

Health Reform Update – Week of September 17, 2012

CONGRESS

FDA user fees likely to be included in automatic sequestration

The Alliance for a Stronger FDA confirmed this week that Food and Drug Administration (FDA) user fees are likely to be included in the across-the-board budget cuts scheduled for January 2nd.

The Office of Management and Budget report required by S.3228 was finally issued last week and outlined the sequester's impact upon all federal agencies. The FDA would be subject to an 8.2 percent reduction from all but \$67 million of its \$3.873 billion budget for fiscal year 2013. FDA officials have acknowledged that this \$318 million cut may result in the loss of all \$2 billion in user fees that the agency was set to collect for drug and device reviews in fiscal year 2013, because by law at least 60 percent of reviews must be funded by these manufacturer fees (see Update for Week of September 10th).

Per the *Budget Control Act of 2011*, Congress can still avert the sequester if it passes alternative legislation that cuts the federal budget deficit by \$1.2 trillion over the next decade (see Update for Weeks of November 21st and 28th). Congress recessed this week until after the November elections, meaning that any such legislation will have to come from the lame-duck session in December.

However, several senior Senate and House Republicans conceded this week that President Obama's re-election may force them to compromise on a package that includes some revenue increases, such as allowing the Bush-era tax cuts to expire December 31st only for the wealthiest Americans. The refusal of newly-elected House Republicans to allow even a dime in higher taxes has been the primary obstacle to any deficit reduction compromise (see Update for Week of August 1, 2011).

CBO increases estimate of those will pay fine for not buying health insurance

The Congressional Budget Office (CBO) released new estimates this week that predict roughly six million Americans will be subject to the tax penalty under the Affordable Care Act (ACA) for failing to obtain health coverage they can afford. The non-partisan scorekeeper had previously projected that only four million would pay the tax, but upgraded its estimate because it now expects more Americans to remain unemployed.

As of 2014, the tax penalty under the "individual mandate" will be either \$695 or 2.5 percent of household income, whichever is greater, and increase over time. It will initially bring in an estimated \$8 billion per year in revenue that will be used largely to pay for the premium and cost-sharing subsidies under the ACA for those earning between 133-400 percent of the federal poverty level.

CBO emphasizes that roughly 80 percent of the 30 million Americans who will remain uninsured after 2014 are exempt from the tax penalty. The Urban Institute has previously concluded that less than three percent of all Americans will be subject to the penalty (see Update for Week of July 2nd), while less than one percent of tax filers actually paid the tax penalty for a similar individual mandate that was enacted by Massachusetts in 2007 (see Update for Week of June 18th).

Energy and Commerce passes bill exempting broker fees from new medical-loss ratios

The House Energy and Commerce Committee voted 26-14 this week to pass H.R. 1206, which would exempt insurance broker commissions from being defined as administrative expenses under the new medical-loss ratios (MLR) imposed by the Affordable Care Act (ACA).

Even though 25 House Democrats signed-on to the legislation (see Update for Week of September 10th), it garnered the support of only one Democrat on the panel, Rep. John Barrow (D-GA). The measure is expected to pass the Republican-controlled House but not be heard in the Democratically-controlled Senate prior to the November elections.

The National Association of Insurance Commissioners supports the measure (see Update for Weeks of November 21st and 28th), as the Government Accountability Office has already confirmed that consumer savings under the new MLRs are to some extent coming at the expense of cuts in broker commissions (see Update for Week of August 29, 2011).

The MLRs cap insurer profits by requiring that individual and small group plans spend at least 80 percent of premium revenue on direct medical care (85 percent for large groups), as opposed to administration, salaries, and profit. Because the Department of Health and Human Services defined broker fees and commissions as administrative expenses, brokers insist that plans are simply cutting these payments in order to stay within the MLR.

FEDERAL AGENCIES

HHS says ACA strengthened Medicare Advantage, will save average enrollee \$5,000 by 2022

A Health and Human Services (HHS) report released this week documents that Medicare Advantage (MA) enrollment is up while premiums are down, thanks to the Affordable Care Act (ACA).

Opponents have steadily attacked the new law for “cutting” Medicare in order to pay for the ACA reforms. However, the HHS Secretary stressed that the ACA merely reduced the rate of growth in reimbursement to private MA plans, which provide one-fourth of all Medicare enrollees with coverage for eyeglasses, hearing aids, and other benefits not provided by traditional Medicare. Curbing wasteful spending on MA plans followed recommendations by the Congressional Budget Office and Government Accountability Office, which found that MA plans were overpaid by at least 14 percent more than traditional Medicare (see Update for Week of June 11th).

As a result, the Secretary trumpeted the latest figures as evidence that the ACA strengthened MA plan, as MA enrollment is now projected to jump by 11 percent over the next year while premiums hold steady. She directly attributed the 28 percent rise in enrollment since 2010 (along with a ten percent drop in premiums) to the ACA reforms, which are expected to save \$136 billion over the next decade.

The Secretary also emphasized that no benefits for MA enrollees were reduced, nor did plans disenroll as critics claimed would occur. For example, the chief Medicare actuary had predicted that the restrained payments under the ACA would cut MA enrollment in half by 2017 as plans either cut benefits or leave the market (see Update for Week of April 23rd).

The HHS figures mesh with those released earlier this summer by the Kaiser Family Foundation, which found that enrollment was at record levels even though the average monthly payment to MA plans is now \$35 instead of a high of \$44 in 2010 (see Update for Week of June 11th). It noted that average premiums for plans with drug coverage are actually running \$5 below average costs for traditional Medicare plus a Part D drug plan.

Overall, the report predicts that the average enrollee under traditional Medicare will save \$5,000 from 2010 to 2022. Those with high prescription drug costs can expect to save over \$18,000 over the same period, as the Part D coverage gap will be gradually reduced until their cost-sharing is the same in or out of the “doughnut hole”.

The latest figures show that more than 5.5 million Part D enrollees have now saved nearly \$4.5 billion on prescription drugs since the ACA was enacted, for an average savings of \$641 just during the first eight months of 2012.

Health premium increases for federal workers decline slightly

Members of Congress, Supreme Court justices, and other federal employees will see only a 3.4 percent rise in their premiums for the coming year.

The increase announced by the Office of Personnel Management (OPM) for the Federal Employees Health Benefits Plan (FEHBP) translates to less than \$3 per paycheck for individuals and roughly \$6 for family coverage. It is slightly less than the four percent increase from a year ago.

FEHBP relies upon an online marketplace where federal workers can shop for plans that all cover a minimum level of benefits, comparable to the health insurance exchanges being created by the Affordable Care Act (ACA).

HEALTH CARE COSTS

Consumer Reports poll affirms Americans are increasingly skimping on needed care

The annual prescription drug poll conducted by *Consumer Reports* confirms that Americans are increasingly forgoing medically-necessary care that they cannot afford.

Results from the survey of over 1,150 adults found that since last year, those under the age of 65 who lack prescription drug coverage have been the hardest hit. Over 45 percent of this group report are not filling prescriptions because of cost, a 19 percent jump from 2011.

Overall, more than 80 percent of Americans acknowledged that they have skipped a medical test ordered by their physician because they could not afford it, up 29 percent from last year. Another 63 percent have skipped a visit to their physician while 51 percent have avoided a needed medical procedure. These are both double-digit increases from 2011.

Nearly half of all adults currently take an average of 4.1 prescription drugs. Researchers were surprised to find that reliance on medications has spread to young adults as well, with at least 25 percent of those age 18-39 taking at least two prescription drugs.

The survey found that all consumers are spending an average of \$63 on out-of-pocket drug costs every month, while those without drug coverage are spending more than \$91 on average.

The *Consumer Reports* survey results are consistent with the findings of other studies over the past year that revealed that at least 60 percent of Americans are skimping on needed medical care due to cost (see Update for Week of June 11th).

STATES

Additional Census data finds that uninsured rate fell last year in 20 states

Supplemental data released this week by the U.S. Census Bureau shows that the uninsured rate dropped in 20 states from 2010 to 2011, with Oregon, Rhode Island, and Vermont experiencing the biggest declines.

Only two states had a “statistically significant” jump in their percentage of uninsured. Missouri jumped by 0.5 percent to 13.7 percent while Montana jumped a full percent to 18.3 percent.

The Census Bureau reported last week that nationwide rate dropped 0.6 percent to 15.7 percent. This was the first decline in the uninsured rate since 2007 and the largest drop since 1999 (see Update for Week of September 10th).

The supplemental figures further amplify the contribution of the ACA to the drop in uninsured, as the biggest drop of 2.2 percent was for those aged 19-25 who can now remain on the parents' group health plan. In the state of Vermont, the uninsured rate for this population fell a whopping 14 percent from 2009 to 2011. By contrast, the uninsured rate for those aged 26-29 continued to increase by 0.8 percent

California

Exchange board wants entertainment industry to help promote Affordable Care Act

The California Health Benefit Exchange Board has approved a marketing and outreach plan that relies on "senior levels [of] California's robust entertainment industry" to promote the benefits of the Affordable Care Act (ACA).

Some of the nation's most popular television shows are specifically targeted in the hopes that they will "incorporate story lines or mentions of health care reform." Celebrities from at least one program, "The Dr. Oz Show", are already appearing in ads urging people to enroll in the new health benefit exchange. The plan even suggests creating a reality television shows to educate Americans on the "trials and tribulations of families living without medical coverage."

The Board has already signed a \$900,000 contract with Ogilvy Public Relations to spearhead its enrollment push. It has obtained over \$237 million in federal exchange grants to create and begin operating the new exchange by October 2013 (see Update for Week of August 20th).

The Board also presented the four final choices for a name for the exchange (Covered CA, CaliHealth, Ursa, and Eureka). Earlier favorite Avocado failed to make the cut.

Georgia

Public health department recommends eliminating hemophilia premium assistance grants

Recommendations released last week by the Department of Public Health would eliminate funding for the state's hemophilia premium assistance program.

The proposed cuts result from the order by Governor Nathan Deal (R) to reduce all state agency budgets by three percent in fiscal years 2013 and 2014. The Department of Public Health would see a \$5.6 million cut each year, which would eliminate \$500,000 in hemophilia grants for 2013 and \$700,000 for 2014.

Patients served by the program would be transferred to the Pre-Existing Condition Insurance Plan (PCIP). Georgia recently eliminated its AIDS Drug Assistance Program (ADAP) waiting list in part by moving 350 clients to the PCIP (see Update for Weeks of August 27th and September 3rd).

The recommendations must eventually be approved by the Governor and the Legislature. Governor Deal restored a similar cut to the hemophilia program that was recommended last year.

Kentucky

Governor appoints exchange board members, despite Republican protests

Governor Steve Beshear (D) appointed 19 members this week to the Kentucky Health Benefit Exchange Advisory Board created by his executive order (see Update for Week of July 16th).

The Governor's order initially created an 11-member board. However, he sought to expand it to 19 in order to ensure that insurers, agents, physicians, providers, and consumers were all adequately represented. Even though the presence of insurers on the oversight board is sure to spark the same conflict of interest controversy as in other states, the appointment of four consumer advocates exceeds the level of consumer representation on most state exchange boards.

Governor Beshear also named the Commissioner of the Department of Insurance as board chair. Members of the board that do not represent state agencies will serve for staggered term limits of two or three years as designated by the Governor.

Democratic lawmakers walked out of a committee hearing this week after Republicans introduced and passed a motion challenging the governor's authority to create the exchange. While the Governor cannot create the exchange as a quasi-governmental or non-profit entity without legislative approval, the Joint Health and Welfare Committee co-chair Tom Burch (D) instead that Republicans had no legitimate basis to contest the Governor's authority to create a new state agency or division within a state agency.

Republicans have been adamantly opposed to the new exchange, even going so far as to block the \$295,000 needed to lease office space for exchange personnel (see Update for Week of July 16th).

Governor Beshear emphasized that "the Affordable Care Act is the law of the land" and he is legally bound to enforce it. He also stressed that the leading representatives of hospitals, business, insurers, and consumers were all adamant that Kentucky needs to retain control over its own exchange and not default to a federally-facilitated exchange (see Update for Week of June 25th).

Michigan

Insurance committee chair seeks to overhaul Blue Cross and Blue Shield

Senate Insurance Committee Chairman Joe Hune (R) introduced legislation this week that would end the tax-exempt status of Michigan's largest health insurer in an effort to "level the playing" field with competitors.

Under the measure sought by Governor Rick Snyder (R), Blue Cross and Blue Shield (BCBS) of Michigan would not be sold or lose its non-profit status. It would instead join 11 other BCBS companies nationwide that are structured as mutual insurers.

BCBS Michigan has been designated by the state as the only "insurer of last resort" meaning it cannot deny coverage based on health status of applicants. In exchange, the charitable trust that serves about 4.4 million state residents has avoided about \$100 million in local and state taxes every year.

The proposed legislation would require that BCBS Michigan pay those taxes and contribute about \$1.5 billion over 18 years to a nonprofit entity that would assume BCBS Michigan's charitable functions. BCBS is not expected to receive a premium increase as result of the change.

The Commissioner of the Office of Financial and Insurance Regulation told the Insurance Committee that the change in status was needed in order to ensure that BCBS Michigan could participate in the new health insurance exchanges authorized by the Affordable Care Act (ACA).

However, Republican lawmakers have thus far rebuffed the Governor's efforts to pass legislation authorizing a state-based exchange. As a result, the Governor is seeking federal approval to at least initially enter into a federal-state exchange partnership so that Michigan does not cede all control over the exchange to the federal government (see Update for Week of August 20th).

Minnesota

Governor moves exchange to budget office, postpones final decisions until after election

Governor Mark Dayton (D) announced this week that he has shifted responsibility for creating the new health benefits exchange from the Department of Commerce to the Office of Management and Budget.

The move comes amid bipartisan complaints about allowing the agency that will ultimately oversee the exchange to design it. Stakeholders including the Minnesota Chamber of Commerce have also criticized the lack of transparency afforded by Commerce, which they claim has been “secretively” using federal exchange grants to establish the exchange pursuant to the Governor’s executive order (see Update for Week of October 31st).

The Chamber of Commerce, which supports exchange implementation, applauded the changes, as Management and Budget commissioner James Schowalter worked under both Republican and Democrat governors and is thus regarded as more bipartisan than the Commerce commissioner.

Republican leaders who currently control the legislature have adamantly sought to block implementation of any part of “Obamacare”, even threatening a lawsuit that challenges the Governor’s authority to create the exchange without authorizing legislation. Governor Dayton acknowledges that legislation will ultimately be needed to make the exchange operational. As a result, he has postponed any final exchange decisions until after the November election, in order to see if a bipartisan compromise is more likely next session.

However, the Governor has already applied for another \$42.5 million in federal exchange establishment grants and awarded a \$41 million contract to MAXIMUS, who will build the information technology infrastructure for the online marketplace.

Montana

Attorney general will use \$1M settlement to provide prescription drug assistance

Attorney General Steve Bullock (D) announced this week that nearly \$1 million from settlements with drug companies will be used to offset the cost of prescription drugs for the uninsured and underinsured.

Governor Brian Schweitzer (D) has made a career out of battling drug companies to lower the prescription drug prices, repeatedly filing litigation against manufacturers for overinflating wholesale prices, seeking federal approval to allow drug re-importation, or personally driving citizens across the border to access lower cost drugs in Canada (see Update for Weeks of August 27th and September 3rd).

His latest litigation resulted in a \$1.67 million with four drug manufacturers. According to Bullock, \$200,000 went to Medicaid, \$480,000 went to the Office of Consumer Protection, and the remaining \$986,000 will be given to local hospital and community health care clinics to provide free or low-cost drugs to eligible patients (so long as the medications are covered by Medicare or Medicaid).

Montana is one of several states where high energy prices have resulted in an unexpected budget surplus (see Update for Week of March 5th).

New Mexico

Over half of likely voters support Medicaid expansion

More than half of New Mexico voters support expanding Medicaid as authorized by the Affordable Care Act (ACA), according to poll results released this week by the *Albuquerque Journal*.

Governor Susanna Martinez (R) has requested additional guidance from the federal government before deciding whether she will exercise the discretion afforded by the U.S. Supreme Court to “opt out”

of the Medicaid expansion required by the Affordable Care Act (ACA) without penalty (see Update for Week of September 10th). At least a dozen other Republican governors have already indicated that they are likely to do so (see Update for Week of July 9th).

However, the poll found that 53 percent of likely voters surveyed favored expanding eligibility to those earning up to 133 percent of the federal poverty level, which would add roughly 17,000 New Mexicans to the Medicaid rolls. New Mexico traditionally has one of the nation's highest uninsured rates even though Medicaid covers one of every four state residents (see Update for Week of September 10th).

Only a third of likely voters were adamantly opposed to the expansion, while the remaining 11 percent are undecided.

A recent study by the University of New Mexico economist predicted that accepting the enhanced federal match to expand Medicaid under the ACA could create up to 10,000 new jobs in the state.

Oklahoma

Attorney General seeks to block premium subsidies in federally-facilitated exchange

Attorney General Scott Pruitt (R) has renewed his efforts to impede implementation of the Affordable Care Act (ACA) in Oklahoma.

As with his counterpart in Virginia, Pruitt had brought a separate challenge to the multi-state challenge that the U.S. Supreme Court denied last summer (see Update for Week of June 25th). Because his lawsuit sought to invalidate the ACA on the same grounds, the federal court in Oklahoma put it on hold pending resolution of the constitutional questions by the U.S. Supreme Court.

As a result, Oklahoma is the only state with an active lawsuit challenging the ACA's constitutionality. Oklahoma and Virginia had filed separate lawsuits instead of joining the multi-state challenge, because voters in their states passed a ballot referendum banning any laws that mandate the purchase of health insurance. Both Attorneys General had claimed that these new state laws supersede federal law, but the Oklahoma federal court is expected to soon follow the decision by the Fourth Circuit Court of Appeals that the U.S. Constitution makes federal law always supreme to conflicting state laws (see Update for Week of September 5, 2011).

However, in the interim Pruitt sought to amend the lawsuit this week to incorporate the latest claim by conservative groups that the ACA does not allow for premium subsidies in federally-facilitated exchanges. Congressional Republicans led by Rep. Michele Bachmann (R-MN) and Senator Jim DeMint (R-SC) have urged governors to make similar challenges on this basis, insisting that the Internal Revenue Service (IRS) overstepped their bounds in making premium subsidies available to all exchange users, regardless of whether a state creates their own exchange or defaults to the federal government.

The Pacific Research Institute insists that the premium subsidy issue is a "serious challenge" (see Update for Week of July 23rd), even though IRS officials have repeatedly scoffed at such claims (see Update for Week of September 10th). The IRS deputy commissioner pointed out that section 36B of the Internal Revenue Code (which was added by section 1401 of the ACA) specifically refers to federal exchanges in requiring all exchanges to report to the federal government on the amount of advance payments of premium credits that taxpayers receive. He emphasizes that such a provision would be rendered senseless if those purchasing coverage through a federally-operated exchange were ineligible.

Rhode Island

Commissioner downgrades rate hikes for employer coverage

Insurance Commissioner Christopher Koller (D) has limited premium increases for employer health plans to their lowest level since 2010.

Rhode Island's largest health insurers, including Blue Cross and Blue Shield of Rhode Island, Tufts Health Plan, and UnitedHealthcare of New England had all sought only single-digit increases for 2013, after health care costs declined substantially last year due to lower utilization. However, Koller downgraded the increases even further, approving rate hikes that average only from 1.65 to 5.5 percent.

The health plans immediately insisted that Koller's action will cause "material financial losses".