3/20/12 PRESENTATIONS: FEDERAL HEALTH LAW AND ALASKA & HEALTH CARE AND FISCAL SUSTAINABILITY

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AMERICAN LEGISLATIVE EXCHANGE COUNCIL

The Federal Health Law and Alaska: What You Need to Know

Christie Herrera
Director, Health and Human Services Task Force
American Legislative Exchange Council
Presentation before the Alaska Legislature
Tuesday, March 20, 2012

An Overview

- **PPACA and Mandates:**
  - -The individual mandate
  - -The employer mandate
- **PPACA, Medicaid, and Alaska:**
  - -Skyrocketing enrollment
  - -Tightening budgets
  - -Restricted access to care
  - -Poor health outcomes
- **PPACA and Exchanges:**
  - -Exchanges in theory and practice
  - -Federal strings
  - -Exchanges and the lawsuit
  - -What other states are doing

PPACA's Individual Mandate

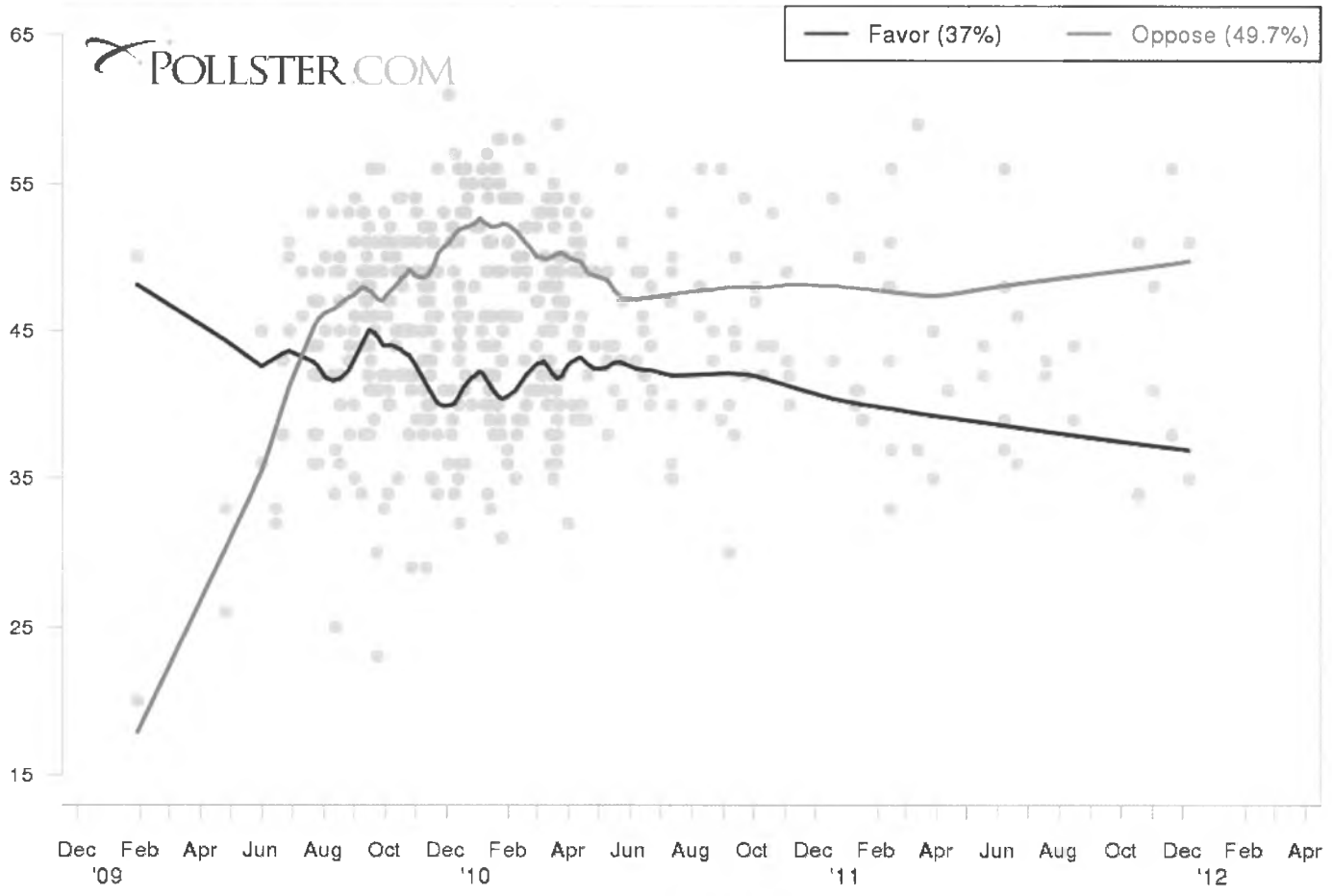
- **Fines are cheaper than health insurance:** In 2014, $95 or 1% of income. In 2016, 2.5% of income.
- **Affects both the uninsured and already-insured** thanks to "minimum essential coverage" criteria.
- **Doesn't really solve the "free rider" problem.**

- ***Florida v. HHS***: District Court struck down PPACA because of unconstitutional mandate; Appeals Court only struck down mandate but upheld the rest of the federal health law.
- **March 26-28:** SCOTUS will hear 5 ½ hours on mandate, Medicaid, and severability.
- **14 states have passed ALEC's *Health Care Freedom Act***, which allows additional challenges to the federal mandate if PPACA is upheld, and prohibits a state mandate is PPACA is overturned.
- **It's unpopular.** 67% of Americans disapprove; 55% say SCOTUS will rule it unconstitutional.

Sources: ***Patient Protection and Affordable Care Act***; Cato Institute; Kaiser Health Tracking Poll (January 2012)

PPACA's Popularity

Health Care Plan: Favor / Oppose
Latest Poll: 12/07/2011



Source: Pollster.com

PPACA's Employer Mandate

- **If you have a business with more than 50 workers, you must provide federally-approved coverage, or pay a $2,000 fine.**
- **50% of all businesses, and up to 80% of small businesses, must drop current coverage** for more costly insurance.

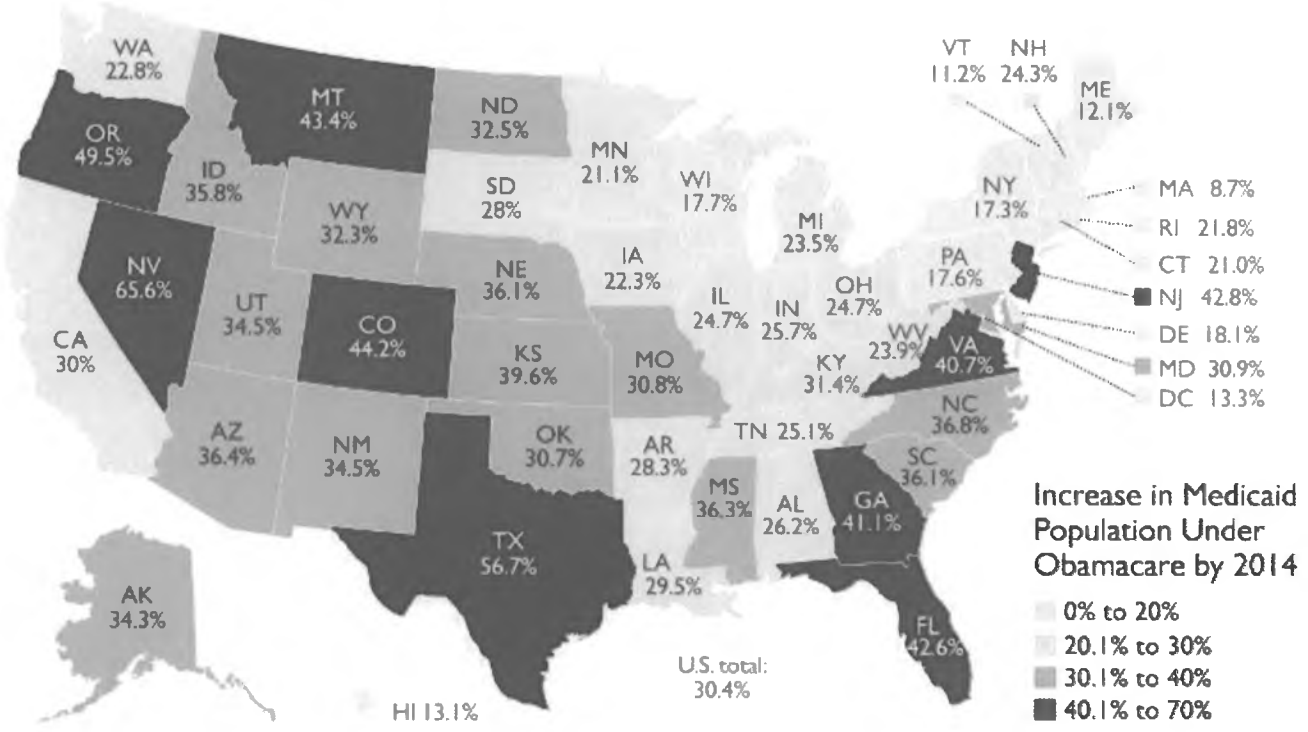
- **States, who collectively employ more than 3.8 million workers, will also be subject to the mandate,** raising costs for state employee health plans and fostering calls for "opt out."
- **NFIB: 57% of small businesses will consider dropping health coverage due to PPACA's employer mandate.** One in ten small businesses have already lost their health coverage, pre-PPACA.

Sources: *Patient Protection and Affordable Care Act*; U.S. Departments of Treasury, Labor, and Health and Human Services; National Federation of Independent Business

PPACA = Skyrocketing Medicaid Enrollment

A Medicaid Monster

Obamacare increases coverage by adding millions of Americans to the low-quality, low-access Medicaid program, requiring billions of dollars from state budgets.

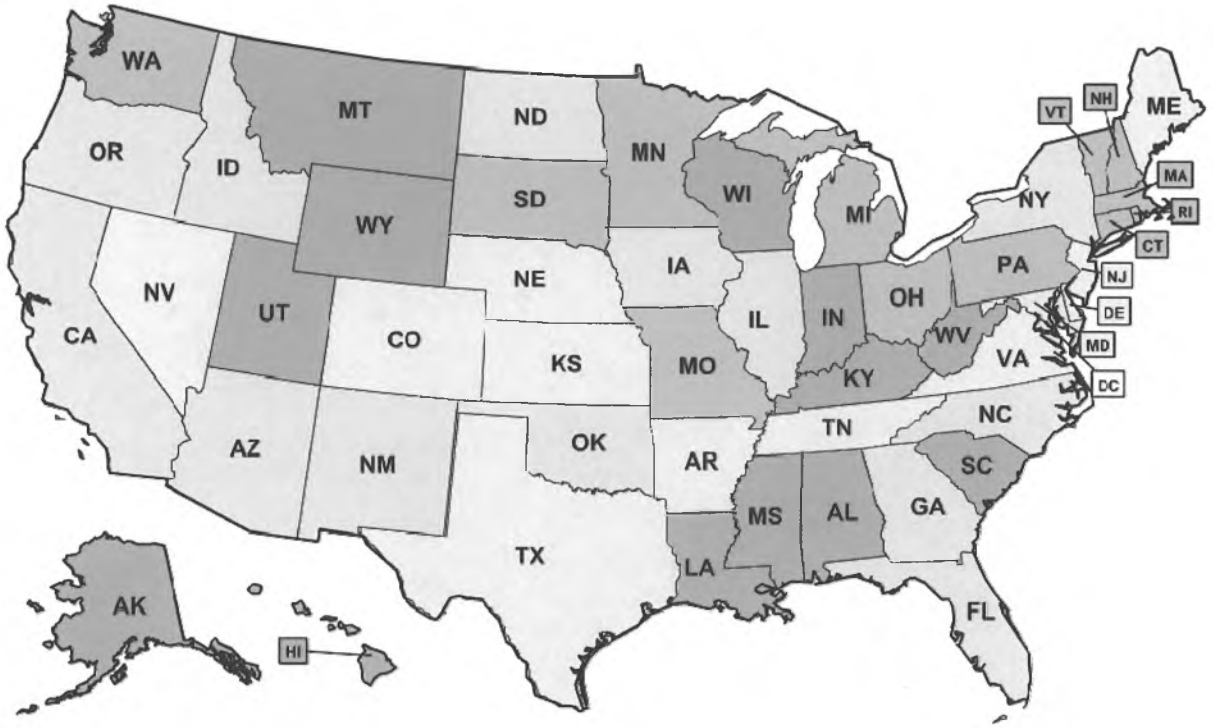


Sources: Centers for Medicare and Medicaid Services, *statehealthfacts.org*.

Obamacare in Pictures heritage.org

Tightening Budgets

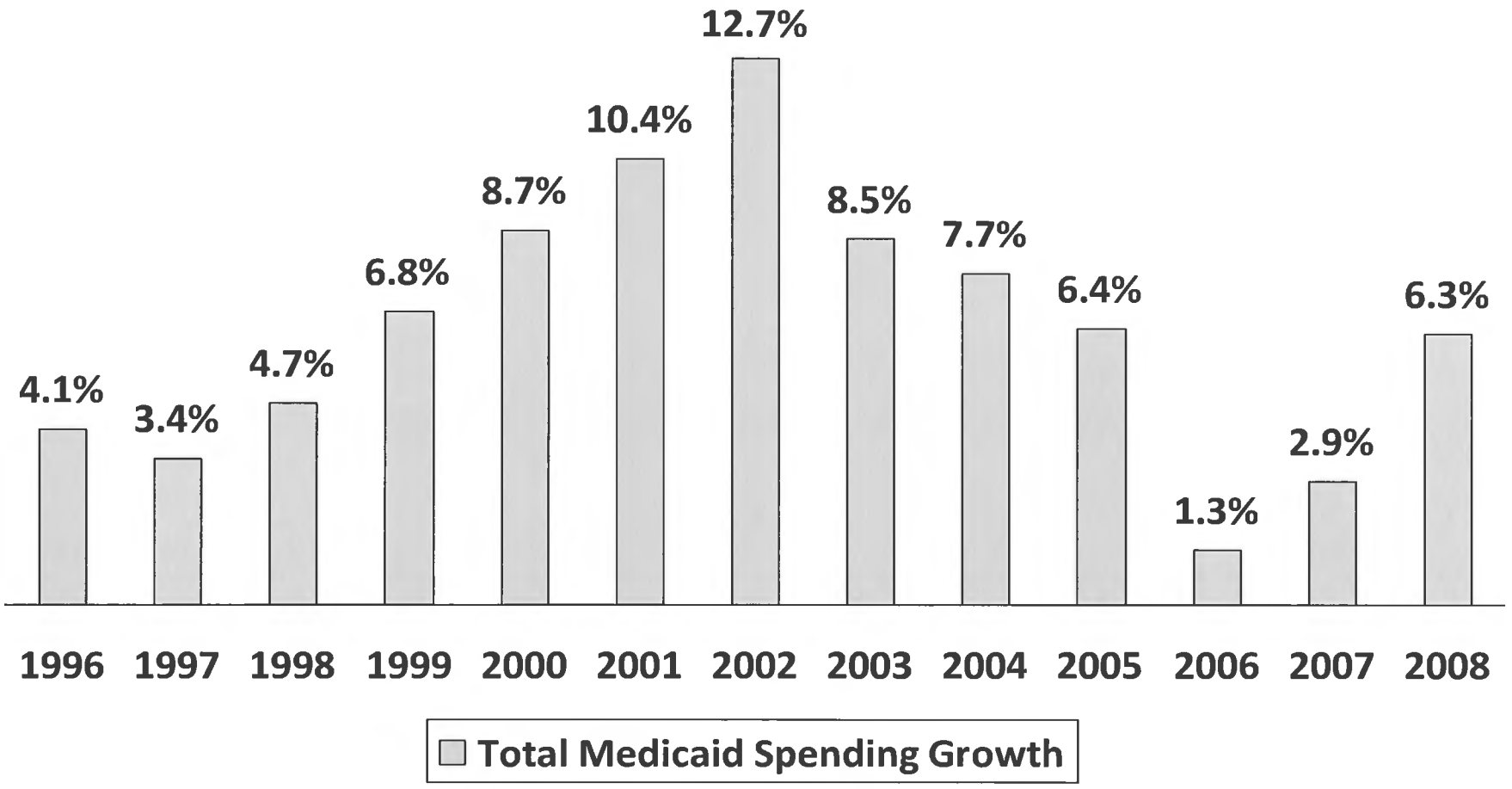
PERCENT OF BUDGET SPENT ON MEDICAID. FY 2010



Source: StateHealthFacts.org

Medicaid Grows in Bad Times … and Good.

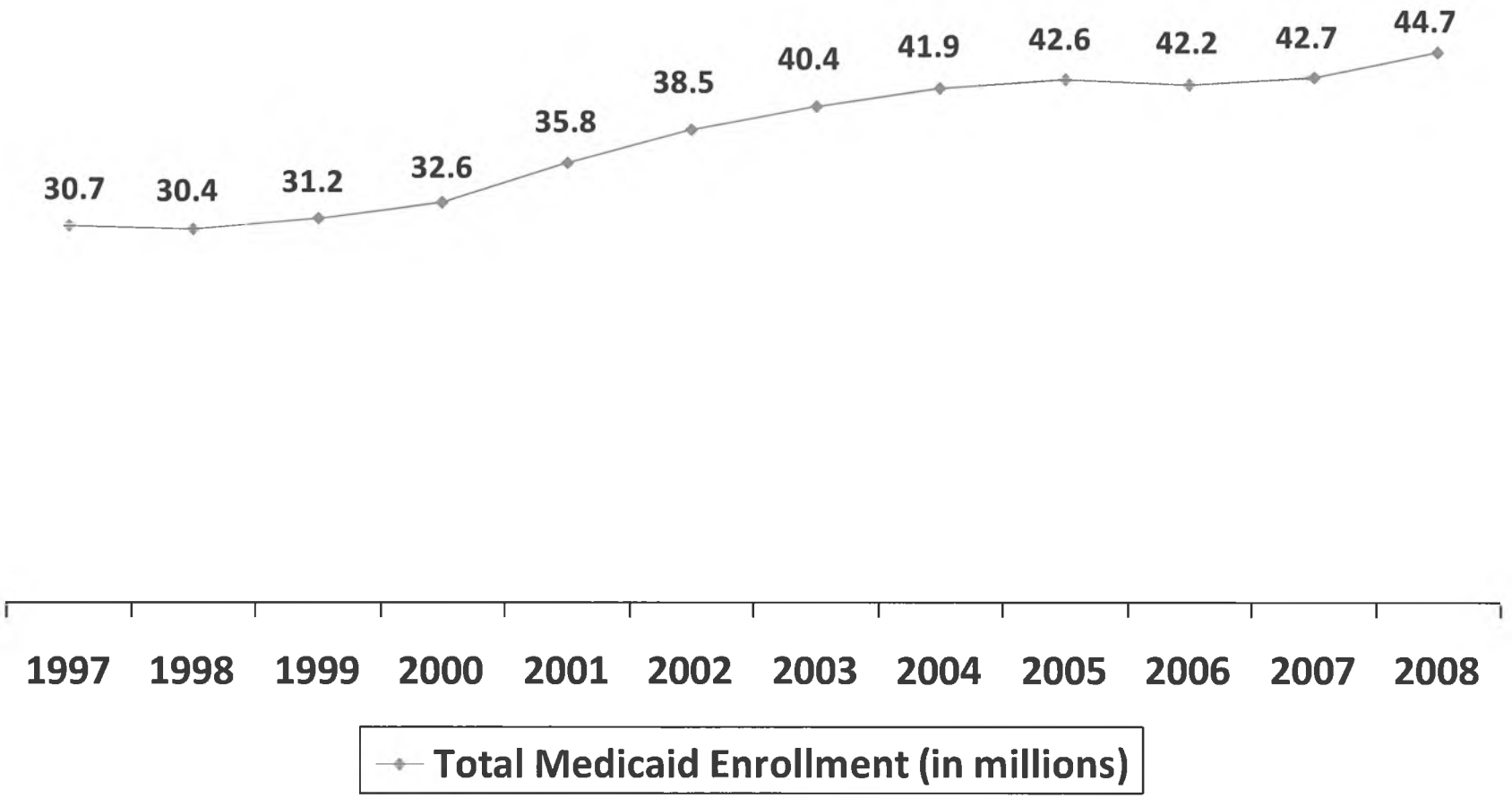
TOTAL MEDICAID SPENDING GROWTH. 1996-2008



Source: Kaiser Commission on Medicaid and the Uninsured

Medicaid Grows in Bad Times … and Good.

TOTAL MEDICAID ENROLLMENT, 1997-2008



Source: Kaiser Commission on Medicaid and the Uninsured

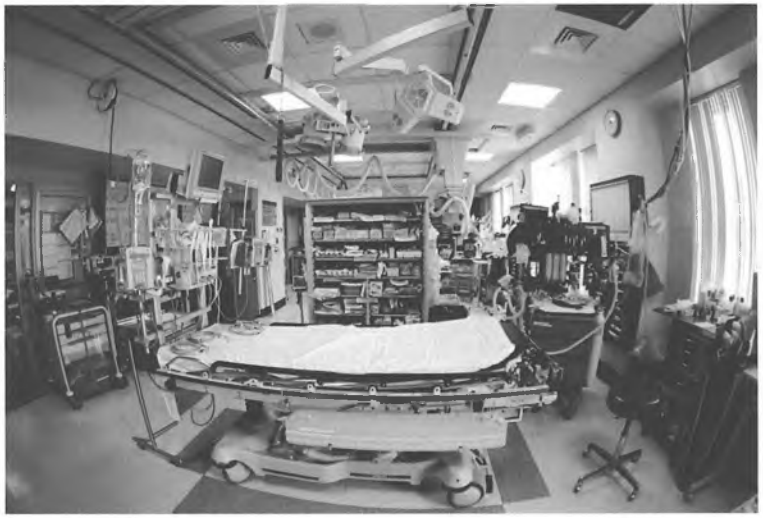
The Problem with Federal Funding

- **Federal money isn't "free"**—everyone pays federal, state, and local taxes.
- **It doesn't cover everyone.** One in four uninsured are already eligible for Medicaid, but not yet enrolled. When they do, states won't get enhanced funding.

- **PPACA's Medicaid "doc fix"** fully subsidizes provider reimbursement rates up to Medicare levels until 2015—when states will face political pressure to pick up the tab.
- **Administrative costs** add 5.5% to total benefit costs, so states are still on the hook even with enhanced federal funding.

Sources: National Institute for Health Care Management Foundation, The Heritage Foundation

PPACA = More Crowded ERs



- **40% of doctors restricted access to Medicaid** due to low reimbursement rates.
- **50% of doctors accept new Medicaid patients** compared with the 70% that accept new Medicare patients.

- **2/3 of ER "frequent fliers" were covered by Medicaid/Medicare.**
- **Medicaid patients are twice as likely** as the uninsured, and **five times as likely** as the privately-insured, **to be an ER "frequent flier."**
- **Medicaid patients are twice as likely** as the uninsured, and **four times as likely** as the privately-insured, **to use the ER.**

Sources: Office of Senator Tom Coburn, *Annals of Emergency Medicine*, National Center for Health Statistics

PPACA = Poor Health Outcomes

- **Medicaid patients who need surgery are 13% more likely to die** than the uninsured, and **97% more likely to die** than those with private insurance.
- **Medicaid patients are 50% more likely to die after bypass surgery** because of poor follow-up care.
- **Medicaid patients with cancer are two to three times more likely to die** from the disease.
- **Medicaid mothers received less prenatal care** and **had higher infant mortality rates** than those with private insurance.
- **Florida: Medicaid patients are 31% more likely** to have late-state breast cancer, and **81% more likely** to have late-stage melanoma.

Sources: Heartland Institute, *Wall Street Journal*, Office of Senator Tom Coburn, National Review Online

Exchanges: In Theory

- **Employers provide a "defined contribution"** towards workers' health insurance premiums
- **Workers choose from a range of coverage options** within the exchange, and can take the coverage with them from job to job

- **All contributions are made with pre-tax dollars**
- **Exchanges help consumers navigate coverage options**
- **Exchanges follow the "farmers market" or "stock exchange" model** that helps transactions between buyers and sellers—without regulatory power

Exchanges: In Practice

- **Massachusetts's Health Connector:**
  -- Determines that only plans of "high quality" and "good value" are sold
  -- 4/5 of the newly-insured get fully- or partially-subsidized insurance
  -- Operating costs are more than $40 million/year
  -- Requires an additional $12 million for PPACA compliance
  -- Since the law was implemented, premiums for family coverage have risen by more than $2,500; overall costs of "reform" total more than $8.5 billion

- **Utah's Health Exchange:**
  -- Began in August 2009 with 36 businesses; by December, only 13 remained
  -- In 2010, strict underwriting rules were imposed outside of the exchange
  -- Now covers only 5,500 people; 75% of them previously had coverage

- **PPACA's Health Insurance Exchanges:**
  -- Subsidize the required purchase of health insurance (individual mandate)
  -- Impose price controls like guaranteed issue and community rating
  -- Limit innovation by standardizing benefits within the exchange
  -- Restrict consumer choice and competition

Sources: Massachusetts Health Connector; The Health Care Blog; *Boston Globe*; Beacon Hill Institute; Office of John R. Graham; Utah Health Exchange

Federal Exchange = State Exchange

- **"My house, my rules":** HHS must approve every detail of a state exchange, and states can't deviate from federal rules and standards. (PPACA Section 1321)
- **Vague regulations:** Proposed federal rules are silent on what states need to do to get their exchanges approved by HHS.
- **Flexibility is a façade:** The 347 pages of proposed federal exchange rules contain the word "require" 811 times.
- **Heritage's Ed Haislmaier**:"The combined effect of these regulations and grant requirements are that a state would have to agree to surrender any last vestiges of meaningful control over how ObamaCare is implemented. ***Thus, a state would now have no more real control over an exchange it set up than over one HHS established."***

Sources: *Patient Protection and Affordable Care Act*; U.S. Senate Republican Policy Committee; The Heritage Foundation

How PPACA Controls State Exchanges

- **Choose (in some cases) essential health benefits that must be paid for by individuals and families** [Section 1302]
- **Control whether HSAs and other consumer plans can be offered** [Section 1302(d)(2)]

- **Pick doctors and other health care professionals that are allowed to provide care in exchange plans** [Section 1311(h)]
- **Decide if your plan's provider network is "adequate" (regardless of whether or not it covers your doctor)** [Section 1311(c)(1)(B)]
- **Decide whether plans provide linguistically appropriate and culturally sensitive information** [Section 1311(i)]
- **Establish cost-sharing requirements, regardless of their effect on premiums** [Section 1302(c)]
- **Impose price controls on health coverage** [Section 1003] **and pick who gets a waiver from annual limit requirements** [Section 1001]
- **Enforce marketing requirements** [Section 1311(c)(1)(A)] **and determine whether a plan is properly accredited** [Section 1311(c)(1)(E)]
- **Compel plans to follow a federal quality improvement strategy** [Section 1311(c)(1)(E)]
- **Decide when individuals can enroll in an exchange plan** [Section 1311(c)(1)(I)(6)]
- **Write rules related to the offering of stand-alone dental plans in the exchange** [Section 1311(d)(2)]
- **Force state governments to pay for existing benefit requirements** [Section 1311(d)(3)]
- **Impose certification and decertification plan requirements written by HHS** [Section 1311(d)(4)]
- **Judge the adequacy of an exchange's internet website** [Section 1311(d)(4)]
- **Impose a rating system consistent with federal rules** [Section 1311 (d)(3)]
- **Create notification requirements for states to inform employers of employee enrollment in an exchange** [Section 1311(d)(3)]
- **Require consultation with healthcare stakeholders during development of an exchange** [Section 1311(d)(6)]
- **Restrict plans from offering coverage in an exchange, if they fail to meet federal certification or other HHS rules** [Section 1311(e)]
- **Determine whether an exchange established rules that conflict with, or prevent the application of regulations promulgated by, the Secretary** [Section 1311(k)]

Source: The Heritage Foundation

The Threat of a Federal Exchange?

- **PPACA didn't fund federal exchanges.** If states decline to set up exchanges themselves, HHS would have to petition Congress for more money, or find money in their current budget.

- **People in federal exchanges may not qualify for subsidies.** Technically, PPACA provides tax credits only to people "in an exchange established by the state under Section 1311" but makes no mention of offering subsidies in the federal exchange.

- **The timetable from HHS keeps moving … because many state exchanges won't be up and running by 2014.**

  --July: HHS will "conditionally approve" exchanges not certified by 2013
  --July: States can start exchange operations in 2015 or any following year
  --July: "HHS will continue working with states to support their progress"
  --July: HHS announces a "hybrid" exchange model for wary states
  --November: States have until June 2012 for Level 1 Establishment Grants
  --November: States can access federal exchange grants until 12/31/2014

Sources: *Politico*; *Investors Business Daily*; U.S. Department of Health and Human Services

The Threat of a Federal Exchange?

- **HHS has granted nearly $1 billion to states for their exchanges.**
- **They've spent only $150 million on a federal exchange—which will be tasked with coordinating eligibility, subsidies, premiums, and benefits for millions of people in at least 22 states.**
- "If the feds are going to be ready to launch 10 or 20 federal fallback exchanges these numbers just don't compute. It is going to take a lot more than the $94 million HHS has contracted for to launch that many federal exchanges in the states that refuse to do so." --- Bob Laszewski, healthcare expert

Sources: WhiteHouse.gov;
Health Care Policy Marketplace Review Blog

State Exchanges Can Strengthen PPACA

- **District Court Judge Roger Vinson, on his order refusing to stop PPACA implementation:**

  "[T]he severity of that injury [from PPACA] is undercut by the fact that at least eight of the plaintiff states … have represented that they will continue to implement and fully comply with the Act's requirements … irrespective of my ruling."

- **If you don't like the individual mandate then you won't like a PPACA exchange.** The federal government has argued that exchanges are critical to enforcing the individual mandate, because they'll be used to determine if individuals are exempt from the mandate—or in compliance with it.

- **Of the 14 states that have passed the *Health Care Freedom Act* (HCFA), only five have taken federal money to establish an exchange.**

Sources: United States District Court, Northern District of Florida; Goldwater Institute; WhiteHouse.gov

State Exchanges Can Be Costly

- **Federal exchange grants expire** in 2014, and cannot be used for ongoing exchange operations after year one.
- **How will states pay for exchanges when the federal money runs out in 2015?**

- **In general, every $1 of temporary federal grants leads to 40 cents of state/local tax increases.**

- **Oregon:** 3% premium tax on exchange-covered lives.
- **California:** Premium and health plan "participation fees."
- **West Virginia:** "User fees" on every health/dental plan sold in WV.
- **Utah:** Broker/technology "user fees" and general revenue funds.
- **Massachusetts:** 3-4% "surcharge" on exchange premiums.

Sources: Mercatus Center; State of Oregon; State of California; State of Utah; Minnesota Department of Commerce

Other Considerations

- **"Early adopter" risks: High costs, early mistakes, buggy technology.**

  "What is the first mover advantage for states to rush ahead and implement this, given all the uncertainty?" --- South Carolina HHS Secretary Tony Keck, on why his state is rejecting an exchange

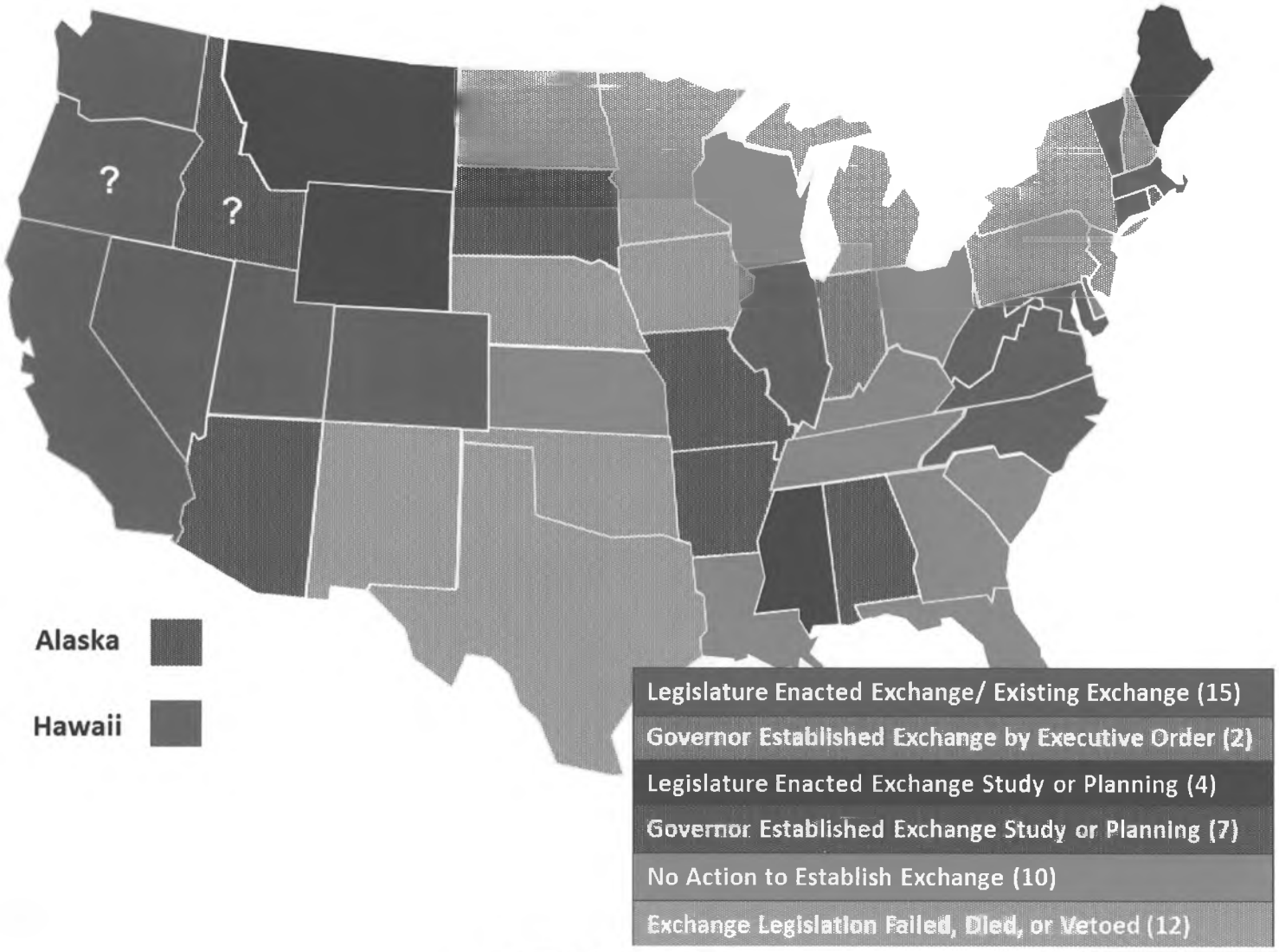
- **State exchanges: All of the accountability, none of the authority.**

  "Envision an exchange which, if we were to run it, has the governor's name at the top of the letterhead. We know we would see a number of letters that would go out to businesses and families throughout the state announcing the increase in premiums." --- Louisiana DHH Secretary Bruce Greenstein, on his exchange decision

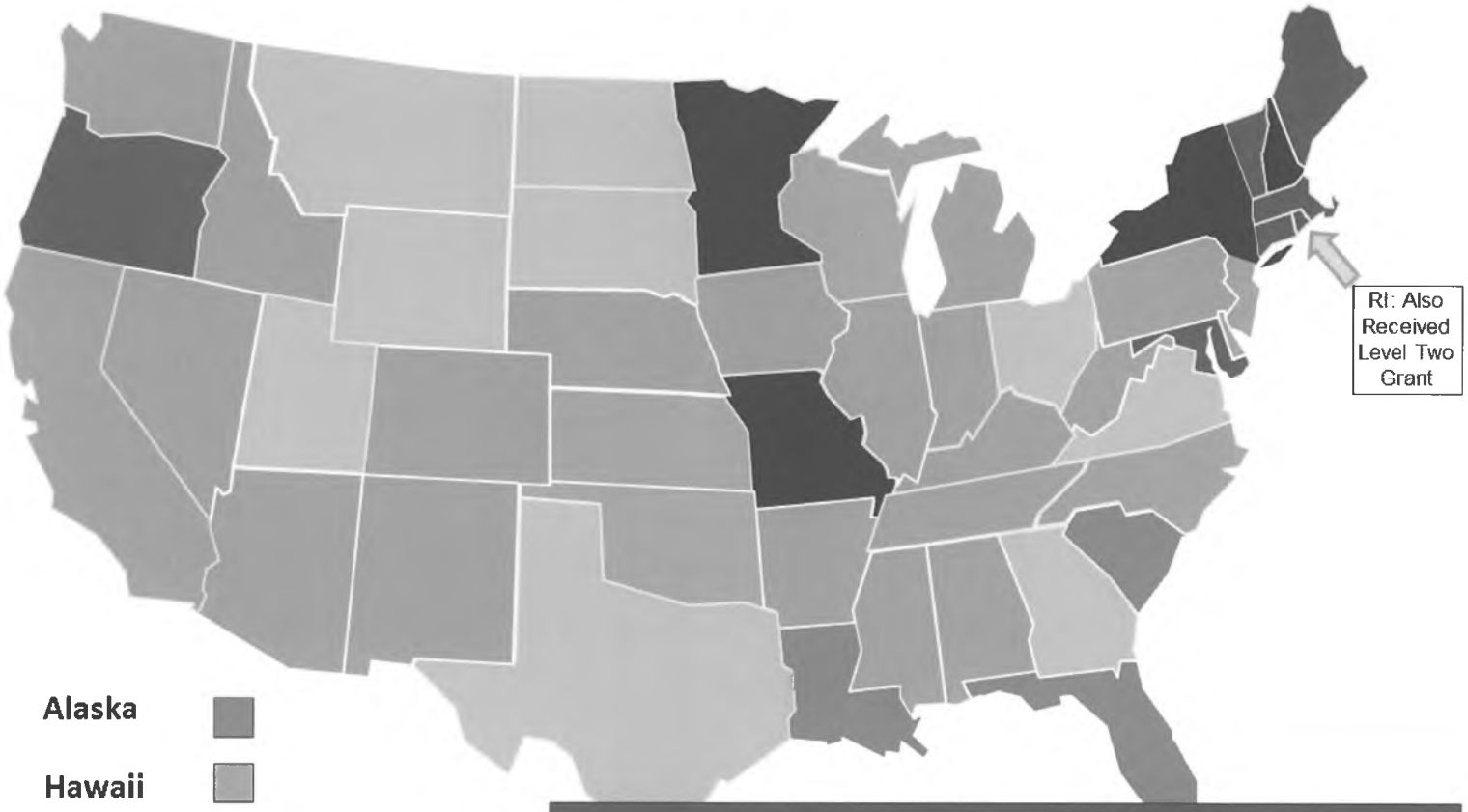
- **Impact of upcoming SCOTUS ruling, 2012 elections, and still-unwritten federal exchange regulations:** PPACA might be struck down, repealed, or defunded. Forthcoming regulations could redefine exchange scope, governance, and operations.

Sources: Kaiser Health News; *The Times-Picayune* (LA)

Exchange Implementation in the States



Exchange Grants in the States



Action Stalled in 2/3 of Exchange States

Slow Going	Second Thoughts	Good Progress
Hawaii	Colorado	West Virginia
California	Illinois	Maryland
Washington	Indiana	Connecticut
Oregon	North Carolina	Rhode Island
Nevada	Virginia	Vermont

Source: Kaiser Family Foundation

More States Are Reconsidering

State	Planning?	Grant?	Progress Report
Alabama	☑	**Level One Grant**	Establishment legislation expected in 2012.
Arkansas	☑	**Planning Grant**	Will pursue hybrid model because of legislative opposition.
Georgia	☑	**Planning Grant**	Will wait until SCOTUS ruling before proceeding.
Michigan	☑	**Level One Grant**	House stripped Level One Grant from appropriations and stalled exchange legislation.
Mississippi	☑	**Level One Grant**	Will establish an exchange under the state's high-risk pool (legislation failed in 2011 session).
Missouri	☑	**Level One Grant**	Will likely put a referendum on the 2012 ballot prohibiting an "executive branch" exchange.
North Dakota	**Legislation passed 2011**	**Planning Grant**	Voted against establishing an exchange in a 2011 special session.
South Dakota	☑	**Planning Grant**	Will wait until SCOTUS ruling before proceeding.

Contact Us!

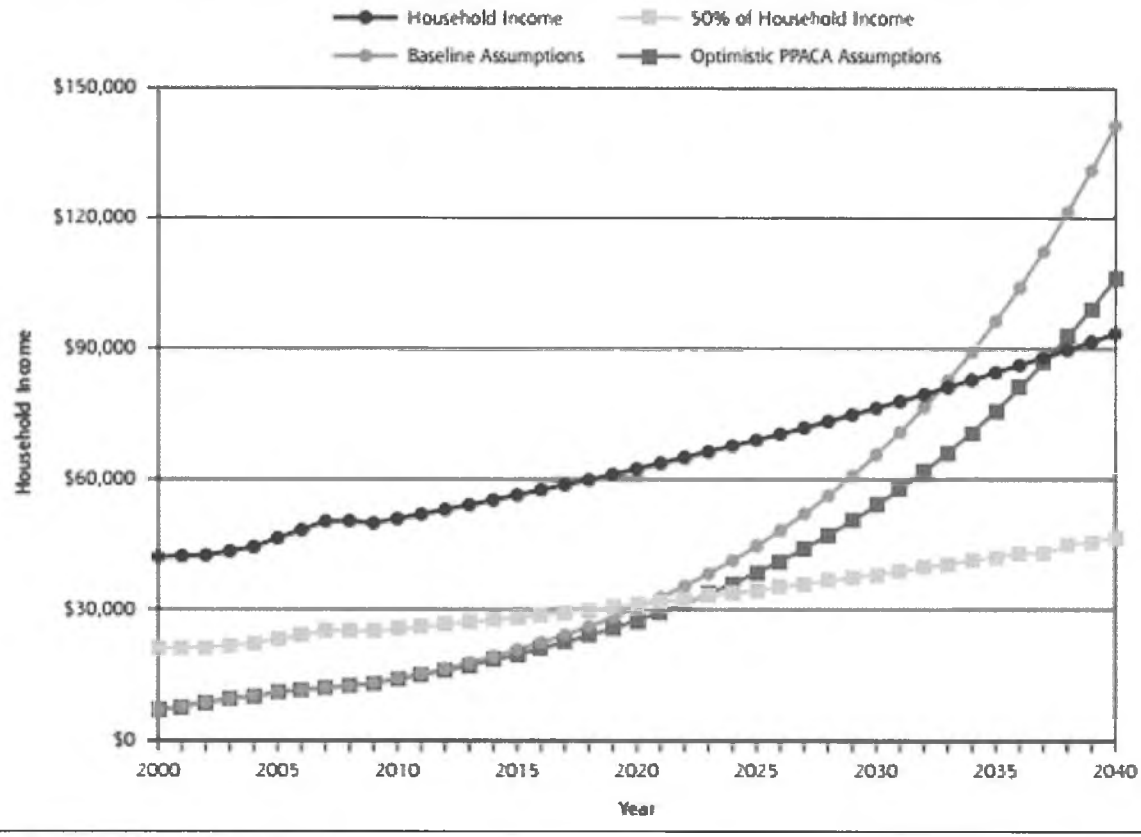
Christie Herrera
Director, Health and Human Services Task Force
American Legislative Exchange Council
(202) 466-3800
christie@alec.org

AMERICAN LEGISLATIVE EXCHANGE COUNCIL


Health Care
and Fiscal
Sustainability
THE SEAL OF THE STATE
OF ALASKA
Commissioner Becky Hultberg
Commissioner Bill Streur

"By 2037, health insurance will swallow your entire paycheck"

Figure 4. Family insurance premiums with and without PPACA assumptions of cost savings.



PPACA = Patient Protection and Affordable Care Act.

Why are we here?

The State of Alaska is a significant health care consumer.

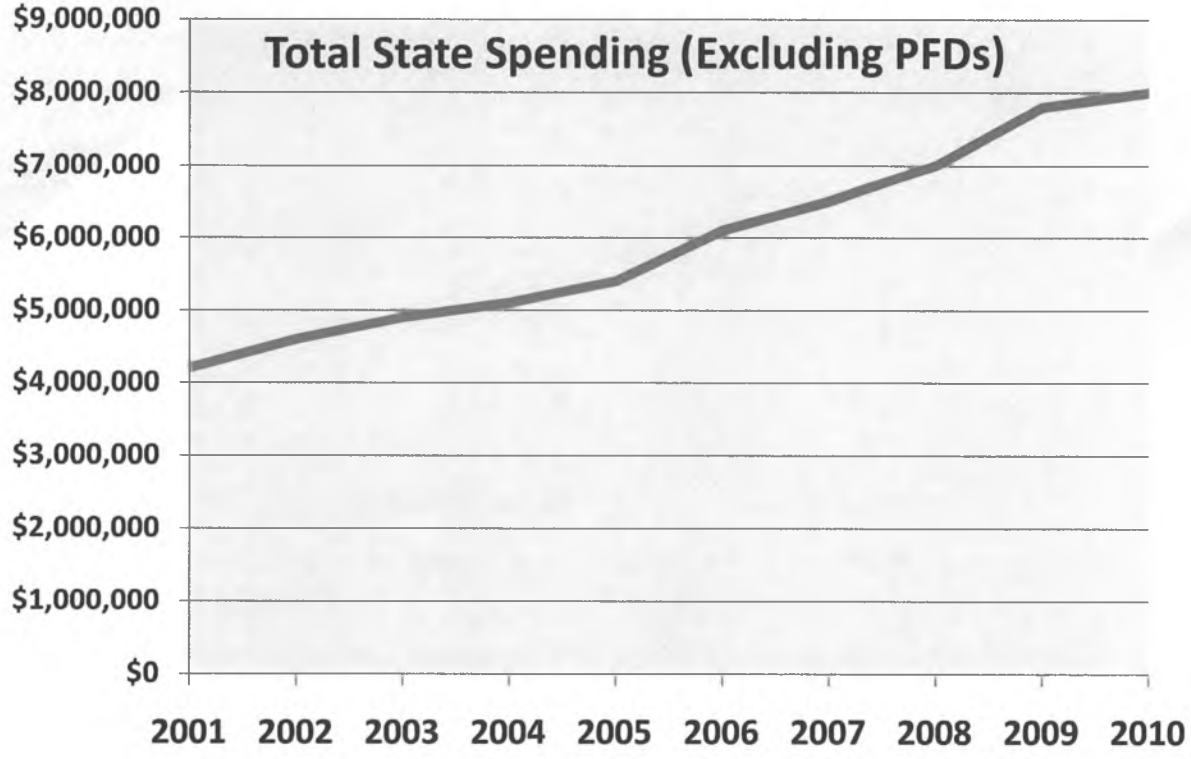
Active plan	**16,346 members** (includes dependents)	**$83.4 million** total spend in FY11
Retiree plan	**63,034 members** (includes dependents) 40% live outside Alaska	**$413.5 million** total spend in FY11
Medicaid	**135,246 Alaskans covered (2010)** 65% children, 28% adults, 7% elderly	**$1.2 billion** total spend in 2010

The state also spends money on health care for inmates, state employees who are members of union health trusts and for state workers' compensation claims.

State budget: 2001 - 2010

Total state spending (operating and capital, PFD excluded) has **doubled from $4 billion to $8 billion in 10 years.**

Spending per capita has increased from **$6,639/person in 2001 to $11,234/person in 2010.**



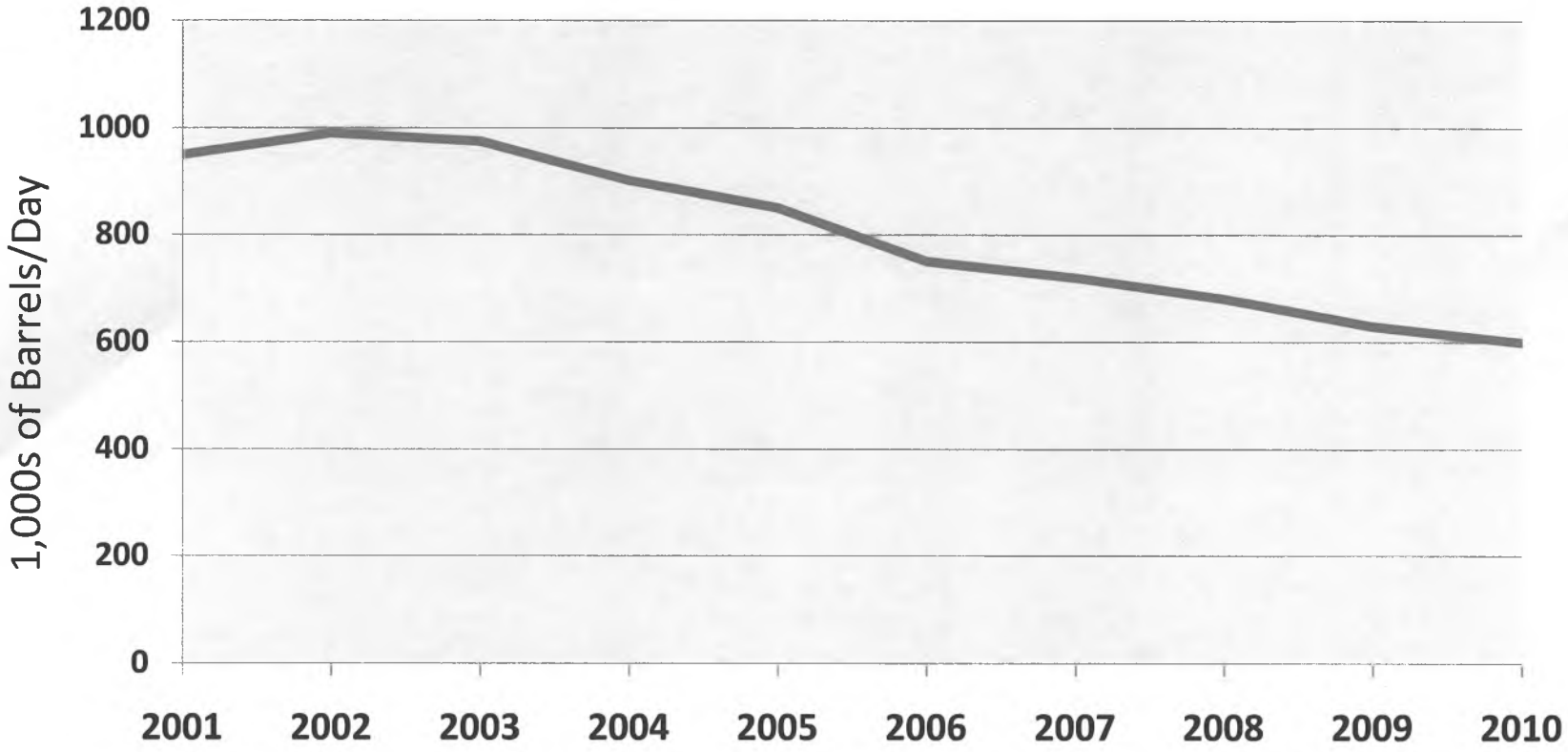
*The rate of spending growth over the last decade averaged **7.5% per year**, but inflation (Anchorage CPI) over the last decade averaged only **2.6% per year**.*

State revenue

TAPS subsidizes much of modern life in Alaska

- Schools - about 66% of K-12 spending
- State - about 90% of state general purpose unrestricted revenue
- PFDs - over $900 million in payouts each year
- State capital projects

State oil production: 2001- 2010



Oil production has steadily declined by just over 5% per year.

State Health Care Spend: 2001-2011

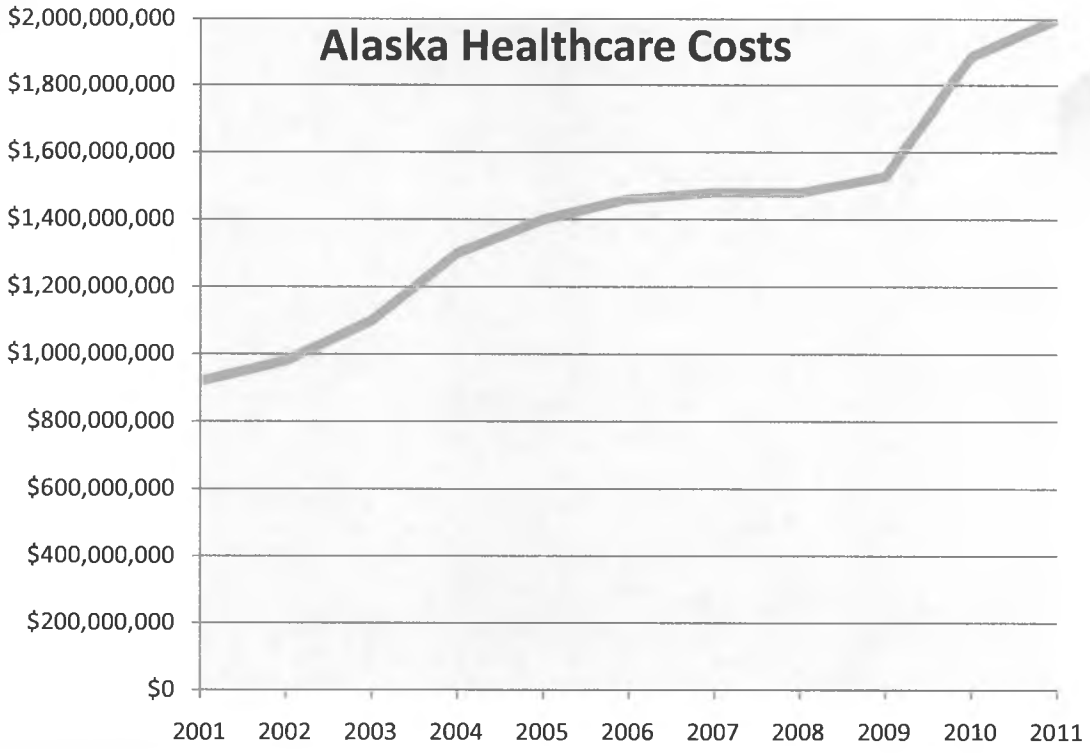
Medicaid, AlaskaCare active, AlaskaCare PERS/TRS, State Workers Compensation, Department of Corrections, union trusts

2001: $886 million

2011: $2 billion

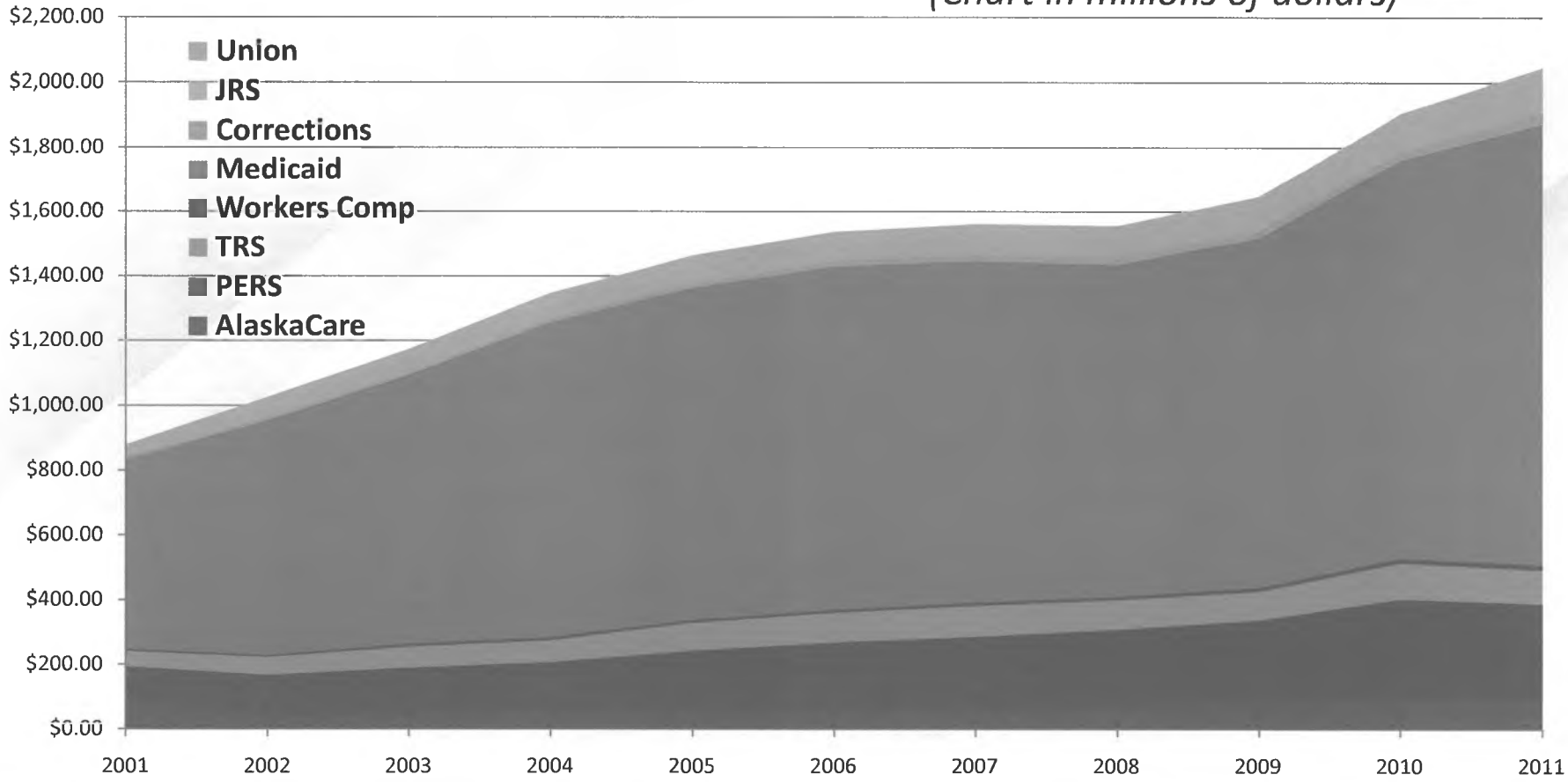
This includes the federal portion of Medicaid.

State health care costs grew at an average of 9%/year during FY01-FY10. 2011 showed improvement and the 10 year mean decreased to 7.9%.



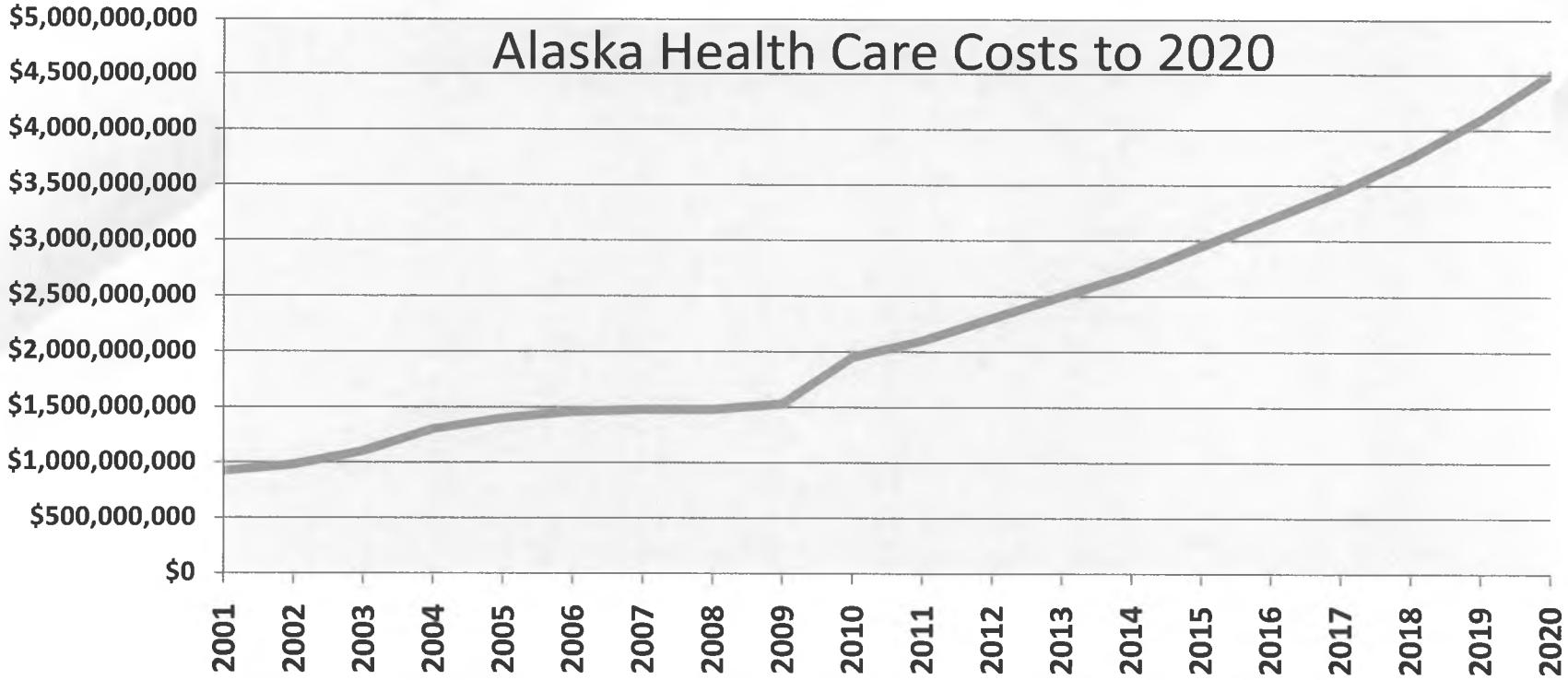
State health care spend

(Chart in millions of dollars)



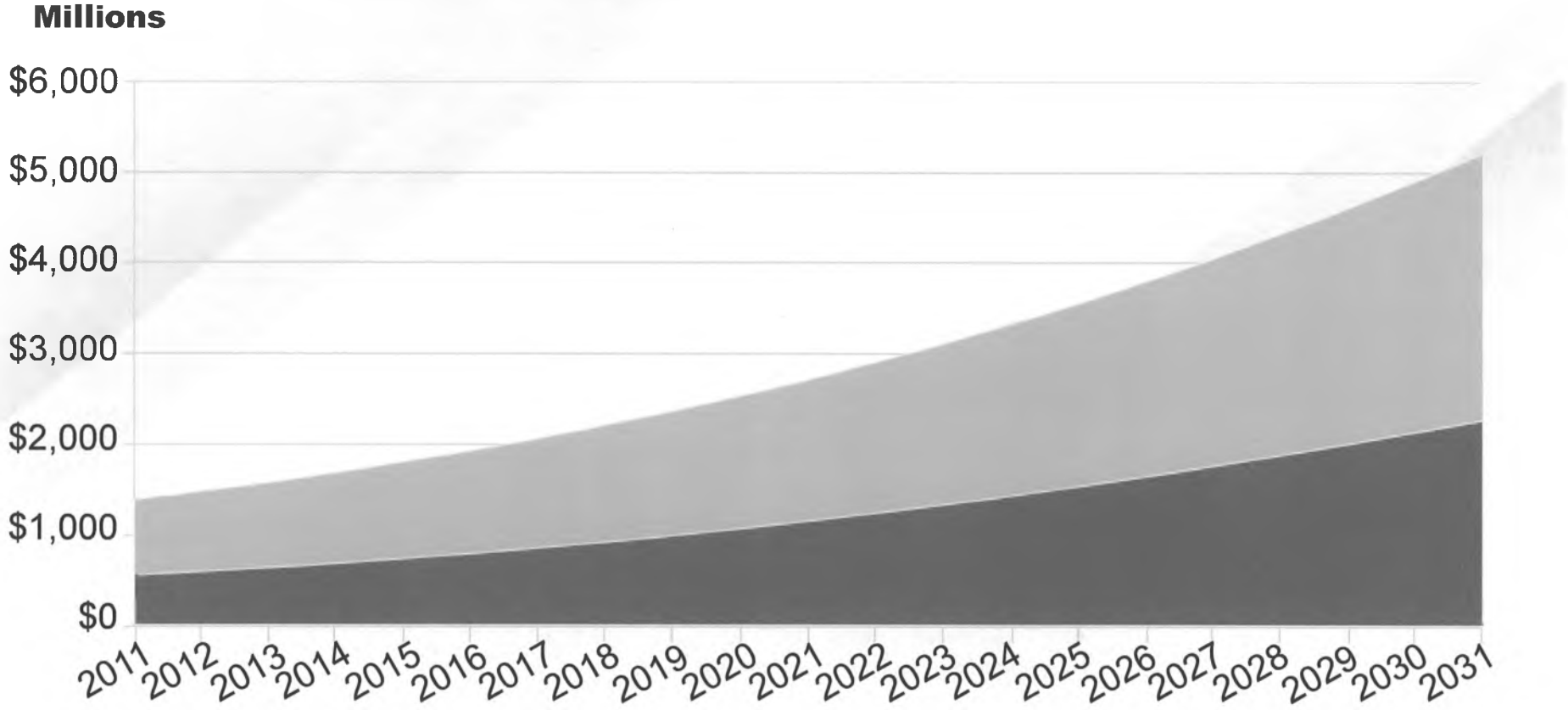
Where does our current path lead?

If state paid health costs continue to increase at 8.95% per year, in FY 2020 they will exceed **$4 billion** (before Medicaid reimbursement).



Challenge: Medicaid

Projected Medicaid Cost Growth



AK DHSS 10-Year plan operating budget

FY2013: $2.6 Billion Projected: FY2022 $6.6 Billion

Unknowns

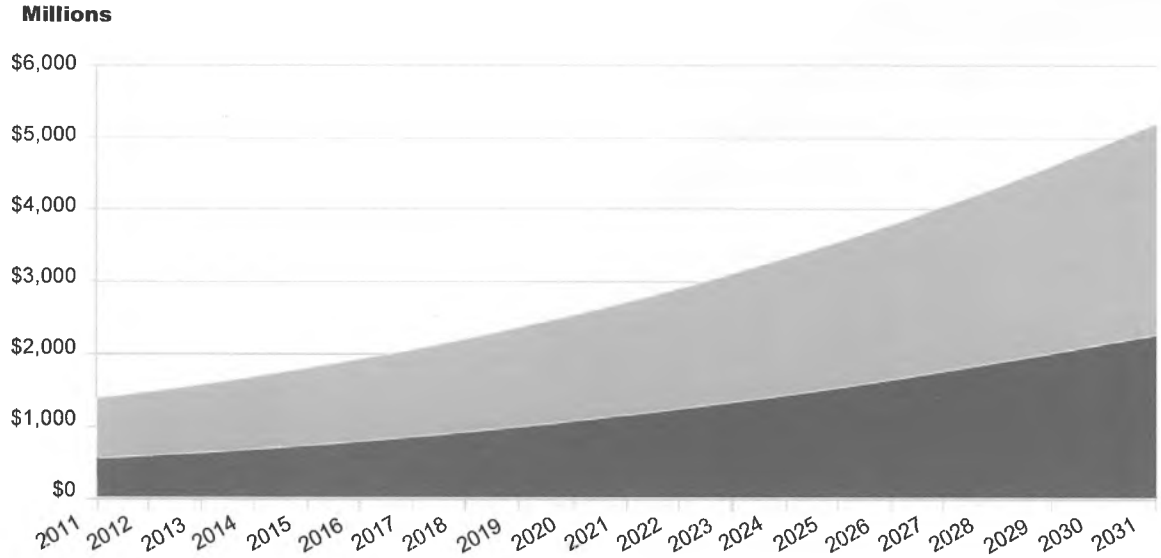
- Cost impact of the federal health care initiative
- Tighter federal and state budgets
- Broad economic problems – e.g. financial markets, energy costs, mortgage defaults, medical inflation

Medicaid

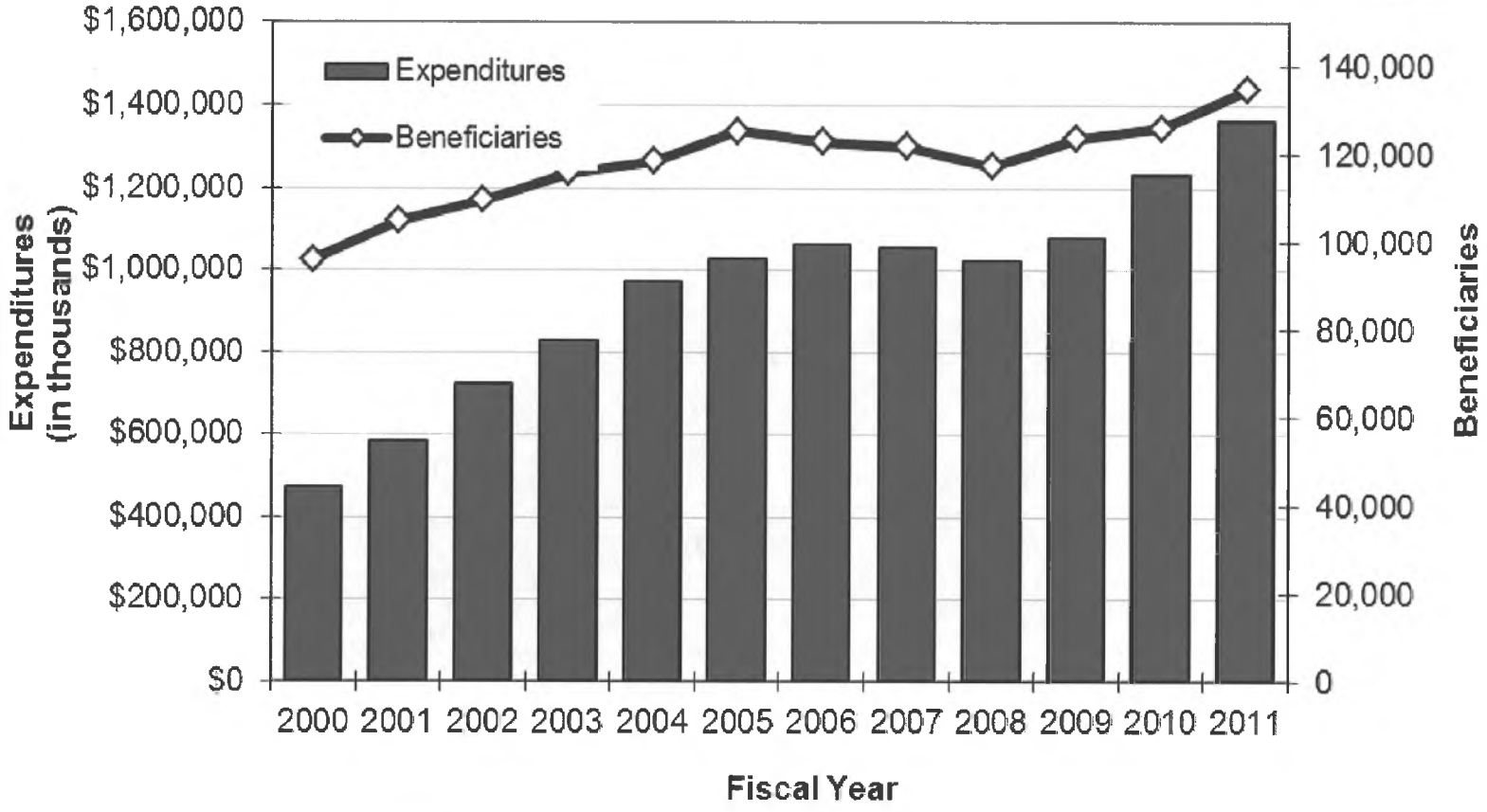
- Population
- Medical inflation

Public Assistance

- Inflation
- Population growth in population 20-34 years
- Population growth 65+ years of age –
- Adult Public Assistance



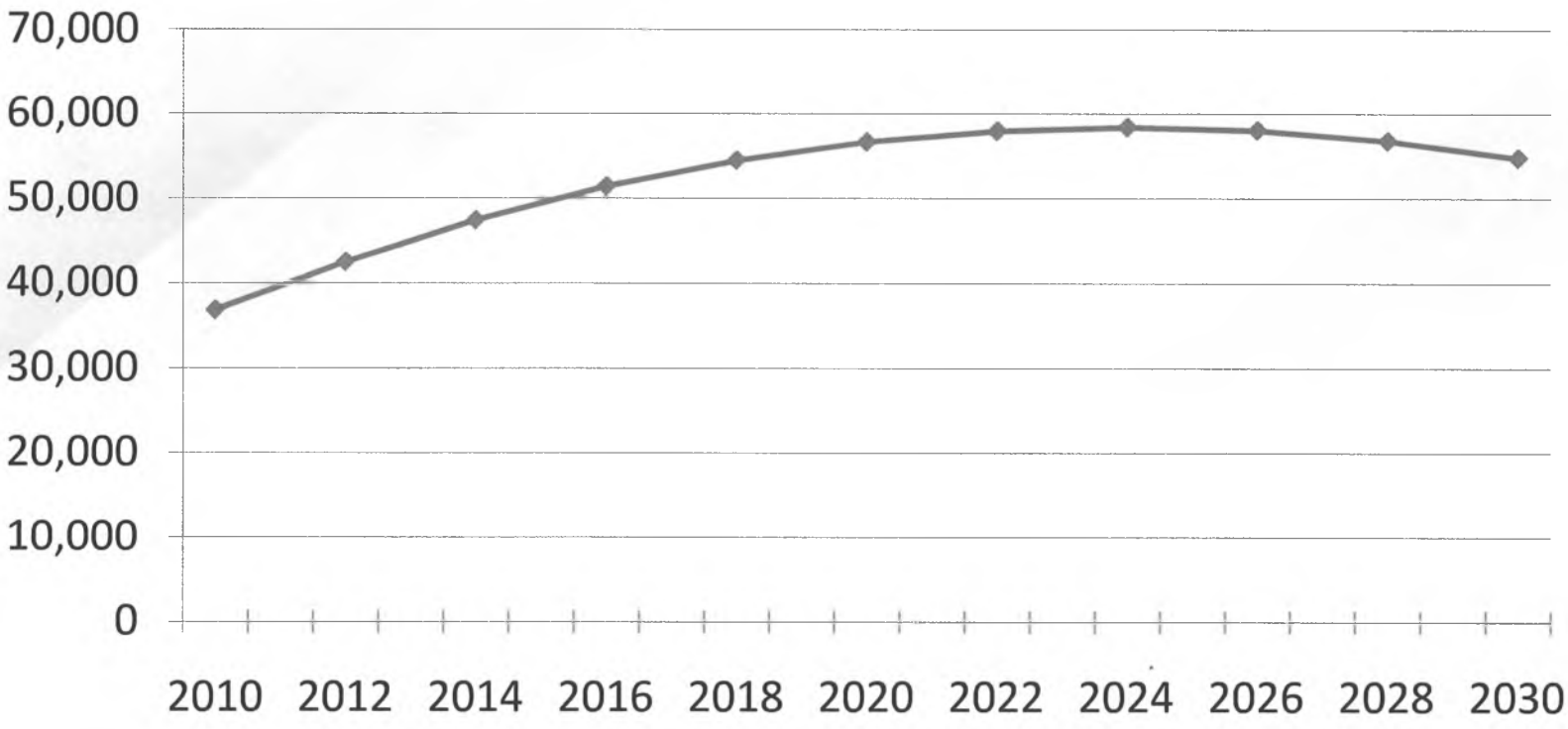
Medicaid direct services
Beneficiaries and expenditures



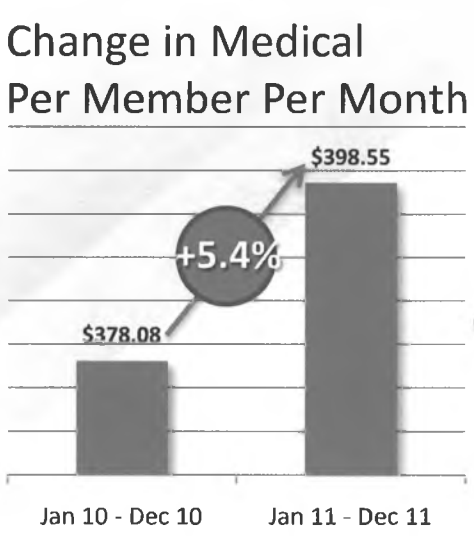
Source: Expenditures are from AKSAS. Beneficiaries are from MMIS-JUCE data.

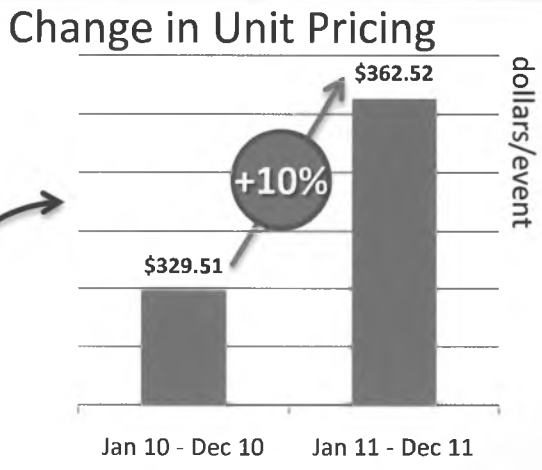
Challenge: PERS/TRS

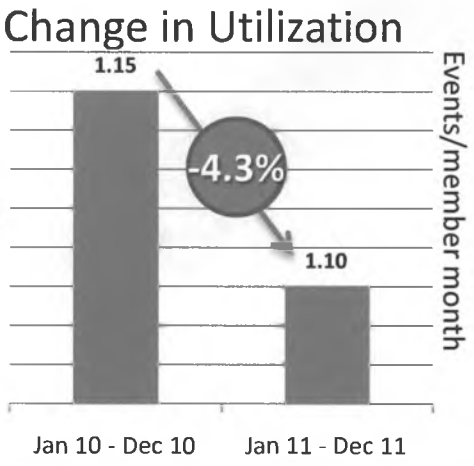
Projected Retirement System Growth



Retiree medical expense growth







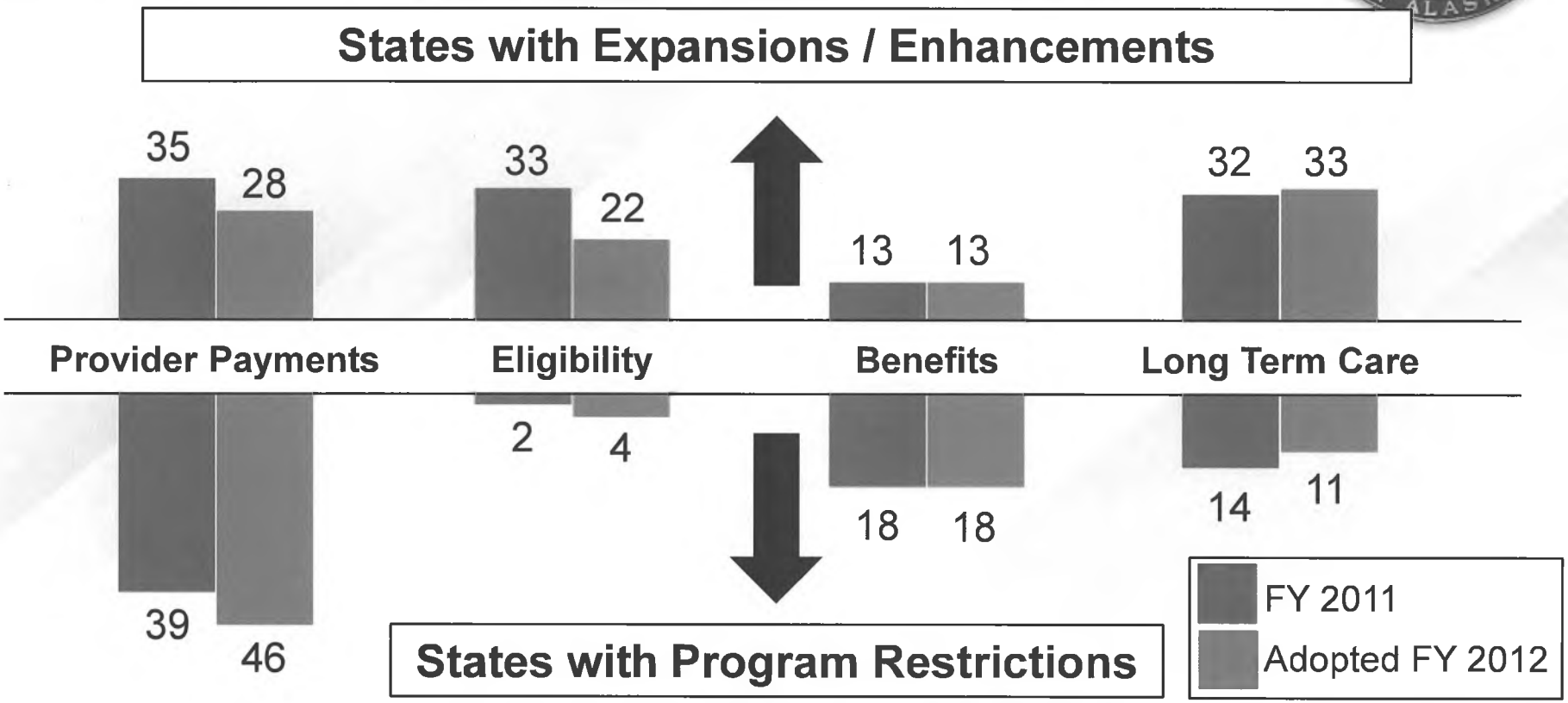
Source: Sightlines Medical Intelligence

Controlled growth in Medicaid

Under the current system, the options are limited.

• Eligibility	• Compliance/Anti-Fraud
• Covered Services	• Innovations in Service Delivery
• Rates	• Technology
• Utilization Controls	• Maximize Revenue

State policy actions implemented in FY 2011 and adopted for FY 2012



NOTE: Past survey results indicate not all adopted actions are implemented. Provider payment restrictions include rate cuts for any provider or freezes for nursing facilities or hospitals.

SOURCE: KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, September 2011.

Medicaid services

Mandatory

- Inpatient hospital
- Outpatient hospital
- Physicians
- Nurse midwives
- Lab and X-ray
- Advanced Nurse Practitioners
- Early Periodic Screening, Diagnosis, and Treatment
- Family planning services
- Pregnancy-related services
- Nursing facility (NF) services
- Home Health (NF qualified)
- Medical/surgical dental services

Optional

- MH Rehab/Stabilization
- Diagnostic/Screening/Preventive
- Therapies (OP, PT, SLP)
- Inpatient psychiatry <21 years
- Drugs
- Intermediate Care Facility for the Intellectually Disabled
- Personal care
- Dental
- Other home health
- Other licensed practitioners
- Transportation
- Targeted Case Management

Controlled growth in AlaskaCare

Options	AlaskaCare retiree plan	AlaskaCare active plan	Union trusts	Political subdivisions
Covered Services	Yes*	Yes	No	No
Utilization controls	Yes*	Yes	No	No
Premiums	Yes*	Yes	Yes*	No
Innovations in Service Delivery	Yes*	Yes	No	No
Eligibility	No	No	No	No
Wellness	Yes*	Yes	No	No

Payment comparisons

	Payment Levels	
	Office Visit (99215)	Obstetrical Care (59400)
Alaska Medicaid	$221.58	$2821.81
Alaska Medicare	$177.40	$2354.90
Alaska Commercial Mean	$290.64	$4704.80
Washington Medicaid	$76.86	$2034.50
Washington Commercial Mean	$183.24	$2601.20
North Dakota Medicaid	$186.19	$2339.40
Idaho Medicaid	$117.01	$1539.21

Milliman Client Report: Physician Payment Rates in Alaska and Comparison States prepared for Alaska Health Care Commission 2011

Payment comparisons: by procedure

Procedure	Area 981 90% UCR (Washington) % Medicare	Area 995 90% UCR (Anchorage area) % Medicare
Total Hip Arthroplasty	**$5,409** 305.2%	**$12,155** 685.9%
Fragmenting of Kidney Stone	**$2,120** 183.6%	**$8,200** 710.1%
Nasal/Sinus Endoscopy, Surgery	**$871** 235.4%	**$2,620** 708.1%
Inject Spine L/S (CD)	**$683** 312.4%	**$1,260** 576.3%
RPR Umbil Hern, Reduc > 5 yr	**$1,229** 232.1%	**$3,385** 639.4%

Source: Ingenix claims data

The hidden cost of health care

Opportunity cost of dollars spent on health care:
roads, public safety, schools and other public services

So what can we do?

Innovations in service delivery/payment

Medicaid

- Medical Home
- Tribal Health – *exemplar of alternative provider types*
- Bundled services
- Integrated BH/Primary care services
- Pay for performance
- Utilization review and management (radiology, Rx)
- Community based long-term care
- Disease/Case Management
- Managed Care
- Dual eligibles

Innovations in service delivery/payment

AlaskaCare

- Better leverage our purchasing power
- Consider expanded travel benefits or Centers of Excellence for certain services
- Develop a robust employee wellness program
- Continue to aggressively pursue contractual discounts
- Align contracting strategies around innovative care delivery models
- Develop a comprehensive health management strategy

The State's approach

Our challenge:

We must lower the rate of growth of our health care spend. Our current path is not sustainable.

Our approach:

- Work together with the hospital and physician community
- Support high-quality, cost-effective health care delivery in Alaska
- Develop and support innovative solutions to our health care challenges

Thank you!

For more information:

www.DOA.alaska.gov and www.HSS.alaska.gov

Questions?