

Health Reform Update – Week of August 29, 2011

CONGRESS

Republican tax expert to lead deficit reduction “super committee”

The chief tax counsel for Senate Finance Republicans was named this week as the new staff director for the powerful “super committee” that will make recommendations by Thanksgiving on how to slice at least \$1.2 trillion in government spending.

The announcement by co-chairs Rep. Jeb Hensarling (R-TX) and Senator Patty Murray (D-WA) was praised by members of both parties. Senate Finance Committee chairman Max Baucus (D-MT) noted that Mark Prater has served for over two decades on the committee and is highly-regarded as a practical moderate who is willing to work across the aisle.

Prater will serve a pivotal role on the Joint Select Committee on Deficit Reduction, which must reach consensus by November 23rd to avoid triggering automatic cuts in domestic and defense spending if the panel fails to reach agreement (see Update for Week of August 1st). Republican and Democratic members held separate private meetings this week to develop their negotiation strategies in advance of the first meeting, which must be held by September 16th.

NAIC panel says CBO overstates savings from Medigap reforms

State insurance commissioners are contesting a cost estimate from the Congressional Budget Office (CBO) that they fear may give the new deficit “super committee” an inflated view of savings from proposed Medigap reforms healthcare savings.

The National Association of Insurance Commissioners was charged by the Affordable Care Act (ACA) with recommending potential cost-saving reforms for supplemental Medicare plans (or Medigap). However, the designated subgroup is also looking closely at Medigap changes that will likely be on the table as the “super committee” begins looking for \$1.5 trillion in deficit reduction cuts.

Among those proposals is a holdover from earlier debt commissions that would bar Medigap plans from offering coverage without cost-sharing. CBO has estimated that the change would save the federal government \$53 billion over ten years.

The subgroup debated this week how best to challenge CBO’s calculations, which they insist are based on figures that cannot readily be verified. They are likely to publicly ask for CBO to provide detail into the assumptions it used to make its cost estimate.

The commissioners are concerned that CBO assumes cost-sharing would become mandatory for existing Medigap plans, not just new policies. However, such change would require Congress to eliminate existing benefits.

Uninsured Americans unaware of how the Affordable Care Act will benefit them

About half of the uninsured Americans who stand to benefit the most from the Affordable Care Act (ACA) are not aware of how the new law will expand access to health insurance.

The Kaiser Family Foundation’s latest monthly tracking poll found that over 53 percent of the uninsured surveyed in the poll did not know that the ACA expanded Medicaid coverage, and nearly half

were unaware of the federal subsidies helping the uninsured earning less than 400 percent of the federal poverty level to purchase affordable coverage in an exchange.

Overall, 47 percent of the uninsured said the law “won’t make much difference” to them. Another 14 percent said the law would hurt them. Only 31 percent said they thought the law would be a benefit. However, nearly two-thirds of those surveyed knew about the controversial provision requiring all Americans to buy health insurance.

Public opinion of the entire ACA has also fallen below 40 percent for this first time, with 44 percent opposed. Only about 60 percent of Democrats now favor the law, the lowest level since passage.

FEDERAL AGENCIES

CMS begins scrutinizing premium increases in ten states, association health plans included

Federal regulations giving states and the Centers for Medicare and Medicaid Services (CMS) greater authority to scrutinize “unreasonable” increases in health insurance premiums went into effect September 1st.

The Affordable Care Act (ACA) requires state insurance departments to automatically review any proposed rate hike of at least ten percent, and require insurers to publicly justify the increase. In states without an effective rate review process, CMS will assume all or part of the responsibility for the review (see Update for Weeks of June 27th and July 4th).

Insurers now have to submit a seven-page form justifying any double-digit rate hike, even though CMS has no ability under the ACA to block or modify increases, or do the 17 states that currently lack that authority. Instead, CMS is hoping that the bad publicity of having justifications for rate hikes posted on federal and state websites will discourage unreasonable increases.

America's Health Insurance Plans, the industry's main lobbying group, found that about half of all increases in the individual-insurance market exceeded ten percent each year for the past three years.

California Insurance Commissioner Dave Jones (D), who is seeking legislative authority to reject unreasonable rates (see article blow), doubts that the “shaming” authority under the ACA will have much effect. However, Kansas Insurance Commissioner Sandy Praeger (R) insisted that her state has seen evidence that the threat of public scrutiny has lowered plan premiums over the past year.

HHS also published amends this week to its earlier final rule on rate review (see Update for Week of May 16th). These clarified that insurers offering “association health plans” through trade groups or other organizations of affiliated members will face the same enhanced scrutiny of premium rate hikes as other types of insurance. CMS had sought public comments on whether “association health plans” should be included.

GAO report validates broker complaints about new medical-loss ratio calculations

A Government Accountability Office (GAO) report released this week concluded that the new medical-loss ratios (MLRs) under the Affordable Care Act (ACA) are saving money for consumers but may lead to fewer plan options.

The GAO study interviewed insurers and regulators about the early impact of the new insurer payout standards that require individual and small group plans to spend 80 percent of premium revenue on medical care. Researchers found that insurers are decreasing premiums or leaving rates unchanged in order to avoid having to pay the consumer rebates for failing to meet these new MLRs. However, the premium changes are coming at the expense of cuts to brokers' commissions, as GAO found that “almost all” of the insurers interviewed have relied on lower broker fees as a way to comply with the MLRs.

Insurance agents and brokers have warned repeatedly that the MLRs will hurt them, and several bipartisan bills in Congress (including H.R. 1206) have sought to exclude their fees and commissions from the MLR calculations and received at least informal support from the National Association of Insurance Commissioner (see Update for Week of July 11th). While consumer advocates have argued that the adverse effects on brokers are overstated, the GAO report appears to support the broker fears.

Commissions to agents and brokers are typically 15 or 20 percent of those revenues that insurance companies can use for administrative expenses and profit. Brokers argue that insurers will cut commissions and redirect that money toward their own bottom lines.

However, the GAO study failed to support complaints by insurers that federal regulations should not exempt healthcare quality improvements from the calculation of administration expenses. Insurers interviewed by GAO indicated that their MLRs will “barely change” by even 0.5 percent because of the deduction for quality improvement.

STATES

Republican Governors renew request for greater Medicaid flexibility

The Republican Governors Public Policy Committee chaired by Mississippi Governor Haley Barbour (R) issued a report this week outlining 31 different recommendations for granting states greater flexibility to operate their Medicaid programs without federal restrictions.

The report follows-up on letter sent by 29 Republican Governors earlier this year to House Energy and Commerce Committee Chairman Fred Upton (R-MI) and Senate Finance Committee ranking member Orrin Hatch (R-UT) endorsing open-ended “block grants for Medicaid and seven guiding principles for giving greater freedom to state Medicaid agencies.

The latest 31 recommendations include the Republican wish list of repealing the Affordable Care Act (ACA), or at least the “maintenance of effort” provision that bars states from cutting eligibility prior to the mandated Medicaid expansion in 2014. It also would do away with federal Medicaid benefit and eligibility requirements in favor of setting goals for health outcomes and spending. Under this outcomes-based model, the federal government would only step in when states deviated from the program goals they decided jointly with the federal government.

Other proposals include raising Medicaid co-payments for enrollees who earn more than the federal poverty level, letting Medicaid patients use health savings accounts combined with high-deductible health plans, and allowing greater freedom to move all Medicaid enrollees into managed care plans (as Florida currently seeks federal approval to do).

The report does not go as far as the “blank check” that Governor Barbour sought from Congress last spring (see Update for Week of February 28th). It is also less broad than the Medicaid “block grant” plan passed by the House of Representatives (see Update for April 4th), which would provide states with \$11,000 per Medicaid enrollee to spend as they wish.

Governor Barbour hoped that the recommendations will become part of the deficit-cutting “super committee” recommendations to cut federal spending by at least \$1.2 trillion (see article above).

Alaska

Governor softens exchange opposition, will proceed with only state funds

Governor Sean Parnell (R) announced this week that he has hired consultants to study how Alaska can design a health insurance exchange with only state funds.

The Governor made Alaska one of only two states to refuse the initial federal exchange implementation grants last year. He also pledged to block implementation of the Affordable Care Act (ACA) pending court challenges (see Update for Week of February 14th).

However, after meeting this week with U.S. Department of Health and Human Services Secretary Kathleen Sebelius, the Governor stated that he would use state-only funds to create an ACA-compliant exchange. The Governor's decision apparently followed promises by the Secretary that HHS would help Alaska to find ways to trim Medicaid spending without enacting eligibility cuts prohibited by the ACA.

Alaska Health and Social Services Commissioner William Streur subsequently announced that his department will issue a request for proposals by mid-September that seek consultants to help design such an exchange. Subsequent RFPs will locate a vendor to operate the exchange.

It is not clear how Alaska will build the necessary information technology infrastructure needed for the exchange without the millions of dollars in federal assistance provide to other states. Streur conceded that fees from insurers are not likely to provide the needed revenue, as his department predicts only a limited number of Alaska insurers will participate in the exchange. Most of Alaska's large employers are oil companies, hospitals, or educational institutions that already self-insure or are insured through a parent corporation located outside the state.

California

Landmark rate review bill falls in Senate for fourth consecutive year

For the fourth year in a row, landmark legislation expanded the state's rate review authority will not pass the Senate.

Assemblyman Mike Feuer (D) agreed to table his measure (A.B. 52), after year long efforts to secure a majority of Senate votes failed. The measure will not be considered until 2012, when the two-year session resumes.

The defeat is a major blow for Insurance Commissioner David Jones (D), who had personally crusaded for the passage of the bill that would give him the authority to reject or modify unreasonable premium hikes. Jones authored a similar measure last year as an Assemblyman, and went so far as to sit in on Assembly and Senate votes for A.B. 52, a move that inspired a backlash from Republican lawmakers (see Update for Weeks of June 27th and July 4th).

California is one of only 17 states whose insurance commissioners lack the authority to reject or modify rate hikes. Consumer advocates believed this was the year that the landmark bill would finally pass, coming on the heels of public outrage over individual rate hikes of up to 59 percent that were found by the Commissioner to be erroneous.

However, A.B. 52 faced a stone wall of opposition from the state's insurance, hospital, and physician industry. Hopes of recruiting Senators on the fence appeared to fade after a score of the bill by Senate Appropriations far exceeded cost estimates in the Assembly.

One state advocacy group, Consumer Watchdog, is trying to place a voter referendum on the 2012 ballot that would given the Insurance Commissioner similar rate review authority as A.B. 52.

Renewed bleeding disorders legislation tabled until next year

Legislation that would establish requirements for entities that provide blood clotting products for home use in the treatment of bleeding disorders was tabled this week by Senator Fran Pavley (D) until the two-year legislative session resumes in 2012.

A.B. 389 had resurrected a similar measure that was vetoed last year by former Governor Schwarzenegger (R) (see Update for Week of February 28th). It unanimously cleared the Assembly (see Update for Weeks of April 18th and 25th) and two Senate committees before dying in Appropriations.

Colorado

Medicaid scales back most childless adult coverage due to higher than anticipated enrollment

The Department of Health Care Policy and Financing (HCPF) announced this week that it will vastly scale back the state Medicaid program after the 2009 expansion has attracted far more enrollees than anticipated.

H.B. 1293 allowed the state to expand Medicaid coverage to childless adults with incomes up to 100 percent of the federal poverty level (FPL) by imposing a fee on hospitals. However, HCPF officials claim the cost of insuring this population is almost nine times the amount initially estimated.

Colorado relied on other states like Indiana, Oregon and Wisconsin to formulate its estimates. However, these states only recently expanded coverage to childless adults and are also now experiencing higher than anticipated costs.

Original fiscal estimates projected that once fully phased-in there would be 49,200 people eligible for the program at a cost of \$197.4 million per year. That cost also included an estimate of annual medical costs of \$3,500 per person, or about \$292 a month

However, Colorado Health Institute data shows there are over 143,000 childless adults living below the FPL in Colorado, many with costly and chronic health conditions like diabetes and HIV. As a result, HCPF is incurring costs closer to \$900 a month per individual, and if everyone up to 100 percent of FPL enrolled, it would cost that state nearly \$1.8 billion.

HCPF now plans to reduce eligibility for childless adults to just ten percent of FPL or \$91 per month. But even at that bare bones level, covering all the state's 49,511 childless adults who qualify will cost \$770 million. Consequently, the state plans to cap the number of people served by the program to just 10,000. Under that scenario, the coverage will cost an estimated \$190 million over two years.

Board identifies four key decisions for implementing health insurance exchange

The Director of the state's Exchange Planning Grant Program presented recommendations to the Colorado Health Benefit Exchange Board on four strategic decisions for implementing the exchange required by the Affordable Care Act (ACA). The decisions include 1) the business model and financing; 2) systems alignment; 3) issues for the SHOP (small business exchange); and 4) plan certification and criteria.

The board chairperson Gretchen Hammer suggested that they create study sessions to educate members on the complexity of these decisions. Members also received summaries of the work of the Enrollment, Verification and Eligibility workgroup, which sparked debate about whether the exchange should allow consumers to enroll in all public benefits at one time, instead of just exchange coverage.

Although consumer groups like the Colorado Consumer Health Initiative (CCHI) favor the concept of integrating all public benefit enrollment into the exchange, they remain undecided about whether it is feasible to develop the necessary information systems to do so by the January 2013 federal deadline.

Illinois

Prominent Illinois providers are refusing to participate in Medicaid managed care demonstration

While states like Florida, Kentucky, and Louisiana are leading the trend towards states moving all or most Medicaid enrollees into managed care plans, a backlash has formed in other states including Illinois.

Some of Illinois' most prominent medical centers and physician practices have refused to participate in the states' first-time effort to ultimately push nearly 40,000 Medicaid adults with disabilities living in the Chicago area in only two HMO plans. The providers are objecting to bureaucratic hassles and cost-savings of the pilot program that come at the risk of lower quality and access to care. These include Northwestern Memorial Hospital, Rush University Medical Center, University of Chicago Medical Center, Children's Memorial Hospital and Loyola University Health System.

Only the University of Illinois at Chicago Medical Center has agreed to join the new Medicaid pilot program in Cook County, though several providers indicated they were keeping open the option of signing up later. Only one of Will County's four general hospitals has come on board.

Under a law passed in January, Illinois has committed to moving half of its 2.8 million Medicaid members to managed care plans by 2015. To persuade hesitant providers to participate, IlliniCare is now assuring payment within 30 days and offering temporary instead of long-term contracts.

However, Medicaid managed care has a poor track record in Illinois. Prior plans enrolled Medicaid members on a voluntary basis and had little success with controlling costs or providing adequate care. One such plan, Amerigroup, paid \$225 million to the state in 2008 to settle charges that it had defrauded Illinois Medicaid.

Iowa

Wellmark waffles on whether to participate in the new health insurance exchange

The chairman of Wellmark Blue Cross and Blue Shield disclosed in an interview this week that the dominant health insurer may stay out of the state's planned health insurance exchange required by the Affordable Care Act (ACA).

Wellmark writes over 75 percent of the state's individual and small business coverage, and its participation was expected to be critical to the success of the exchange as the insurer has by far the most extensive network of Iowa physicians and hospitals. Wellmark's huge market share also gives it the most leverage to negotiate lower provider prices.

Chairman John Forsyth insisted that Wellmark wants to participate in discussions of how the exchange will be designed and "we'll be there" so long as they can at least break even". However, the insurer has significant concerns about "losing lots of money" on exchange plans.

Insurance Commissioner Susan Voss scoffed at the notion that Wellmark would make a decision about participating before any authorizing legislation passed. The Iowa Division of Insurance is moving ahead on plans to design the state's own exchange, instead of defaulting to the federal government. However, lawmakers have still failed to agree on basic details of the exchange.

The CEO of the Independent Insurance Agents of Iowa urged Wellmark to join, noting that a similar effort in 1990s failed after Wellmark declined to participate.

Mississippi

Federal judge agrees to hear constitutional challenge to the ACA that he initially dismissed

A federal court decided this week to allow an amended constitutional challenge to the Affordable Care Act (ACA) to proceed.

The lawsuit originally filed by Mississippi's Lt. Gov. Phil Bryant (R) and ten other individual plaintiffs in 2010 was initially dismissed earlier this year by U.S. District Judge Keith Starrett for lack of standing because they could not speculate whether they would comply with the ACA mandate that everyone buy health insurance (see Update for Week of January 31st). However, the appointee of President George W. Bush allowed the plaintiffs to file an amended complaint to correct this flaw.

Judge Starett's latest decision partially dismissed the plaintiff's new complaint, including most of those brought by Lt. Governor Bryant. The judge noted that Bryant is currently running for Governor and thus may not be a state employee after this year, much less when the mandate goes into effect in 2014.

However, Judge Starett allowed several broad constitutional challenges to the individual mandate to proceed and be heard on their merits. This includes challenges under the Commerce Clause and Tenth Amendment that are the hallmark of related ACA lawsuits.

Judge Starett also became the first in the nation to agree to hear a claim that the individual violates the plaintiff's rights to medical privacy by forcing them to disclose protected health information to a health insurer. Starett's reasoning indicates that he may be receptive to such an argument.

His ruling also reversed part of his earlier dismissal. Citing a recent U.S. Supreme Court decision, Judge Starett held that any individual and not just the state may bring a claim that a federal law "intrudes upon the sovereignty and authority of the states" under the Tenth Amendment.

Puerto Rico

Senate considers the impact of returning or refusing federal grants to implement ACA

Republican efforts to block Affordable Care Act (ACA) grants are not limited to state legislatures. The Senate of Puerto Rico heard legislation on August 15th that would create a federal relations commission to investigate the return or refusal of ACA implementation grants and how it would threaten local health reforms. S.2225 was introduced in July by Senator Melinda Romero Donnelly (R).

The governorship and both chambers of the Puerto Rico legislature are controlled by Republicans.

South Carolina

Governor refuses to move forward on health insurance exchange, for now

Governor Nikki Haley (R) announced this week that she will not apply for additional federal grants to create a health insurance exchange pursuant to the Affordable Care Act (ACA).

Insisting that the state cannot afford an exchange and does not want one, both the Governor and Director of the Department of Health and Human Services decided to forgo exchange creation and allow the federal government to instead operate a default exchange in South Carolina. However, they did not rule out exercising the option allowed by recent federal regulations to create an exchange several years down the road, once state experience with exchanges makes their benefits and costs more clear (see Update for Week of July 11th).

Governor Haley has gone back and forth on exchange implementation, initially supporting authorizing legislation (H.B. 3738) until key lawmakers defected in the face of local tea party opposition (see Update for Week of March 28th). She also had initially pledged to block all ACA implementation pending court rulings, before later allowing some projects including the exchange to move forward (see Update for Week of March 14th).

A state committee that the Governor created through executive order used the initial \$1 million federal exchange grant obtained by former Governor Mark Sanford (D) to begin planning for the exchange. It estimated that just the initial design process will cost the state about \$5.3 million in fiscal 2012. Final recommendations from the panel are due by October.

H.B. 3738 would have created a health insurance exchange that prohibited insurers from serving on the oversight board, a major source of controversy in neighboring North Carolina.

Washington

State Supreme Court says Attorney General could independently join ACA litigation

The Washington Supreme Court ruled this week that Attorney General Rob McKenna (R) properly exercised his currently “broad authority” to join the multi-state lawsuit challenging the Affordable Care Act (ACA), even over the objections of Governor Christine Gregoire (D).

Seattle City Attorney Pete Holmes (D) sued to block McKenna from making Washington one of 26 states to join the suit. Despite McKenna’s initial victory, Holmes noted that the Supreme Court held that the Attorney General’s authority flows from state law, not the state constitution. This means that the Democratically-controlled Legislature could theoretically change the law to direct the Attorney General to withdraw from the multi-state lawsuit and prevent him from independently joining future lawsuits.

McKenna insisted that Holmes’ was incorrectly reading the Supreme Court’s decision and that he still has independent authority under the state constitution to file or join the state to lawsuits. Governor Gregoire (D), who faces a re-election challenge next year from McKenna, insists that she will not seek to force McKenna’s withdrawal from the suit.