of the land.” He also pledged that consumers would have input into the legislative process. Bruno owns a chain of pharmacies and served as chairman of the Dirigo Health Agency Board of Trustees, an agency that Governor LePage successfully sought to eliminate earlier this year (see Update for Week of June 20th).

Bruno indicated that the committee will hire a Massachusetts-based consultant to help it draft recommendations for the Legislature, which are due September 1st (though Bruno plans to ask for an extension as the committee will not meet until August 16th). The Governor has stated that he would prefer the exchange follow the limited “Utah model” of an information clearinghouse where the state is not an active purchaser and does not negotiate exchange rates. Maine has already received a \$1 million federal grant to create the exchange and the Governor pledged to apply for a second grant in the coming weeks.

Massachusetts

Expanded coverage did not reduce patient volume in safety-net hospitals

A study published this week in the *Archives of Internal Medicine* found that while Massachusetts' landmark health reforms have increased coverage to over 97 percent of residents, the number of patients receiving care in safety-net hospitals actually increased.

Former Governor Mitt Romney (R) signed legislation in 2006 mandating that all residents buy health insurance or pay a fine, and creating a health insurance exchange where the state negotiated lower premiums and cost-sharing, while guaranteeing a comprehensive level of benefits. The Massachusetts model was largely copied by the Affordable Care Act (ACA) that became law last year.

The study found that the 2006 law has restrained premium growth to single-digits and limited the number of costly uninsured patients seeking care in safety-net hospitals. However, researchers from George Washington University's Public Health Department surprisingly found that these patients continued to seek treatment from safety net hospitals despite now having insurance. The overall number of patients treated at safety-net hospitals increased by about 31 percent during the first three years after the new law passed, and non-emergency visits increased by nine percent, or nearly twice the rate of standard hospitals.

Researchers concluded that the increase was a result of individual preferences by newly-insured patients to receive care at facilities with which they were already familiar. However, they noted it may also partly reflect a shortage of primary care physicians elsewhere. As a result, they emphasized the need for federal and state governments to resist the "certain temptation to cut back on the funding to safety-net providers" and continue support even after the ACA is fully implemented in 2014.

Rhode Island

New budget hikes premiums, ends cost-sharing assistance for Rite Care and Rite Share

The state budget for fiscal year 2012 signed last month by Governor Lincoln Chafee (I) will significantly raise premiums for enrollees in the state-subsidized Rite Care program, as well as end the state's cost-sharing assistance program under Rite Share.

Consumer advocates howled at the \$78 million in spending cuts for health and social service programs, which represented more than half of the \$150 million in cuts under the new budget. They complained that the Democratically-controlled legislature passed only \$30 million of the \$165 million in new revenues proposed by the independent Governor.

However, Democratic lawmakers point out that the higher premiums and cost-sharing will only affect about 13,000 people in Rite Care, the very successful demonstration program in which the state pays the premiums and cost-sharing for Medicaid enrollees or those just above Medicaid eligibility to enroll in one of three guaranteed issue managed care plans or any employer plan for which they may be eligible. Rhode Island claims that Rite Care saves the state about \$1 million per every 1,000 enrollees, or \$222 per family every month as compared to the costs of Medicaid.

Starting October 1st, RiteCare enrollees with incomes between 150 to 250 percent of the federal poverty level will have to pay premiums equally to about five percent of their income (about a \$30 increase in most cases.) Furthermore, the state will no longer pay all or part of the cost-sharing for prescriptions or physician visits for nearly 12,000 enrollees in its accompanying Rite Share program, which helped families afford employer-based coverage.

Lawmakers emphasize that only about ten percent of Rite Care and Rite Share enrollees will be impacted. However, advocates point out that the paltry \$810,000 in projected savings could easily have been obtained from other areas in the budget that did not severely impact these enrollees' access to care.