

Health Reform Update – Week of September 10, 2012

CONGRESS

Deficit reduction impasse imperils FDA user fees, NIH grants, ACA funds

The House voted 329-91 this week to pass a continuing resolution that would extend current government funding levels for six months past the September 30th expiration of the current fiscal year.

“Tea party” conservatives had sought to block the measure, as it continues funding for implementation of the Affordable Care Act (ACA). However, most conservatives including vice presidential nominee Paul Ryan (R-WI) joined with Democrats in seeking to postpone another polarizing debt showdown until past the fall elections (see Update for Weeks of August 27th and September 3rd).

However, the continuing resolution omits the necessary language allowing the Food and Drug Administration (FDA) to collect the new user fees for biosimilar and generic drugs that were enacted earlier this year (see Update for Week of May 21st). Excluding these new fees heightened fears this week that the entire user fee reauthorization may be subject to the automatic sequestration or “fiscal cliff” set to go into effect in January 2013.

The severe across-the-board cuts created by the *Budget Control Act of 2011* were intended to force the so-called “super committee” created by the law to compromise on a more rational package of deficit reduction measures (see Update for Week of August 1, 2011). The failure of the “super committee” means that the automatic cuts will go into effect on January 2nd if Congress does not act during a “lame duck” session in December to pass an alternate package that cuts the federal deficit by \$1.2 trillion over ten years (see Update for Weeks of November 21st and 28th).

Certain funding was exempted from the sequester such as Medicaid and Social Security disability payments while Medicare spending cuts are limited to two percent (or \$11 billion). However, FDA funding was not included within the exemptions and is expected to cut about eight percent of the agency’s \$2.5 billion appropriation (or \$200 million).

The Alliance for a Stronger FDA warned last week that several lawmakers and federal officials have indicated that the Office of Management and Budget is likely to subject these new FDA user fees to the sequester. Drug and device manufacturers had reached an agreement with the Obama Administration last year to greatly increase the user fees they pay to the FDA in exchange for faster drug and device approvals (see Update for Week of May 21st). These user fees were slated to bring in \$6.4 billion in revenue over the next five years.

FDA officials acknowledged this week that these all user fee revenues may actually be in jeopardy if they are included within the sequester, as by law they are required to fund 60 percent of drug and device reviews and not exceed a certain amount of agency funding. As a result, the FDA could potentially lose all of the \$2 billion in user fees that are to be collected for fiscal year 2013 if the agency does not receive a certain amount of the \$2.5 billion appropriated by Congress for other programs.

According to the Alliance for a Stronger FDA, the eight-percent sequester itself should not set off such a trigger, though FDA officials declined to identify exactly what level would do so.

The Administrator for the National Institutes of Health warned that a quarter of all grants that NIH plans to issue in 2013 would not be funded if the sequester cuts \$2.5 billion from the agency’s budget. Mandatory appropriations under the ACA such as funding for exchange grants and preventive services

would also be impacted, although unobligated funds from previous years would remain exempt (such as funds for the pre-existing condition insurance plans that have yet to be distributed).

House Speaker John Boehner (R-OH) expressed doubt this week that Congress could reach a compromise after the elections that would avert the sequester. The uncertainty created by the “fiscal cliff” caused Moody’s Investors Service to threaten to downgrade the nation’s AAA debt rating if an agreement was not reached, as did Standard and Poor’s last summer (see Update for Week of August 8th).

The American Hospital Association, the American Medical Association and the American Nurses Association warned this week that just the two-percent cut in Medicare reimbursement under the sequester would cause the health care industry to lose roughly 496,000 jobs next year, and up to 766,000 jobs by 2021. Health care has consistently leads all other sectors in job creation since the recession.

House panel votes to carve out insurance agents from new medical-loss ratios

The House Energy and Commerce health subcommittee passed H.R. 1206 this week, which seeks to remove the commissions paid to insurance agents and brokers from the medical loss ratio (MLR) calculation under the Affordable Care Act (ACA).

The MLR provision requires individual and small group plans to spend at least 80 percent of premium revenue on medical costs instead of administration and profit (85 percent for small groups). Implementing regulations issued by the Department of Health and Human Services (HHS) drew the ire of insurance agents and brokers by defining the commissions they receive as administrative expenses. However, both HHS and the National Association of Insurance Commissioners (who provided guidance for the regulations) insist that they lack the legal authority to exclude broker commissions.

The NAIC and at least 18 House Democrats have supported the legislative fix provided by H.R. 1206 (see Update for Weeks of November 21st and 28th), insisting that insurers will no longer pay commissions in order to stay within the new MLR threshold and avoid having to rebate the excess to consumers. An earlier Government Accountability Office report appeared to validate broker complaints, concluding that consumer savings under the new MLRs were already coming at the expense of cuts in broker commissions (see Update for Week of August 29, 2011).

The bill now moves on to the full committee and then to the House. However, it is not expected to be considered by the Democratically-controlled Senate prior to the November election.

Republicans claim ACA will overburden IRS, does not authorize tax credits in federal exchanges

The House Ways and Means oversight subcommittee held a hearing this week on the implementation and administration by the Internal Revenue Service (IRS) of the tax provisions in the Affordable Care Act (ACA).

Subcommittee leaders used the hearing to renew their attack on the tax provisions in the new law, insisting that it will force individuals and businesses to spend nearly 80 million hours complying with the individual mandate, employer mandate, etc. They claim that nearly half this time will be spent related to the new tax credits offered to small businesses that provide employee health coverage.

Republicans were adamant that the myriad of “confusing and burdensome” regulations would result in a “quagmire”, and accused the IRS Commissioner of violating the intent of the ACA by making the law’s premium tax credits available to those who purchase coverage in a federally-facilitated exchange (FFE). FFEs will be at least initially operated in those states that fail to make substantial progress on a state-based exchange by January 2013 (see Update for Week of May 14th).

Several conservative think-tanks are already preparing legal challenges to the IRS counsel’s opinion that the ACA statute authorizes tax credits within the FFEs (see Update for Weeks of July 23rd

and 30th). However, IRS counsel stands by their interpretation and insists that it was not dictated by the White House or influenced by political considerations.

The IRS Deputy Commissioner scoffed at Republican claims that his agency would have to hire 16,000 employees to carry out its duties under the new law. He insisted that only 859 IRS employees would be assigned to ACA enforcement and implementation in 2013.

A former IRS Administrator from the first Bush Administration testified that the penalties and incentives under the existing law are far too low to prevent employers from dropping coverage and compelling young and healthy individuals to purchase coverage. He also recommended that the new health insurance exchanges be unburdened from the responsibility for determining the amount of the premium tax credits that help eligible individuals buy exchange coverage.

AHIP wants Congress to relax new consumer protections in order to keep premiums affordable

The nation's largest health insurance trade group urged Congress this week to make the new benefits under the Affordable Care Act (ACA) less generous so that health insurers do not have to substantially raise premiums.

The executive vice president for America's Health Insurance Plans (AHIP) specifically recommended that the minimum actuarial value for coverage in the new health insurance exchanges be lowered. Starting in 2014, exchange plans must offer four benefit levels at an actuarial value of 60 percent (bronze), 70 percent (silver), 80 percent (gold), and 90 percent (platinum). However, AHIP insisted that this will simply require millions of Americans to purchase coverage that is more comprehensive and expensive than they currently have or need.

AHIP also wants Congress to eliminate the fees that health insurers must pay to finance the ACA as well as increase the new age rating band mandated by the law from 3:1 to 5:1. This would allow insurers to charge up to five times more for older subscribers so that premiums can remain affordable for the youngest, healthiest, and least costly subscribers.

MedPAC to enter debate over Republican plan to privatize Medicare

The influential panel that Congress relies on for advice on Medicare policy waded this week into the politically-charged debate over the Republican plan to offer Medicare beneficiaries "premium support" to purchase private health coverage.

The "premium support" model initially proposed last year by Rep. Paul Ryan (R-WI) would have forced beneficiaries to move into the marketplace. Although it overwhelming was passed by the Republican-controlled House, the plan was very unpopular among voters and watered down this year to allow beneficiaries to remain in traditional Medicare if they so choose (see Update for Week of April 2nd).

Rep. Ryan's selection as the Republican vice-presidential nominee all but ensured his "premium support" model would be a focus of the campaign, especially after it has been endorsed by the presidential nominee Mitt Romney. Democrats wasted little time running ads insisting that the Romney-Ryan "voucher care" model would "end Medicare as we know it".

The debate has compelled the Medicare Payment Advisory Commission (MedPAC) to consider issuing its own recommendations on the model, as lawmakers will rely heavily on the panel's advice should they choose to enact it. Even though MedPAC has yet to specifically address the issue, it has long-endorsed the concept of giving Medicare beneficiaries a private plan option to traditional Medicare, as have members of the President's deficit reduction commission (see Update for Week of December 6th).

However, in order to start with a "blank sheet of paper" and not prejudice their review, MedPAC chairman Glenn Hackbarth immediately choose to refer to the model as "competitively determined plan contributions" and avoid the terms "premium support" or "voucher". He noted that the private Medicare

Advantage plans that now exist under Medicare are paid based on “administered pricing” , which rely on average per capita costs in traditional Medicare and are not determined by market forces. By contrast, “competitively determined plan contributions” would be based on competitive bids by private plans.

Among the questions that MedPAC will address are whether Medicare enrollees should be offered a standard benefit package or if plans can vary benefits. In addition, the panel will recommend whether federal contributions should vary locally or be the same nationally, and if it should be based on an average of what private plans bid or the costs of the traditional Medicare fee-for-service program.

The chairman did not set a specific timetable for developing panel recommendations but indicated that he wants the panel to be prepared to advise Congress on various designs that it may pursue after the election.

Medicaid would lose \$1.26 trillion under House-passed plan to block grant Medicaid

The House-passed budget plan to block grant Medicaid would strip the federal-state program of more than \$1.26 trillion over nine years, according to a Bloomberg Government study released this week.

The Congressional Budget Office (CBO) previously warned that the proposal advanced by House Budget Committee chairman Paul Ryan (R-WI) would cut benefits and increase costs for Medicaid enrollees, as the proposed inflation adjustments to an \$11,000 lump-sum payment per beneficiary would be woefully inadequate to cover the cost of their care under existing benefit and eligibility standards (see Update for Week of April 4, 2011).

Despite these figures, Republican presidential nominee Mitt Romney remained supportive of his vice presidential nominee’s Medicaid block grant plan, which could be implemented as soon as 2014. However, he has not indicated what if any federal strings would be attached to the block grants.

FEDERAL AGENCIES

ACA rebates and reviews have already saved health insurance consumers \$2.1 billion

The Department of Health and Human Services (HHS) announced this week that consumers have saved \$2.1 billion thanks to new rules limiting insurer profits and requiring greater accountability and transparency for excessive rate hikes.

The Affordable Care Act (ACA) required that individual and small group plans spend at least 80 percent of premium revenue on direct medical care in a given plan year (or 85 percent from large groups). Those that spent too little on medical care instead of salaries and profits were forced to rebate the difference to consumers by each August 1st. According to HHS, nearly 13 million consumers nationwide received roughly \$1.1 billion in rebates last month, or an average rebate of \$151 per household (see Update for Week of June 18th).

Starting last fall, state insurance commissioner were also required to collect and publicly display the actuarial justifications for double-digit rate hikes sought by individual and small group plans, and determine whether they were excessive. HHS assumed this role for the ten states that did not have the capability to do so (see Update for Week of August 29th) and are continuing to do so in six states. According to HHS, these reviews have already saved over 800,000 consumers roughly \$1 billion.

The Director for the agency’s Center for Consumer Information and Insurance Oversight (CCIIO) told reporters that they wound up making 31 percent of all rate review decisions, while states made the remaining 69 percent. Overall, insurers voluntarily withdrew 12 percent of proposed increases, while an additional 26 percent were rejected and another 26 percent were modified. CCIIO estimates that federal and state reviews reduced proposed rate hikes by an average of 2.8 percent.

Although most states have the authority to reject or modify excessive rate hikes, the ACA did not give HHS this authority. As result, the agency had to rely on “jawboning” or “shaming” insurers that sought unreasonable rate hikes. As of last April, CCIIO had already deemed 20 of the 28 planned rate hikes they reviewed to be unsupported by actuarial data (see Update for Week of April 16th). However, an Epstein, Becker, and Green report noted that none of the “shamed” insurers had adjusted or rescinded their proposed rate hikes, nor did any of their plans cover a large number of subscribers (see Update for Week of March 19th).

HHS has given \$160 million in federal grants to 45 states and the District of Columbia so that they could strengthen and increase the transparency in their rate review process. According to CCIIO, they still have about \$90 million in grant money left to distribute in 2012 and 2013.

Health insurance premiums rose more modestly in 2012

According to new report released this week by the Kaiser Family Foundation, health insurance premium increases are still outpacing wages and inflation, but grew by far less in 2012 than in 2011.

The report found that premiums rose in cost by four percent this year, down from a nine percent increase in 2011. This reflects a continued slowdown since premiums jumped by ten percent in 2004 and 13 percent in 2003.

The researchers acknowledge that the recession may largely explain the decline in premium growth, as it corresponds with an overall slowdown in health spending by consumers during this time. However, prior research has suggested that other factors already started to curb runaway health care costs earlier last decade, including a continued transition away from inefficient fee-for-service reimbursement (see Update for Week of August 20th).

The report surveyed 2,000 small and large employers during the first half of 2012 and found that family premiums for employer-sponsored plans now average \$15,745 per year, while single coverage averages \$5,615 per year (workers on average pay \$951 towards single coverage).

Copayments for in-network physician office visits averaged \$23 for primary care among the surveyed employers and \$33 for specialty care. For prescription drug plans with three or more tiers, average copayments were \$10 for generic drugs, \$29 for preferred brand-name drugs, \$51 for non-preferred brand-name drugs, and \$79 for specialty drugs.

Although premium growth has moderated, the four percent rise in 2012 still far outpaces growth in workers' wages (1.7 percent) and general inflation (2.3 percent). Over the past decade, premiums have increased 97 percent, over three times as fast as wages (33 percent) and inflation (28 percent). The employers that were surveyed expect to increase premiums by at least seven percent next year, due largely to uncertainty over costs of the Affordable Care Act (ACA).

The Kaiser survey also reveals that firms where at least 35 percent of workers earn \$24,000 or less per year require workers to pay an average of \$1,000 more per year towards their family coverage than higher-wage firms. This occurs even though workers at low-wage firms pay less in total premiums for family coverage.

In addition, workers at lower-wage firms are also more likely to face high deductibles. The survey found that 44 percent of workers at lower-wage firms face an annual deductible of at least \$1,000, compared with only 29 percent at firms with many high-wage workers. Across all employers, 34 percent of workers face a deductible of that size, including 14 percent with annual deductibles of at least \$2,000.

At least 61 percent of survey employers are offering employee health coverage, which is nearly unchanged from 2011. However, employers are increasingly extending coverage to part-time employees. Roughly 45 percent of employers with more than 200 workers offered part-time health benefits, a six percent jump from 2010.

Census Bureau confirms first drop in uninsured rate since 2007 despite record poverty

Figures released this week by the U.S. Census Bureau revealed a surprising 0.6 percent fall in the nation's uninsured population, the first drop since 2007 and largest single year decline since 1999.

According to census data, 48.6 million Americans or 15.7 percent of the nation were uninsured in 2011, down from nearly 50 million in 2010, the year in which the recession officially ended. The Bureau attributes at least 40 percent of the drop to the new provision in the Affordable Care Act (ACA) that allows young adults to remain on their parents' group health plans until age 26. Those aged 19-26 experienced a 2.2 percent drop in their uninsured rate to 27.7 percent in 2011.

The state that traditionally leads the nation in uninsured, Texas, saw an even greater drop of 0.8 percent. However, its 23.8 percent rate of uninsured remains more than a full point above Nevada at 22.6 percent. Louisiana and Florida follow at 20.8 percent, while two states that typical are among the national leaders fell out of the top five (New Mexico and Oklahoma). However, the largest state, California, jumped 0.3 percent to 19.7 percent, which is over two full percentage points higher than 2002.

The census figures mesh with data released last week by the Kaiser Family Foundation documenting that Texas, Florida, and Nevada lead the nation in the number of working age adults that are uninsured (see Update for Weeks of August 27th and September 3rd).

The Bureau emphasized that 2011 is the first year in a decade where the rate of private insurance coverage (which held steady at 63.9 percent) did not fall, while enrollment in government programs jumped a full percent due to persistently high unemployment resulting from the recession. Nearly a third of all Americans (32.2 percent) are now covered by Medicare, Medicaid, or other government plans.

This public safety-net, combined with enhanced unemployment benefits under the American Recovery and Reinvestment Act (i.e. the federal stimulus), enabled the national poverty rate to remain at 15 percent in 2011 even though the number of poor Americans now stands at a record high. In addition, the gap between rich and poor Americans is now wider than at any time since 1967 thanks to a 1.6 percent gain last year for the top-fifth of wage earners while wages for low-income Americans remains stagnant.

Median household income actually declined by 1.5 percent in 2010 to \$50,054 as more workers moved from full to part-time employment. It now stands a full eight percent below pre-recession levels in 2007, as three out of every five jobs created since the recession are low-wage, low-skill jobs.

New common application form available for HIV patient access programs

The Department of Health and Human Services (HHS) has collaborated with the National Alliance of State and Territorial AIDS Directors (NASTAD), seven pharmaceutical companies, and community stakeholders to create a Common Patient Assistance Program Application Tool.

Effective September 12th, the common form is a one-stop shop that patients and providers can use to collect the necessary information required of HIV patient assistance program (PAP) applicants. Prior to its development, PAP applicants had to fill out different sets of paperwork for each company. The new form is available on the websites for HHS and NASTAD.

STATES

Arkansas

Governor will seek legislative approval to expand Medicaid

Governor Mike Beebe (D) announced this week that has decided to fully support expanding Medicaid pursuant to the Affordable Care Act (ACA).

The Governor had favored the expansion, even after the U.S. Supreme Court afforded states the discretion to “opt out” without penalty (see Update for Week of June 25th). However, he would not commit to seeking legislative approval until the federal Centers for Medicare and Medicaid Services (CMS) clarified how much flexibility they will provide to states that expand (see Update for Week of July 16th).

Governor Beebe was ultimately persuaded by CMS’ decision to allow states that initially expand to still “opt out” without penalty in subsequent years should the Medicaid expansion prove too costly (see Update for Weeks of August 6th and 13th). His position was also bolstered by a study from his own Department of Human Services (DHS) concluding that the Medicaid expansion would actually save Arkansas over \$372 million in the first six years (see Update for Week of July 16th).

However, the Governor has an uphill battle in trying to secure the three-fourths vote in the legislature to approve the appropriation of funds needed to expand, estimated by DHS to be \$4 million per year. Despite Democratic control of both chambers and the support of the Board of Health and Arkansas Hospital Association, Republican lawmakers have adamantly refused to implement any part of “Obamacare” and are insistent that any decision on expansion wait at least until the results of the fall elections (see Update for Weeks of July 23rd and 30th). Republicans also point out that Arkansas Medicaid is already projected to have a \$250-400 million shortfall over the next fiscal year.

Idaho

Cost savings estimates cause some Republicans to consider Medicaid expansion

An analysis published this week by the *Spokesman-Review* predicts that Idaho taxpayers would save up to \$380 million over six years if Governor Butch Otter (R) expands Medicaid pursuant to the Affordable Care Act (ACA).

Idaho’s Catastrophic Health Care Fund currently spends over \$60 million to care for low-income childless adults that do not qualify for Medicaid. The newspaper notes that Idaho would not only save this \$60 million by expanding Medicaid for those earning up to 133 percent of the federal poverty level (FPL), but would receive a 100 percent federal match until 2016 and at least 90 percent thereafter.

The analysis expands upon a recent Kaiser Family Foundation study, which also found that the state would spend \$300 million less than their current Medicaid expenditures if accepted the federal match for expanding.

The U.S. Supreme Court gave all states the discretion to “opt out” of the ACA expansion without penalty. Governor Otter indicated that he was likely to follow the lead of at least 12 other Republican governors and do so (see Update for Week of July 2nd). However, he first wanted to get the recommendations of committee he created to analyze the potential cost or savings from expanding (see Update for Week of July 9th).

Republican leaders in the House had been adamantly opposed to implementing any part of “Obamacare” including the expansion. However, the recent savings estimates have already caused House Majority Leader Mike Moyle (R) to reconsider whether their ideological objections are outweighing pragmatic concerns. He and retiring Senator Joyce Broadsword (R) are among those who are now encouraging Republicans to “get the facts” before deciding whether to vote against the expansion.

Governor Otter is expected to announce his decision in the coming weeks. However, legislative approval will ultimately need to be obtained next session.

Maine

Federal court dismisses Maine lawsuit to force federal decision on Medicaid cuts

The First U.S. Circuit Court of Appeals dismissed a lawsuit brought by Governor Paul LePage (R) seeking to expedite a federal decision on his attempt to cut Medicaid eligibility for 33,000 low-income Mainers as of October 1st.

The Governor was the first of several Republican governors to insist that the recent U.S. Supreme Court decision giving states discretion to opt-out of the Medicaid expansion required by the Affordable Care Act (ACA) means that states can also opt-out of the law's maintenance of effort (MOE) provision banning Medicaid eligibility cuts below 133 percent of the federal poverty level (see Update for Week of July 9th).

CMS has refused to grant waivers from this MOE prohibition citing a Congressional Research Service finding that the ban was not altered by the U.S. Supreme Court decision (see Update for Week of July 16th). As a result, the Governor is trying to effect the change through a State Plan Amendment (see Update for Weeks of August 27th and September 3rd).

By law, CMS has 90 days to act on the Governor's request, which expires on November 1st. The court rejected the Governor's argument that an expedited decision is warranted because Maine balanced its budget based on the \$20 million in anticipated savings from the Medicaid cuts that were passed last spring by the legislature. It held that CMS refusal to decide before the October 1st effective date does not amount to a denial that can be appealed and thus deemed the lawsuit to be premature.

Governor seeks legislative fix to continue providing Canadian drugs to state/local employees

Governor Paul LePage (R) joined with two state senators in bipartisan support for a legislative fix that would allow 1,200 Maine households to continue purchasing lower-cost prescription drugs through a Canadian firm that distributes medications by mail.

The MaineMeds program operated by CanaRx was shut down on August 15th after Attorney General William Schneider (R) determined that the Canadian firm cannot be licensed as a pharmacy in Maine. CanaRX has been providing mail-order pharmacy services since 2003 to public-sector health plans in Maine, as well as a handful of other states like Illinois, Rhode Island, and Vermont. Such an international delivery system enabled 900 state employees and nearly 300 other city and private employees to access lower-cost medications. It was expected to save the state employee health plan about \$3 million this year.

CanaRx cuts costs by sending medications directly to prescription holders from pharmaceutical plants in Canada, the United Kingdom, New Zealand and Australia. However, Schneider determined that the international delivery system makes it impossible for the Maine Board of Pharmacy to license CanaRx under Maine law.

Senators Troy Jackson (D) and Doug Thomas are pursuing separate bills that would allow CanaRx to resume supplying prescription drugs within Maine. The Governor expressed support for the initiatives though has yet to indicate whether he will pursue a different legislative remedy. However, the President of the Maine Board of Pharmacy warned that a legislative fix could be problematic unless it ensured that international pharmacies meet the same safety standards as drugs distributed by licensed pharmacies in Maine.

The safety issue could also raise the ire of the Food and Drug Administration (FDA), which has previously sent warning letters stating that it was illegal for CanaRx to ship drugs to the United States, though declined to strictly enforce federal laws banning drug re-importation. However, the FDA has recently stepped up enforcement after cases earlier this year where counterfeit drugs were sent to the

United States from Canadian pharmacies, including Roche's popular cancer drug Avastin and Teva's popular attention-deficit disorder drug Adderall.

Safety concerns derailed efforts by both Republican and Democratic members of Congress to allow drug re-importation as part of FDA user fee reauthorization and the Affordable Care Act (see Update for Weeks of August 27th and September 3rd).

Massachusetts

Massachusetts becomes first to sign agreement to move dual eligibles into managed care

Massachusetts became the first state this month to agree to move dual eligible beneficiaries into managed care plans under a demonstration project authorized by the Affordable Care Act (ACA).

At least 26 states have already submitted proposals to the federal Centers for Medicare and Medicaid Services (CMS) seeking to participate in the demonstration, which is set to launch this January and could wind up enrolling over a third of the nine million low-income Americans enrolled in both Medicare and Medicaid. This population often has multiple chronic conditions and is thus the mostly costly to treat, accounting for almost 40 percent of Medicaid expenditures (see Update for Weeks of July 23rd and 30th).

However, CMS has been under pressure from the Medicare Payment Advisory Commission, American Medical Association, Federation of American Hospitals, and other stakeholders and members of Congress to "slow down" implementation due to quality of care issues that arose under state transitions of special needs populations to managed care in California, Florida, and other states (see Update for Weeks of August 27th and September 3rd). They are specifically concerned that the "shared savings" model would give physicians and providers incentives to skimp on care since they share in any savings that arise from coordinating care.

The Memorandum of Understanding (MOU) that Massachusetts signed with CMS attempts to address some of these concerns. For example, beneficiaries will have the ability to "opt-out" of the newly-created Integrated Care Organizations (ICOs) at any time or switch plans on a month-to-month basis. ICOs must also not contract with providers that fail to comply with the Americans with Disabilities Act.

However, consumer advocates insist that many "red flags" remain, as it is unclear whether the ICOs will have the necessary capacity, network adequacy, and competency to serve the complex needs of these populations when the demonstration starts. A recent study by the California Health Care Foundation found that provider networks under that state's managed care demonstration lacked the specialists needed to treat many of the costly illnesses within the transition population, causing major disruptions in care (see Update for Weeks of August 27th and September 3rd).

Consumer advocates also warn about a lack of external oversight, consumer outreach, and cost control. They note that the MOU lacks any independent ombudsman or process for consumer engagement. They also question whether the four percent savings target for the third year is realistic, and insist that the risk-mitigating strategies are insufficient to remove incentives for providers to avoid or underserve the highest-cost dual eligibles.

Minnesota

Medicaid managed care plans thrive despite cap on profits

A report released this week by an independent financial analyst shows that health maintenance organizations (HMOs) serving Medicaid beneficiaries continue to thrive despite the one-percent cap on profits mandated by state law.

Medicaid HMOs were forced to return \$73 million in excess profits earlier this year, after the new cap went into effect in July 2011 (see Update for Week of April 2nd). Governor Mark Dayton (D) negotiated the cap after plan filings for 2010 showed that the leading plan, Blue Cross and Blue Shield (BCBS) of Minnesota had over \$1.15 billion in reserves thanks to a 20 percent profit gain (see Update for Week of December 12th).

The latest report shows that the cap had little if any impact on the bottom line for Medicaid HMOs, who reported over \$230 million in net income for 2011 on \$7 billion in revenue. These results are down only slightly from 2010, when net income broke \$264 million.

The analysis found that Medicaid and other public programs now account for 53.6 percent of the revenue generated by Minnesota HMOs. However, the cap limit meant that only 32 percent of profits now comes from public programs.

The analysis also documented that HMOs still reserves that are more than \$1 billion above that required by state law.

New Mexico

Governor still undecided on Medicaid expansion, seeks more federal guidance

Governor Susanna Martinez (R) has not yet indicated whether she will exercise the discretion afforded by the U.S. Supreme Court to “opt out” of the Medicaid expansion required by the Affordable Care Act (ACA) without penalty (see Update for Week of June 25th).

The Secretary for the Department of Human Services sought additional federal guidance this week to help the Governor decide whether to accept the enhanced federal funding to expand. The letter identified the following five specific questions for the Centers for Medicare and Medicaid Services (CMS) to answer:

1. Must New Mexico enroll everyone who is newly-eligible at once or could it phase them in over time?
2. For how long will the federal government guarantee the enhanced federal match under the ACA (100 percent until 2016 and at least 90 percent thereafter)?
3. If the federal government lowers the match, can states then lower their eligibility requirements?
4. Could the state pay premiums for people who enroll in exchange programs instead of in the traditional Medicaid program and still receive federal matching funds?
5. Could the state expand eligibility to less than the 133 percent of the federal poverty level threshold set forth in the ACA?

CMS has yet to respond to all of the separate questions posed by the National Governors Association and Republican Governors Association, but has already indicated that states can opt-in at any point after 2014 and can opt-out if the expansion proves to be costly (see Update for Weeks of August 6th and 13th). This response was sufficient to persuade at least one Democratic governor to participate (see Arkansas article above).

The decision has huge implications for New Mexico, a state that traditionally has one of the nation’s highest uninsured rates. However, census data released this week showed a marked improvement for the first time in a decade, as New Mexico’s uninsured rate fell by 2.4 percent to 19.6 percent in 2011, dropping the state out of the top five nationwide (see article above).

North Carolina***Decline in child spending eliminates Medicaid shortfall***

Medicaid officials informed that Health and Human Services oversight committee this week that the program expects to spend roughly \$4 million less than initially forecast, thanks to substantially lower spending for women and infant children.

The decrease over the past two months has outweighed Medicaid's increased spending on the aged, blind, and disabled, the most expensive population to cover (an average of \$1,422 per month per enrollee). Even though women and infant children only cost about \$177 per month, utilization among this group has declined far more than predicted, enabling the Medicaid program erase its \$275 million shortfall and operate in the black.