

Health Reform Update – Week of April 1, 2013

CONGRESS

Senate Finance to finally hold confirmation hearing on re-nomination for CMS Administrator

The Senate Finance Committee will hold a hearing next week on President Obama's second nomination of Marilyn Tavenner to head the Centers Medicare and Medicaid Services (CMS).

If confirmed by the full Senate, Tavenner would be the agency's first permanent administrator since 2006. She has served as acting administrator since late 2011, when the recess appointment of Donald Berwick expired. Dr. Berwick was a political lightning rod who never received a confirmation hearing due to previous comments that Republicans claim endorsed government rationing of health care (see Update for Weeks of November 21 and 28, 2011).

Despite broad bipartisan support, Tavenner likewise never received a confirmation hearing last year due to election year politics. At least one Finance Democrat, Senator Maria Cantwell (D-WA) has threatened to pull her support this year due to CMS' delay of certain Affordable Care Act regulations (see Update for Week of March 25th). However, the leading Finance Republican, Senator Orrin Hatch (R-UT), indicated that she is likely to be approved by the panel.

Medicare Advantage cut rescinded due to Congressional assurances of permanent "doc fix"

The Centers for Medicare and Medicaid Services (CMS) announced this week that it is rescinding a proposed 2.2 percent cut in federal payments to Medicare Advantage (MA) plans and instead will revise its reimbursement calculation method to increase payments by 3.3 percent.

The chief actuary for CMS had proposed cutting MA payments in order to reflect historically low growth in health care spending documented by the Congressional Budget Office (see Update for Week of February 18th). However, the cuts met with stiff opposition from lawmakers and insurers, who claimed they would reduce reimbursement by \$11 billion and force offsetting benefit cuts or premium hikes.

The Secretary for the Department of Health and Human Services (HHS) intervened this week to overturn the payment cut, after a memo from the Congressional Research Service (CRS) concluded that CMS could assume Congress will act to block the 26.5 percent cut in Medicare physician payments set to take effect at year's end (see Update for Weeks of December 24th and 31st). Congress has delayed this cut every year since it was enacted in 1997.

Although the actuary agreed that Congress would not allow the cut to go into effect, it criticized the Secretary for relying on that assumption instead of current law. By assuming Congress would act, CMS was able to change the MA cut to an increase for 2014.

The Secretary based her decision partly on pledges by Republican leaders from two of the most powerful House committees that Congress would vote to permanently repeal Medicare's sustainable growth rate (SGR) by this summer. There is overwhelming bipartisan support for a "doc fix" that would negate the need for Congress to come up with costly offsets for each extension. However, Republican and Democratic lawmakers are still unable to agree on how to offset the cost of repeal.

Both parties want to take advantage of the momentum generated by the lower Congressional Budget Office (CBO) score earlier this year. CBO now estimates that cost of a permanent repeal would

be only \$138 billion over ten years due to lower health care spending increases, a drop of more than \$100 billion from their previous estimate (see Update for Weeks of January 28th and February 4th).

The plan proposed this week by the Energy and Commerce and Ways and Means committees met with some skepticism by providers, as it would use SGR repeal as an opportunity to make dramatic changes to healthcare delivery within Medicare. For example, after several years it would partly tie Medicare physician payments to certain performance and efficiency measures that are tailored for each medical specialty. Physicians would also still see a smaller cut in Medicare reimbursement.

Similar bipartisan legislation (H.R. 574) that would replace the SGR formula with a temporary system of physician pay raises, followed by a transition to a more efficient payment methodology, has attracted only 22 cosponsors since being reintroduced earlier this year.

Republicans continue calls for greater funding of federal high-risk pools

Many of the same Republican leaders who have spent three years trying to repeal or defund the Affordable Care Act (ACA) held a rare recess hearing this week without Democratic lawmakers to criticize them for not providing enough funding for the temporary federal high-risk pools created by the law.

The Obama Administration was forced to suspend enrollment in the pre-existing condition insurance plans (PCIPs) last month in order to ensure that the roughly 135,000 existing enrollees have sufficient funding through the end of this year, when they can move to the new health insurance exchanges or other guaranteed issue coverage. Although the Centers for Medicare and Medicaid Services (CMS) still has half of the \$5 billion allotment available, costs per PCIP enrollee have been far greater than anticipated (see PCIP Update for Week of February 25th).

The Commonwealth Fund testified at the hearing that strict eligibility requirements held down PCIP enrollment for healthier individuals, especially the requirement that applicants be uninsured at least six months. As a result, total enrollment was only a third of the 375,000 projected by the Government Accountability Office as the PCIPs attracted only the sickest populations. This caused only 4.4 percent of PCIP enrollees to account for more than half of the claims paid.

Energy and Commerce health subcommittee chair Joe Pitts (R-PA) declared that Congress should have instead allocated the \$25 billion that Republican alternatives to the ACA have sought in order to expand state high-risk pools, while Rep. Michael Burgess (R-TX) suggested the figure should have been at least \$30 billion. Republicans on the panel repeated their calls for the Administration to redirect funding from other ACA programs that have sought to weaken or repeal, including the Prevention and Public Health Fund that provides free preventive care and the controversial Medicare cost-cutting panel (see Update for Week of March 25th).

Ways and Means to hold hearings on President's proposed entitlement reforms

House Ways and Means Committee chair Dave Camp (R-MI) announced this week that he will start a series of hearings this month on controversial entitlement reforms previously advanced by the White House that could save up to \$660 billion. These include raising the Medicare eligibility age, means-testing premiums for Medicare Part B and D, combining Medicare Part A and B premiums, and moving to a new formula to more restrictively calculate cost-of-living adjustments under Social Security.

The President will reportedly include some of these changes, as well as cuts to Medicare provider payments, in his budget plan to be released by April 10th, which will seek to replace the sequester with a package of \$400 billion in health spending cuts and \$9 billion in new revenues that will reduce the deficit by \$1.8 trillion over ten years. However, the budget will not include structural Medicaid changes, consistent with his earlier pledge (see Update for Weeks of January 28th and February 4th).

Because the President's proposals have drawn stiff opposition from Democratic lawmakers and constituencies, Rep. Camp views them as areas of potential bipartisan agreement in ongoing

negotiations. However, Republicans continue to insist that any alternative to the sequester must include major entitlement reforms without any new revenue increases (see Update for Week of February 25th).

The hearings will also resurrect proposals offered by the President's National Commission on Fiscal Responsibility and Reform (Simpson-Bowles Commission) and the Bipartisan Policy Center Debt Reduction Task Force (Domenici-Rivlin Task Force) (see Update for Week of December 13, 2010).

Rep. Camp insisted that without entitlement reform, Medicare will be bankrupt by 2023 and seniors will lose 25 percent of their Social Security benefits by 2033.

FEDERAL AGENCIES

CMS issues long-awaited proposed rules setting limits on exchange navigators

Proposed rules released this week by the Centers for Medicare and Medicaid Services (CMS) give states the guidance they have long sought on how to develop standards for the navigators and in-person assisters that will help facilitate enrollment in federal and state health insurance exchanges.

While states can go beyond the minimum standards set by the Affordable Care Act (ACA) for navigators, many will likely not be pleased with provisions of the proposed rule that prevent any licensing, certification or other standards that conflict with those already set by the law. For example, under the ACA statute, navigators cannot be health insurance agents, brokers, or stop loss insurers who currently receive compensation from insurance companies. However, CMS clarifies that navigators can be licensed to professionally sell lines of insurance other than health (such as auto or life insurance).

Consumer groups like Families USA were pleased that CMS adhered to the "letter of the law." However, several Republican-led states have already enacted or are pursuing legislation that would allow brokers and agents participate in either a state or federal exchange. The rule appears to rule out any chance that CMS will recognize this conflicting legislation.

The proposed rule reinforces the ACA prohibition on navigators selecting health plans for consumers and emphasizes that their role is merely to provide "fair, impartial, and accurate information." Navigators also are not in charge of determining whether customers are eligible for federal subsidies, which is the role of the exchange.

Additional details define conflict of interest standards for navigators as well as the 30 hours of required training. CMS does not predict the number of navigator applicants or grantees, but does project a salary of \$20 an hour for lower level navigator staff members and \$48 an hour for senior executives.

CMS finalizes rule that increases federal matching funds for Medicaid expansion states

The Centers for Medicare and Medicaid Services (CMS) finalized rules this week that increase the federal medical assistance percentage (FMAP) for states that participate in the Medicaid expansion under the Affordable Care Act (ACA).

Under the final rule, an increased FMAP rate is available to cover all state costs for "newly eligible" adult individuals under the age of 65 who earn up to 138 percent of the federal poverty level (FPL). The 100 percent FMAP will decline to 95 percent starting in 2017, and gradually phase down to 90 percent for 2020 and subsequent years.

The rule clarifies that an increased FMAP rate is also available for expenditures for non-pregnant, childless adults in a defined "expansion state." CMS defines an "expansion state" as one that offered Medicaid coverage statewide to parents and childless adults with incomes of at least 100 percent of FPL when the ACA was signed into law on March 23, 2010. While the "expansion state" FMAP is initially lower than the "newly eligible" FMAP, they will both be equal starting in 2019.

HHS guidance sets parameters for private sector Medicaid expansion alternatives

New guidance released late last week by the Department of Health and Human Services (HHS) clarifies the types of Medicaid expansion alternatives that will be federally-approved.

HHS has agreed to allow a “limited number” of states to still accept the enhanced federal match under the Affordable Care Act (ACA) for expanding Medicaid, but instead cover newly-eligible individuals within a health insurance exchange or other private sector alternative. Since HHS conditionally approved this concept for Arkansas (see Update for Week of March 25th), several Republican-led states including Florida, Indiana, Louisiana, Missouri, Oklahoma, Ohio, Pennsylvania, Tennessee, Texas, and Virginia are pursuing similar alternate models (see below).

However, the new guidance appeared to throw cold water on alternatives considered by some of these states which are more restrictive. It stipulates that HHS will only consider applications that still provide newly-eligible Medicaid enrollees with a choice of at least two qualified health plans on the exchange, are limited to the Medicaid expansion adult population who must enroll in “benchmark coverage”, and that make arrangements with private health plans to provide necessary wrap-around benefits and cost sharing that apply to traditional Medicaid.

The guidance clarifies that certain proposals like wrap-around benefits will require premium assistance demonstration waivers. Because the waivers are meant to “help inform policy” for the state innovation waivers under the ACA that begin in 2017, they will expire by the end of 2016.

HHS also requires that any premium assistance demonstration be reviewed for actuarial, economic and budget justifications, including budget neutrality. This could make it difficult for many states including Arkansas, as CBO has previously estimated that it is more costly to cover the newly-eligible Medicaid population in private exchange plans instead of traditional Medicaid (see Update for Week of March 18th).

The guidance suggests that states target newly-eligible Medicaid adults with incomes from 100-138 percent of the federal poverty level for their premium assistance demonstrations, because this group is more likely to “churn” between Medicaid and private coverage as their income changes.

States can also pursue Medicaid premium assistance as a state plan option without a waiver, as Arkansas initially has done. However, HHS emphasizes that under such an arrangement the newly-eligible population remains entitled to all Medicaid benefits and cost-sharing protections, and they must have the option of choosing an alternative to private insurance to receive Medicaid benefits.

Nearly all state exchanges will keep individual and small group markets separate

According to *Inside Health Policy*, only a handful of states have informed the Centers for Medicare and Medicaid Services (CMS) by last week’s deadline that will merge their small group and individual insurance markets when their health insurance exchanges become operational in 2014.

Although the Affordable Care Act (ACA) gave state exchanges this option, the vast majority have elected to keep the markets separate at least for the first year. States are concerned that merging the markets could create additional confusion and potentially destabilize them.

Massachusetts did merge their markets under the landmark reforms in 2006 that become the model for the ACA and Vermont did so last summer as a precursor to that state’s forthcoming single-payer system (see below). However, only the District of Columbia and Rhode Island appear to be considering doing so in 2014 (the District failed to meet the March 29th deadline to notify CMS). New York had considered the merge but opted against it, according to the United Health Fund.

OIG says CMS needs to do more to ensure accuracy of health insurance “plan-finder”

A report released this week by the Department of Health and Human Services (HHS) Office of Inspector General (OIG) stated that the agency needs to do more to make sure that health insurers are supplying complete and accurate information to the “plan finder” on the www.healthcare.gov website.

The “plan finder” was mandated by the Affordable Care Act (ACA) as a precursor to the insurance exchanges that will begin in 2014. It is a first-ever attempt to help consumers locate health insurance plans most suitable for them and includes data on individual and small group policies, as well as public coverage options like Medicaid and SCHIP. However, unlike the exchanges, it is purely informative.

As of March, the “plan finder” includes data from about 8,000 private health insurance products. Although most insurers reported the required pricing and benefit information, the OIG report (OEI-03-11-00560) found that HHS failed to follow-up with the 13 percent of insurers who did not. In addition, HHS has not required insurers to certify as to the completeness of the data they submitted, nor are they able to identify all the insurers who are required to submit data.

The acting administrator for the Centers for Medicare and Medicaid Services (CMS) within HHS claimed that the report overstated problems with the “plan finder” and maintained that her agency reaches out to insurers when errors are reported. She also insisted that regulations currently under review for 2014 should help make the finder operate more efficiently.

FDA releases fourth guidance on new approval pathway for biosimilars

The Food and Drug Administration (FDA) released its fourth draft guidance this week relating to the regulatory pathway for biosimilar products created by the Affordable Care Act (ACA).

The latest guidance clarifies how sponsors should plan to interact with regulators in formal meetings before and during the review of a regulatory application. These formal meetings (face-to-face, teleconferences or videoconferences) often involve a sponsor seeking input from FDA on the best way to submit a product, information that needs to be included in a submission, the best design for clinical research, and likely post-marketing requirements.

FDA encourages sponsors and applicants to use these formal meetings, which it views as critical to the approval process. The draft guidance establishes five different types of meetings to be used at various junctures. These include initial advisory meetings held within 90 days of FDA receiving a request from a sponsor that discuss preliminary matters such as whether the biosimilar pathway is appropriate for a given product. Later biosimilar product development (BPD) meetings are divided into four types and set the evaluation protocols, discuss safety issues, resolve disputes, dispense targeted advice, review data, and discuss the format and content of the application. All BPD meetings are subject to user fees, while the initial advisory meetings are exempt.

FDA has already received 51 meeting requests for 12 different potential biosimilar products, as well as 15 investigational new drug applications (INDs). However, no biologics licensing applications (BLAs) have yet been submitted under the new pathway.

STATES

Florida

Second GOP alternative to Medicaid expansion would give uninsured only a \$10 monthly subsidy

Senator Aaron Bean (R) introduced a bare-bones alternative this week to both the Medicaid expansion under the Affordable Care Act (ACA) and the private sector alternative advanced last month by Senator Joe Negron (R).

The Health Choice Plus plan by Senator Bean (S.B. 1744) is an effort to recruit support from Republican lawmakers who do not want Florida to accept any federal expansion funds under the ACA. Unlike Negron's plan (S.B. 1816) which uses \$55 billion in federal funds over ten years to provide private coverage in the expanded SCHIP to those earning up to the ACA threshold of 138 percent of the federal poverty level (FPL) (see Update for Week of March 18th), Bean's proposal would use \$30-40 million in state funds to provide bare-bones coverage only to those earning up to 100 percent of FPL. Recipients would get only a \$10 monthly state subsidy and contribute \$20 per month to purchase private coverage.

The Obama Administration has indicated a willingness to consider Negron's plan, as it is modeled after the Medicaid expansion alternative it approved for Arkansas (see Update for Week of March 11th). Negron's plan also has the support of Governor Rick Scott (R).

Unlike the Senate, House Speaker Will Weatherford (R) has refused to consider any expansion alternative. House Democrats protested by refusing to support his planned budget this week.

Senate panel approves bill to limit biosimilar substitution

Florida became the latest state this week to advance legislation that would limit the use of biosimilar copies of brand-name biologic drugs.

The Committee on Health Policy sent S.B. 732 to the Appropriations subcommittee on Health and Human Services. It is similar to the legislation recently enacted by Virginia and being pushed by brand-name manufacturers in at least a dozen other states (see Update for Week of March 18th).

As with the Virginia law, S.B. 732 would require pharmacists to notify patients and physicians before an interchangeable biosimilar product is substituted for the reference product. It also includes a sunset clause that will automatically terminate the requirement five years after the FDA deems a biosimilar as interchangeable.

The Affordable Care Act created the new regulatory pathway that for the first time will allow such copies of high-cost biologic drugs. However, the Generic Pharmaceutical Association is fighting the types of bills that create roadblocks frustrating Congress' intent to bring lower-cost biosimilars to market in 2015 (see Update for Weeks of January 28th and February 4th).

Indiana

House committee alters Governor's Medicaid expansion alternative

The House Public Health Committee passed but altered the Governor's Medicaid expansion alternative this week that had already cleared the Senate.

Instead of expanding Medicaid under the Affordable Care Act (ACA), Governor Mike Pence (R) is seeking federal approval to merge the newly-eligible population with the state's Healthy Indiana plan that provides health savings accounts for the uninsured. Pence prefers the mix of higher copayments as well as managed care and preventive health options within Healthy Indiana, which was created in 2007 with bipartisan support.

However, new federal guidance makes clear that the higher copayments and more restrictive benefits under Healthy Indiana could not apply to the newly-eligible population (see above). In a bipartisan vote, the committee thus decided to amend S.B. 551 to give the Governor greater flexibility to negotiate an alternative that would be more likely to secure federal approval. The measure now goes to the Ways and Means committee.

A recent study by the Indiana Hospital Association estimated that expanded under the ACA would cost the state \$503 million through 2020 but bring in nearly \$10.5 billion in federal matching funds.

Maryland

Health officials seek ambitious federal waiver to limit hospital spending to economic growth

The Secretary for the Department of Health and Mental Hygiene released this week what famed health policy analysts like Uwe Reinhardt are calling the “most ambitious initiative in the country to control soaring medical spending” by controlling hospital costs.

The blueprint, which was submitted as a federal waiver request, would supplement Maryland’s unique rate-setting system to keep hospital spending from growing no faster than the overall economy, a move that would cut hospital cost increases by roughly half from recent levels. The plan also includes sweeping measures to move the state away from fee-for-service reimbursement, reward efficiency, and coordinate care.

The Maryland Hospital Association and state’s largest insurer (CareFirst Blue Cross and Blue Shield) reacted with skepticism to the “tectonic change”, objecting largely to the fact that most details would be left to the discretion of the Health Services Cost Review Commission that has set rates in the state for the past three decades. Other stakeholders were concerned that while the waiver application focuses initially on hospital spending, it eventually broadens to all health care costs.

The rate-setting commission has allowed Maryland to be the only state that has kept hospital spending per admission below national trends. The state’s “all payer” approach fixes hospital prices for commercial insurers, government programs, and self-pay patients, thus avoiding the cost-shifting that occurs elsewhere. The system also builds expenses for indigent care into statewide rates, ensuring that hospitals with high levels of uncompensated treatment stay in business.

However, hospital costs have risen in recent years, threatening to break the waiver condition that waives allows Maryland to set Medicare prices. Maryland hospitals have experienced exceptionally high rate of costly readmissions. As a result, the Department’s request actually seeks to renew the existing federal waiver to expand incentives to reduce hospital readmissions and allow providers to share in the cost-savings from coordinated care (similar to the accountable care demonstration under the Affordable Care Act).

Despite their reservations, hospitals have an incentive to maintain the waiver and approve some kind of new cost-control system. Although the state has kept growth in Medicare spending on hospital admissions below the national rate, Medicare payment per Maryland case is still far higher than what it spends in other states. Losing the waiver would cause hospitals to forego roughly \$1 billion in annual hospital revenue.

Minnesota

Despite federal delay, Minnesota will have small business options in health insurance exchange

Small business workers buying coverage in the new MNSURE health insurance exchange will have more than one plan option in 2014, despite the one-year delay in federal enforcement of the choice requirement for all exchanges.

Under the Affordable Care Act (ACA), exchanges in each state must include a Small Business Health Options Program (SHOP) that offer multiple plan options, as well as offer plans for individuals. However, proposed rules published by the Obama Administration will offer only one SHOP option in the federal marketplace next year and gave states the option to likewise delay offering multiple SHOP plans until 2015 (see Update for Week of March 11th).

MNSURE’s executive director announced this week that despite the option to delay, the exchange will give small businesses multiple choices starting January 1st. Minnesota has been far ahead of other states in designing the exchange infrastructure thanks to an executive order issued by Governor Mark Dayton (D) that circumvented legislative opposition (see Update for Week of October 31, 2011).

According to the National Federation of Independent Business (NFIB), the U.S. Department of Health and Human Services (HHS) simply underestimated the time and cost required to design the new information technology needed to operate these online marketplaces. While the move was applauded by insurers, both Congressional Republicans and Democrats have expressed displeasure at the delay, with the chair of the House Small Business Committee demanding a more detailed explanation from HHS by April 22nd.

North Carolina

Governor announces plan to move Medicaid towards full managed care

New Governor Pat McCrory (R) rolled out his promised plan for privatizing Medicaid this week, outlining how he intends to open up the program to competitive bidding for managed care contracts.

The Governor has formally submitted a request for a federal waiver to operate his “Partnership for a Healthy North Carolina” proposal, under which at least three comprehensive care entities (CCEs) would be awarded contracts to administer and coordinate all care paid for by Medicaid and share in any savings. Once established in 2015, the CCEs would compete against one another for enrollees.

The state Medicaid program insists that the plan is based on roughly 160 public comments received earlier this year, though a list of respondents has not been released.

As Governor McCrory predicted, lawmakers from his own party were largely unenthusiastic about the plan. Rep. Tom Murry (R) emphasized that the Republican supermajority in the legislature has thus far resisted calls to follow the lead of states like Arizona, Florida, Kentucky, Louisiana, Tennessee, and Texas in expanding Medicaid managed care to all or most enrollees, noting that not several have been dissatisfied with the results. Senator Tommy Tucker (R) questioned whether the state’s untested Medicaid information system could handle such dramatic reforms. Provider and consumer groups were even less supportive, with the North Carolina Medical Society and Covenant with North Carolina’s Children declaring that the Governor’s plan would result in the same access to care problems that resulted under Florida’s five-county Medicaid managed care demonstration (see Update for Week of August 1, 2011).

Missouri

Partial Medicaid expansion bill advances, despite slim odds for federal approval

The House Government Oversight and Accountability Committee passed a Medicaid expansion alternative this week, even though it is not likely to receive federal approval.

The measure (H.B. 700) sponsored by chairman Jay Barnes (R) would use federal Medicaid expansion funds under the Affordable Care Act (ACA) to make those earning up to 100 percent of the federal poverty level (FPL) eligible for coverage in the new federal marketplace operated in Missouri (see Update for Week of March 11th). However, the federal Centers for Medicare and Medicaid Services (CMS) has already made clear that states will not receive the higher federal match unless they cover everyone earning up to 138 percent of FPL, either under traditional Medicaid or through an ACA exchange (see Update for Weeks of December 3rd and 10th).

Rep. Barnes insisted this week that CMS would approve partial expansions once a state actually passed legislation. Several Democrats supported the legislation in order to get it through committee, despite doubts that it would be federally-approved.

Another committee must still approve the legislation before it reaches the House floor. The bill will likely require Democratic support to pass, despite a Republican supermajority, as a handful of conservatives led by Rep. Mark Parkinson (R) have withheld their support due to ideological opposition to any part of “Obamacare”. The conservative Heritage Foundation also opposes the plan CMS recently approved for Arkansas that covers everyone up to 138 percent of FPL in the exchange (see Update for Week of February 25th), insisting that it “isn’t anything different” from the ACA expansion.

It also remains unclear if Governor Jay Nixon (D) will sign a partial expansion. He had supported a traditional expansion that was previously rejected by Republicans (see Update for Week of March 11th) and has signaled that he would support an Arkansas-style plan. Republican-led states like Florida, Ohio, Louisiana, Maine, Oklahoma and Pennsylvania are considering that model. More conservative members in Florida and Missouri are also pushing a partial expansion (see above).

Oregon

Exchange board approves 22 qualified health plans

The board overseeing the Cover Oregon health insurance exchange has given 22 health insurers permission to participate in the new online marketplace starting in 2014. Ten of the carriers will offer only medical plans in the exchange created pursuant to the Affordable Care Act (ACA), while five will offer both medical and dental plans (the remaining will be dental only). The carriers still have to submit applications by April 30th for specific plan offerings.

Two of the insurers approved are new non-profit, member-owned, health insurance cooperatives created by the new law, Community Care of Oregon and Freelancers CO-OP of Oregon. These are two of the cooperatives in 24 states that received loans under the ACA before funding was rescinded by Congress (see Update for Week of January 21st). Other carriers include Regence Blue Cross and Blue Shield, the state's dominant health insurer, as well as United HealthCare, Kaiser Foundation Health Plan of the Northwest, PacificSource HealthPlans, LifeWise Health Plan of Oregon, and ODS Health Plan.

New bill creates temporary reinsurance program to spread risk of high-cost subscribers after 2014

H.B. 3458 was introduced this week in the House Ways and Means Committee. It establishes the Oregon Supplemental Reinsurance Program to be administered by the Oregon Medical Insurance Pool Board until December 31, 2016. It will be funded by an annual assessment on all insurers for 2014-2016, which will pay a portion of high claims costs and help stabilize individual market premiums after the guaranteed issue and community rating requirements under the Affordable Care Act (ACA) fully go into effect January 1st. The measure would spread a portion of exceptional claims costs for about 2,100 high-risk Oregonians to large and small groups as well as individuals.

A separate three-year \$20 billion reinsurance program under the ACA is so front-loaded for 2014 that many states are reconsidering plans to keep their state high-risk pool operating for several years in order to mitigate the number of high-cost patients that enter the individual market next year (see Update for Week of February 25th).

Tennessee

New federal guidance throws cold water on Governor's Medicaid expansion alternative

Governor Bill Haslam (R) appears to have not received the "clarity" he sought in the latest guidance on Medicaid expansion alternatives issued by the Obama Administration (see above).

The guidance says no to several key provisions of the Governor's Tennessee Plan that he unveiled this week to the legislature. Although the plan largely follows the concept of the federally-approved alternative for Arkansas (see Update for Week of March 25th), it does not allow states to mandate that the newly-eligible population be covered under private exchange plans instead of Medicaid.

The Governor also wanted the newly-eligible population to have the same benefit and cost-sharing as other exchange plan subscribers. However, the federal guidance very explicitly states that states must seek a waiver to provide "wrap-around benefits" in order to ensure the newly-eligible population receives the same benefits as Medicaid, including transportation. Federal limits on Medicaid cost-sharing will also continue to apply, which are lower than the ACA cost-sharing limits for exchanges.

Tennessee hospitals and chambers of commerce are clamoring for the expansion, which will prevent higher uncompensated care costs and penalties on businesses that do not provide comprehensive or affordable coverage. However, the Governor has already decided that only a private sector alternative will be acceptable enough to pass the legislature (see Update for Week of March 25th).

Texas

Republicans offer Arkansas-style alternative to expanding Medicaid under the ACA

Rep. John Zerwas (R) confirmed this week that he will incorporate into his own Medicaid reform bill (H.R. 3791) a proposal by Senator Tommy Williams (R) to use premium tax revenue from the federally-facilitated insurance exchange to subsidize private health policies for the low-income uninsured starting in late 2015, similar to the model approved by the Obama Administration for Arkansas (see Update for Week of February 25th).

The measure is intended to serve as a private sector alternative to expanding Medicaid under the Affordable Care Act (ACA), which taken off the table by Republican last month after Governor Rick Perry (R) reiterated his opposition (see Update for Week of March 4th). It will allow the state to still draw down the higher federal matching rate for the “newly-eligible” population while covering them under private exchange plans that include copayments and wellness incentives.

Rep. Zerwas has released few details of his plan, stating that he will offer it next week as a substitute for his bill in the House Appropriations Committee. The Governor favors an alternative that simply grants Texas a lump-sum block grant without any strings attached (see Update for Week of March 4th) and has yet to take a position on Senator William’s proposal. However, Williams acknowledges that it is intended to “buy some time” until the Medicaid expansion can fully be debated under another governor.

Republican lawmakers have been under intense pressure from provider, consumer, and business groups to expand given that Texas has one of the leanest Medicaid programs in the nation and a record rate of uninsured (see Update for Week of March 4th). Opting-out of the ACA expansion would create a huge subset of the population that are ineligible for both Medicaid and premium subsidies under the ACA. It would also dramatically increase uncompensated care costs for Texas hospitals that face lower federal payments for indigent care next year, as well as subject employers to as much as \$448 million in ACA penalties if the more than 149,000 workers eligible for the ACA subsidies actually receive them (see Update for Week of March 11th).

As a result, Republican lawmakers have openly weighed whether to override the Governor’s veto of any Medicaid expansion. Several large Texas counties have also asked the Obama Administration for permission to expand Medicaid within just their borders (see Update for Week of January 21st).

Vermont

“Rate shock” fails to materialize under exchange premiums for 2014

Vermont became the first state this week to release premiums for plans participating in the new Vermont Health Connect exchange that will begin enrollment October 1st.

The Department of Financial Regulation and Department of Health Access emphasized that new premiums fail to meet the “rate shock” predictions from the insurance industry and Republican lawmakers (see Update for Week of March 18th). However, they acknowledge that Vermont may not be the best barometer, since it is one of only seven states that already require guaranteed issue and community rating. In fact, Vermont goes further than the Affordable Care Act (ACA) in requiring premiums to be the same regardless of age (while the ACA limits age rating to a 3:1 ratio).

The two commercial non-profits in the exchange will be Blue Cross and Blue Shield of Vermont (BCBSV) and MVP Health Care. Monthly premiums for 2014 will range from an average of \$265 for catastrophic coverage for young adults to \$609 for platinum coverage, which has the lowest cost-sharing

among the four categories (bronze, silver, gold, platinum). Annual premiums for bronze plans will range from \$4,200-4,440, lower than the Congressional Budget Office estimate of \$4,500 for individuals.

Exchange premiums for BCBSV, which control two-thirds of the individual market in Vermont, will be roughly the same as for other BCBSV subscribers, despite the removal of lifetime and annual limits, restricted cost-sharing, minimum essential benefit packages, and other ACA market reforms.

A cooperative created by the ACA, Vermont Health Co-op, will also participate in the exchange. However, as a start-up their proposed premiums will not be made public until the company has won approval to sell insurance in the state.

The Department of Financial Regulation still must review rates for all three plans and submit them for approval by the Green Mountain Care Board in June. However, the Vermont Insurance Agents Association said they appear to fall in line with the ten percent increase for the individual market that was approved in January. Premiums for the gold and platinum policies appear lower than similar products in the individual market, but silver and bronze policies are higher.

State officials acknowledged that those who purchase the more limited products will pay more than in the individual market, but stressed that they will receive broader coverage and incur lower out-of-pocket costs. More than 100,000 uninsured and small business employees are expected to purchase coverage through Vermont Health Connect before the exchange gets folded into Vermont's single-payer system over the next several years (see Update for Week of May 23, 2011).

Earlier this year, Vermont became the second state this week after California (see Update for Week of February 11th) to standardize the cost-sharing for individual and small group plans in and outside of the exchange (see Update for Week of February 25th).