Health Law and Policy Update:
March 1, 2013

This week's updates:

- **Medicaid bill introduced!**
- **HCPF reported to the JBC today on Efficient Contracting in Managed Care**
- **TIME Magazine's Bitter Pill: Why Medical Bills are Killing US claims health care is "eating away our economy and treasury**"
- **New Jersey will expand**

What's New

Medicaid bill introduced!

The bill to extend coverage to Coloradans under 133% of the Federal Poverty Level was introduced this afternoon as

SB13-200. If you would like to join the list of bill supporters please contact mk.hurd@state.co.us who is the lobbyist for the Colorado Department of Health Care Policy and Financing. Passage of this bill, which will secure coverage for so many low income Coloradans, is CCLP's top priority this legislative session.

HCPF reported to the JBC today on Efficient Contracting in Managed Care

The Department of Health Care Policy and Financing (HCPF) was required by HB12-1281 to submit a report to the Colorado Joint Budget Committee (JBC) regarding contracts for managed care in the Medicaid program. Specifically the Department was charged with making an assessment of managed care contracts, including policy goals and efficacy, and reviewing administrative costs in light of the policy goals of each contract. The Department was also required to offer recommendations for streamlining and simplifying contracts.

The report released today offers strong support for the Accountable Care Collaborative (ACC) Program pointing to its overall effectiveness, support of regional flexibility and innovation, and highlighting both savings realized to date and the potential for future savings and better integration and coordination of care. The report also discusses the challenge of running a variety of different programs (beyond the ACC) within Medicaid, saying that the "aggregate challenge of running many separate Medicaid programs is greater than the sum of directing the individual

components...". Accordingly, programs often compete with each other for resources or have misaligned policy goals and operational procedures.

Among the recommendations made are that HCPF:

- Use reprocurement of BHO contracts to create incentives and targets for further integration of behavioral and physical health.
- Continue aligning, as much as possible, all Medicaid managed care programs within the ACC structure.
- Explore the potential for lifting the prohibition on inclusion of long term care services and supports in the HB12-1281 pilot.
- Consider whether to have fewer RCCOS across regions, but two within each region so that people have a choice of plans. The report notes that doing this would also help to increase continuity of care, and mitigate some of the impact of churn between Medicaid and private health coverage through the Colorado Health Benefit Exchange. There is also a discussion of the potential risks and benefits of fostering competition between the RCCOs.

CCLP is following the managed care discussion in Colorado closely and supports using the ACC as the base for further innovation. However, as is noted in the report, there is benefit in maintaining some very specialized and highly successful programs, for example the Program of All Inclusive Care for the Elderly (PACE). In addition, CCLP advocated for the exclusion of Long Term Care from the payment reform pilot programs authorized by HB12-1281. We thought it was important to test and refine new payment models and examine their impact on access to care and quality, before deciding how to move forward with any redesign of programs and incentives that impact what are typically highly vulnerable populations. Much has been written about the risks of potential capitated managed care in Medicaid, and Colorado should pay close attention to those lessons. For a good synthesis of information about Medicaid managed careclick here.

Advancing the Debate

TIME Magazine's Bitter Pill: Why Medical Bills are Killing USclaims health care is "eating away our economy and treasury"

Author Steven Brill spent seven months investigating Americans' health care bills,

examining what we spend on health care services and where the money goes. This must read article explores the irrational and frequently unjust model of medical billing and illuminates some reasons the United States is spending 20% of GDP on health care. Brill's point is that we seem to be skipping past the main point in our discussions about controlling health care costs and what we need to examine why why medical bills are so high. Ultimately, Brill says "when you follow the money, you see the choices we've made knowingly or unknowingly." The system we have has enriched labs, drug companies, medical device makers and a host of other players, while squeezing those who "don't otherwise game a system that is so gameable."

The TIME report has kicked off a media fire storm about the cost of health care including articles in the Huffington Post, CBS news and responses from the American Medical Association and medical-device company, IPG.

Here are some of his key findings:

- Hospitals and other providers have master pricing lists of the cost of providing specific services, called a chargemaster. A chargemaster includes pricing for items like an ibuprofen pill and surgical gown, and services like a CT scan or the cost of a doctor reading scan results. All medical centers have their own unique chargemaster. Although a set price is associated with items and services, what appears on a bill is often a negotiated rate, usually in the form of a set percentage discount, between an insurer and provider. The article reports that there seems to be no "no process, no rationale," behind the chargemaster, which leaves uninsured or underinsured consumers frequently paying the full list price for health care. Examples of charges include $24 for a pill that costs about 5 cents at a drugstore or $18 for a diabetes strip that can be bought on line for about 55 cents apiece. Chargemaster negotiations also leave insurance companies paying prices that far exceed the cost of the service because the starting price is artificially high for negotiations. Chargemaster billing practices are largely responsible for the million dollar profit margins experienced by hospitals, pharmaceutical companies, and medical devices companies.
- Hospitals are buying up other providers and hospitals. This consolidation makes it more difficult to negotiate percentage rates off chargemaster pricing

because larger hospital groups with substantial market share gain negotiating power.
- The U.S. has very high pharmaceutical costs compared to other countries. According to Brill, if we paid the same prices as other developed countries, the U.S. would save about $94 billion a year.
- Doctors may have incentives to use high cost medical devices. A growing number of physicians have a financial stake in medical-devices companies,including compensation arrangements through "stock options, royalty agreements, consulting agreements, research grants and fellowships".

Brill concludes that health care reform is about "facing the reality that our largest consumer product by far-one-fifth of our economy-does not operate in a free market."

Brill then outlines ways we could change our behavior. Such as:

- Tightening antitrust laws that relate to hospitals to keep them from becoming dominant in a particular region;
- Taxing hospital profits at 75% along with a tax surcharge on high nondoctor hospital salaries;
- Outlawing the current chargemaster system and create a better pricing system that is transparent;
- Limiting the amount that pharmaceutical companies can charge for "wonder drugs";
- Tightening or perhaps cap, what insurance companies can pay for imaging, for example, CT and MRI scans;
- Capping profits on lab tests done in house by hospitals or doctors

We recommend that you read this article and share it as widely as you can. This is a conversation that we need to have. CCLP will be coming back with more on our take on health care costs in the coming weeks. .

For more on this story:
Listen to a news story from NPR's Planet Money
See a behind the story interview with Steven Bill

Medicaid Expansion across the states:

New Jersey will expand

New Jersey Governor Chris Christie announced his intention to expand Medicaid to people under 133% of the Federal Poverty Level this week. Politico reported that Governor Christie said: "Accepting these federal resources will provide health insurance to tens of thousands of low-income New Jerseyans, help keep our hospitals financially healthy and actually save money for New Jersey taxpayers," ...estimating it would save state residents $227 million in the next fiscal year. According to Politico, Governor Christie also said that "Expanding Medicaid ... is the smart thing to do for our fiscal and public health". While Medicaid expansion had been largely a partisan issue, Governor Christie is the 8th Republican Governor to announce support for expansion. In other news this week, it looks like Alaska will not expand, at least for now.

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