



### Health Reform Update – Week of January 7, 2013

#### CONGRESS

##### ***AHIP circulates study showing ACA will increase premiums for young adults***

Young adults will see higher health insurance premiums due to an Affordable Care Act (ACA) provision that limits how much rates can vary for older subscribers, according to actuaries from the consulting firm Oliver Wyman.

The findings predict that the law's age rating restrictions will cause a 42 percent hike in individual plan premiums for those aged 21-29, four million of whom are uninsured. Premiums would also increase 31 percent for those in their 30s, while the aged 60-64 group would see only a one percent bump.

America's Health Insurance Plans (AHIP) circulated the study as evidence that prohibiting insurers from charging more than 300 percent more for older subscribers will simply raise costs for younger groups to the point where it will be cheaper for them to pay the tax penalty under the ACA for not buying health insurance. This will, in turn, cause a "destabilization of the individual market" and higher premiums "for enrollees of all ages".

#### FEDERAL AGENCIES

##### ***CMS misses deadline for physician payment sunshine regulations***

The Centers for Medicare and Medicaid Services (CMS) has again missed its deadline to publish final rules implementing the physician payment sunshine provisions of the Affordable Care Act (ACA).

The proposed regulations released in 2011 outlined procedures for how drug and device manufacturers will have to disclose all consulting fees, travel reimbursements, research grants and other gifts with values over \$10 that they give to physicians and teaching hospitals. Those that fail to comply could face up to a \$1 million fine. However, they missed the statutory deadline for over two months, forcing CMS to already delay the January 2012 start date for data collection under the ACA and March 2013 date for publishing payments on the CMS website (see Update for Week of December 12, 2011).

CMS had pledged to irate members of Congress from both parties that final rules would be published by the end of 2012 and they have been awaiting final paperwork clearance by the Office of Management and Budget since arriving shortly after the election (see Update for Week of November 19<sup>th</sup> and 26<sup>th</sup>). It is not clear how the latest delay will impact the scheduled start dates.

##### ***CMS announces 106 new accountable care organizations in ACA demonstration***

The Centers for Medicare and Medicaid Services announced that 106 new Accountable Care Organizations (ACOs) have been formed under the third round of contracts released this week. Most of these will participate in the shared savings demonstration created by the Affordable Care Act, which allows physicians and providers to collaborate and share savings that result if they meet targets for limiting duplicative tests, needless procedures and other inefficiencies (see Update for Week of October 17<sup>th</sup>). At least 259 ACOs have now been created since the ACA was enacted, which CMS projects will save Medicare roughly \$940 million over four years.

### ***HHS credits ACA for limiting growth in Medicare spending***

A new report issued this week by the Department of Health and Human Services (HHS) says that the Affordable Care Act (ACA) is already having a substantial effect on reducing Medicare spending.

According to the agency, Medicare spending growth hit historic lows for the three years since the ACA was enacted. Spending per capita increased by just 0.4 percent in fiscal 2012, compared to a considerably larger but still modest 3.6 percent growth rate last year and only 1.8 percent in 2010.

The study finds that this slow rate, combined with projections that Medicare spending for 2012-2022, will only grow at the rate the gross domestic product increases, "is unprecedented in the history of the Medicare program."

Researchers specifically credited the ACA with much of the decrease, emphasizing that the new law restrains the rate of growth in Medicare Advantage payments, as well as hospitals and other providers, all while making major investments in efforts to reduce fraud and abuse. However, they also acknowledge that part of the decline may be due to the same lower utilization of health care services that occurred in the private market during the recession (see Update for Weeks of December 24<sup>th</sup> and 31<sup>st</sup>).

Conservative groups such as the American Enterprise Institute insist that overall Medicare spending, which increased 6.2 percent last year, is a more relevant figure than per capita spending.

### ***CMS actuary says national health spending growth remains at lowest rate in half century***

For a third year in a row, national health spending grew at its lowest rate in the 52 years that federal officials have tracked the figure, according to annual statistics released this week by the Centers for Medicare and Medicaid Services (CMS).

The Office of the Actuary calculated that health spending grew by only 3.9 percent in 2011, consistent with other studies that have noted a dramatic decline in utilization during the recession (see Update for Weeks of December 24<sup>th</sup> and 31<sup>st</sup>). However, out-of-pocket spending on health care continued to rise as insurers increasingly hike cost-sharing, jumping from 2.1 percent to 2.8 percent in 2011.

Despite the record low growth in spending, the United States still spends nearly 18 percent of its gross domestic product on health care, by far the largest percentage among industrialized nations.

Medicaid expenditures also grew at a dramatically slower pace in 2011 (only 2.5 percent compared to 5.9 percent in 2010).

The CMS actuary found that the Affordable Care Act had only "minimal effects" on healthcare spending growth in both 2010 and 2011.

### ***FDA announces first two "breakthrough therapy" designations***

The Food and Drug Administration (FDA) announced this week that it has granted the first two Breakthrough Therapy Designations created by the FDA user fee reauthorization legislation enacted last summer (see Update for Week of June 18<sup>th</sup>).

Two cystic fibrosis treatments from Vertex Pharmaceuticals received the designations for potential indications beyond their currently approved uses. The initiative is intended to expedite the development and review of drug candidates that are "intended, alone or in combination with one or more other drugs, to treat a serious or life-threatening disease or condition, and preliminary clinical evidence indicates that the drug may demonstrate substantial improvement over existing therapies." It will minimize the number and duration of clinical trials, when "scientifically appropriate."

## STATES

### California

#### ***Study says Governor's price tag for expanding Medicaid will be offset by "substantial savings"***

The proposed budget released this week by Governor Jerry Brown (D) not only projects a budget surplus for the first time in over a decade, it proposes that California spend \$350 million over the next two years to participate in the Medicaid expansion under the Affordable Care Act (ACA).

Most Democratic governors and two Republicans (see below) have elected to participate after the U.S. Supreme Court gave states the flexibility to opt-out without penalty (see Update for Week of July 2<sup>nd</sup>). However, a dozen Republicans have insisted that the expansion would "bankrupt" their states despite the full federal match through 2016, which phases down to 90 percent in 2020 and thereafter.

These Republicans largely claim that the federal match will not account for the administrative costs of expanding, as well as the "woodwork" effect that may overrun Medicaid programs as those who are currently eligible decide to enroll in order to take advantage of simplified enrollment or avoid the ACA's mandate in that everyone who can afford insurance must buy it. In his estimate, Governor Brown (D) acknowledges such a concern, attributing most of the \$350 million in costs to this "woodwork" effect.

Brown's estimates with projections released this week by the UC-Berkeley Center for Labor Research and Education and the UCLA Center for Health Policy Research. These researchers projected that it would cost California between \$188 million-\$453 million to expand Medi-Cal in 2014 for everyone up to 133 percent of the federal poverty level. This cost would rise slightly in 2015 and 2016.

The study did acknowledge that more than 75 percent of the state's costs would be spent on individuals already eligible for the program, consistent with the "woodwork" effect cited by the Governor. As a result, California will incur sizeable costs whether it expands or not.

However, the study emphasizes that by expanding California will bring in up to \$3.5 billion in 2014 (and for years thereafter). These funds will not only spur job creation and reduce uncompensated care burdens and costs for other state health programs, they will create "substantial savings" for the state that will likely more than offset their expenditures for those newly-eligible for Medicaid.

#### ***Anthem rate hike deemed unreasonable***

Insurance Commissioner Dave Jones (D) declared this week that the most recent rate hike sought by the state's largest health plan was "unreasonable".

Both state law and the Affordable Care Act (ACA) give Jones the ability to demand and publicize the actuarial data supporting double-digit rate hikes by private health plans. However, he still lacks his long-sought authority to reject or modify increases (see Update for Week of August 29, 2011).

However, Jones can "shame" insurers seek "excessive" rate hikes that are not reflected by increased medical costs or the insurer's financial status. He exercised that authority this week by denouncing the premium increase sought by Anthem Blue Cross, which would average 19.5 percent over two years for 250,000 small group subscribers.

The commissioner cited Anthem for hiking rates so dramatically despite a "21% return on equity" and his request to delay the increase. Anthem disputed the findings, claiming that the average increase will only be about 7.5 percent when considered alongside changes in benefits.

## Florida

### ***Backlash forces Governor to back-off cost estimates for Medicaid expansion***

This week's meeting between Governor Rick Scott (R) and the Secretary for the U.S. Department of Health and Human Services was overshadowed by his use of disputed cost estimates for participating in the Medicaid expansion under the Affordable Care Act (ACA).

While the meeting produced no immediate results, controversy over e-mails obtained by *Health News Florida* swirled around the Governor's office all week after they showed that Scott was warned by his legislative budget analyst and state economists that the ACA expansion would actually cost only a fraction of the inflated estimates he used. That figure (\$26 billion over ten years) came from an initial state agency report that was redone after federal regulations were released last month.

The Agency for Health Care Administration (AHCA) now projects a state cost of up to \$5 billion over ten years, while the Urban Institute, Kaiser Family Foundation, and Georgetown University Health Policy Institute all predict a net gain for Florida when factoring in savings from less uncompensated care and other state health programs. AHCA acknowledges that its prior estimate was based on a "faulty assumption" that the federal match for the expansion would continue at the past 20-year average of only 58 percent, instead of the 93 percent average match until 2020 under the ACA (and at least 90 percent thereafter).

Although the Governor pledged later in the week to focus on the revised estimate, his new coordinator for health policy and budget insisted that the initial figure will be submitted to the legislature as an "alternative forecast" in the event the higher federal match under the ACA does not materialize.

Despite the third highest uninsured rate in the nation, Florida has done less than any other state in ACA implementation, choosing instead to lead the U.S. Supreme Court challenge that upheld the law but allowed states to opt-out of the expansion without penalty (see Update for Week of June 25<sup>th</sup>). The HHS Secretary urged Governor Scott to at least apply for an initial federal-state exchange partnership by the February 15<sup>th</sup> deadline, which the Governor has yet to rule out.

## Idaho

### ***Governor will not participate in Medicaid expansion under the ACA***

Governor Butch Otter (R) announced this week that he will not seek to participate in the Medicaid expansion under the Affordable Care Act (ACA).

A commission created by the Governor had unanimously recommended that the Governor take the "pragmatic" approach and participate in the expansion, in order to spare safety net providers the increased uncompensated care costs that they will face as the ACA phases-down federal indigent care payments starting in 2014 (see Update for Week of November 12<sup>th</sup>). Consumer advocates had hoped that the Governor would follow their recommendation, as he did when becoming one of only five Republican governors to seek to create a state-based health insurance exchange under the new law (see Update for Weeks of December 3<sup>rd</sup> and 10<sup>th</sup>).

According to several analyses, the move will cost Idaho roughly \$3.7 billion in federal funding through 2022, compared to only \$261 million that it would cost the state to add nearly 107,000 Medicaid enrollees (see Update for Week of November 12<sup>th</sup>).

Only two Republican governors have agreed to participate (see below) after the U.S. Supreme Court gave states the flexibility to opt-out without penalty (see Update for Week of July 2<sup>nd</sup>). At least 16 other states and the District of Columbia have already elected to do so.

Illinois***House adopts resolution to extend specialty-tier study***

The House adopted a resolution this week sponsored by Rep. Jehan A. Gordon (D) that would extend the study concerning specialty-tier medications tasked last session to the Department of Insurance. Under H.R. 1310, the Department would have until November 30<sup>th</sup> to report to the Legislature on the prevalence and impact of specialty tier pricing and coinsurance.

Maine***Obama Administration scales back Governor's Medicaid eligibility cuts***

The Centers for Medicare and Medicaid Services (CMS) informed Governor Paul LePage (R) this week that he will not be able to terminate Medicaid coverage for all 19 and 20 year old enrollees.

In a split decision, CMS will allow Maine to drop about 20,000 enrollees from Medicaid on March 1<sup>st</sup> if they earn more than 133 percent of the federal poverty level. However, CMS will not waive the maintenance of effort (MOE) provision in the Affordable Care Act (ACA) prohibiting eligibility cuts below that threshold before 2014.

Maine will also have to again prove to CMS that it is still facing a deficit in order to carry the approved cuts into their next fiscal year starting July 1<sup>st</sup>. The Medicaid program currently has a \$100 million budget shortfall.

As a result, about 17,000 Mainers will retain Medicaid coverage. The move removes \$18 million of the \$23 million in Medicaid savings approved by the Governor and Republican-controlled legislature last session.

Acting CMS Administrator Marilyn Tavenner insisted that "Maine still has substantial flexibility to achieve budgetary objectives" in ways that do not violate the ACA. For example, Maine can "adjust benefit levels or provider payment rates and...increase the effectiveness and efficiency of service delivery consistent with many of the new opportunities afforded states [by the ACA]."

The Governor has yet to indicate whether he will seek judicial review of the decision within 60 days. His previous appeal to the U.S. First Circuit Court of Appeals was rejected for being premature (see Update for Week of October 29<sup>th</sup>).

Democrats that assumed control of both legislative chambers this session had pledged to reverse the Governor's Medicaid cuts if they were federally-approved (see Update for Week of November 5<sup>th</sup>).

Massachusetts***Governor signs legislation requiring parity in chemotherapy coverage for state employees***

Governor Deval Patrick (D) signed S.B. 2363 into law last week, requiring that any employee receiving health insurance coverage through the group insurance commission to receive coverage for both intravenous and oral chemotherapy medications. At least 20 other states have enacted legislation requiring chemotherapy parity coverage for the private marketplace (see Update for Week of October 1<sup>st</sup>).

Minnesota***Several Republicans now support exchange bills after losing legislative control***

After four years of stalwart opposition to a state-based health insurance exchange, several moderate Republicans are backing authorizing legislation that will create the online marketplace authorized by the Affordable Care Act (ACA).

As Senate Majority Leader, Rep. David Hann (R) had fought to block any implementation of the ACA including the health insurance exchange being created pursuant to an executive order from Governor Mark Dayton (D). Rep. Hann had even gone so far as to refuse to make his appointments to the exchange oversight board and block any bills that would fund the exchange, forcing the Governor to delay exchange action until after the election (see Update for Week of October 1<sup>st</sup>).

Hann remains staunchly opposed to the ACA. However, Democrats took control of both legislative chambers this session, relegating Hann to minority status. The election results have also persuaded at least three moderate Republicans led by Rep. Greg Davids (R) to cosponsor exchange-authorizing legislation needed to make the exchange operational.

Rep. Davids echoed the sentiments of moderate Republicans that a state-based exchange was far preferable to defaulting to full federal control. Both H.F. 5 and S.F. 1 introduced this week would allow state agencies to use the \$70.3 million the Governor has already obtained in federal exchange establishment grants. Supporters of the legislation claim the exchange will serve one of out every five Minnesotans and save the average family at least \$500 per year in premiums.

The bills are supported by key stakeholders such as the Minnesota Chamber of Commerce, which had been pressuring Republican leaders to stop resisting exchange implementation (see Update for Week of November 5<sup>th</sup>).

#### Montana

##### ***New Governor supports participation in Medicaid expansion under the ACA***

New Governor Steve Bullock (D) released his proposed budget upon assuming office this week that included participating in the Medicaid expansion under the Affordable Care Act (ACA).

Governor Bullock had previously been non-committal on the expansion, which was strongly supported by his predecessor Brian Schweitzer (D). However, he included the plan to accept federal funds to add an expected 60,000 Montanans to the Medicaid rolls as part of a broader coverage initiative he calls Access Health Montana that seeks to boost physician recruitment to the primarily rural state.

The Governor plans to fund the expansion by taking the state's budget surplus down from \$400 million to \$300 million. His plan still faces tough sledding in the Republican-controlled legislature. However, several Republican lawmakers including new Senate President Jeff Essman (R) have pledged to work with the Governor on his expansion plan, which is strongly supported by safety net providers.

#### Nevada

##### ***State board approves \$6 million contract to publicize health insurance exchange***

A state board approved a \$6 million marketing and branding contract for the Silver State Health Insurance Exchange this week in an effort generate public awareness about the online marketplace created pursuant to the Affordable Care Act (ACA).

Governor Brian Sandoval (R) was the first Republican (and one of only five) that sought to create a state-based exchange instead of defaulting to full or partial federal control. He also becomes the first to sign-off on the use of federal exchange establishment grants to promote this key feature of "Obamacare". Congressional Republicans have previously sought subpoenas to investigate similar contracts in California and Hawaii (see Update for Week of October 22<sup>nd</sup>).

The Governor, who sits on the Board of Examiners that approved the marketing contract with Reno-based KPS 3 Inc., emphasized that no state funds would be used to market the exchange. The Board has already approved a separate \$72 million contract for Xerox to design the exchange technology infrastructure (see Update for Weeks of August 6<sup>th</sup> and 13<sup>th</sup>).

#### New Mexico

##### ***Governor becomes second Republican to participate in ACA Medicaid expansion***

Governor Susana Martinez (R) announced this week that she will seek legislative approval to participate in the Medicaid expansion under the Affordable Care Act (ACA).

Governor Martinez join's Nevada's Brian Sandoval as the only two Republicans thus far to opt-in to the expansion, after the U.S. Supreme Court gave all states the flexibility to opt-out without penalty (see Update for Week of July 2<sup>nd</sup>). However, both states traditionally have among the highest uninsured rates in the nation, and opting-out of the expansion would have greatly increased uncompensated care costs on already overburdened safety net providers in their states.

Martinez cited recent figures from the Urban Institute and Kaiser Family Foundation projecting that participating in the expansion would add 208,000 New Mexicans to Medicaid at a cost of \$268 million through 2022. However, this cost would pale in comparison to the \$4.9 billion in federal dollars it would bring to the state.

#### New York

##### ***State law boosting rate review authority will save New Yorkers over \$500 million this year***

Governor Andrew Cuomo (D) announced this week that a new state law giving the Insurance Commissioner the authority to limit rate hikes will save New Yorkers more than \$500 million on health insurance premiums for 2013.

The Governor cited data from the Department of Financial Services showing that the agency was able to hold average increases at 7.5 percent, instead of the 12.4 percent sought by health insurers. The authority to modify rate hikes stems from a 2011 law that affects 2.3 million New Yorkers covered by small or large group plans, as well as individual direct-pay plans and Medicare supplemental policies. New York is one of 37 states with this authority.

##### ***Several new bills would impact persons with high-cost medical conditions***

Several measures were introduced at the outset of the regular legislative session this week that would impact persons with certain high-cost disorders like HIV, Hepatitis, C, or cancer.

Assemblywoman Eileen Gunther (D) introduced legislation this week that would prohibit Medicaid from using any prior approval or preferred drug list for HIV/AIDS or Hepatitis C medications. A.B. 1168 was referred to the Health Committee.

Assemblyman Micah Kellner (D) introduced legislation this week that would provide those with hemophilia and other clotting protein deficiencies that are eligible for the Child Health Plus or Family Health Plus programs shall have access to reimbursement for outpatient blood clotting factor concentrates and other necessary treatment and services. A.B. 962 was also referred to Health.

Senator Toby Ann Stavisky (D) introduced legislation this week that would remove deductibles, coinsurance, and copayments from cancer treatments covered by certain health plans. S.B. 639 was referred to the Insurance Committee.

## Virginia

### ***Lawmakers introduce bills to create state or partnership exchanges***

Senator John Watkins (R) wasted little time reintroducing legislation at the outset of the legislative session this week that would create the Virginia Health Benefit Exchange within the State Corporation Commission (SCC). S.B. 924 was referred to the Committee on Commerce and Labor.

Multiple exchange bills from both Republicans and Democrats were tabled last session after Governor Bob McDonnell (R) elected to first wait until the U.S. Supreme Court ruling on the constitutionality of the Affordable Care Act (ACA) (see Update for Week of February 6<sup>th</sup>) and then for last fall's election results (see Update for Week of July 2<sup>nd</sup>) before deciding whether to create a state exchange or default to a federally-facilitated exchange (FFE). McDonnell ultimately chose the latter path, though he left the door open to later pursue a state or partnership exchange once the federal government provides better guidance (see Update for Week of November 12<sup>th</sup>).

However, several Republican lawmakers including Senator Watkins had urged the Governor to follow the recommendation on his own advisory council and create the state-based exchange. Since the deadline for certifying a state exchange by 2014 has now passed, both Senator Watkins and Delegate Patrick Hope (D) introduced legislation this week that would direct the SCC to pursue an initial exchange partnership with the Obama Administration by their February 15<sup>th</sup> deadline. S.B. 922 and H.B. 1664 seek to ensure that Virginia at least retains control over plan management functions in the exchange, including the power to approve rates.

The Governor has previously rejected calls for a special session to focus on exchange legislation (see Update for Weeks of November 19<sup>th</sup> and 26<sup>th</sup>).

### ***New bills seeks to align Virginia with the ACA, allow cost-sharing to be paid in installments***

Senator John Watkins introduced a measure at the start of the regular legislative session this week that would better align the Commonwealth's insurance laws with the market reforms under the Affordable Care Act (ACA). S.B. 921 would put into place the new federal restrictions on premiums as well as the elimination of pre-existing condition insurance denials for both adults and children.

A separate bill from Delegate John O'Bannon (R) would permit pharmacists to dispense the interchangeable biosimilar drug products now allowed under the new law, so long as these generic copies are approved under the guidelines implemented last year by the Food and Drug Administration (FDA) (see Update for Week of February 6<sup>th</sup>). H.B. 1422 requires that the pharmacist notify the patient prior to dispensing any biosimilar.

Legislation supported by PSI (S.B. 945 and H.B. 2030) would also require health plans to allow covered persons to pay cost-sharing obligations for pharmacy benefits in 12 equal monthly installments, if these obligations are expected to exceed their total annual cost-sharing under the plan. Senator Toddy Puller and Rep. Chris Peace introduced S.B. 945 and H.B. 2030,

## Washington

### ***Republicans to control Senate despite minority status***

Senate Democrats acknowledged this week that a "majority coalition" of 23 Republicans and two Democrats will control the chamber this session.

Democrats hold a 26-23 edge after the result of last fall's elections. However, newly elected Senate Majority Leader Rodney Tom (D) and Senator Tim Sheldon (D) have agreed to caucus with Republicans, giving them control by a one-seat margin. Leaders from both parties are trying to negotiate



a power-sharing plan where Republican will chair six committees including the one that controls state budgeting, while Democrats will control the other six.

According the National Conference of State Legislatures, this is the eighth time in the past 30 years that the Washington Senate has changed hands, a feat matched only by the Indiana and Montana Houses.