

Health Reform Update – Weeks of March 12, 2012

CONGRESS

CBO now says ACA will cost less, cover few people

The Congressional Budget Office (CBO) predicted this week that coverage provisions of the Affordable Care Act (ACA) will cost less than initially projected, but extend coverage to fewer Americans.

The non-partisan scorekeeper issued a revised cost estimate showing that about two million fewer people than anticipated are expected to gain coverage by 2016 as a result of the new law. However, the lower figure means that roughly 27 million will remain uninsured two full years after the individual mandate, employer mandate, and health insurance exchanges go into effect.

The lower figures are due to greater restrictions eligibility for the federal subsidies under the law that were enacted over the past year, as well as a slower than expected economic recovery. As a result, four million workers are expected to no longer have workplace coverage (see below), while 1-2 million fewer uninsured and small business workers will be able to purchase coverage in the new health insurance exchanges (although an extra one million are expected to qualify for Medicaid and the State Children's Health Insurance Provision (SCHIP)).

Less coverage means that the overall cost of the ACA had declined to \$1.083 trillion over the next ten years, nearly \$50 billion less than CBO projected when the law was enacted. These figures are based on CBO's prediction that healthcare spending will continue to grow more slowly than in previous years, while health insurance premiums will drop by roughly eight percent.

The combined effects of the revised estimates from 2012–2021 add up to:

- An increase of \$168 billion in projected outlays for Medicaid and CHIP;
- A decrease of \$97 billion in projected costs for exchange subsidies and related spending;
- A decrease of \$20 billion in the cost of tax credits for small employers; and
- An additional \$99 billion in net deficit reductions from penalty payments, the excise tax on high-premium insurance plans, and other effects on tax revenues and outlays.

CBO predicts that the ACA will not cause a “sharp decline” in employer health coverage

An analysis published this week by the Congressional Budget Office (CBO) and the Joint Committee on Taxation (JCT) refuted claims by Republican lawmakers that the Affordable Care Act (ACA) will cause a “sharp decline” in employer-sponsored coverage.

Echoing their earlier findings, CBO and JCT concluded that most large employers will continue to have a strong incentive to offer employee health benefits in order to attract and retain the talent needed to remain competitive. They predicted that a “sharp decline” in employer-sponsored insurance was “unlikely” and “would not dramatically increase the cost” to the federal budget if it did occur.

CBO and JCT did predict that roughly four million workers would likely lose employer health coverage from 2019-2022 under the new law. They acknowledge this figure is much less than projected by Republican lawmakers, but emphasize that the ACA does not alter the fundamental economic incentives for employers to offer health benefits (including the tax deductibility of employer coverage), and in fact creates new incentives. However, they concede that their estimate is far from definitive, and that the actual figure could range from a net gain of three million to a net loss of 20 million.

Republicans trumpeted a study last year by McKinsey and Co. as evidence that President Obama would not be able to keep his pledge that you could “keep your health insurance if you like it.” (see Update for Week of June 6th). The report was widely criticized for claiming that up to 30 percent of employers would end their coverage, a figure that was contradicted by analyses from Avalere Health, Mercer Consulting, RAND, et al. (see Update for Week of August 1st). The Urban Institute concluded that only those employers with a large number of workers earning below 250 percent of the federal poverty level were likely to discontinue employer health coverage.

A Center for Studying Health System Change (HSC) report this week did acknowledge that the recent economic downturn has accelerated a long-term trend of fewer Americans having employment-sponsored coverage, documenting a ten percent drop in the number of children and working-age adults with workplace coverage from 2007 to 2010. HSC stressed that these figures were compiled before enactment of the ACA and did not expect the new law to accelerate this trend.

A separate study released this week by Aon Hewitt estimated that the ACA raised insurance premiums by an average of 1.5 percent in 2011, and will cause another 0.6 percent bump for 2012.

Repeal of Medicare cost-cutting panel losing bipartisan support

At least 20 House Democrats ultimately supported the Republican plan to repeal the Affordable Independent Payment Advisory Board (IPAB) created by the Affordable Care Act (ACA). The measure (H.R. 452) cleared two House committees as a stand-alone bill (see Update for Week of March 5th). However, several key Democrats defected from the legislation after House Republicans proposed this week to offset the cost of the repeal by placing new limits on medical malpractice damages.

Republicans are under pressure to come-up with offsetting savings prior to a full House vote, as the Congressional Budget Office estimated last week that repealing the Medicare cost-cutting board would add \$3.1 billion to the federal budget deficit (see Update for Week of March 5th). However, the most outspoken Democratic opponent of the IPAB, Rep. Allyson Schwarz (D-PA), announced this week that she would not support any repeal that was tied to malpractice caps long-sought by Republicans.

Retiring Rep. Barney Frank (D-MA), another repeal supporter, claimed using the repeal bill to promote an ideological wish-list was merely an acknowledgement by House Republicans that the measure was dead anyway in the Democratically-controlled Senate. President Obama has also reiterated his strong support for the IPAB (see Update for Week of March 5th).

FEDERAL AGENCIES

Justice Department shifts defense of individual mandate to mesh with conservative precedent

Filings this week before the U.S. Supreme Court reflect a shift in legal strategy by the Department of Justice, as it attempts to persuade the court’s most conservative jurists that their own precedent should be used to uphold the new federal mandate that everyone buy health insurance.

The “individual mandate” remains the most unpopular and controversial part of the Affordable Care Act (ACA) (see Update for Week of March 5th). It also is the only provision to be overturned by a lower court (see Update for Week of August 8th).

The 11th Circuit Court of Appeals decision to be heard later this month by the high court struck down the “individual mandate” on the basis that it violated Congress’ traditionally broad power to regulate interstate commerce. Justice Department lawyers have consistently argued an individual’s decision not to purchase health insurance they can afford impacts interstate commerce, as others must subsidize the uncompensated costs of their care when they inevitably get sick or injured.

Justice arguments have focused on Gonzales v. Raich, a 2005 U.S Supreme Court decision upholding Congress' authority under the Commerce Clause to prevent people from growing their own medical marijuana in states that allow medical marijuana sales, instead of purchasing medical marijuana from a sanctioned dispensary. Justice sought to emphasize this case, because two key votes on the ACA decision, moderate Justice Anthony Kennedy and conservative Justice Antonin Scalia, surprisingly joined with their liberal colleagues in upholding Raich.

The Justice Department initially drew a direct analogy to the majority's finding that regulating individual use of medical marijuana was within Congress' broad power to regulate interstate commerce—an apparent attempt to mesh with Justice Kennedy's reasoning in Raich. As the only Supreme Court moderate, Kennedy often provides the critical swing vote and is expected to again do so on the ACA decision.

However, Justice's latest filings this week departed from this argument, and instead focused on the concurring opinion in Raich offered by staunchly conservative jurist Scalia. Judge Scalia wrote in Raich that even if Congress did not have the authority to regulate the growing of medical marijuana under the Commerce Clause, it could have done so under the Constitution's Necessary and Proper Clause, which allows Congress to enact laws needed to carry out any of its other enumerated powers.

This shift in strategy by the Justice Department appears to be a not so subtle effort to persuade Justice Scalia that overturning the individual mandate under the ACA would conflict with his own precedent, something judges rarely do. Filings by Justice stress that the plaintiffs acknowledge that the individual mandate is necessary to achieve the other insurance market reforms in the ACA, since they argued that they all must be struck down in the individual mandate fails. As a result, Justice is now arguing that the individual mandate is "necessary and proper" for Congress to carry out its goal of reforming the interstate market in health insurance, which the plaintiffs conceded in their earlier filings was a legitimate statutory objective.

The National Federation of Independent Business, who joined as a plaintiff, insisted that the "individual mandate" still must fail under the Necessary and Proper Clause, because Congress "can't force people to buy cars because of federal safety regulations that raise the price of cars." However, Timothy Jost, a Washington and Lee University law professor and prominent ACA supporter, argued that the Necessary and Proper Clause is now the strongest defense for the "individual mandate" because NFIB and other plaintiffs already conceded that the law's bar on pre-existing condition denials and other market reforms will dramatically raise premiums in the health insurance market if the "individual mandate" is removed (see Update for Week of January 30th).

Lawyers with the National Senior Citizens Law Center concurred with Jost in noting that there is "simply no way" that Justice Scalia could strike down the mandate without reversing his position in Raich. However, it noted that the U.S. Supreme Court has seen fit to recently strike down decades of precedent on other issues like campaign finance law (see Update for Week of January 2nd).

Feds continue to give states greater flexibility/authority over new health insurance exchanges

The Department of Health and Human Services (HHS) issued long-awaited regulations this week that finalize the standards that states must follow in implementing health insurance exchanges required by the Affordable Care Act (ACA).

States have until January 2013 to make "substantial progress" towards implementation or allow HHS to instead operate a federal fallback exchange in their state. However, Republican governors have increasingly elected to wait until the U.S. Supreme Court resolves the constitutionality of the ACA before proceeding, with many complaining that they lack sufficient federal guidance on how to move forward (see Update for Week of March 5th).

The mammoth interim final rule combines two sets of proposed regulations issued last summer (see Update for Week of July 11th and Week of August 8th). It defines how states can create and operate

their exchange in order to comply with the ACA, certify plans that can be offered, and streamline enrollment. However, HHS still has to issue final regulations relating to reinsurance and risk adjustment for exchange plans, while the Department of Treasury is preparing to finalize rules on the premium tax credits to help those with incomes up to 400 percent of the federal poverty level to purchase exchange coverage.

The final rules were largely praised by consumer groups and insurers, but panned by Republican governors who complained that HHS remains coy about how the federal fallback exchange will operate. Nor do they identify how the default exchange will be funded; since it is not specified in the ACA statute (see Update for Week of August 15th).

Republicans specifically want to know if the fallback exchange will follow the “active purchaser” model already in place in Massachusetts where the exchange can negotiate prices and selectively contract with only those plans that “play ball”. Republicans largely favor the more passive “information clearinghouse” model used by Utah, where any insurer that meets minimum standards can participate. As a result, they need to know whether the fallback exchange will employ the objectionable “active purchaser” model before deciding whether to simply allow a federal fallback exchange.

The Obama Administration prefers that states create their own exchange, as reflected in guidance issued last fall that will extend federal exchange grants for up to two years should resistant states change their minds. The guidance also clarified that states can initially partner with HHS until they get their exchange fully operational, so that some exchange functions will remain under state and not federal control (see Update for Weeks of November 21st and 28th).

The final rules codify this guidance and provide even greater flexibility. For example, states can now choose to let HHS handle the complex function of determining who is eligible for the premium tax credits, while retaining control over all other exchange functions. They can also use their own Medicaid agencies to determine which exchange applicants are instead eligible for Medicaid or SCHIP.

Republican lawmakers in at least one state stated that the greater flexibility would have no impact on their decision to forgo implementation until after the U.S. Supreme Court acts. Missouri State Senator Scott Rupp (R) claimed that HHS insistence on a January 2013 deadline “has pretty much fallen on deaf ears” as HHS routinely delays supposedly hard deadlines.

The final rules also attempt to resolve a simmering controversy in several states where exchange oversight boards lack any consumer representation and are instead dominated by insurers (see Update for Week of August 1st). Consumer groups were not able to get HHS to bar insurer representation, which they often compare to the “fox guarding the henhouse”. HHS instead sought to retain their earlier provision barring insurers only from comprising more than half of an exchange board. However, the final rules will require exchange governance in every state to have at least one consumer representative.

The rule also prohibits insurance agents and brokers from performing exchanging eligibility functions or offering incentives for consumers to enroll in particular exchange plans. However, they can continue to sell plans through the exchange’s web portal and advise consumers how to navigate coverage options. The American Cancer Society and the Multiple Sclerosis Society are among the consumer groups that will object to this provision during the upcoming 45-day public comment period, despite their overall support for the final rules.

The interim final rules emphasize that exchange boards will have the full authority to decide the number of type of exchange plans offered to consumers, subject to broad federal standards. Exchanges must also still be financially self-sufficient by 2015 (through premiums and assessments on participating plans).

They also finalize guidance to states on how to coordinate eligibility and enrollment between the exchanges and other programs like Medicaid and SCHIP.

Nearly 40 percent of those with employer coverage would use health insurance exchange

According to a new survey released this week by J.D. Power and Associates, nearly four of every ten workers with employer-sponsored health plans would prefer to buy coverage from a health insurance exchange, if it were available to them. Workers in Michigan, Illinois, Indiana, and Ohio are the most satisfied with their employer coverage, while those in the Rocky Mountain States are the least satisfied.

AARP says price of most popular drugs rose by nearly 26 percent

The price of prescription drugs that are most widely used by older Americans rose by nearly 26 percent from 2005 to 2009, according to a new report released this week by AARP. The increase is nearly twice the rate of inflation over that period and occurred despite the proliferation of cheaper generic alternatives, which now account for the vast majority of prescriptions.

The Pharmaceutical Research and Manufacturers of America (PhRMA) criticized the report, insisting that the expanded availability of generic drugs has slowed the increase in drug prices in recent years. However, a recent report by the Government Accountability Office found "mixed results regarding the [cost-saving] effect of using these generics" (see Update for Week of March 5th).

The AARP report, which examined the retail prices of 514 brand name and generic drugs most widely used by Medicare recipients, documented that the price of generic drugs has dropped by nearly 31 percent from 2005 to 2009. However, brand-name drug prices grew by nearly 41 percent during the same period, while specialty drugs rose more than 48 percent. By contrast, the rate of inflation grew by just over 13 percent.

PhRMA pointed out that more recent data than 2009 has shown that the rate of growth in drug spending appears to be slowing. The Centers for Medicare and Medicaid Services found last year that total retail spending on prescription drugs was up just 1.2 percent in 2010, a record low rate. The IMS Institute for Healthcare Informatics also reported that spending on prescription drugs grew by 2.3 percent in 2010, compared with 5.1 percent in 2009.

AARP emphasized that studies reporting a slower growth in spending did not look at the price of individual drugs, which are critical to those who have to pay out-of-pocket.

HEALTH CARE COSTS

Health insurance premiums to exceed average household income by 2037

A new study published this week in the *Annals of Family Medicine* predicts that even if the Affordable Care Act (ACA) slows the rate of growth in health spending, health insurance premiums will still surpass average household income by 2037.

At the current pace, the average cost of a family health insurance premium will equal 50 percent of average household income by the year 2021 and exceed average household income by the year 2033. If out-of-pocket costs are added to premium costs, the 50 percent threshold will be crossed by 2018 and the household income threshold by 2030. The employee contribution to a family premium plus out-of-pocket costs will also comprise one half of the household income by 2031 and total income by 2042.

The study acknowledges that their projections do not take into account the most recent year of health spending data, which showed that health care costs have slowed to the same rate of growth as the overall economy. However, there is a lack of consensus about whether the slower rate of growth in health care costs represent the start of a long-term trend, or merely reflect consumers forgoing needed medical treatment during the recession (see Update for Week of March 5th).

STATES

Connecticut

Governor wants to hold-off on Basic Health Plan to evaluate impact on insurance exchange

Governor Daniel Malloy (D) is urging lawmakers to hold-off on using the discretion under the Affordable Care Act (ACA) to create a Basic Health Plan for low-income adults with incomes up to 200 percent of the federal poverty level (FPL) who will not be eligible for Medicaid after 2014.

Several states including California, Hawaii, Illinois, New Jersey, and Washington are considering legislation that would create a BHP in order to take advantage of enhanced federal funding for this population. However, exchange governing boards already in place in states like California have expressed concern that the BHP would draw so many applicants away from the new health insurance exchange that it would threaten the ability of the exchange to remain financially self-sustaining, as the ACA requires by 2015 (see Update for Week of July 25th).

In testimony before the Human Services committee on pending legislation, Office of Policy and Management Secretary Benjamin Barnes insisted that the state still lacked "sufficient information at this point in time to evaluate whether it would be in the best interest of consumers, the State, and the Connecticut Health Insurance Exchange to establish such a program."

Low-income advocates are promoting the BHP, arguing that it will be difficult for those with incomes who fluctuate just above and below the new Medicaid eligibility limit (133 percent of FPL) to have to identify and pay for exchange coverage. They would prefer a state-run BHP that has the same design and network of health care providers as Medicaid.

Secretary Barnes asked lawmakers for additional time to evaluate the impact of the BHP on the viability of the exchange, whether there will be enough Medicaid providers to adequately serve BHP members, and whether the state would be allowed to administer a BHP using the administrative model now used in Medicaid.

Barnes said the basic health program must be cost-neutral to the state or reduce costs, and said the decision about whether to create a basic health program must be made in consultation with the board designing the exchange.

Delaware

House committee passes legislation equaling reimbursement for oral and IV cancer treatment

The Economic Development, Banking and Insurance Committee passed H.B 265 this week, which would require insurers to make equal reimbursement for oral and intravenous anti-cancer medications. The bill mirrors New York's oral parity law and similar legislation being debated in most states (see Update for Week of March 5th).

Hawaii

Senate-passed specialty tier legislation moves quickly through key House committee

Legislation that bars the use of specialty tier coinsurance by Hawaii insurers unanimously cleared the House Health Committee, only one week after passing the Senate with only one dissenting vote (see Update for Week of March 5th).

In addition to prohibiting private health plans from requiring subscribers to pay a percentage of the cost for specialty drugs, S.B. 2106 would prevent any copayments that exceed \$150 month for a one-

month supply. PSI Government Relations had urged the passage of the legislation (see Update for Weeks of January 16th and 23rd).

Maryland

Senate-passed measure would extend prescription drug assistance for seniors

The Assembly Health and Government Operations Committee has scheduled a March 29th hearing on S.B. 121, which extends the termination of the Senior Prescription Drug Assistance Program until December 31, 2014 and lengthens the period of time during which the subsidy required under the program may not exceed \$14,000,000.

The measure unanimously passed the Senate last month.

Missouri

House committee passes bill that would penalize state officials who implement ACA provisions

The General Laws Committee passed legislation on a straight party-line vote that would impose criminal penalties for state officials who attempt to enforce provisions of the Affordable Care Act (ACA). H.B. 1534 sponsored by Rep. Kurt Bahr (R) is intended to block Governor Jay Nixon (D) from using an executive order to create all or part of the health insurance exchange required by the new law.

Similar Republican-backed measures were proposed last session or this session in states like Idaho, Maine, and New Hampshire. None was enacted, as they would likely be struck down by the courts given the supremacy of federal law to state law under the U.S. Constitution.

New Jersey

Consumer groups push Governor to sign exchange bills passed by the Legislature

Consumer advocates put on a full-court press this week to urge Governor Chris Christie (R) to sign legislation creating the health insurance exchange required by the Affordable Care Act (ACA).

A.2171 and S.1319 passed both chambers this week on a largely party-line vote. However, despite his support for the exchange concept, it is not clear if Governor Christie will allow the measures to become law.

The Governor has already joined with several of his Republican colleagues in refusing to move ahead on exchange implementation until after the U.S. Supreme Court resolves the constitutionality of the new law in June, and delayed applying for additional federal grants (beyond the \$9 million he initially accepted). Christie also has openly thrown his hat into the vice presidential race should former Massachusetts Governor Mitt Romney (R) receive the Republican nomination for President. Romney has been heavily criticized by conservatives for implementing a health insurance exchange that served as the model for the ACA exchanges. As a result, creating an analogous exchange may be politically problematic for Governor Christie in the near term.

The exchange model passed by the Legislature is also largely disfavored by Republicans as it would allow the exchange governing board to serve as an "active purchaser" and selectively contract only with insurers who agree to negotiate rates. The insurance industry likewise objects to the bills 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 (see Update for Week of February 27th).

South Carolina

Governor will not have to return federal exchange grant, despite dictating panel outcome

The U.S. Department of Health and Human Services (HHS) announced this week that South Carolina will not have to return its \$1 million federal exchange planning grant; even though Governor Nikki Haley (R) preordained the negative conclusion of an advisory panel she created to recommend how the state should use the grant.

At the request of U.S. Senator Tom Harkin (D-IA), federal auditors had been investigating whether the Governor violated the terms of the grant she accepted (see Update for Week of December 19th). E-mails obtained by newspapers under the state's *Freedom of Information Act* found that the Governor directed the Health Planning Committee to conclude that South Carolina should not create the health insurance exchange required by the Affordable Care Act (ACA). Several panel members acknowledged that their resultant decision not to proceed was influenced by her directive (see Update for Week of December 12th).

According to the state spending report submitted to HHS, South Carolina spent less than a third of the \$1 million grant (see Update for Week of January 30th). However, HHS has declined to force the state to return any of the funds

South Dakota

New law would void federal consumer protections if ACA declared unconstitutional

Governor Dennis Daugaard (R) signed legislation into law this week (H.B. 1220) that would automatically repeal new consumer protections implemented last year by South Dakota should the U.S. Supreme Court declare the entire Affordable Care Act (ACA) unconstitutional.

The new protections relate to network adequacy standards, quality assessment and improvement requirements, utilization review and benefit determination requirements, grievance procedures for managed health care plans, and other standards that were required by the ACA. Even though the constitutionality of these provisions is not at issue, Republican lawmakers did not want to be bound by the new federal rules should the entire ACA be struck down due to the unconstitutionality of any one provision.