Health Reform Update – Weeks of February 27, 2012

CONGRESS

Full House and Senate to vote on repealing Medicare cost-cutting panel

The House Energy and Commerce health subcommittee voted 17-5 this week to back a measure that would repeal the 15-person Independent Payment Advisory Board (IPAB) created by the Affordable Care Act (ACA).

Sponsored by Rep. Phil Roe (R-TN), H.R. 452 ultimately attracted the support of 17 Democratic cosponsors that fear ceding control over politically-contentious Medicare spending cuts to an independent panel of "unelected bureaucrats". Ranking subcommittee member Frank Pallone (D) also reversed course to vote in favor of repeal, after initially holding out despite his broad criticism of the IPAB (see Update for Week of February 20th).

The full Energy and Commerce committee and Ways and Means subcommittee on health promptly announced that it will hold March 5-6 hearings about the bill. The Chief Actuary for the Centers for Medicare and Medicaid Services (CMS) provide them with additional ammunition by conceding in a House Budget committee hearing this week (see article below) that the IPAB has the "potential" to restrict access to care for Medicare enrollees.

The measure is expected to easily pass the Republican-controlled House, but faces an uphill battle in the Senate, where the IPAB provision originated. Two Senate bills to repeal the IPAB (S. 668, S. 2118) have failed to garner any Democratic support, especially as the later of the two measures (which was sent directly to the Senate floor) seeks to offset the projected savings from IPAB by cutting deeper into ACA subsidies (Congress has twice cut the amount of subsidies to overcome legislative roadblocks).

The White House sent a clear message this week that President Obama would veto the legislation if it passed the Senate. Not only does the President's fiscal year 2013 budget already strengthen the IPAB (see Update for Week of February 20th), Department of Health and Human Services Secretary told House lawmakers that the President is already identifying IPAB nominees (although the IPAB would not be in place until 2018). His deputy chief of staff also emphasized that the IPAB is statutorily barred from increasing Medicare cost-sharing or cutting benefits, a contrast with Republican's "premium support" or voucher plan that the Congressional Budget Office found would do both (see Update for Week of April 4th).

Under the ACA, the IPAB is charged with recommending budget cuts whenever Medicare spending exceeds targeted growth rates. The recommendations would automatically go into effect if Congress fails to pass measures that achieve equivalent savings.

Senate Minority Leader pledges to renew assault on Affordable Care Act

Senate Minority Leader Mitch McConnell (R-KY) vowed this week to make March "Repeal Obamacare Month" and push for repeated Senate votes to attack the Affordable Care Act (ACA).

McConnell appeared to bow to political reality only one day prior, acknowledging that it was pointless to continue holding repeal votes until after the November elections determined whether Republicans would take control of the Senate or White House. However, the move sparked anger from conservative advocates, including the Restore America's Voice Foundation who threatened to "unleash" its 2.3 million activists to call for McConnell to resign from his leadership post.

Senate Republicans have been planning a full-scale media blitz late March to bash the ACA, timed to coincide with the law's second anniversary and oral arguments in the Supreme Court. A floor vote to repeal portion of the free preventive services mandate relating to contraceptives failed this week, and an effort to repeal the law's Medicare cost-cutting panel is likewise expected to fail next week (see above).

Senator McConnell saw no need to pursue additional bills with no chance of success, since an unsuccessful amendment to repeal the entire ACA law already forced vulnerable Democrats to go on the record in their support of the controversial law. The repeal measure was only able to get 47 of the 60 votes needed to bring the measure to the floor last February. However, conservative advocates want to continue a pursuing a total repeal in the hopes of at least getting a symbolic majority of more than 50 Senators in support of repeal.

Most Americans oppose plans to privatize Medicare, remain split on ACA

The Kaiser Family Foundation tracking poll released this week found that most Americans, even Republicans, oppose the Republican plan to privatize all of Medicare, even with protections against higher out-of-pocket costs from using federal subsidies to purchase private coverage.

The February results gauged opinions of the "premium support" plan advanced by Rep. Paul Ryan (R-WI) and passed by the House (see Update for the Week of April 4th). Only 25 percent of those surveyed approved of the plan, with 70 percent preferring the status quo. Even among Republicans, a narrow majority want to keep Medicare as it is.

The results did not change when asked about the bipartisan plan by Rep. Ryan and Senator Ron Wyden (D-OR) that would primarily give enrollees greater protection against higher costs in the private market. The poll was conducted before yet another alternative premium support model was proposed by Senators Coburn (R-OK) and Burr (R-NC) that would give enrollees the option to remain in traditional Medicare (see Update for Week of February 13th).

However, Kaiser noted one-third of respondents became "more interested" in the Ryan plans when told that Medicare would otherwise go bankrupt.

The tracking poll also found that most Americans do not favor major reductions to Medicare spending to rein in the federal budget deficit, with 13 percent supporting sizeable cuts, 36 percent favoring minor reductions, and half opposed to any cuts. Not surprisingly, the strongest opposition comes from seniors.

Respondents were evenly split though on proposals to increase Medicare's eligibility age, and remain equally divided on the Affordable Care Act (ACA) overall. However, support for the ACA ticked up slightly since January, due mostly to higher approval from independents.

FEDERAL AGENCIES

HHS extends deadline for federal exchange establishment grants by nearly 2.5 years

The Department of Health and Human Services (HHS) announced in the *Federal Register* this week that it has formally extended the final deadline for applying for Level II exchange establishment grants. States can now continue to pursue exchange funding through November 3, 2014, instead of the final deadline that was to be June 29, 2012. As with prior grants, this will be in the form of a "rolling deadline". States that apply by August 1, 2012 should receive funding by October 2012, states that apply by November 1, 2012 should receive funding by January 2013, and so on.

HHS officials have repeatedly emphasized that their objective is to enable as many states as possible to create their own exchange, instead of defaulting to a federal fallback (see Update for Week of

February 20th). As a result, they have often verbally signaled that the agency may extend their January 2013 deadline for states to have made substantial progress towards exchange implementation, especially as many states with Republican governors have elected to "wait and see" if the U.S. Supreme Court overturns the Affordable Care Act before proceeding with implementation of the required exchanges. However, HHS has yet to take any formal action to extend that deadline.

CMS Actuary says neither "premium support" plan nor ACA reforms will cure Medicare's ills

The chief actuary for the Centers for Medicare and Medicaid Services (CMS) warned lawmakers this week that neither the "premium support" model sought by Republicans nor cost-savings measures under the Affordable Care Act (ACA) will ensure the solvency of the Medicare trust fund.

Testifying during a House Budget Committee hearing on strengthening federal entitlement programs, Richard Foster explained how both proposals fail to address the primary drivers of Medicare cost growth, such as overutilization of services, medical inflation led by prescription drug prices, and a heavy reliance on the most expensive technologies. He cited two provisions of the Affordable Care Act (ACA)—bundled payments and accountable care organizations—as well as the plan by Budget chairman Paul Ryan (R) to move Medicare enrollees into the private market, as illustrations of how reducing costs will not trim the overall growth rate in spending.

According to Foster, personal health care spending has grown by an annual average of 9.7 percent since Medicare's inception in 1965. He attributed four percentage points of that growth to medical inflation and nearly three percentage points to more expensive medical technology and overutilization.

Foster did not make many specific recommendations for slowing the growth rate, but broadly suggested that lawmakers should continue to promote research into the comparative effectiveness of different treatments, as well alternative health care delivery systems and payment methods. However, Republicans have bitterly opposed ACA provisions funding comparative effectiveness and blocked the permanent nomination of CMS Administrator Donald Berwick for praising the use of such research in funding decisions under the British national health care system (see Update for Weeks of November 21st and 28th).

New CMS bulletins define actuarial value and federal subsidies

The Centers for Medicare and Medicaid Services (CMS) released informational bulletins this week that describe how the agency will define the actuarial value of individual and small-group market health plans, as well as reimburse plans for reducing cost-sharing to lower income individuals.

The Affordable Care Act (ACA) directs CMS to issue regulations on the calculation of actuarial value and its application to the four different tiers of plans that the law creates. For example, a bronze plan is required to have an actuarial value of 60 percent; a silver plan 70 percent; a gold plan 80 percent; and a platinum plan 90 percent.

The CMS bulletin explains that the actuarial value measures the percentage of expected health care costs that will be covered by the plan and "can be considered a general summary measure of health plan generosity." It is intended to help consumers readily compare plans with different designs.

Using options laid out by the American Academy of Actuaries, CMS chose to determine actuarial value by compiling a national database of the average claims for those likely to enroll in individual and small group plans. States can then refine the database using state-specific claims.

To reflect geographic variations in the use and costs of health care, CMS will place states in one of three pricing categories. These will identify the costs in a local market based on factors such as salaries and medical supplies. CMS specifically requests comments on whether including more pricing factors would improve the accuracy of the calculation.

In order to ensure that all insurers are calculating their actuarial value scores the same way, CMS will develop its own standard population and create an "AV calculator" that will score plans based on key features of their benefit designs.

The second part of the bulletin outlines how CMS will make monthly advance payments to plans to cover projected costs for lowering annual out-of-pocket limits, deductibles, and co-payments. The advance payments would be reconciled with actual costs at the end of the calendar year. The method is similar to that used for the low-income subsidy program under Medicare Part D

The bulletin follows the Obama Administration's recent strategy to set a national standard, but allow for state flexibility in implementing the ACA.

STATES

Budget deficits remain in 29 states, though size of gaps have dramatically declined

The Center on Budget and Policy Priorities announced this week that state budget shortfalls for the coming year total only about $47 billion, the smallest aggregate deficit since the recession began in late 2007.

However, despite unexpected budget surpluses in several states due to a recovering economy, improved tax revenues, and high energy prices, fiscal year 2013 budget deficits still remain in 29 states while another ten states report current year shortfalls. The figures are similar to those reported earlier this year (see Update for Week of January 9th). However, the size of state budget gaps is dramatically smaller than years prior. For example, the $47 billion total gap for FY 2013 pales in comparison to the $106 billion so far this fiscal year and $430 million the prior three fiscal years covering the recession.

Alaska

New bill requires notice before imposing specialty tier coinsurance on highest cost drugs

The House Health and Social Services Committee held a hearing this week on legislation from last session (H.B. 218) that requires 90 days prior notice before a health plan can impose higher cost-sharing for a unique category or specialty tier prescription drug.

Connecticut

Insurance committee considers mandating higher cap on insurer profits than required by the ACA

The Joint Insurance and Real Estate Committee held a hearing this week on legislation that would limit health insurer profits.

The measure (S.B. 204) would require individual and small group plans in Connecticut to spend at least 82 percent of premium revenue on medical, instead of administration, salaries, and profit. This 82 percent medical-loss ratio (MLR) is slightly above the 80 percent federal MLR required starting last year by the Affordable Care Act.

Iowa

Senate Democrats seek public support in effort to pass exchange-authorizing legislation

The Senate held a public forum with consumer advocates this week build statewide support for legislation that would create a health insurance exchange compliant with the Affordable Care Act (ACA).

S.F. 2042 cleared its first legislative hurdle earlier in the week, clearing the Senate Commerce Committee in a strict party-line vote. Sponsored by Senator Jack Hatch (D), chair of the Health and Human Services Appropriations subcommittee, the bill may be able to clear a Senate narrowly controlled by Democrats, but faces an uphill battle in the Republican-dominated House.

It is also not clear if Governor Terry Branstad (R) would veto the measure. He has followed the lead of many of his Republican counterparts in electing to wait until the U.S. Supreme Court rules on the constitutionality of the ACA before proceeding with implementation efforts. Senator Hatch warned that such a delay would force a federal fallback exchange on Iowa, but the Governor insists that the state could still meet the January 2013 federal implementation deadline if need be.

Maine

Maine's highest court says insurers do not have the right to profit on every line of business

In a decision that insurers fear will reverberate throughout the nation, Maine's highest court has again upheld rate modifications by former Insurance Superintendent Mila Kofman (D) that severely limited the profit margin allowed for the state's largest health insurer.

The Supreme Judicial Court concluded this week that Kofman "properly balanced the competing interests" in approving an individual plan rate increase of only 5.2 percent in 2011. Anthem Health Plans bitterly complained that the downgrade violated the state and federal constitutions by limiting them to a mere one percent profit margin, instead of the "fair and reasonable return" they sought of three percent.

The decision marks the third consecutive year that the high court has sided with Kofman in Anthem disputes. The court previously upheld a zero and 0.5 percent profit margin for Anthem in both 2009 and 2010 respectively.

Anthem's parent company, Wellpoint, pledged to appeal the limitation to the U.S. Supreme Court, insisting that they have a substantive due process right to a rate of return that covers both "the medical costs for our members and…an adequate risk margin to cover unanticipated costs." They are supported by conservative groups, who argue that private companies should be able to earn a profit. However, the high court concurred with Maine's attorney general 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 (see Update for Week of October 31st).

Maine is one of 26 states and the District of Columbia where insurance regulators can reject or modify rates they deem excessive, inadequate, or unfairly discriminatory. Despite advocating for such authority, the National Association of Insurance Commissioners insists that limiting plans to a near zero percent profit margin is a bridge too far and could greatly destabilize a key aspect of insurance regulation across the nation.

Kofman has since returned to the Georgetown Health Policy Institute after resigning last spring in response to the dismantling of popular consumer protections by new Governor Paul LePage (R) (see Update for Week of May 16th). Premiums in Maine have soared by up to 90 percent after many community rating restrictions on premiums were scaled back (see Update for Week of October 3rd).

Nebraska

Governor implementing health insurance exchange, despite "wait and see" approach

According to a report this week in *POLITICO*, the Department of Insurance has e-mailed potential vendors to inform that that the state will soon issue a Request for Information "for the continued planning and design of Nebraska's potential Health Insurance Exchange."

The move somewhat surprised lawmakers, as Governor Dave Heineman (R) had been among the first Republican governors to officially delay exchange implementation until the U.S. Supreme Court rules on the constitutionality of the Affordable Care Act (ACA) (see Update for Weeks of November 21st and 28th). Even though the constitutionality of the exchanges has not been challenged, the high court has agreed to consider whether to invalidate the entire ACA should the mandate that everyone buy health insurance be deemed invalid (see Update for Week of January 2nd).

However, Governor Heineman has also pledged to "protect Nebraska from a federal takeover" of the exchange should the ACA remain in place (see Update for Week of January 9th). It is not clear how Nebraska can meet the January 2013 federal deadline unless the Obama Administration extends it as expected or the legislature passes exchange-authorizing legislation. Hearings were held last week on competing bills by Senator Jeremy Nordquist (D) and Rich Pahls (R) (L.B. 835 and 838). However, neither measure has yet to progress.

New Jersey

Senate and House committees have now passed exchange-authorizing legislation

The Senate Commerce Committee passed legislation this week that would create the health insurance exchange required by the Affordable Care Act (ACA). The measure now heads to the full Senate.

Sponsored by committee chair Nia Gill (D), S. 1319 is the counterpart to the Assembly measure (A.2171) that cleared committee earlier this month (see Update for Week of February 6th). Both measures would create an "active purchaser" exchange model where oversight board can directly negotiate rates and exclude unaffordable plans. They also exercise the discretion under the ACA to create a separate Basic Health Plan for those just above Medicaid eligibility levels after 2014 (i.e. earning from 133 to 200 percent of the federal poverty level).

Both bills are opposed by the insurance industry because they ban those who serve on the eight-member oversight board from being employed by or affiliated with insurers (including brokers and agents), both while on the board for two subsequent years. The exchange would be established "in but not of" the Department of Banking and Insurance and independent of any supervision or control by the department.

Vermont

House passes measure creating health insurance exchange, limiting prescription drug costs

The House overwhelming passed legislation this week that would create the health insurance exchange required by the Affordable Care Act (ACA) and limit out-of-pocket costs for prescription drugs.

The exchange is part of a comprehensive bill (H.559) that moves the state towards its ultimate goal under H.202 enacted last session of abolishing private insurers and creating a single-payer health care system by at least 2017 (see Update for Week of May 23rd).

H.559 also allows Vermont to offer "wrap-around" subsidies that go beyond the tax credits under the ACA for those earning less than 400 percent of the federal poverty level (FPL) who purchase exchange coverage. As with neighboring Massachusetts, Vermont's existing state health plan already offers more generous subsidies than the ACA, but only extends subsidies to those earning up to 300 percent of the federal poverty level (see Update for Week of January 30th).

H.559 also limits subscriber out-of-pocket expenditures for prescription drugs (including high-cost specialty tier drugs) to no more than $1,000 per individual or $2,000 per family (while barring any annual limits).

Governor Peter Shumlin (D) had to make some minor concessions to business groups in order to get his bill passed, such as backing-off provisions that would have immediately opened the exchange to small business with less than 100 workers, instead of the 50 worker limit in place under the ACA until 2016. The Governor also agreed to drop the prohibition on "bronze" exchange plans, which are the lowest cost but also lowest benefit plan (see Update for Week of February 6th). In the end, the measure passed by an 88-38 margin.

H.559 now goes to the Senate, which is already debating competing measures such as S.208.