

Health Reform Update – Week of May 6, 2013

CONGRESS

Senator Harkin lifts hold on CMS Administrator nominee, pushes alternate funding source

Senator Harkin (D-IA) agreed to lift his hold this week on the re-nomination of Marilyn Tavenner to head the Centers for Medicare and Medicaid Services (CMS). However, he refused to back down from his criticism of CMS for diverting \$332 million from the Prevention and Public Health Fund created by the ACA to instead facilitate enrollment in the federal marketplace.

Harkin had blocked the nomination to make a point over the continued “raiding” of the fund despite written assurances to the contrary from the President following passage of the measure to avert the “fiscal cliff” (see Update for Weeks of December 24th and 31st). The fund was intended to make certain preventive services available without cost-sharing but has frequently been used to offset deficit reduction measures (see Update for Weeks of April 23rd and 29th).

The Senator continues to recommend that CMS instead divert funds from the newly-created Center for Medicare and Medicaid Innovation that received \$10 billion under the ACA to test potential payment and delivery system reforms. He has received no response from the agency.

Republicans refuse to submit nominations for controversial Medicare cost-cutting panel

Republican leaders refused this week to submit their nominations for the Independent Payment Advisory Board (IPAB) that will recommend Medicare cost-cutting measures whenever spending exceeds preset targets.

At least 20 House Democrats have joined prior Republican efforts to repeal the 15-member panel over fears that it will cede authority away from Congress and into the hands of “unelected bureaucrats” (see Update for Week of March 19, 2012). The panel’s recommendations would automatically go into effect if Congress does not pass equivalent cuts.

President Obama has yet to submit his designated nominations for the panel, which would not be begin until at least 2015 as Medicare spending for next year is expected to remain below the amount that would trigger its recommendations (see Update for Weeks of April 22nd and 29th). However, House Speaker John Boehner (R-OH) and Senate Minority Leader Mitch McConnell (R-KY) insisted that they will not nominate anyone to serve on the panel, either now or in the future.

Republicans weigh second vote on funding high-risk pools, 34th vote on repealing ACA

House Speaker John Boehner (R-OH) indicated this week that Republican leaders are continuing to seek the additional votes necessary to pass legislation that would provide the supplemental funding needed to resume enrollment in the pre-existing condition insurance plans (PCIPs).

H.R. 1549 had been pulled from the House floor after more conservative members refused to break their pledge not to legitimize any part of “Obamacare” (see Update for Weeks of April 22nd and 29th). However, high-risk pools have long had Republican support and are one part of the ACA that House Minority Leader Eric Cantor (R-VA) has deemed a top priority to preserve.

Even if passed by the House, the measure faces certain death in the Senate unless it is revised so that the \$4 billion in supplemental funds are not diverted from the Prevention and Public Health Fund under the ACA (see above).

Rep. Cantor acknowledged later in the week that Republican leaders were planning to hold yet another vote on repealing the entire ACA. House Republicans have already voted 33 times to repeal all or part of the ACA; however freshman conservatives have not yet had an opportunity to vote against the law. It is not clear if granting them another repeal vote will be tied to their support of H.R. 1549.

Rep. Cassidy resurrects bill to set per capita caps for Medicaid

Rep. Bill Cassidy (R-LA) is renewing his prior efforts to institute per capita caps on Medicaid spending, insisting that there is a “new energy” in the House for the concept.

Cassidy's *Medicaid Accountability and Care Act* failed last year, but now comes on the heels of a spending cap blueprint offered by both House Energy and Commerce Chairman Fred Upton (R-MI) and Senate Finance ranking member Orrin Hatch (R-UT). He called the plan a “game changer” that would give states the flexibility to tailor Medicaid programs to their own needs and resources.

H.R. 1853 would divide the Medicaid population into four categories: the elderly, the blind and disabled, children and other adults. Each group would receive a per-beneficiary payment based on costs for that population, rather than a payment blended across all four groups. State matching rates would be set at a uniform level of 25 percent while prohibiting the use of intergovernmental transfers and certified public expenditures to fund that share. Bonuses would be offered to states with the best quality of care in each of the categories.

Rep. Cassidy, a physician, noted his proposal includes an option that allows states to combine Medicaid and Medicare payments for dual eligible to help aggregate care.

Proposal to combine Medicare deductibles picks-up steam as study finds \$180B in savings

Combining Medicare coverage under a unified benefit could save \$180 billion over ten years while lowering out-of-pocket costs, according to a new study by The Commonwealth Fund.

The study provided a boost to proposals to combine deductibles for Medicare Parts A and B that the Obama Administration, Medicare Payment Advisory Commission (MedPAC), and Republican lawmakers have debated as part of stalled negotiations to avert the ongoing budget sequester (see Update for Week of April 8th).

Democratic lawmakers and AARP remain staunchly opposed to combining deductibles. However, The Commonwealth Fund found that if it Parts A, B, and D were combined along with a first-time cap on Medicare out-of-pocket costs, enrollees would spend an average of \$354 per month in 2014 instead of \$427. Those who use “high-value medical providers” would spend 40 percent less or \$254 per month.

FEDERAL AGENCIES

HHS releases more grants to boost exchange enrollment, strengthen rate reviews

The Department of Health and Human Services (HHS) announced this week that \$150 million in federal grants will be awarded to community health centers (CHCs) that help enroll uninsured patients in the new health insurance exchanges created by the Affordable Care Act (ACA).

Under the initiative, each state will receive a set amount of funding based on its number of CHCs and the state's proportion of uninsured patients. For example, California will receive the most funding at about \$22 million, while North Dakota will receive the least at \$313,467.

CHCs have until May 31st to apply. The funds will provide each grantee a base of approximately \$50,000 to hire and train staff, conduct community outreach efforts and provide in-person assistance to apply for benefits under the law. HHS said it hopes to double the 4,000 CHC employees at 1,200 CHCs nationwide who currently are focused on enrollment efforts.

CMS also announced this week that it would provide an additional \$87 million for states to enhance their process to review and identify unreasonable increases in health plan premiums (see Update for Week of August 29, 2011).

HEALTHCARE COSTS

Commonwealth Fund says about half of working-age adults lack adequate health insurance

A Commonwealth Fund report released last week found that about half of working-age adults lacked adequate health insurance for at least part of 2012, even though the proportion of young adults without health insurance has significantly declined due to the Affordable Care Act (ACA).

Nearly 80 percent of young adults are now adequately insured after the ACA allowed them to remain on their parents' group plan, up from 69 percent before the provision went into effect with the 2011 plan year. However, this "abrupt reversal" was not enough to mitigate uninsured rates for other adults up to age 64, which either rose or remained constant.

The survey of nearly 4,500 working-age adults showed that about 30 percent lacked health insurance at some point during 2012. Another 16 percent had coverage that imposed such high out-of-pocket costs relative to their income that they were effectively uninsured.

The survey also affirmed that people are increasingly skipping needed health care they cannot afford (43 percent of respondents compared to 37 percent in 2003) (see Update for Week of April 8th). It found that about 40 percent had trouble paying medical bills or incurred medical debt—42 percent of whom received a lower credit rating as a result.

Two studies conclude that health care spending slowdown may be permanent

Two new studies released this week argue that the unusual slowdown in health spending growth may be due more to structural changes than the lagging economy and thus could be permanent.

National health spending grew by 3.9 percent a year from 2009-2011, the lowest rate of increase in half a century. Researchers with the Harvard Medical School acknowledge that job losses during the recession dragged down health care utilization, as workers increasingly lost their employer-based coverage, bringing health care spending growth down from five percent per year to less than two percent. However, they emphasize that utilization patterns have not returned to normal as these workers regained coverage and estimate that the higher cost-sharing that plans increasingly have imposed is thus responsible for about 20 percent of the slowdown in spending growth.

The second study by Harvard economists found that national health spending from 2003-2012 was 16 percent below the level predicted by the chief actuary for the Centers for Medicare and Medicaid Services (CMS). These economists concluded that only 45 percent of the slowdown could be attributed to the recession, the decade-long erosion in employer-based coverage, and Medicare payment cuts. The remaining 55 percent they attribute to "a host of structural changes—including less rapid development of imaging technology and new pharmaceuticals, increased patient cost sharing, and greater provider efficiency." These structural changes pre-date the 2007-2009 recession and could cause public sector health spending to be as much as \$770 billion less than CMS predicted.

The conclusions of the Harvard studies contrast with those released earlier this month by the Kaiser Family Foundation and the Altarum Institute's Center for Sustainable Health Spending, which claimed that 85 percent of health care spending patterns are attributable to inflation and economic growth. They estimated that the recession was responsible for 77 percent of the recent decline in health spending, and therefore likely to be temporary.

A separate Urban Institute report also released this week disputed the notion that the slowdown will be permanent, given that health spending growth has historically "rebounded after every major attempt at cost containment."

STATES

Large insurers are holding back on exchange participation

The chief executive officer of Aetna told investors last week that the company plans to participate in the individual market exchanges for only 14 states where it has significant "network strength", and an even smaller number of small business exchanges. The numbers mesh with indications previously given by large insurers such as UnitedHealth Group, WellPoint, and Humana.

According to their CEO, Aetna is "entering these exchanges very carefully" and is already about two-thirds of the way contracted for their exchanges. He added that Aetna anticipates narrow exchange networks that are roughly 25-50 percent of the size of their base networks and the rates they are currently receiving for most of those networks are between Medicare and commercial rates. Exchange rates are trending closer to Medicare as the networks get narrower.

Neither Aetna, Humana, nor UnitedHealth revealed which specific states they are considering. UnitedHealth is eyeing 10-25 state exchanges, although it believes the impact on its commercial market revenue will be minimal for 2014. UnitedHealth is also crafting products tailored to states like Arkansas with alternative Medicaid expansion models that will boost exchange enrollment (see Update for Week of March 25th).

Arizona

Legislature sends new healthcare pricing transparency bill back to Governor

Governor Jan Brewer (R) will likely be able to sign a revised version of a bill she vetoed last month that would require hospitals, physicians, and other providers to post the prices for their most common procedures.

A House and Senate conference committee signed off on the changes sought by the Governor this week, putting it on a path to the Governor's desk if both chambers formally approve. Her veto of S.B. 1115 previously brought an angry response from Republican sponsors of the legislation, who accused her of bowing to pressure from the hospital industry. However, the Governor insisted that she supported the concept but just believed the measure was overly broad, would increase litigation, and impair the state medical board's ability to investigate billing abuses (see Update for Week of April 15th).

Bill sponsor Senator Nancy Barto (R) amended a House budget bill (H.B. 2045) to include language worked out with the Governor's office that eliminates the legal liability for hospitals and providers in emergency departments from pricing structure details that end up delaying care. The latest version would require hospitals to post prices online for 50 common inpatient and outpatient services, while physicians and other need only list prices for their 25 most common procedures.

The move comes just as the federal Centers for Medicare and Medicaid Services released inpatient hospital prices for the 100 most common Diagnosis Related Groups, revealing dramatic and unexplained cost differentials for identical treatments provided by neighboring hospitals in the same cities. (CMS is expected to shortly release outpatient pricing to the public).

H.B. 2045 will also change the inpatient hospital reimbursement methodology under Medicaid so that hospitals receive a flat payment per diagnosis instead of a daily payment.

California

State law grants California exchange unprecedented secrecy

According to the Associated Press (AP), authorizing legislation that created the Covered California health benefits exchange pursuant to the Affordable Care Act (ACA) granted it unprecedented authority to conceal spending on the contractors that will perform most of its functions.

The AP's survey of other state-based exchanges found that the degree of secrecy afforded to Covered California appears to be unique. For example, the Massachusetts exchange that became the model for the ACA after starting in 2007 is specifically covered by the same open records laws that apply to other state agencies. Maryland and Minnesota likewise subjected its exchange to public disclosure laws, although some types of commercial and financial information are exempt. Even states where the exchange is being created as a private, non-profit corporation, such as Idaho and New Mexico, have required it comply with open records laws.

In setting up the California exchange, lawmakers gave it the authority to keep all contracts private for a year and indefinitely withhold the amounts paid. According to agency documents, Covered California plans to spend nearly \$458 million on outside vendors by the end of 2014, covering lawyers, consultants, public relations advisers, and other functions. The indefinite ban on releasing rates paid to companies and individuals receiving contracts goes beyond exemptions for other state health programs in California, such as the Healthy Families SCHIP which withholds this information for four years.

Other exchange records that are allowed to be kept secret include those that reveal recommendations, research, or strategy, as well as those that provide instructions, advice or training to employees. Minutes of board meetings also are exempt from disclosure.

The state constitution requires the legislature to produce findings that demonstrate the need for shielding information from the public. However, the authorizing legislation simply states that the secrecy for exchange contracts was needed to protect its ability to negotiate on behalf of the public. As a result, public interest groups like Californians Aware are seeking to have the concealment of exchange costs declared unconstitutional.

In response to an AP request, Covered California did disclose amounts paid for a dozen competitively bid contracts, including \$14 million to Ogilvy Public Relations for marketing and other services and \$327 million to Accenture for building a web portal and enrollment system. However, Covered California insists that "all other existing contracts are confidential and privileged."

Assembly panel votes to accept donation to fund Medicaid expansion outreach

The Assembly Budget Subcommittee on Human Services voted unanimously this week to accept a \$26.5 million donation from The California Endowment to facilitate Medicaid enrollment once the program expands under the Affordable Care Act (ACA). The panel also directed state officials to apply for federal matching funds for a total of \$53 million in outreach money.

The Covered California health benefit exchange has committed \$43 million to its outreach effort, but under federal guidelines those funds can only be spent on enrollment efforts related to the exchange.

Panel members stressed that expansion outreach fund will support successful Medi-Cal applications of the navigator/assistor enrollment program as well as the state's Community Based Organization grants program for Medi-Cal outreach and enrollment, which targets vulnerable populations. Roughly one million Californians are eligible for Medi-Cal and not receiving it, and another 1.4 million

people will become eligible under the ACA expansion. State officials had previously refused to fund outreach to those 1.4 million, prompting the Endowment to step in.

Governor Jerry Brown (D) and the Democratically-controlled legislature are still at odds over the terms of the ACA expansion, but they are expected to reach a compromise on authorizing legislation.

Governor signs bills enacting Affordable Care Act market reforms

Governor Jerry Brown (D) signed into law two bills this week (ABX1-2 and SBX1-2) that will implement key market reforms in the Affordable Care Act (ACA) to ban pre-existing condition denials, prohibit higher premiums for health status and gender, and limit differential premiums for age and tobacco use. The measure also allows set 19 geographic regions across the state by which insurers can vary premiums (see Update for Week of February 25th).

Colorado

Exchange board seeks additional federal funding, lawmakers approve plan levy

Conservative voices on the Connect for Health board governing Colorado's new health benefit exchange objected this week to the board's plan to apply for another \$125 million federal grant to create the online marketplace authorized by the Affordable Care Act (ACA).

The exchange is already funded by \$61 million in federal exchange establishment grants. States can continue to receive federal grants until November 2014, but must be self-sustaining starting in 2015. Applications for the next rounds of grants are due next week, however board members put off a formal decision on their next application until consulting with a legislative oversight commission.

The grant request will likely include \$14.4 million for marketing and outreach (including navigators to facilitate enrollment), \$33 million to operate a customer call center, and more than \$50 million for hardware, software and technology management. Consumer groups promptly objected to the cut in marketing and outreach from \$20 million to \$14.4 million, pointing out that maximizing enrollment is critical to the ability of the exchange to be self-sustaining and the board's own research shows that only one of ten Coloradans are aware of the exchange and what it will do.

The board did start a \$2 million two-month advertising campaign this week to increase exchange awareness. Kentucky and Oregon plan to start an effort in the coming weeks.

The Senate also approved a House-passed measure this week (H.B. 1245) allowing the exchange to fund itself in 2015 with a \$1.80 per member levy on participating plans. Another measure was sent to Governor John Hickenlooper (D) this week (H.B. 1115) that would terminate coverage in the CoverColorado high-risk pool three months after the exchange starts operating on January 1st.

Delaware

Senate panel approves bill limiting specialty tier coinsurance

Legislation that would impose dollar limits on specialty tier coinsurance cleared the Health and Social Services Committee this week. S.B. 35 would limit 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 Week of April 15th).

Florida

Committees fail to advance measure to limit out-of-pocket costs for prescription drugs

A moratorium on specialty tiers for prescription drugs (H.B. 1003) that was sought by health care executive Rep. Janet Cruz (D) died last week in the House Health Innovation Committee (see Update for Week of March 25th). A related measure (S.B. 1010) by Senator Jeremy Ring (D) that would prohibit

higher cost-sharing for non-preferred prescription drugs also failed to clear the Senate Banking and Insurance Committee before the session ended.

Kansas

Appropriations seeks to move developmentally disabled into managed care without further delay

Republicans on the House Appropriations Committee added provisions to budget legislation this week moving the developmentally disabled into Medicaid managed care plans, despite continued protests from advocacy groups and several fellow House and Senate Republicans.

Governor Sam Brownback (R) previously agreed to delay until 2014 the transition of the developmentally disabled into his federally-approved KanCare plan that shifts all Medicaid enrollees into one of three managed care plans (see Update for Week of April 23, 2012). Hundreds of groups had protested the inclusion of the developmentally disabled, warning about erosion in quality of care that occurred in other states such as Florida's five-country managed care demonstration (see Update for Week of August 1, 2011).

However, House Appropriations voted to cut \$4 million from efforts to eliminate waiting times for those with developmental disabilities if they were further delayed from moving into KanCare. The outcry from disabled advocates forced Reps. John Rubin (R) and Arlen Siegfried (R) to hold public hearings on additional delays or a potential carve-out of the developmentally disabled. Rubin insisted that managed care plans do not have experience managing the special needs care required for this population. He predicts the House will support another delay.

Governor Brownback insists that he will not further delay the transition of the developmentally disabled past January 1st.

Kentucky

Governor becomes last Democrat to support Medicaid expansion under ACA

Governor Steve Beshear (D) announced this week that he will support Kentucky's participation in the Medicaid expansion under the Affordable Care Act (ACA).

The Governor was the lone Democrat not to decide on the expansion, after West Virginia Governor Tomblin (D) came out in favor last week. None have opposed it. Governor Gary Herbert (R) in Utah still has not announced his decision. Only eight Republican governors have sought to participate, although North Dakota is the only state where a Republican legislature has approved their Governor's decision to participate (see Update for Weeks of April 22nd and 29th). Governor Beshear will likely have similarly tough sledding in the Senate, which remains under Republican control.

Stating that he was "tired of being at the bottom", Governor Beshear emphasized that accepting the federal funding to expand Medicaid will greatly improve health outcomes in Kentucky, which ranks 44th in the nation. Roughly 308,000 Kentuckians would receive Medicaid coverage under the expansion.

Louisiana

House panel approves bill trying to block ACA employer mandate

The House Committee on Health and Welfare proposed a constitutional amendment this week that would prohibit employers from being penalized for not providing the adequate or affordable coverage under the Affordable Care Act (ACA).

H.B 429 passed on a party-line vote in the Republican-controlled committee and now heads to the Committee on Civil Law and Procedure. Even if enacted, place on next year's ballot, and approved by voters, its impact would likely be symbolic as federal law always supersedes conflicting state laws under the Supremacy Clause under the U.S. Constitution.

Maryland

Governor signs legislation conforming Maryland insurance law to Affordable Care Act

Governor Martin O'Malley (D) signed H.B. 361 last week, which conforms Maryland insurance law to the market reforms required by the Affordable Care Act (ACA) and corresponding federal regulations.

Most provisions take effect on January 1st except for those setting fees for navigators in the Small Business Health Options Program (SHOP) Exchange, specifying open enrollment period requirements, and repealing the termination date on a law relating to health insurance for self-employed individuals. These all take effect June 1st.

Michigan

House Republicans back Medicaid expansion if adults are limited to four years of coverage

Legislation introduced this week in the Republican-controlled House (H.B. 4714) would agree to participate in the Medicaid expansion under the Affordable Care Act (ACA), but only if the Obama Administration lets Michigan limit Medicaid coverage to four years for non-disabled adults.

The move appears primarily symbolic as the unprecedented coverage ban after four years violates federal Medicaid law and is likely to be rejected by the Centers for Medicare and Medicaid Services (CMS). House Democrats ridiculed the "immoral" proposal, insisting it was "unrealistic....unless you [also] cap diseases at 48 months."

House Republicans have been the primary stumbling block in the proposal by Governor Rick Snyder (R) to add more than 400,000 low-income residents to Medicaid by accepting the federal funds to expand (see Update for Week of March 18th). The Michigan Health and Hospital Association, which supports the expansion in order to prevent the increase in uncompensated care that would otherwise occur, credited House Republicans for at least recognizing that just saying no was not acceptable and some alternative needs to be explored in order to break the impasse.

House Speaker Jase Bolger (R) had acknowledged that Republicans were waiting to see what alternatives CMS approves for other states before proceeding. He insisted that requiring Medicaid enrollees to pay up to five percent of their cost-sharing and premiums was integral to any proposal.

Oregon

Two insurers ask for redo after proposed rate hikes show no "rate shock" from ACA reforms

Providence Health Plan and Family Care Health Plans immediately asked the Insurance Division this week for permission to downgrade their proposed rate hikes for 2014 after the Division exercised its new authority under the Affordable Care Act (ACA) to post them online.

The two insurers elected not to wait for the Division's review of whether the rate hikes were "reasonable". Providence promptly sought to lower the rate hike request by 15 percent, claiming that it realized that its actuarial assumptions were incorrect. Family Care sought an even greater decrease.

The proposed rate hikes for 2014 are the first in which individual and small group plans have to comply with the four tiers of plan set forth by the ACA, as well as cover the full package of benefits that Oregon defined as "essential" and comply with the ACA's other market reforms such as guaranteed issue and community rating. The public release of all proposed rate hikes proved the huge increases sought by Providence and Family Care to be gross outliers, as the expected "rate shock" for most plans failed to materialize despite somewhat higher rates for younger individuals.

At least half of Oregon's individual plan subscribers are expected to qualify for the premium tax credits offered by the ACA to those earning up to 400 percent of the federal poverty level.

Utah***Feds back down to Utah's demands for partnership exchange***

Governor Gary Herbert (R) appears to have received everything he wanted in negotiations with federal regulators over Utah's role in the federal-state partnership exchange that will start enrollment on October 1st.

Under the terms of the agreement, the federal Centers for Medicare and Medicaid Services (CMS) will run the online marketplace only for individuals, while Utah will retain control over its existing Avenue H exchange for small business employees without any competition from the federal marketplace. CMS even acceded to the Governor's demands to prevent the federal data hub from accessing any data on state employers or participants in the exchange, and not to screen Medicaid eligibility for those participating in Avenue H or determine federal tax credits offered under the Affordable Care Act (ACA).

The agreement is unique to Utah and potentially opens up a fourth alternative for operating the federally-mandated exchanges. It is not yet clear what impact it will have on other states.

One area of potential disagreement remains as Governor Herbert has publicly stated that the agreement permits Utah not to do anything to enforce the individual or employer mandates under the ACA, which CMS appears to dispute.

Utah had received conditional approval from CMS if it brought Avenue H into compliance with ACA standards. However, Governor Herbert changed course in February, negotiating his "split-system" proposal with CMS after lawmakers balked at approving a state-based exchange just for individuals.

Under the CMS agreement, Utah will award grant funds to two navigators to help small businesses enroll in Avenue H. According to the Governor's office, 344 Utah companies are enrolled in the Avenue H exchange that was created in 2009 and 8,035 individuals get insurance through its plans.

At least one consumer group, the Utah Health Policy Project, blasted the agreement, arguing that preventing Avenue H subscribers from being screened for Medicaid eligibility erects a "pointless brick wall" that defeats a major purpose of exchange to simplify enrollment.