

Health Reform Update – Week of September 26, 2011

CONGRESS

White House tries to expedite high court review of Affordable Care Act

The Obama Administration petitioned the U.S. Supreme Court this week to overturn the decision by the 11th U.S. Circuit Court of Appeals that declared the Affordable Care Act (ACA) mandate that everyone buy health insurance to be unconstitutional.

In a more significant move, the Administration elected not to ask the full 11th Circuit court to review the decision by a three-judge panel last month (see Update for Week of August 8th). The full court's review could have taken several months and delayed an ultimate decision by the Supreme Court until after the 2012 election. Instead, the high court should rule by the end of their term in June 2012.

The Administration's decision to expedite a final review signals both a belief in a favorable outcome and a desire to resolve the political controversy over the individual mandate before the general election campaign begins. Their confidence was echoed this week by retired Supreme Court justice John Paul Stevens, who pointed out that the court's critical swing vote Anthony Kennedy and most conservative justice Antonin Scalia sided with the majority in 2005 in holding that Congress had the power to regulate medical marijuana sales even when they did not cross state lines. Justice Stevens predicted that both justices would follow this precedent in finding that Congress likewise had the power to mandate the purchase of health insurance because of its impact on interstate commerce.

The Supreme Court appears likely to focus on the 11th Circuit case in its review. It is by far the most prominent case, with 26 state attorneys general and the National Federation of Independent Business (NFIB) signed-on as plaintiffs. However, it is also the only appellate court that has upheld the remainder of the ACA even if the individual mandate is unconstitutional. (A lower court in the Florida panhandle had struck down the entire law last January).

For these reasons, the Obama Administration specifically asked the Supreme Court to review the 11th Circuit case and not Sixth Circuit ruling that upheld the entire law (see Update for Weeks of June 27th and July 4th).

Oral arguments held last week suggest that a panel of two Republican-appointed judges and one Democratic-appointed judge may also strike down the individual mandate. However, that panel also indicated that it was considering decisions by the Fourth and Ninth Circuits that the mandate cannot be challenged until it goes into effect in 2014 (see Update for Week of September 19th). The Obama Administration did not adopt this procedural approach, preferring instead to resolve the issue once and for all this term.

Both the D.C. and Eighth Circuits are expected to issue decisions later this fall. If no other court strikes down the entire law, it appears very likely that the Supreme Court will only rule on whether the individual mandate is constitutional, and not other challenges to the ACA.

Democrats and Republicans seek recusal of Supreme Court justices from ACA decision

The imminent review of the Affordable Care Act (ACA) by the U.S. Supreme Court has intensified partisan efforts force the recusal of justices with potential conflicts of interest.

A group of 20 House Democrats have been openly seeking to redistribute the court's ideological divide by seeking the recusal of conservative Justice Clarence Thomas. They formally asked the Judicial Conference of the United States this week to open an ethics investigation into his alleged failure to disclose all of his wife's income from an ardent opponent of the ACA. Thomas' wife worked for the conservative Heritage Foundation until 2007 and recently founded a conservative group promoting the unconstitutionality of the new law.

Republicans have countered by demanding the recusal of Supreme Court Justice Elena Kagan. Senator Orrin Hatch (R-UT) claims that Kagan was involved in deliberations over the ACA while she served as Solicitor General during the law's drafting. During her confirmation hearing last year, Kagan denied being party to the crafting of the new law, emphasizing that her role as Solicitor General is solely to represent the federal government before the Supreme Court.

Congress passes stopgap spending bill to avert government shutdown, at least for one week

The Senate overwhelmingly approved stopgap spending bills this week that would avert a federal government shutdown through November 18th. The full measure (H.R. 2608) would provide \$1 billion less in the \$3.65 billion of disaster relief funding sought by Democrats, which was the sticking point in last week's negotiations (see Update for Week of September 19th).

Because the House was in recess this week, it elected to exercise the option provided by the Senate under H.R. 2017 to merely pass a one-week extension on a *pro forma* voice vote (with only three members present). The full House will then decide next week whether to pass the full stopgap until November 18th.

House passage is far from certain, as Republicans struggled to pass their initial version of H.R. 2608, with "tea party" backed members seeking more severe cuts than agreed to in the bipartisan debt limit accords last month (see Update for Week of September 19th). They have also remained adamant that any disaster relief funding be offset with cuts to other discretionary programs.

However, both House and Senate leaders have largely agreed that the continuing resolution (H.R. 2608) hold firm to the spending caps in the debt limit accord. As a result, negotiations will likely focus on whether or how to offset the disaster relief.

House Appropriations Committee moves again to block funds for the Affordable Care Act

The House Appropriations Subcommittee for health and human services released a draft fiscal year 2012 budget bill this week that blocks \$8.6 billion in funding for the Affordable Care Act (ACA) until all legal challenges to the new law are resolved.

Total spending under the draft bill (H.R. 3070) would fall \$4 billion from 2011, in line with the bipartisan debt limit accord (see Update for Week of August 1st). Subcommittee Republicans also agreed to restore at least \$14.2 billion of the severe cuts they sought in the FY2012 budget resolution they passed last spring (see Update for Week of April 4th).

However, the subcommittee signaled their willingness to pick another fight with Senate Democrats by targeting the ACA. The draft legislation specifically would eliminate the Center for Consumer Information and Insurance Oversight (CCIO), the division within the Department of Health and Human Services (HHS) that oversees much of the implementation for the ACA. It also would rescind \$1 billion for the new preventive health care fund and \$15 million for the new Independent Payment Advisory Board, which has drawn the ire of Republicans and some Democrats for ceding control over Medicare spending cuts away from Congress.

The measure also cuts funding for other HHS entities like the Centers for Disease Control and Prevention, as well as key education programs favored by Democrats.

FEDERAL AGENCIES

Kaiser study says ACA not to blame for nine percent jump in employer health premiums

Democrats and Republicans seized on a new Kaiser Family Foundation survey released this week estimating that employer-sponsored plan premiums jumped by nine percent in 2011 to \$15,073—or the price of some new cars.

Republican lawmakers promptly claimed that the figures showed that the Affordable Care Act (ACA) has failed to reduce or curb premiums as Democrats predicted. However, the White House defense of the new law was already posted on its health reform blog at the same time as the Kaiser findings were announced.

Deputy Chief of Staff and former Centers for Medicare and Medicaid Services (CMS) Administrator Nancy-Ann DeParle emphasized that the Kaiser survey is “backward looking” and demonstrates the need for the new federal health insurance reforms. She pointed out that the major provisions of the new law will not be in effect until 2014.

However, DeParle stressed that ACA consumer protections that already went into effect have indeed reduced the cost curve when it comes to premiums, especially those requiring health plans publicly justify any double-digit rate hike and spend at least 80 percent of premium revenue on medical care (85 percent for large group plans). She noted that the average premium for the eight million subscribers in the enrolled in the Federal Employees Health Benefits Program (FEHBP) will increase by only 3.8 percent in 2012, just over half of the 7.3 percent increase in premiums for 2011. (Individual and family plan members under FEHBP will also see a slight drop in their premiums.)

DeParle also cited the recently released survey by Mercer consulting concluding that employer health insurance costs were expected to increase only by an average of 5.4 percent next year, the slowest growth rate since 1997 (see Update for Week of September 19th).

Kaiser’s President defended the White House position, pointing out that their survey found the ACA is only responsible for roughly 1.5 percent of the nine percent increase last year, and that was attributable solely to expanding coverage to 2.3 million young adults and free preventive care—provisions that will reduce premiums over the long-run through better health outcomes.

According to OPM, the smaller premium hike is due to lower utilization and costs over the last year rather than changes in the way the agency manages the program or benefits offered to enrollees. This is the lowest increase since 2008, when premiums rose 2.1 percent.

FDA to issue biosimilar guidance within weeks or days

Food and Drug Administration officials indicated this week that they are only “weeks...maybe even days” from issuing the required guidance on implementing a regulatory pathway for biosimilar drugs.

Congress created the regulatory pathway for the cheaper generic versions of biologic drugs under the Affordable Care Act (ACA), but granted the initial manufacturer 12 years of product exclusivity. The ACA charged FDA with developing rules for the approval process by January 15th.

FDA submitted a request for public input last May and disclosed this week that they have completed work on the regulations. Minutes of industry meetings suggest that the agency tentatively reached agreement over the user fees companies would pay to support the biosimilar approval process. The agency had initially proposed that manufacturers of lower-cost biosimilars should have to pay the same user fees as the initial manufacturer (see Update for Week of May 9th).

An article published in last month's *New England Journal of Medicine* also hinted that the FDA will require biosimilar manufacturers to provide far more data than traditional generics (see Update for Week of August 1st). However, reaching a consensus on what data to require was complicated by the fact that, unlike generic drugs, the complex manufacturing process for generic biosimilars makes it more difficult to produce exact copies of the "reference" product. The biosimilar pipeline is also more costly as it requires more clinical trials.

FDA officials acknowledge that they have already received about two dozen meeting requests for proposed biosimilar products, involving potential versions of 9-10 "reference" products. Potential players include traditional generic drugmakers, such as Novartis' Sandoz division, as well as large manufacturers like Pfizer and Merck, all of whom participated in deliberations with the FDA. Other traditional biotechnology companies like Amgen and Biogen have also expressed interest.

Members on an FDA panel last week testified that the price of biosimilar products thus far have run about 20-40 percent less than their brand-name or "reference" competitor.

Institute of Medicine to release essential health benefits guidance next week

The Institute of Medicine announced this week that it will release its long-awaited essential health benefits guidance on October 7th.

The Affordable Care Act (ACA) charged IOM with issuing recommendations by September 30th on how federal regulators should define the essential health benefits that the new law requires all insurers to cover. IOM has been lobbied heavily by interest groups seeking to ensure specific benefits are included within the essential benefit package. However, IOM has indicated that its guidance will not produce specific benefit standards but rather recommend the criteria and methods that the Department of Health and Human Services (HHS) should use in determining which benefits are "essential".

HHS states that it will use the IOM guidance to issue final regulations by the end of the year. They are perhaps the most highly anticipated rulemaking under the ACA as many states and insurers have indicated that they are waiting to see how essential benefits will be defined before choosing whether to create or participate in the new state-based health insurance exchanges.

HHS extends comment deadline for initial exchange regulations

The Department of Health and Human Services has extended the public comment period for proposed regulations to implement the new health insurance exchanges authorized by the Affordable Care Act (ACA). Public comments will now be accepted through October 31st for two sets of initial regulations were published last summer (see Update for Week of July 11th).

Census data confirms shift from employer-based coverage to government health plans

An analysis released this week by the nonpartisan Employee Benefit Research Institute (EBRI) found that employer-sponsored coverage among the non-elderly declined over the past decade from 69.3 percent while individual coverage remained unchanged.

Based on estimates from the March 2011 data released by the U.S. Census Bureau, EBRI not only confirmed that employer-sponsored coverage was continuing to erode, it also found that the percentage of the uninsured continued to slightly increase to 18.5 percent in 2010, the highest level since it began measurements in 1994.

By contrast, enrollment in government plans jumped to 21.6 percent of non-elderly by 2010, with Medicaid and SCHIP accounting for nearly 17 percent of the non-elderly (up from ten percent in 1999).

EBRI attributes the continued shift from employer-based coverage to public programs to high unemployment caused by the economic downturn.

GAO says cost of coverage young adults under TRICARE will be minimal

The Government Accountability Office (GAO) issued a report this week (GAO-11-837R) finding that the cost of implementing a key Affordable Care Act (ACA) provision will impose minimal cost on the Department of Defense (DoD) health insurance program (TRICARE).

Although the ACA consumer protections that went into effect last September did not apply to TRICARE, Congress created a special TRICARE Young Adult (TYA) program that went into effect last May (see Update for Weeks of April 18th and 25th). GAO found that as of June 2011, the TYA program had enabled 4,549 young adults up to age 26 to be enrolled under their parents' coverage at a cost of \$4.4 million.

DoD informed GAO that the estimated costs for implementing these provisions were "minimal" because no new staff or significant resources were required to do so. The DoD also elected to fund the expanded coverage through a two percent increase in all premiums.

GAO notes that it is not clear how adverse selection may affect program premiums, and that DoD will adjust them accordingly in 2014 based on the average costs for providing benefits.

OIG report finds inadequate federal oversight for ADAPs

The Office of the Inspector General (OIG) for the Department of Health and Human Services (HHS) issued a new report this week (A-05-10-00088) that recommended better oversight of federal Ryan White funding for the purchase of HIV/AIDS medications.

Part B of the federal Ryan White legislation in 1990 provides grants to states and territories for their respective AIDS Drug Assistance Programs (ADAPs). These funds may not be used to pay for items or services that are eligible for coverage by other federal, state, or private health insurance.

However, OIG found that five of the nine states they examined failed to comply with this "payer of last resort" requirement. Two of the states also lacked adequate documentation of ADAP eligibility.

OIG recommended that the Health Resources and Services Administration (HRSA) that oversees Ryan White programs should improve its oversight to ensure that states comply with payer-of-last-resort and eligibility requirements.

STATES

Landmark Medicaid reimbursement challenge first on fall agenda for U.S. Supreme Court

While constitutional challenges to the Affordable Care Act (ACA) will likely dominate the next term for the U.S. Supreme Court (see article above), the first agenda item for returning justices next week will be a critical Medicaid reimbursement case that could hinder the Medicaid expansion under the ACA.

The high court will hear a plea from the Obama Administration and state officials to prevent Medicaid providers and beneficiaries from being able to sue over low reimbursement. Federal law requires that Medicaid payment be at least sufficient to ensure beneficiaries can access care to the same extent as the general population, a nebulous standard that is poorly enforced by the Centers for Medicare Services (CMS). The Ninth U.S. Court of Appeals held that providers and beneficiaries thus could sue privately to enforce this provision, and blocked ten percent across-the-board cuts in Medicaid payment enacted by California in 2008 and 2009.

Consumer advocates were surprised last spring when President Obama sided with California and 30 other state attorneys general in claiming that allowing a right-of-action to millions of private litigants could wreak havoc on over-burdened federal courts (see Update for Week of June 6th). However, several former CMS administrators and officials filed briefs supporting a private right-of-action, insisting that it is “very dangerous to allow states to just keep cutting Medicaid” without meaningful enforcement.

State attorneys general are not using new stimulus authority to enforce HIPAA violations

Only two state attorneys general have pursued the authority Congress gave them in 2009 to prosecute privacy and security breaches of health information under the Health Insurance Portability and Accountability Act (HIPAA).

The authority to enforce HIPAA violations traditionally belonged only to the Office for Civil Rights (OCR) within the Department of Health and Human Services (HHS). However, Congress also gave jurisdiction to state attorneys general in conjunction with a \$27 billion stimulus to facilitate greater use of electronic health records initiated by the American Recovery and Reinvestment Act (ARRA).

Despite training from federal agencies and a consensus among privacy groups that HHS OCR was uninterested in vigorous enforcement, only former Connecticut Attorney General Richard Blumenthal and Vermont Attorney General William Sorrell have used their new power to bring civil privacy cases on behalf of state residents in federal court. (They could always prosecute such cases under state medical privacy laws.)

However, new OCR Director Leon Rodriguez insists that his office has greatly stepped-up enforcement since its authority was enhanced by the stimulus act. The law increased HIPAA penalties from a maximum of \$25,000 to a tiered range between \$100 and \$50,000 for each violation, with a maximum of \$1.5 million if the action is pursued by federal agencies.

Individuals continue to lack a private right of action to enforce their rights under HIPAA.

Arkansas

Insurance Commissioner scuttles exchange grant application in face of Republican opposition

House Minority Leader John Burriss (R) joined with five other Republican lawmakers this week to successfully urge Insurance Commissioner Jay Bradford (D) not to apply for a \$3.8 million federal grant to help create the health insurance exchange required by the Affordable Care Act (ACA).

The Democratically-controlled Legislature failed to pass authorizing legislation last session. Governor Mike Beebe (D) has refused to order lawmakers to consider exchange bills during next year's budget-only session, saying they would have to “live with” their decision to allow a federal takeover of the exchange (see Update for Week of August 22nd).

Even though legislative authorization is not required for the Insurance Commissioner to procure exchange grants, Governor Beebe refused to allow Bradford to apply by the September 30th deadline without first getting lawmakers to sign-off on a letter indicating “strong consensus” for obtaining the grant (see Update for Week of September 19th). However, Republican leaders immediately sent a letter to Bradford reiterating their opposition to accepting federal funds to implement any provision of “Obamacare”, even though Bradford kept lowering his grant request from \$20 million to only \$3.8 million.

Commissioner Bradford was “disappointed” that Republicans would not provide the consensus to move forward, emphasizing that “losing the health regulation [over the exchange] to the federal government is not good for Arkansans.” His department will move forward on implementation using the initial \$1 million federal grant received last year, but Bradford ranked the chances of Arkansas actually creating an exchange by the January 2013 federal deadline as three out of ten.

Connecticut

Insurance department rejects double-digit rate hike by Anthem

The new Insurance Commissioner followed through this week on his pledge to reign-in unreasonable premium increases by rejecting a double-digit rate hike by the state's largest health plan.

Anthem Blue Cross and Blue Shield had sought a 12.9 percent average increase for more than 25,000 individual subscribers, claiming it was needed to cover for rising utilization and the new federal health insurance reforms. However, Commissioner Thomas Leonardi instead granted Anthem only a 3.9 percent increase effective January 1st.

Anthem created a firestorm last year by seeking a 20 percent average rate hike. Then Insurance Commissioner Thomas Sullivan (R) was forced to resign after approving the increase without review or public hearing, only to have actuaries hired by then Attorney General Richard Blumenthal (D) find that Anthem erroneously blamed most of the increase on costs imposed by the Affordable Care Act (ACA) (see Update for Week of November 1st). Acting Commissioner Barbara Spear (D) ultimately ordered a public hearing before rejecting all of Anthem's increase.

Although Commissioner Leonardi promised greater oversight and transparency of the rate review process, he drew the ire of consumer advocates last summer for urging Governor Dan Malloy (D) to veto legislation that would have created a new public review process mandating hearing for any double-digit increase (see Update for Weeks of June 27th and July 4th). The Governor and Commissioner insisted that the existing rate review process was more than adequate to reign-in unreasonable increases. However, Leonardi later sought to avert a potential veto override by agreeing to a compromise where he would hold up to four public hearings per year at the request of the State Healthcare Advocate for any rate hike of at least 15 percent (see Update for Week of July 25th).

The Commissioner also approved a ten percent rate cut for individual subscribers under Aetna, as well as a 14.3 percent average increase for Golden Rule Insurance Company (concurring with the insurer's analysis that medical costs were already 22 percent higher than expected when the current rates were approved.) Several requests for single-digit rate hikes are still pending.

Physician groups seek to create non-profit insurance cooperative under Affordable Care Act

The Connecticut State Medical Society and its network of physician practices have created a non-profit cooperative organization that they hope will receive federal funding to offer an affordable health insurance option to individuals and small businesses.

Under the Affordable Care Act (ACA), the U.S. Department of Health and Human Services (HHS) is making available nearly \$4 billion in federal loans to facilitate the creation of Consumer Operated and Oriented Plans (CO-OPs) (see Update for Week of July 18th). The HealthyCT CO-OP created by the medical society has applied for these loans and anticipates a response by January.

HealthyCT would sell health coverage through the new health insurance exchange as well as outside of it. The oversight board would be made up of consumers and physicians.

Consumer groups praised the new CO-OP, as it will provide more options for affordable coverage. However, America's Health Insurance Plans insists the loans will not be nearly enough to enable CO-OPs to compete with large insurers. Proposed federal regulations last summer appeared to concede this point, acknowledging that 35-40 percent of CO-OPs will default on the loans, causing the federal government to lose up to \$230 million from 2012-2013 (see Update for Week of July 18th).

Colorado

Republican lawmakers block exchange board from applying for \$22 million exchange grant

Similar to Arkansas (see article above), Republican lawmakers have successfully blocked the new health insurance exchange board from applying for a \$22 million federal grant to help create the exchange required by the Affordable Care Act (ACA).

Republican lawmakers specifically balked at application language that would change Colorado regulations to “conform with federal requirements”. Local tea party chapters objecting to implementing any part of “Obamacare” nearly derailed exchange-authorizing legislation last session that passed only thanks to the strong support from the business and insurers (see Update for Week of May 30th).

As a result, Colorado failed to meet the September 30th application deadline for the grant, though members hope to try again later this year. Colorado has already received the initial \$1 million federal exchange grant. However the board needs the additional funds to create the technology framework that will allow consumers to shop online for policies that best meet their budget and medical needs.

Delaware

New law brings Delaware in line with ACA removal of cost-sharing for certain preventive services

Governor Jack Markell (D) signed S.B. 98 into law on September 23rd. The measure brings Delaware insurance law into conformance with the new Affordable Care Act (ACA) requirements for health plans to remove all cost-sharing liabilities from certain preventive services.

Florida

Nearly one-third of all non-elderly Floridians are now uninsured

Almost a full third of non-elderly Floridians went without health insurance last year, according to data released last week by the U.S. Census Bureau.

Florida’s uninsured rate continues to be the fourth highest in the nation with nearly four million people or over 21 percent of Floridians lacking coverage. While some of the nation’s highest unemployment rates have pushed many Floridians out of employer-sponsored coverage and into Medicaid, strict eligibility requirements imposed by Governor Rick Scott (R) have limited this safety-net option and increased the number of Floridians who are uninsured.

Florida Medicaid rolls topped three million for this first time last year, despite new rules requiring applicants show proof of U.S. citizenship. However, these citizenship requirements have greatly curbed SCHIP enrollment, which grew at less than one percent last year, despite growing annually at roughly eight percent in years past.

Governor Scott has also cut funding to programs that facilitate enrollment among those who are SCHIP eligible but do not apply. Florida, along with California and Texas, account for 40 percent of the five million children nationwide who are SCHIP eligible but not enrolled.

Michigan

Republican committee chairs introduces bill to create health insurance exchange

Senator Jim Marleau (R) introduced legislation this week that could create the health insurance exchange required by the Affordable Care Act (ACA).

S.B. 693 will be heard by the Joint Health Policy Committee chaired by Senator Marleau. The Senator held hearings last summer to urge his fellow Republicans not to simply allow a federal takeover of the exchange if Michigan does not act by January 2013.

Michigan was one of only 12 states that had yet to introduce exchange-authorizing legislation. The measure would create the exchange as a non-profit corporation. Following the lead of most state legislatures, S.B. 693 would prohibit any of the seven members of the oversight board from being employed directly or indirectly by the health insurance industry.

Montana

Governor seeks federal approval for Montana to create its own universal health care program

Governor Brian Schweitzer (D) announced this week that he will seek federal approval for Montana to create a universal state health care plan.

The flamboyant second-term governor is known for controversial proposals to remedy rising health care costs, including personally driving seniors to neighboring Canada to purchase lower-priced prescription drugs. As a result, his universal care plan is not surprisingly modeled upon the global-budget single-payer system used in nearby Saskatchewan. The Governor's plan would allow those with private insurance to drop their coverage and enroll in the cheaper state-run plan, which would have the ability to negotiate drug prices and limit non-emergency procedures such as MRIs.

Senator Jason Priest (R), who led the Republican effort last session against implementing "Obamacare", did not reject the Governor's proposal out of hand, saying that he would like to first see the details of the Governor's waiver request.

The Centers for Medicare and Medicaid Services (CMS) has the discretion to waive key provisions of the Affordable Care Act (ACA) if state initiatives meet or supersede the objectives of the new law. For example, CMS is expected to approve Vermont's plan to opt-out of the ACA and create a single-payer health care system by 2015.

However, the Governor acknowledges that CMS will likely reject his single-payer proposal, as it recently did with his proposal to require prescription drugs be sold at Medicaid prices to all Montanans.

Governor Schweitzer has been a staunch advocate of expanding Medicare to all Americans, and frequently criticized the ACA for being a "pack of crap" for its "giveaway" to the pharmaceutical industry.

New Hampshire

Health department seeks to move all Medicaid enrollees into managed care

The Department of Health and Human Services announced this week that it is preparing to solicit bids for managed care plans that would serve all New Hampshire Medicaid enrollees by next July.

State analysts project that the transition from fee-for-service to managed care will save Medicaid \$16 million over the next 18 months. However, the plan still requires federal approval. A similar proposal by Florida Medicaid has met with some opposition by federal regulators, who are seeking to impose safeguards against rationing of care by managed care plans (see Update for Week of September 19th).

The HHS Commissioner insists his agency will come up with \$16 million in savings, even if the managed care transition is not approved.

Pennsylvania

Department of Insurance study supports restoration of state health plan for working age adults

The Department of Insurance reported this week that nearly 40 percent of the 41,000 enrollees in the terminated state health plan for low-income adults remain uninsured.

Governor Tom Corbett (R) shut down the popular state-funded adultBasic plan in February, which provided low-cost coverage to working-age adults ineligible for Medicaid. The Governor insisted that tobacco settlement funds could no longer be used for adultBasic since the state faced a \$4 billion deficit.

Blue Cross and Blue Shield, which had partly funded the program, allowed adultBasic subscribers to join Special Care, a “bare bones” insurance product they offered to anyone regardless of pre-existing conditions. However, only about 15,700 adultBasic subscribers paid the \$192 monthly premiums to enroll in the limited-benefit plan (adultBasic cost only \$36 per month).

Special Care enrollees are expected to dwindle further after the insurer sought a nearly ten percent increase in premiums for next year, arguing that former adultBasic enrollees had more chronic conditions than others and thus were more costly. The Department of Insurance eventually reduced the increase to nearly five percent.

However, the Governor’s plan to simply enroll former adultBasic subscribers into the PA FairCare federal high-risk pool fell through when the Centers for Medicare and Medicaid Services (CMS) insisted that it lacked the authority to waive Congress’ requirement that applicants first be uninsured for six months (see PCIP Update for Week of February 21st). Since only about 2,300 of these individuals were eligible for Medicaid, that left over 23,000 people or 40 percent of all adultBasic enrollees without any coverage whatsoever.

In addition, there were over 500,000 uninsured Pennsylvanians on the waiting list when adultBasic closed. The Department was unable to estimate how many of those remain uninsured. However, it concludes that many former adultBasic enrollees are overburdening the state’s safety-net providers and imposing huge costs in uncompensated care. The study notes that emergency room visits to certain Philadelphia-area hospitals have increased by at least 30 percent since adultBasic ended.

Auditor General Jack Wagner (D) also documented last June that adultBasic funds were wrongly diverted to non-health related programs. He held five public hearings to demonstrate “overwhelming” public support for redirecting tobacco settlement funds to restore adultBasic coverage.

Senator Erickson (R) acknowledged this week that closing adultBasic may have been a mistake in light of the Department’s findings. He insisted that the increase in newly uninsured was “obviously not a good situation” and something that lawmakers need to “deal with”, but stopped short of advocating for a restoration of adultBasic.

Minority Senate Leader Jay Costa (D) said it was unlikely that adultBasic plan will be reinstated, despite the findings. He noted that the Republican-controlled Legislature blocked renewed funding for adultBasic last session, even after state officials learned it had \$785 million surplus this fiscal year.

Washington

Physicians and hospitals oppose new Medicaid limits on “non-emergent” emergency room visits

The State Health Care Authority (HCA) plans on October 1st to start limiting Medicaid enrollees to only three non-emergent emergency department visits per year.

HCA officials predict that the new limit will save \$72 million per year in state and federal funds. However, opponents including the Washington State Medical Association insist that such severe and arbitrary limits will endanger the state’s most vulnerable citizens and are urging the Center for Medicare and Medicaid Services (CMS) not to issue the required federal approval.

The Washington chapter of the American College of Emergency Physicians (ACEP) filed suit this week to block the limits, arguing that HCA created their list of 700 non-emergent diagnoses without any input from hospitals and physicians. In particular, they maintain that HCA’s use of discharge diagnoses instead of presenting symptoms is a clear violation of the “prudent layperson” standard required for

Medicaid managed care plans. (Nearly 60 percent of Washington Medicaid beneficiaries are enrolled in managed care.) This standard requires managed care plans to cover emergency room visits based on an average person's belief that he or she may be suffering a medical emergency and not a final diagnosis.

ACEP also wants CMS to ensure that the state must ensure that those who reach the limit have access to viable primary care services before denying coverage. In addition, ACEP is seeking a notification system to inform providers when an enrollee reaches their "non-emergent" limit.

Wyoming

Wyoming has healthiest state budget over past decade

A study released this week by the Virginia-based State Budget Solutions found that mineral-rich states with tiny populations had the strongest state budgets in the nation over the past decade.

Wyoming had the largest "total funds surplus" at 21.56 percent, with North Dakota, West Virginia, Texas, and Alaska lagging far behind. By contrast, the state with the biggest "total funds deficits" during that time was Wisconsin at over 29 percent, with Oregon, Ohio, Hawaii and California far behind.

Wyoming also tied with Massachusetts and Oregon for the biggest per capita drop in total spending (1.90 percent). Arkansas, Louisiana, and Hawaii led the nation with the biggest increase in total per capita spending (all over two percent).

Unlike many analyses of state budgets, the study examines not only general-fund revenues and spending over a short time, but overall state collections and expenditures over a decade. The state ranking is quite different when taking into account only general fund spending. However, SBS argues that general fund spending presents a very inaccurate snapshot of state fiscal health, due to the budgetary "gimmicks" that states rely on to meet laws requiring them to have a balanced budget.