Health Law and Policy Update: February 3, 2012

This week's updates

Headlines of the week

Critics attack Medicaid, but advocates urge a long-term view

Debate continues at the Colorado Legislature among critics of Medicaid spending and health advocates for people with low incomes, as The Denver Post noted in a story published Sunday.

Talking points among the critics include the ideas of "shared responsibility" and "skin in the game" in the form of higher co-pays and enrollment fees for participants in public health care programs for low-income families, children, seniors and people with disabilities. Advocates for the programs, though, point out higher fees could cost more in the long run by discouraging preventive care and channeling patients to much more costly emergency room visits when health conditions reach a crisis.

"We absolutely should not be balancing the budget by making it more difficult for sick, low-income people to get necessary medical care," Colorado Center on Law and Policy Health Care Program Director Elisabeth Arenales told the Post.

An issue brief prepared by Arenales details the history of Medicaid, which shows the value of the program for combating poverty and providing access to health. The brief was published as part of last week's edition of Health Law and Policy Update, and it's now available as a stand-alone paper.

Hospital Payment Assistance Program is introduced in the General Assembly

A bill designed to help working families who cannot afford insurance to responsibly pay their hospital bills was introduced Tuesday in the Colorado General Assembly. Senate Bill 12-134, establishing the Hospital Payment Assistance Program, is sponsored by Sen. Irene Aguilar, D-Denver, and supported by the Colorado Center on Law and Policy.

Uninsured patients, who do not have the bargaining power of large insurance companies or public programs, are charged much higher prices for hospital care than those with insurance. Public programs and private insurers negotiate lower prices with hospitals. Uninsured patients are the only group that pays the full listed prices for hospital care. The latest Medicare cost reports show hospital charges in Colorado were 384 percent of hospital costs, demonstrating charges were significantly more than the cost of delivering care.

Those prices are a significant hardship for uninsured, working families that already struggle to afford medical care, forcing many patients to go into debt, or even declare bankruptcy, to pay for medical care. An American Journal of Medicine Study reported 62.1 percent of bankruptcies nationwide in 2007 were

attributable to high medical costs. The average out-of-pocket medical costs for a family that declared medical bankruptcy were $17,943.

SB 12-134 addresses those issues and creates a path for uninsured patients to responsibly pay their hospital bills without being forced into bankruptcy. The Hospital Assistance Program contains three components:

- *Increased transparency standards*: Hospitals would be required to make information about the discount program and charity care policies available in their facilities and on their websites. Patients would also receive the information while they are in the hospital and along with their hospital bills.
- *Debt collection standards*: Hospitals would be required to screen uninsured patients for the discount program and other financial assistance or charity care programs offered by the hospital before beginning collections procedures, and to offer payment plans to uninsured patients to provide them an option to pay for their own care. The amount paid by uninsured patients annually would be limited to 5 percent of income.
- *Limits on hospital prices for the uninsured*: Low-income patients (those with incomes up to 400 percent of the federal poverty level) could not be required to pay hospital charges that exceed the cost of providing care. A hospital's cost of providing care would be established by reference to annual Medicare cost reports.

The Colorado Center on Law and Policy seeks support from advocates who support giving uninsured families the opportunity to responsibly pay their hospital bills. If your organization would like to sign on as a supporter, contact CCLP Rice Fellow Daniel Rheiner.

More information about SB 12-134 is available in a fact sheet, put together by the Colorado Center on Law and Policy and the Colorado Consumer Health Initiative.

2011-12 spending amendments mostly minor, include additional $62.4 million for Medicaid
The package of amendments to the 2011-12 state budget that the Colorado General Assembly will consider in the coming days includes only minor changes in spending, according to an issue brief released Thursday by the Colorado Fiscal Policy Institute, a project of the Colorado Center on Law and Policy. Perhaps most significant is what lawmakers are not including in the budget amendments: an attempt stop cuts in services that will hurt low-income Coloradans, the brief notes.

On public health care programs, the issue brief notes the Department of Health Care Policy and Financing (HCPF) estimates a larger-than-expected increase in the number of people seeking health care through Medicaid means the state needs to spend an additional $62.4 million on the budget's primary Medicaid line item to maintain the current level of services. HCPF is expected to release an updated and more accurate caseload estimate in February. JBC members chose to leave that line item unchanged for now, promising to revisit the issue in March when the committee writes the 2012-13 budget.

Advancing the debate

Essential Health Benefits: Process moves forward but with much yet to be decided
This is the first in a series of pieces the Colorado Center on Law and Policy will release in the coming

weeks regarding the development of the Essential Health Benefits package in Colorado.

The Patient Protection and Affordable Care Act (ACA) will soon expand health coverage to hundreds of thousands of Coloradans who are currently uninsured or are unable to obtain affordable coverage that meets their needs. However, a crucial aspect of the law - what benefits must be covered - has yet to be defined. The ACA requires the federal Secretary of Health and Human Services (HHS) to define an Essential Health Benefits (EHB) package that will serve as the basis of coverage in the individual and small group markets. Moreover, the EHB package will apply to all health plans offered both inside and outside of newly-established health benefit exchanges. Defining the EHB package will be critically important to ensuring all Coloradans have access to comprehensive coverage.

On Dec. 16, HHS issued a bulletin to states proposing an approach to establishing the EHB standard based in part on a 2011 report by the Institute of Medicine (IOM). The IOM report, which explicitly prioritizes cutting costs over meeting the health needs of the public, has been widely criticized by health policy advocates. The HHS bulletin suggests that instead of a single standard for defining the EHB, HHS will allow states to benchmark to a "reference plan" that is based on a currently available health plan in the state, modified as needed to meet the EHB requirements found in the ACA. The bulletin specifies states will have the flexibility to choose one of the following benchmark plans as the basis for their EHBs:

- 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

The HHS bulletin indicated that once a benchmark plan is selected, the EHB package must still comply with the ACA's requirement that the EHB cover 10 categories of services. Those categories include:

- Ambulatory patient services
- Emergency services
- Hospitalization
- Laboratory services
- Maternity and newborn care
- Mental health and substance use disorder services, including behavioral health treatment
- Pediatric services, including oral and vision care
- Prescription drugs
- Preventive and wellness services and chronic disease management
- Rehabilitative and habilitative services and devices

If the benchmark plan selected doesn't cover one or more of the mandatory categories of services (or, arguably, if the benchmark doesn't provide adequate coverage of the service), the service must be added to the EHB package. Furthermore, the state's EHB package must comply with other ACA requirements that prevent discrimination on the basis of age, health condition and expected length of life.

The proposal for benchmark options raises important questions: Do any of the options provide the comprehensive coverage the ACA envisioned? How can states determine what the three largest small

group products are when data are often difficult to obtain or unavailable? What entity in state government should make the decisions? What criteria should states use to determine if one of the 10 mandatory categories of services is not covered adequately by the selected benchmark plan? How should states fill in the gaps of missing/inadequate coverage?

The bulletin, which is a first step in a long process, was meant to advise states of the direction HHS is considering with respect to defining the EHB package. HHS asked for written comments on its bulletin to be submitted by Jan. 31. CCLP submitted comments on the following points:

- *National standard*: HHS should set a strong national benefit design standard, allowing states to expand upon national minimums.
- *Limit insurer flexibility*: Excessive benefit design flexibility should be reduced, prohibiting insurers from setting or altering the EHB standard.
- *Benchmark should ensure comprehensive coverage*: If there is no national standard, benchmark options should be based on the most robust large-group plans in the state, which offer the most comprehensive benefits.
- *Comprehensive coverage of 10 categories*: HHS should require substantial coverage of the 10 mandatory categories of services required by the ACA.
- *Include state mandates*: HHS should include valuable state mandates in the EHB package.
- *Comprehensive children's coverage*: HHS should take prescriptive steps to ensure comprehensive coverage for children, using the Early Periodic Screening Diagnosis and Treatment (EPSDT) program as a model.
- *Transparent process*: HHS should establish a transparent process to ensure adequate consumer stakeholder participation.

Now that the window for states and stakeholders to comment on the HHS bulletin has closed, it is expected the formal rulemaking process will begin. Before issuing proposed rules, however, HHS is expected to release a document answering the most frequently asked questions concerning the proposed EHB design process. Information on the FAQ and the EHB process in general will be covered in future editions of Health Law and Policy Update.

Fact sheet spells out options for small businesses under health reform
Small businesses will have a range of options for providing health insurance to their employees as implementation of the Patient Protection and Affordable Care Act continues. A new fact sheet from the Kaiser Family Foundation outlines how the law will affect small businesses and their employees.

The document discusses provisions of the law that apply to "grandfathered" plans (those in place before March 23, 2010), and the provisions that apply to new plans. The distinction will be important. About 72 percent of businesses with 100 or fewer workers had at least one grandfathered plan in 2011, the fact sheet notes.

Health reform law saves $2.1 billion for 3.6 million Americans with Medicare
Nearly 3.6 million Medicare beneficiaries saved $2.1 billion on prescription drugs last year thanks to the Patient Protection and Affordable Care Act, the Department of Health and Human Services reported Thursday.

The average person with Medicare will save nearly $4,200 by 2021 because of the new law, the department reported.

The health reform law provides a 50 percent discount on brand-name prescription drugs and this year, a 14 percent discount on generics. Last year, the law provided a 7 percent discount on covered generic

medications for people who hit the prescription drug coverage gap known as the "donut hole," with 2.8 million beneficiaries receiving $32.1 million in savings on generics.

In 2011, the 3.6 million Americans who hit the donut hole saved an average of $604 on the cost of their prescription drugs.

"The Affordable Care Act is already saving money for millions of Americans with Medicare," Health and Human Services Secretary Kathleen Sebelius said in a news release. "As we move forward, we will close the donut hole completely and save even more money for everyone with Medicare."