Health Reform Update – Week of November 14, 2011

CONGRESS

Supreme Court to review constitutionality of entire Affordable Care Act

The United States Supreme Court announced this week that it will review the most prominent challenge to the constitutionality of the Affordable Care Act (ACA).

The justices were widely expected to hear at least one of the three cases that have already reached the court, given the conflict of decisions among appellate courts. They were also predicted to choose the Florida case, as it was joined by 26 other state attorneys general and selected by the Obama Administration as the case that the Court should review (see Update for Week of October 31st).

However, in a surprise move that may worry the ACA supporters the Court will also consider issues that were already resolved by appellate courts or not on its docket last week. In addition to deciding whether Congress can mandate that everyone buy health insurance or pay a tax penalty, the Court announced that it will also determine whether the entire law must be struck down if the individual mandate is found unconstitutional. The Court will also review whether Congress can mandate that states expand Medicaid, even though none of the lower or appellate courts found it invalid.

Since no appellate court has ruled that the unconstitutionality of the individual mandate means other parts of the law must be struck down, legal commentators had widely predicted that the Court would limit its review solely to the individual mandate. In fact, the 11th Circuit overturned the only lower court ruling that found it not to be severable from the rest of the law, which was the same Florida case the Court agreed to hear (see Update for Week of August 8th).

The Court also announced that it will decide whether it can even hear challenges to the individual mandate before the tax penalty actually goes into effect. The Obama Administration has discouraged the Court from effectively “punting” on a resolution by following this rationale from the Fourth Circuit, where three Democratically-appointed judges insisted that the federal Anti-Injunction Act bars adjudication of a tax penalty before it is enforced (see Update for Week of September 5th). A conservative judge in the D.C. Circuit sided last week with the Fourth Circuit’s decision (see Update for Week of November 7th).

As a result, the Court’s announcement heightens the uncertainty surrounding the scope and impact of their ultimate decision, which could invalidate part or all of the law or leave the matter unresolved until 2015. However, the Court signaled that the case is a priority, as it is allowing an unprecedented 5.5 hours for oral arguments (which typically are limited to one hour). If tradition holds, both sides will argue before the Court in March, with a decision rendered at the end of the term in June.

All nine justices participated in the decision to hear the case, indicating that Justices Elena Kagan and Clarence Thomas have refused partisan calls for them to recuse themselves due to conflicts of interest. Justice Kagan served as Solicitor General for the Obama Administration while the ACA was being drafted, although she did not actually argue any parts of the law before the Supreme Court. The wife for Justice Thomas works for a conservative advocacy group seeking to repeal the ACA.

The Supreme Court’s decision comes the same week that a CNN poll found that public support for the individual mandate is increasing. Their most recent survey of over 1,000 Americans found for the first time that over 50 percent favor the mandate as a means to ensure that everyone pays their fair share

of health care costs. A new Commonwealth Fund and Modern Healthcare survey found that 89 percent of medical providers continue to support the measure.

Debt panel seeks to defer tax issue in last-ditch effort to break stalemate

With only days until the statutory deadline to strike a deal, the Joint Deficit Reduction Committee remained at loggerheads this week while individual members desperately sought a way to avoid the automatic across-the-board spending cuts that will be triggered if the committee is unable to pass any recommendations by November 23rd. One of the "hail Mary" proposals would have the panel agree on the amount of new revenue to be raised but defer to the tax-writing committees of Congress to fill in the details sometime next year.

Higher taxes remain the sticking point preventing any agreement on recommendations to shave the required $1.2 trillion of the federal budget deficit over the next decade. A Republican plan to raise $300 billion in revenue by eliminating deductions and loopholes was largely panned by Democrats as it would raise taxes on everyone and dramatically lower the top rate for the most affluent (see Update for Week of November 7th). Democrats also want more than $1.2 trillion in deficit reduction, largely through at least $1 trillion in higher revenues.

Republicans are under pressure to strike some sort of deal on tax revenues as the Bush-era tax cuts for the wealthy will ultimately expire in 2012 and hike tax rates for the upper bracket. However, any recommendations need to be submitted to the Congressional Budget Office by November 21st in order for official cost estimates to be available in advance of a panel vote on the November 23rd deadline.

President will not modify automatic spending cuts should debt panel fail

President Obama announced late last week the he will not support any bills that limit or repeal the across-the-board spending cuts that will automatically be triggered after November 23rd if the Joint Deficit Reduction Committee fails to pass the required recommendations to cut the federal deficit by $1.2 trillion over the next ten years.

The automatic sequestration was a key component of the bipartisan accord reach last August to raise the nation's debt ceiling (see Update for Week of August 1st). The Budget Control Act of 2011 would impose the cuts equally across both military and civilian programs, starting in 2013.

However, both Republicans and Democrats fear that the cuts could roil the financial markets and cause a further downgrade in the nation's credit rating. Republicans are also staunchly opposed to the military spending cuts that would result.

Despite the concerns, the President insisted that members of the "super committee" will have to live with the consequences of their failure to compromise, as he will veto any legislation to modify the automatic spending cuts.

Proposed Medicare changes would hike cost-sharing for three-quarters of "healthy" enrollees

Proposals being considered by the Joint Deficit Reduction Committee to raise Medicare cost-sharing and means test premiums for higher-income Medicare enrollees would actually increase costs for three-quarters of the healthiest program beneficiaries.

Among the more popular measures under consideration are combining the Part A and Part B deductible into one $550 annual deductible, imposing a 20 percent coinsurance on all services up to a $5,550 annual limit, and raising premiums for the most affluent enrollees. Kaiser Family Foundation concluded this week that such a model would increase out-of-pocket costs for three-quarters of "healthy" enrollees by an average of $180 per year. However, the five percent of current enrollees who use

hospital services most frequently would benefit from an average of $1,570 in lower costs per year. The rest of the enrollees would see no change.

FDA funding to increase by $50 million, instead of $285 million cut sought by House Republicans

For the first time since 2009, Republicans and Democrats were able to reconcile bills in conference committee.

The fiscal year 2012 spending resolution passed this week by the House and Senate (H.R. 2112) set Food and Drug Administration (FDA) funding at $3.8 billion. While the $50 million increase from fiscal year 2011 pales in comparison to the $284 million bump sought by the Administration, it is a clear victory for Patient Services, Inc. (PSI) and other organizations who urged appropriators to reject the $285 million that the House-passed proposal would have cut from the FDA (see Update for Week of October 31st).

A second spending bill that includes funds to implement provisions of the Affordable Care Act (ACA) remains in dispute. However, the House was able to pass the Senate version of a bill (H.R. 674) that would fix a glitch in the formula used to calculate federal subsidies under the ACA. The measure is likely to be signed by President Obama, as it would prevent middle-income early retirees from qualifying for Medicaid (see Update for Week of October 10th).

H.R. 2112 includes a temporary spending resolution that averts a government shutdown until December 16th. The current spending resolution was set to expire this week (see Update for Week of September 19th). The bill allows the federal government to keep operating past the end of federal fiscal year 2011 on September 30th, while Congress hashes out a fiscal year 2012 spending for all agencies.

Senate considers proposal to more quickly expedite orphan drug approvals

Senate staffers confirmed this week that negotiations to renew the user fees from drug manufacturers that fund Food and Drug Administration (FDA) reviews include proposals to fast-track evaluations for the treatment of disorders with no known cure.

According to the Biotechnology Industry Organization (BIO), the occasional exemptions currently granted by the FDA are “unclear and unpredictable”. Draft plans put forward by Senator Kay Hagan (D-NC) and BIO would expand and more clearly define the customary clinical trial requirements that manufacturers could bypass before brining products to market.

The accelerated approval pathway would allow shorter trials on patients based on a measured effect of a drug instead of an actual clinical outcome. For example, for some cancer drugs the shrinkage of a tumor may be considered a sufficient sign of survival to justify more quickly approving a product. (FDA would still require manufacturers to prove the anticipated benefit once the treatment is cleared.)

The proposal may be incorporated into legislation renewing manufacturer user fees. FDA and the industry have agreed to a six percent fee increase as part of a plan that would run through fiscal 2017. Drugmakers would pay $712.8 million in fiscal 2013 under the deal Congress must approve before September 30, 2012.

The FDA emphasized that they already have many tools in place to expedite approval of promising drugs, which they have used to expedite 75 percent of the 85 rare disease drug approvals since 2006. The “orphan drug status” granted by FDA also provides tax breaks and a seven-year market monopoly for products that treat rare disorders affecting fewer than 200,000 patients.

FEDERAL AGENCIES

Large insurers threaten to cut jobs if no medical-loss ratio waiver for expatriate plans is granted

Four of the nation's largest health insurers are threatening to cut 1,100 jobs if the Obama Administration does not grant their request to permanently exempt health plans sold to Americans overseas from the new insurer payout rules under the Affordable Care Act (ACA).

In letters to the Department of Health and Human Services (HHS) Secretary, 15 members of Congress joined calls by Aetna, CIGNA, MetLife, and UnitedHealth Group to allow them to waive the requirement that they spend at least 80 percent of premium revenue from individual and small group plans on direct medical care (85 percent for large group plans) sold to expatriate Americans. Employers that send workers overseas routinely offer such expatriate coverage, which also may be obtained by individuals.

CIGNA controls about 30 percent of the market for expatriate coverage, and derives roughly ten percent of premium revenue from the sale of such plans to 800,000 American workers overseas. The insurer has threatened to move jobs to offshore locations if a permanent waiver is not granted. It insists that the new standards put the insurer at a competitive disadvantage globally, as it would only increase premiums for overseas workers who already face higher costs because of the need to build a global network of overseas providers and hire staff who speak multiple languages.

The Center for Consumer Information and Insurance Oversight, (CCIIO) within HHS has already granted the four insurers a one-year reprieve and expects to make a final decision on a permanent exemption in future rulemaking.

The permanent waiver is being urged largely by lawmakers from the home states of the health plans, including both Democratic Senators and the Democratic Governor from Delaware.

AMA opposes "active purchaser" model for exchanges

The American Medical Association (AMA) announced this week that its members have voted to endorse an "open market" model for the new state-based health insurance exchanges required by the Affordable Care Act (ACA).

Consumer advocates have urged states to follow the "active purchaser" model already in place in Massachusetts and endorsed by federal exchange regulations. Under this model proposed in states like California, Maryland, and Oregon, the state exchange can negotiate rates with insurers and allow only those who are affordable to participate.

However, federal regulators will also allow states to rely on the "passive" or "open market" model. Under this model already in place in Utah any plan that meets the new consumer standards under the ACA can participate. Several Republican-controlled states are pursuing this more laissez-faire approach to ameliorate political opposition to implementing any provision of "Obamacare".

AMA delegates and their annual meeting this week voted to join with the insurance industry in calling for the federal government not to allow the "active purchaser" model. Instead of creating more competition among health plans, the AMA insists that allowing exchanges to exclude insurers will only make health insurance markets even more concentrated among 1-2 dominant insurers and heighten the imbalance in negotiating power between physicians and health plans.

The AMA also adopted a policy calling on states to include physicians on their exchange oversight boards.

HEALTH INSURERS

Employee health insurance costs jumped 63 percent in seven years

A new report from the Commonwealth Fund confirmed that employer-sponsored health coverage continues to cost more and cover less, regardless of what state you live in.

Employee share of plan premiums rose 63 percent from 2003 to 2010, as employers shifted more of the burden of rising medical costs to individuals and families. The total cost of family coverage also jumped 50 percent to an average of $13,871 per year.

Workers in Michigan, Montana, Vermont, Pennsylvania and Kentucky pay the lowest share, while those in Delaware, Maine, Virginia, Texas and Florida face the highest premium contributions.

Cost-sharing also climbed dramatically, as three-quarters of workers now pay deductibles compared to only half in 2003. Average deductibles for individuals exceeded $1,000 in 29 states by 2010, with Wyoming workers paying an average of $1,479 while those in Hawaii averaged only $519.

The Commonwealth Fund notes that at the current rate, the average premium for family coverage will increase 72 percent to almost $24,000 a year by 2020. However, provisions of the Affordable Care Act that go into effect in 2014 may slow premium and deliver save families more than $2,000 per year.

STATES

National Governors Association to work with six states on exchange implementation

The National Governors Association (NGA) announced this week that it will help six states facilitate discussion on creating the health care exchanges required by the Affordable Care Act (ACA).

State officials from Alabama, Illinois, Kentucky, Nevada, Utah and Washington will be meeting over the next six weeks with NGA to discuss how states should create the exchanges that best provide the "one-stop shopping" marketplace envisioned by the new law. NGA views their role as an “external catalyst” to facilitate the often limited communication between state Medicaid directors and insurance commissioners regarding how to coordinate exchange efforts.

NGA only had funding to work with six states, which were chosen through a competitive application process.

<u>California</u>

Severely lagging revenues trigger automatic mid-year cuts to Medi-Cal, disabled programs

The Legislative Analyst Office (LAO) confirmed this week that $2 billion in automatic mid-year budget cuts will be triggered by budget revenues that are lagging nearly $4 billion below projections.

The budget plan signed last June by Governor Jerry Brown (D) relied heavily on the assumption that state revenues would increase by $4 billion over what was projected through June 2012. It also created a “trigger” where automatic cuts would go into place on January 1, 2012 if state officials determine in December that revenues came in $1 billion short of expectations.

State Controller John Chiang (D) warned last month that the automatic across-the-board cuts were likely to be triggered as revenues were running well-behind projections (see Update for Week of October 17th). However, California’s Medicaid program can ill afford any further reductions in payment, which are already the lowest in the nation and currently being challenged in the U.S Supreme Court (see Update for Week of September 26th). The fiscal year 2012 budget also already imposed a ten percent

Medi-Cal payment cut that was approved by the Obama Administration, as well as new benefit limits and higher Medi-Cal copayments that await federal approval (see Update for Week of October 24th).

The news does not get any better for the new fiscal year that begins July 1st. The LAO currently forecasts a $13 billion shortfall in fiscal year 2013 that will force even deeper budget cuts.

While higher than expected tax revenues in energy-producing states are producing budget windfalls in states like Alaska, North Dakota, Texas, West Virginia, and Wyoming, larger states like Florida, New York, and Oregon are facing a similar predicament as California (see Update for Week of October 17th).

Consumer advocates sues Anthem over mid-year cost-sharing hikes

The non-profit Consumer Watchdog filed a class action lawsuit against Anthem Blue Cross this week, alleging that the giant health insurer breached contracts with individual subscribers when it increased annual deductibles and other out-of-pocket costs on May 1st. The lawsuit is the second in eight months filed against Anthem for mid-year rate hikes, as a similar case by an Anthem subscriber remains pending in Los Angeles Superior Court.

Anthem had announced last spring that it would reduce its proposed 16.4 percent premium increase for individual subscribers down to 9.1 percent, the third time in less than a year that Anthem downgraded rate hikes in response to regulatory review (see Update for Week of June 20th). The move sought to quell the continued controversy over Anthem's staggering rate hikes last year that drew increased scrutiny from the Department of Insurance, which found errors in Anthem's calculations (see Update for Week of August 23, 2010).

As part of Anthem's rate reduction, it pledged to delay the increase until July 1st and postpone the planned April 1st increase in copayments and deductibles until next January. However, the cost-sharing changes were actually delayed only subscribers who have plans regulated by Department of Insurance. According to Consumer Watchdog, cost-sharing was not delayed as promised for the more than 150,000 subscribers enrolled in capitated plans regulated by the Department of Managed Health Care

Consumer Watchdog also alleges that on August 1st Anthem improperly changed renewal periods on policies from one year to one month, which allowed them to change benefits, copayments, and other costs several times during the year, when they previously were prohibited from doing so.

Colorado

Uninsured rate jumps as employer health coverage erodes

A new survey from The Colorado Trust and the Colorado Health Institute found this week that nearly one in three Coloradoans either have no health insurance or are underinsured (meaning they spend more than ten percent of their income on out-of-pocket medical expenses).

The survey revealed that the two percent jump in the state's overall uninsured rate was attributable largely to a dramatic loss of employer-sponsored coverage during the economic downturn, which has dropped over six percent over the past two years to 57.8 percent. Over 16 percent of Coloradans went without health insurance for at least part of last year.

Connecticut

Consumer advocates seek ethics inquiry into exchange board composition

Eight advocacy groups have signed a letter asking the Office of State Ethics to investigate whether insurance industry representatives serving on the new exchange oversight board have conflicts of interest that should bar their participation.

Consumer groups were outraged last summer when Governor Daniel Malloy (D) and leading lawmakers selected former executives from three of the nation's largest insurers to serve on the 11-member board, while neglecting to appoint a single consumer advocate as a voting member (see Update for Week of August 22nd). Authorizing legislation signed by the Governor (S.B. 921) prohibits board members from being affiliated with insurers and bars their participation if they have conflicts of interest.

The Governor insists that the three former insurance executives he appointed do not currently have any prohibited conflicts. However, Citizens for Economic Opportunity (which headlined the letter) pointed out that at least one of the former executives still serves on a patient care board that has insurance companies as clients.

Florida

Obama Administration delays decision on medical-loss ratio waiver

Analysts widely expected the U.S. Department of Health and Human Services (HHS) to reject Florida's request for a federal waiver this week that would allow insurers in the state to phase-in the new insurer payout standards required by the Affordable Care Act (ACA).

The new law requires individual and small group plans to spend at least 80 percent of premium revenue on medical care. HHS has granted waivers to six states that have demonstrated that immediate compliance with this medical-loss ratio would disrupt the market by causing smaller insurers to fold or leave (see Update for Week of November 7th).

However, HHS also rejected waivers for two states (Delaware and North Dakota) that were unable to make this showing. Because Florida has a highly competitive marketplace, the agency was also expected to reject its waiver request. Florida's Governor and Insurance Commissioner have also refused to implement any other provision of "Obamacare" and returned or refused federal grants to do so (see Update for Week of September 5th). However, HHS has instead asked for 30 additional days to review their submission.

An extension is not unusual, as HHS done so for six of the last eight applications. Florida is one of ten waiver requests that remain pending (see Update for Week of October 10th).

Michigan

Republican-controlled Senate votes to create health insurance exchange

The Republican-controlled Senate passed S.B. 693 this week by a 25-12 vote. The measure would create the health insurance exchange required by the Affordable Care Act (ACA).

Democrats supported the measure introduced by the chair of the Joint Health Policy Committee, Senator Jim Marleau (R) (see Update for Week of September 26th). Senator Marleau along with Governor Rick Snyder (R) remains adamant that Republicans could not simply allow the federal government to take over the exchange in 2013, if they failed to act. Michigan had been one of only 12 states not to introduce exchange-authorizing legislation.

Nearly half of Senate Republicans were still reluctant to legitimize "Obamacare" by implementing even the provisions they support. However, others like Senator Rick Jones (R) said they would "hold my nose" and support the exchange measure, which now must clear the Republican-controlled House.

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.

Oklahoma

Some Republican lawmakers re-thinking their defiance to health insurance exchange

The health insurance exchange authorized by the Affordable Care Act (ACA) gained a surprising ally this week, as U.S. Senator Tom Coburn (R-OK) insisted that state lawmakers should drop their defiance to legitimizing "Obamacare" and create the new online marketplace they initially supported.

Oklahoma received the largest federal Early Innovator grant of any state ($54.6 million), due to the proactive steps taken by former Governor Brad Henry (D) to develop the information technology needed to create the new exchange. However, Governor Mary Fallin (R) returned the grant in the face of "tea party" opposition to implementing any provision of "Obamacare", despite her ardent support for exchange-authorizing legislation that failed (see Update for Week of April 11th).

Governor Fallin has since insisted that the Joint Committee on Federal Health Care Law authorize a more limited exchange that did not comply with all the consumer protections required by the Affordable Care Act (ACA), and do so only with state or private funds. However, measures like S.B. 971 failed to move, as they created little more than an online search engine for plans and referrals.

Senator Coburn met privately with lawmakers this week to urge them to avoid a federal takeover of the exchange and instead comply with the ACA by creating the more limited of two exchange models allowed by the federal government. This type of "open market" exchange would allow participation by any health plan that meets the minimum standards set by the ACA, has been operating since 2009 in Utah, and is endorsed by the American Medical Association (see above). It would not allow the exchange to negotiate rate or exclude insurers, like the "active purchaser" model used in Massachusetts.

Senator Coburn, a physician, was one of the ACA's fiercest critics during its mark-up in the Senate Finance Committee. However, he believes that the law will be upheld by the U.S. Supreme Court and thus prefers that his state move forward on the parts of the ACA that have Republican support.

The Joint Committee on Federal Health Care Law held its last meeting this week and will issue final recommendations next month, upon which any proposed legislation will be drafted. Co-chairman Rep. Glen Mulready (R) echoed Coburn's sentiments in urging members to act. Rep. Stanislawski (R) also favored creating an ACA-compliant exchange, noting that Oklahoma already has most of the information technology infrastructure in place through the Insure Oklahoma program helping small business employees afford private insurance and the Oklahoma Health Information Exchange to promote greater use of information technology in health care.

Oregon

Oregon Insurance Administrator joins Centers for Medicare and Medicaid Services

Oregon's top insurance regulator has decided to become a senior adviser to the federal government agency overseeing state implementation of the health insurance exchanges required by the Affordable Care Act (ACA).

Insurance Administrator Teresa Miller will join the Center for Consumer Information and Insurer Oversight (CCIIO) next month. Housed within the Centers for Medicare and Medicaid Services (CMS), CCIIO implements regulations governing the exchanges and is trying to partner with states to get the new insurance marketplaces running by 2014.

Miller's prominence within National Association of Insurance Commissioners and her role in Oregon's creation of an "active purchaser" exchange are expected to help ameliorate the criticism that CMS has faced from state officials frustrated with the lack of federal guidance on exchange creation.

CCIIO has had to shuffle exchange personnel since the sudden departure of Director Joel Ario (formerly the Pennsylvania Insurance Commissioner) earlier this year (see Update for Week of August 1st). His duties have been absorbed by two top CCIIO officials.

South Carolina

Health director urges planning committee to allow a federal takeover of insurance exchange

The Director of the South Carolina Department of Health and Human Services (HHS) officially urged this week that a committee appointed by the Governor Nikki Haley (R) to study whether to create the health insurance exchange required by the Affordable Care Act (ACA) vote to simply allow the federal government to do so instead.

The formal recommendation authored by the Director comes as no surprise, as both he and the Governor announced over the summer that the state would not apply for any additional federal exchange implementation grants (see Update for Week of August 29th). Governor Haley issued an executive order earlier this year using the initial $1 million federal grant obtained by her Republican predecessor to create the Health Planning Committee in the hope of creating the health insurance exchange she initially supported. However, she reversed course after key lawmakers defected from the needed authorizing legislation (H.B. 3738) in the face of local tea party opposition (see Update for Week of March 28th).

The HHS Director now insists that his department's resources are "fully committed to improving the current Medicaid program" so that it can handle the influx of at least 600,000 enrollees after the state is required by the ACA to expand Medicaid eligibility in 2014. South Carolina Medicaid currently covers less than one million residents.

However, neither the Governor nor Director ruled out exercising the option allowed by recent federal regulations to create the required exchange several years down the road, should they become less politically toxic to Republican lawmakers (see Update for Week of July 11th).

The Health Planning Committee was granted an extension in order to submit its final recommendations by the end of November.