

GOVERNMENT RELATIONS

Health Reform Update - Week of October 10, 2011

CONGRESS

Democrats and Republicans outline their health priorities for deficit "super committee"

The new deficit reduction "super committee" was bombarded again this week with proposals on how to trim at least \$1.2 trillion from the nation's budget deficit over the next ten years.

House Democrats on key health committees sent letters to the panel just before the deadline for standing committees to submit recommendations. They urged members to pass their traditional list of cost-saving proposals, headlined by allowing Medicare to negotiate Part D drug prices and expanding Part D drug rebates to both Medicare and Medicaid. The latter was already proposed by the President and sought by legislation (H.R. 2190) introduced by Energy and Commerce ranking member Henry Waxman (D-CA) (see Update for Week of June 13th).

Rep. Elijah Cummings (D-MD) also recommended allowing the Office of Personnel Management to contract with pharmacy benefit managers to get lower drug prices for the Federal Employee Health Benefit Plan. That provision could save \$1.6 billion over ten years.

Both Reps. Waxman and Cummings also asked the panel to support the ban on "pay for delay" agreements between brand-name and generic drug manufacturers that keep lower-cost prescription drugs off the market. President Obama, the Federal Trade Commission, and Senators Herb Kohl (D-WI) and Chuck Grassley (R-IA) have pushed for a similar ban (S. 27).

However, House Democrats did not concur with the President's proposal to cut the Prevention and Public Health Fund under the Affordable Care Act (ACA). The President's recommendations would shave \$3.5 billion from the \$15 billion allocated over ten years to remove cost-sharing from certain preventive services covered by Medicare (see Update for Week of September 19th).

Ways and Means ranking member Sander Levin (D-MI) joined with Waxman and Cummings in also urging the panel to rebuff Republican recommendations to raise the current Medicare eligibility age or shift more Medicare and Medicaid costs on beneficiaries. They argued that such cost-shifting would merely increase outlays for other federal programs.

The recommendations put together by Senate Finance Republicans this week included the traditional GOP "wish list". It includes the House-passed plan to block grant Medicaid, but softened the proposal to turn Medicare into a voucher program (see Update for Week of April 4th).

Repealing the entire ACA and imposing long-sought restrictions on medical malpractice awards were featured prominently on the list. The recommendation to means-test Medicare is the most prominent Republican proposal to engender any significant bipartisan support.

Senator Kohl wants to extend drug discounts to Medicare Part B, inpatient facilities under 340B

Senator Herb Kohl (D-WI) became the latest Democrat to introduce a bill this week that would cut Medicare's payments for prescription drugs.

The bill (S. 1699) would apply to fewer drugs than H.R. 2190 (see Update for Week of June 13th). However, while lawmakers including Rep. Henry Waxman (D-CA) sought major cuts in the cost of drugs under Medicare Part D, Kohl's bill would also cut costs for Part B drugs administered by a physician.

Senator Kohl, who chairs the Special Committee on Aging, reiterates Waxman's call to expand Part D rebates to dual eligibles, a move that the Health and Human Services Inspector General estimates will save up to \$2.4 billion over ten years for just the 20 most expensive drugs. Kohl also supports allowing Medicare to negotiate Part D prices.

However, Senator Kohl wants to extend that authority to Part B drugs, for which Medicare is the majority purchaser. In addition, he would expand the 340B discount program for outpatient safety-net providers to some inpatient facilities.

The Senator sent a letter this week to the deficit reduction "super committee" urging the panel to adopt his proposed legislation in their recommended spending cuts.

Ways and Means passes measure to fix flaw in subsidy formula under Affordable Care Act

The House Ways and Means Committee passed a measure this week that seeks to fix a flaw in the subsidy formula under the Affordable Care Act (ACA) that would enable up to three million middle-class retirees to erroneously qualify for Medicaid.

Republicans had pounced on a report last summer by the Centers for Medicare and Medicaid Services (CMS) chief actuary concluding that changes in the way Social Security income is counted could cost the federal government up to \$450 billion over ten years in improper Medicaid expenses. This is because a married couple could earn up to 400 percent of the federal poverty level (FPL) and still qualify for Medicaid after 2014 if they retired at age 62 because Social Security benefits under the ACA would no longer be treated as income when determining eligibility (see Update for Week of June 20th).

The Congressional Budget Office estimated that fixing this "glitch" through H.R. 2576 would raise \$13 billion over ten years, as up to one million few people would enroll in Medicaid per year (see Update for Week of July 25th).

CMS has already pledged a regulatory fix and President Obama included a similar correction in his deficit reduction plan. However, few Democrats supported the Republican-backed measure. Rep. Ron Kind (D-WI) was the lone Democrat to vote for H.R. 2576 in committee, while Rep. Kurt Schrader (D-OR) is listed as a cosponsor.

FEDERAL AGENCIES

Congress demands to know why CMS missed ACA deadline for physician payment sunshine rules

Senators Herb Kohl (D-WI) and Chuck Grassley (R-IA) are pressing the Centers for Medicare and Medicaid Services (CMS) for answers about why the agency missed the statutory deadline for new rules regulating financial payments between physicians and manufacturers.

The Physician Payments Sunshine Act legislation that was long-sought by the two Senators was eventually incorporated as part of the Affordable Care Act (ACA). The Act requires manufacturers to report all payments to physicians, including consulting fees, honoraria, and travel and entertainment expenses. The act also requires CMS to publicly disclose on the internet the identity of the manufacturer, physician, and the drug or device associated with the payment.

Congress required CMS to implement rules by October 1st that define how manufacturers submit the required information and how it would be publicly disseminated. CMS had assured the Senators as last as September 23rd that the rules were being submitted to the Office of Management and Budget for the required paperwork clearance. However, the rules were not published as required by October 1st.

Under the ACA, manufacturers and group purchasing organizations are required to collecting payment data beginning January 1, 2012, and must begin reporting this information to CMS on March 31, 2013. Starting September 30, 2013, the details of these payments must be made available to the public. It is not yet clear how the CMS delay will affect these deadlines.

Supply of rural physicians has nearly tripled under Obama Administration

The Department of Health and Human Services (HHS) announced this week that the number of physicians in underserved areas has nearly tripled since President Obama took office.

The American Recovery and Reinvestment Act and Affordable Care Act (ACA) provided funding to expand the National Health Service Corps (NHSC), which offers scholarships and loan repayment to physicians who practice in underserved communities. According to HHS, this funding has increased participation to more than 10,000 clinicians, up from only 3,600 in 2008. Corps physicians served roughly 3.7 million people when President Obama took office, but now provides care to over 10.5 million in need.

The current shortage of primary care physicians is a major concern for both Republican and Democratic lawmakers, as the ACA is estimated to bring at least 32 million newly-insured customers into the health care system. One in five Americans lives in underserved areas targeted by NHSC.

Prescription drug costs are high on OIG agenda for fiscal year 2012

The Office of the Inspector General (OIG) for the Department of Health and Human Services (HHS) released its work plan last week for fiscal year 2012.

Prescription drug costs are a major focus of the investigative and enforcement agency. Among the items on its radar include payments for off-label cancer drug and biologics, physician-administered drugs and biologics, and billing for immunosuppressive drugs. OIG will also be focusing on drug payments under Medicare Part D, especially billing for HIV drugs and Revatio. State and federal share of drug rebates by manufacturers also make the list, as does an examination of medical-loss ratios required by managed care plans serving Medicaid enrollees.

OIG will also be reviewing oversight of investigational new drug applications by the Food and Drug Administration, and payer of last resort rules for the Ryan White program administered by the Health Resources and Services Administration.

SSA adds 13 immune and neurological disorders to Compassionate Allowances program

Social Security Administration (SSA) Commissioner Michael Astrue announced this week that 13 new immune system and neurological disorders will be added to the list of conditions that receive expedited review for federal disability benefits.

The Commissioner released the news at a National Organization for Rare Disorders conference, as the majority of the 113 conditions now under the Compassionate Allowance program are rare disorders. The program was started in 2008 with a list of only 50 diagnoses, but expands each year based upon input from medical experts. It was last updated in July (see Update for Week of July 11th).

The move enables more than 60,000 applicants with severe disabilities to receive benefit decisions within days. Other applicants can wait several months for an initial determination, and 18 months or more to receive an appeal hearing.

The 13 additional conditions subject to expedited review are:

Malignant Multiple Sclerosis
Paraneoplastic Pemphigus
Multicentric Castleman Disease

Pulmonary Kaposi Sarcoma Primary CNS Lymphoma Primary Effusion Lymphoma Angelman Syndrome Lewy Body Dementia Lowe Syndrome Corticobasal Degeneration Multiple System Atrophy Progressive Supranuclear Palsy ALS/Parkinsonism Dementia Complex

NORD report applauds FDA flexibility in approving rare disease drugs

A report released this week by the National Organization for Rare Disorders praised the Food and Drug Administration (FDA) for taking a flexible approach to approving new drugs that treat rare disorders.

The report concludes that drugmakers should not fear investing in the development of rare disease treatments because for two of every three orphan drugs approved, the FDA has historically been flexible in how it reviews effectiveness data. However, the report also recommends that such flexibility be recognized in a formal FDA policy so that regulators systemically incorporate it into their evaluations of each new therapy.

FDA released a draft five-year plan last month outlining how it intends to bolster its Rare Disease Program (see Update for Week of September 12th).

Health industry continues to add jobs, despite economic stagnation

Health care continues to be the one sector of the American economy experiencing healthy job growth in 2011, despite persistently stagnant job figures for other sectors.

According to the latest employment report from the Bureau of Labor Statistics, the health care industry added 43,800 positions in September and has grown by over 335,000 jobs over the past 12 months. The biggest gains were in ambulatory care settings such as physician offices who added over 26,000 jobs. Hospitals also gained 13,300 jobs.

A separate survey by MedSynergies and *HealthLeaders Media* found that at least 70 percent of hospitals and health systems plan to employ more physicians over the next 1-3 years due to uncertainty about federal health reform implementation.

STATES

Kaiser report finds that insurers face only "modest" competition in most states

The Kaiser Family Foundation released a new report this week confirming that health insurers face only "modest" competition in most states.

Researchers found that a just one dominant insurer controls at least half of the individual market in 30 states and DC, and at least 51 percent of the small group market in 24 states and DC. The report also found that 45 states have minimal competition in the individual market (39 states for small groups).

Alaska

Democrats revive vetoed effort to restore KidCare eligibility

Democrats held a rally and a hearing this week on new legislation that would restore eligibility cuts to Denali KidCare that were made in 2003.

Senator Bettye Davis (D), chair of the Health Committee, sponsored the revived measure to be heard next session, which failed to clear committee last session by one vote. Governor Sean Parnell (R) also

vetoed a similar measure in 2010, reversing his earlier support for the expansion after opponents argued that some of the money would be used to fund abortions.

S.B. 5 would expand coverage in the state-funded program to an additional 1,300 uninsured children and 200 pregnant women. However, Governor Parnell has pledged a veto should it reach his desk.

Alaska is one of a handful of mineral-rich states with a budget surplus (see Update for Week of September 26th). However, it is also one of only four states with SCHIP eligibility set below 200 percent of the federal poverty level (which in Alaska is \$55,880 per year for a family of four.) S.B. 5 would move SCHIP eligibility under KidCare from 175 percent of FPL back to the 200 percent level it was at in 2003.

The expansion would cost only \$1 million. However, the Governor refuses to sign it because of a 2001 state Supreme Court ruling requiring KidCare to pay for "medically necessary" abortions. Advocates point out that less than 0.20 percent of KidCare funding went for abortion services in 2010.

Arizona

CMS partially approves Arizona Medicaid waiver, rejects enrollment freeze for low-income parents

The Centers for Medicare and Medicaid Services (CMS) approved the new Medicaid cost-sharing sought by Arizona Medicaid officials, but rejected key provisions of the state's proposed waiver that would have capped enrollment for low-income parents earning between 75-100 percent of the federal poverty level and terminated eligibility for 30,000 enrollees next year (see Update for Week of October 3rd).

CMS determined that Governor Jan Brewer (R) failed to show that the enrollment freeze was motivated by any criteria other than filling the state budget deficit. Under federal Medicaid law, budgetary pressures cannot be the only basis for cutting eligibility, benefits, or payment. CMS was especially sensitive to this provision as the Ninth U.S. Circuit of Appeals recently ruled that CMS failed to adequately enforce it when approving Arizona Medicaid copayments in 2003 (see Update for Week of August 22nd).

The Governor had relied on the enrollment freeze to cut \$52 million of the \$500 million needed to balance the fiscal year 2012 budget she signed earlier this year. However, the Governor insists that her office never expected CMS to approve the "long-shots" in her entire waiver request and was pleased that her "big-ticket" items will be allowed to go into effect. However, it is not immediately clear how she will seek to offset the lost \$52 million, other than seeking "extra savings" from the freeze on childless-adult enrollment currently being challenged in court (see Update for Week of August 1st), as well as higher federal reimbursement for prescription drugs.

CMS is still reviewing a separate proposal by Arizona to cut Medicaid provider reimbursement.

California_

Blue Shield follows through on pledge to refund premiums to subscribers

Blue Shield of California announced this week that it would immediately return \$167 million in excess 2010 profits to subscribers, and an additional \$283 million to its subscribers by the end of this year, fulfilling its earlier pledge to limit net income to two percent of revenue.

Individual and fully-insured group subscribers will each get a 54 percent credit against one month of premiums. That translates into about \$135 for an individual and \$420 for a family of four.

Blue Shield made the pledge last June in order to change the narrative emanating from its controversial effort to hike rates by up to 86 percent for certain subscribers (see Update for Week of June 6th). Embarrassing revelations from an Insurance Commissioner audit forced the insurer to withdraw its erroneous rate filing, and spurred calls for passage of landmark rate review legislation (A.B. 52).

While the move may have helped stall the legislation until at least next session (see Update for Week of August 29th), Blue Shield's competitors have labeled the refunds a "PR joke" and chose not to follow their lead. Industry analysts noted that Blue Shield's non-profit status means that the insurer was required anyway to funnel excess profits back to subscribers over time through lower premiums.

However, the White House was quick to praise Blue Shield. It also recognized Kaiser Permanente for a similar initiative to lower premiums for small businesses and provides \$13.7 million in credits to those who had paid higher rates. Deputy Chief of Staff Nancy-Ann DeParle cited the two California insurance giants, as well as curbs on double-digit rate hikes in New Mexico and New York (see below), as evidence that the new rate review authority under the Affordable Care Act (ACA) is already working to prevent unreasonable rate hikes only weeks after its September 1st implementation (see Update for Week of August 29th).

Los Angeles County seeks to expand no-cost medical care in advance of federal reforms

According to a *Los Angeles Times* article this week, Los Angeles County is launching one of the country's largest expansions of health services to prepare for the federal expansion of Medicaid in 2014.

County officials are seeking to expand services as a way to compel newly-insured working age adults to choose county medical services. At the core of their effort is the Healthy Way LA program, which is not a health plan but instead allows patients to obtain no-cost primary and specialty care, emergency treatment, mental health care, chronic disease management, and medication. Treatment will not be given outside of the county.

The county expects the program to enroll up to 550,000 individuals with annual incomes below 133 percent of the federal poverty level (FPL), the new minimum Medicaid eligibility level under the Affordable Care Act (ACA). County health care workers have already enrolled 24,000.

The county will pay half the cost of the program over the next two years, or roughly \$300 million. Once the ACA expansion goes into effect in 2014, the federal government will pay the entire cost.

Consumer advocates like Neighborhood Legal Services of Los Angeles are concerned that the county's outdated technology and lack of electronic health records may impede enrollment.

Colorado

Exchange board will apply for exchange establishment grant, despite continued opposition

The Colorado Health Benefits Exchange Board moved this week to apply for a Level I federal Exchange Establishment grant by the next scheduled deadline of December 30th. The Board will work with legislative committees to prepare the application, after opposition from Republican lawmakers forced the Board to miss the last application deadline (see Update for Week of September 26th)

The Board will remove application language that would change Colorado regulations to "conform with federal requirements". This compromise may win the support of several key Republicans, although local tea party chapters continue to oppose implementing any provision of "Obamacare" including an exchange (see Update for Week of May 30th).

Colorado was one of 48 states to receive the initial \$1 million federal exchange grant last year. However, the Board is seeking up to \$22 million in additional grants to create the technology framework that will allow consumers to shop online for policies that best meet their budget and medical needs.

Connecticut

Healthcare advocate saved consumers over \$9 million so far this year, twice as much as 2010

State Healthcare Advocate Victoria Veltri announced this week that her office generated \$2.9 million in savings for Connecticut residents during the third quarter of 2011. The figure represents the cost of health care services that would have been paid by consumers without intervention from the state agency, which helps state residents resolve issues with their managed care plans.

The Advocate has now saved consumers over \$9.3 million this year, nearly twice as much as the office generated for all of 2010. The office's caseload is also on pace to more than double last year's total.

Veltri noted that the economic downturn has led to a dramatic jump in the number of consumers seeking help to find health insurance. Consumers increasingly also want assistance with appeals, as state law now requires insurers to provide contact information for the Healthcare Advocate on all denial notices (and federal law requires the same for self-insured plans). However, she acknowledges that the higher demand for her office's services still represents only a mere fraction of the need for assistance.

Delaware

Governor signs measure to study specialty tier coinsurance for prescription drugs

Governor Jack Markell (D) signed S.B. 137 into law on September 14th, which requires the Delaware Healthcare Commission to study whether the state should ban the use of specialty tiers, where plans require subscribers to pay 25-30 percent or more of the price for the highest cost drugs. The report is due by March 15, 2012.

New York remains the only state to enact such a ban (see Update for Week of September 27, 2010). However, at least 14 other states considered similar legislation last session (Missouri and West Virginia were the only states were they cleared at least one legislative chamber).

CORRECTION: The Update for the Week of October 3rd incorrectly stated that S.B. 137 also included a one-year moratorium on specialty tiers. That provision was removed from the final legislation.

<u>Florida</u>

Insurers, small businesses unenthusiastic about substitute health insurance exchange

Governor Rick Scott (R) is following through on his pledge to create a state-funded health insurance exchange that bears little resemblance to the model required by the Affordable Care Act (ACA).

His proposed public-private partnership resurrects the Florida Health Choices initiative from 2008 that was spearheaded by former House Speaker Marco Rubio (R), who is now Florida's junior U.S. Senator. Health Choices has since languished, but the Governor signed legislation last summer to get the marketplace moving (see Update for Week of June 20th), and recently hired a program administrator to submit cost and benefit data for a target opening in 2012.

The new exchange will give small employers with 50 or fewer workers an online marketplace where they can shop for up to four different employee health plans within their county. However, it will not be open to individuals, offer subsidies for those who cannot afford coverage, mandate coverage for "essential health benefits", or limit cost-sharing—all of which are mandatory elements of an ACA-compliant exchange.

Small employers will get a base premium from the exchange website but will have to work with a participating agent for exact premiums, which can vary based on the age and health status. However, they need only file one application.

The plan drew only tepid support from small business associations, health plans, and insurance agents, as participation would require plans to pay two percent of the premium for every exchange policy they sell while agents would have to pay a \$300 annual fee. The insurance industry noted that these

assessments would doom the exchange, because the extra costs would simply be passed on to consumers and make exchange plans less affordable than other coverage.

The Florida Association of Health Plans insisted that the industry supports the exchange concept, but that Health Choices was an unacceptable substitute. The Florida chapter for the National Federal of Independent Business concluded that the Health Choices model would provide "minimal" benefits for small employers.

Consumer advocates like Florida CHAIN question the viability or need for Health Choices since the Governor's refusal to create an ACA-standard exchange will cause the federal government to do so. Florida CHAIN insists that the minimal "junk" insurance offered by Health Choices fails to provide any "meaningful" health coverage (see Update for Week of June 20th).

Despite having the nation's third highest uninsured state for the past three years, the Governor has refused to implement provisions of the ACA until court challenges are resolved. He refused federal grants to create the exchange (see Update for Week of September 5th) and returned the \$1 million to grant to strengthen their premium review process (see Update for Week of February 7th).

According to the Commonwealth Fund, Florida also remains one of 16 states and the District of Columbia where the average annual premium for family coverage equaled 19.9 percent or more of median household income.

Leading Democrat seeks to expand state health coverage for children

Senate Minority Leader Nan Rich (D) resurrected her bill this week to lift Florida's ban on enrolling dependent children of state employees in the Florida KidCare SCHIP.

The Florida legislature passed the ban in 2004, arguing it was the policy of the combined federalstate program not to provide matching funds for families who are eligible for private insurance but choose not to purchase it. However, the Affordable Care Act (ACA) effectively rescinded the ban, making state employee dependents now eligible for Florida KidCare

The measure by Senator Rich (S.B. 510) would take advantage of the federal grants that help states facilitate the enrollment of these newly SCHIP-eligible children. Senator Rich cited reports predicting that lifting the ban could allow more than 2,000 state employee dependents to enroll in KidCare. They also show that it would cost less money to cover the children in KidCare than to insure them through the state employee health plan, as it would save the employee plan more than \$4.3 million. KidCare monthly premiums of \$15-20 are also more affordable for families than the state employee plan.

Senator Rich insists that more than 2,000 state employee dependents could ultimately become SCHIP-eligible, based on the experience of other states that had similar bans. However, prospects for passage in the Republican-dominated legislature are still unclear. The measure passed the Senate last year, but was rejected in the House.

According to the Children's Defense Fund, Florida's uninsured rate for children exceeds 18 percent, which trails only the 19 percent of children uninsured in New Mexico.

Georgia

HHS delays decision on whether Georgia can phase-in new insurer payout standards

The Department of Health and Human Services (HHS) postponed it decision on Georgia's request to phase-in the new medical-loss ratios (MLR) required by the Affordable Care Act (ACA).

Starting last January, individual and small group plans must spend at least 80 percent of premium revenue on medical care (85 percent for large group plans) or issue rebates to consumers. At least 14

states or territories have applied for a federal waiver that would allow it to gradually move up to this new standard, provided they can show that significant market disruption will result from immediate compliance.

HHS has granted all or part of the request from five states (Maine, New Hampshire, Kentucky, Nevada and Iowa). It also rejected applications from two states (Delaware and North Dakota).

Georgia was scheduled to receive a decision on their application by last week. However, HHS has delayed its verdict until November 9th. The state is seeking to phase-in the new standards over the next three years, as they currently do not require insurers to meet any MLR.

Louisiana and Indiana are slated to be the next waiver decisions, as the public comment period for both applications expired last week. Indiana's request for a permanent waiver is likely to be denied, though a temporary phase-in may be granted by HHS. Florida is the next state that is expected to have a temporary waiver denied, given their competitive insurance marketplace.

Massachusetts

Proposed specialty tier ban receives committee hearing

The Joint Committee on Financial Services held its first hearing this week on a bill that would prohibit insurers from using specialty tiers that require consumers to pay a percentage of the highest-cost prescription drugs. S.B. 455 would also ban prescription drug copayments in which the maximum copay exceeds by more than 500 percent the lowest prescription drug copay charged under the health plan.

New Mexico

Insurance Superintendent makes surprise decision to reject ten percent rate hike by BCBS

The Insurance Division announced this week that it has rejected Blue Cross and Blue Shield (BCBS) of New Mexico's effort to impose a nearly ten percent increase on 27,000 individual plan subscribers, concluding that it was not supported by data showing an equivalent rise in medical inflation.

The decision by Superintendent John Franchini came as a surprise, given that the state actuary had approved the full increase. However, fallout from last year's controversial 21 percent hike by BCBS likely played some role in his determination. Franchini had to revamp the Division's rate review process after the National Association of Insurance Commissioners placed it on probation for approving rate hikes without requesting supporting documentation (see Update for Week of September 20, 2010).

The embarrassing revelations also spurred new state laws that will allow rate decisions after next January 1st to be appealed to the state Public Regulation Commission. The Division will also be required for the first time to post all rate filings on their website.

New York

Health insurers fight federal mandate to disclose justification for double-digit rate hikes

Several of New York's largest health insurers are fighting the new federal mandate that they publicly disclose their actuarial and financial data justifying any double-digit rate hike.

The new federal rate review authority under the Affordable Care Act (ACA) went into effect September 1st and is administered by 40 states like New York that already have an adequate process for determining whether rate hikes are ""unreasonable" (see Update for Week of August 29th).

However, at least ten health plans seeking double-digit rate hikes in New York promptly filed objections with the Department of Financial Services, insisting that such data fits within a long-standing "trade secret" exception in state insurance law protecting it from public disclosure. Superintendent

Benjamin Lawsky ordered the insurers this week to release the data by the end of November, setting-up a major legal battle as plans pledge to seek court injunctions. Lawsky"s decision sided with consumer advocate Health Care for All New York, who had first sought this data on behalf of Emblem Health subscribers facing rate hikes of up to 270 percent.

The Department traditionally had little authority to curtail unreasonable rate hikes in New York. However, nation-leading premiums inspired a landmark state law last year that allowed the Department to begin rejecting rate hikes in the individual and small group markets. The Department has since been overwhelmed by consumer complaints about double-digit premium increases, and frequently exercised their new authority to reject or modify them (see Update for Weeks of October 11th and 18th, 2010).

Aetna and United Health are among the insurers insisting that forced release of "trade secrets" was a matter of "critical importance" that would only harm consumers if not blocked by the courts.

Ohio

Insurance department claims that startup exchange technology would costs up to \$63 million

A KPMG study released this week by the Department of Insurance (DOI) projects that startup technology costs for a health insurance exchange would be about \$20 million if the exchange is run by the federal government and as much as \$63 million if it is a state-run exchange.

The study also recommended that Ohio immediately begin design and implementation if it intends to create a state-run exchange by the federal January 2013 deadline. Governor John Kasich (R) has instead taken a "wait and see" approach, electing to use its \$1 million federal exchange grant to simply study the issue while legal challenges move through the courts (see Update for Week of September 12th).

A related Milliman study also commissioned by DOI estimated that individual premiums will soar 55-85 percent after full implementation of the ACA, while small group plans will rise 5-15 percent and large group plans by 3-5 percent (see Update for Week of September 19th). DOI Director and Lt. Governor Mary Taylor (R) is using the KPMG and Milliman findings as evidence that "Obamacare will result in bigger government [and] unsustainable costs."

Ohio remains one of only 11 states that have yet to even introduce legislation authorizing the health insurance exchange required by the Affordable Care Act (ACA). The Governor has thus far refused to apply for a second round of grants.

Oregon

Insurance Division confirms that HIPAA portability plans are subject to new federal rate review

The Oregon Insurance Division published guidance this week confirming that the federal Centers for Medicare and Medicaid Services has determined that portability plans under HIPAA are subject to the new federal rate review authority that went into effect on September 1st. As a result, these plans must also file justification for any proposed premium increases of at least ten percent with the Division, which will be publicly displayed pursuant to the Affordable Care Act (ACA).

Rhode Island

State court says Insurance Commissioner can regulate insurer/hospital contracts to contain costs

A Superior Court ruling in late September has cleared the way for Insurance Commissioner Christopher Koller (D) to continue regulating contracts between insurers and providers in an effort to constrain rising health care costs.

The decision is likely to end Koller's long-standing dispute with the Care New England hospital group, which had sued the Commissioner for nullifying contract provisions with Blue Cross and Blue Shield of Rhode Island (BCBSRI). Care New England had withdrawn an earlier appeal to the state Supreme Court after their new CEO elected to "work with state regulators, rather than to battle them."

BCBSRI has already agreed with state's largest hospital chain to meet unique new regulations issued by the Commissioner (see Update for Week of October 25, 2010). Koller sought for the past several years to require that health insurer contracts with hospitals meet six new conditions for improving efficiency and quality of care by moving away from fee-for-service payments and capping increases that exceed inflation. The Commissioner's rules require that contracts be entered into as part of the rate review process and made available for public inspection (see Update for Week of July 5, 2010).

The Commissioner blames hospital for at least 40 percent of increased medical costs borne by insurers. Under his contract model, BCBSRI has agreed to adopt a more efficient payment system similar to that used by Medicare inpatient and outpatient hospital reimbursement that pays a flat fee to cover all care for a given condition instead of paying for each procedure or day in the hospital. A similar global payment model failed to clear the Massachusetts legislature (see Update for Week of July 5, 2010).

Texas

New report disputes success of medical malpractice reform in Texas

A report released this week by Public Citizen concludes that the 2003 law signed by Governor Rick Perry (R) has not only failed to boost the supply of physicians, it also caused health care spending to rise by more than the national average and increased consumer costs. The findings specifically contradict the central claim of the Governor that the strict caps on malpractice damages have encouraged 21,000 additional physicians to practice in Texas.

The Texas Medical Association and the Texas Alliance for Patient Access disputed the report's findings, though acknowledging that consumer costs have risen. However, they insist that the caps were meant to decrease physician costs, not consumers. TMA insists that the state licenses 60 percent more doctors each year thanks to the new law.

However, Public Citizen accused the law's supporters of distorting these figures by relying on the number of licensed physicians, not the number actually practicing. PolitiFact backed-up Public Citizen's calculations, noting that only 12,788 of the 21,000 new physicians cited by the Governor were actually practicing medicine in Texas.

Publlic Citizen also documented that the number of doctors in underserved areas of Texas have actually declined by one percent since the law passed, despite climbing by nearly 24 percent before 2003. Premiums for all markets also rose, while Medicare spending shot-up 25 percent faster than the national average after the reforms. The report also claims that access to care has continue to erode, noting that Texas' nation-leading rate of uninsured has continued to climb.

TMA responded by insisting that the law's impact should be assessed over the long-term and not merely the 2003-2010 time period used by Public Citizen. Governor Perry quickly issued a statement insisting that the number of practicing doctors has outpaced population growth since 2003 by 84 percent, while premiums for employer-sponsored insurance have risen more slowly than 27 other states.

U.S. Representative Lamar Smith (R-TX) also emphasized that the Congressional Budget Office has estimated that the House Republican plan to cap malpractice damage awards and limit liability (H.R. 5) would save \$40-57 billion over ten years.

<u>Virginia</u>

Liberty University appeals Fourth Circuit denial of ACA challenge to U.S. Supreme Court

Liberty University and two individuals became the sixth set of plaintiffs last week to file an appeal with the U.S. Supreme Court of a constitutional challenge to key Affordable Care Act (ACA) provisions.

A three-judge panel from the U.S Fourth Circuit Court of Appeals rejected Liberty's challenge to both the individual and employer health insurance mandates under the ACA (see Update for Week of September 5th). The U.S. District Court for the Western District of Virginia had ruled last year that the mandates were a valid exercise of Congress' constitutional authority to regulate interstate commerce. However, the Fourth Circuit did not answer this question and instead chose to dismiss both the Liberty case and a related challenge brought by the Virginia Attorney General on the grounds that the penalty for not buying insurance was a "tax" that could not be challenged until its goes into effect in 2014.

Liberty's appeal of the Fourth Circuit decision thus presents the court with an issue not addressed by the decisions of the Sixth and 11th Circuit that have also been appealed. As a result, the high court is very likely to hear the case.

The Obama Administration last week expressed a desire for the Supreme Court to resolve the constitutionality of the ACA once and for all in its upcoming term, and not "punt" the politically thorny issue until after 2014 by following the Fourth Circuit's reasoning (see Update for Week of October 3rd). The Supreme Court could issue its decision as early as November or when the court term ends in June.

Medicaid eligibility errors cost Virginia up to \$263 million

Eligibility verification errors by local Department of Social Services caseworkers are responsible for the greatest number of improper Medicaid payments, according to report presented to lawmakers this week by the Joint Legislative Audit and Review Commission (JLARC).

The legislatively-mandated review found that lack of automation, needed technology, and oversight caused many ineligible recipients to be enrolled in Medicaid, resulting in up to \$263 million in overpayments for fiscal year 2009. By comparison, the report found that provider fraud accounted for less than 0.3 percent of Medicaid expenditures, or only about \$6 million.

In a federal review of Medicaid services upon which the JLARC study partially relies, 20 percent of Virginia cases reviewed had errors in the eligibility process. The Department of Medical Assistance Services insisted that the federal sample was "misleading", though it acknowledged that the eligibility process is paper-driven, lacks local supervision, and "requires significant improvement."

The Affordable Care Act (ACA) provides states with billions in federal grants to upgrade their Medicaid enrollment and eligibility systems to ensure compatibility with the new state-based health insurance exchanges that go online in 2014. Governor Bob McDonnell (R) signed legislation declaring the Commonwealth's intent to use federal funds to create the required exchange (H.B. 2434). However, it merely directed the Virginia Health Reform Initiative Advisory Council to submit recommendations by October 1st. Separate authorizing legislation is still needed (see Update for Week of September 12th).

Wyoming

Republican Governor strongly supports state health exchange recommendation

Governor Matt Mead (R) announced this week that he strongly supports the recommendation of the Wyoming Health Benefits Exchange Steering Committee to partner with the federal government in order to create a state-run health insurance exchange pursuant to the Affordable Care Act (ACA).

The legislative committee had presented an initial set of recommendations that urged the highly-conservative Legislature not to simply allow the federal government to take over the exchange in 2014 (see Update for Week of September 12th). The Governor's Health Policy Adviser reiterated those

findings in her presentation this week to the Labor, Health and Social Services Committee, urging members to allow Wyoming to maintain the maximum flexibility to design an exchange that best meets its unique needs. However, she made clear that the Governor wants the legislature to make the ultimate decision on the exchange, and simply leave all the options on the table as it deliberates.

Reps. Elaine Harvey (R) and Bill Landen (R) also support the committee's "pragmatic" approach, although colleagues such as Rep. Frank Peasley (R) already denounced it as a "Trojan horse.

A consultant hired by the state estimates between 38,000 and 41,000 people would enroll in a Wyoming exchange by 2016. That represents about seven percent of the state's limited population.

Committee members will meet again in October before sending an interim report to the Legislature. Legislation authorizing the committee (H.B. 50) requires a final report by January.