

Health Reform Update – Week of October 31, 2011

CONGRESS

Former debt panels endorse Republican models to voucherize Medicare, block grant Medicaid

The architects of two failed bipartisan deficit-reduction plans last winter made their pitch to the Joint Deficit Reduction Committee this week.

The public hearing featured former Sen. Alan Simpson (R-WY) and former White House Chief of Staff Erskine Bowles, as well as Alice Rivlin, founding director of the Congressional Budget Office, and former Senate Budget Chair Pete Domenici (R-NM). The Simpson-Bowles and Rivlin Domenici panels failed last winter to pass any of their recommendations for deficit reduction (see Update for Week of December 6th). However, major elements of their previous efforts were included in their respective plans to cut the deficit by far more than the “super committee” mandate of \$1.2 trillion over ten years.

Simpson and Bowles proposed to cut the deficit by \$2.6 trillion over a decade, with \$600 billion in cuts to Medicare and Medicaid and \$800 billion in new revenue (far less than the \$2 trillion they proposed last winter). The Simpson-Bowles plan clearly sought to “split the difference” between Republican and Democratic positions. It supports Republican plans to raise the Medicare eligibility age and replace Medicaid’s current open-ended system with fixed Medicaid block grants. However it also would allow Medicare to negotiate for Part D drug prices, one of the Democrats’ top goals.

Meanwhile, Rivlin and Domenici proposed a \$4 trillion package, a figure supported by at least 100 Congressional members from both parties. However, it includes a new “premium support” model for Medicare that would allow seniors to get services through private plan vouchers or remain in the existing program. All four witnesses agreed that cost-sharing should be increased for higher-income enrollees.

Similar plans to voucherize Medicare and block grant Medicaid were vehemently opposed by Democrats after being passed by House Republicans last spring (see Update for Week of April 4th). The modified models proposed by the witnesses were similarly denounced by Democrats on the “super committee” including Senate Finance Committee chair Max Baucus (D-MT), who insisted it would lead traditional Medicare into a “death spiral” as it would be left with mostly sicker and more costly enrollees.

Rivlin predicted “devastating” consequences if members did not move off of entrenched positions that have led to an impasse in negotiations (see Update for Week of October 24th). The panel only has until November 23rd to pass their recommendations or allow automatic across-the-board spending cuts to be triggered. However, the second highest-ranking House Democrat, Steny Hoyer (D-MD), suggested this week that Congress could simply extend that deadline if the panel were still deadlocked.

House Speaker John Boehner (R) hinted this week that Republicans may be willing to slightly increase revenues by closing certain tax loopholes, but only as part of “significant” entitlement reforms that include higher beneficiary cost-sharing. A bipartisan group of 40 House Republicans and 60 House Democrats urged the panel to consider all spending and revenue options needed to reach a compromise.

Bipartisan delegation urges “super committee” not to tax employer health coverage

Removing the tax deduction for employer-sponsored benefits is a proposed deficit reduction measure that is very popular with health economists who have long-insisted that it distorts employee health care purchasing decisions. Since taxing employer health coverage would raise over \$1 trillion, it

was also seriously considered by the Senate Finance Committee for inclusion in the Affordable Care Act (ACA), but ultimately rejected as politically unfeasible.

However, both the Simpson-Bowles and Domenici-Rivlin deficit reduction packages presented this week to the “super committee” (see article above) seek to initially cap and eventually phase-out the tax exemption. The proposal was immediately opposed by at least 160 Republican and Democratic lawmakers, insisting that it would simply inflate overall healthcare costs as more employers would drop coverage and force employees to purchase coverage in the new health insurance exchanges. The members also claim that such a huge tax hike for over 160 million workers would only impede the economic recovery and further increase the deficit.

CBO says that new discretionary spending caps will not fully-fund existing programs

Spending caps mandated by the Debt Control Act of 2011 will constrain discretionary spending in future years and not allow some programs to continue at current levels. That was the warning from the Director of the Congressional Budget Office (CBO) during his latest presentation to the Joint Deficit Reduction Committee last week.

The caps were part of the debt ceiling compromise last summer that created the new “super committee” (see Update for Week of August 1st). They are designed to hold increases in non-emergency defense and domestic spending below the rate of inflation for the next decade. CBO projects that the caps will cause discretionary spending to decline to 5.5 percent in 2021 from seven percent of gross domestic product in fiscal 2012. The federal budget deficit will also decline by \$778 billion over the next decade, not including savings from lower interest rates,

However, he cautioned “super committee” members that the caps may also frustrate their efforts to agree on recommendations that meet their statutory mandate of \$1.2 trillion deficit reduction over the next ten years. Even if spending were to grow at the rate of inflation, he emphasized that there would still be insufficient federal funds to pay for some government programs such as defense, veterans’ health care, and federal education loans.

Panel members face the prospect of even bigger cuts if the automatic across-the-board cuts under the new law are triggered by a failure of the “super committee” or Congress to meet the \$1.2 trillion target. CBO projects that 71 percent of the savings from automatic cuts would come from further reducing the caps on discretionary spending, 13 percent would come from a reduction in selected mandatory spending, and 16 percent would result from lower debt-service costs arising from those cuts.

FDA funding increased in Senate spending bill, but slashed in House version

Senate passage this week on one of at least two fiscal 2012 “minibus” appropriations packages has set-up the first conference committee on a spending measure in two years.

The conference on that measure (H.R. 2112) is expected to conclude next week. It combines Senate versions of agriculture and transportation spending bills (S. 1572 and 1596) to provide a total of about \$128 billion in discretionary spending for the fiscal year that began October 1st.

The measure also includes a \$50 million increase for the Food and Drug Administration (FDA), funding that is critical as they assume new duties of implementing the food safety law signed by President Obama last January, creating a regulatory pathway for lower-cost biosimilar drugs authorized by the Affordable Care Act, and developing and maintaining emergency responses to bioterrorism threats. This is a dramatic departure from the \$285 million cut in FDA funding include in the House-passed version.

The measure is likely to ultimately include another temporary spending resolution to keep the federal government operating past the November 18th expiration of the current stopgap measure.

FEDERAL AGENCIES

Presidential executive order responds to shortages and price-gouging for life-saving drugs

As part of his recent initiatives to implement stalled Congressional legislation, President Obama issued an executive order today that seeks to resolve severe shortages in life-saving medications by pressuring drugmakers to report supply problems more quickly and thoroughly.

Drug shortages have tripled over the past five years, according to the American Society of Health-System Pharmacists. Vital drug therapies for leukemia and other types of cancer, as well as many types of infectious disorders are among the more than 180 medications unavailable this year, forcing patients to rely on less effective drugs and delaying at least 300 clinical trials funded by the National Cancer Institute, including over 2,500 patients waiting for Johnson and Johnson's Doxil drug.

An investigation by Premier found that price-gouging by resellers was greatly compounding the crisis, as they often hoarded the most highly-demanded drugs and attempted to sell them for an average of 650 percent more than the manufacturer's price (see Update for Week of August 15th).

Democrats in both the House and Senate have held hearings over the past year to focus attention on this emerging "gray market". The Food and Drug Administration (FDA) and Government Accountability Office (GAO) also continue to investigate how price-gouging and structural problems within the marketplace are exacerbating the supply problems (see Update for Week of October 3rd).

Drug resellers have been fighting demands by Rep. Elijah Cummings (D-MD) earlier this month that they start disclosing any profits made from steep mark-ups on drugs in short supply. Rep. Cummings announced this week that he was expanding his investigation after at least one reseller has refused to return calls or provide any of the requested documentation.

Senator Amy Klobuchar (D-MN) introduced legislation last winter (S.296) that would require drugmakers to notify the FDA of possible drug shortages that result from discontinuances or other problems in manufacturing. Her bill also would require the FDA to speed reviews of applications to begin or alter production of drugs in short supply, as well as provide more information to the Department of Justice about possible cases of collusion or price-gouging by resellers.

The President's executive order attempts to adopt these provisions of S. 296, which remains stalled in the Senate with only one Republican cosponsor (although the Administration that legislation is still required to make most of them mandatory). It is the first executive order in over 25 years to directly affect the FDA, an agency that regulates 25 cents of every dollar that consumers spend.

The President is also seeking to add personnel to the FDA's shortage team and notify manufacturers of their duty to report supply disruptions, while encouraging them to report events that may lead to disruptions (even when not required to do so). However, the President has thus far elected not to pursue more ambitious proposals, like requiring government agencies or manufacturers to stockpile certain short-supply drugs (as they already do for drugs needed to respond to bioterrorism threats).

Ongoing shortages have also increased calls among the industry to bolster the "scant" regulation that allows such a "gray market" to thrive. Generic drugmakers recently agreed to provide the FDA with nearly \$300 million annually to bolster inspections and speed drug applications. That amounts to about one percent of the industry's revenue and about five percent of its United States profits.

Drug regulators tout banner year for new approvals ahead of Hill fight on user fees

The Food and Drug Administration is touting a banner year for drug approvals as Congress prepares to renew industry user fees that fund the approvals.

A new FDA report released this week showed that the agency approved 35 new drugs in the fiscal year that ended September 30th, the second highest number in a decade trailing only the 37 approvals in 2009. These approvals included the first new lupus drug in 50 years and major advances in treating hepatitis C and late-stage prostate cancer. The report concludes that 24 of the 35 drugs were approved first approved in the U.S., allowing it remain the world leader in new medicines.

The report coincided with debate over renewing industry user fees that expires next September. The authors specifically concluded that the U.S. has been able to approve drugs more quickly than other countries while still ensuring safety, thanks largely to the "expedited approval authorities, flexibility in clinical trial requirements and resources collected under the Prescription Drug User Fee Act."

FDA officials have reached agreement with the two main drug lobbies - Pharmaceutical Research and Manufacturers of America (PhRMA) and the Biotechnology Industry Organization (BIO) - on a deal that would trade a \$100 million increase in fees over five years in exchange for a more predictable drug approval process. A final agreement must be approved by Congress.

GAO refutes "favoritism" in early retiree reinsurance program

Senator Mike Enzi (R-WY) slammed the Department of Health and Human Services (HHS) this week for alleged "favoritism" in distributing funds under the Early Retiree Reinsurance Program (ERRP), even after government auditors found nothing untoward about the process.

The Affordable Care Act (ACA) allocated \$5 billion to help cover retirees who are older than 55 but not yet eligible for Medicare, at least until the full reforms are implemented in 2014. HHS has spent about \$2.9 billion of the total funding but projects that the full allocation will run dry next year.

Enzi insisted that HHS was distributing the funds solely to Democratic constituencies such as labor unions. A Government Accountability Office (GAO) report released this week did acknowledge that unions received a large share of ERRP funds, as did state and local governments. However, GAO specifically concluded that the distribution of funds by HHS is "consistent with the provision of retiree health benefits in the marketplace," noting that government agencies offer coverage to retirees more often than private firms. Auditors also found that HHS accepted "nearly all" of the requests it received for the retiree program.

Small businesses had urged HHS to set up a review process that would prevent government offices and unions from dominating the ERRP. However, GAO emphasized that the grants were awarded on a first-come, first-served basis.

GAO also confirmed that the \$5 billion allocation will run out in 2012. As a result, it concluded that HHS appropriately cut off applications last spring (see Update for Week of March 28th).

This is the second time that GAO has refuted Republican claims of "political cronyism" in the Obama Administration's distribution of ACA funds. Republicans had insisted that the Administration was issuing waivers of the new annual limit restrictions largely to political allies. However, GAO specifically found that the Administration acted in a "fair and unbiased" manner, noting that 90 percent of all applications were approved (see Update for Week of June 13th).

Public comments urge CMS to delay start of new health insurance exchanges

State officials and health insurers are urging the Centers for Medicare and Medicaid Services (CMS) to plan for delays in launching key functions of the health insurance exchanges required by the Affordable Care Act (ACA).

Public comments on proposed exchange regulations that were due October 31st reflect deep concerns that short time frames and limited vendor capacity to create the online marketplaces will prevent states from being ready by 2014. The National Association of Medicaid Directors recommended that

CMS “begin working with states to develop transitional, phase-in, and contingency plans.” America’s Health Insurance Plans also pleaded with the agency to re-evaluate the implementation time frame...in consultation with the states and the health plan community.”

The insurer trade group added that CMS should ensure that quality improvement strategies adopted by exchanges are consistent from state to state, that exchanges should not exclude health plans based on their premium charges, and that exchanges developed for small businesses should not be expanded eventually to include the large group market.

The Federation of American Hospitals insisted that hospitals should remain a “natural point of access [and]...portal of [exchange] enrollment...for all insurance affordability programs.”

Medicare fee reschedule includes long-delayed steep cut in physician payments

The Centers for Medicare and Medicaid Services (CMS) released their final regulations this week that implement the Medicare fee schedule for 2012. It includes a 27.4 percent cut in physician payments.

Since 2002, Congress annually has passed short-term bills to block scheduled physician payment cuts resulting from the sustainable growth rate formula enacted by the Balanced Budget Act of 1997. The most recent of these “doc fix” bills averted a 29.4 percent cut and is set to expire January 1st.

The Secretary for the Department of Health and Human Services insisted that President Obama is committed to fixing the flawed formula. It remains unclear whether the newly-created deficit “super committee” will include such a fix in their recommendations on \$1.2 trillion in deficit reduction (see above).

Fight over prescription drug discount coupons flares up as patents expire

A new report released this week by the Pharmaceutical Care Management Association (PCMA) claims that brand-name drug manufacturers are flooding the market with copayment coupons in an effort to combat the wave of patent expirations.

The association for pharmaceutical benefit managers estimates that these discount coupons will inflate healthcare costs by \$32 billion over the next decade if current trends continue. It argues that the coupons further remove consumers from the true cost of their healthcare choices by sticking health plan sponsors with an ever larger portion of drug coverage costs.

The industry and some patient advocates claim that the coupons simply help patients afford life-saving medications. However, PCMA insists that they really are a “marketing ploy” meant to hook patients on expensive brand-name drugs instead of low-cost generic alternatives that are coming onto the market.

The report found that coupon programs have increased by more than 260 percent in the past two years as more drugs begin to face generic competition. It estimates that brand-name manufacturers spend \$4 billion annually on copay coupon programs.

The report claims that these coupons dramatically increase employer costs, which rise whenever employees covered under their employer’s health plan choose expensive brands over more affordable options. According to PCMA, “each time a drug company can sell a \$150 product by helping cover a \$50 copay, it gains \$100 in revenue, which is paid by the employer that offers coverage.”

The Pharmaceutical Research and Manufacturers of America countered by pointing out that high cost-sharing is a leading reason why patients are unable to access coverage and adhere to medications. They argue that copay coupons help patients stay on medications and reduce overall healthcare costs.

However, PCMA estimates that halting enforcement of Medicare Part D’s ban on the coupons would cost \$18 billion over ten years. It also predicts that allowing copay coupons in Massachusetts - the only state to ban the practice - would increase prescription drug costs for employers and other plan

sponsors by \$750 million over the same period. (The Massachusetts House voted this year to lift the ban, but a Senate version requiring drugmakers to offer the coupons indefinitely derailed final passage.)

STATES

Alabama

Exchange commission says implementation will cost state \$50 million per year

The Alabama Health Insurance Exchange Study Commission voted this week to recommend that the annual \$50 million cost to operate the exchange should be borne entirely by consumer premiums, instead of an assessment on health plans participating in the exchange.

The \$50 million price tag was presented by consultants hired by the commission, who estimated that between 206,000 and 460,000 Alabamans would purchase coverage in the exchange starting in 2014. Similar commissions in Illinois (see below) and Ohio (see Update for Week of October 10th) have made analogous cost estimates, though Democrats in both states insist the figures are over-inflated.

Governor Robert Bentley (R) is one of several Republican Governors to have used an executive order to proceed with exchange implementation despite a lack of legislative authorization (see Update for Week of September 19th). The commission must submit a final report to the Governor by December 1st.

Medicaid further limits coverage for brand-name prescriptions

Effective November 1st, the Alabama Medicaid agency reduced from five to four the number of brand-name prescriptions that will be covered per month. Those with HIV/AIDS will continue to be able to fill up to ten brand-name drug prescriptions per month because so many of their prescribed drugs lack a generic competitor. There also remains no limit for generic prescriptions.

Because Medicaid in Alabama is so lean, state officials have few other cost-saving options besides eliminating optional benefits like prescription drugs or further limiting coverage. Medicaid eligibility for adults in Alabama is also at the lowest level allowed by the federal government, or only 11 percent of the federal poverty level (\$2,425 in annual income for a family of four).

Georgia

Exchange committee approves some recommendations as deadline nears

The exchange advisory committee created by Governor Nathan Deal (R) recommended this week that Georgia create the exchange as a quasi-governmental structure similar to the Georgia Lottery Corporation. Members also agreed that the state should create separate exchanges for individuals and for businesses with 50 employees or fewer, with both governed by the single authority.

However, the committee remains at odds over whether insurers should serve on the exchange oversight board, a potential conflict-of-interest that has engendered controversy in the roughly seven states that already allow it. Consumer groups opposed the industry representation that is supported by Insurance Commissioner Ralph Hudgens (R), who insisted that such a ban would be "ignorance".

Despite his fervent opposition to other provisions of the ACA, the Governor supports the creation of an exchange and created the advisory panel after authorizing panel failed last session (See Update for Week of June 6th). Their final report to the Governor is due December 15th.

Illinois

Committee chair introduces exchange-authorizing legislation

Illinois lawmakers are moving forward with legislation to create the health insurance exchange required by the Affordable Care Act (ACA), despite concerns about its costs.

Rep. Frank Mautino (D) introduced legislation this week that would create an exchange modeled after the state high-risk pool. Similar authorizing legislation failed last session, resulting in passage of a more limited measure that created a legislative committee headed by Rep. Mautino to recommend how to design and implement an exchange (see Update for Week of July 11th).

Because of the January 2013 deadline to make significant progress or risk a federal takeover of the exchange, Mautino wants lawmakers to vote on his measure during the veto session, instead of waiting until next spring. He noted that Illinois is well-behind many other states that already have a governing board in place, as well as a funding mechanism.

Republican and Democratic lawmakers immediately debated the price tag for the new exchange. Republicans cited a study last month by the Wakely Group estimating that an Illinois exchange would cost \$57-\$89 million in annual operating costs. Democrats scoffed at the inflated price tag, noting that Mautino's legislation would be largely self-sustaining as it imposes an assessment or dedicated user fee on health insurers that would raise \$55-75 million per year to pay for exchange operations.

Illinois has also applied for and received federal grants and has \$94 million in state and federal funds already earmarked to create the information technology need to operate the exchange. The Department of Health Care and Family Services noted that upgrading state technology will be no easy task as the agency's computers date back to the 1970s.

Maine

Landmark rate review case worries insurance commissioners nationwide

The Maine Supreme Court has scheduled oral arguments next week for a lawsuit brought by one of the nation's largest health plans challenging the former Insurance Commissioner's rejection of their proposed rate hikes.

The case by Anthem Blue Cross and Blue Shield (a division of WellPoint) has drawn the concern of insurance commissioners nationwide, as an adverse ruling could greatly limit their ability to hold down unreasonable premium increases.

The District of Columbia and 26 other states (including Maryland and Virginia) have the authority to block or modify individual or small business rate hikes that they deem excessive. (Seven other states, including California, have the power to review rate increases in advance but not to block them.)

However, former Insurance Superintendent Mila Kofman drew national praise in 2009 for reducing Anthem's built-in profit margin of three percent down to zero, and then allowing the insurer only a 0.5 percent profit margin in 2010 and one percent in 2011. She also reduced Anthem's proposed average increase for individual plans from 18 to 11 percent. Anthem challenged the commissioner's action, arguing that it violated state law and the U.S. Constitution to deprive them "a fair and reasonable return." However, the Maine Supreme Court sided with Kofman on Anthem's initial challenges.

The National Association of Insurance Commissioners has filed a brief with Maine's top court, worried that a decision in Anthem's favor would "destabilize a key aspect of insurance regulation and will have far reaching effects impacting all states." Anthem executives concur that the court's ruling will have a "big impact on the industry" across the nation.

Conservative groups have sided with Anthem, insisting that private companies have the right to earn a profit. However, Maine regulators and their attorney general continue to insist that health plans do not have a right to earn a profit on every single line of business, especially when they are profiting

handsomely in other markets. Anthem's own rate filing showed that they had earned more than \$15 million in pre-tax profits from Maine policyholders during the past 12 years and had company-wide financial reserves of \$229 million.

Kofman had the full support of former Governor John Baldacci (D) in 2009. However, she immediately resigned earlier this year after new Governor Paul LePage (R) removed many of the state's landmark consumer protections and limited her authority to reject unreasonable rate hikes (see Update for Week of May 16th). New rate filings have shown that removing these consumer protections has cause premiums to increase by as much as 90 percent (see Update for Week of October 3rd).

Consumers criticize Governor's demand to house exchange board within state government

Despite his campaign to remove many of the state's landmark consumer protections, Governor Paul LePage (R) has decided to move forward on creating the health insurance exchange required by the Affordable Care Act (ACA). However, consumer advocates at a public hearing this week criticized the Governor's plan to place the exchange oversight board within a state agency, fearing that it will allow board decisions to be dictated by administration politics.

Members of the Legislature's Insurance and Financial Services heard from advocates who largely approved most of the plan crafted by the special nine-member panel advisory panel appointed by the Governor. However, they were adamant that exchange governance be created as an independent agency instead of within the Department of Professional and Financial Regulation (DPFR). Only one state (West Virginia) has housed their exchange oversight board within a state agency.

Rep. Sharon Treat (D), an advisory committee member, acknowledged that the panel wanted the board to be an independent agency in order to make the process as transparent as possible, but that they ultimately acceded to the Governor's demands that it be housed within DPFR. The Governor's decision was supported by the Maine Association of Health Underwriters and other insurance industry lobbyists.

Consumer advocates and Maine Democrats had previously been very critical of the Governor's board appointments, which failed to include any consumer representation (see Update for Week of August 8th). Members of the advisory committee will meet again in December before sending final exchange recommendations to the full Legislature in January.

Maryland

Exchange board issue RFPs to create eligibility and enrollment system

The Maryland Health Benefit Exchange issued Request for Proposals last week to support an eligibility and enrollment system to help Marylanders obtain health coverage under the Affordable Care Act (ACA). The new system will help individuals enroll in Medicaid and the new Health Insurance Exchange, calculate subsidies, and allow Marylanders to choose qualified health plans.

Maryland was the third state to pass exchange-authorizing legislation earlier this year (see Update for Week of April 11th).

Minnesota

Executive order creates task force to design and develop new health insurance exchange

Governor Mark Dayton (D) issued an executive order Monday that establishes a new state task force to begin implementing the health insurance exchange required by the Affordable Care Act (ACA).

The order requires the Commerce Department and the 17-member Minnesota Health Care Reform Task Force to design and develop the exchange that the Republican-controlled legislature refused to authorize last session. Some Republican lawmakers have even threatened to sue to block the

Governor's reversal of his predecessor's executive order barring acceptance of federal funds to create the exchange (see Update for Week of August 15th).

Commerce Commissioner Mike Rothman acknowledged that authorizing legislation would ultimately be required, but noted that the order would enable the state to meet the January 2013 deadline to avoid a federal takeover of the exchange.

Governor Dayton appointed representatives from the administration, business, labor, nonprofit groups and healthcare organizations. Republican lawmakers are only allowed to appoint up to four seats, much to the consternation of Rep. Steve Gottwalt (R), chair of the House Health and Human Services Reform Committee, who insisted that greater legislative input was needed to "legitimize whatever executive actions he wants to take."

Dayton is the first Democratic governor to rely on an executive order to circumvent legislative roadblocks. Republican Governors in at least Alabama, Georgia, Idaho, Indiana, and Mississippi have already done so, as has independent Governor Lincoln Chafee in Rhode Island (see Update for Week of September 19th). The Democratic Governor of Arkansas has refused to do so, insisting that Republican lawmakers instead must "live with" their decision to allow a federal takeover of the exchange (see Update for Week of September 19th).

New York

Largest health insurers drop fight against disclosing justification for rate hikes

Seven more large insurers have followed the lead of UnitedHealth last week and dropped earlier objections to the public disclosure requirements of the Affordable Care Act (ACA) being implemented by the Financial Services Department.

The insurers, who represent 90 percent of the individual and small group market, initially balked at disclosing the actuarial justification for proposed double-digit rate hikes filed with the state on or after September 1st, claiming that such data was protected by state law exempting disclosure of trade secrets (see Update for Week of October 10th). However, two smaller carriers still have not withdrawn the formal objections they filed last month.

The Department granted the insurers one concession in an effort to facilitate a compromise. As a result, the health plans will not have to disclose details of contracts with hospitals or other health care providers. Insurers argue that other providers could use that information to demand higher payments.

Consumer advocacy groups like Health Care for All New York praised the agreement, noting that consumers in Maine had to go to court to get the same information that health plans in New York are now agreeing to disclose.

Vermont

Costs of moving to single payer are still below costs of staying with private insurance system

State officials issued a new report this week estimating that the forthcoming single-payer health will cost between \$8.2 billion and \$9.5 billion a year by 2020, or up to \$14,000 per resident. However, retaining the current private insurance system would cost residents more than \$10 billion by 2020.

The landmark law (H.202) signed by Governor Peter Shulmin (D) puts Vermont on the path to a single-payer system that abolishes all private insurance by 2015 (see Update for Week of May 23rd). However, lawmakers still must figure out how to pay for the overhaul. Residents can offer suggestions during forums in November and December, although a final decision will not be made until 2013.

With or without the changes, health care spending in Vermont is expected to double over the next decade after already doubling between 2000 and 2009. Vermont's population is aging faster than other states, causing health care spending to already approach nearly 20 percent of all state expenditures.

Supporters of a single-payer model insist that less paperwork and administration will lead to broad cost-savings across the system. Eliminating private insurers will save up to \$149 million per year by 2019, while having to submit claims to only one entity will save up to \$90 million during the same time.

Washington

Governor works with non-profit charities to “pick up the slack” from severe health care cuts

Governor Christine Gregoire (D) proposed last week to cut at least \$664 million from state health care programs in order to help balance the state's \$2 billion budget deficit. The severe cuts would, reduce benefits in Apple Health for Kids, suspend adult Medicare pharmacy benefits, eliminate the Disability Lifeline medical program and the state-subsidized Basic Health Plan, and establish a drug formulary for Medicaid.

The Governor acknowledged that her cuts would force many low-income Washingtonians to seek uncompensated care in emergency rooms, but insisted that the state simply lacked the resources to meet the health care needs of its most vulnerable citizens. She pledged to immediately begin working with religious and charitable organizations to “pick up the slack”.

The cuts come on top of new service limits as of October 1st. The Washington State Medical Association is urging the federal government not to allow the new limit on three non-emergent emergency room visits per year. The Washington chapter of the American College of Emergency Physicians filed suit to block the limits, arguing that HCA the list of 700 non-emergent diagnoses were created without any input from hospitals and physicians (see Update for Week of September 26th).

Governor Gregoire imposed similar across-the-board emergency reductions in the face of bipartisan opposition last fall, which cut \$113 million from health programs while eliminating Medicaid outpatient payments and Part D assistance for dual-eligibles, while reducing funding for the AIDS Drug Assistance Program and lowering SCHIP eligibility. Those cuts came on top of a \$169 million reduction earlier in 2010, which had been referred to as the worst Medicaid cuts in two decades (see Update for Week of September 27, 2010).

Wisconsin

Exchange authorizing bill would prohibit insurers from serving on oversight board

Senator Kathleen Vinehout (D) introduced S.B. 273 this week, which would create the Badger Health Benefit Authority as an independent agency in charge of creating the health insurance exchange required by the Affordable Care Act (ACA). The measure specifically does not allow insurers to serve on the oversight board, in an effort to avoid a major source of controversy in at least seven other states.

It is not clear whether the measure has enough support to pass the Senate, where Republicans hold a one-seat majority, much less the House where Republicans hold a more significant majority. Despite his strident opposition to the ACA, Governor Scott Walker (R) has pledged to use the federal exchange grant obtained by his predecessor to create an exchange, albeit one that does not include the full consumer protections required by the ACA (see Update for Week of August 15th).