

Health Reform Update – Weeks of December 5, 2011

CONGRESS

Republicans continue efforts to tie payroll tax break extension to health measures

Despite bipartisan support for extending President Obama's payroll tax holiday, Republicans and Democrats remained at odds this week on how to do so before its December 31st expiration.

If Congress fails to act, roughly 160 million Americans will be forced to pay an average of \$1,000 per family in higher taxes, as the payroll tax will be restored from 4.2 to 6.2 percent. However, the latest plan sought by House Republicans is expected to be blocked by Senate Democrats next week, as it offsets the \$110 billion cost of extending the tax holiday into next year by cutting Affordable Care Act (ACA) payments by \$43 billion, ending enhanced unemployment benefits, and raising Medicare premiums for those earning more than \$1 million.

While Senate Democrats favor the Republican effort to also tie the tax holiday extension to a correction to the 27 percent Medicare physician payment cut, the attempt to gut ACA funding for prevention and eliminate subsidies for 170,000 people, as well as not extending unemployment benefits, are deal-breakers. However, Republicans will not sign-off on the Democrats' proposal to fund the payroll tax holiday with a surtax on rich "job creators".

The impasse is likely to force Congress to remain in session past the beginning of their scheduled recess on December 16th.

Supreme Court to hear ACA challenge in March, consider whether to add plaintiffs

Three advocacy groups that oppose the Affordable Care Act (ACA) are seeking to be added as plaintiffs to the constitutional challenge that the U.S. Supreme Court has scheduled for March.

The high court has agreed to hear the lawsuit brought by 26 state attorneys general to the constitutionality of both the individual mandate and Medicaid expansion under the ACA. However, the court has allotted an unprecedented amount of time to additional argument on whether the entire law must be struck down if either of these provisions is found unconstitutional, or whether the tax penalty for not buying health insurance can even be challenged before it actually goes into effect in 2014 (see Update for Week of November 14th).

Fearful that the court may follow the latter argument, Freedom Watch, the Association of American Physicians and Surgeons (AAPS) and the Alliance for Natural Health USA all filed motions that will be heard this week seeking to be added as additional plaintiffs. AAPS in particular insists that their members are already impacted by the individual mandate because it will "dramatically change medical practice" and is affecting the private market for health insurance.

However, at least one of the existing plaintiffs, the National Federation of Independent Business, opposes the addition of other plaintiffs who may "complicate the process". The court schedule released this week indicates that final briefs are due on March 13th, suggesting a trial date later in March.

FEDERAL AGENCIES

Early Retiree Reinsurance Program will run out of funds at year end

The Centers for Medicare and Medicaid Services (CMS) announced this week that the Early Retiree Reinsurance Program (ERRP) will end earlier than expected on December 31st.

Created by the Affordable Care Act (ACA), the ERRP was intended to subsidize employer health care costs through 2014 for retirees above age 55 who do not yet qualify for Medicare. Participating employers could collect reimbursement for up to 80 percent of claims costs between \$15,000 and \$90,000. The program proved to be extremely popular, forcing CMS to close enrollment last May (see Update for Week of March 28th).

The agency has now spent \$4.5 billion of the \$5 billion allocated by the ACA for the ERRP and thus has no more funding to cover new claims after the end of the year. A Government Accountability Office (GAO) audit had projected that the funds would last until September 2012 (see Update for Week of October 31st).

Because most program beneficiaries were labor unions or state/local governments, many Republican lawmakers accused the Obama Administration of using the ERRP to reward political allies. However, GAO concluded that the funds were allocated on a first-come, first-served basis in a fair and unbiased manner (see Update for Week of October 31st).

Final rules seek to create at least one non-profit health insurance cooperative in every state

The Department of Health and Human Services (HHS) issued final rules this week that will provide federal loans to create at least one health insurance cooperative in every state.

The Affordable Care Act (ACA) allocated \$3.8 billion to provide start-up funds for the non-profit cooperatives that are intended to compete with private plans options in the new health insurance exchanges. These Consumer Operated and Oriented Plans (CO-OPs) were a substitute for the more controversial proposal to create a government health insurance option. However, CO-OPs are very different from the so-called "public option", since they cannot be run by a state or local government entity. They also represent a new product, since the ACA prevents any entity that sold insurance as of July 2009 from becoming a CO-OP.

Proposed rules issued last summer acknowledged that 35-40 percent of CO-OPs will default on the loans offered by CMS, causing the federal government to lose up to \$230 million from 2012 to 2013. However, CMS will seek to create at least one CO-OP in every state (see Update for Week of July 20th).

CO-OPs currently cover only 2.1 million people in four states (Minnesota, Washington, Idaho and Wisconsin), or just slightly more than one percent of the private insurance market. However, the head of the National Alliance of State Health Cooperatives predicted this week that the federal loans will initially lead to CO-OPs in at least 25 states, where they eventually will spread "like wildfire." Physician groups in Connecticut have already created a CO-OP in hopes of obtaining federal loans (see Update for Week of September 26th).

NASTAD announces additional private relief for cash-strapped ADAPs

The National Alliance of State and Territorial AIDS Directors (NASTAD) announced this week that Janssen Therapeutics has agreed to enhance the voluntary discounts and rebates they offer on products purchased by state AIDS Drug Assistance Programs (ADAPs), as well as extend their price freeze through 2013.

The move supplements a similar decision last week by Gilead Sciences, the largest provider of ADAP medications, as well as an additional \$35 million in federal relief that President Obama recently redirected in order to help further relieve the nationwide ADAP funding crisis (see Update for Weeks of November 21st and 28th). NASTAD and community partners are seeking a \$55 million increase federal ADAP funds for fiscal year 2012, consistent with President Obama's budget request.

STATES

Regional gap in per capita health spending continues to grow

Per capita health care spending by insurers, government agencies and individuals averaged \$6,815 nationwide from 2005-2009, according to a report released this week by the Centers for Medicare and Medicaid Services actuary.

The results revealed a huge and widening gap in health spending across different parts of the country. For example, the southwest and Rocky Mountain states spent 15 percent below the national average. This includes the largest state in the country, California, which spent only \$6,238 per resident (above only eight other states).

According to *California Healthline*, California's ranking is due to the state's seven million uninsured residents and traditionally poor Medicaid reimbursement. No state spent less per capita on low-income care in 2009 than California.

By contrast, New England states with traditionally lower uninsured rates and stronger safety nets spend 29 percent more than the national average from 2005-2009.

Arkansas

Insurance Commissioner acknowledges defeat on health insurance exchange

Insurance Commissioner Jay Bradford (D) has joined with Governor Mike Beebe (D) in acceding to Republican demands to allow the federal government to operate the health insurance exchange required by the Affordable Care Act (ACA).

Governor Beebe has refused to follow the lead of at least 11 other governors who relied on executive actions to circumvent legislative opposition to creating an exchange. He also elected not to order the Democratically-controlled legislature to take up the issue during their budget-only session next year. Instead, he has consistently insisted that lawmakers have to "live with" their decision to allow for federal intervention (see Update for Week of September 19th). (A federal fallback exchange will operate in states that fail to make substantial progress by January 2013.)

However, the Governor allowed Bradford to continue to try and drum up support for authorizing legislation. The Commissioner used the state's initial \$1 million federal planning grant to study exchange designs and solicit public input. He has also pledged to apply for federal exchange establishment grants to develop the necessary information technology.

Despite these efforts, any hope of creating a state-based exchange prior to the federal deadline appeared to fade last week when the advisory group formed by Bradford voted to disband and allow a federal fallback exchange.

Commissioner Bradford is still seeking up to \$7 million in federal grants to explore a federal-state partnership permitted under the latest regulations by the Centers for Medicare and Medicaid Services (CMS), where Arkansas could still retain some state control of exchange functions.

Arizona

Appeals court uphold cap on Medicaid enrollment for childless adults

The Arizona Court of Appeals has upheld a lower court decision that refuses to lift a cap on state Medicaid enrollment for childless adults.

The fiscal year 2012 budget signed by Governor Jan Brewer (R) capped enrollment for childless adults on July 8th, despite a voter-approved ballot measure in 2000 that specifically expanded Medicaid to include everyone below the poverty level. Judge Mark Brain with the Maricopa County Superior Court had held that while the voter referendum may require coverage, it does not force the legislature to pay for it if funding is unavailable (see Update for Week of August 8th).

The three-judge appeals panel disagreed with Judge Brain's ruling, noting that Proposition 204 explicitly required the expansion to be funded with available funds. However, it claimed whether lawmakers actually had available funds was a "political decision, not a legal one" as it is not the responsibility of the courts to determine whether the state has the necessary funding for a given program.

AHCCS had estimated that roughly 110,000 Arizonans will lose coverage because of the enrollment cap, although initial figures have been less than feared (see Update for Week of October 17th). The plaintiffs have pledged to appeal to the Arizona Supreme Court, even though it has previously refused to hear the case (see Update for Week of August 8th).

Connecticut

State officials seek to scale back expanded Medicaid coverage for childless adults

State officials acknowledged this week that they have sent a "concept paper" to the federal government that proposes to scale back Connecticut's expansion of Medicaid coverage to childless adults.

Prior to passage of the Affordable Care Act (ACA), only seven states including Connecticut provided Medicaid coverage for childless adults. Governor Daniel Malloy (D) made Connecticut one of these states (including Minnesota and the District of Columbia) to take advantage of enhanced federal funding offered by the ACA for expanding Medicaid childless adult coverage to those earning up to 133 percent of the federal poverty level before the 2014 deadline for all states to do so.

Connecticut previously covered childless adults with incomes up to 56 of the federal poverty level and assets under \$1,000 through a state-funded program that was separate from traditional Medicaid. State officials expected to save money by transferring these individuals to a newly-created Medicaid Low-Income Adult (LIA) program with no asset limit in order to receive enhanced federal funds.

However, LIA has instead become "financially unsustainable" as enrollment skyrocketed by over 60 percent. As a result, the program has a nearly \$140 million shortfall. While full ACA funding for the Medicaid expansion in 2014 will resolve this shortfall, DSS has petitioned the federal government for temporary relief.

Suggested measures include imposing an asset limit, counting family instead of just individual income, and explicitly capping enrollment subject to the availability of federal funds. However, these all require a federal waiver. Only the creation of an alternative benefit package is allowed under current law.

Consumer advocates immediately urged the Centers for Medicare and Medicaid Services (CMS) to reject all of the proposed changes, which they insist would only increase the number of uninsured.

Florida

New Medicaid premium on the lowest-income enrollees could cause massive disenrollment

The most recent evaluation of Florida's Medicaid managed care demonstration by the Georgetown University Health Policy Institute warns that as many as 800,000 enrollees (including 660,000 children) may be forced out of Medicaid if the state is allowed to impose monthly premiums of as little as \$10.

The Florida Legislature passed the new premiums as part of its plan to move all Medicaid beneficiaries into managed care plans by 2015, which is pending federal approval (see Update for Week of September 19th). However, Georgetown noted that while \$10 may seem like a nominal charge to lawmakers, it would force a family of three earning only \$11,000 per year to pay three percent of their income for Medicaid.

Georgetown researchers also emphasized that nominal premiums have resulted in massive Medicaid disenrollment in other states including Oregon. For this reason, the federal Centers of Medicare and Medicaid Services (CMS) has refused to waive the statutory prohibition on imposing premiums for those earning below 150 percent of the federal poverty level (see Wisconsin article below).

If approved by CMS, Governor Rick Scott (R) expects to save \$4.3 billion from the Medicaid managed care waiver. He announced this week that he will seek to wring out an additional \$2 billion in Medicaid next year in order to increase funding for education.

Maine

Governor seeks drastic cuts in Medicaid, prescription drug assistance for dual eligibles

Governor Paul LePage (R) continued his campaign this week to dramatically reign in the state's safety net by calling for severe cuts to Medicaid.

Since taking office last year, the Governor has successfully eliminated Maine's landmark Dirigo health plan for small employers and the uninsured and curtailed many of the state's most popular consumer protections in the private insurance market (see Update for Week of June 20th). His latest initiative seeks to slash Medicaid benefits and eligibility in order to fill a \$220 million shortfall in the traditionally generous MaineCare program and bring it in line with national averages.

Consumer advocates strongly protested the drastic cuts, which would automatically eliminate Medicaid coverage for 65,000 Mainers, including 19,000 childless adults. The Maine Hospital Association also attacked the Governor's plan to lower Medicaid reimbursement and place service limits on hospital care, insisting it would only increase the uncompensated care burden on hospitals. However, the Governor insisted that Maine could no longer afford to spend roughly a third of its annual budget on Medicaid.

The Governor's cuts would also end or scale back state programs that help low-income enrollees in both Medicaid and Medicare afford their premiums for Medicare Part D prescription drug plans.

The overhaul is part of the Governor's supplemental budget proposal that lawmakers will consider when the next legislative session convenes in January. However, the Joint Appropriations Committee will begin hearings on the plan next week.

Massachusetts

Public option and single payer bills to get legislative hearing

The Joint Committee on Health Care Financing will hold a hearing next week on Senate and House bills (S.B. 500/H.B. 1128) that would allow the Commonwealth Connector Authority to offer a public health insurance option that would compete with private plans in Massachusetts' health insurance exchange. Massachusetts was the first state to create a health insurance exchange as part of their landmark 2006 reforms that became the model for the Affordable Care Act (ACA).

The hearing will also focus on Medicare for All legislation (S.B. 501/H.B. 338) that would fund a single-payer health care system through assessments on employers and individuals.

Montana

Montana becomes latest state with unexpected windfall

The Legislature's chief revenue forecaster testified this week that Montana will likely have a nearly \$427 million budget surplus by mid-2013, or three times more than expected.

The Legislative Finance Committee had projected a slight budget surplus when it adjourned last spring, similar to most of the energy-producing states (see Update for Week of September 26th). However, a slight bump in economic growth has increased state revenues nationwide and resulted in dramatically unexpected surpluses for states like Alaska and Minnesota (see Update for Week of November 21st and 28th).

Governor Brian Schweitzer (D) had insisted during the past legislative session that revenue estimates were too pessimistic and failed to reflect a state economy that was already improving. However, Republican lawmakers insisted on cutting general fund spending by six percent.

It is not immediately clear how the state will spend the surplus, which Senator Dave Lewis (R) notes is \$200 million above the five percent surplus recommended by the National Conference of State Legislatures. A referendum on the 2012 ballot in Montana calls for individual tax credits if state revenue exceeds forecasts. Should it pass, the tax credits must equal one-half of the revenue that exceeds 125 percent of the state's projected general fund balance, if the excess amount is at least \$5 million.

Nevada

Governor targets uninsured as budget priority

The Director of the Nevada Department of Health and Human Services announced this week that Governor Brian Sandoval (R) intends to make reducing the state's traditionally high rate of uninsured a legislative priority for the next budget cycle that begins in 2013.

According to the U.S. Census Bureau, Nevada trails only Texas with an uninsured rate exceeding 23 percent of state residents. However, 17 percent of Nevada children are uninsured, the highest in the nation.

The Sandoval Administration is considering several incremental spending measures to make health coverage more affordable, especially for expectant mothers in need of prenatal care.

New York

Legislature passes tax overhaul to halve state budget deficit, may help avert new health cuts

Governor Andrew Cuomo (D) reached agreement with lawmakers this week on state income tax reforms that will nearly halve the state's \$3.5 billion budget gap.

The overhaul increases taxes for the highest-income residents, but by less than the state's existing income tax on millionaires that expires December 31st. It also reduces tax rates for millions of other New Yorkers, including a reduction in the payroll tax.

The agreement passed both chambers nearly unanimously and will go into effect in January. It should also ease the burden on lawmakers who return next spring to remainder of the budget deficit. Prior to the agreement, lawmakers were weighing an additional round of severe cuts to health programs, as state tax revenues had lagged far behind projections.

Virginia

Governor clarifies that he does support a state exchange, just not until U.S. Supreme Court rules

Governor Bob McDonnell (R) announced this week that he wants Virginia to operate its own health insurance exchange, but only if and after the U.S. Supreme Court upholds the federal mandate that all individuals have health insurance.

The Governor had remained silent on the issue when he submitted recommendations last week from the Virginia Health Reform Initiative Advisory urging lawmakers to create a state-based exchange, instead of defaulting to a federal exchange. However, he clarified this week that he does favor a state exchange and has directed agencies to continue to plan for an exchange, but he prefers that lawmakers not pass authorizing legislation unless the U.S. Supreme Court finds the individual mandate constitutional during their next term.

The Governor's view was not supported by Republicans like Delegate Terry Kilgore, who did not want to risk failing to meet the January 2013 deadline to avoid a federal fallback exchange. Delegate Kilgore was among several who have asked for authorizing legislation to be drafted for introduction when the General Assembly convenes next month.

Wisconsin

Governor reverses course on prescription drug assistance for seniors

Governor Scott Walker (R) announced last week that he has authorized the Department of Health Services (DHS) to seek an extension of a federal waiver allowing Wisconsin to provide discount prescription drugs to low-income seniors.

The current Senior Care waiver expires at the end of 2012. The ten-year old program is very popular among Wisconsin residents as it provides more comprehensive drug coverage than Medicare Part D plans, yet only imposes a \$30 annual enrollment fee and copayments of \$5-15.

The extension sought by the Governor is a reversal from his earlier effort to severely limit Senior Care by mandating all participants enroll in Medicare Part D and receive reimbursement only for costs not paid for by Part D. That proposal spurred a bipartisan backlash and was rejected by the Republican-controlled legislature (see Update for Week of May 23rd).

Medicaid may lose 65,000 enrollees on January 1st, after CMS only partially approves waiver

The federal Centers for Medicare and Medicaid Services (CMS) gave preliminary approval this week to only a part of the proposal by Governor Scott Walker (R) to dramatically raise Medicaid premiums and slash benefits.

The Governor exercised the broad new authority granted to him last spring by the Republican-controlled Legislature to make dramatic changes to Medicaid coverage and payment with only limited legislative oversight (see Update for Week of June 20th). The Republican-controlled legislature approved

the majority of the Governor's changes, which seek to fill the \$554 million gap in the Medicaid budget by hiking Medicaid premiums for adults and children 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 November 7th).

CMS notified state officials last week that it would not allow these changes to apply to children or the lowest income enrollees. However, CMS will permit the tenfold premium hike for adults with incomes above 150 percent of the federal poverty level (FPL), so long as premiums do not exceed five percent of beneficiary income. This move is consistent with CMS' approval of Medicaid premium hikes in Arizona and California (see Update for Week of October 31st). Wisconsin can also drop adults who miss but one premium payment, but only if they earn more than 133 percent of FPL, and can only shift Medicaid adults to lower-cost state plans or private coverage if their share of the premium is below 9.5 percent of their income.

However, CMS stated that it is "unlikely" that they could make a full decision on all the state's premium hikes by the December 31st deadline the legislature placed into state law. Lawmakers had hoped to force CMS' hand by requiring 65,000 enrollees to be dropped from Medicaid rolls on July 1st if the federal government did not fully approve the state's proposal by the end of 2011. Lawmakers must now decide whether to pass additional legislation to delay that deadline.

Wyoming

Lawmakers push exchange decision into 2013 session

The Joint Labor, Health and Social Services Committee unanimously agreed this week to delay a final decision on exchange authorizing legislation until the next full legislative session in 2013.

The move threatens to leave Wyoming out of compliance with federal regulations requiring states to make substantial progress towards exchange implementation by January 1, 2013 or allow the federal government to instead operate a fallback exchange.

Governor Matt Mead (R) and Senator Elaine Harvey (R) had strongly favored the creation of state-based exchange in place of a "federal takeover". Senator Harvey chaired the Governor's advisory committee that urged lawmakers to give state officials the maximum flexibility to tailor an exchange to Wyoming's unique needs by keep control of the exchange in state hands (see Update for Week of October 10th). However, she conceded last week that conservative opponents were urging state officials to create their own exchange that failed to incorporate many of the consumer protections mandated by the Affordable Care Act (ACA) and dare federal regulators to enforce the higher standards (see Update for Weeks of November 21st and 28th).

Several Republican-controlled states including Florida, Nebraska, and Ohio have already decided not to move forward on exchange implementation until the U.S. Supreme Court rules next term on the constitutionality of the ACA. However, Republican governors in states like Alabama, Georgia, Idaho, Indiana, Mississippi, and Texas have issued executive orders to circumvent legislative opposition and begin designing and creating the exchange (see Update for Weeks of November 21st and 28th).

It is not yet clear if Governor Mead will call a special session next year to act on exchange authorizing legislation, or if he will likewise issue an executive order to move forward with an exchange. However, he has already authorized the use of the state's \$1 million initial federal exchange planning grant to commission a study by Gorman Actuarial that predicted an exchange and other ACA market reforms would halve Wyoming's uninsured rate over the next five years. The authors also concluded that the ACA will reduce out-of-pocket costs and eliminate cost-shifting to those with comprehensive coverage.