

## Health Reform Update – Week of July 25, 2011

### CONGRESS

#### ***Debt ceiling compromise protects most entitlements, ACA funds from automatic cuts***

The House and Senate passed last-minute compromise legislation this week that averts the default on federal debt obligations that was set to occur on August 2<sup>nd</sup> and cuts federal discretionary spending by \$2.4 trillion.

S.365 provides an immediate \$900 billion increase in the amount the federal government can borrow. This “debt ceiling” will be increased by an additional \$1.2 to \$1.5 trillion at a later date to be determined by the President, depending on the amount of corresponding spending cuts.

A new “super committee” will be charged with recommending these additional cuts by November 23<sup>rd</sup>. The 12-member legislative panel will be evenly split among Democrats and Republicans appointed by House and Senate leaders. If they fail to reach agreement or Congress does not enact their recommendations, the legislation will automatically “trigger” \$1.2 trillion in mandatory across-the-board spending cuts to both defense and non-defense programs starting in 2013. (The recommendations will require only a simple majority of Senate votes to pass, not the 3/5 majority required to break a filibuster).

The White House successfully included a “firewall” that would exempt Medicaid and Social Security from these automatic cuts, as well as funding to implement key provisions of the Affordable Care Act. While the legislation allows an automatic two percent cut in Medicare reimbursement, it prohibits reductions to Medicare benefits or increased cost-sharing. The measure also would avoid the need for another bruising debate over the debt ceiling until after the 2012 elections.

Despite this victory, many Democratic lawmakers were angered that this “firewall” applies only to automatic cuts, and not the panel’s recommendations. Republicans on the panel are likely to keep pushing for broad entitlement reforms, including the House-passed plan to privatize Medicare and block grant Medicaid (see Update for Week of April 4<sup>th</sup>). The panel also may consider many of the Medicare changes proposed last winter by the President’s deficit commission, including increasing the age for retirement/Medicare eligibility and raising Medicare premiums and deductibles for the wealthy (see Update for Week of December 13<sup>th</sup>).

Many Democrats likewise complained that the legislation fails to extend the enhanced unemployment benefits or reduction in the payroll tax that were included in the federal budget that ends September 30<sup>th</sup>. The White House also was unable to include any increased revenues, either by ending the Bush-era tax cuts for the wealthy or eliminating certain corporate tax breaks and subsidies.

On the other side, “tea party” Republicans were likewise upset that S.365 did not include the full \$1.8 trillion in spending cuts that were part of their initial legislation (S. 627). They also were unable to make an upcoming vote on a balanced budget amendment contingent upon an increase in the debt limit.

Lawmakers from both parties criticized the bill for just “putting out the fire” and failing to deliver a more comprehensive, long-term deficit reduction package. However, S.365 passed by sizeable margins in both chambers as it became clear that no alternative legislation would receive enough support from “tea party” Republicans in the House.

### ***First Affordable Care Act challenge reaches U.S. Supreme Court***

The conservative Thomas More Law Center formally petitioned the U.S. Supreme Court this week to review the decision by the Sixth Circuit Court of Appeals to uphold the new federal mandate that everyone buy health insurance.

A three-judge panel from the Sixth Circuit held last month that Congress did not exceed its authority under the U.S. Constitution to regulate interstate commerce when it passed the individual mandate under the Affordable Care Act (ACA). The decision was significant in that it was joined by Judge Jeffrey Sutton, the first conservative justice to uphold the constitutionality of the mandate (see Update for Week of June 27<sup>th</sup> and July 4<sup>th</sup>).

Although the Sixth Circuit case is the first to reach the Supreme Court, it is likely to soon be joined by decisions from the Fourth and 11<sup>th</sup> Circuit courts of appeal. Although the Supreme Court has repeatedly refused to intervene before the appellate courts have ruled (see Update for Weeks of April 18<sup>th</sup> and 25<sup>th</sup>), the political firestorm surrounding the expected conflict in decisions makes it very likely that the high court will agree to review them and rule as early as June 2012.

### ***AARP backs legislation to extend new insurer payout standards to Medigap plans***

Rep. Pete Stark (D-CA) and Senator John Kerry (D-MA) introduced bills this week that would require Medigap plans to meet the same medical-loss ratios mandated by the Affordable Care Act (ACA).

The measures (H.R. 2645/S.1416) were promptly endorsed by AARP, even though they would increase the amount of premium revenue that Medigap plans often sponsored by AARP have to spend on direct medical care. (AARP derives significant royalties from endorsing Medigap plans). However, America's Health Insurance Plans (AHIP) opposed the legislation, claiming it would disrupt the market and reduce access to covered services for enrollees.

Since 1990, MLRs for Medigap plans are only 75 percent in the large group market and 65 percent for individual plans. However, AHIP notes administrative costs for Medigap plans are typically higher than for other plans as they have less of a premium base, making it more difficult for them to comply with the higher ACA thresholds (85 percent for large group, 80 for small group and individuals). According to AHIP, this was precisely the reason that Congress excluded almost all supplemental coverage from the stricter standards under the ACA.

### ***CBO projects that fixing Medicaid early retiree "glitch" in ACA would save billions***

The Congressional Budget Office (CBO) predicted this week that the federal government would save \$13 billion over ten years if Congress fixed a "glitch" in the Affordable Care Act (ACA) that could allow up to three million middle-class retirees to erroneously qualify for Medicaid.

Republicans had pounced on a report by the Centers for Medicare and Medicaid Services (CMS) chief actuary concluding that changes in the way Social Security income is counted could cost the federal government up to \$450 billion over ten years in improper Medicaid expenses. This is because a married couple could earn up to 400 percent of FPL and still qualify for Medicaid after 2014 if they retired at age 62 because Social Security benefits under the ACA would no longer be treated as income when determining eligibility (see Update for Week of June 20<sup>th</sup>).

The Obama Administration has promised a regulatory fix. However, House and Senate Republicans quickly introduced legislation to count Social Security benefits when calculating eligibility for Medicaid and insurance subsidies under the new law. CBO's initial score of this legislation found that the fix would save billions, as up to one million fewer people would enroll in Medicaid per year.

However, many advocates for the disabled remained concerned that proposed fix would adversely affect those receiving federal Social Security disability that are caught in the two-year waiting period before becoming eligible for Medicare.

## **FEDERAL AGENCIES**

### ***Next round of health insurance exchange regulations will focus on enrollment***

The Centers for Medicare and Medicaid Services (CMS) plan to give states more guidance soon on the technical process for enrolling people in the new health insurance exchanges authorized by the Affordable Care Act (ACA).

Long-awaited exchange regulations published this month by CMS did not address eligibility and enrollment (see Update for Week of July 11<sup>th</sup>). The information technology (IT) infrastructure required for these systems is such a major logistical undertaking that even conservative Governors have asked for heavy federal involvement. Seven states received federal "early innovator" grants earlier this year for taking the lead on developing the necessary IT systems (see Update for Week of February 14<sup>th</sup>).

CMS officials announced at a conference this week that eligibility and enrollment regulations would be among the next regulations to be issued by the agency, which already sent rules on determining eligibility for ACA subsidies to the Office of Management and Budget on July 25<sup>th</sup>.

Future ACA regulations and guidance will also focus on premiums and cost-sharing credits, exemptions from the individual mandate, the federal fallback exchange, and the definition of "essential health benefits" (once the Institute of Medicine completes their recommendations in September).

### ***Medicare Part D avoids unnecessary acute and post-acute care***

Researchers at Harvard Medical School and Brigham and Women's Hospital have found that Medicare Part D saved the federal government at least \$12 billion per year in acute and post-acute care.

Published in the *Journal of the American Medical Association*, the new study used Medicare claims data from 2004 to 2007 to compare spending on non-drug health care before and after the implementation of Part D in 2006. It determined that spending on non-drug health services for those with limited drug coverage declined by ten percent or \$1,200 per beneficiary annually. (About \$800 of those savings are attributable to greater adherence to medications.)

The study did not identify which drugs helped create the savings or whether the savings offset the cost of administering the drug benefit. Instead, it concluded that the savings are likely are a "partial offset" to the total cost of Part D.

Researchers noted that closing the Part D "doughnut hole" would yield even greater savings as enrollees would no longer skip medications while in the coverage gap and thus remain healthier and not need more intensive and costly acute or post-acute care.

### ***Seniors eligible for Medicare Part D still struggle to enroll***

The Medicare Rights Center released a new report this week documenting that many eligible Medicare Part D beneficiaries are still struggling to enroll due to the complexity of the program.

The study highlights how hard it is for the elderly to choose among "a multitude of plans that have different benefit structures, pharmacy networks, formularies and rules for accessing benefits." It found that only 43 percent of respondents to a recent survey chose to enroll in plans recommended by Medicare's online Plan Finder tool, while 57 percent chose not to.

The Medicare Rights Center recommends that the Centers for Medicare and Medicaid Services (CMS) reorganize the data in the Plan Finder to include a "decision tree" that will guide seniors to their most affordable options. They also urged that CMS further consolidate the number of Part D plans that lack meaningful differences in order to give enrollees access to a manageable number of distinct choices.

### ***CMS actuary says ACA will expand coverage while health spending will remain the same***

Health care spending will account for almost a fifth of the nation's economy by 2020, with federal expenditures making up almost half that amount. That was the principal finding of a report by the chief actuary for the Centers for Medicare and Medicaid Services (CMS) published this week in *Health Affairs*.

However, Democrats pounced on the actuary's prediction that after a one-time 8.3 percent spike in health spending in 2014, the growth in national health spending will remain essentially unchanged despite at least 30 million more Americans receiving coverage under the Affordable Care Act (ACA).

The growth in national health spending reached a historical low of 3.9 percent in 2010, thanks largely to lower utilization during the economic downturn. While the chief actuary predicts the growth rate will jump to 5.8 percent from 2010 to 2020, this is only 0.1 percent higher than he projects it would have been without the coverage expansion under the ACA.

The amount of spending for Medicare and private health plans should also remain constant at 20 and 32 percent respectively. However, Medicaid spending will grow at least four percent by 2020, due to the ACA's mandated expansion in 2014.

The report also details how health expenditures will be allocated under the law. Prescription drug and physician/clinical services will grow much faster than without the ACA, while the law should not significantly effect hospital spending as many of the newly insured will be "younger and healthier" and thus use prescription drugs and physicians more than intensive services like hospital care.

The ACA will also rearrange who pays for care. All governments (federal, state and local) should account for 49 percent of health spending, with the federal share growing from 27 percent in 2009 to 31 percent in 2020. However, employer contributions will decline from 20 percent in 2014 to 18 percent in 2020, while overall consumer out-of-pocket costs will remain at 26 percent.

### ***Large health insurers continue to profit from fewer medical claims***

Two of the nation's three largest health insurers by market value reported higher than expected second quarter earnings this week due to a continued decrease in medical utilization.

Insurers have profited enormously over the past year as Americans increasingly postpone needed medical care during the economic downturn (see article above and Update for Week of June 20<sup>th</sup>), while premiums increase by double digits. As a result, profits for insurers like Aetna and WellPoint easily exceeded estimates as their stock prices jumped 30-40 percent, instead of just six percent for entire S&P 500 index.

## **STATES**

### ***Some states hit harder by "cliff" in stimulus relief for Medicaid***

All 50 states lost the additional federal Medicaid relief on July 1<sup>st</sup> that they had received since passage of the American Recovery and Reinvestment Act (ARRA) in February 2009. However, data released last week by Federal Funds Information for States showed that states were disproportionately impacted by this “cliff”, as those with high unemployment received significantly more stimulus relief than other states.

Hawaii suffered the biggest drop in Medicaid funding (16 percent), followed by Louisiana, Washington, and Alaska (12-13 percent). Alabama and Kentucky lost the least (nine percent apiece).

A report this week by Moody’s Investor Service also warned that Medicaid reimbursement for hospitals will likely be cut even further after July 1<sup>st</sup> as a result of the lost stimulus relief. Medicaid already consumes an average of 22 percent of state budgets, and hospital payment is one of the few areas where states can continue to cut in order to balanced record deficits (the ARRA and Affordable Care Act prevented states from cutting eligibility). At least 37 states have already cut Medicaid hospital reimbursement for fiscal year 2012.

### California

#### ***Health benefit exchange board opposes legislation expanding rate review, coverage options***

The board of the California Health Benefit Exchange unanimously voted last week to urge lawmakers to exempt the exchange from landmark legislation yet to pass the Senate that would allow the state insurance commissioner to modify or reject excessive health plan rate hikes.

In their third meeting, the board expressed concerns that A.B. 52 may contradict exchange efforts by allowing the commissioner to potentially undo rates the board negotiates with participating exchange plans. A.B. 52 has been long-sought by the commissioner and consumer advocates but is bitterly opposed by the insurers, physicians, and hospitals (see Update for Weeks of June 27<sup>th</sup> and July 4<sup>th</sup>).

Representatives from the Department of Insurance urged board members to defer judgment on A.B. 52 until necessary amendments are made to secure passage. They also warned that exempting the exchange from expanded rate review (just like they did for Medi-Cal) would have “huge unintentional consequences.”

The board also voted to oppose S.B. 703, which would exercise the state’s discretion under the Affordable Care Act (ACA) to create a basic health plan for persons earning between 133 and 200 percent of the federal poverty level. A basic health plan could potentially provide up to 800,000 exchange customers with alternative coverage at lower premiums. Board members insisted that giving up 800,000 customers would be “disastrous for the exchange”

### Connecticut

#### ***Both sides praise compromise on vetoed health insurance rate review legislation***

State Healthcare Advocate Victoria Veltri and Insurance Commissioner Thomas Leonardi (D) both praised an agreement with Democratic lawmakers that will resurrect key provisions of vetoed legislation to increase oversight of health plan premium hikes.

Governor Daniel Malloy (D) had shocked consumer advocates and physician groups by rejecting legislation earlier this month that would have allowed the Healthcare Advocate or Attorney General to order a public “symposium” for any double-digit rate hike (see Update for Weeks of June 27<sup>th</sup> and July 4<sup>th</sup>). The measure (S.B. 11) drew fierce opposition from some of the nation’s largest insurers that are headquartered in Connecticut. As a result, Governor Malloy insisted that the state’s current rate review process was more than adequate.

The Governor's veto was particularly surprising given his campaign pledge to increase transparency into the rate review process after his predecessor's Insurance Commissioner was forced to resign last fall over complaints that he "rubber-stamped" inflated rate hikes without hearing or review (see Update for Week of November 1<sup>st</sup>). Commissioner Leonardi thus immediately sought to mollify consumer advocates and Democratic lawmakers by agreeing to hold up to four public hearings per year at the request of the Healthcare Advocate, so long as an individual or small group plan seeks a rate hike of at least 15 percent. The Commissioner could also hold any additional hearings he deemed necessary.

The compromise voids the possibility that the Governor's veto would have been overridden by the Democratically-controlled legislature, which appeared to have sufficient Republican support. However, Senate Majority Leader Martin Looney (D) insists that he "never took a headcount" for a veto override.

Bill sponsor and Insurance committee chair Senator Joseph Crisco (D) supported the compromise as positive "first step" towards greater transparency of the rate review process. However, he remains concerned that the compromise lacks the force of law and pledged to pursue additional public hearing legislation next session.

#### Delaware

##### ***New law bans pre-existing condition insurance denials for children***

Governor Jack Markell (D) signed H.B. 161 into law this week. The measure amends Delaware insurance code to conform with the Affordable Care Act (ACA) prohibition on pre-existing condition insurance denials for children under age 19.

#### Louisiana

##### ***Five insurers win bids to enroll Medicaid recipients into managed care***

The Department of Health and Hospitals (DHH) announced this week that five insurers have won bids to enroll nearly 900,000 Medicaid recipients into managed care plans starting early next year.

Governor Bobby Jindal (R) expects the state to save up to \$135 million per year through his new coordinated care network (CCN) initiative which he has been pursuing since 2007. Republican lawmakers have disputed his estimates and passed legislation last month seeking greater oversight of the managed care transition, which was modeled after the controversial Florida demonstration (see Update for Week of June 13<sup>th</sup>).

The five plans were selected from a group of 12 applicants (see Update for Weeks of June 27<sup>th</sup> and July 4<sup>th</sup>). Each were chosen because they had "significant experience" running Medicaid plans in other states and successfully changed "the behavior of enrollees" and doctors to drive costs down.

Three of the plans can accept patients statewide (Centene, AmeriHealth Merck of Louisiana, and AmeriGroup). UnitedHealthcare and Community Health Solutions won bids to run managed care plans under a different set of rules that would limit their financial risk in caring for patients. The state can still choose a sixth winner at a later date.

The DHH Director blamed uncertainty created by the Affordable Care Act for causing some of the state's largest insurers like Blue Cross and Blue Shield to shy away from participating.

Centene and AmeriGroup are expecting a 6-12 jump in business for 2012 thanks to Medicaid managed care expansion. However, the winning bidders still must build networks of doctors and pass a review process with the state before signing contracts.

About one-third of Louisiana Medicaid's \$6.7 billion budget next year will be allocated for the new managed care contracts. More than 20 other states are planning similar expansions of Medicaid managed care.

#### New York

##### ***Governor signs measure conforming New York insurance law to Affordable Care Act***

Governor Andrew Cuomo (D) signed S.B. 5800/A.B. 8460 into law last week. The measures conforms New York insurance law to the new consumer protections under the Affordable Care Act (ACA) that went into effect last September. This includes prohibiting lifetime caps, pre-existing condition insurance denials for children, and cost-sharing for certain preventive services.

However, the Governor was unable to get his proposed bill implementing an ACA-complaint insurance exchange through the legislature last session (see Update for Week of July 11<sup>th</sup>). It is not yet clear whether he will call a special session to do so this year, or wait until the 2012 legislative session. The Department of Health is moving forward with implementation absent the necessary legislation (see Update for Week of July 18<sup>th</sup>).

#### Ohio

##### ***Voters will decide whether to denounce individual mandate, limit health benefits for state workers***

Secretary of State Jon Husted (R) announced this week that petitioners have successfully put two voter referendum's on this fall's ballot relating to health care reform.

A coalition of Tea Party and constitutional rights activists submitted more than 546,000 signatures to Husted's office earlier this month, in an effort to put S.B. 1 before the voters in November. The measure would amend the state constitution to invalidate any federal or state laws mandating the purchase of health insurance. Similar ballot referendums passed last year in Arizona, Missouri, and Oklahoma, but failed in Colorado (see Update for Week of November 1<sup>st</sup>).

Husted certified 426,998 of the coalition's signatures (only 385,245 valid signatures were required.) Liberal activist groups like ProgressOhio insist that many of the signatures are erroneous and have petitioned the Ohio Supreme Court to block the referendum.

However, an unrelated health care referendum could influence the outcome of S.B.1. Voters will also have to decide whether to uphold or overturn Ohio's new law (S.B. 5) that limits the ability of public employees to collectively bargain for health care benefits. A similar measure stirred intense controversy in Wisconsin and led to recall elections for several Republican lawmakers who backed the bill. Proponents of S.B. 1 hope that S.B. 5 will increase voter turnout among conservatives who staunchly oppose the new federal mandate to buy health insurance.

#### Pennsylvania

##### ***Highmark seeks to raise premiums for "last resort" guaranteed-issue plans***

Almost 30,000 uninsurable residents of western Pennsylvania will face nearly a ten percent hike in monthly premiums under a rate filing submitted last week by Highmark Inc.

The Department of Insurance will publish the proposed increases on August 5<sup>th</sup> and allow 30 days for public comment. After that, they have 45 days to decide whether the nonprofit "insurer of last resort" in Pennsylvania will be able to increase premiums for the five guaranteed-issue plans it sells to those who cannot get individual or large-group coverage.

Highmark is claiming that it loses money on the plans, even though they cover only about one percent of its three million members in Pennsylvania, because this population uses far more health services. Their filing states that they spent \$98.9 million in the past two years subsidizing the rates charged to guaranteed-issue policy holders and expects to contribute \$46.3 million next year.

Highmark also pointed out that more than half of the 30,000 residents are covered under Special Care, a program that was meant to fill the gap when the Governor closed the state-funded adultBasic health plan for the working poor last February. Without the proposed rate hike, Special Care is 3.5 times more expensive than adultBasic.

However, the proposed rate hike has sparked criticism from consumer advocates who argue that it is “unjustified” given that Highmark’s cash reserves exceed \$3 billion and the insurer plans to spend at least \$475 million to acquire West Penn Allegheny Health System, as well as its proposed takeover of Blue Cross Blue Shield of Delaware. They also complained that the rate review process in Pennsylvania does not require Highmark to defend rate hikes in light of these acquisitions, as there is no required public hearing or public justification by the department for a rate approval. However, the insurance department can modify or deny the increase if it is excessive or unfairly discriminatory.