Health Law and Policy Update: February 10, 2012

This week's updates

Headlines of the week

Hospital Payment Assistance Program hearing set for Thursday

Senate Health and Human Services Committee members next week will consider a bill to establish a Hospital Payment Assistance Program, a measure advanced by the Colorado Center on Law and Policy and other advocates for health care consumers.

The hearing on Senate Bill 12-134 is scheduled for 1:30 p.m. Thursday, Feb. 16, in Room 356 of the State Capitol. The bill would help people pay their hospital bills by making it easier to get information about hospital charity care and discount plans, limiting the amount uninsured people can be asked to pay on a hospital bill and establishing standards that must be met before a hospital can send someone who is uninsured to collections. Find more detail in a fact sheet prepared by CCLP and theColorado Consumer Health Initiative.

People who favor the bill can support its passage in a number of ways:

- *Attend the hearing*. Committee hearings are open to the public and a great way to connect with other supporters.
- *Tell your story*. If you or someone you know is uninsured and has had difficulty paying hospital bills, contact CCLP Communications Director Perry Swanson by e-mail or at 303-573-5669, ext. 306. Personal stories are one of the most persuasive ways to emphasize to lawmakers that Senate Bill 12-134 would be helpful to their constituents. You don't have to be an expert; just consider sharing your own experience.
- *Keep informed and be ready to act*. As the bill works through the legislative process, CCLP will post frequent updates to a new page on our Policy Matters blog. Visit the page to find more resources and ways to get involved.

Bill to cut Medicaid fails in committee

A proposal to undo years of policy development toward increasing access to health coverage for Coloradans failed at the Colorado General Assembly on Thursday when the sponsor asked for the measure to be killed. The Colorado Center on Law and Policy was among the organizations opposing Senate Bill 12-85, sponsored by Sen. Shawn Mitchell, R- Broomfield. Among other cuts to benefits, services and eligibility, the bill would have cut major Medicaid expansions that have been implemented during the past several years by:

- Reducing income eligibility for children and pregnant women in Child Health Plan Plus (CHP+) from 250 percent to 205 percent of the federal poverty level
- Eliminating an expansion of Medicaid for adults without dependent children
- Eliminating a Medicaid buy-in program for people with disabilities
- Eliminating eligibility for pregnant legal immigrants and legal immigrant children in Medicaid

The bill would have reduced the federal revenue Colorado receives and, by violating a federal Medicaid maintenance-of-effort provision, would have jeopardized all of Colorado's federal Medicaid funding.

Legislation would protect insurance profits and harm consumers
Legislation introduced last week by U.S. Sen. Mary Landrieu, D-La., would exclude insurance agent and broker commissions from medical loss ratio medical loss ratio (MLR) calculations. The MLR is one of the most important consumer protections in the Patient Protection and Affordable Care Act (ACA). It requires that health insurers in the individual and small group market spend at least 80 percent of premium dollars on payments for medical services or quality improvement. In other words, the MLR requires insurers to spend 80 cents of every dollar on health care, limiting administrative expenditures and profit margins. The MLR requires insurers that spend more than 20 percent of premium revenue on administrative costs to issue their enrollees refunds to make up the difference.

The Obama Administration issued a final rule last December declaring insurance agent and broker fees are not medical care and that they must be included in calculations of administrative costs.

Landrieu's proposed law would eliminate insurance agent and broker commissions from the calculation of administrative costs, jeopardizing the nearly $900 million in estimated rebates that health insurers will soon be required to issue to consumers. Moreover, the bill would result in significantly higher premiums for consumers. America's skyrocketing health care costs were the impetus behind the insurance reforms in the ACA, including the MLR requirement. The proposed law would make health insurance less affordable for Colorado families while bolstering health insurer profits.

EPSDT offers broad benefits, strong protection for children
Early Periodic Screening Diagnosis and Treatment (EPSDT) is the comprehensive medical benefits package available to Medicaid-eligible children younger than 21. That includes all children who have Medicaid coverage, regardless of the basis of their eligibility. The eligibility could be based on poverty-level income, being a beneficiary of Supplemental Security Income, receiving federal foster care or adoption assistance and receiving Home and Community-Based Services.

As Colorado moves forward with payment and delivery system reforms in the Medicaid program, it is important to keep the requirements of EPSDT in mind and understand the policy framework that led to the establishment of those requirements, Colorado Center on Law and Policy Health Care Attorney George Lyford explained an issue brief released Monday.

What's new

Seats open on Accountable Care Collaborative Program Improvement Advisory Committee
The Colorado Department of Health Care Policy and Financing is seeking two new representatives to serve on the Accountable Care Collaborative Program Improvement Advisory Committee. The new seats are designed to represent the interests of two new populations that will be served through the ACC program: adults without dependent children and dual eligibles (people who are eligible for Medicare and Medicaid).

"These committee members will be expected to act as liaisons between the ACC Program Improvement Advisory Committee and the AwDC Advisory Committee and Duals Stakeholder Groups, respectively. The Department plans to enroll both dually eligible individuals and adults without dependent children into the ACC program," the department said in an announcement of the open seats.

Details on how to be considered for one of the seats are on the state'swebsite.

Advancing the debate

Essential Health Benefits: A uniform package is needed to serve as a national floor

This is the second in a series of pieces from the Colorado Center on Law and Policy regarding the development of the Essential Health Benefits package in Colorado. The first in the series is on CCLP's website.

The U.S. Department of Health and Human Services issued a bulletin in December that proposed a process for states to establish an Essential Health Benefits (EHB) package. The HHS bulletin suggests that instead of a single standard for defining the EHB, the department will allow states to benchmark to a "reference plan" based on a currently available health plan in the state, modified as needed to meet the EHB requirements found in the Patient Protection and Affordable Care Act (ACA). The HHS bulletin specifies states will have the flexibility to choose one of the following benchmark plans as the basis for their EHB:

- One of the three largest small group products in the state
- One of the three largest state employee health plans
- One of the three largest federal employee health plans
- The largest HMO plan in the state

Those options might not provide the robust level of coverage envisioned by the ACA. For example, small-group plans are more likely than large employer plans to use restrictive benefit design features to control costs. Such features include limited provider networks, aggressive medical management and high cost-sharing. Those benefit design features can create unnecessary disruptions in care, and serve as a barrier for people unable to navigate the complex rules or pay the out-of-pocket expenses.

In addition the HHS bulletin suggests insurance issuers might be allowed to adjust the benefits defined as "essential." The HHS bulletin suggests allowing insurers to make substitutions in benefits so long as they are "substantially equal" to the benefits of the benchmark plan as modified to meet the 10 mandatory categories of coverage under the ACA. Granting insurers flexibility to define or substitute benefits would be problematic, as it would likely result in a cost-driven calculation by the insurer and restrictive benefit design features that limit coverage.

Allowing states and insurers the degree of flexibility indicated in the HHS bulletin is concerning because the intent of the ACA was clear regarding the need to create a comprehensive and national standard for insurance coverage to ensure all populations could access comprehensive care that meets their needs across all states.

Varying EHB standards and benefits as proposed by the HHS bulletin are likely to result in individuals having different benefits depending on where they live rather than on their medical needs. There are real and legitimate reasons to accommodate regional and local health interests in states such as Colorado. However, a federal EHB package should set a national floor and oversee those regional differences. That floor should represent the minimum package of benefits individuals need to meet all of their health care needs. Regional or local considerations, by states and plans, should be relevant to decisions about providing additional coverage. Colorado should be free to expand benefits packages to improve upon the national standard or take geographic differences into account. That is explicitly contemplated by the ACA, which allows states to add to the federally defined EHB. At minimum, a firm and comprehensive federal EHB package must be the starting point.

The EHB package should uphold the principles of health reform: to develop a simple and navigable insurance market for consumers, promote health care systems that are unified as opposed to siloed, and ensure widespread and comprehensive access to coverage for all people.

People with low incomes less likely to have insurance or a regular source of care

The nation's health reform law will go a long way toward removing disparities in access to health care between lower-income and higher-income families, The Commonwealth Fund reports in an issue

brief released Tuesday. The paper reports results of a nationwide survey conducted last year that measured inequities in access to health care by income. Among the findings:

- Nearly three of five adults in families earning less than 133 percent of the federal poverty level were uninsured for a time in 2011. Two of five were uninsured for one or more years.
- Low- and moderate-income adults who were uninsured during the year were much less likely to have a regular source of health care than people in the same income range who were insured all year.
- Uninsured, lower-income adults were more likely than insured adults in the same income group to cite factors other than medical emergencies as reasons for going to the emergency room.

Kaiser Health News provides a quick summary of the report.