

Health Reform Update – Weeks of May 28 and June 4, 2012

CONGRESS

House votes to repeal medical device tax and FSA limits imposed by Affordable Care Act

House Republicans voted this week for the thirtieth time to repeal specific provisions of the Affordable Care Act (ACA).

Unlike previous repeal efforts, 37 Democrats from states with a heavy device industry presence joined with Republicans to pass H.R. 436, which would eliminate the 2.3 percent tax on medical device manufacturers as well as the prohibition on using employee health savings accounts (HSAs) or flexible spending accounts (FSAs) for over-the-counter expenses. It would also give enrollees access to up to \$500 of an unused balance in their HSA or FSA accounts.

In order to offset the \$37 billion in revenue that will be lost over ten years by repealing these provisions, House Republicans sought to remove any cap on the amount that recipient of ACA subsidies would have to repay if their income increased during a given year. This \$1,500 cap has already twice been increased by Congress to offset the lost revenue from repealing a small business reporting requirement under the ACA and postponing a dramatic cut in Medicare physician payments.

The Congressional Budget Office found that removing the cap on subsidy on overpayments would more than offset the lost revenue and, combined with the other bill changes, would reduce the deficit by \$6.7 billion over ten years. However, the Joint Committee on Taxation found that it would also cause another 350,000 people to forgo exchange coverage due to cost, on top of the several hundred thousand who were already excluded when the cap was nearly quadrupled from \$400 to \$1,500.

President Obama pledged to veto the legislation if it reached his desk. However, it likely will not even be considered in the Senate as Majority Leader Harry Reid (D-NV) pledged not bring it to a vote.

FDA user fee reauthorization easily clears House, but Appropriations seeks agency funding cut

Bipartisan legislation to reauthorize Food and Drug Administration (FDA) user fee programs overwhelmingly passed the House last week after it was changed to more closely match the costs of its Senate counterpart.

Only five lawmakers voted against the amended measure (H.R. 5651), which would grant a five-year reauthorization for FDA programs that help fund the agency's review of prescription drugs and medical devices. The bill also would create new user fee programs for generic drugs and biosimilars.

The Senate nearly unanimously passed its version (S. 3187) last week (see Update for Week of May 21st). Both chambers are now starting the conference committee process to reconcile differences and set up quick votes in both chambers for final passage. House and Senate leaders have set a goal of delivering a final bill to President Obama by July 4th.

Although the two bills are mostly similar, key differences remain on the regulation of medical devices and incentives for companies to create new antibiotics. However, H.R. 5651 will now reduce the federal deficit by \$370 million over ten years (including a \$5 million increase in revenue), according to a new score from the Congressional Budget Office, putting it much closer to the cost of S.3187.

The CBO had projected that the version approved by the Energy and Commerce Committee would increase federal deficits by \$247 million over ten years (see Update for Week of May 21st). However, chair Fred Upton (R-MI) promptly modified a provision so that lower-cost generic drugs can reach the market more quickly by reducing the FDA deadline to respond to citizen petitions requesting stays on pending applications for generic drugs or biosimilars from 180 to 150 days. (Currently there is no time limit for the FDA to respond).

The House Appropriations agriculture subcommittee also advanced draft legislation this week that includes a lower level of FDA funding for fiscal year 2013 than sought by its Senate counterpart (S. 2375). The measure would also cut current year funding by \$16.3 million.

The Alliance for a Stronger FDA was quick to protest the funding cut, though noting that it was a significant step forward from the \$285 million reduction sought by House Republicans last year (see Update for Week of November 14th). The Alliance specifically criticized the measure for eliminating funds for biologics oversight at a time where the FDA was implementing a new approval pathway and user fee program for biosimilars.

Urban Institute finds that ACA will not “kill jobs” or slow economy

A new study released this week by the Urban Institute and Robert Wood Johnson Foundation refutes the claim by Republican lawmakers that the Affordable Care Act (ACA) will lead to massive job losses and slow economic growth.

House Republicans have consistently used this line of attack since the very first bill introduced this year entitled the *Repealing the Job-Killing Health Care Law Act*. The authors note that Presidential candidate Mitt Romney has even accused the Administration of “knowingly” impeding economic growth by pursuing health insurance reform.

However, researchers reviewed the impact of the Massachusetts health reform law that was enacted by Governor Romney in 2006 to conclude that the ACA would neither harm job creation or economic growth. According to their findings, employment in Massachusetts remained largely stable after Governor Romney signed the new law and has since followed national trends.

The study emphasizes that the Massachusetts reforms and the ACA share the same core policies, including individual and employer mandates, health insurance exchanges, and federal subsidies to help low-to-moderate income people purchase affordable coverage in the exchange. However, the penalties under the Massachusetts law are higher for not complying with the individual mandate (see Update for Week of March 19th), but lower for not complying with the employer mandate.

Study shows that majority of those eligible for ACA subsidies have never heard of them

A new study by CVS Caremark revealed last week that 78 percent of consumers who would be eligible for federal subsidies to purchase affordable coverage in new state-based health benefit exchanges are unaware of this provision of the Affordable Care Act (ACA)

According to CVS Caremark management, the news coverage related to the ACA has only confused most Americans about the benefits and requirements of the new law. Their survey of more than 1,000 consumers focused only on those who are uninsured or covered by individual policies and did not include enrollees in employer coverage, Medicare, or Medicaid.

Senate bill would expand access to Medicare Advantage, Medigap plans for the disabled

Senator John Kerry (D-MA) introduced legislation this week to expand access to Medicare Advantage (MA) and supplemental Medigap policies for all Medicare beneficiaries, including the disabled.

Medicare beneficiaries aged 65 and older can currently buy Medigap policies without being denied coverage or charged higher premiums because of their medical history. However, only 29 states likewise prevent such discrimination for those under age 65 who qualify for Medicare based on disability or end-stage renal disease.

Senator Kerry's legislation would thus extend guaranteed issue rights under Medigap to those enrolled in MA plans who want to switch to traditional Medicare because of a premium increase or change in benefits. Currently, those enrollees are not guaranteed the ability to buy Medigap supplemental policies if they change their coverage to traditional Medicare.

In addition, beneficiaries with end-stage renal disease could join MA plans, which they are generally prohibited from doing now. (MA plans are private managed care plans that serve as an alternative to traditional fee-for-service Medicare.)

Senator Kerry criticized his colleagues for allowing such discrimination in Medigap and MA plans, while preventing private health plans from doing so under the Affordable Care Act (ACA). He insisted that this discrepancy was "inconsistent and unconscionable." Nearly 50 consumer groups have already endorsed his measure.

Senator Kerry introduced legislation last summer (S.1416) that would also apply the new medical-loss ratios under the ACA to Medigap plans. However, it has only one cosponsor.

Commonwealth Fund survey shows that ACA has expanded coverage to 6.6 million young adults

A new survey by The Commonwealth Fund reported this week that 6.6 million young adults under age 26 have joined the parents' group health plan as a result of the Affordable Care Act (ACA)—the largest single-year increase for that population.

Figures released by the Department of Health and Human Services (HHS) on the second anniversary of the ACA showed that 2.5 million uninsured young adults were able to gain coverage under the new law and keep it over time (see Update for Week of March 19th). However, The Commonwealth Fund survey also counts young adults who switched to their parents' plan from other coverage.

Commonwealth Fund researchers insist that economic hardship remains the primary factor in the high rate of uninsured among young adults. They stressed that the results show that most young adults simply cannot afford health insurance not provided through an employer. It also revealed that most young adults "don't think they are immortal" and will take advantage of affordable policies, contrary to the popular myth that "young invincibles" often deliberately choose to forgo coverage they can afford.

The online sample of nearly 1,900 adults age 19-29 found that nearly two-thirds of young adults enrolled in employer-sponsored coverage once they were eligible, while only six percent went without affordable coverage that was offered to them. Over 36 percent reported difficulty paying medical bills while 41 percent delayed medically necessary care due to cost.

Tracking polls by the Kaiser Family Foundation consistently rank the young adult provision as the single most popular part of the ACA, as it remains favored by over 70 percent of those surveyed. Getting the young adult population insured had been particularly problematic during the recession, as unemployment for those under age 25 is nearly double the rate for older Americans.

As a result, the co-chair of a caucus of 21 Republican lawmakers with medical backgrounds stated this week that House Republicans will move to reinstate the young adult provision if the ACA is struck down by the U.S. Supreme Court. Rep. Phil Gingrey (R-GA), a physician, insisted that the measure is "good policy" even though fellow Republicans like Senator Jim DeMint (R-SC) claim it costs up to three times more than the one percent increase in premiums estimated by HHS.

However, Gingrey acknowledged that Republicans would likely not reinstate another overwhelmingly popular provision of the ACA, the ban on pre-existing condition denials. Rep. Tom Price (R-GA), also a physician, recently insisted that a guaranteed issue requirement was a “terrible idea” (see Update for Week of May 7th).

FEDERAL AGENCIES

HHS says consumer assistance grants under ACA saved subscribers over \$18 million

The Department of Health and Human Services (HHS) announced a new round of federal grants this week to support state-based Consumer Assistance Programs (CAP) that help consumers with questions or concerns regarding their health insurance.

The announcement coincided with a new agency report concluding that the initial round of grants under the Affordable Care Act (ACA) has saved policyholders over \$18 million.

CAP grantees can be state agencies or local non-profits contracted by the state to answer insurance questions, file appeals of health plan denials, and education consumers on their insurance options. Initial awards were issued in 2010 to 35 states, the District of Columbia, and four territories. Over the following year, these entities directly assisted more than 200,000 consumers and reached hundreds of thousands more through outreach and education efforts.

The HHS report found that CAP grantees recovered at least \$18 million in direct savings, not including the millions of dollars saved by securing better health plan coverage for consumers. According to HHS, more than 75 percent of all cases closed by CAPs were resolved in the consumer’s favor.

HHS proposed rule clarifies how state must define essential health benefits

Proposed regulations issued this week by the Department of Health and Human Services (HHS) further clarify how the agency wants states to define the essential health benefit package that plans must cover starting in 2014.

The rulemaking incorporates some of the 11,000 stakeholder comments received in response to the agency’s earlier guidance bulletin (see Update for Week of January 30th). As set forth in that guidance, essential health benefits will be defined by a benchmark plan selected by each state, which will serve as a reference for the scope of services and limits to be offered.

A fact sheet released by CMS after the initial bulletin stated that states cannot adopt different benchmark plans for the individual market and small-group markets, and urged them to choose their benchmark by the third quarter of 2012 (see Update for Week of February 20th).

In the initial bulletin, HHS proposed four possibilities for benchmark plans if a state does not select its own benchmark. However, HHS is now proposing to limit this option to the small group market plan and product with the largest enrollment.

To begin that process, HHS proposes that data be collected from the three insurers with the largest plan and product enrollment in the small group market. The data would include information on enrollment, covered benefits, and treatment limitations, as well as a list of covered drugs and information regarding any prior authorization or step therapy required. (HHS plans to revisit this approach in 2016.)

The agency also proposes that the National Committee for Quality Assurance and the Utilization Review Accreditation Commission serve as the interim accrediting organizations for plans seeking to be part of the new state-based health insurance exchanges. These organizations are already responsible for most health plan accreditations and will help keep accreditation on track to begin in early 2013.

Future rulemaking will outline an application process, standards for recognition, criteria-based review of applications, public participation, and public notice of the recognition. HHS is soliciting public comments through July 4th

CMS uses ACA funds to improve coordination of primary care services

The Center for Medicare and Medicaid Services (CMS) innovation center created by the Affordable Care Act (ACA) announced this week that it will be collaborating with 45 commercial, federal and state insurers in seven markets to provide financial incentives for better primary care coordination.

About 75 primary care practices from each market will be selected for the Comprehensive Primary Care initiative. These include states of Arkansas, Colorado, New Jersey, and Oregon, as well as the metro Cincinnati and Albany, New York regions. The application period remains open until July 20th.

Under the initiative, CMS will pay participating primary care practices a care management fee averaging \$20 per month per Medicare beneficiary. At the same time, the other insurance partners will offer payments to those practices that provide similar services for their members.

In order to receive the new care management fee, primary care practices must agree to provide enhanced services for their patients, including longer hours, greater use of electronic health records, more preventive care, and improved coordination with other providers.

The Center for Medicare and Medicaid Innovation was launched in 2010 and given \$10 billion in funds over the next decade to support the testing of new payment and service delivery models that aim to reduce spending while maintaining or increasing quality of care. The Center has since started 12 projects, including the implementation of the Accountable Care Organization provisions of the new law (see Update for Week of October 17th).

The Center also announced that it may launch a second initiative this year that will allow state facilities to test global payment systems or other models that move away from traditional fee-for-service.

IRS issues new guidance on lower FSA limits for 2013

The Internal Revenue Service (IRS) issued Notice 2012-40 last week, which clarifies how the agency will enforce the new \$2,500 limit on Flexible Spending Account (FSA) reimbursement.

The Affordable Care Act (ACA) reduces the FSA limit from \$5,000 to \$2,500 per "tax year" starting in 2013. The Notice notes that IRS defines a "tax year" as the cafeteria plan year, so that plans that do not use a calendar year can still fall into 2013 without being subjected to the lower limit.

The IRS also stressed that an employee and spouse can each maintain separate accounts with a \$2,500 limit, even if they work for the same company. The new limit also does not apply to premium conversion or Premium Only Plans, as well as other options in a cafeteria plan such as dependent care.

In an unexpected move, the IRS is also request public comments on how to construct new rules that currently require employees to use their entire FSA balance in a given year or lose it. House Republicans passed legislation this week that would allow employees to access to up to \$500 of an unused balance (see above).

HEALTH CARE COSTS

Public health spending up dramatically, but overall growth rate likely to continue to decline

A new study released this week by the National Institute for Health Care Management Foundation (NIHCMF) shows that the public sector paid for 45 percent of total spending on health care in 2010, a significant jump from the one-third share in 1987.

Spending for Medicare alone nearly tripled as a share of overall spending, increasing from 3.4 percent in 1987 to nearly ten percent in 2010. At the same time, federal Medicaid expenditures doubled to 10.7 percent, although health spending by private business and households declined.

Overall, the report found that the U.S. spent 18 percent of gross domestic product on health care in 2010 (or \$8,400 per capita), which is projected to reach nearly 20 percent by 2020. The vast majority of spending (84 percent) went for personal health care services, while administrative insurance costs, public health activities, and public and private health investments accounted for 16 percent.

Hospital care accounted for the largest portion of total spending and grew more rapidly than other sectors. Overall hospital spending increased 21 percent from just 2006-2010, or nearly 40 percent of the total change during that time.

The study confirmed that spending growth has slowed significantly in the last three years largely due to patients forgoing needed care during the recession, but emphasized that the downward trend preceded the recession and is likely to continue due to shifts towards more efficient delivery systems, increasing prevalence of lower cost generic drugs, and expiring patents for many blockbuster drugs. However, despite this trend, the growth rate in health spending is still likely to exceed economic growth.

A separate study released this week by PricewaterhouseCoopers (PwC) echoed the NIHCMF findings in concluding that lower growth in health spending may be the “new normal”. The company’s Health Research Institute found that health care spending is only expected to rise 5.5 percent next year when accounting for high deductibles and copayments imposed on subscribers. That represents the fourth consecutive year where the annual cost increase will stay below eight percent.

PwC noted that its earlier projections of nine percent growth in health spending for 2010 and 2011 exceeded actual growth by at least two full percentage points. According to the Centers for Medicare and Medicaid Services, national health spending slowed to 3.9 percent in 2010 after registering up to 9.5 percent in 2002.

PwC predicts that the Affordable Care Act will cause a brief “spike” in spending. However, this may be offset by health industry trends and state laws that are holding down prices, some of which may actually be spurred by the new law. For example, the number of Americans enrolled in high-deductible plans increased 18 percent from 2010 to 2011, according to America’s Health Insurance Plans. PwC researchers also noted that prescription drugs worth roughly \$54 billion in American sales are losing patent protection in 2011 and 2012, leading to even greater use of lower cost generic drugs.

The study also cited the passage of transparency laws in at least 37 states, which now require hospitals and clinics to publish at least some pricing information, enabling consumers to more readily shop around for the best price.

More than half of the 1,400 employers surveyed by PwC are likely to further increase the share of health insurance costs borne by their employees in 2013.

Kaiser survey confirms that near-seniors struggle more than seniors with access to health care

An analysis released this week by the Kaiser Family Foundation found that near seniors face more difficulties obtaining access to affordable health care than those already enrolled in Medicare.

The survey found that 40 percent of respondents who are uninsured and age 55-64 report having unmet health care needs or delaying treatment, while 30 percent of this group lives with families reporting

problems paying their medical bills due to the cost. However, seniors on Medicare report access problems “at a significantly lower rate”

STATES

Alaska

Governor signs law requiring 90-day notice for specialty tier drugs

As expected, Governor Sean Parnell (R) signed legislation this week that allows private health plans to apply cost-sharing for the highest cost specialty drugs that exceeds the cost-sharing for non-preferred brand drugs, but only if the insurer notifies the subscriber at least 90 days in advance (see Update for Week of April 16th). H.B. 218 goes into effect January 1st.

California

Health reform bills move forward, including limits on out-of-pocket costs

The Assembly passed legislation this week that limits out-of-pocket costs for subscribers of individual or small group plans and creates a single deductible in place of separate deductibles for health care, pharmacy, etc. (see Update for Week of April 30th).

A.B. 1800, which is backed by numerous consumer groups including PSI, now moves on to the Senate. Similar legislation from Speaker Pro Tempore Fiona Ma (D) that prohibited the use of specialty tier coinsurance died last session (see Update for Weeks of April 18 and 25, 2011).

Other health reform measures that passed the Assembly over the past two weeks include:

A.B. 1453 to define the essential health benefit package that plans must cover per the ACA.

A.B. 1461 to reform individual health insurance consistent with the Affordable Care Act (ACA). (Its identical S.B. 961 counterpart likewise cleared the Senate). Because the measure would ban pre-existing condition denials, the insurance industry is lobbying for the final measure to include the same individual mandate found in the ACA. Governor Jerry Brown (D) has indicated that he may pursue an individual mandate if the U.S. Supreme Court removes it from the ACA (see Update for Week of March 26th).

A.B.1526 to streamline and expand eligibility for the state high-risk insurance pool, remove annual and lifetime caps, and otherwise make its requirements similar to the federal high-risk pool created by the ACA (see Update for Week of March 26th).

A.B. 2350 to require greater public disclosure of the types of insurance products being sold in the California market.

In addition to S.B. 961, health reform measures that cleared the Senate include:

S.B. 970 to facilitate the "no wrong door" to eligibility and enrollment for health and social services programs, including the California Health Benefit Exchange created by the ACA. (This was the only measure to receive broad Republican support.)

S.B.1410 to strengthen the independent medical review process for subscribers whose care has been denied by a private insurer.

S.B. 1431 to prevent stop-loss carriers from issuing policies with an individual attachment point that is less than \$95,000 for a policy year or an aggregate attachment point for a policy year that

is below \$19,000 times the total number of covered employees and dependents, 120 percent of expected claims, or \$95,000. The federal government is currently seeking comments on the extent to which such low attachment points are being used to evade key provisions in the ACA (see Update for Week of April 30th).

A measure to increase price transparency by requiring hospitals to disclose all potential charges for medical procedures failed in committee last month and was declared dead for this session. S.B. 1373 had the support of Insurance Commissioner Dave Jones (D) but was staunchly opposed by providers (see Update for Week of April 16th). Similar legislation was also promptly squashed in Florida.

Three largest health plans owe California subscribers over \$51 million in ACA rebates

Two of California's three largest health plans will have to rebate roughly \$51 million to subscribers for exceeding the new medical-loss ratios imposed by the Affordable Care Act (ACA).

Starting with the 2011 plan year, the ACA required individual and small group plans to spend at least 80 percent of premium revenue on direct medical care (85 percent for large-group plans) or rebate the difference to subscribers this August. Figures furnished last week to federal and state officials revealed that Anthem Blue Cross will owe policyholders nearly \$40 million in rebates while non-profit rival Blue Shield of California must pay about \$11 million.

Anthem spent only about 77.5 percent of premiums on medical care, compared to 78.2 percent for Blue Shield. However the state's largest health plan, Kaiser Permanente, will owe only \$280,000 in rebates, or an average of \$12 per subscriber, because its medical-loss ratio fell only 0.4 percent below the required 80 percent threshold. .

State awards exchange contract that could be voided by U.S. Supreme Court decision

State officials announced last week that the California Health Benefit Exchange will award a \$359 million contract to Accenture to build the online eligibility and enrollment system needed to operate the new marketplace required by the Affordable Care Act (ACA).

The contract is subject to federal approval and funded largely through federal exchange establishment grants. It will be voided should the U.S. Supreme Court overturn the entire ACA (see Update for Week of March 26th).

California was the first state to pass exchange-authorizing legislation and expects meet the January 2013 federal deadline for exchange certification. Roughly 4.4 million Californians are expected to participate in the exchange by the end of 2016.

Iowa

Governor signs controversial law requiring exchange navigators to be licensed

Governor Terry Branstad (R) signed budget legislation into law last week that includes a "problematic" provision requiring state licensure of navigators who will assist consumers with obtaining coverage in a future health insurance exchange.

AARP lobbied heavily against the provision, which it claims is merely a "premature" and "backdoor" method of hampering the implementation of the exchange required by the Affordable Care Act (ACA), should the law be upheld by the U.S. Supreme Court. Governor Branstad has opposed moving forward on exchange implementation until the court rules later this month.

AARP and Iowa Insurance Commissioner Susan Voss (D) have petitioned the federal Centers of Medicare and Medicaid Services (CMS) to refuse to certify the exchange if it retains the licensure provision (see Update for Week of May 7th), as final regulations issued last spring specifically state that

navigators should not be subject to the same as licensing standards as brokers (see Update for Week of March 12th). States must show “substantial progress” by January 2013 or risk having a federal fallback exchange operated in their state in January 2014.

The navigator licensure requirement is slated to go into effect on July 1st even though Iowa has not created or authorized an exchange or established any other criteria for navigators. It would require that navigators be licensed in the same manner as insurance agents or brokers.

AARP insists that agents or brokers, though they can become navigators, would need additional training to perform the functions of a navigator such as determining eligibility for federal premium subsidies. The fees and surety bonds required for a license may also deter many navigator applicants.

Massachusetts

House and Senate to reconcile similar bills to transform fee-for-service to global budgets

It may have taken years to reach a floor vote, but landmark legislation to transform all third-party payer reimbursement to a system of prospective global budgets has now quickly cleared both chambers after overwhelmingly passing the House this week.

A similar version of S.B. 2260 nearly unanimously cleared the Senate shortly after being introduced (see Update for Week of May 14th). A conference committee will now reconcile the House and Senate versions, which differ on certain provisions like the surcharge on hospitals and other health care providers. The Senate bill does not call for any surcharge (see Update for Week of May 14th), while the House version would require hospitals that charge more than 20 percent above the state median price for a service to pay a ten percent surcharge.

Both versions set a target growth rate 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 with tougher penalties and thus is expected to save \$160 billion instead of \$150 billion over 15 years.

The reconciled bill is likely to be signed by Governor Deval Patrick (D), who has proposed global budget legislation over the past two sessions (see Update for Week of May 7th).

Health committee passes legislation limiting use of specialty tier coinsurance

Legislation introduced last session by Senator Anthony Petrucci (D), chair of the Joint Committee on Financial Services, has cleared its second legislative committee.

S.B. 455 would prohibit insurers from using specialty tiers that require consumers to pay a percentage of the highest-cost prescription drugs. It also bans prescription drug copayments in which the maximum copay exceeds by more than 500 percent the lowest prescription drug copayment charged by the plan.

The measure passed the Joint Committee on Health Care Financing last week, after clearing the Joint Committee on Financial Services earlier this year (see Update for Week of January 30th).

New Hampshire

Exchange prohibition impedes reconciliation of final bill to require child-only coverage

Legislation that would require individual health plans to offer child-only coverage without regards to health status so long as it is grandfathered under the Affordable Care Act (ACA) appears to have hit a roadblock as House and Senate conferees have been unable to reconcile different versions of the bill.

S.B. 219 introduced by Senator Raymond White (R) at the request of the Department of Insurance easily passed the Republican-controlled Senate. However, Republicans in the House are far more conservative and have adamantly refused to implement any provision of the ACA. As a result, they only passed the measure after it was amended to forbid the creation of the health insurance exchange also required by the new law.

Senate Republicans refused to concur with the amendment, which is the subject of another bill (H.B. 1297) expected to be vetoed by Governor John Lynch (D), who supports the exchange. That measure was only passed after House Republicans agreed to the demands of their Senate counterparts to at least allow the Department of Insurance to explore a federal-state exchange partnership, so that a federal fallback exchange would not automatically be operated within the state.

Wisconsin

Republican Governor survives recall election, Democrats temporarily gain Senate control

Governor Scott Walker (R) became the first governor this week to survive a recall election, prevailing by an unexpectedly comfortable margin. However, Democrats appear to have gained the one additional seat needed for control of the Senate in a contest decided by less than 800 votes.

The outcome was largely unprecedented. California Governor Gray Davis (D) in 2003 and North Dakota Governor Lynn Frazier (R) in 1921 are the only two Governors to have previously been forced into a recall election—both of whom lost. Additionally, it is only the fifth time that a political party gained control of a legislative chamber via the recall process.

However, the Senate victory may prove to be largely symbolic. Even if a likely recount in the recall of Senator Van Wangaard (R) upholds the outcome, the Democrats are likely to lose their newfound majority before the legislature reconvenes next January. Redistricting completed by the Republican-controlled legislature has given a prolific advantage to Republicans in the 16 Senate districts at stake in the November elections.

Recall elections over the past year were inspired by the bitterly-contested measure sought and enacted last year by the Governor that stripped state employees of their right to collectively bargain for health benefits and gave him unprecedented authority to cut Medicaid eligibility and benefits with limited legislative oversight. The Wisconsin Supreme Court narrowly upheld the law, which passed without Democratic lawmakers who fled the state to prevent a quorum (see Update for Week of June 20th).

Major Wisconsin health plans all meet new profit caps imposed by Affordable Care Act

The Wisconsin Association of Health Plans announced this week that all 12 of its health plan members met the new medical-loss ratio (MLR) required by the Affordable Care Act (ACA) for 2011.

Starting with the 2011 plan year, individual and small group plans had to spend at least 80 percent of premium revenue on direct medical care (85 percent for large-group plans) or rebate the difference to subscribers this August. Wisconsin's insurance commissioner had argued that this threshold was too onerous and petitioned the federal government for a waiver to phase it in over three years. However, the Centers for Medicare and Medicaid Services (CMS) rejected the waiver request, concluding that Wisconsin has one of the most competitive insurance markets in the country, as affirmed by an actuarial analysis commissioned by the state (see Update for Week of February 13th).

Figures provided by health insurers last week to federal and state officials confirm that Wisconsin insurers were largely all able to meet the new MLR. In addition to the 12 major in-state plans referenced above, the two largest national health insurers in the state, Anthem Blue Cross and Humana both exceed the thresholds and will not have to pay consumer rebates. (UnitedHealthcare is still waiting for CMS to review its data.)