



Health Reform Update – Week of May 7, 2012

CONGRESS

House Republicans pass sequester alternative that would drop 300,000 kids from Medicaid/SCHIP

House Republicans voted this week to pass a budget reconciliation measure that would dramatically slash Medicaid spending in order to avert automatic cuts in defense spending.

The *Sequester Replacement Reconciliation Act* that passed without any Democratic support faces certain death in the Democratically-controlled Senate but signals the Republicans intent to protect defense spending from the sequester that will go into effect January 2013 unless Congress passes an alternative package that will reduce the federal budget deficit by the \$1.2 trillion required under last summer's debt ceiling compromise (see Update for Week of April 23rd).

Although H.R. 5652 would cancel over \$98 billion in automatic cuts, it would allow the scheduled cuts in Medicare and pare more than \$310 billion over the next decade from mandatory spending, over 25 percent of which would come from Medicaid, SCHIP, and other federal safety-net programs. It also targets the Affordable Care Act (ACA) by further cutting premium subsidies, eliminating the \$12 billion remaining the Prevention and Public Health Fund that provides free preventive services to Medicare enrollees, and removing the "maintenance of effort" provision that protects Medicaid and SCHIP enrollees from eligibility cuts through 2014. The Congressional Budget Office (CBO) estimated that the latter would drop more than 300,000 children from Medicaid and SCHIP.

H.R. 5652 would also strip about \$400 million in bonuses for states that improve their enrollment process to better identify and enroll children who are eligible for Medicaid or SCHIP (see Update for Week of April 30th).

Senate Majority Leader Reid (D-NV) promptly blocked the measure from coming to the Senate floor without a more "balanced approach" that includes an elimination in tax loopholes and higher taxes for millionaires. President Obama also pledged to veto any measure that relied solely on spending cuts.

If Congress fails to pass alternative offsets, the automatic sequester would slice 7.8 percent from the FY 2013 budgets for health agencies. A report released this week by Research America showed that this would result in a \$2.39 billion cut for the National Institutes of Health, while the Centers for Disease Control and Prevention would lose \$445 million or more than the amount it spends on all cancer prevention and control programs. The Food and Drug Administration (FDA) would also lose \$191 million, or "virtually the same amount FDA spent in fiscal year 2011 to review and approve biologics."

Affordable Care Act repeal will add \$20K to \$240K that retirees must spend on health care

Retirees will likely pay about \$20,000 more for medical care if the entire Affordable Care Act (ACA) is overturned or repealed, according to Fidelity Benefits Consulting.

Fidelity's annual cost estimate projects that a 65-year old couple retiring this year will now incur roughly \$240,000 in out-of-pocket costs over the rest of their life. That is about a \$10,000 or 4.3 percent increase from last year and includes costs for Medicare premiums, cost-sharing, and Medigap coverage.

However, overturning or repealing the ACA will impose additional costs on seniors, who are benefiting from the discounts the new law requires for prescription drug coverage within the Medicare Part D coverage gap. They also would no longer receive certain preventive services for free.

Fidelity noted that roughly 78 percent of Americans surveyed by Kaiser Family Foundation support the ACA provision requiring Part D discounts. It also documented that prior to passage of the ACA, estimated out-of-pocket costs for seniors were increasing at roughly six percent per year, instead of the 4.3 percent increase this year.

Republican leaders still unsure how to replace Affordable Care Act if overturned

Republican leaders appear to be backing-off from plans to offer a comprehensive health reform alternative should the Affordable Care Act (ACA) be struck down in June by the U.S. Supreme Court (see Update for Week of March 26th).

The chairman of the Energy and Commerce health subcommittee, Rep. Joe Pitts (R-PA), had indicated after oral arguments in the high court that Republicans were already developing a “replacement” to the ACA. However, Rep. Phil Gingrey (R-GA) and Senator Jim DeMint (R-SC) are among several Republicans now pushing for “incremental” reform bills that may reinstate specific popular provisions in the ACA or traditional Republican proposals like interstate health plans and medical malpractice reform (which was included as part of the sequester alternative discussed above).

However, the chair of the Republican Policy Committee has taken the opposite approach, insisting that “the status quo is not acceptable and that there has to be some kind of comprehensive solution.” Rep. Tom Price (R-GA) sponsored a broad alternative in 2009 that was re-introduced last year and has 38 Republican cosponsors (H.R. 3000). It relies on refundable tax credits small businesses, as well as sliding-scale tax credits of up to \$2,000 for individuals or \$4,000 for families, so long as they are uninsured. Similar to the House-passed budget plan for the last two years, those in government or military health programs could instead use the tax credits to purchase coverage on the private market.

Notably absent from H.R. 3000 is one of the most popular provisions in the ACA, namely the ban on pre-existing condition denials. Rep. Price, a physician, called such a guaranteed issue mandate a “terrible idea” and instead advocates giving states block grants to expand high-risk pools.

Price’s bill also contains a broader medical malpractice remedy than other Republican proposals that mostly cap non-economic damages. H.R. 3000 would create “health courts” that specialize in malpractice cases and create a “safe harbor” in which doctors who follow the clinical practice guidelines of their medical societies would be immune from lawsuits.

Health spending remains at heart of impasse on student loan interest rate debate

Senate Republicans blocked a Democratic bill this week (S.2343) that would prevent interest rates on federal student loans from doubling this July, in exchange for no longer allowing wealthy taxpayers to avoid paying Social Security and Medicare taxes by classifying their income as dividends. The move came after Democrats refused to hear House-passed legislation (S.2366/H.R. 4628) that would instead offset the \$6 billion cost of delaying the interest hike by eliminating the remaining \$12 billion in the Affordable Care Act (ACA) Prevention and Public Health Fund (see Update for Week of April 30th).

Bipartisan bill resurrects effort to replace Medicare physician payment formula

Reps. Allyson Schwartz (D-PA) and Joe Heck (R-NV) introduced legislation this week to try and finally correct the payment formula created by the *Balanced Budget Act of 1997* that threatens to cut Medicare physician reimbursement by more than 30 percent next year.

The dramatic cuts that would be imposed by the sustainable growth rate formula have been delayed each year by Congress while lawmakers continue to debate a permanent fix (see Update for Week of February 13th). The latest bill (H.R. 5707) would repeal the entire formula, freeze current payment levels through 2013, and set-up a five-year transition period during which the Centers for Medicare and Medicaid Services would develop four payment models from which physicians can choose.

Physician payment rates would increase by 0.5 percent annually during the transition while primary care, preventive care and care coordination services would get an annual increase of 2.5 percent. By 2018, physicians in the new models would get stable reimbursement rates, along with opportunities for higher reimbursements based on improving quality and effectiveness and lowering costs. Physicians also could choose to stay in the traditional fee-for service system (though their payment updates would be reduced), while others would be allowed to participate in an alternative fee-for-service system that includes incentives to coordinate care and manage high-risk patients.

However, the Congressional Budget Office has estimated that such a total repeal/replacement would cost \$316 billion over ten years. Republican lawmakers largely panned the Schwartz-Heck plan to offset this cost with projected savings from winding-down military actions in Iraq and Afghanistan, calling it a “budgetary gimmick”.

Several physician groups, including the American Osteopathic Association, American College of Physicians and American Academy of Family Physicians, did endorse the legislation, while the American Medical Association approved only certain elements.

Energy and Commerce unanimously approves reauthorization/addition of FDA user fees

The House Energy and Commerce unanimously approved a reauthorization of the user fee program that funds Food and Drug Administration (FDA) reviews of drugs and devices.

A similar Senate measure (S.2516) sailed through committee two weeks ago and now awaits floor action (see Update for Week of April 23rd). However, some House Republicans had balked at approving the “back-door” agreement in which manufacturers voluntarily agreed to a \$100 million increase in user fees in exchange for faster agency reviews. Lawmakers from both parties also remain concerned that user fees on drug and device manufacturers currently account for 36 percent of the FDA budget and are set to increase to 44 percent in 2013 (see Update for Week of April 16th).

However, committee Republicans ultimately agreed to drop demands that the FDA mission be changed to emphasize job creation and agreed to support H.R. 5651. The bill adds new user fees for generic and biosimilar drugs (as authorized by the Affordable Care Act). It also incorporates several pending bills to curb drug shortages and accelerate the approval of life-saving drugs, including the Creating Hope Act which is not in the Senate version (see Update for Week of April 2nd).

Chairman Upton indicated that a full House vote would likely be held before the end of May. Congress must pass the reauthorization before the program expires on September 30th.

FEDERAL AGENCIES

CMS delays implementation of physician payment sunshine provisions within ACA

The Centers for Medicare and Medicaid Services (CMS) confirmed late last week that it has postponed implementation of Affordable Care Act (ACA) provisions requiring the agency collect and disclose drug and device manufacturer payments to physicians that exceed more than \$100 per year.

Senators Herb Kohl (D) and Charles Grassley (R) immediately expressed disappointment that CMS has delayed enforcement of the “physician payment sunshine” rules they sought to include in the new law. They already took the agency to task for missing the October 1st deadline for issuing proposed regulations (see Update for Week of October 10th), and were urging final regulations be released promptly so that the required data could be collected in time to meet the ACA’s mandate to start reporting payments on March 31, 2013 (see Update for Week of April 2nd).

However, CMS already indicated in proposed rules that it likely would not meet ACA deadlines (see Update for Week of December 12th). Acting Administrator Marilyn Tavenner stated that the agency needs more time to respond in a “thoughtful manner” to over 300 comments received “from a wide range of stakeholders”. She did not set a date for release of the final rules.

Proposed rules could dramatically boost Medicaid reimbursement for primary care in some states

Proposed rules released this week by the Centers for Medicare and Medicaid Services (CMS) would temporarily bring primary care reimbursement under Medicaid in line with Medicare rates, as directed by the Affordable Care Act (ACA).

According to CMS, the new law already increased Medicare primary care reimbursement by nearly \$560 million last year for over 150,000 providers. Under the proposed regulation, state Medicaid programs would now receive more than \$11 billion in federal funds to use on Medicaid primary care delivery in 2013 and 2014.

Raising primary rates to Medicare level will mean a substantial increase for physicians in states where Medicaid payment is exceptionally low. For example, Urban Institute data from 2008 showed that Medicaid primary care reimbursement in New York and Rhode Island is only 36 percent of Medicare rates and only 55 percent in Florida.

Acting CMS Administrator Marilyn Tavenner emphasized that the higher payments will help prepare primary care networks for the ACA expansion of Medicaid that will start in 2014.

CMS to let states move two million dual eligibles into managed care next January

Providers and consumer advocates grilled the Centers for Medicare and Medicaid Services (CMS) last week about the agency’s plan to let states move two million dual eligibles into managed care.

At least 27 states have already sought permission to participate in the program, which will start in January. However, the Federation of American Hospitals and Georgetown University Health Policy Institute were among those who echoed earlier concerns expressed by the Medicare Payment Advisory Commission that CMS was moving too quickly and may be violating beneficiary rights by forcing them into the managed care plans. They compared the initiative to the Republican budget passed last year by the House that forced all Medicare beneficiaries to accept subsidies to purchase private coverage (see Update for Week of April 4, 2011).

Under the Medicare program, beneficiaries have the “freedom of choice” to choose whether to enroll in Parts B or D, or the Medicare Advantage managed care plans. However, advocates warn that up to two million of those enrolled in both Medicare and Medicaid could essentially now lose that choice.

The director of the CMS Medicare-Medicaid Coordination Office acknowledged that in some states, dual eligibles may indeed be automatically enrolled in managed care against their choice. However, she stressed that all dual eligibles can still opt back into traditional fee-for-service.

CMS will sign memos of understanding with participating states this summer, with plan options to be sent to beneficiaries in October.

CMS releases first set of Health Care Innovation Awards authorized by Affordable Care Act

The Centers for Medicare and Medicaid Services (CMS) announced this week that it has issued 26 Health Care Innovation awards to entities that best presented ideas on how to more efficiently deliver affordable health care to enrollees in Medicare, Medicaid and Children’s Health Insurance Programs.

The \$122.6 million in awards are the first of \$1 billion allocated by the Affordable Care Act (ACA). They are expected to lower health care spending by \$254 million over the next three years, according to CMS, and continue to save money in subsequent years.

The 26 winners were selected from over 2,000 applications and will impact nearly 750,000 patients nationwide. The second and final set of awards will be announced in June.

Nearly three million small employers failed to claim Affordable Care Act tax credit

A new report released this week by Families USA concludes that only 360,000 small businesses have claimed the tax credit under the Affordable Care Act (ACA) for purchasing employee health coverage, although 3.2 million were eligible.

The new law made more than \$15 billion in tax credits available, however small businesses largely remain unaware of their availability. Although the tax credits require that small businesses must employ fewer than 25 workers, pay an average salary of less than \$50,000, and cover at least half their employee premiums, at least 70 percent of small businesses (employing 20 million Americans) met this criteria in 2011 according to Families USA, while 1.3 million qualified for the maximum tax credit compensating 35 percent of the employer's health insurance costs.

The National Federation of Independent Business claims that the lack of interest is due to the fact that the tax credit is severely inadequate and fails to make a difference in employer costs.

HEALTH CARE COSTS

Study confirms that hospital consolidation is key cause of premium hikes

A study released this week by the non-partisan Center for Studying Health System Change and the Robert Wood Johnson Foundation affirms that the market power of hospitals is a primary contributor to double-digit increases in health insurance premiums.

America's Health Insurance Plans (AHIP) has long-insisted that health insurers were being unfairly maligned for double-digit rate hikes that were largely the result of higher prices being charged by large hospital systems dominating major markets. Studies by the Urban Institute and Commonwealth Fund provided some support for this claim, documenting that hospital and physician prices are the main difference between the health spending between the U.S. and other industrialized nations (see below).

Based on surveys in 12 markets, researchers confirmed that hospital systems with significant market clout are effectively bullying large insurers into accepting high hospital charges. The study notes that large insurers often fear losing popular systems from their provider networks, which in turn would cause them to lose large employer customers if workers demand access to those systems.

Because insurers can readily pass along higher hospital charges to subscribers in the form of higher premiums or cost-sharing, insurers prefer this path of least resistance to relying on rate-setting or other contracting advantages that would constrain hospital prices. However, they note that insurers often lose a "critical bargaining chip" if employer customers are not willing to limit their workers' choice of providers by excluding popular hospitals from plan networks.

The study also found that from 2000-2009, the amount that hospital prices paid by private plans exceeded hospital costs more than doubled from an average 16 percent to 34 percent. Data provided by the Medicare Payment Advisory Commission (MedPAC) refuted hospital claims that the higher private plan charges are needed to offset Medicare underpayment, as this 34 percent gap between private plan payment and hospital costs far exceeds the amount that Medicare payments are below hospital costs.

Latest Commonwealth Fund study affirms U.S. leads in health costs, lags in quality of care

The Commonwealth Fund updated its earlier studies last week by affirming that the United States continues to “dwarf” 12 other industrialized countries in health spending, but get little value in return.

The latest data from the Organization for Economic Cooperation and Development compared the U.S. with Australia, Canada, Denmark, France, Germany, Japan, the Netherlands, New Zealand, Norway, Sweden, Switzerland and the United Kingdom. It found that the U.S. continues to lag in major quality of care indicators such as infant mortality and life expectancy, despite spending nearly \$8,000 per capita in 2009, as compared to other countries that spend a fraction of that amount. The U.S. spends over 17 percent of Gross Domestic Product on health care, while no other country surveyed exceeds 12 percent.

The authors reiterated the findings of an earlier Commonwealth Fund study concluding that higher prices for prescription drugs and physician/hospital services were the primary cost difference between the U.S. and other countries (see Update for Week of March 5th). The report specifically disputes claims that patient overutilization of health services is driving rising health costs. It notes has the lowest physician visit rates (3.9 per capita), among the shortest hospital lengths of stay, and some of the lowest hospital discharge rates of any of the countries surveyed.

The Commonwealth Fund previously found that higher prices in the U.S. are the leading reason why at least 42 percent of chronically or severely ill Americans surveyed failed to get recommended medical care, a rate that is more than double that in Canada, France, Great Britain and other industrialized countries (see Update for Week of November 7th). The International Federation of Health Plans reiterated these findings earlier this year, documenting that Americans pay far more for 22 of the 23 health services surveyed (see Update for Week of March 5th).

STATES

Access to health care deteriorating in nearly every state, will worsen if ACA overturned

Two studies released this week by the Urban Institute show that the ability of adults to access basic health care has declined in every state but West Virginia (and the District of Columbia), with dramatic drops in those states most opposed to the Affordable Care Act (ACA). It concludes that this downward trend will only be exacerbated if the ACA is struck down by the U.S. Supreme Court.

Researchers specifically found that nearly half of uninsured adults in 2010 had an unmet health need due to cost, compared to only 11 percent of insured adults. This represents a “marked deterioration” from 2000, when nearly 12 percent fewer uninsured adults and only half as many privately-insured adults reported an unmet health need due to cost.

The decline in access to care was most pronounced in conservative states leading the charge against “Obamacare”. Florida, Georgia, and Tennessee reported the greatest increase since 2000 in adults under age 65 (both insured and uninsured) who report unmet medical needs. And more than 25 percent of this population in Mississippi, Texas, and Florida continue to report unmet needs in 2010.

By contrast, only eight percent of North Dakota adults reported unmet medical needs due to cost in 2010, while states with near universal coverage like Massachusetts and Hawaii are close behind.

Recession fuels \$70 billion jump in Medicaid spending

A report released this week by the Kaiser Family Foundation found that Medicaid spending increased at an average annual rate of 6.6 percent from fiscal years 2007-2010, compared to a mere 1.3 percent growth rate from 2005-2006.

The authors blamed the \$400 billion in Medicaid spending in FY 2010 on job losses and declining income during the recession that caused state Medicaid rolls to skyrocket. Over eight million Americans were forced into Medicaid from 2007-2010, with family enrollment in particular increasing over seven percent per year, as compared to only 0.4 percent from 2004-2007.

Spending on medical services alone (which includes acute care and prescription drugs) experienced the greatest increase of nearly seven percent per year.

The spending jump caused record deficits in most states that have only recently abated, though several are still not out of the woods (see Update for Week of April 23rd). A National Conference of State Legislatures published last week found that at least ten states have already exceeded their annual Medicaid budget for fiscal year 2012, with California, Georgia, and Illinois facing another round of severe cuts to fill gaps in their Medicaid programs.

Alabama

Senate delays action on health insurance exchange over concerns about BCBS monopoly

The Alabama Senate vote this week to delay action on legislation that would create the health insurance exchange required by the Affordable Care Act (ACA).

H.B. 245 cleared the House last month, but faced significant opposition from Senators who raised concerns about whether it would effectively give a “monopoly” to the state’s dominant insurer. Alabama Blue Cross and Blue Shield already controls 86 percent of the individual market and 96 percent of the small group market (see Update for Week of April 16th), and is currently the only carrier that offers plans in every county of the state, which the bill requires for exchange participation.

Many Senate Republicans also backed-off after Governor Robert Bentley (R) pledged to veto the legislation. An earlier supporter of creating a state-based exchange, Bentley has since elected to follow the lead of nearly all other Republican governors and delay implementation until the U.S. Supreme Court resolves the constitutionality of the ACA this June (see Update for Week of March 26th). The Governor also insists that the state still lacks sufficient federal guidance to proceed.

H.B. 245 has also drawn the ire of consumer groups for requiring nine of the 21 members on the governance board be affiliated with insurers or providers, while initially barring consumer representation (see Update for Week of April 16th).

Colorado

Governor signs Hospital Payment Assistance Program into law

Governor John Hickenlooper (D) signed bipartisan legislation this week that requires hospitals to make information about discount programs and charity care available in hospitals and on hospital websites. The Hospital Payment Assistance Program created by S.B. 134 also mandates that hospitals offer reasonable payment plans to uninsured patients before initiating collection proceedings and limits the amount that low-income uninsured can be required to pay.

Connecticut

Senate fails to move bill adding consumer representation to exchange board

Consumer advocates were bitterly disappointed this week that legislation adding consumer representation to the health insurance exchange board was left to die at the end of the legislative session.

Senate approval had appeared likely after the House unanimously passed H.B. 5013 last month. The bill would have effectively added three consumer advocates to the exchange governing board while banning insurer representation (see Update for Week of April 23rd).

However, Senate Democrats accused minority Republicans threatening to filibuster the measure to the point of delaying other critical legislation that needed to pass before the session came to a close. Senate Minority Leader John McKinney (R) acknowledged that he objected to the move by House Democrats to add five new members in total, instead of the three new members allowed by the initial version of the legislation (see Update for Week of April 9th). But he insisted that the measure was never called to a vote because Senate Democrats lacked the votes to pass it.

District of Columbia

Consumer groups oppose plan to eliminate small group/individual coverage outside exchange

The Health Reform Implementation Council (HRIC) is scheduled to vote on final recommendations on May 17th that will guide the District of Columbia's implementation of the health insurance exchange required by the Affordable Care Act (ACA).

The D.C. Council passed exchange-authorizing legislation last winter that created the HRIC and sought to create an "active purchaser" exchange in which the governing board can negotiate rates and excludes plans that are not affordable. The measure (B19-2) also imposes among the strictest conflict of interest provisions sought by any state. It not only bars individuals with a financial stake in health insurance from serving on the oversight board, it prohibits all members from being employed by a health insurer within one year after their departure from the board (see Update for Week of December 19th).

However, subsequent recommendations by the HRIC have drawn the ire of consumer advocates as it would entirely eliminate the insurance market outside the exchange and require all small employers and individuals in the District purchase their insurance via the exchange. Only the limited number of plans offered through the exchange would be available to these populations.

Vermont is the only state that has adopted a similar approach (see Update for Week of April 23rd). However, that state is seeking a federal waiver to move towards a single-payer system with the goal of abolishing all private health insurance by 2015. Massachusetts, which already had an exchange prior to the ACA, is the only state that has even merged the small group and individual markets.

Consumer advocates note that the other 11 states that have enacted exchange-authorizing legislation all view the exchange as a supplement and not a replacement for the existing insurance market for small businesses and individuals. They insist that the HRIC's approach would reduce competition, which is contrary to the intent of the ACA exchange provisions.

The public comment period for the HRIC recommendations concluded this week.

Florida

AHCA commissions exchange study in case U.S. Supreme Court upholds Affordable Care Act

The Agency for Health Care Administration (AHCA) is requesting bids for a \$700,000 study on the information technology that will be required to operate a new state-based health insurance exchange.

The move comes as somewhat as a surprise as Governor Rick Scott (R) has consistently refused to implement any provision of the Affordable Care Act (ACA) until the U.S. Supreme Court resolves the its constitutionality (see Update for Week of March 26th). He even returned two \$1 million federal grants for exchange implementation and premium reviews that were obtained by his predecessor Charlie Crist (I).

However, AHCA acknowledges the need for the state to be ready in the event the Supreme Court does not strike down the entire ACA. Because a federal fallback exchange will operate in Florida if the state does not make substantial progress towards implementation by January 2013, AHCA has set a July 30th deadline to complete the study (with the contract to be awarded May 22nd).

Governor Scott has not yet committed to creating a state-based exchange if the ACA is not overturned. However, such a short timeframe may force him to accept a federal fallback exchange if the Obama Administration does not extend the January 2013 deadline. (At least one potential bidder, KPMG, has already indicated that it cannot complete the required study in only seven weeks.)

Iowa

House and Senate pass “problematic” bill requiring licensure for exchange navigators

The House and Senate passed a budget bill this week that includes a controversial provision requiring navigators in any health insurance exchange to be licensed, even though the legislature has yet to act on exchange-authorizing legislation.

The Affordable Care Act (ACA) requires boards governing the new health insurance exchanges to award grants to navigators who can facilitate exchange enrollment and provide “fair and impartial” guidance to consumers on plan options, availability of federal tax credits for exchange premiums and cost-sharing, and questions about grievances, complaints, and appeals. The Centers for Medicare and Medicaid Services (CMS) recently finalized rules that gave states significant flexibility in defining who could serve as a navigator, subject to basic federal standards (see Update for Week of March 12th).

However, the same federal rules also prohibit states from requiring that navigators be insurance agents, brokers, or paid a percentage commission. Consumer advocates and even Insurance Commissioner Susan Voss (D) were immediately troubled by the licensure requirement, arguing that it may run afoul of this prohibition and give agents and brokers an unfair advantage. AARP called it a “national embarrassment” as it effectively would preclude anyone but insurance agents or brokers from serving as navigators. The Commissioner asked CMS for a ruling on the “problematic” provision last month, but has yet to receive a decision.

Democrats had mixed opinions about the provision. Senate Health Committee chairman and sponsor of exchange-authorizing legislation Jack Hatch (D) opposed the measure, while Senator Tom Rielly (D), an insurance agent, supports it, noting that Maine has a similar licensure requirement.

It is not yet clear if the full measure (H.F. 2465) will be approved by Governor Terry Branstad (R).

Maryland

Governor signs latest exchange bill, which includes criteria for navigators

Governor Martin O'Malley (D) signed the *Health Benefit Exchange Act of 2012* into law last week. The legislation builds on the exchange framework authorized last year and will allow the exchange to meet all federal deadlines and become operational by 2014. H.B. 443/S.B. 238 specifically creates a navigator program that defines what entities can help to facilitate consumer enrollment (see Update for Week of March 19th).

Massachusetts

House and Senate roll out similar measures to transform fee-for-service to global budgets

The long-sought initiative by Governor Deval Patrick (D) to move the entire Commonwealth away from fee-for-service reimbursement is again moving forward. Two years after his initial legislation failed to advance, the House and Senate rolled-out their latest proposals to transform all third-party payer

reimbursement to a system of prospective global budgets, similar to the model in place in Canada and being implemented for Medicaid in Oregon (see Update for Week of April 30th) and the entire state of Vermont (see Update for Week of April 23rd).

The measures are very similar, in that they set a target growth for state health care spending and establish a new regulatory authority to enforce it on providers. However, the House bill sets a far lower spending target, limiting the global cap to the rate of growth in the gross state product (GSP) for 2015 and a half-percent below the growth in GSP in 2016. By contrast, the Senate cap starts at a half-percent above GSP growth for 2015 and equal to GSP growth in 2016.

The House bill also imposes far tougher penalties for health plans and providers that spend above the global budget cap. The Senate plan only assesses fines on those who fail to submit an improvement plan to get within the cap or make a good-faith effort to comply. However, the House plan would penalize those who fail to stay under the cap without good cause by renegotiating their contracts.

Business groups who have historically been pounded by some of the nation's highest health insurance premiums were disappointed that the measures do not go far enough in restraining costs. They had advocated for a spending cap that would be a full two percentage points below the annual growth in GSP. By contrast, the Massachusetts Medical Society insisted that the measures were unnecessary as the Patrick Administration was already doing a sufficient job of limiting premium increases to single digits over the past two years (see Update for Week of April 30th).

The Governor has already received federal approval for his global budget model (see Update for Week of December 19th).

Minnesota

Governor blocks effort to make Minnesota the sixth state to opt-out of Medicare and Medicaid

Governor Mark Dayton (D) vetoed legislation last week that sought to make Minnesota the sixth state to join an Interstate Health Care Compact that would use unrestricted federal block grants to provide services as they see fit to Medicare and Medicaid enrollees.

Republican lawmakers in Texas, Georgia, Louisiana, Oklahoma, and Utah have already joined the Compact, which is under consideration in several other states including Idaho and South Carolina (see Update for Week of March 5th). However, the measures are largely symbolic as they would require a federal waiver and may not pass constitutional muster without further Congressional legislation since both Medicare and Medicaid are governed by federal law.

The Minnesota compact bill (S.F. 1933) was sought by Senate Health and Human Services Committee chairman David Hann (R), who has threatened to sue the Governor to block implementation of a health insurance exchange via executive order (see Update for Week of October 31st).

New Jersey

Governor vetoes health insurance exchange bill, citing U.S. Supreme Court uncertainty

Governor Chris Christie (R) vetoed legislation this week that would have created the health insurance exchange required by the Affordable Care Act (ACA).

The Governor had supported the "market-based reform" and obtained over \$8.7 million in federal grants to design the new exchange. However, his support waned over the past year in the face of "tea party" opposition to legitimizing any part of "Obamacare". As a result, the Governor elected to follow the lead of nearly all Republican governors and delay all implementation until the U.S. Supreme Court resolves the constitutionality of the new law this June (see Update for Week of March 26th).

The Governor had been urged by consumer advocates to sign the exchange bill (A.2171/S.1319), given that polls commissioned by AARP found that nearly 60 percent of New Jerseyans under age 65 favor a state exchange over the federal fallback exchange that will now likely result (see Update for Week of April 2nd). However, business and insurer support for the bill had also waned after the version enacted by Democratic lawmakers followed the “active purchaser” model in Massachusetts, where the exchange board can selectively contract only with those insurers who offer the best value. Federal regulations allow states to either follow this model or the “clearinghouse” model in Utah where any insurer that meets minimum standards can participate. The latter is typically favored by conservatives.

Oklahoma

House and Senate reconciling bills to allow “bare-bones” interstate health plans

House and Senate conferees are nearing approval of legislation that would allow out-of-state insurers to sell “bare bones” policies in Oklahoma that do not comply with state coverage mandates.

Bill sponsor Senator Bill Brown (R) has vigorously pursued the legislation for the past two sessions, insisting that the extra competition will lower cost. He claims that during his career as an insurance salesman, most customers only want “bare bones” catastrophic coverage and should not be forced to purchase more comprehensive and costly plans that included state mandated coverage.

The legislation passed in mostly party line votes despite the opposition of consumer groups who fear consumers will be unwittingly stuck with plans that fail to meet even their most basic health needs. They also point out insurers have expressed zero interest in interstate health plans allowed under a new Georgia law passed last year (see Update for Week of April 30th).

Virginia

Health reform panel stalls on essential health benefits decision

A gubernatorial advisory panel inched closer last week to deciding what essential health benefits would have to be offered in a Virginia-operated insurance exchange.

The Virginia Health Reform Initiative Advisory Council was appointed last year by Governor Bob McDonnell (R) to propose how or even if the Commonwealth should create the new health insurance exchange required by the Affordable Care Act (ACA). Chaired by Health and Human Resources Secretary Bill Hazel, the panel recommended that Virginia create its own state-based exchange instead of allowing a federal fallback exchange (see Update for Weeks of November 21st and 28th). However, the Governor and Republican lawmakers have elected to wait until the U.S. Supreme Court resolves the constitutionality of the ACA before proceeding (see Update for Week of February 6th).

In the interim, the panel is debating how to comply with the Obama Administration’s decision to let states define the essential health benefits that must be provided by exchange and non-exchange plans starting in 2014 (see Update for Week of December 12th). Members came just short last week of selecting a small-group option offered by Virginia's biggest insurer, Anthem Blue Cross as the benchmark plan required by federal guidance. However, they instead decided to wait for a detailed comparison of benefits currently provided under other Virginia health plans, as well as a better understanding of what services would be covered for mental health, substance abuse, and developmentally delayed children.

The Centers for Medicare and Medicaid Services (CMS) has indicated that it will use the most popular of the small-group plans in states that elect to allow a federal fallback exchange (see Update for Week of February 20th).