

Health Reform Update – Week of November 7, 2011

CONGRESS

Conservative appeals court panel refuses to overturn mandate to buy health insurance

A federal appeals court judge appointed by President Reagan cast the deciding vote this week to uphold the federal mandate that everyone buy health insurance or pay a tax penalty, holding that “the right to be free from federal regulation is not absolute, and must yield to the need for Congress to solve national problems, no matter how local or passive their origin.”

Even though the U.S Supreme Court will ultimately determine the fate of the individual mandate, the decision by the District of Columbia U.S. Court of Appeals is significant because it was authored by Judge Laurence Silberman, who thus becomes the third conservative appellate judge to break ranks and uphold the individual mandate. Only one Democratic-appointed judge (a compromise nominee of President Clinton) has taken the opposite position (see Update for Week of August 8th).

The only dissenting judge on the D.C. Circuit’s three-judge panel, Brett Kavanaugh, also became the first conservative justice to side with an earlier Fourth Circuit decision that the Anti-Injunction Act bars judicial review of a tax penalty until it actually goes into effect (see Update for Week of September 5th).

Their decisions come as a surprise, as both judges indicated during oral arguments that they were alarmed about Congress’ power to regulate interstate commerce becoming limitless (see Update for Week of September 19th). However, each eventually declined to overrule two centuries of U.S. Supreme Court precedent giving Congress broad authority under the constitutional Commerce Clause.

Many legal commentators, including retired Supreme Court justice John Paul Stevens, expect the high court to ultimately follow the parallel Judge Silberman drew to the interstate commerce authority the high court gives Congress under the Civil Rights Act and federal medical marijuana laws (see Update for Week of September 26th). Silberman concluded that even though mandating the purchase of insurance “certainly is an encroachment on individual liberty...it is no more so than a command that restaurants or hotels are obligated to serve all customers regardless of race, [or] that gravely ill individuals cannot use a substance their doctors described as the only effective palliative for excruciating pain.”

Judge Silberman used these analogies to reject the plaintiffs’ argument that forgoing health insurance was “inaction” that fails to constitute interstate commerce. He insisted that people need not be active participants in a given market in order to be subject to federal mandates and agreed with the Obama Administration that health care is a unique market that “virtually everyone will enter or affect”, as those who are uninsured will eventually “inflict a disproportionate harm on the rest of the market.”

The D.C. Circuit case was brought by the conservative American Center for Law and Justice, as well as four individuals who refuse treatment on religious grounds or pay out-of-pocket for holistic care. Even though they are not one of the cases that the Supreme Court will decide whether to hear this week, the decision may still affect its review as two of the three appellate courts to rule on the merits of the individual mandate have found it constitutional. The Supreme Court also traditionally pays close attention to D.C. Circuit decisions, since four justices including Chief Justice Roberts ascended from that court.

The Fourth Circuit declined to rule on the merits, holding that constitutional challenges were premature. The Obama Administration is encouraging the Supreme Court to instead issue a definitive resolution this session and not effectively “punt” the decision until 2014 by following the Fourth Circuit’s rationale (see Update for Week of October 3rd).

“Super committee” still at an impasse despite concessions

Republicans and Democrats on the Joint Deficit Reduction Committee took turns this week shooting down competing plans to reduce the deficit by \$1.2 trillion over ten years. The continued stalemate appears to have greatly increased the odds that the so-called “super committee” will miss the November 23rd deadline to pass recommendations or trigger automatic across-the-board spending cuts.

Democrats quickly rejected a Republican concession to raise tax revenues by nearly \$300 billion over the next decade, primarily by eliminating itemized deductions and write-offs. Even though it was the first retreat from their hard-line stance against higher taxes, the proposal actually would have significantly cut the top tax rate for the wealthy from 35 to 28 percent, making it a non-starter for Democrats.

Republicans also sought to raise the Medicare eligibility age to 67 and cut Medicare and Medicaid spending by \$275 billion, proposals that have only limited Democratic support.

A competing plan from Democrats would have reduced the federal deficit by over \$1 trillion more than the committee’s \$1.2 trillion mandate. However, it immediately drew fire not only from Republicans, but also Democratic constituencies, as it would gut the Prevention and Public Health Fund under the Affordable Care Act (ACA). Consumer advocates who were already upset that President Obama proposed to cut the fund by 25 percent through fiscal year 2015 (see Update for Week of September 19th) were furious that “super committee” Democrats were willing to cut \$8 billion of the \$15 billion Congress allocated over the next ten years to remove cost sharing for certain Medicare services.

Although the latest Democratic plan is more limited than prior versions, it still cuts about \$400 billion from Medicare and Medicaid, mostly by increasing cost-sharing for certain enrollees. It also expands drug manufacturer rebates for the nine million people enrolled in both Medicare and Medicaid.

CBO nearly doubles projected savings from ban on “pay-to-delay” generic drug settlements

A Congressional Budget Office (CBO) cost estimate this week concludes that legislation banning “pay-to-delay” generic drug settlements will save more than they initially projected.

The Federal Trade Commission (FTC) has sought for over a decade to bar “anti-competitive” patent litigation settlements that allow generic drugmakers to receive huge payments from brand-name manufacturers in exchange for an agreement to delay introduction of lower-cost drugs for several years. They lobbied the so-called “super committee” last month to include such a ban as part of any recommendations they pass to reduce the federal deficit, insisting that it would save as much as \$3.5 billion per year (see Update for Week of October 24th). President Obama made a similar presentation, claiming a “pay-to-delay” ban would save \$8.8 billion over ten years.

Senators Herb Kohl (D-WI) and Chuck Grassley (R-IA) have introduced legislation the past two sessions that would enact the ban sought by the President and the FTC. However, CBO predicted earlier this year that their latest bill (S.27) would save only about \$2.6 billion over a decade. Their latest cost estimate nearly doubles that projection to \$4.8 billion over ten years.

Both brand-name and generic drugmakers remain strongly opposed to the proposed ban.

Latest polling shows most Americans want government more involved in health care

Despite recent surveys finding that a majority of Americans prefer more limited government, a new poll released this week by the Robert Wood Johnson Foundation and Harvard School of Public Health found that more than half of Americans (52 percent) want government more involved in providing health services while only 37 percent want government to limit the health services it currently provides.

Nearly two-thirds of those surveyed also said improving Medicare should be a top priority for the federal government, with another 56 percent supporting the same emphasis on improving Medicaid. Six in ten believe that the U.S. will save money in the long run by spending more on preventive services.

Although the new federal mandate to buy health insurance remains intensely unpopular, the poll found significant support for another controversial provision in the Affordable Care Act (ACA). Over 45 percent of those surveyed believed that providing federal tax credits to help the uninsured afford coverage should be a top priority of the federal government.

FEDERAL AGENCIES

Final rule on medical-loss ratios awaits OMB clearance

The Department of Health and Human Services (HHS) has submitted final rules to the Office of Management and Budget (OMB) that will clarify how new medical-loss-ratios (MLRs) will be applied to limited benefit or “mini-med” plans.

The Affordable Care Act (ACA) requires that individual and small group health plans spend at least 80 percent of premium revenue on medical care (85 percent for large groups). Interim final rules released last year by HHS allowed for one-year waivers for limited benefit plans so that they could continue to operate while employers and plans and time to adjust to the new MLR standard. However, the rule required plans to report data about “mini-med” expenses and profits early in 2011 so that HHS could decide how to apply the standard in the future.

Prior HHS guidance has required employees enrolled in limited benefit plans to receive written notice detailing the how their coverage fails to meet ACA standards (see Update for Week of December 6, 2010).

OMB’s paperwork clearance is the last stage before publication. It typically takes less than 30 days, though recent regulations have been stalled at OMB for over six months.

Affordable Care Act has reduced Part D “doughnut hole” costs by over \$1.2 billion

More than 2.2 million Medicare Part D enrollees have saved an average of \$550, thanks to the 50 percent discount on brand-name drugs required by the Affordable Care Act (ACA) as of January 1st. This is an increase from the \$530 average discount last month (see Update for Week of October 3rd).

The latest monthly figures from the Centers for Medicare and Medicaid Services (CMS) show that Part D enrollees have saved more than \$1.2 billion in drug costs. New Jersey residents received the greatest average discount of \$686, while the lowest discounts of \$274 were in Hawaii.

Nearly two million more Medicare beneficiaries also received at least one free preventive benefit in October, as a result of the ACA.

Treasury refutes study claiming few small businesses are taking advantage of ACA tax credits

The Treasury Department quickly fired back this week to refute a study by their own Inspector General (OIG) claiming that fewer small businesses than expected are receiving federal tax credits to help them purchase employee health insurance coverage.

The OIG report found that as of mid-May only around 228,000 employees benefited from \$278 million in tax credits pursuant under the Affordable Care Act (ACA). These figures were disappointing, given that the marketing effort by the Internal Revenue Service (IRS) to notify more than four million taxpayers that are eligible for the credit.

Treasury officials insist that the OIG figures are outdated, claiming that their recent data shows that \$435 million in credits had been claimed. However, this is still far below the \$2 billion in tax credits that the Congressional Budget Office (CBO) predicted taxpayers may claim in 2010 alone.

The IRS notes that many small businesses file their tax returns in the fall, meaning that the OIG data would not reflect returns from a “substantial number of employers”. They also point out that the tax credit was not implemented until the middle of 2010.

CMS admits physician payment sunshine regulations will be delayed until spring 2012

The Administrator for the Centers for Medicare and Medicaid Services (CMS) acknowledged this week that the agency will likely not issue regulations implementing the physician payment disclosure provisions of the Affordable Care Act (ACA) until next spring.

Congress had demanded to know why CMS failed to meet the October 1st deadline required by the ACA (see Update for Week of October 10th). Donald Berwick, MD insisted that President Obama’s recent executive order requiring federal agencies to study and trim back excessive regulations has resulted in the delay.

The Physician Payments Sunshine Act legislation long-sought by Senator Herb Kohl (D-WI) was incorporated into Section 6002 of the ACA. Implementing regulations by CMS were supposed to require manufacturers and group purchasing organizations to collect data on payments to medical professionals starting January 1, 2012 and begin reporting this information to CMS on March 31, 2013 for public dissemination by September 30, 2013. It is not yet clear how the rulemaking delay will affect these dates.

Census Bureau says poverty figures are greater than first concluded

The United States Census Bureau released a first-ever supplemental poverty measure showing that the number of Americans in poverty exceeds even the record figures they reported earlier this fall (see Update for Week of September 12th).

The controversial revised formula accounts for expenses not included in the traditional, half-century old poverty measure such as out-of-pocket medical care, child care and commuting costs. It also excludes food stamps and tax credits that are part of the traditional formula and no longer assumes that the average family spends one-third of its income on food (as food costs have actually shrunk to one-seventh of average family incomes).

The revisions raise the number of Americans under the poverty level from 46.2 to 49.1 million, or 15.9 percent of the United States population instead of 15.1 percent. Including out-of-pocket medical expenses nearly doubles the rate of poverty among senior citizens to almost 16 percent, thanks to rising Medicare premiums, deductibles, and costs for prescription drugs.

Sickest adults in United States fare worse than other countries because of cost

The United States ranks near the bottom of many measures in caring for the sickest patients compared to other nations, according to a study of 11 economically advanced countries released this week by the Commonwealth Fund.

The study published in *Health Affairs* website concluded that chronically and severely ill adults fare best when they have stable relationships with providers. While these adults are most likely to have stable relationships in Great Britain and Switzerland, they are least likely to have stable relationships in the United States, resulting in health outcomes that trail behind the other ten countries.

The Commonwealth Fund points to cost as the primary reason why at least 42 percent of chronically or severely ill Americans surveyed failed to get recommended medical care, a rate that is

more than double that in Canada, France, Great Britain, the Netherlands, Norway, Sweden, and Switzerland.

Recent Commonwealth Fund studies also found that the United States has the highest rate of preventable deaths among these countries, despite spending more on health care than any other nation (see Update for Week of October 3rd).

STATES

Republicans gain control of two legislatures, but Democrats prevail in other key contests

The handful of statewide elections this week produced no clear trends for next year's Presidential and Congressional races.

Republicans scored two landmark victories in both Mississippi and Virginia, where they now control the House, Senate, and Governor's office. The Mississippi House fell to Republicans for the first-time since Reconstruction. The Virginia Senate is tied, which gives Republicans an effective majority since Lt. Governor Bill Bolling (R) can break any deadlocked votes. Republicans also expanded their dominant majority in the Virginia House of Delegates.

However, Democrats held on to their narrow majority in the Iowa Senate as well as the Kentucky governorship, and easily prevailed in New Jersey races that were expected to be competitive (see below). They also defeated controversial ballot initiatives in Maine, Mississippi and Ohio (see below).

Two Republican lawmakers were recalled. The Majority Leader for the Arizona Senate Russell Pearce (R) will be replaced by a more moderate Republican after his anti-immigration initiatives stoked intense controversy. The chair of Michigan's House Education Committee will also be replaced in a special election after Rep. Paul Scott (R) was recalled for pursuing severe teacher cuts and reforms.

Several states using ACA to expand health coverage for kids

At least six states have already opened their State Children's Health Insurance Program (SCHIP) to the children of low-income state employees, an option that was prohibited until the passage of the Affordable Care Act (ACA).

The federal government had closed that option to most states when SCHIP was established in 1997, even though federal employees were allowed to enroll their children. At the time, members of congress were concerned that states could shift some of their health costs to the federal government if state employees were allowed to enroll their children in SCHIP.

However, with so many state employees suffering wage freezes, furloughs, and severe cuts to health benefits, SCHIP has become a critical health insurance option during the economic slowdown. As a result, the ACA allowed states to expand SCHIP coverage to children of state employees, so long as the state can show that they have cut their share of employee health insurance costs in order to do so.

Since the ACA passed, Alabama, Georgia, Kentucky, Montana, Pennsylvania and Texas have all received federal approval to allow children of state employees to enroll in SCHIP. Georgia expects at least 42,000 children to enroll during open enrollment that began last month, saving the state over \$32 million in fiscal year 2012. That would exceed the number of state employee children enrolled in any of the other five states.

Florida could exceed this total if legislation introduced for next session by Florida's leading Democrat is enacted, as the state trails only New Mexico in the percentage of uninsured children. However, similar legislation was blocked by House Republicans, even though it cleared Florida's Republican-dominated Senate (see Update for Week of October 10th).

Georgia

Georgia becomes sixth state to receive federal waiver from new insurer payout standards

The U.S. Department of Health and Human Services (HHS) made Georgia this week the sixth state to receive a federal waiver allowing it to phase-in the new federal medical-loss ratios.

The Affordable Care Act (ACA) requires individual and small business health plans to spend at least 80 percent of premium revenue on direct medical care. Georgia had asked to lower this standard to only 65 percent in 2011, and gradually increase it to 80 percent by 2014. Insurance Commissioner Ralph Hudgens (R) noted that 12 of Georgia's roughly 20 individual insurers are now spending less than 70 percent of premiums on medical care and would be likely to leave the market if the higher standards were immediately enforced.

HHS instead will allow individual insurers in Georgia to spend 70 percent of their revenues on medical costs for 2011 and 75 percent in 2012. The full 80 percent will take effect in 2013.

Maine, New Hampshire, Kentucky, Nevada, and Iowa are the other states to receive similar waivers, while HHS rejected requests from Delaware and North Dakota. Ten waiver requests are still pending (see Update for Week of October 10th).

Kansas

Governor seeks to move nearly all Medicaid beneficiaries to managed care

Governor Sam Brownback (R) released the details of his Medicaid overhaul, which as expected will follow the lead of states like California, Florida, Louisiana, Kentucky, and Texas by moving nearly all Medicaid enrollees into capitated private managed-care plans.

The Governor announced that the Department of Social and Rehabilitative Services (SRS) has drafted request for proposals (RFPs) from managed care plans and expects to select three vendors statewide. He predicts that his plan will slow growth in Medicaid spending to nearly one percent per year, while saving the state more than \$350 million over the next five years.

Federal government approval is far from certain. The Centers for Medicare and Medicaid Services (CMS) has forced Florida to make substantial changes to its statewide Medicaid managed care initiative in order to protect against rationing of care by capitated plans that occurred under that state's initial demonstration (see Update for Weeks of June 20th and September 19th). If approved, Kansas Medicaid beneficiaries would begin enrolling in managed care by November 2012.

Despite access and quality of care concerns, most states are seeking to transition significant numbers of Medicaid enrollees into managed care in order to combat rising Medicaid costs (see Update for Week of September 5th).

New Jersey

Health committee chair becomes Senate Majority Leader

Senator Loretta Weinberg (D) was chosen this week by the Democratic caucus to be the new Senate Majority Leader, replacing Barbara Buono (D) who decided to step down from the post.

Senator Weinberg is the chair of the Health, Human Services, and Senior Citizens Committee and the sponsor of several health-related bills, including S.370 that would create a "Bleeding Disorders Treatment Fund", S.1438 that would increase health insurance continuation coverage to 36 month for small employer health plans, S. 1834 that would require insurance coverage for oral cancer drugs to be

equivalent to intravenous medications (see Update for Week of October 31st), and S.2239 creating the NJ Health Care Reform Implementation Council (see Update for Week of August 22nd). Senator Weinberg also joined with Senator Buono in seeking legislation (S.2893) that would expand the state's authority to modify and reject premium increases for individual and small employer health plans (see Update for Week of October 17th).

In somewhat of a blow to the political clout of Governor Chris Christie (R), Republicans lost every competitive race and were unable to dent the Democratic majorities in either the House or Senate during this week's elections.

New York

Consumers to receive \$114.5 million in rebates from 11 health insurers

Governor Andrew Cuomo (D) announced this week that over a half million New Yorkers will receive \$114.5 million in rebates from 11 health insurers who overcharged them in 2010.

State law requires health plans in New York to spend at least 82 percent of premium revenue on medical care and issue consumer rebates if they fail to comply. The Department of Financial Services (DFS) disclosed that \$44.7 million of the refunds will go to large group subscribers by December 15th, while individual and small group subscribers have already received over \$52 million. Those on Medicare supplemental or complementary policies will receive nearly \$15 million.

Empire Blue Cross and Blue Shield (BCBS) will refund more than \$61 million, by far the highest among the 11 insurers. Excellus BCBS is returning \$21 million while Aetna will refund \$11.5 million.

A similar medical-loss ratio provision of the Affordable Care Act (ACA) requires individual and small group health plans nationwide to spend at least 80 percent of premium revenue on medical care (85 percent for large groups) starting this year, or issue refunds to consumers in 2012.

North Dakota

House Republicans reject legislation creating a health insurance exchange

North Dakota appeared poised this week to become the first Republican-controlled state government to enact legislation creating the health insurance exchange required by the Affordable Care Act (ACA). However, House Republicans ultimately decided that implementing portions of the ACA that they support would merely "legitimize Obamacare" and overwhelmingly rejected the plan.

The Health Care Reform Review Committee had passed H.B. 1474, the measure it drafted after being created by the H.B. 1126 law signed last session by Governor Jack Dalrymple (R). Though H.B. 1126 directed the Insurance Commissioner to start using the state's \$1 million federal exchange grant to recommend exchange designs, it specifically did not commit the state to create the exchange (see Update for Weeks of April 18th and 25th).

H.B. 1474 would have provided the authorization to move forward. However, the structure of the bill itself generated controversy as it would have established the exchange oversight board within a newly-created division of the Office of Management and Budget (OMB). Only one state (West Virginia) has housed their exchange board within a state agency, although Maine Governor Paul LePage (R) has proposed to do so (see Update for Week of October 31st).

Representatives the insurance industry would also be allowed to serve on the 13-member board. Similar provisions have engendered intense conflict-of-interest controversy in several states, including Colorado, Connecticut, North Carolina, and Oregon.

OMB projected North Dakota's exchange to cost \$39.6 million to implement, which would be covered by federal funds. However, since all state exchanges must be self-sustaining by 2015, H.B. 1474 would have assessed a tax on insurance companies to pay for the exchange to pay for the \$10.2 million in anticipate annual operating costs.

Insurance Commissioner Adam Hamm (R) became the first key player to retreat from his earlier support for the exchange, suggesting that North Dakota would be better off letting the federal government at least initially operate the exchange (see Update for Week of August 15th). However, committee chairman Rep. George Keiser (R) steadfastly insisted that North Dakota can "do a better job" than the federal government of creating an exchange that best meets their needs.

The exchange also had the support of the state's dominant insurer, Blue Cross Blue Shield of North Dakota, as well as the North Dakota Hospital Association. However, in the end H.B. 1474 succumbed to the same "tea party" opposition that derailed exchange bills in Alabama, Georgia, Idaho, Indiana, Mississippi, and South Carolina, despite the support of their Republican governors. It is not yet clear if Governor Dalrymple will follow the lead of at least six of his fellow Governors and circumvent legislative opposition via executive order (see Update for Week of October 31st).

Ohio

Two-thirds of Ohio voters reject laws mandating the purchase of health insurance

Voters this week overwhelmingly approved a proposed constitutional amendment that would prohibit any state or federal mandate to buy health insurance.

Two-thirds of Ohioans who went to the polls voted in favor of S.B.1, the largely symbolic ballot referendum to denounce the individual mandate in the Affordable Care Act (ACA). Opponents promised legal challenge, insisted that the preamble misled voters by stating that the measure would preserve their "freedom to choose their health care and health care coverage." Similar language was deemed "manifestly misleading" by the Florida Supreme Court forcing the entire referendum to be struck from the ballot last year (see Update for Week of August 30, 2010).

Even though they will have no legal effect due to the constitutional supremacy of federal law, similar referendums have already been approved by voters in Arizona, Missouri, and Oklahoma, are on the ballots next fall in Alabama, Florida, Montana, and Wyoming, and are moving through the New Hampshire and Wisconsin legislatures (see Update for Week of October 17th). Colorado is the only state where voters rejected such a measure (see Update for Week of November 1, 2010).

The one-sided passage of the Republican-backed bill did little to help the most controversial Republican effort on the ballot (S.B. 5). Roughly 60 percent of voters favored repealing the new law signed by Governor Kasich (R) that would terminate the rights of state workers to collectively bargain for health benefits (see Update for Week of July 25th). A similar law narrowly survived court review in Wisconsin, but led to the recall of several Republican lawmakers (see Update for Week of August 15th).

Washington

Temporary injunction blocks new limits on emergency room use by Medicaid enrollees

A county court judge put the brakes this week on new regulations that limit the non-emergent use of emergency rooms by Washington Medicaid enrollees.

The temporary injunction was sought by the Washington chapter for the American College of Emergency Physicians, who argued that the list of 700 non-emergent diagnoses were created by the Health Care Authority (HCA) without input from hospitals and physicians (see Update for Week of September 26th).

HCA pledged to rewrite the regulations, which they claim will save more than \$30 million over two years and would impact only about three percent of Medicaid enrollees who exceed the three visit limit (often by as much as 100 non-emergent visits). However, the judge's ruling requires the agency to hold public hearings allowing opponents to voice any concerns.

The new limits were effective October 1st and are part of severe health cuts sought by Governor Christine Gregoire (D) to balance the state's \$2 billion deficit (see Update for Week of October 31st).

Wisconsin

Legislature approves most of Governor's dramatic Medicaid cuts, premium hikes

The Legislature's nonpartisan budget office projects that 65,000 enrollees of state health programs (nearly half of them children) will be dropped or barred from coverage from the severe cuts passed this week by the Joint Finance Committee.

Governor Scott Walker (R) proposed last month to use the new authority granted to him by the Legislature to help fill the \$554 million gap in the Medicaid budget by hiking Medicaid premiums up to tenfold, dropping coverage for at least a year for those who miss one premium payment, and shifting at least 215,000 enrollees to lower-cost state plans or private coverage (see Update for Week of October 3rd). The Joint Finance Committee voted on a straight party-line vote to pass most of the Governor's plan, which requires no further legislative approval under the unprecedented new law upheld by the state supreme court (see Update for Week of June 20th).

Consumer advocates fear that most of 65,000 enrollees denied Medicaid coverage will become uninsured and overburden safety net providers. The Secretary for the Department of Health Services and Republican co-chair of the Joint Finance Committee instead that many will simply move to private insurance or the state high-risk pool.

However, most of the cuts require federal approval, which is far from guaranteed given the Obama Administration's reluctance to approve parts of the severe Medicaid cuts sought in Arizona and Medicaid managed care initiative in Florida (see Update for Weeks of June 20th and September 19th). However, the Administration did approve higher Medicaid premiums in both Arizona and California (see Update for Week of October 31st), though not to the extent sought by Wisconsin.