

### Health Reform Update – Week of July 18, 2011

#### CONGRESS

##### ***Both parties attack potential compromise to raise debt ceiling, cut spending***

President Obama and House Speaker John Boehner (R-OH) inched closer this week to a compromise to raise the nation's debt ceiling before an August 2<sup>nd</sup> default, cut spending for entitlements, and raise revenue through a future overhaul of the tax code (see Update for Week of July 11<sup>th</sup>).

The deal would essentially be the compromise reached two weeks ago that House Republicans refused to consider as it included revenue increases. However, the President and Speaker immediately backed-off any agreement after it was attacked by members of both parties as conceding too much to the other side. Senate Democrats were furious that the President appeared willing to drop his demand to end the Bush Administration tax cuts for the wealthy, cut Medicare, Medicaid, and Social Security, and put off tax increases to a future date. Freshman House Republicans backed by the "tea party" also remained staunchly opposed to any future tax hikes, despite the urging of Republican leaders to compromise.

House Republicans passed legislation early in the week (H.R. 2560) that would impose even deeper spending cuts, caps on future spending, and a constitutional amendment requiring a balanced budget. The measure was blocked by the Democratically-controlled Senate on a straight party-line vote.

Senate Majority Leader Harry Reid (D-NV) cancelled the weekend Senate session, leaving negotiations up to the President and Speaker.

##### ***Senate Judiciary Committee passes ban on "pay-to-delay" generic drug settlements***

The Senate Judiciary Committee advanced legislation this week that would prohibit brand-name drug companies from paying manufacturers of generic drugs to delay the research, manufacturing, marketing, or sales of cheaper versions of their medications.

The measure to ban such anti-competitive "pay-to-delay" settlements (S. 27) was approved 10-8, with only one Democrat and one Republican breaking ranks. A similar measure failed to clear committee last session after key Democrats and Republicans from states with a heavy drug industry presence defected from the legislation (see Update for Week of December 13<sup>th</sup>).

The Federal Trade Commission (FTC) has sought since at least 2001 to ban such "pay-to-delay" settlements, insisting that they force consumers to pay artificially higher drug prices that can often deny access to life-altering or life-saving therapies. The agency has urged a Congressional "fix" and threatened to pass their own regulations since the U.S. Supreme Court refused last spring to hear an appellate court decision allowing the settlements (see Update for Week of March 7<sup>th</sup>).

FTC claims that banning "pay-for-delay" would save at least \$12 billion over the next decade, although the Congressional Budget Office previously estimated only \$2.7 billion. President Obama's proposed budget for fiscal year 2012 included a similar ban, projecting \$8.8 billion in savings.

The bipartisan sponsors of the bill, Senators Herb Kohl (D-WI) and Chuck Grassley (R-IA), stressed that generic medicines cost about 80-90 less than brand-name drugs and should be allowed to compete in an open market without anti-competitive "pay-for-delay" settlements restricting their introduction. However, the Generic Pharmaceutical Association (GPhA) called a ban on these

settlements “misguided”, insisting that they do little to restrict competition. The association also opposed a provision in the bill applying the ban retroactively in an effort to undo past settlements.

### ***Making Medigap enrollees pay more could save Medicare up to \$4.6 billion per year***

A new study released this week by the Kaiser Family Foundation found that Medicare could save between \$1.5 and \$4.6 billion in a single year if Congress limited the extent to which supplemental Medigap policies can cover out-of-pocket expenses not covered by Medicare.

According to Kaiser, about one in six Medicare beneficiaries purchased Medigap coverage in 2008 to cover their relatively high out-of-pocket expenses. However, several studies document that Medigap beneficiaries use an estimated 25 percent more services than other beneficiaries.

As a result, Senators Joe Lieberman (I-CT) and Tom Coburn (R-OK) proposed spending cuts two weeks ago that would limit Medigap coverage in order to reduce unnecessary utilization, similar to a recommendation from the National Commission on Fiscal Responsibility and Reform last winter (see Update for Week of December 6<sup>th</sup>). In addition to raising the Medicare eligibility age and increasing Part B and D premiums for those earning more than \$150,000 per year, the Lieberman/Coburn plan would establish minimal cost-sharing for all Medicare services, up to a cap of \$7,500 per year (with a higher-cap for wealthier beneficiaries). All of these changes would save Medicare over \$250 billion over ten years.

The Kaiser analysis concludes that raising cost-sharing for Medigap beneficiaries would reduce claims and premiums, because of the reduced utilization. However, they acknowledge that for certain types of services like inpatient hospital care, higher cost-sharing could have a “disproportionately negative impact on Medigap enrollees who are in relatively poor health.”

### ***ACA “firewall” could leave employees with huge out-of-pocket costs for family coverage***

Several of the Obama Administration’s health reform allies warned this week that a provision of the Affordable Care Act (ACA) designed to prevent businesses from dropping employee health coverage could inadvertently leave families without access to subsidized health insurance in the new exchanges.

Georgetown University’s Center for Children and Families, First Focus, and the Center on Budget and Policy Priorities are among the advocates who recently urged the Administration or Congress to “fix” an unintended consequence of a “firewall” that denies federal tax credits to otherwise eligible workers if their employers offer quality, affordable, coverage that costs less than 9.5 percent of an employee’s income. The provision was supposed to prevent “crowd out” where private plan subscribers dump their existing coverage in favor of more attractive federal health programs.

Initially, advocates thought the threshold also applied to family coverage. However, the Joint Committee on Taxation interpreted the “firewall” to mean that families are not eligible for subsidized coverage if the employer’s individual (and not family) coverage is affordable. As a result, Georgetown warned that an employee could be forced to go uninsured or remain in unaffordable family coverage from his or her employer, because subsidized family coverage in the exchange would be unavailable to them.

Advocates expect upcoming Department of Treasury regulations to soon clarify whether families will also be eligible for subsidized coverage in the exchange. However, costs could be an impediment to revising the requirement. A recent study by the Employment Policies Institute estimates that such a change in policy could cost taxpayers \$50 billion per year, although advocates have dispute this figure.

## FEDERAL AGENCIES

### ***HHSto provide \$4 billion in loans to launch CO-OP plans, though many will default***

The Centers for Medicare and Medicaid Services (CMS) released proposed rules this week governing the new consumer-operated and oriented health plans (CO-OPs) authorized by the Affordable Care Act (ACA).

CO-OPs are non-profit insurance cooperatives governed by consumers, which were introduced by the Senate Finance Committee into the final ACA law as an alternative to the controversial “public option”. However, CO-OPs are very different, since they cannot be run by a state or local government entity. They also represent a new product, since the ACA prevents any entity that sold insurance as of July 2009 from becoming a CO-OP.

The proposed rules will also require two-thirds of CO-OP business to come from selling plans to individuals or small businesses, rather than large groups. They must re-invest their revenues into either lowering premiums or improving quality.

CMS will provide CO-OPS with two rounds of loans. The first \$600 million will help CO-OPs develop business models. The second \$3.2 billion are intended to ensure that the new products have enough cash on hand to cover unexpected claims. The money will help CO-OP meet the same solvency standards that apply to traditional for-profit insurers. (The insurance industry had heavily lobbied CMS not to give CO-OPs a break from these solvency standards in order to get them started.)

Agency officials estimate that roughly 57 entities could be funded with the \$4 billion, but cautioned against assuming that will be the final number. CMS intends would like at least one CO-OP in every state. Actual loan amounts will depend on plan size and how much risk they are willing to assume.

The ACA initially sought to provide \$6 billion in CO-OP loans, but Congress stripped out \$2.2 billion in order to pass a temporary spending resolution to keep the federal government running through September (see Update for Week of April 11<sup>th</sup>).

The insurance industry claims that the loans, which must be fully repaid, are not nearly enough for CO-OPs be able to survive against large insurers. That is because of the leverage big companies have to hold down costs through bulk purchasing and their power to command lower rates from providers by steering more customers their way. The proposed rule appears 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 to 2013.

CMS emphasized that CO-OPs are not experimental, as several cooperatives currently cover nearly two million individuals. The agency claimed that physician groups in Arizona, Connecticut, Illinois, Maryland, and Rhode Island have already expressed interest in forming CO-OPs.

The proposed rules will allow CO-OPs to sell health plans through the state-based health insurance exchanges authorized by the ACA.

### ***No word from CMS on timing for “active purchaser” decision in federally-operated exchanges***

The Director for the Center for Consumer Information and Insurance Oversight (CCIIO) briefed reporters this week on his department’s progress in implementing key provisions of the Affordable Care Act (ACA).

Proposed regulations published last week did not address whether health insurance exchanges operated by the Centers for Medicare and Medicaid Services (CMS) would be an “active purchaser” similar to the Massachusetts model that excludes certain insurers, or an “information clearinghouse”

similar to the Utah model that gives consumers better purchasing information. Director Steve Larson acknowledged that CCIIO has yet to decide which model to follow and offered no timetable for a decision that will be published in either additional regulations or guidance later this year.

The ACA requires CMS to assume control of any state exchange that is not ready to be operational by January 1, 2014. However, Director Larson conceded that this was a “soft deadline” that may need to be adjusted if many states do not make sufficient progress by that date. He emphasized that although only about 12 states have passed some form of authorizing legislation, at least 40 states are working with stakeholder groups on developing exchange designs.

Larson reiterated the agency’s earlier commitment to issues rules this fall that will define the “essential benefits package” that insurers must cover, both in and out of the exchange. HHS is currently awaiting guidance from the Institute of Medicine that is due this fall.

### ***HHS partially approves medical-loss ratio waivers for Iowa and Kentucky, rejects North Dakota***

The Department of Health and Human Services (HHS) announced late this week that it has partially approved two more waivers from the new medical-loss ratios (MLRs) under the Affordable Care Act (ACA), while rejecting another.

Under the new waivers, Iowa will have until 2013 to require small business and individual insurers to meet the new standard requiring that at least 80 percent of premium revenue be spent on medical care. Kentucky insurers will have to meet this standard starting in 2012. However, HHS rejected North Dakota’s request for a waiver after concluding that the state’s three largest carriers already meet or nearly meet the 80 percent threshold and thus are not likely to exit the market.

Maine, Nevada, and New Hampshire have already received MLR waivers from HHS. North Dakota becomes the first state to be rejected. At least seven other waiver requests are pending.

### ***Nearly 1,500 annual limit waivers have been granted by HHS***

The Department of Health and Human Services (HHS) announced that it has granted 39 waivers last month that will allow recipients to continue offering “mini-med” plans, even though they do not comply with new annual limit restrictions under the Affordable Care Act (ACA). The agency has now granted 1,471 one-year waivers.

Applicants have until September 22<sup>nd</sup> to seek a new waiver or an extension until 2014. HHS will no longer approve requests after that date (see Update for Week of June 20<sup>th</sup>).

The waivers have become somewhat of a political liability for the Obama Administration as House Republicans have continually sought to use them as evidence that the ACA is not working as intended (see Update for Week of May 16<sup>th</sup>).

The Director for the Center for Consumer Information and Insurance Oversight (CCIIO) announced this week that his department expects to issue regulations by the end of the year addressing the status of “mini-med” plans under the new medical-loss ratio (MLR) standards.

### ***AARP finds that generic drug prices declined for fifth year in a row***

A new study released this week by AARP found that the cost of generic drugs has fallen for the fifth consecutive year.

The survey of 185 generics commonly used by Medicare beneficiaries revealed that generic drug prices fell 7.8 percent in 2009. AARP previously reported that the cost of brand-name drugs increased by more than eight percent that same year. However, the pharmaceutical industry disputes their findings, insisting that it does not reflect the price consumers actually pay.

AARP has been measuring drug prices for the past five years. Among the products that have been on the market that entire time, the powerful senior citizen lobby found that the average retail price has fallen by roughly 35 percent.

## STATES

### Alabama

#### ***New pricing model to save Alabama Medicaid \$30 million in prescription drug spending***

The Director of Alabama Medicaid announced this week that the agency expects to cut prescription drug spending by six percent this year as a result of a federal waiver approved last fall.

States traditionally have used the average wholesale price (AWP) published by drug manufacturers to determine how much to reimburse pharmacies who dispense drugs to Medicaid enrollees. However, Alabama found that pharmacies typically pay less than the published wholesale price, which vary widely among states for the same name-brand and generic drugs.

Under the new pricing method sought by Alabama, Medicaid conducts a twice-yearly random survey of about 350 of the state's 1,350 drug stores. The stores turn over a month's worth of receipts for all of their drug purchases and file updates to those prices weekly. Medicaid then determines an average acquisition cost (AAC) based on the average prices pharmacies actually pay for drugs rather than the average prices drug manufacturers report to pay.

Alabama pharmacies remain concerned about the AAC model, noting that small and independent stores tend to pay higher prices than big chains, so switching to an average cost would mean the reimbursements some of them receive would be less than what they paid. The Medicaid program sought to allay some of these concerns by nearly doubling dispensing fee it pays for each prescription to \$10.64.

Oregon received federal approval to adopt a similar plan in January. The U.S. Department of Health and Human Services is urging other states to do the same.

### Florida

#### ***More than 100 organizations urge CMS to reject Florida's effort to fully privatize Medicaid***

More than 100 state organizations sent a letter to the federal Centers for Medicare and Medicaid Services (CMS) this week urging the agency to reject Florida's forthcoming request for a waiver that would allow Medicaid to move nearly all beneficiaries into capitated managed care plans.

The statewide expansion of Florida's demonstration that was signed into law last month by Governor Rick Scott (R) has been beset by controversy, after studies by Georgetown University, the Urban Institute, and others revealed that quality of care had eroded under the initial five-county experiment. CMS has already indicated that it will not renew the state's waiver that expired June 30<sup>th</sup> unless the state institutes new safeguards to protect against skimping on care by managed care plans (see Update for Week of June 20<sup>th</sup>).

Consumer advocates and five of the state's physician societies are adamantly opposed to the expansion, arguing that the evidence from the demonstration should more than prove that privatizing Medicaid will compromise the health of enrollees. They also note that the only supporters of the plan are Republican lawmakers and the insurance industry.

Florida's Medicaid program has until August 1<sup>st</sup> to submit their waiver application. If approved, the medically-frail elderly (including nursing home residents) would be the first to transition into managed

care next year, since they cost the most (see Update for Week of May 2<sup>nd</sup>).

## Idaho

### ***Governor reverses course, will allow some “non-objectionable” ACA grants***

Governor Butch Otter (R) has issued ten waivers of his executive order last spring that barred state agencies from accepting federal funds authorized by the Affordable Care Act (ACA).

Despite the Governor’s support for a health insurance exchange, he remains staunchly opposed to implementing other provisions of the new federal law. Idaho is also one of 27 states that joined the multi-state federal lawsuit to block certain provisions of the ACA.

However, Governor Otter has decided to allow a handful of requestors to accept ACA funds so long as they would further existing state programs or are not directed towards implementation of ACA provisions. As a result, Idaho agencies will receive up to \$19 million in ACA grants to support physician residency or training programs, operate smoking cessation programs, create medical homes for those with chronic conditions, or other non-objectionable purposes.

However, the Governor denied a waiver that would have allowed the Department of Health and Welfare to use federal funds to expand home and community based services to those who currently do not qualify for Medicaid. Governor Otter insisted that project too closely-aligned with the ACA’s expansion of Medicaid to those earning up to 133 percent of the federal poverty level, a provision that the Governor vehemently opposes.

The Governor also has no plans to return the state’s \$2.5 million grant to implement the health insurance exchange authorized by the ACA. He previously vetoed legislation (S.B. 298) that would have barred all federal funding under the ACA, solely to preserve the federal exchange grant. The Governor then substituted an executive order to ban the remainder of ACA funding, consistent with the Legislature’s intent (see Update for Week of April 18<sup>th</sup> and 25<sup>th</sup>).

## Illinois

### ***New law requires insurers to cover medical costs for patients in cancer trials***

Governor Pat Quinn (D) signed legislation last week that prohibits insurers from excluding coverage of related medical costs for patients participating in clinical cancer trials. H.B. 1191 takes effect in January.

## Massachusetts

### ***Some hospitals, insurers favor price controls to curb rising health care costs***

Three Commonwealth hospitals and one large health plan testified before a legislative panel last week in favor of temporary government limits on health care prices.

Support for any form of pricing controls came as a surprise for an industry that has long favored letting the market decide how much providers are paid for treating patients. However, three of the four hospital executives who testified urged lawmakers to use temporary price controls to close the wide gap between what insurers pay hospital and doctor groups with the market leverage to demand high prices and what they pay to those without it.

The chief executive officers for MetroWest Medical Center, Lowell General Hospital, and Tufts Medical Center insisted that free market “got out of hand” as large hospital and physician groups continue to hike prices to demand higher payment from insurers. Although they applauded the Patrick Administration for successfully crusading against double-digit rate hikes, they emphasized that the primary culprit for the Commonwealth’s health care cost spiral is hospital and physician pricing, not insurance premiums that mostly reflect cost increases. The three hospitals are lower-paid hospitals that are losing physicians to larger competitors who can charge and be reimbursed at higher rates.

Tufts Health Plan was the only insurer to favor “some government intervention” in the form of temporary price controls

Presenters representing Governor Deval Patrick (D) and Attorney General Martha Coakley (D) provided data to support the claim that provider pricing is driving-up health premiums and costs.

### Nebraska

#### ***Federal health reform opponent to lead lobbying efforts by nation’s governors***

Governor Dave Heineman (R) was installed this week as chairman of the National Governors Association (NGA), becoming the first Nebraska governor in 60 years to lead the prominent lobby group.

Heineman gained prominence last year for his staunch opposition to implementing the Affordable Care Act (ACA). However, the Urban Institute found that he and several fellow Republican governors were greatly overstating the costs of the ACA’s Medicaid expansion upon their states (see Updates for Week of September 13<sup>th</sup> and October 25<sup>th</sup>). A new report this week by the Urban Institute reiterated that state governments are likely to save \$92-\$129 billion over the first five years after full implementation of the ACA, and continue to reap savings every year thereafter.

The NGA vice-chair for this year will be Delaware Governor Jack Markell (D), an ACA proponent.

### New Hampshire

#### ***New laws would decline exchange grants, invalidate any mandate to buy health insurance***

Two Republican-passed bills opposing federal health reforms became law last week without the signature of Governor John Lynch (D).

H.B. 601 creates a committee to provide legislative oversight, policy direction and recommendations for any legislation relating to the Affordable Care Act (ACA). The measure requires the insurance commissioner to obtain prior approval from the committee before implementing any of the federal reforms and decline any federal grants to create a health insurance exchange.

S.B. 148 would amend the state constitution to prohibit any federal or state law from mandating the purchase of health insurance.

### New York

#### ***Health department moves forward on exchange implementation, despite lack of legislation***

Despite failing to pass exchange-authorizing legislation by the end of the legislative session (see Update for Week of July 11<sup>th</sup>), the Department of Health posted Request for Proposals (RFP) last week for the New York State Health Benefit Exchange. Responses are due August 15<sup>th</sup>.

New York has already received a \$27.4 million “Early Innovator” federal grant for being a national leader in developing the information technology infrastructure needed to operate the exchange.

## Ohio

### ***Ohio may opt-out of creating an “Obama [health insurance] exchange”***

Lt. Gov. and Department of Insurance Director Mary Taylor (R) indicated this week that the Kasich Administration is leaning towards becoming only the second state besides Louisiana to absolutely refuse to create a health insurance exchange required by the Affordable Care Act (ACA).

Despite support for exchange implementation from Governor John Kasich (R), Lt. Gov Taylor argued against the “one size fits all” exchange design being pushed by the federal government. She insisted that the consumer protections mandated by the ACA would increase premiums and harm Ohio’s “robust” health insurance marketplace (see article below).

Taylor’s comments appeared also to conflict with Governor Kasich’s acceptance of a federal exchange implementation grant, support for his predecessor’s exchange panel, and assurances that the state would move forward in implementing all of the ACA unless the law is invalidated in court. Kasich later clarified that he wants an exchange, just not an “Obama exchange.”

The panel created last year by former Governor Ted Strickland has recommended that Ohio create its own exchange instead of refusing to proceed and allowing a “federal takeover” of the exchange.

### ***Ohio insurance premiums are lowest among large states***

A new study of health insurance premiums by the Agency for Healthcare Research and Quality (AHRQ) found that Ohio has the lowest annual cost for both single coverage and family coverage among the ten largest states in the country.

According to data from the 2010 Medical Expenditure Panel Survey, the average annual cost of single coverage in Ohio is \$4,669 while the national average is \$4,940. New York has the highest single premiums at \$5,220. For family plans, Ohioans pay an average of \$13,083 per year, compared to a national average of \$13,871 and a national high of \$15,032 in Florida.

Nationwide, private-sector employees with single coverage contributed 21 percent of the cost of their health insurance and employees with family coverage paid 27 percent. Only 18 percent of employees with single coverage and ten percent of employees with family coverage were not required to pay for any part of their employer-sponsored health insurance.