

Health Reform Update – Weeks of December 24 and 31, 2012

CONGRESS

Entitlement fight, sequester postponed in last-minute deal to avert fiscal cliff

Congress waited until the early hours of the new year to pass a package of new revenues and spending cuts that will temporarily avert the so-called “fiscal cliff”.

Over \$600 billion in automatic tax hikes and spending cuts were slated to automatically go into effect if Congress failed to act (see Update for Week of December 17th). The legislation signed by the President (H.R. 8) avoids most of the tax hikes by making permanent the Bush-era tax cuts for the 98 percent of Americans who earn less than \$400,000 per year for individuals or \$450,000 for families. However, tax cuts for those earning higher amounts were allowed to expire, as well as the two percent reduction in the payroll tax that was in effect since the 2009 federal stimulus package. The latter will take roughly \$1,000 out of the paychecks of those earning around \$50,000 per year.

The controversial 26.5 percent cut in Medicare reimbursement for physicians once again received a full-year reprieve, as it has every year since 2003. Congress has yet to formulate a permanent fix, and it offset the \$25.1 billion cost of the delay largely by targeting Medicare hospital reimbursement (see Update for Weeks of November 19th and 26th). Safety net providers particularly objected to further cuts in disproportionate share payments for indigent care that are already slated to decline by 18 percent from 2014-2020 under the Affordable Care Act (ACA). Congress also rescinded the remaining \$2.3 billion in unobligated funds to create consumer-oriented non-profit health insurance cooperatives under the ACA.

At least 151 House Republicans withheld their support for the bipartisan deal as it does not contain any of the \$300 billion cuts they sought for entitlement programs and the ACA. It also merely postpones the across-the-board sequester for two months, at which time most agency budgets will be cut by 8-10 percent without further congressional action. Medicaid and Social Security programs remain exempt from this sequester, although Medicare reimbursement would fall by another two percent.

The deal also sets up another showdown over raising the debt ceiling, which must be negotiated in February to avoid defaulting on the federal government’s financial obligations. House Republicans are already pledging to block any increase unless President Obama agrees to deep spending cuts and drops his demand for additional revenues. The last stalemate over the debt ceiling resulted in the sequester as well as a first-ever downgrade in the nation’s credit rating (see Update for Week of August 1, 2011).

Congress must also pass legislation to continue funding the government past March 27th, when the current continuing spending resolution expires. These temporary patches have been difficult to enact, with House Republicans threatening to shut down the government if deep spending cuts are not passed.



The White House disputes Congressional Budget Office (CBO) estimates that H.R. 8 will increase federal spending by \$330 billion over the next decade while adding \$3.9 trillion to the federal deficit. It emphasized that CBO did not account for Bush-era tax cuts expiring for wealthy Americans and wrongly assumed the Medicare physician payment cut would go into effect. When adjusting for these and other factors, it insists that H.R. 8 will actually reduce the deficit by \$737 billion.

Insurance commissioners warn against hiking Medigap cost-sharing to help reduce deficit

The National Association of Insurance Commissioners (NAIC) have warned Congress not to raise premiums and cost-sharing for supplemental Medicare (or Medigap) coverage in order to achieve the entitlement cuts needed to reduce the federal deficit and avoid automatic budget cuts.

The NAIC is charged under the Affordable Care Act with making recommendations on whether Medicare beneficiaries would reduce their use of inappropriate care if the Medigap packages were “less generous.” However, NAIC argues that hiking premiums would be counterproductive as it would force enrollees to also forgo medical necessary care when they need it—a trend that has been very pronounced during the recession (see Update for Week of June 11th).

The President’s deficit reduction panel and Medicare Payment Advisory Commission have recommended higher Medigap premiums and cost-sharing over the past 18 months. However, NAIC insists that none of the studies evaluating these proposals provided evidence that they would encourage enrollees to be better consumers and seek more appropriate care.

According to the Congressional Budget Office, the suggested increases in Medigap premiums could generate \$53 billion in savings over a decade. As of 2010, about nine million Medicare beneficiaries also purchased Medigap plans, with about two thirds selecting “first-dollar” coverage that generally pays all of an enrollees Medicare cost-sharing.

New Congress likely to follow familiar battle lines on Affordable Care Act

The 113th Congress convened this week with limited expectation that Democratic gains in the House and Senate (see Update for Week of November 5th) would help resolve the partisan gridlock.

Despite their narrower majority and the President’s re-election, House Republicans showed little willingness to retreat from efforts to impede implementation of the Affordable Care Act (ACA). Rep. Michele Bachmann (R-MN) immediately made a full repeal of the ACA the very first bill introduced in the new Congress, even though the Democratically-controlled Senate has refused to consider almost the entire 33 prior House votes to repeal all or part of the law. The House also promptly adopted a package of new rules (H.Res. 5) exempting members from having to follow any of the cost-control recommendations approved by the new Independent Payment Advisory Board (IPAB).



House Republicans, along with up to 20 Democrats, have repeatedly voted to repeal the IPAB, whose recommendations will automatically become binding under the ACA unless Congress enacts equivalent Medicare payment cuts whenever spending exceeds preset targets (see Update for Week of November 5th).

The new chair for the House Appropriations subcommittee that oversees the Department of Health and Human Services (HHS) also pledged this week to renew efforts to strip funding from the ACA and hold further hearings to examine the agency's implementation of the new law. Rep. Jack Kingston (R-GA), one of the most fiscally conservative Appropriations members, plans to meet or exceed the eight hearings held last year by the Labor-HHS subcommittee, though he insisted they would be done in a bipartisan manner. He also stated that he would work with the Obama Administration on developing a plan to overhaul Medicare.

Key Senate appointments include longtime Senator Barbara Mikulski (D-MD) to serve as the chair of the Senate Appropriations Committee. Senator Mikulski has been a staunch proponent of funding for both the National Institutes of Health (NIH) and Food and Drug Administration (FDA) and was responsible for including the provision in the Affordable Care Act (ACA) that removed cost-sharing for women's preventive services.

Congress finally passes measure to spur pancreatic cancer research

President Obama signed into law this week a bipartisan bill that aims to tackle the most dangerous forms of cancer.

After six years of trying, the Recalcitrant Cancer Research Act (H.R. 733/S. 3566) finally passed both chambers as part of an overall defense authorization bill (H.R. 4310). The law requires the Director of the National Institutes of Health (NIH) National Cancer Institute (NCI) to develop a scientific framework to conduct and support research on cancers with a five-year survival rate of less than 50 percent. It has no significant budgetary impact, according to the Congressional Budget Office.

The measure was a project of Senator Sheldon Whitehouse (D-RI) and Rep. Anna Eshoo (D-CA) and initially provided \$888 million in new funding to create an advisory board targeting pancreatic cancer, which has only a six percent rate of survival. However, both the funding and the advisory board were scrapped in the final legislation, which was broadened to include a range of deadly cancers.

The National Cancer Institute (NCI) had argued that the initial bill would undermine its peer-review system and warned of an "unhealthy trend" and "slippery slope" that would emerge if advocacy groups could routinely get Congress to legislate the requirements that govern NCI decisions. Other lawmakers also openly worried that focusing on a single cancer contributed to a "Disease Olympics" in which conditions with the loudest advocates receive the most federal money.



The NCI director had instead urged members of Congress to focus on preventing automatic budget cuts that could stifle all NIH research. NCI would lose up to 40 percent of new grants if the sequester goes into effect in two months (see article above). In addition, a quarter of all grants that NIH plans to issue in 2013 would not be funded if the sequester cuts \$2.5 billion from the agency's budget (see Update for Week of September 10th).

Survey shows that most small business owners remain confused about the ACA

A survey released last month by the nation's first and largest health information exchange revealed that a large majority of small business owners remain confused about the Affordable Care Act (ACA) and unwilling to assess how it will affect them.

The analysis by eHealthInsurance showed that 78 percent of small business owners surveyed were not aware of the new health insurance exchanges that their workers could use to purchase affordable coverage. In addition, nearly 70 percent either incorrectly believed that the ACA requires them to provide coverage to their employees or were unsure if the employer mandate applied to them.

The law specifically exempts companies with less than 50 employees from the employer mandate (see below) and offers them sliding-scale tax credits to help them afford to offer health insurance for their workers. However, a comparable percentage was unaware of the assistance provided by the ACA and insisted that the law would increase their costs of doing business, contrary to projections by the Urban Institute that it would reduce small business costs (see Update for Week of October 8th).

Perhaps most surprisingly, 77 percent of those surveyed admitted that they had not done any long-term planning to assess how the ACA will impact their business, with many acknowledging they had been waiting for election results to see if the law would simply be repealed.

FEDERAL AGENCIES

IRS issues proposed regulations to implement ACA employer mandate

The Internal Revenue Service (IRS) issued proposed rules this week that govern the implementation of the employer mandate under the Affordable Care Act (ACA).

The law requires companies with more than 50 employees to pay a \$2,000 per worker assessment every year (excluding their first 30 full-time employees) if they do not provide affordable health coverage that provides a minimum level of benefits for full-time employees. The proposed rule clarifies that the unaffordability standard kicks in if the employer's coverage costs more than 9.5 percent of individual and not family income. In addition, employers must offer dependent coverage for children but not spouses.



The regulations also explain that the employer mandate applies to any company where a combination of full-time and part-time employees equals at least 50. Employers average their number of employees across the months in the year to see whether they meet this large employer threshold.

A consumer backlash recently forced several large restaurant chains to abandon plans to cut employee hours or hike prices in response to this ACA mandate (see Update for Week of December 17th). Participation in Medicare shared savings demonstration expected to double this month

The total amount of accountable care organizations (ACOs) participating in the new Medicare demonstration are likely to double in January, according to the Center for Medicare and Medicaid Innovation.

The new division of the Centers for Medicare and Medicaid Services was created by the Affordable Care Act (ACA) along with the shared savings demonstration program (see Update for Week of February 20th). Currently, 153 ACOs contract with Medicare to provide team-based care that received financial incentives to meet specific cost and quality measures. However, CMS expects that number to jump to over 300 when a third round of contracts is announced this month.

Between 25 million to 31 million people are already being treated by ACOs according to a report released last month by the Oliver Wyman consulting firm.

FDA had banner year for new drug approvals

The Food and Drug Administration (FDA) approved 39 new drugs and biologics in 2012, the highest number since 53 were approved in 1996 and nearly double the figure for 2010.

The number of drug approvals helped offset roughly \$21 billion in losses that brand-name drugmakers sustained as a result of patent expirations that greatly expanded generic competition. FDA emphasized that at least ten of the new drugs approved this year received fast-track status and several others were for rare disorders like cystic fibrosis and Cushing's disease, demonstrating that the agency lived up to its commitment under the Prescription Drug User Fee Act to more quickly bring drugs to market if companies paid more in user fees (see Update for Week of June 18th).

Study links cancer recurrence to ongoing drug shortages

A new study published this week in the New England Journal of Medicine blames the shortage of a key injectable drug for a recurrence of high-risk Hodgkin's lymphoma.

Researchers from the Stanford University School of Medicine said they were "blindsided by the results" showing that replacing mechlorethamine for a decades-old chemotherapy drug caused the number of patients that remained cancer free after two years to abruptly fall from 88 to 75 percent. Mechlorethamine has been in short supply since 2009 due to plant closings.



The Food and Drug Administration (FDA) credited the President's 2011 executive order with dramatically curbing record drug shortages by giving regulators more power to track shortages, quickly approve replacement manufacturing sites and punish price gougers (see Update for Week of April 30th). Provisions of the Prescription Drug User Fee Act enacted last summer also provided additional authority (see Update for Week of June 18th). However, the study revealed that drug shortages which were relieved by these measures have started to again recur.

GAO finds that less than four percent of Medicaid enrollees report difficulty accessing care

A report released last month by the Government Accountability Office (GAO) found that less than four percent of Medicaid beneficiaries who had coverage for at least a year reported difficulty obtaining medical care in 2008 and 2009. However, the study also showed that beneficiaries who had coverage for less than a year were far more likely to have difficulty obtaining healthcare.

The findings are somewhat surprising in light of reports from more than two-thirds of states that they struggle to ensure there are enough Medicaid providers to serve the growing number of enrollees. States generally attributed these challenges to a shortage of providers and poor Medicaid payment rates, but also cited other issues, such as missed appointments and administrative burdens.

HEALTH CARE COSTS

Kaiser surveys show that small firm workers pay significantly more for health insurance

A recent analysis from the Kaiser Family Foundation found that workers at small firms contribute significantly more for family coverage than those at large employers, despite lower premiums.

The average annual premium for family coverage by companies with up to 200 employees was \$15,253 compared to \$15,980 at larger firms, based on Kaiser's survey earlier this year. However, small firm workers paid an average of 35 percent of this premium, compared to 25 percent at larger companies.

A separate Kaiser analysis found that workers at private firms also pay more on average towards their health insurance costs than either public or non-profit employees. While premiums on average were less expensive at private firms, their workers contributed an average of 30 percent for family coverage, compared to 23 percent at public and non-profit entities.

STATES

CMS conditionally approves seven more state exchanges, one partnership exchange

Eight more states won conditional approval this week from the Centers for Medicare and Medicaid Services (CMS) allowing them to retain control over all or part of the new health insurance exchanges required by the Affordable Care Act (ACA).

California, Hawaii, Idaho, Nevada, New Mexico, Vermont and Utah were approved to run a fully state-based exchange. Four of these states (Idaho, Nevada, New Mexico, and Utah) are significant in that they are led by Republican governors that opposed the ACA. However, Utah's approval was made contingent upon the state upgrading its existing clearinghouse exchange to add individual eligibility, administer premium tax credits, interface with the Medicaid program, and undertake other responsibilities required by the ACA. Governor Gary Herbert (R) has previously been unwilling to do so (see Update for Week of December 17th), although he somewhat softened his opposition after CMS' announcement.

Arkansas joins Delaware as the only states to be approved for an initial exchange partnership with CMS. The move allows each to retain control of certain exchange functions, such as verifying eligibility and enrollment. CMS also issued further guidance for states weighing whether to seek approval for a partnership exchange by the February 15th federal deadline (see Update for Weeks of November 19th and 26th).

CMS specifically decided not to act on Mississippi's application for a state-based exchange, acknowledging that the agency is still trying to resolve whether the state insurance commissioner can seek approval over the objections of Governor Phil Bryant (R). Commissioner Mike Chaney (R) insists that state law allows the Mississippi high-risk pool to "serve as a mechanism to provide health and accident insurance to citizens of this state under any state or federal program designed to help person obtain or maintain coverage". He submitted exchange blueprints with the full support of the statute's author, Senator Buck Clarke (R), although the Governor remains opposed to implementing any part of "Obamacare" (see Update for Week of October 8th).

A total of 20 states (including the District of Columbia) have now been conditionally approved.

HHS sheds light on to how states must apply new eligibility measure under ACA

The Department of Health and Human Services (HHS) issued guidance last week to Medicaid directors on how the Affordable Care Act (ACA) alters calculations of Medicaid and SCHIP eligibility for the next six years.

The new law creates a major change by moving to the use of new measure called Modified Adjusted Gross Income (MAGI) that follows Internal Revenue Service (IRS) rules for counting income. Unlike current Medicaid rules, MAGI does not allow for disregards and deductions, such as for childcare and work-related expenses.



To prevent children in families that failed to receive disregards and deductions from being excluded from Medicaid or SCHIP, the ACA requires states to increase their income thresholds to compensate for the loss of those disregards and deductions. The new guidance details how states should proceed based on input from child advocacy groups. For example, states can now either use the new MAGI standard, or ask HHS to approve a different standard created by the state so long as it does not systematically decrease or increase the number of people eligible for coverage.

In addition, HHS has scrapped plans to take the average value of disregards and deductions for all those in an eligibility category. HHS will instead consider the value of disregards and deductions only for people whose eligibility is potentially affected by their availability. HHS has estimated these are individuals with family income within 25 percentage points of a state's net income threshold.

HHS also clarifies that it will use the MAGI thresholds not only for maintaining Medicaid and SCHIP eligibility through October 1, 2019, but also to (1) establish minimum eligibility thresholds in states that opt-out of the Medicaid expansion under the ACA, (2) determine which families can receive premium tax credits, and (3) calculate the enhanced federal match for adults that are newly-eligible for Medicaid.

States will have the next several months to work with HHS to adopt their new MAGI-equivalent thresholds, with final results expected in June of 2013.

Half of state legislatures will have veto-proof majorities in 2013

Fully half of state legislatures will have veto-proof majorities this session, according to final election tallies compiled by the National Conference of State Legislatures (NCSL).

Before the fall elections, 21 legislatures were veto-proof. However, with Democrats losing veto power in one state and gaining it in two, Republicans losing veto power in three states and gaining it in six, and all other states holding steady, a whopping 25 states will have veto-proof majorities when legislative sessions start opening this month.

The biggest shift occurred in Arkansas, where control over both chambers switched from Democrats to Republicans (see Update for Week of November 5th). Arkansas is one of only seven states (along with Alabama, Indiana, Kentucky, Pennsylvania, Tennessee and West Virginia) that require only a simple majority vote to overturn a gubernatorial veto. The swap was particularly significant because it made Arkansas one of just three states (including Missouri and Rhode Island) where one party holds a veto-proof legislative majority while another controls the governorship.



California

CMS approves transition of SCHIP children to Medi-Cal managed care plans

The federal Centers for Medicare and Medicaid Services (CMS) announced this week that it has approved California's plan to eliminate the Healthy Families SCHIP and transition nearly 900,000 enrollees into Medi-Cal managed care plans during 2013.

The transition was approved last year by Governor Jerry Brown (D) as a means to save \$72 million by consolidating all low-income children into one program (see Update for Week of June 18th). It is fiercely opposed by over two dozen consumer groups citing documentation of disruptions in access to care resulting from a similar transition of elderly and disabled Medi-Cal enrollees into capitated plans (see Update for Weeks of August 27th and September 3rd). (A lawsuit was brought this week to block that transition). However, the state went ahead and notified 450,000 families of the SCHIP transition last fall (see Update for Week of November 5th) and promptly moved over 197,000 children on January 1st.

CMS did acknowledge the concerns about access and quality of care. They agency created an ongoing monitoring and evaluation process for each phase of the transition and will halt the shift at any point if it is not pleased with evaluation results. California will have to meet specific standards for network adequacy and continuity of care in order to receive written CMS approval to continue past each phase. CMS is also requiring that the state conduct beneficiary surveys and listening session to hear directly from families who are affected by the transition.

The legislature has already held several oversight hearings and is planning several more throughout the year.

Exchange board seeking public comments on health plan contracting, outreach efforts

The Board for the Covered California health benefits exchange took actions over the past several weeks that continue to put the state ahead of most others in implementing the new online marketplace.

The Board released a model contract for participating plans this week and will solicit public comments through next week. It also is seeking comment on an options paper for selectively contracting with plans that are willing to negotiate rates. California is one of a handful of states pursuing this "active purchaser" exchange model as opposed to the more passive clearinghouse model where any plan that meets minimum standards can participate. Additional details are available at www.healthexchange.ca.gov.

The public comment period closed this week on the marketing and outreach program developed by the Board based on more than 400 in-person interviews conducted last fall. The Board notes that the survey results were very positive with 78 percent of respondents indicating that they would likely purchase a plan through Covered California when they become available.



California became one of 20 states this week to be conditionally approved to begin exchange enrollment in October of this year (see above).

Colorado

Governor will seek to participate in Medicaid expansion under Affordable Care Act

Governor John Hickenlooper (D) formally declared his support this week for participating in the Medicaid expansion under the Affordable Care Act (ACA).

The move was largely expected despite prior concerns the Governor expressed about the cost of the expansion to Colorado taxpayers. However, he now supports the expansion after cost estimates showed it would save the state roughly \$280 million over the next decade. If approved by the legislature and enacted in 2014, expanding eligibility to those earning up to 133 percent of the federal poverty level (nearly \$15,000 per year for an individual) is projected to add 161,000 residents to Medicaid.

The Colorado Hospital Association and Coalition for the Medically Underserved were among the many provider and consumer groups supporting the expansion. The expansion will greatly reduce uncompensated care costs for hospitals, which still total over \$1 billion per year in Colorado despite a Medicaid provider fee enacted in 2009. The provider fee is expected to help defray the ten percent of the expansion costs that Colorado must continuously assume starting in 2020. (The federal government will assume at least 93 percent of costs from 2014-2020).

Insurance division emphasizes that health care costs, not ACA, driving double-digit rate hikes

The Division of Insurance issued a press release this week to respond to public criticism over recent double-digit rate hikes it approved for Colorado health insurers.

The Division's statement reiterates earlier findings that less than five percent of the rate hikes for 2013 are attributable to new federal health insurance reforms. Instead, the rate hikes are driven by the continued increase in health care costs that started long before the Affordable Care Act (ACA) was enacted in 2010.

Premiums for the ten largest individual plan carriers in Colorado will increase by an average of 12.9 percent. However, the Division insists that the increases are justified based on medical inflation, despite the more active scrutiny over unreasonable rate hikes afforded by the ACA and the law's new profit caps that went into effect for the 2011 plan year.



West Virginia

Study shows that Medicaid experiment increased emergency room visits

A new report by the Mercatus Center at George Mason University shows that West Virginia's experiment to limit benefits for unhealthy Medicaid enrollees had the unintended consequence of increasing emergency room use.

The Mountain Health Choices program demonstration aimed to cut costs by reducing non-urgent visits emergency rooms by Medicaid enrollees. However, House Health and Human Resources chairman Don Perdue (D) cited the study as evidence that it actually had the opposite effect.

The program created a two-tier system starting in 2007. Medicaid enrollees who committed to healthy behaviors received more benefits than what the traditional Medicaid program offered. Those who did not received fewer benefits.

West Virginia scrapped the program in 2010 after new federal regulations required adult enrollment in such programs to be voluntary. However, only 14 percent of recipients chose the enhanced plan before it ended. Although emergency room use among this group declined by five percent, the vast majority of enrollees lost benefits because they would not commit to healthy behaviors. The benefits they lost as a result meant that this group had to more frequently use the emergency room as their primary care provider.