

Health Reform Update – Week of June 10, 2013

CONGRESS

House Republicans move away from Medicaid block grants, back per capita spending caps

House Republicans are continuing to push for a Medicaid overhaul that would give states greater leeway in how to operate their programs. However, proposals released this week by House Energy and Commerce chairman Fred Upton (R-MI) move away from the earlier plan advanced by Rep. Paul Ryan (R-WI) that would give states lump-sum block grants with no strings attached and would instead limit the amount of federal Medicaid spending per beneficiary.

Rep. Upton, along with Senate Finance ranking member Orrin Hatch (R), cite a similar proposal by the Clinton Administration in the 1990s as evidence of “bipartisan support” for the per capita caps. Rep. Bill Cassidy (R-LA) introduced legislation last month following that approach (see Update for Week of May 6th), and according to Cassidy addresses concerns raised about Ryan’s “block grant” model twice passed by the House. The Congressional Budget Office had previously warned that such unrestricted block grants would cause states to dramatically scale back Medicaid benefits and eligibility (see Update for Week of April 2, 2012).

Democratic leaders on Energy and Commerce insisted that the same concerns apply to both models, as per capita spending caps would simply shift costs onto the most vulnerable beneficiaries. They instead urged reluctant states to participate in the Medicaid expansion under the Affordable Care Act (ACA) and favored extending the temporary boost in Medicaid reimbursement for primary care physicians provided by the ACA.

Rep. Upton also promoted changes in federal Medicaid regulations that would allow states to more freely vary benefits by Medicaid population or condition and streamline the process for federal demonstration waivers that let states experiment with different methodologies.

Republican bill would repeal health insurance exchanges if implementation is delayed

Senator Pat Roberts (R-KS) introduced legislation this week that would repeal the health insurance exchanges created by the Affordable Care Act (ACA) if they are not ready to begin open enrollment as required on October 1st.

The Department of Health and Human Services (HHS) has repeatedly assured Congress that the federal marketplace will meet the October 1st deadline, although they acknowledge that creating the technology infrastructure needed to operate the online marketplace has been far more costly than anticipated (see Update for Week of April 8th).

The measure (S.1154) would also repeal the controversial ACA mandate that everyone purchase adequate health insurance coverage they can afford. It is not expected to gain much momentum in the Democratically-controlled Senate.

Democratic bill would makes churches eligible for small business tax credits under ACA

Senators Mark Pryor (D-AR) and Chris Coons (D-DE) introduced a bill this week that would change the Affordable Care Act (ACA) statute so that churches can qualify for the small employer tax credits offered under the law. The *Church Health Plan Act* (S.1164) would create a new category of

“qualified church plans” that could also participate in the new health insurance exchanges created for individuals and small businesses.

Bipartisan support for the measure is unclear. Republican lawmakers have previously attacked the ACA for unfairly discriminating against religious institutions by requiring that health plans cover preventive services like contraceptives without any cost-sharing.

One-fifth of retailers plan to cut employee hours in response to ACA

A survey released this week by Mercer consultants found that employers have slightly increased their projections of the cost to comply with the Affordable Care Act (ACA).

Only nine percent of the 900 companies surveyed now expect the law to account for less than a one percent increase in their expenses, down from 2011 when Mercer found that 25 percent believed the ACA would have little financial impact. As a result of the ACA, roughly 28 percent of respondents now plan to increase worker contributions for family coverage and 13 percent will raise the contribution for employee-only coverage. Another two percent will stop contributing entirely for dependent coverage.

One-third of currently do not offer coverage to employees that work at least 30 hours per week, the threshold for the ACA employer mandate. This figure was even higher (46 percent) for retail, hospitality, and health care service industries.

Roughly 12 percent of respondents acknowledged plans to cut worker hours in order to avoid triggering the ACA employer mandate. This is again higher for retailers (20 percent). However, several large restaurant chains have already backtracked from plans to cut hours after a consumer backlash (see Update for Week of December 17th), while others like Wendy’s acknowledge that the costs of complying with the employer mandate will be only one-fifth of what it initially feared. The National Restaurant Association estimates that roughly 43 percent of restaurant employees are under age 26 and many of this group may remain on their parents’ group plan as allowed by the ACA.

The survey found that many employers remain unprepared for the implementation of the law. Almost 25 percent have not decided how to track the hours of their employees with schedules that vary. Another 32 percent “don’t know” whether the law will increase their costs, while 19 percent expect increased costs of five percent or more and 39 percent expect costs to rise 1-4 percent.

However, more than one-third of employers have already started taking steps to scale back generous plans in order to avoid the ACA tax on high-cost plans scheduled to take effect in 2018.

FEDERAL AGENCIES

Medicare Advantage enrollment hits record high despite ACA slowdown in payment growth

The Kaiser Family Foundation (KFF) reported this week that enrollment in Medicare Advantage has grown by nearly ten percent in the last year and by 30 percent since 2010.

The new record of 14.4 million subscribers dispels predictions by Affordable Care Act (ACA) opponents that curbing plan overpayments by restricting growth in MA payment rates would force MA plans out of business. Growth in MA plans has continued unabated since the enactment of Medicare Part D in 2006, despite the \$156 billion in lower MA payments.

HHS sides with state insurance commissioners in rejecting higher Medigap cost-sharing

Consumer groups praised the Department of Health and Human Services (HHS) Secretary this week for accepting National Association of Insurance Commissioners recommendations against adding nominal cost-sharing to Medigap plans C and F.

It is not clear if the Secretary's decision will have any impact on congressional and White House proposals to impose a surcharge on Medicare Part B premiums for those who purchase Medigap plans with first dollar coverage. President Obama included a surcharge of up to 15 percent in his proposed budget for fiscal year 2014 and House Republican leaders have supported including such a surcharge as part of any bipartisan deficit reduction compromise. Such a surcharge was also recommended by the influential Medicare Payment Advisory Commission in order to curb overutilization but strongly opposed by the insurance industry, claiming it will hurt the 90 percent of Medigap subscribers with annual incomes below \$50,000 (see Update for Week of April 8th).

The Affordable Care Act (ACA) required NAIC to study whether adding "nominal cost-sharing" for Medigap plans C and F would "encourage the use of appropriate physicians' services." However, the group said it found no peer-reviewed evidence demonstrating that added cost-sharing would reduce overutilization by Medigap subscribers.

NAIC directly disputed MedPAC's conclusion that Medigap is a major driver of unnecessary care. It stated that such an assertion "fails to recognize that Medigap coverage is secondary and that only Medicare determines the necessity and appropriateness of medical care utilization and services."

STATES

Arizona

Governor secures passage for traditional Medicaid expansion

Governor Jan Brewer (R) has won her hard-fought battle to make Arizona only the second state under full Republican control (aside from North Dakota) to participate in the Medicaid expansion under the Affordable Care Act (ACA).

The Governor had to play hard-ball with House Republicans led by Speaker Andy Tobin (R) who had repeatedly refused to go along with her proposal to accept federal funds to expand Medicaid to everyone earning up to 138 percent of the federal poverty level (FPL) even though the Republican-led Senate passed it earlier this month. Conservative Republicans heading the House Appropriation Committee rejected her plan earlier in the week before the Governor called a special session to force a full House debate on the expansion. She had earlier vetoed five bills, following through on her pledge to reject all legislation until the expansion is passed (see Update for Week of May 27th).

The expansion will add nearly 300,000 Arizonans to Medicaid, include more than 100,000 childless adults whose coverage was previously eliminated by Governor Brewer (see October 17, 2011). In 2000, voters made Arizona one of only six states to cover childless adults through a federal waiver. However, that waiver expires at year's end, meaning another 60,000 childless adults would have lost Medicaid coverage in 2014 if Arizona did not expand.

The Obama Administration rejected an earlier alternative sought by Senate President Biggs and Speaker Tobin that would have used the ACA funds to cover the upper end of the newly-eligible Medicaid population in the federal marketplace, similar to the model in Arkansas that was conditionally approved. However, that alternative would have continued the cap on childless adults (see Update for Weeks of April 22nd and 29th).

Governor Brewer surprised conservative lawmakers by so fervently backing the ACA expansion (see Update for Week of January 14th). However, she insisted that accepting \$1.6 billion per year in federal funds was a "no brainer", given the higher uncompensated care costs that would be imposed on hospitals by opting-out of the expansion, as well as penalties that Arizona businesses would have to pay for not provide affordable coverage to those who would otherwise be made Medicaid-eligible. She also

pointed out that Arizona already accepts over \$12 billion in federal funds every year without objection from conservative lawmakers.

California

Insurance commissioner seeks Blue Cross exclusion from SHOP exchange

Insurance Commissioner David Jones (D) recommended this week that Covered California exclude Anthem Blue Cross from the Small Business Health Options Program (SHOP) exchange created pursuant to the Affordable Care Act (ACA).

Under the “active purchaser” exchange model authorized by the California legislature, Covered California can selectively contract only with those plans that are the most affordable, instead of having to allow every plan that meets minimum federal and state standards to qualify. Covered California recently announced that it excluded 19 of 32 plans that initially applied for the exchange (see Update for Weeks of May 13th and 20th).

Commissioner Jones urged the board to likewise exclude Anthem Blue Cross and Blue Cross of California for a “pattern of excessive and unjustified premium increases” over the past several years. Jones has repeatedly jawboned Anthem into downgrading past increases that he determined were unreasonable and based on erroneous claims data and actuarial assumptions, and already cited them four times in 2013. Department of Insurance actuaries found that Anthem’s 17.6 percent cumulative increase on small business subscribers grossly overestimated future medical costs, as well as their 18 percent hike for individuals which they voluntarily decreased to 14 percent after public disclosure (see Update for Week of February 18th). The commissioner specifically criticized Anthem for charging subscribers \$1.5 million in 2013 for ACA fees that are not due until late 2014, despite a 25 percent profit margin last year.

Consumer Watchdog says exchange rates are still too high, despite being less than feared

A prominent consumer advocacy group criticized proposed premiums in the new Covered California health benefit exchange this week, even though the recently disclosed figures were less than initially projected.

Proposed rates averaged about \$3,600 per year before subsidies, far lower than the \$5,200 estimated by the Congressional Budget Office. In addition, the \$321 average premium for all silver-level plans (to which the ACA premium subsidies are tied) was far lower than the \$450 average predicted by the Milliman consulting firm hired by the exchange (see Update for Weeks of May 13th and 20th).

However, Consumer Watchdog insisted that these rates were still unaffordable for many uninsured Californians and above the rates that subscribers would pay if voters give the Insurance Commissioner his long-sought authority to reject or modify unreasonable rate hikes. At least 37 state states have this authority, but legislation to add California to the list has been blocked the past few years by the insurance industry. As a result, Consumer Watchdog put a voter referendum on the 2014 ballot that would expand the Commissioner’s authority to regulate health insurance premiums the same way as auto insurance (see Update for Week of August 20th).

Consumer Watchdog singled out Kaiser Permanente this week for criticism, noting it consistently had the highest proposed premium amounts for the exchange. For example, a 40 year old purchasing a Kaiser exchange plan in Los Angeles County would pay \$325 a month, compared to only \$242 for Health Net and \$287 for Blue Shield of California.

Delaware

House committees pass bills limiting specialty tier cost-sharing, enacting ACA market reforms

The House Health and Human Development committee unanimously approved a substitute measure this week for S.B. 35, which would limit patient coinsurance or copayments to \$150 for up to a 30-day supply of any single specialty tier drug. A provision of the bill will allow patients to request an exception to obtain a specialty drug that would not otherwise be available on a health plan formulary.

The substitute measure cleared the Senate last week. A previous version passed by the Senate Health and Social Services committee would have limited cost-sharing on specialty tier drugs to \$100 per month for up to a 30-day supply, which could not exceed \$200 per month per enrollee for all specialty tier covered drugs (see Update for Weeks of May 13th and 20th).

The House Economic Development, Banking, Insurance, and Commerce Committee also unanimously passed legislation (H.B 162) that would align Delaware insurance law with ACA market reforms, including the new cap on out-of-pocket expenses that includes specialty drug costs.

Louisiana

House and Senate resolutions would require study of HIV, HCV drug access

The House and Senate passed resolutions before adjourning last week (H.R. 164 and S.R. 175) that request the Department of Health and Hospitals to study the most effective means by which to ensure access to HIV/AIDS and Hepatitis C (HCV) medications by Medicaid managed care enrollees.

Maine

House and Senate pass retooled Medicaid expansion with Republican support

House and Senate Democrats gave final approval this week to a retooled Medicaid expansion bill, though they failed to attract enough Republican votes to override a repeat veto from Governor Paul LePage (R).

The new bill (L.D 1094) contains several key additions from the previous version (L.D. 1546) that would have allowed Maine to participate in a traditional expansion under the Affordable Care Act (ACA). The Senate came up two votes short of overriding the Governor's prior veto (see Update for Week of May 27th) and is currently one vote short if he likewise vetoes L.D. 1094.

The latest version includes the opt-out clause in 2016 that was proposed by Republican leadership. It also makes the expansion contingent upon federal approval of higher copayments for certain Medicaid enrollees and federal assurances that childless adults will receive a 100 percent federal match, including those covered as of December 2009.

Governor LePage has insisted that he will approve only a Medicaid expansion alternative that extends the 100 percent federal match under the ACA from 2016 to 2024. The Obama Administration has already rejected that condition (see Update for Week of May 27th).

Massachusetts

State seek permission to fix ACA "glitch" that may leave employee dependents uninsured

A congressional drafting error that the Kaiser Family Foundation predicts may cause nearly four million dependents to be ineligible for federal tax credits under the Affordable Care Act (ACA) has prompted Massachusetts officials to seek federal approval to fill the gap.

Under the ACA, employer health plan subscribers can still be eligible for the tax credits if their employer offers coverage that it is either too inadequate or unaffordable (more than 9.5 percent of worker income). However, Internal Revenue Service regulations insist that the statute allows affordability to be calculated based only on the cost of worker-only coverage and not family coverage that is typically three

times more costly. As a result, uninsured spouses and children will not qualify for the law's premium assistance.

IRS has refused to reverse its position, despite the urging of the Government Accountability Office and Democratic authors of the ACA provision. Partisan gridlock has also prevented Congress from simply rewriting the statute, leading Governor Deval Patrick (D) and state health officials to propose a pilot program that would at least allow some workers who cannot afford family coverage to qualify for subsidies offered through the Massachusetts Medicaid program. The proposal, which is estimated to cost \$33 million in state and federal dollars, would require an expansion of the state's current federal demonstration waiver.

Michigan

House panel advances Medicaid expansion bill, with a catch

Governor Rick Snyder (R) made some progress this week on his proposal for Michigan to participate in the Medicaid expansion under the Affordable Care Act (ACA), albeit with a controversial stipulation that the Obama Administration may not accept.

Republican lawmakers had steadfastly opposed accepting ACA funds to expand Medicaid and it appeared that the Governor's plan would require a ballot referendum to be enacted after it was stripped from budget plans passed by the House and Senate (see Update for Weeks of May 27th). However, the House voted this week to approve a separate measure (H.B. 4714) that would impose a five percent copayment on those who earn from 100 to 138 percent of the federal poverty level, or the upper end of the ACA expansion population. For enrollees that are not "medically frail", this copayment would increase to seven percent after four years, unless the enrollee opts to instead buy coverage through the new federal marketplace.

A Senate vote on H.B. 4714 is expected before the legislature adjourns next week. However, passage is far from certain as the chamber has a larger Republican margin and tea-party backed conservatives remain staunchly opposed to implementing any part of "Obamacare", insisting that the state should not "throw more money at a failed program."

It is also not clear that H.B. 4714 would be federally-approved, as the Obama Administration previously rejected proposals by House Republicans to explicitly limit Medicaid coverage to four years (see Update for Week of May 6th).

Mississippi

Democrats withhold Medicaid reauthorization in effort to force ACA expansion

Democratic lawmakers are refusing to vote for the annual reauthorization of Medicaid unless the Republican-controlled legislature participates in some form of the Affordable Care Act (ACA) expansion.

The stand-off began in April when the legislature adjourned without the required annual reauthorization of Medicaid. Although such reauthorization is traditionally a technicality, Democratic lawmakers refused to give Republicans the three-fifths majority required unless they agreed to at least a federally-approved alternative to the ACA expansion, such as the private sector model that the Obama Administration conditionally approved for neighboring Arkansas (see Update for Week of March 25th).

However, Governor Phil Bryant (R), an ardent opponent of the law, refused to seek federal approval for any bipartisan alternative, insisting that if Democrats did not reauthorize Medicaid he could operate the program himself via an executive order (see Update for Week of June 3rd).

New Hampshire

Senate Republicans reject partnership exchange, consumer outreach grant

Republicans that narrowly control the Senate have voted to block legislation allowing New Hampshire to partner with the federal government on the health insurance exchange required by the Affordable Care Act (ACA) or accept a \$5.3 million federal outreach grant that would help facilitate exchange enrollment.

The Democratic-led House had passed both measures. However, Republican lawmakers insisted that legislation enacted last session when both chambers were Republican-controlled made clear that the health insurance exchange was to be a federal and not state responsibility (see Update for Week of May 27th).

Governor Maggie Hassan (D) had already obtained federal approval for the partnership exchange (see Update for Week of March 4th) and backed the legislation (H.B. 688) to relax the Republican prohibition on the state participating in any ACA exchange and align state insurance law with the ACA's market reforms (see Update for Week of February 25th). She pledged this week to continue seeking the needed authorizing legislation that will allow New Hampshire to retain control over certain exchange functions like consumer outreach. However, with open enrollment set to begin on October 1st it appears likely that New Hampshire will have to default to full federal control over the exchange for at least 2014.