Health Reform Update – Week of June 13, 2011

CONGRESS

House appropriators de-fund individual mandate, AMA votes on whether to rescind support

House appropriators this week approved a $19.9 billion financial services spending bill for fiscal year 2012 that prohibits the Internal Revenue Service (IRS) from enforcing the new federal mandate that everyone buy health insurance. The measure is certain to be removed by the Democratically-controlled Senate.

House Republicans hope to maintain symbolic opposition to the individual mandate as popular support wanes. A recent Kaiser Family Foundation poll found that 60 percent of Americans now disapprove, while the American Medical Association (AMA) plans to vote this weekend on whether to rescind its earlier support. The individual mandate was sought by the Obama Administration largely on the basis that it could win the support of powerful constituencies like America's Health Insurance Plans and the AMA, as it would ensure their members over 32 million new customers.

Author of Medicare voucher plan remains open to traditional fee-for-service option

Rep. Paul Ryan (R-WI) announced this week that he is open to amending his Medicare privatization proposal to allow future Medicare enrollees to remain in a traditional fee-for-service option.

House Republicans overwhelmingly passed Ryan's plan (H.Con.Res. 34) to require those now under age 55 to use federal premium subsidies to purchase private health coverage once they become eligible for Medicare (see Update for Week of April 11th). However, the unpopularity of the plan among seniors was largely blamed for a surprising special election loss last month (see Update for Week of May 23rd), causing several key Republicans to consider alternative proposals in the face of a forthcoming campaign by AARP to block it.

Rep. Ryan expressed cautious optimism that his "compromise" on retaining a Medicare fee-for-service option could lead to a bipartisan deal on on-going negotiations to raise the $14.3 trillion debt ceiling before the federal government defaults in August. However, he remained adamant that any final compromise include a "permanent" reduction in the payroll tax, instead of the temporary cut included as part of the spending resolution that ends on October 1st.

Ryan's fee-for-service option has the support of former Minnesota Governor Tim Pawlenty (R), a presidential candidate, as well as Alice Rivlin, a former budget director under President Clinton.

Democrats resurrect bills to lower Part D drug costs for dual eligibles

House and Senate Democrats unveiled legislation this week to reduce drug costs in the Medicare Part D program.

The measure resurrects Democratic proposals to require drug makers to provide rebates to those eligible for both Medicare and Medicaid, as well as to those enrolled in the low-income subsidy plan under Part D. The Congressional Budget Office previously estimated that such rebates would reduce the deficit by $112 billion over ten years. However, the Pharmaceutical Research and Manufacturers Association (PhRMA) insisted that the "price controls" would lead to higher premiums for certain beneficiaries and emphasized that drug makers have already agreed to discount drugs in the Part D "doughnut hole" by 50 percent as part of the Affordable Care Act (ACA) negotiations.

Republicans lifted the existing requirement that manufacturers pay rebates on drugs used by "dual eligibles" as part of the 2003 legislation creating the Part D program. President Obama's bipartisan fiscal commission had recommended restoring the rebates as part of their recommendations last winter (see Update for Week of December 6th). However, legislation to do so has repeatedly foundered, including the effort by then Energy and Commerce chairman Henry Waxman (D-CA) to include such a provision in the ACA.

Under the Democrats' latest bill (H.R. 2190); drug manufacturers would be required to pay the difference between the average rebate they pay to Part D plans and 23.1 percent of the drug's average manufacturer price, starting in 2013. If the prices increase more quickly than the rate of inflation, manufacturers would pay additional rebates.

AHIP urges Congress to protect popular health savings accounts

Health savings accounts (HSAs) are used by roughly 11.4 million people as of January 2011, a 14 percent increase since January 2010, according to data released this week by America's Health Insurance Plans (AHIP). The biggest jump in HSA use came from health plans offered by large employers, which increased 26 percent, followed by a 15 percent rise among individual plan subscribers.

AHIP warned that the Affordable Care Act prohibition on the use of HSAs (or flexible spending plans) to pay for over-the-counter medication would severely undermine the use of the popular accounts, which receive special tax treatment and offer low premiums in exchange for high deductibles. AHIP also urged members of Congress to exempt HSAs from the new medical-loss ratios, which limit the amount insurers can spend on administrative expenses and salaries.

Senator Orrin Hatch (R-UT) has already introduced a bill (S. 1098) to expand the use of HSAs.

FEDERAL AGENCIES

GAO says annual limit waivers are being granted in a "fair and unbiased" manner

House Republicans were deprived of ammunition this week for their claims that the Obama Administration is granting waivers of new annual limit restrictions to curry favor with political supporters.

The stopgap spending measure passed by Congress (see Update for Week of April 11th) required the Government Accountability Office to conduct an audit of the 1,350 annual limit waivers granted by the Department of Health and Human Services (HHS). House Republicans have held a series of hearings to charge Administration officials with granting the one-year reprieve from the new annual limits under the Affordable Care Act (ACA) to quell criticism of the new law or rewards organizations whose support was critical to get it passed (see Update for Week of March 21st) They specifically cited the fact that nearly 20 percent of waivers granted in April went to "posh entertainment venues" in the district of former Speaker Nancy Pelosi (D-CA) (see Update for Week of May 16th).

GAO documented that of the 1,415 waiver applications received by HHS by April 25th, more than 95 percent were approved in their entirety, while only 25 were partially rejected and 40 denied. They also found that HHS used an objective standard to grant waivers when applications showed that the new annual limit restriction would result in a "significant premium increase of more than 10 percent, in addition to a significant decrease in access to benefits." HHS also denied applications where the projected premium increase was six percent or less.

Based on this data, GAO concluded that the waivers were granted "in a fair and unbiased manner [needed to] ensure a smooth transition until the full array of reforms are in place [in 2014]. The ranking member of the Energy and Commerce Committee, Rep. Henry Waxman (D-CA) trumpeted GAO's findings as evidence that Republican allegations of favoritism "have no basis in fact".

Waxman and HHS also insisted that Energy and Commerce members already received details showing that roughly 60 percent of denied waivers were actually for Democratic allies like labor unions.

The waivers will allow plans covering about three million people (or roughly two percent of the private insurance market) to continue offering “mini med” plans that apply annual limits of less than $750,000 for plan year 2011. Only 153,000 people are in plans that were denied waivers.

OIG says Medicaid agencies lack adequate oversight over discounted 340B drugs

The Office of the Inspector General (OIG) for the Department of Health and Human Services reported this week that Medicaid agencies lack policies or information needed to oversee reimbursement for drugs purchased under the 340B Drug Discount Program to safety net providers.

The Health Resources and Services Administration (HRSA) administers the 340B Drug Discount Program at the federal level, which requires drugmakers to calculate 340B ceiling prices and sell products at or below these prices to safety net providers. State Medicaid programs may set specific policies for safety net providers that dispense 340B-purchased drugs to Medicaid enrollees. However, the Centers for Medicare and Medicaid Services (CMS) does not require states to do so.

As a result, the OIG’s report (OEI-05-09-00321) found that only 25 states have written policies that direct safety-net entities to bill 340B-purchased drugs at cost and only one state has a prepay edit to ensure accurate reimbursement specifically for 340B claims. OIG noted that states are typically unable to create prepay edits to prevent paying more than provider costs for 340B-purchased drugs because they do not have access to either 340B ceiling prices or costs

The report claims that CMS has agreed at OIG’s request to require that states create policies for safety net providers who bill Medicaid for 340B-purchased drugs and educate states about methods to identify reimbursements for such drugs. The OIG also recommended that HRSA share 340B ceiling prices with sates and improve the accuracy of 340B pricing and cost data, although HRSA has yet to acknowledge that it will do so.

STATES

Study shows impact of limited safety net among poorer states

Researchers at the University of Washington released a new study this week showing that life expectancy in the United States rose at a far slower rate than 37 other countries from 1997-2007. However, the most revealing part of the study showed a startling disparity in life expectancy among and within various states.

Overall, 80 percent of American counties lagged behind increases in life expectancy witnessed by the ten nations where people live the longest. The study attributed lagging life expectancy rates in the United States largely due to a lack of preventive care. States like California, Colorado, Massachusetts, Minnesota, Vermont, Washington, and Wisconsin that traditionally rank highly in health outcomes and access to care not surprisingly have life expectancy rates comparable to countries with universal health care like Australia, France, Japan, and Switzerland. In fact, those who live in affluent counties near San Francisco or Washington, DC can expect to live longer than most anywhere else in the world. However, states with high rates on of uninsured whose residents are unable to access preventive care have shockingly low rates of life expectancy beneath even third-world countries.

In particular, those living in a wide swath of the country extending through the deep south from rural Appalachia to the southern plains can expect to live no longer than those in Costa Rica, Syria, or Vietnam.

American men can now expect to live until nearly age 77, an increase to 24th worldwide from 32nd. However, while women still live longer (81.3 years on average), female life expectancy in the United States declined dramatically, falling from 20th worldwide to only 35th. Researchers attribute increasing rates of tobacco use among women for the sharp decline.

California

Governor vetoes "unrealistic" budget that fails to include tax hikes, deep spending cuts

Governor Jerry Brown (D) promptly vetoed an "unrealistic" budget compromise passed this week by the Legislature to close the state's $9.6 billion budget deficit.

The Legislature had initially passed a budget plan last March that included the Governor's tax hike package and all but the "most cruel" of his Medi-Cal service limits and deep spending cuts (see Update for Week of March 14th). However, Democrats were unable to get the four Republican votes necessary for the three-fifths majority needed to put the tax hike extensions before the voters.

As a result, Democrats stripped out the tax hikes in order to exercise their new authority to pass budget bills with only a bare majority. The ballot referendum that passed last fall (see Update for Week of November 1st) thus allowed the legislature to pass only its second on-time budget in the last 25 years, even without any Republican support.

However, the Governor blasted Democrats for trying to fill the deficit with accounting "gimmicks" and "unrealistic" savings projections. The Governor refused to consider the measure to be a "partial victory" and instead tried to force at least four Republicans to support putting his plan to extend tax hikes before the voters.

Democrats control both legislative chambers but lack the votes to override a veto without Republican support.

Connecticut

Medicaid director says no to Medicaid managed care, cites higher administrative costs

The Director of Connecticut's Medicaid program announced at a conference this week that his state was retreating from plans to move most Medicaid enrollees into managed care plans.

States have been increasingly looking to capitated private plans as a way to curb exploding Medicaid costs, with Florida and Texas leading the way towards transitioning nearly all of its enrollees into managed care. However, a new report released this week by the Commonwealth Fund warned that Medicaid managed care plans that are publicly traded score poorly in terms of quality and efficiency.

The study specifically found that publicly traded for-profit plans spend 14 percent of premium revenue on administrative costs, compared to only 8-10 percent for those owned by provider groups, health systems, or community health centers. The publicly traded plans also scored 11-13 points lower than other plans when it comes to prevention and chronic care management.

According to the Centers for Medicare and Medicaid Services, 72 percent of Medicaid enrollees were already fully or partially covered by a managed care plan, up from 55 percent in 2000. The number of enrollees in managed care plans owned by publicly traded companies jumped significantly (from 5.6 million to 9.8 million people) between 2004 and 2009. These figures are likely to climb even higher as states continue relying on managed care to combat enrollment spikes caused by high unemployment.

Connecticut's Medicaid director citied the Commonwealth Fund findings in explaining that his state was not convinced that managed care was more efficient and would save money. Instead, state officials have elected to rely on tools provided by the Affordable Care Act to deliver care more efficiently,

such as medical homes and accountable care organizations. He also noted that Connecticut Medicaid was continuing to use federal stimulus funds to broaden the use of electronic health records.

The director also joined with his counterparts in Washington and West Virginia by dismissing a proposal advanced by Republican Governors and members of Congress to convert federal matching funds into unrestricted "block grants". He noted that Connecticut's federal match is "relatively generous" and would be greatly reduced under their "block grant" plan.

Hawaii

State ends Medicare Part D assistance under SPAP

The Department of Human Services (DHS) announced this week that the department will no longer subsidize Medicare Part D co-payments under the State Pharmacy Assistance Program (SPAP) as of July 1st.

The program began in 2007 and enrolls over 43,500 Hawaiians. However, it wound up costing the state over $1.5 million in fiscal year 2010.

Indiana

Insurance department seeks distinctive relief from new federal insurer payout standards

Indiana is one of at least 12 states seeking a federal waiver allowing it to phase-in the new medical loss ratios (MLRs) for individual and small group health plans that are currently required by the Affordable Care Act (ACA).

The application by the Department of Insurance differs from other states in that Indiana is seeking four years instead of three to gradually move up to the new requirement that individual and small group plans spend at least 80 percent of premium revenue on direct medical care. Indiana proposes to require an MLR of only 65 percent for the 2011 plan year, while not reaching the 80 percent threshold until 2015, one year after the ACA is fully implemented. The Department insists that the extra year is necessary because individual plans typically maintain the same premium for at least a full year.

Indiana's waiver request is also distinct because it seeks permanent relief for consumer driven health plans (CDHPs), or those that offer lower monthly premiums in exchange for very high deductibles. Indiana currently has the fifth highest percentage of CDHPs in the nation (8.1 percent of the state's population) as its signature Healthy Indiana Plan (HIP) is a Medicaid alternative that essentially operates as a CDHP.

Indiana's waiver request also seeks an exemption through 2014 for new market entrants, which it defines as carriers that have not participated in Indiana's individual market for at least ten years.

The Department of Insurance insists that nearly ten percent of the state's health insurance carriers have already withdrawn from Indiana solely because of higher insurer payout standards.

Louisiana

Governor battles with Republican lawmakers over his Medicaid privatization plan

Governor Bobby Jindal (R) is locked in a high-stakes battle with Republican lawmakers over his signature health reform initiative.

The Jindal plan would convert the traditional Medicaid fee-for-service program into a system of capitated coordinated-care provider networks that are awarded state contracts. Medicaid enrollees would be enrolled in a given network, which will operate much like HMOs.

Modeled after Florida's Medicaid managed care demonstration, the Governor sought to implement the initiative by July 1st. However, the Republican-controlled Legislature was upset that the Governor developed the plan without legislative input or oversight. Earlier this month, the Senate unanimously passed S.B. 207, which would require annual reports to the legislature and give lawmakers the authority to terminate the Coordinated Care Network if it fails to deliver on the promised cost-savings or improvements in quality. The measure cleared the House Health and Welfare Committee on a series of divided votes and is set for a floor vote early next week.

The House-passed budget (H.B. 1) also stripped $81 million from the Governor's initiative. However, the Senate Committee on Finance promptly restored the funding before the bill moved to the Senate floor.

Governor Jindal has pledged to veto any legislation that impedes his Medicaid privatization plan. However, the legislative wrangling is likely to delay implementation past July 1st.

Maine

Legislature votes to repeal ban on unfair PBM practices

The Republican-controlled Maine Legislature voted this week to pass L.D. 1116, which repeals a 2003 law that protects consumers from rising drug prices and prevents fraud by pharmacy benefit managers (PBM).

Lobbyists for the PBM industry had repeatedly urged new Governor Paul LePage (R) to rescind the law as part of his pledge to make the health insurance market more business-friendly. The Governor has already succeeded in weakening some of the state's most popular consumer protections, including community rating, state coverage mandates, and the state's 15-year ban on insurers requiring rural residents travel only to Bangor or Portland for care (see Update for Week of May 2nd).

The PBM industry insisted that the transparency requirements under the *Unfair Prescription Drug Practices Act* were discouraging pharmaceutical business in the state and driving-up drug costs through lower competition. The law specifically prevented PBMs from switching patients to more expensive drugs, required prompt payment of pharmacies and good-faith price negotiation, and protected consumers from higher co-payments when the actual drug price is cheaper.

By repealing this law, the legislature also removed prohibitions on kickbacks and self-dealing, oversight and auditing of state PBM contracts, and unfair practices by mail-order pharmacies.

Opponents of L.D. 1116 blasted the LePage Administration for removing consumer protections that 14 states and the District of Columbia sought to pass in the early 2000's. However, Maine was the only state that still imposed fiduciary-disclosure requirements on PBMs after similar provisions in the District of Columbia were struck down last year by a federal appeals court.

The original Maine law was in response to a lawsuit filed against one PBM by 20 states including Maine for violating consumer protection and mail-fraud laws for switching prescriptions. The industry has steadily worked to repeal the law, but lobbying intensified once Republicans took control of the House and Senate last winter for the first time in the last 40 years. Critics of the repeal noted that Governor LePage's transition team was headed by a former PBM and PhRMA lobbyist.

Michigan

Republican Governor refuses to call for ACA repeal, proceeds with creating insurance exchange

Governor Rick Snyder (R) announced this week that he has declined to join 29 other Republican governors in asking Congress to repeal the entire Affordable Care Act (ACA) and provide states with unrestricted "block grants" that allow greater flexibility in how to operate their Medicaid programs.

The letter to Rep. Fred Upton (R-MI) and Senator Orrin Hatch (R-UT) was prominently displayed on the Republican Governors Association website. However, Governor Snyder insisted that he was elected last fall to "focus on Michigan issues" and not be involved in divisive partisan issues on a national scale. He decided instead to send a separate letter to Rep. Upton noting that Michigan has been able to balance its budget this year without needing the greater flexibility sought by Republican Governors to cut Medicaid eligibility.

Governor Snyder has consistently sought to avoid comparisons with new Republican Governors in neighboring Ohio and Wisconsin who have taken strongly partisan positions that have courted national controversy, such as eliminating collective bargaining rights for public employees. The Governor has refused to call for a repeal of the ACA and is instead implementing its provisions, including the creation of a state-based health insurance exchange.

New Hampshire

Supreme Court refuses to force Attorney General to join multi-state lawsuit against ACA

The New Hampshire Supreme Court ruled this week that state lawmakers cannot force the Attorney General to join a multi-state challenge to the constitutionality of the Affordable Care Act (ACA).

Republicans gained control of the House of Representatives and Senate this year and immediately demanded that Attorney General Michael Delaney (D) add New Hampshire to the list of 26 state attorneys general who have signed-on to the multi-state lawsuit filed by former Florida Attorney General Bill McCollum (R). When Governor John Lynch (D) promised to veto any such legislation, the legislature voted instead to seek the intervention of the Supreme Court.

However, the Court held that the decision on whether to join the lawsuit was solely in the purview of the executive branch, and that the legislature may only set forth the duties of executive branch officials without usurping their essential powers.

New Jersey

Governor identifies cost savings for his plan to severely cut Medicaid eligibility

Governor Chris Christie (R) released his long-anticipated outline this week of how the state proposes to drastically restructure New Jersey's Medicaid program through more than $300 million in spending cuts.

The Department of Human Services expects to save as much as $32.5 million alone by severely reducing New Jersey's traditionally broad eligibility to a mere 25-29 percent of the federal poverty level for parents with children. The state had previously estimated that at least 23,000 Medicaid enrollees would lose coverage from the lower limit (see Update for Week of May 16th), but this week's announcement was the first time they projected the savings from the cut.

During his first year, Governor Christie had already cut Medicaid eligibility for adults from 200 percent of FPL to the 133 percent minimum mandated by the Affordable Care Act (ACA) after 2014. The new limit eliminates coverage for persons making less than roughly $5,000 per year, compared to the current income limit of $24,600.

Congressman Frank Pallone (D-NJ), author of the federal law that helped the state create the FamilyCare offshoot to Medicaid, blasted the Governor's efforts to merely shift costs to emergency rooms and other safety net providers. However, the Governor insists that cutting enrollment is the only way to fill the Medicaid program's $1.4 billion deficit and recover the loss of $1 billion in federal stimulus funds that

artificially propped-up the program during the recession. He also emphasized that he remains committed to the state's 350 percent of FPL limit for children, as well as obtaining enhanced federal funds by expanding coverage to childless adults (see Update for Week of April 11th).

The eligibility cut requires federal approval and is part of the "Comprehensive Medicaid Waiver" that the Governor plans to submit later this month. He claims that he was had "productive conversations" with the Centers for Medicare and Medicaid Services about the waiver. The Obama Administration has previously refused to waive the ACA provision barring states from cutting eligibility to fill deficits. However, they are being lobbied heavily by Republican and some Democratic Governors to relax this prohibition.

New York

Governor and Republicans introduce competing exchange bills

Governor Andrew Cuomo (D) submitted legislation this week that would create a health insurance exchange that complies with the standards under the Affordable Care Act (ACA).

Unlike the Republican bill introduced last week (S.5652), the Governor is proposing that the governmental board overseeing the exchange be able to negotiate benefits on behalf of consumers, similar to the active purchaser model in neighboring Massachusetts. The chairmen of the Senate Committee on Health and Committee on Insurance are seeking instead to create an exchange more like Utah's, which is essentially an information clearinghouse where consumers can comparison shop for plans that best suit them.

Governor Cuomo's plan would allow the exchange board to exclude insurers who not meet minimum quality and price standards, a key distinction from the Republican bill which also bars the board from regulating health insurers or imposing fees or assessments to operate the exchange. The Republican measure also does not explicitly prohibit insurers from serving on the board, a key source of controversy in other states.

Consumer groups predictably praised the Governor's plan while the New York Health Plan Association representing insurers opposed giving negotiating authority to the board.

The Senate Insurance Committee had set an end of May deadline for exchange legislation, since the first session concludes next week. However, lawmakers are rushing to pass a bill, since failure to do so this session could cause the state to miss out on future establishment grants and force the federal government to assume control of the exchange if the state cannot meet federal benchmarks by January 2013 (see Update for Week of May 30th). Despite a slight Republican majority, there is strong bipartisan support for the exchange concept and some form of authorizing legislation is ultimately expected to pass.

North Dakota

Legislative committee begins review of health insurance exchange

North Dakota was one of two states along with Virginia (see below) whose legislature passed bills last session that put the state on a path towards creating the new health insurance exchange required by the Affordable Care (ACA), without actually committing to exchange implementation.

However, H.B. 1126 did commit the Insurance Commissioner to use the state's $1 million federal exchange grant to develop recommendations for the exchange, which he plans to use to hire design consultants (see Update for Weeks of April 18th and 25th). The Legislature's interim Health Care Reform Review Committee began preparing authorizing legislation this week for possible introduction during a special legislative session in November. The committee heard testimony from former Utah governor and U.S. Department of Health and Human Services (HHS) Secretary Michael Leavitt, who urged members to

create their own health insurance exchange before 2013 instead of defaulting to the federal government, as HHS would likely allow state-operated exchanges more flexibility.

The Committee chairman, Rep. George Keiser (R), also supports North Dakota's creation of an exchange. Senator Tim Mathern (D) urged lawmakers to consider a regional exchange with neighboring rural states.

Virginia

Legislative committee hears arguments for and against health insurance exchange

Despite the efforts of Attorney General Ken Cuccinelli (R) to overturn key provisions of the Affordable Care Act (ACA), the Joint Commission on Health Care met this week to move forward on creating the health insurance exchange authorized by the new law.

Health and Human Resources Secretary Bill Hazel, MD emphasized the need to continue implementing the exchange despite court challenges, noting that failure to be prepared by January 2013 would result in the federal government assuming control over the exchange. However, the Director of Health Policy Studies for the libertarian Cato Institute insisted that the Commonwealth should not give a "hint of legitimacy" by implementing any provision of a law whose constitutionality is in question.

A lower court ruled in Attorney General Cuccinelli's lawsuit last winter that the ACA mandate that everyone purchase health insurance was unconstitutional, but upheld the remainder of the new law (see Update for Week of December 13th). However, a lower court in Florida struck down the entire law due to the individual mandate's unconstitutionality (see Update for Week of January 31st). Both cases are currently being heard in appellate courts (see Update for Week of June 6th).

Although the Legislature passed a measure last session creating an advisory panel to study exchange implementation, it will need to pass authorizing legislation once the panel makes it formal recommendations to Legislature this fall.

The Virginia Health Reform Initiative panel chaired by Dr. Hazel has previously urged the Joint Commission on Health Care to promptly create a "market oriented" exchange that will allow a large number of insurers to participate. They also made several recommendations that go beyond the ACA, including higher Medicaid cost-sharing for certain services, increasing the number of physicians, and creating an innovation center to improve care for those with chronic conditions (see Update for Week of December 13th).