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What You Missed While on Holiday Break

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Washington, D.C., was spared a snowstorm, but there was a flurry of health reform activity during the holiday season.

Three agencies released key guidance on implementing the federal health overhaul, HHS issued a closely watched proposal on how health insurance companies **would have to justify** significant premium hikes, federal and a wave of patient protections took effect on Jan. 1. The efforts capped off a busy year that began with **questions over whether the overhaul would pass** and ended with every state having **implemented at least one aspect** of the law.

Between the federal provisions slated to take effect in 2011 and ongoing resistance to the reform law, the coming months promise to be equally eventful. HHS officials are shifting from "phase one" of the overhaul -- an effort to roll out consumer protections and insurance industry regulations -- into "phase two": work focused on delivery system reform. At the same time, Republicans will use their new House majority to kick off a sweeping GOP challenge to the law, and questions about the overhaul's constitutionality continue to overshadow its implementation.

Upcoming columns will detail these new health policy issues; this edition will quickly review key updates since we last looked in on the road to reform.

New Patient Protections

Democrats "frontloaded the law with a number of consumer-protection related provisions that they expect will boost support for the overhaul," **according to *The Hill***. Some of the measures that took effect on Jan. 1 include:

- Medicare beneficiaries who reach the "doughnut hole," or gap in prescription drug coverage, will get a 50% discount on brand-name medications if their total drug costs fall between $2,840 and $6,448. At the same time, beneficiaries with annual incomes higher than $85,000 for individuals and $170,000 for couples will receive less in government subsidies for their drug coverage;
- Drugmakers are subject to a $2.5 billion tax that will be assessed based on sales volume;
- Medicare beneficiaries will be able to receive coverage for about 20 preventive health services, including screenings and smoking cessation services, at no cost. Medicare also will cover one no-cost "wellness visit" annually;
- Medical-loss ratio rules require insurers to spend 80% of revenue from small-group plans and 85% of revenue from large-group plans on medical care;
- The creation of the Center for Medicare and Medicaid Innovation, a new agency with a mission to slow down costs by fostering innovations in care and processing payments and claims; and
- Certified midwives will be paid at the same rate as physicians providing similar services under Medicare.

Meanwhile, California has moved forward with its own patient protections "by both implementing and improving on" the federal overhaul, according to Anthony Wright, executive director of Health Access California. Some of the state's largest health insurers have **retracted their previous decision** to stop selling policies for children in light of a new California law (**AB 2244**) that prohibits companies that lack child-only plans from selling new policies on the broader individual market.

CMS Rulemaking on Other Key Issues

CMS officials also made several important announcements related to carrying out the law.

- *New federal office for dual eligibles*: Officials on Dec. 22 announced the new office, which was mandated under the health reform law and will foster overall improvements in care for people eligible for both Medicare and Medicaid and streamline patient management. About nine million people are dual eligibles, ***MedPage Today* notes**, and these individuals are "often very poor and sick, and considered one of the most expensive [populations] to care for."
- *End-of-life counseling provision*: In an abrupt reversal, the Obama administration **will remove references** to end-of-life counseling as part of annual physical examinations covered by Medicare. The provision, which had been dropped from the federal health reform law in 2009 because of criticism that it would establish so-called "death panels," had been **resurrected and took effect this month**.

Key Federal Guidance on Implementation

HHS, IRS and the Department of Labor on Dec. 22 issued guidance on how industries can comply with various aspects of the federal overhaul. "Not surprisingly, these issuances received virtually no press coverage," law professor Timothy Jost **wrote on the *Health Affairs* blog**. "Nevertheless, they are important both in their own right and for what they signal about the future of ACA implementation."

- *Wellness programs*: Can wellness programs actually incent individuals to improve their health? Jost writes that the programs lack empirical evidence of success, and some consumer advocates suggest that wellness programs "may provide a back door" to penalize individuals with pre-existing conditions or poor health. However, the **guidance signals** that the three agencies will eagerly support wellness programs that abide by federal nondiscrimination requirements, Jost notes.
- *Lower burden on businesses:* **Notices from IRS** allow more flexibility in taking deductions around medical-loss ratios for certain insurers, relaxing compliance on requiring employers to offer equivalent benefits to their lowest- and highest-paid workers and allowing more liberal use of debit cards to purchase over-the-counter medications.

Altogether, the guidance suggests that the Obama administration is seeking to "delay compliance deadlines [and] maximize flexibility" in order to build support from insurers and employers, according to Jost. While winning over these key constituencies could be crucial to the law's long-term survival, Jost cautions that federal officials must avoid making concessions that could weaken the overhaul and alienate reform advocates that the White House needs, too.

We'll continue to watch this careful balance as industry stakeholders carry on their tug-of-war over the reform law. Meanwhile, here's a look at other recent developments shaping reform implementation -- or challenging it -- across the nation.

Rolling Out the Reform Law

- The new, government-sponsored high-risk health plans for individuals with pre-existing conditions has failed to attract the number of customers officials hoped for, leading the Obama administration and states to increase enrollment efforts. Although Medicare's chief actuary estimated that 375,000 U.S. residents would sign up for the program, just 8,000 individuals had enrolled by early November, **HHS** reported. Federal health officials said it will take time to spread the word and adjust health care costs and benefits so the plans will be more attractive (Goldstein, ***Washington Post***, 12/28/10).
- Last week, **HHS announced** $206 million in bonus Medicaid payments to 15 states that adopted at least five of eight recommended measures to ease children's enrollment in federal insurance programs. The grants are aimed at enrolling 4.7 million children who are eligible for subsidized coverage. Thirty-two states did not apply for the grants and three of the 18 states that did apply -- California, Texas and Florida -- were rejected (Sack, ***New York Times***, 12/27/10).
- The **Department of Justice**'s antitrust lawsuit against **Blue Cross Blue Shield of Michigan** is considered a "test" of the implementation of the federal health reform law. The suit -- filed in October -- contends that BCBSM included most-favored-nation clauses in hospital contracts, pushing them to charge rival insurers as much as 40% more for care. Proponents of the reform law say that large single insurance carriers that

stifle competition could subvert the goals of the insurance exchanges planned for 2014 by impeding the growth of new business and less costly coverage (Abelson, ***New York Times***, 12/20/10).

- The federal health reform law's new Medicaid prescription drug rebate formula will allow pharmacists to receive more accurate reimbursements, according to a **Government Accountability Office report**. Medicaid programs are entitled to matching federal funds for generic drug reimbursements up to a certain amount, known as the federal upper limit. The reform law calls on **CMS** to determine federal upper limits that are no less than 175% of the weighted average manufacturer price -- which is based on utilization -- instead of using an average manufacturer price based on the lowest-cost version of the drug available (Millman, "**Healthwatch**," *The Hill*, 12/20/10).
- Regulators have adopted at least 18 new rules in the eight-and-half months since the passage of the federal health reform law, many of which were implemented without giving the public time to comment on the provisions, **according to a report** by the **Congressional Research Service**. The report found that many of the rules -- which included health insurance reforms, the creation of an early retiree reinsurance program and high-risk pools run by states for people with pre-existing conditions -- were not specifically required by the law. The report also found that in 12 of 18 cases, officials allowed public comment only after the preliminary regulation already was adopted (Pecquet, "**Healthwatch**," *The Hill*, 12/14/10).

Challenging the Overhaul

- On Monday, **Wisconsin Gov. Scott Walker (R)** authorized state **Attorney General J.B. Van Hollen (R)** to mount a legal challenge on behalf of the state against the federal health reform law's individual mandate. Just hours after he was sworn into office, Walker sent a **sent a letter** to Van Hollen stating that he could join the pending Florida-based multistate lawsuit or file a stand-alone state lawsuit (Millman, "**Healthwatch**," *The Hill*, 1/3).
- Last month, three conservative legal organizations and 12 House Republicans filed amicus briefs in support of a Michigan-based lawsuit that is challenging the constitutionality of the overhaul's individual mandate. The three organizations -- the **Washington Legal Foundation**, the **Cato Institute** and the **Mountain States Legal Foundation** -- and the 12 GOP lawmakers filed the briefs on Dec. 22 in the **U.S. Court of Appeals for the 6th Circuit** in Cincinnati, where the lawsuit is being reviewed (Norman, *CQ HealthBeat*, 12/23/10).
- As legal challenges to the federal health reform law's individual mandate continue, experts say the argument might shift focus from the Constitution's commerce clause to its necessary-and-proper clause. The necessary-and-proper clause grants the federal government authority "to make all laws which shall be necessary and proper for carrying into execution the foregoing powers." The Obama administration argues that the clause protects the individual mandate, while some state officials contend that it prohibits the mandate (Sack, ***New York Times***, 12/28/10).
- A new **Congressional Budget Office** report delineates which spending in the federal health reform law is discretionary and which is mandatory, giving Republicans a potential roadmap for blocking spending for the overhaul. Discretionary spending must be approved by Congress -- which means Republicans could block such spending with their new majority in the House -- while mandatory spending is automatic. According to the CBO report, the federal health reform law includes a minimum of $115 billion in discretionary spending (Reichard, *CQ HealthBeat,* 12/22/10).

Eye on the Industry

- Health insurers currently are bidding for privately managed Medicaid plans in various states to access $40 billion in program expansions under the federal health reform law. States over the next three years are expanding privately run Medicaid plans in order to prepare for expansions under the overhaul. Large insurers, such as **UnitedHealth Group**, and more specialized insurers, such as **Molina Healthcare**, are seeking new contracts. Some states, such as Georgia and Texas, will begin soliciting new plans next year, while California, Florida and others are committed to doing so before 2014, according to various companies and states (Johnson, ***Wall Street Journal***, 12/29/10).
- An increasing number of small businesses are beginning to offer employee health benefits, according to reports from several major U.S. insurers. The trend primarily is the result of a tax credit granted by the federal health reform law to small companies that offer coverage to their workers. In the six months following the enactment of the overhaul, **UnitedHealth Group**, the largest insurer in the U.S., increased its

enrollment by 75,000 new customers who work for companies with fewer than 50 employees (Levey, ***Los Angeles Times***, 12/27/10).

- Despite restrictions in the federal health reform law against annual dollar limits on coverage, health insurers are finding other ways to restrict coverage, such as putting limits on the number of doctor visits, prescriptions or other services. Although most companies so far have not added new numerical limits on services, industry observers say this could become a bigger issue in the future. In the coming months, **HHS** will define "essential health benefits" that must be covered by plans in state-based health insurance exchanges, those sold to individuals in companies with fewer than 100 employees and to individual policies (Andrews, ***Kaiser Health News/Washington Post***, 12/20/10).

In the States

- Several states are notable for the challenges they face as they work to implement the federal health reform law. For example, Alaska was one of two states that did not pursue federal money to plan a statewide health exchange and one of five that rebuked an opportunity for increasing funds to review insurance rates. In addition, new **Vermont Gov. Peter Shumlin (D)** campaigned on creating a single-payer health option, and experts are waiting to see whether a single-payer plan can work alongside federal reform provisions (Kliff, ***Politico***, 1/3).
- Although at least a dozen states expressed reservations regarding the medical-loss ratio rules under the federal health reform law, as of Dec. 30 Maine was the only state to request an adjustment to the provision. Maine has asked for a medical-loss ratio of 65% for plans in its individual market and also to use its own definition of activities that can be considered an improvement to customers' health. **HHS** has yet to decide whether Maine has provided enough information in its application and could take up to 40 days to decide whether to approve the adjustment (Aizenman, ***Washington Post***, 12/30/10).
- The **Iowa Health Care Coverage Commission** recently voted 10-1 in favor of developing a health insurance exchange under the federal health reform law, despite the law being challenged in numerous lawsuits. According to the law, states must have their own health insurance marketplaces running by 2014 or the federal government will implement the exchanges (Leys, ***Des Moines Register***, 12/16/10).