Health Reform Update – Week of October 3, 2011

CONGRESS

House easily passes stopgap bill funding the federal government until November 18th

As expected, the House easily passed a stopgap measure this week funding the federal government until November 18th. The bill has already cleared the Senate, but met some resistance from "tea party" Republicans in the House who were demanding that spending targets be lowered to the level sought in the House-passed budget last spring (see Update for Week of September 26th). However, Speaker John Boehner (R-OH) and other Republican leaders were openly weary of renewing the debt reduction fight last summer that led to a first-ever downgrade in the nation's credit rating (see Update for Week of August 8th). As a result, the final measure stayed true to the spending caps in the bipartisan Budget Control Act of 2011.

House Appropriations Committee Chairman Harold Rogers (R-KY) and his Senate counterpart Daniel Inouye (D-HI) now have to reach agreement on how to allocate the $1.043 trillion in discretionary spending among 12 annual spending bills for fiscal year 2012.

House Democrats urge "super committee" to allow Medicare to negotiate drug prices

The Joint Select Committee on Deficit Reduction was heavily criticized this week for holding mostly private deliberations despite its pledge of public transparency. However, lawmakers and lobbyists continued to bombard members with their recommendations for how to reach the required $1.2 trillion in spending cuts needed to avoid automatic across-the-board sequestration.

The leading proposal this week came from 78 House Democrats, who signed on to a letter urging the so-called "super committee" to recommended the prominent item on the Democratic wish list, which would give Medicare authority to negotiate prices for prescription drugs. Democrats failed to get this authority included in either the Medicaid Part D legislation or Affordable Care Act (ACA). However, the newfound focus on deficit reduction has resurrected the debate.

The proposal mirrors bipartisan legislation introduced last summer by Reps. Jo Ann Emerson (R-MO) and Peter Welch (D-VT) (see Update for Week of June 20th). The Congressional Budget Office estimated that such a measure could save the government $156 billion over ten years, and save enrollees another $27 billion. However, Republicans and the pharmaceutical industry consistently argue that allowing Medicare to negotiate Part D prices would simply result in higher prices for other plans.

The plan presented by President Obama to the "super committee" did not include this authority and instead focused on reduced provider payments, drug rebates for dual eligibles, and facilitating the use of lower-cost generic drugs (see Update for Week of September 19th).

Industry stakeholders have been relentlessly lobbying "super committee" members for other preferred cuts (see below). These include caps on medical malpractice awards, increasing the use of generic drugs, and eliminating the Independent Payment Advisory Board under the ACA that would cede control over Medicare spending cuts away from Congress. Groups are also lining up to oppose proposals floated by "super committee" members, including the transfer of some drug therapies from Medicare Part B to D and new limits on Medigap coverage (see Update for Week of September 19th).

BCBSA releases list of recommendations for "super committee" to curb health spending

The Blue Cross and Blue Shield Association (BCBSA) released a list of recommendations this week for ways to improve quality while cutting federal health spending by $319 billion over ten years.

Their recommendations focus on rewarding safety, implementing effective practices, reinforcing primary care and promoting healthy living. The Association praised Affordable Care Act (ACA) initiatives that address each of these areas, but urged the Obama Administration to move more quickly to implement initiatives that are still in the demonstration stage.

The proposal specifically recommends that high-performing hospitals be rewarded with bonus payments, while poor-performing hospitals receive lower payments. However, it also calls for caps on medical malpractice awards and accelerating the trend to move the nation's nine million dual eligibles into managed care programs.

Kenneth Thorpe, who served in the U.S. Department of Health and Human Services during the Clinton Administration, prepared the recommendations that rely on savings previously projected by the Congressional Budget Office.

Although the "super committee" created by the Budget Control Act passed by Congress last summer is the intended target of these recommendations, it is unlikely that the debt panel will have enough time to consider the systemic reforms proposed by BCBSA before their November 23rd deadline (see Update for Week of August 1st).

MedPAC approves substitute Medicare physician payment formula, despite opposition

Despite overwhelming provider opposition, the Medicare Payment Advisory Commission (MedPAC) voted 15-2 this week to approve their plan to replace a troublesome Medicare physician payment formula that has been delayed 11 times by Congress since being enacted in 1997 (see Update for Weeks of June 27th and July 4th).

MedPAC proposes to eliminate the sustainable growth rate (SGR) formula entirely, which would have cut Medicare physician payments by 29.5 percent for calendar year 2012. In its place, MedPAC urges Congress to cut Medicare payment to specialists by 5.9 percent for three consecutive years and then freeze payments for seven more years. Payments to primary care doctors would also be frozen at current levels for ten years (see Update for Week of September 19th).

The Congressional Budget Office (CBO) projects that the substitute formula would cost $220 billion over ten years. In order to offset the costs, MedPAC recommends that Congress implement their prior proposals to restructure Medicare payments for hospitals and other providers. Remaining savings would come from proposals by CBO and the HHS Inspector General. These include extending drug rebates to dual eligibles, an excise tax on Medigap plans, and restructured out-of-pocket charges to low-income Medicare enrollees to encourage the use of generics (see Update for Week of September 19th).

The American Medical Association and specialty physican groups had lobbied heavily against the offsets, claiming that they threaten access to care by widening the 20 percent gap that already exists between Medicare payment and practice expenses. About 34 percent of the funding for the substitute formula would come from the drug industry, 21 percent from post-acute care, 15 percent from higher cost-sharing by beneficiaries and 11 percent from hospitals.

House Democrat launches investigation into price-gouging for scarce life-saving drugs

Representative Elijah Cummings (D-MD) launched an investigation this week into price-gouging by drug suppliers that are buying drugs that are facing record shortages in an effort to receive exorbitant markups.

The senior Democrat on the House Oversight and Government Reform Committee insisted during a hearing this week that the "unconscionable" practice has forced hospital to change medical practices and often rely on less effective treatments. He noted that some companies are even charging children with cancer more than 80 times the typical price for their medications.

An analysis released last summer by Premier's alliance of hospitals and health-care systems studied more than 1,700 offers made by "gray market" vendors to hospital pharmacists over a two-week period earlier this year. It demonstrated an average mark-up of 650 percent higher than the manufacturer's price for prescription drugs in short supply (see Update for Week of August 15th).

Senate Democrats and the Food and Drug Administration have already held hearings trying to focus attention on the "gray market" that has emerged due to shortages of life-saving drug therapies that have tripled over the last five years. Senator Amy Klobuchar (D-MN) co-sponsored legislation last winter (S.296) that would require drugmakers to notify the Department of Health and Human Services (HHS) of possible drug shortages that result from discontinuances or other changes or problems in manufacturing. Senator Richard Blumenthal (D-CT), a former state attorney general, joined with other Senators in directing the Government Accountability Office (GAO) last May to investigate the "price-gouging" by sellers seeking to take advantage of desperate hospitals and providers.

Lifesaving therapies for cancer, seizures and sedation are among the list of more than 180 medications unavailable this year, according to the American Society of Health-System Pharmacists. Rep. Cummings (D-MD) sent letters to several companies this week demanding their disclosure by October 19th of the profits they made from steep mark-ups for these drugs.

The President of one of the targeted companies, PRN Pharmaceuticals, insisted that lawmaker claims of "Gordon Gekko" like behavior were simply off-base, claiming that they "don't have the resources to hoard drugs in an effort to drive-up prices. He argued that the mark-ups claimed by Rep. Cummings and his Senate counterparts do not reflect the costs resellers incur for storage, shipping, and employee time to locate scare drugs. The PRN President instead tried to blame some of the nation's largest distributors such as McKesson and Cardinal Health for the short supply.

Howard Koh, Assistant Secretary for the Department of Health and Human Services, argued at a September Energy and Commerce committee hearing that the "gray market" is thriving because of scant regulation to prevent resellers from hoarding highly-demanded drugs. He noted that even commonly-used anesthetics like propofol are being sold for $25,000 instead of the typical price of $1,500.

FEDERAL AGENCIES

IOM recommends that HHS first consider cost in defining essential health benefits

The Institute of Medicine released long-awaited guidance this week that recommends how the Department of Health and Human Services (HHS) should define the "essential health benefits" that health plans must cover starting in 2014.

Instead of defining benefits and worrying later about affordability, the report urges HHS to first consider the cost of any minimum benefit that health plans must cover per the Affordable Care Act (ACA). The 18-member committee suggested that HHS define the "typical employer plan" as the type of coverage commonly provided by small employers, and not by larger employers that tend to provide more generous but costly coverage. They specifically recommend that HHS predict the national average premium of typical small employer plans for 2014 and limit the national average cost of the "essential health benefit" package to that amount.

IOM concluded that the "essential health benefit" package should reflect small employer costs because it will be offered as part of the new state-based health insurance exchanges that will begin serving an estimated 68 million small business workers and uninsured individuals in 2014.

The report's somewhat unexpected focus on affordability was widely praised by the health insurance industry, including America's Health Insurance Plans. Business groups also supported IOM's recommendations, as they fear that an expansive, costly package of "essential health benefits" would force many employers to drop coverage.

However, the response from consumer advocates was muted, as tying "essential health benefits" to small employer plans that are typically less generous could result in critically-needed health benefits being left out of the minimally-mandated coverage under the ACA.

Republican critics of the new law may also pounce on IOM's recommendation that HHS should not require coverage of new treatments unless they show "meaningful improvement in outcomes over current effective services." IOM urged HHS to specifically evaluate the "medical effectiveness, safety, and relative value [of health benefits] compared with alternative options." This may provide ammunition to those who have accused Centers for Medicare and Medicaid Services Administrator Donald Berwick of seeking to ration healthcare by cost-effectiveness, a la Great Britain or the Oregon Health Plan (see Update for Week of July 5, 2010).

Republicans may also highlight IOM's conclusion that most employer health plans will have to incur the additional cost of expanded their benefit package in order to cover all of the ten mandated benefit categories under the new law.

However, Republicans should favor the IOM's recommendations not to automatically include state-mandated benefits in the "essential health benefit" package, although they may oppose applying the same above-referenced review criteria. IOM also sought to give states greater flexibility to offer different exchange benefit designs that meets ACA standards.

HHS is not bound by the IOM guidance. However, the Secretary insisted that the agency will rely upon it in defining the essential health benefit package in final regulations to be released early next year. HHS will also consider the Department of Labor survey completed last spring that shows how many employer plans currently cover the essential benefit categories identified in the ACA (see article below and Update for Week of April 11th).

It is not yet clear if HHS will meet the May 1st deadline proposed by IOM, as the Secretary has pledged to hold "listening sessions" nationwide in order to incorporate public comment into the definitions (consistent with IOM's recommendation). IOM urged HHS to expedite the rulemaking process as many states and insurers are waiting to see how essential benefits will be defined before choosing how to design or participate in the new health insurance exchanges. HHS' June 2010 interim rule restricting annual limits also cannot be finalized until the essential benefits are defined.

Labor Department disputes OIG claim that it is failing to adequately implement ACA provisions

The Assistant Secretary for the Department of Labor announced this week that the Employee Benefit Security Administration (EBSA) will begin examining group health plan compliance with the Affordable Care Act (ACA) as part of its standard compliance audits for fiscal year 2012.

The announcement came as part of the Department's rebuttal to criticisms by the Office of Inspector General (OIG) that EBSA was lagging in implementing key provisions of the ACA. The most significant criticism in the OIG's September 30th report found that EBSA failed to provide the Department of Health and Human Services (HHS) with a sufficiently broad survey of the health benefits typically covered under large group plans (see article above). The ACA had charged EBSA with providing this

guidance to HHS for use in HHS definitions of the essential health benefits that all plans must cover starting in 2014 (see Update for Week of April 11th).

According to the OIG, the EBSA survey completed last spring did not address all of the benefits requested by HHS. As a result, OIG fears that HHS may not be able to ensure that the new health insurance exchanges offer each of the essential health benefit categories identified in the new law.

However, the OIG also found that EBSA failed to include compliance with ACA requirements as part of their ongoing audits of large group plans. They also faulted EBSA for not adequately working with HHS and the Internal Revenue Services to establish a public timeline to respond to comments on proposed regulations, and failing to timely promulgate rules for ACA provisions under their jurisdiction.

The Assistant Secretary defended EBSA by claiming that its survey of typical large group plans did meet HHS' expectations and that the ACA did not require the EBSA to define what benefits should be considered "typical". As a result, the detailed data provided by EBSA on the incidence of different health benefits among large group plans fulfilled the intent of the ACA without usurping HHS' duty to define what constitutes an "essential health benefit".

She also insists in her response that a "phased implementation approach" of other ACA provisions was needed to incorporate regulations from related agencies and ensure plans were educated about the new requirements. EBSA insists that ACA compliance will be part of future audits.

Medicare enrollees increasingly benefit from free preventive care, drug discounts under ACA

The Centers for Medicare and Medicaid Services (CMS) announced this week that nearly 20.5 million Medicare enrollees have now taken advantage of the free preventive services provided by the Affordable Care Act (ACA), an increase of over 1.5 million since last month (see Update for Week of September 5th). In addition, nearly 1.8 million Part D enrollees have received the 50 percent discount on brand-name drugs within the "doughnut hole," since it went effect for 2011. The total value of Part D discounts now approaches $1 billion, or an average savings of $530 per beneficiary (a slight increase from last month's figures).

CMS attributed the jump in the utilization of free preventive services to the media blitz launched by the agency last summer, after it found that only one of six Medicare enrollees had accessed the new benefit provided by the ACA (see Update for Week of June 20th).

The latest figures were released by CMS coincident with the start of next year's open enrollment period on October 15th, which begins one month earlier than in year's past. Medicare beneficiaries only have until December 7th to enroll in or change plans.

CMS previously announced that Medicare Advantage premiums for 2012 will be 4 percent lower on average, while enrollment is projected to increase by at least ten percent (see Update for Week of September 12th).

Federal health reform website now allows consumers to view proposed rate hikes by state

The Department of Health and Human Services (HHS) published a new tool this week on their www.healthcare.gov website that will alert consumers to steep hikes in their health plan premiums.

The move is part of the new rate review authority granted by the Affordable Care Act (ACA). In an effort to lower premiums by increasing public transparency of the rate review process, HHS has used their new ACA authority to require individual and small group plans to justify any double-digit premium increase on or after September 1st (see Update for Week of August 29th). As of this week, HHS is publishing the insurer justification on the website for public review.

Proposed rule lets CMS drop poor quality Part D prescription drug plans

The Centers for Medicare and Medicaid Services (CMS) released proposed regulations this week that would allow the agency to drop private health plans that get low marks for quality.

Under the new rules, CMS could terminate either Part D or Medicare Advantage plans that fail for three years to earn at least a three-star rating under the agency's five-star rating system. The provision is part of a regulatory proposal for 2013 that also would implement parts of the Affordable Care Act (ACA), including a codification of the 50 percent discount on brand-name drugs in the Part D coverage gap.

Aetna and CVS to offer co-branded Part D prescription drug plan

Aetna and CVS Caremark announced this week that they are teaming up to co-brand a new Medicare prescription drug plan.

The move follows the lead of other health insurers that have partnered with big drugstores such as Walgreen's (see Update for Week of August 8th). The Aetna/CVS Prescription Drug Plan will be available to Part D enrollees in 43 states and Washington, DC. It charges a $26 monthly plan premium, with no deductible for generic drugs and a $3 co-payment for preferred drugs.

HHS releases $885 million for AIDS Drugs Assistance Programs, waiting lists fall by 20 percent

The Department of Health and Human Services (HHS) released more than $1.89 billion in federal grants last week through the Ryan White HIV/AIDS Program. Roughly $1.21 billion of this amount will go directly to state states and territories under Part B of Ryan White, including the $885 million appropriated by Congress in fiscal year 2011 for the AIDS Drug Assistance Program (ADAP). Part B funds can be used for health insurance continuation programs that pay all or part of the premiums and cost-sharing to prevent ADAP clients from becoming uninsured and more costly.

From the ADAP appropriation, 30 Part B states and territories will receive $40 million in ADAP Emergency Relief Funding for the purpose of eliminating or reducing ADAP waiting lists and/or supporting cost containment strategies to prevent implementation of a waiting list. The number of ADAP clients on waiting lists nationwide has already declined by nearly 20 percent from August to October, according to the National Association of State and Territorial AIDS Directors (NASTAD). However, over 7,400 applicants still remain wait listed (see Florida article below).

At least 75 percent of Part A and B funds must be spent on "core medical services," which include outpatient HIV/AIDS primary care services, prescription drug assistance, and insurance continuation.

Kaiser study finds that Medicaid enrollees with HIV/AIDS are up to five times more costly

The Kaiser Family Foundation published a new report this week documenting that although Medicaid enrollees with HIV/AIDS represent a small fraction of the Medicaid population, they consume more Medicaid spending than other high-cost populations.

Kaiser's analysis of data reported by state Medicaid programs to the Department of Health and Human Services attributed the high cost of HIV/AIDS drugs as the primary reason for the cost discrepancy, as prescription drugs account for the largest share of Medicaid spending for HIV/AIDS.

Even though less than one percent of Medicaid enrollees have HIV/AIDS, Medicaid functions as the primary safety net for 47 percent of those with the illness. Spending for enrollees with HIV/AIDS represents only about two percent of all Medicaid spending, but prescription drugs constitute 31 percent of this amount. Overall, Medicaid enrollees with HIV/AIDS were up to five times more expensive per individual than other Medicaid enrollees.

According to the authors, the findings only underscore the critical importance of Medicaid as a safety net for the HIV/AIDS population, as well as the need to curb runaway prescription drug costs for HIV/AIDS that threaten the viability of state Medicaid and AIDS Drug Assistance Programs (ADAPs).

HEALTH CARE COSTS

Nearly half of Americans skimping on medical care despite lower medication costs

A Consumer Reports Index survey released this week confirmed that a record number of Americans are still forgoing needed medical care due to cost.

In its third annual survey, the Consumer Reports National Research Center found that the proportion of over 2,000 consumer respondents who skipped prescribed treatment for financial reasons climbed to 48 percent. The nine percent jump from last year was the highest increase ever recorded.

Consumers increasingly skipped treatment despite a decline in the average out-of-pocket expense for prescription medication from $68 in 2009 to $59 this year. Consumer Reports attributes lower costs to the fact that three-quarters of respondents opted for generic drugs. However, over 40 percent of respondents claimed that their physicians never or rarely recommended generic alternatives.

The findings are consistent with a survey last summer by Deloitte Center for Health Solutions, which found that at least a quarter of those surveyed are forgoing medical care, with nearly half blaming cost (an increase from 35 percent in 2009) (see Update for Week of June 20th).

United States ranks last in preventable deaths

The Commonwealth Fund released a study this week ranking the United States last among 16 high-income, industrialized nations when it comes to deaths that could have been prevented with timely access to effective health care. According to the analysis, other nations lowered their preventable death rates an average of 31 percent between 1997–98 and 2006–07, while the American rate declined by only 20 percent, from 120 to 96 per 100,000. At the end of the decade, the preventable mortality rate in the United States was almost twice that in France, which had the lowest rate of 55 per 100,000.

STATES

<u>Arizona</u>

CMS extends existing Medicaid waiver while deciding whether to allow steep cuts, copayments

The federal demonstration waiver for Arizona's largely managed care version of Medicaid expired on September 30th. However, federal regulators granted Arizona a two-week extension this week while they decide whether to approve the new waiver requested last March by Governor Jan Brewer (R).

The Governor has sought to replace the Arizona Health Care Cost Containment System (AHCCCS) with a greatly scaled-back version of Medicaid. She insists that Arizona can no longer be one of the few states to cover all optional categories of low-income residents and must eliminate up to $500 million in Medicaid spending in order to fill its mammoth budget deficit for the next fiscal year.

The U.S. Department of Health and Human Services already gave Governor Brewer the green light to terminate eligibility for all 250,000 childless adults that were covered under the AHCCCS waiver (see Update for Week of February 7th). However, the Governor later elected to drop only 120,000 while freezing childless adult enrollment and imposing higher copayments for the remainder (see Update for Week of March 14th).

The Arizona Supreme Court is currently considering whether to review a lower court decision allowing Governor Brewer to impose the cuts for childless adults, despite a successful ballot referendum in 2000 that expanded coverage to childless adults (see Update for Week of August 1st).

CMS must now decide whether to let Arizona freeze enrollment of parents whose incomes are between 75 and 100 percent of the federal poverty limit, raise Medicaid copayments for all parents, and eliminate emergency services to non-citizens who do not qualify for Medicaid. The Governor also wants to require eligibility to be reviewed every six months, cut reimbursement rates for hospitals, set new benefit limits, and impose "no show" penalties for missed doctor appointments.

The Governor ignited controversy by including the mandatory Medicaid copayments as part of her waiver request. CMS approval of mandatory Medicaid copayments of up $30 imposed by Arizona in 2003 for childless adults was recently vacated by the Ninth Circuit U.S. Court of Appeals (see Update for Week of August 22nd).

Delaware

Governor signs one-year moratorium on specialty tier coinsurance for prescription drugs

Governor Jack Markell (D) signed S.B. 137 into law on September 14th, which enacts a one-year ban prohibiting health insurers from charging subscribers a percentage of the costs for prescription drugs. The temporary moratorium is intended to give lawmakers time to study whether to enact a permanent ban on the use of specialty tiers, where plans require subscribers to pay 25-30 percent or more of the price for the highest cost drugs.

New York remains the only state to enact such a ban (see Update for Week of September 27, 2010). However, at least 14 other states considered similar legislation last session (Missouri and West Virginia were the only states were they cleared at least one legislative chamber).

Florida

No more budget shortfall in Florida's ADAP, for now

The director for the Florida AIDS Drug Assistance Program (ADAP) informed the Health and Human Services Appropriations Committee this week that the program will be in the black for fiscal year 2012, thanks to last year's $14.5 million bailout by the pharmaceutical industry.

The Florida ADAP ran out of money for the last two months of ADAP fiscal year 2011 and avoided dropping 6,500 clients only after five drugmakers donated free products that were distributed by the non-profit Welvista (see Update for Week of January 31st). Welvista wound up providing medication to 60 percent of the state's ADAP clients, or 5,403 prescriptions that cost nearly $24 million.

Committee chair Senator Joe Negron (R) used Welvista as an example of how he believes charitable contributions can effectively plug the gaps in safety net programs without the need for government intervention.

Recent federal emergency relief may have somewhat mitigated the explosion of clients on ADAP waiting lists. The latest figures by the National Association of State and Territorial AIDS Directors (NASTAD) show a nearly 20 percent drop in applicants on ADAP waiting lists nationwide over the last two months (see article above). Florida's waiting list dropped from 3,917 to 3,692 individuals. However, that figure continues to represent over half of all waiting list cases nationwide.

Maine

Premiums soar after health insurance regulations were scaled back

The campaign by Governor Paul LePage (R) to remove the state's consumer protections against health insurance discrimination has initially resulted in dramatically higher premiums for Mainers.

The Republican-controlled Legislature "fast tracked" legislation last spring that eliminated the state-subsidized health plan for the uninsured and small business workers, greatly scaled back community rating laws limiting how much premiums could vary for age and health status, weakened the state's rate review authority, and allowed the sale of limited-benefit plans from other states that did not comply with Maine's coverage mandates. The "industry friendly" bill passed without the input of Maine's "consumer friendly" Insurance Commissioner, who resigned in protest (see Update for Week of May 16th).

The Governor had claimed that the removal of "burdensome" regulations would lower insurance costs for Mainers. However, after the new law (L.D. 1333) took effect last month, premiums for policies effective October 1st have instead jumped dramatically.

Most of the premium increases are attributable to removing the limitations on age rating. Maine traditionally prohibited health plans from charging older subscribers more than 150 percent more than younger subscribers. However, the new law allows insurers to charge up to 500 percent higher premiums based on age, far above the 300 percent limit set by federal law in the Affordable Care Act (ACA).

Because Maine has the nation's oldest population, rates have soared by as much as 90 percent according to Bureau of Insurance rate filings.

New York

Governor's Medicaid reforms already saved $600 million

The first phase of the Governor's Medicaid overhaul has achieved almost $600 million in savings in its first six months, according to a progress report released this week by the Department of Health.

The Medicaid Redesign Committee assembled by Governor Andrew Cuomo (D) reviewed the development of the new Medicaid Visual Data Mining system, which allows state officials to track spending in a more targeted and quick-response fashion. It was one of 78 cost-cutting measures the Governor successfully pushed through last session (see Update for Week of February 21st). At least 20 of those changes have already received federal approval while 32 remain pending.

New York Medicaid added another 72,000 enrollees in August and now covers nearly five million people or a quarter of the state population. However, more than two-thirds of these enrollees have now been transitioned to managed care plans that are less costly than traditional fee-for-service.

The initial recommendations are expected to save $2.2 billion by the end of this fiscal year. The Committee will incorporate the second round of recommendations into next year's budget before disbanding in April. The Governor's overhaul set a Medicaid spending cap of $15.3 billion for this fiscal year and $15.9 billion in 2012-2013.

Wisconsin

Governor uses new authority to hike Medicaid premiums, shift enrollees to limited benefit plans

Governor Scott Walker (R) released his plan this week to help fill a $554 million gap in the Medicaid budget by sharply raising Medicaid premiums and shifting at least 215,000 enrollees to lower-cost state plans or private coverage.

Under the Governor's proposal, Wisconsin would impose premiums up to five percent of household income for Medicaid enrollees earning more than 150 percent of the federal poverty level (FPL), in order to bring premiums "more in line with private insurance" or more than 11 times what some

enrollees currently pay. For example, monthly Medicaid premiums would jump from $10 to $116 for a single mother with two children earning just under $28,000 per year.

Governor Walker insisted that the severe measures were needed as deficit estimates jumped by $110 million through June 2013. He emphasized that none of the changes will affect Medicaid enrollees with incomes at or below FPL, which is currently $22,350 for a family of four.

Department of Health Services (DHS) Secretary Dennis Smith said that the state would also try to avoid dropping Medicaid enrollees who have no other options for health insurance. Instead, officials will look at shifting more those individuals into lower-cost "benchmark" coverage with fewer benefits.

However, Smith warned that if the Centers for Medicare and Medicaid Services (CMS) does not provide the needed federal approval, the state would have no alternative by to eliminate coverage for at least 53.000 adults who earn above the 133 percent of FPL minimum eligibility level mandated by the ACA. A former CMS Administrator, Smith has joined with his counterparts in other states to aggressively push for waivers of the Affordable Care Act (ACA) provision prohibiting states from cutting Medicaid eligibility through 2014.

The Governor's controversial budget repair bill that was upheld last summer by the Wisconsin Supreme Court gives his Administration unprecedented and nearly unilateral authority to cut Medicaid benefits and payment without approval from state lawmakers (see Update for Week of June 20th). The ranking Democrat on the Assembly Health Committee warned that such "devastating" cuts were a predictable outcome of such broad authority. While the Joint Finance Committee can hold public hearings and ensure the Governor's changes comply with state statutes, it appears they can do little else to block his plan which no longer requires traditional rulemaking.

The Republican co-chairs of the Finance Committee, Senators Alberta Darling and Robin Vos, both praised the Governor's proposal. Darling narrowly survived a recall election last summer that would have tilted the balance of power in the Senate to Democrats. Governor Walker faces a similar recall election generated by anger over the budget repair bill that also stripped state employees of their right to collectively bargain for health benefits (see Update for Week of August 15th).

The Governor has pledged to dramatically scale back the nation's most generous Medicaid program. He notes that over the past two decades, Medicaid enrollment has increased to nearly one in five Wisconsin residents at nearly ten times the rate of state population growth. Under his plan, Medicaid enrollment would remain steady for at least the next two years.

Democratic lawmakers seek to implement consumer protections under ACA

Senator Jon Erpenbach (D) introduced S.B. 206 last week that would conform Wisconsin law to the new consumer health insurance protections of the Affordable Care Act (ACA). The bill specifically would implement the ACA's prohibition on pre-existing condition denials and rescissions, remove lifetime caps and impose restrictions on annual limits, and eliminate cost-sharing for certain preventive services.

Despite the strong support of AARP and other consumer groups, the bill may have trouble passing as Republicans hold a one-seat majority in the Senate and control the House and governorship.