

Health Reform Update – Week of August 22, 2011

CONGRESS

Republican supercommittee co-chair says tax increases may be part of deficit reduction plan

Rep. Jeb Hensarling (R), co-chair of the new Joint Select Committee on Deficit Reduction, insisted this week that he would consider tax increases as part of a deficit reduction package, as well significant revisions to the Affordable Care Act (ACA). Stating that “everything is on the table”, Rep. Hensarling appeared to back-off the entrenched position of some of his conservative colleagues on the “supercommittee”, who had declared that they would not consider any revenue increase whatsoever.

Rep. Hensarling also announced that he is working with co-chair Senator Patty Murray (D-WA) to develop a meeting timetable and select an all-important staff director. The debt reduction law creating the panel (P.L. 112-25) required that the first meeting be open to the public and held no later than September 16th. However, the co-chairs have yet to decide whether subsequent meetings will be open or closed, although they agreed to build a website to provide the public with a way to “weigh in with their ideas and their thoughts for what the supercommittee can do.”

The panel must agree on deficit recommendations to Congress by November 23rd or automatic across-the board cuts in domestic and defense spending will be triggered (see Update for Week of August 1st).

Commonwealth Fund urges Congress to resurrect COBRA subsidies

The Commonwealth Fund published a new report this week documenting how the unemployed are skimping on needed medical care.

Researchers found that 57 percent of those who lost their employer health insurance between 2008 and 2010 became uninsured. Over 72 percent of these newly uninsured did not fill prescriptions, get recommended tests, or see a doctor because of the high cost barrier. At least 60 percent of the newly uninsured were unable to afford health insurance in the individual market.

The Commonwealth Fund used the finding to urge members of Congress to reinstate the federal subsidy for COBRA benefits under the American Recovery and Reinvestment Act (ARRA). The COBRA subsidy was passed by a Democratically-controlled Congress but refused to extend eligibility past May 31, 2010 due to deficit reduction concerns (benefits will be discontinued this month for those involuntarily terminated in May 2010). New COBRA subsidies are not likely to pass a House of Representatives that is currently controlled by Republicans with little appetite for further stimulus relief.

CBO forecast falling deficits but struggling economy

According to a Congressional Budget Office (CBO) estimate released this week, federal budget deficits over the next decade will fall substantially, thanks to the debt limit law passed by Congress earlier this month. However, the non-partisan scorekeeper warned that the economy will continue to struggle in coming years, with anemic growth that may jeopardize federal health reform funding and implementation.

In its August update of the Budget and Economic Outlook, CBO projects cumulative deficits over the 2012-2021 period will fall to \$3.49 trillion, compared to the \$6.74 trillion it had predicted in March. About two-thirds of that reduction is attributable to the new debt reduction agreement, which set caps on

future discretionary spending and created a trigger for additional automatic cuts if Congress does not approve another \$1.2 trillion in deficit reduction by December 23rd (see Update for Week of August 1st).

However, CBO's estimate is based on several huge and unlikely caveats, including the 2012 expiration of the Bush-era tax cuts for everyone. CBO also assumes that Congress will not pass any fixes to the Medicare physician payment formula that would avoid a 21 percent reimbursement cut.

Despite the projected reduction, the fiscal year 2012 federal deficit is still the third largest shortfall in the past 65 years, exceeded only by the \$1 trillion-plus deficits of the past two years.

Although CBO expects the economic recovery to slowly continue, the agency said growth will stay "well below" the economy's potential for several years. It projects real gross domestic product (GDP) will increase by 2.3 percent this year and by 2.7 percent next year. The agency projects unemployment will fall below nine percent in the fourth quarter of this year, but remain above eight percent until 2014.

FEDERAL AGENCIES

HHS grants first round of three-year waivers from new annual limit restrictions

The Department of Health and Human Services approved 106 waivers last month from the new annual limit restrictions under the Affordable Care Act (ACA) that went into effect starting with 2011 plan years. The new waivers are the first round of three-year waivers that come on top of 1,472 one-year waivers approved through the end of July that cover over 3.4 million Americans (or two percent of those with private insurance).

HHS announced last month that it will stop granting new waivers after September 22nd (see Update for Week of June 20th). The agency insists that the cut-off was always intended, although Republican lawmakers have accused the Obama Administration have ending the waivers due to the political controversy they have generated (see Update for Week of May 16th).

The Centers for Medicare and Medicaid Services (CMS) also published supplemental guidance last week that exempts Health Reimbursement Arrangements (HRAs) that are subject to the new annual limits from having to apply individually for annual limit waivers.

CMS launches cost-saving bundled payment initiative under Affordable Care Act

The Centers for Medicare and Medicaid Services (CMS) announced a new initiative this week to bundle Medicare payments to physicians and other providers in an effort to reduce costs through improved coordination of care.

Authorized by the Affordable Care Act (ACA), the demonstration reimburses care providers for a patient's entire treatment process rather than for each consultation or service. It creates four broadly defined care models that can receive payment, three of which models involve retrospective bundled payments while the remaining model relies on prospective payments. These models are:

- Model 1: Only care provided during an acute care hospital stay;
- Model 2: The acute care hospital stay, plus associated post-acute care;
- Model 3: Only post-acute care services;
- Model 4: A single prospective payment that encompasses all services delivered during an inpatient stay.

Administrator Donald Berwick insisted that the models give providers an incentive to avoid unnecessary or duplicative treatments that are the hallmark of the traditionally inefficient fee-for-service model. It seeks to avoid punishing the providers who succeed at keeping their patient healthy.

The American Hospital Association praised the initiative for allowing applicants to shape their own programs to meet local requirements rather than establishing a single model for the entire nation. However, she cautioned that hospitals will have to first study whether the incentives are strong enough before deciding whether to participate. Some providers fear they will receive less money overall in a bundled payment than under fee-for-service.

STATES

Arizona

Federal appeals court says higher AHCCCS copayments violate Medicaid law

A three-judge panel for the Ninth U.S. Circuit Court of Appeals ruled this week that higher mandatory Medicaid copayments first imposed in 2003 violate federal law.

The court found that the U.S. Department of Health and Human Services (HHS) abused its statutory discretion in initially approving the copayments, because they failed to serve any purpose besides cutting the state's Medicaid budget. Federal Medicaid law only allows the Secretary to approve "budget neutral" waivers of statutory requirements so long as the proposed state experiments have a "research or demonstration value."

After a seven-year court battle, Arizona raised copayments last November for more than 200,000 childless adults covered through a federal Medicaid waiver and made them mandatory, even though existing federal law does not allow care to be denied to enrollees who cannot afford their cost-sharing. However, the Ninth Circuit found that the "administrative record reveals that the purpose of Arizona's waiver application was to save money" and that "little, if any, evidence [showed] that the secretary considered the factors (federal law) requires her to consider before granting Arizona's waiver."

The copayments range from \$4 to \$30 and were in place for only four months before a class-action suit forced a freeze. That stay was lifted in November by a separate appeals court panel. As a result, childless adults and those Medicaid-eligible through a spend-down were wrongly being denied coverage by the Arizona Health Care Cost Containment System (AHCCCS) if they cannot afford the Medicaid copayment.

Current HHS Secretary Kathleen Sebelius has two weeks to decide whether to appeal the Ninth Circuit's reversal, or provide the court with additional information needed to uphold the copayments.

Both HHS and a separate state court are allowing Governor Jan Brewer (R) to proceed with her plans to drop Medicaid coverage by October 1st for childless adults earning below the federal poverty level, even though that coverage was approved by the voters in a 2000 ballot referendum (see Update for Week of August 8th). The Arizona Supreme Court has repeatedly refused to intervene in that decision.

Arkansas

Governor splits with surgeon general on health insurance exchange legislation

Governor Mike Beebe (D) and his Surgeon General differed this week on whether the 2012 fiscal session of the legislature should be confined only to budgetary issues or consider measures authorizing the health insurance exchange required by the Affordable Care Act (ACA).

Despite Democratic control of both chambers, authorizing legislation stalled last session in the face of strident tea party opposition and concerns that the new law would not withstand legal challenges. Surgeon General Joe Thompson (D) stressed that the legislature must pass the necessary legislation next session in order to have any possibility of meeting the January 2013 deadline under federal

regulations. If the legislature fails to act, Arkansas could lose not only state control of the exchange but also the \$1 million federal establishment grant it received last year.

However, next year's session is limited to budgetary issues unless a two-thirds majority in both the House and Senate agree to consider other business. Governor Beebe has thus far refused to join his Surgeon General's call for the legislature to do so, insisting that lawmakers have to "live with" their decision last session to allow a federal takeover of the exchange.

Insurance Commissioner Jay Bradford (D) suggested that the state instead pursue the flexibility granted by the Obama Administration in proposed exchange regulations to "partner" with the federal government in the first few years of exchange operation, and then ultimately assume full state control (see Update for Week of July 11th). Such a model likely would not require legislative approval.

Medicaid seeks federal waiver to pay by treatment episode, instead of fee-for-service

Governor Mike Beebe (D) submitted Arkansas' request for a federal waiver last week that will allow it to alter how it pays physician and providers under Medicaid.

State officials initially considered a program-wide overhaul in order to fill a \$60 million shortfall in the state's Medicaid budget. However, after months of statewide meetings with providers, Department of Human Services (DHS) Director John Selig elected to only select nine priority areas where greater payment efficiencies would bring about the necessary savings.

DHS already received federal approval in May to prepare a proposal to shift physician payments under Medicare from fee-for-service to payments based on an entire episode or course of treatment (similar to the federal model in the article above). The state now seeks to implement such "episodic" payments for maternal and neonatal care, diabetes, cardiovascular diseases, development disabilities, preventive care, and other specific conditions.

The Governor's letter to federal regulators emphasized that the state chose this "episodic" payment approach in lieu of the "deep program cuts seen in other states." He also noted that Blue Cross and Blue Shield of Arkansas agreed to front half the \$3 million cost to hire a consulting firm to develop the new payment model.

California

Landmark rate review legislation heads to Senate floor, similar ballot measures in the works

A leading California consumer rights group is trying to place voter referendums on the 2012 ballot that would create a public health insurance option, a 20 percent rollback in health insurance rate, and greater oversight of premium increases.

The initiative is sponsored by Consumer Watchdog, the same organization responsible for Proposition 103, the landmark 1988 ballot measure that established regulatory and cost oversight of state auto insurance rates.

Consumer Watchdog Executive Director Jamie Court insisted that their proposed 2012 measures would be a "bellweather" and be passed by "every other major state" once approved by California voters. However, state passage is far from certain. The group must first get 700,000 signatures and then face opposition from an insurance industry that has pledged to invest more than \$100 million to fight it.

Insurers, as well as physician and hospital groups, are already massing to oppose landmark legislation that would allow give the state insurance commissioner that same authority to reject or modify health plan rates that his office was given under Proposition 103. A.B. 52 cleared a major obstacle this week when it passed the Senate Appropriations Committee on a straight party-line vote (without any Republican support). It now heads to the Senate floor, after already passing the Assembly in June.

Senate passage remains in doubt, as the Department of Finance recently estimated that the measure would cost nearly \$58 million just in first year administrative and start-up costs (see Update for Week of August 15th). The floor vote must be held before the session ends on September 9th.

The Appropriations Committee in the Assembly also approved a measure (S.B. 51) implementing the new medical-loss ratios in the Affordable Care Act (ACA). However, measures related to enrollment in the new health insurance exchange (A.B. 714 and A.B. 792) and the creation of a Basic Health Plan authorized by the ACA (S.B. 703) were held over until next session.

Federal regulator, former consumer advocate named to head exchange board

The California Health Benefit Exchange unanimously approved the appointment of Peter Lee this week to be its first executive director.

Lee will oversee planning, development and ongoing administration and evaluation of the exchange. A longtime consumer advocate in California and for the National AIDS Network, he currently serves as deputy director for the Center for Medicare and Medicaid Innovation within the U.S. Department of Health and Human Services (HHS), an office created by the Affordable Care Act (ACA). In this position, he has overseen that development of initiatives to identify, test and support new models of care in government programs that can result in higher quality care while reducing costs.

Lee also has an industry background, having served as CEO for the Pacific Business Group on Health. However, consumer advocates were still quick to praise his appointment as a good indication that the Board will actively use its “bargaining power to negotiate for price and value.”

Office of AIDS expands premium assistance programs

The California Office of AIDS has greatly expanded its premium assistance programs effective July 1st. The changes effect the premium assistance offered by CARE/HIPP for those with employer-based coverage and AIDS Drug Assistance Program (ADAP) clients enrolled in Medicare Part D. They also offer premium assistance to enrollees in the new federal high-risk pool.

The CARE/HIPP program expanded eligibility, increased the amount of monthly premium assistance, and remove time limitations on assistance. For the first time, it will also pay partial premiums for plans whose premium exceeds the new limit of \$1,339 per month for non-ADAP clients and \$1,938 per month for ADAP clients. The changes also effect premium payments for ADAP clients who have Part D prescription drug coverage.

The Office of AIDS is also offering new premium assistance for those who are uninsurable and enrolled in the new Pre-Existing Condition Insurance Plan (PCIP) created by the Affordable Care Act (ACA). After a slow start, California’s PCIP is the second largest federal high-risk pool in the nation (see PCIP Update for Week of August 22nd).

Connecticut

Advocates distressed over insurance-heavy exchange board, lack of consumer representation

Connecticut became the latest state this week to create a health insurance exchange board with a heavy insurance industry presence.

Allowing insurers to serve on the boards overseeing exchange creation and operations has been a source of intense controversy in several other states. As a result, the Democratically-controlled legislature insisted on prohibits insurers from serving on the exchange board created by authorizing legislation (S.B. 921) enacted earlier this year (see Update for Week of June 6th).

As a result, consumer advocates were shocked when the Governor Daniel Malloy (D) and leading lawmakers selected former insurance executives from three of the nation's largest insurers to serve on the 11-member board, while neglecting to appoint a single consumer advocate as a voting member.

The Governor's special advisor on health reform insisted that consumers will have plenty of other opportunities to participate in the exchange development progress, but that the design of the exchange should be left up to those with an expertise in health insurance and information technology. In addition to former insurance executives, the board will also be composed of the head of a coalition for unionized health workers, an academic lecturer, and the CEO of a green energy alliance. The lone voice for consumers is the State Healthcare Advocate, a non-voting member.

The Advocacy for Patients with Chronic Illness was quick to slam the selections, pointing out that the lack of consumer representation conflicts with recently published federal regulations, which state that "exchanges are intended to support consumers, including small businesses, and as such, the majority of the voting members of governing boards should be individuals who represent their interests" (see Update for Week of July 11th).

Idaho

Republican lawmakers come around to Governor's support for creating an insurance exchange

Governor Butch Otter confirmed this week that Idaho will apply by September 30th for a \$40 million federal grant to establish the insurance exchange authorized by the Affordable Care Act (ACA).

Idaho's Republican-dominated legislature has been adamantly opposed to accepting any federal grants under the ACA, fearful that it would effectively "marry" the state to a law that is very unpopular in the highly conservative state. However, Insurance Commissioner Bill Deal (R) told an interim health care committee that forgoing exchange funds would have a far more adverse impact upon the state, as up to 2,500 insurance agents could be forced out of business if Idaho simply allows the federal government to operate their own "one size fits all" exchange. Deal warned of a "very disruptive...economic disaster" from a federal "takeover" of the exchange, and insisted that it would be more advantageous to Idaho to tailor an exchange to their own needs.

Earlier this year, Governor Otter vetoed legislation (S.B. 298) that would have prohibited him from accepting any federal funds under the ACA and force him to return \$2.5 million in exchange grants. Instead, he issued an executive order that banned state agency implementation of every ACA provision except the exchange (see Update for Weeks of April 18th and 25th). He has since agreed to accept \$19 million in federal ACA grants for "unobjectionable" provisions (see Update for Week of July 18th).

Despite their previous differences, Republican lawmakers now largely support the Governor's position. Senator John Goedde (R) acknowledged that Idaho would not be able to create an exchange with state-only funding, given its current budget constraints. Senator Joe Stegner (R) agreed that it would be "extremely short-sighted" to forgo \$40 million just to make a political statement opposing the new law.

Republican lawmakers also formed a work group that has already drafted potential exchange-authorizing legislation. The bill proposes create a nine-member exchange board that could include health insurers, a source of controversy in states like Colorado and North Carolina. The exchange would be free from taxation, as well as state personnel and procurement regulations. The exchange legislation would also automatically be rescinded if the ACA was declared unconstitutional by the U.S. Supreme Court.

Mississippi

Governor moves ahead with insurance exchange, despite lack of authorizing legislation

Insurance Commissioner Mike Chaney (R) announced this week that he expects Mississippi to have an operational health insurance exchange by next year.

Mississippi was awarded a \$20 million federal exchange establishment grant earlier this month to create an exchange compliant with the Affordable Care Act (ACA), in addition to the initial \$1 million it received last year.

Governor Haley Barbour (R) has pushed for a state health insurance exchange since 2007 and sought both grants, despite his vociferous criticism of the new federal law. He has identified a voluntary, market-driven exchange as central to his efforts to reduce Mississippi's traditionally high uninsured rate, as well as nation-leading rates of obesity, heart disease, and other health problems.

However, the Governor's authorizing legislation was blocked last session by the House of Representatives. As a result, his Insurance Commissioner had to use his authority to move forward on implementation without legislation. Commissioner Chaney has already selected the non-profit Comprehensive Health Insurance Risk Pool Association to operate the exchange, designated a subgroup of the state high-risk pool administrator to serve as the exchange oversight board. The Commissioner also held public hearings across the state to solicit input on exchange design options.

The model sought by the Commissioner echoes the plan that failed in the House. Mississippi remains the only state seeking to house the exchange within its existing state high-risk pool, an option advised by Leavitt Partners, the consulting firm hired by Mississippi and other states. However, the oversight board for existing high-risk pool that would serve as an exchange board does include four representatives of health insurers or brokers, a potential conflict that has created intense controversy in states like Colorado and North Carolina.

Republican lawmakers have been split on whether to support the Commissioner's initiative. State Rep. Gregg Harper (R) opposes implementing any ACA provision until the U.S. Supreme Court has ruled on the multi-state lawsuit challenging the individual mandate under the ACA, which Mississippi joined. However, U.S. Senator Thad Cochran applauded the Governor and Commissioner for ensuring that Mississippi had an exchange tailored to state needs, instead of allowing a federal takeover.

Missouri

Nine state attorney generals file briefs opposing Eighth Circuit challenge to Affordable Care Act

At least 21 state officials including nine state attorneys general have now filed "friend-of-the-court" briefs in the Eighth Circuit U.S. Court of Appeals supporting the constitutionality of the new federal mandate that everyone buy health insurance.

Missouri Lt. Governor Peter Kinder (R) filed his own lawsuit in 2010, as the Attorney General refused to do join the multi-state lawsuit challenging the constitutionality of the individual mandate under the Affordable Care Act (ACA). A lower court dismissed the case last April; ruling that the Lt. Governor and other plaintiffs lacked standing because they currently had health insurance and could not speculate whether they would be required to purchase coverage after the individual mandate is effective in 2014.

Lt. Governor appealed to the Eighth Circuit, which has agreed to accept briefs through August 30th and hear oral arguments on October 17th. The Sixth Circuit has already upheld the mandate, while the 11th Circuit declared it unconstitutional (though upholding the rest of the new law). The D.C Circuit is scheduled to hear oral arguments on a similar lawsuit on September 23rd.

Kinder had used his lawsuit as a platform to challenge Governor Jay Nixon (D). However, he has since become embroiled in a personal scandal that threatens his declared candidacy.

Missouri Attorney General Chris Koster (D) ultimately acceded to demands from Kinder and other Republican lawmakers that he support the multi-state litigation in the 11th Circuit. However, instead of

formally joining the lawsuit, Koster merely filed a “friend-of-the-court” brief urging the 11th Circuit to invalidate the individual mandate, as it did earlier this month (see Update for Week of August 8th). A former Republican, Koster remains the only Democratic Attorney General to challenge the individual mandate’s constitutionality.

Montana

Insurance department to proceed with exchange, even if it means federal partnership

State Auditor Monica Lindeen (D) announced this week that her office will continue to implement the health insurance exchange required of the Affordable Care Act (ACA), despite legislative opposition.

Republican lawmakers who control the House and Senate refused to pass the necessary exchange-authorizing legislation last session and forced Governor Brian Schweitzer (D) to veto several bills seeking to block state agencies from accepting federal implementation grants or implementing any ACA provision (see Update for Week of April 11th).

However, the Governor and State Auditor are refusing to accept federal government control over the exchange that will occur if the state is not prepared to go forward in January 2013. Instead, they are seeking to take advantage of the greater flexibility afforded by recent federal regulations to partner with the federal government (see Update for Week of July 11th).

Lindeen announced that her chief legal counsel and related staff will meet with federal regulators in the coming weeks to develop a plan to partner with the U.S. Department of Health and Human Services (HHS) to create an exchange that will ultimately be under full control of state officials. Her office will also apply by September 30th for an additional exchange establishment grant.

Her decision followed the presentation this week by a regional HHS official before a legislative panel in Montana, outlining the steps the state could still take to avoid a federal takeover of the exchange since the legislature will not be back in session until after the deadline. The HHS official emphasized that HHS will design Montana’s exchange based on input they receive from state officials.

Despite blocking all exchange efforts last session, the legislature did create the interim Economic Affairs Committee to study and possibly draft an exchange authorizing bill for the 2013 session. The federal-state partnership model met with the approval of committee chair, Rep. Tom Berry (R), who insisted that there “may be enough mainstream Republicans” in the legislature who realize that “the more input Montana has on our own exchange will be a great benefit to the citizens of the state.” However, other members of the panel were skeptical that the partnership would enable state agencies instead of lawmakers to direct exchange implementation.

New Jersey

Senate finally passes bill creating health reform implementation council, exchange bill awaits

The Senate passed legislation this week on a largely party-line vote creating a 29-member Health Care Reform Implementation Council. (A companion bill remains under consideration in the Assembly.)

The measure (S.2239) introduced last September would assure consumer representation as organizations like AARP New Jersey and the Statewide Parent Advocacy Network will each be able to appoint one member. Insurer and provider groups can also directly appoint members. The Council is charged with developing recommendations for state agencies, lawmakers, providers, and payers to consider in implementing provisions of the Affordable Care Act (ACA).

Even though New Jersey has a Democratically-controlled legislature and a Republican Governor who supports implementing some provisions of the ACA, the state has lagged well-behind others in moving forward. Legislation authorizing the state to create a health insurance exchange (A.1930/S.2553)

passed the Assembly last June but still awaits Senate action. It would prohibit insurers from serving on the exchange oversight board, a major source of controversy in other states.

Oklahoma

Governor rejects any state-federal partnership to create health insurance exchange

Governor Mary Fallin (R) emphatically affirmed her commitment this week to implementing a state-funded or privately-funded health insurance exchange that “is not going to be associated with the president’s health care plan or federally run exchange.”

The Governor had been under pressure from Democratic lawmakers and some Republicans to back-off her rejection of any federal grants or assistance in creating a health insurance exchange compliant with the Affordable Care Act (ACA). Despite her earlier support for exchange-authorizing legislation, Fallin reversed course earlier this year in the face of intense tea party opposition and returned the state’s \$54 million “Early Innovator” exchange grant, the largest in the nation. She has since pledged that any Oklahoma exchange will be built without federal funds and be more limited than required by the ACA (see Update for Week of April 11th).

Governor Fallin insisted that she was uninterested in the Obama Administration’s latest proposal to partner with states to implement the exchange by the January 2013 deadline, or to allow states to ultimately operate the exchange, even if they opted for the federal government to initially assume control (see Update for Week of July 11th). The Governor stated that she would take her lead only “from the state leadership” and pursue “state-only solutions”.

However, it is not yet clear how the Governor will obtain the necessary state or private funds to create an exchange, given the \$500 million budget shortfall faced by the state.

Oregon

Governor appoints insurance industry representatives to exchange board

Governor John Kitzhaber (D) named his appointees this week to the Oregon Health Insurance Exchange Board.

Despite lamenting the fact that the authorizing legislation did not bar insurers from serving on the exchange oversight board (see Update for Week of May 30th), the Governor nominated two representatives of health insurers, the maximum allowed by the new law. S.B. 99 likely would not have secured sufficient Republican support to pass the evenly-divided House without allowing for insurer representation (see Update for Week of June 6th).

Oregon is one of only eight states whose authorizing legislation allows insurers to serve on the exchange board. Similar legislation has created intense controversy in states like Colorado and North Carolina.

The Governor’s appointments are contingent on Senate confirmation and will be heard by the Senate Rules Committee on September 22nd. The Board is charged with working with the Oregon Health Authority and Department of Consumer and Business Services to develop a “business plan” by the February 1st start of the next legislative session that details how to implement the exchange. The Board will principally recommend whether the state should be an “active purchaser” and exclude health plans that do not meet minimum coverage and affordability standards (similar to the Massachusetts model).

Wisconsin

Office of Free Market Health Care distorts impact analysis of Affordable Care Act

The Office of Free Market Health Care created by Governor Scott Walker (R) issued a one-sided version of an analysis of the Affordable Care Act (ACA) ordered by his predecessor.

Governor Walker issued an executive order last spring that converted the Office of State Health Reform created by Governor Jim Doyle (D) into the Office of Free Market Health Care, charged with pursuing only market-based reforms (see Update for Week of March 21st). The Office of State Health Reform had used federal planning grants to contract for an impact analysis of the ACA by Gorman Actuarial and economist Jonathan Gruber, who advised Massachusetts on their universal care model upon which the ACA is based, as well as Vermont on its new single-payer health system legislation.

The market surveys completed as the first phase of the analysis were posted last spring on the Office's website. They found that Wisconsin had highly-competitive health insurance markets with most plans already meeting or exceeding the new insurer payout standards under the ACA (see Update for Week of March 14th).

The second phase included modeling the actuarial and economic impacts resulting from the ACA. Democrats such as Assembly health committee member Rep. John Richards (D) were quick to criticize the excerpts posted on the Office's website this week that appeared to selectively identify adverse conclusions or distort the findings. For example, the Office ignored the finding that Wisconsin will see a 65 percent decrease in its rate of uninsured, or that projected premium increases from the expanded coverage for high-risk uninsurables would be mitigated by federal premium subsidies for those earning up to 400 percent of the federal poverty level. The study found that once the subsidies go into effect in 2014, about 60 percent of individual plan subscribers will see their premiums rise up to 31 percent. However, over 40 percent experience up to a 56 percent drop in premiums.