

SAMHSA's Weekly Financing News Pulse: National Edition

National News

- HHS Announces High-Risk Pool Enrollment Exceeds 21,000; HHS Reports Health Reform Regulations Were Reviewed too Recently to Duplicate Review
- Update: ARC Announces Community-Based Substance Abuse Grant Recipients
- House Approves Military Construction Bill, Includes Funding for New VA Mental Health Center

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- MACPAC Finds 71 Percent of Medicaid Beneficiaries Enrolled in Managed Care Plans, Accounting for 21 Percent of Program Spending
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Around the Hill: Hearings on Health Financing

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National News

- **HHS Announces High-Risk Pool Enrollment Exceeds 21,000; HHS Reports Health Reform Regulations Were Reviewed too Recently to Duplicate Review:** On June 10, **U.S. Department of Health and Human Services** (HHS) officials announced that enrollment in the national health care reform law's high-risk health insurance pools reached 21,454 on April 30, up from approximately 18,000 in March. HHS officials originally anticipated that 375,000 individuals would have enrolled in the pools by the beginning of 2011. Beginning July 1, HHS will reduce premiums by up to 40 percent and simplify the application process in 18 of 24 federally-administrated high-risk pools as part of an effort to spur enrollment ([The Hill, 6/10](#); [Kaiser Health News, 6/13](#)). In other health care reform news, on June 13, HHS officials testified before the **U.S. House Energy and Commerce Subcommittee on Oversight and Investigations** that HHS will not review health reform regulations as part of their review efforts under **President Barack Obama's** executive order requiring federal agencies to conduct regulatory reviews. President Obama ordered the review to find federal regulations that can be streamlined or eliminated. HHS officials say they already reviewed health reform regulations before implementing them and that not enough time has elapsed to warrant an additional review ([The Hill, 6/13](#); [Kaiser Health News, 6/14](#)).
- **Update: ARC Announces Community-Based Substance Abuse Grant Recipients:** On June 2, the **Appalachian Regional Commission** (ARC) awarded a total of \$150,000 to 30 coalitions under its Competition for Community-Based Substance Abuse Initiative grants. Designed to address disproportionately high rates of substance abuse in Appalachian counties, particularly targeting prescription drug abuse, ARC provided the grants to counties deemed economically "distressed" or "at-risk." Under the program, awardees receive training, technical assistance, and \$5,000 each to expand their efforts to address substance abuse. Recipient organizations are located in: Alabama, Kentucky, Mississippi, North Carolina, New York, Ohio, South Carolina, Tennessee, Virginia, and West Virginia ([ARC, 6/2](#); [AP via The Republic, 6/8](#)).
- **House Approves Military Construction Bill, Includes Funding for New VA Mental Health Center :** On June 14, the **U.S. House** approved the **Military Construction and Veterans Affairs and Related Agencies Appropriations Act, 2012 (H.R. 2055)**. The bill would provide \$589 million for FY2012 military construction, a \$600 million reduction from current funding levels. The construction budget includes \$2.84 million to build a **U.S. Department of Veterans Affairs** (VA) mental health clinic in Fort Wayne, Indiana. The measure now goes before the **U.S. Senate Appropriations Committee** ([THOMAS; The Journal Gazette, 6/15](#)).

Studies Released

- **MACPAC Finds 71 Percent of Medicaid Beneficiaries Enrolled in Managed Care Plans, Accounting for 21 Percent of Program Spending:** On June 15, the **Medicaid and CHIP Payment and Access Commission** (MACPAC) released a [report](#) examining the use of managed care in Medicaid, finding that 71 percent of Medicaid beneficiaries are enrolled in managed care plans. However, the authors also determined that managed care plans account for only 21 percent of Medicaid spending, primarily because beneficiaries with the highest medical costs are not enrolled in managed care. In addition, the report found that the percentage of Medicaid beneficiaries enrolled in the most prevalent type of managed care plans, known as comprehensive risk-based managed care plans, rose from 15 to 47 percent between 1995 and 2009. The authors project that, as health reform is implemented, more high-cost beneficiaries will be enrolled in managed care plans to reduce costs through improved care coordination ([Modern Healthcare, 6/15](#); [Kaiser Health News, 6/16](#)).

- **CBO Projects Gradual Medicare Reimbursement Rate Increase Would Cost \$388 Billion Through 2021:** On June 14, the **Congressional Budget Office** (CBO) released a [report](#) projecting various cost estimates for plans to avoid a scheduled 29.4 percent Medicare physician reimbursement rate reduction on January 1, 2012. The CBO estimates that freezing rates at their current level and allowing a 34 percent cut to occur in 2013 would cost \$22 billion over 10 years. The authors estimate that 2 percent increases each year through 2021 would cost \$388 billion ([Kaiser Health News, 6/15](#)).
- **Commonwealth Fund Finds Publicly Traded Medicaid Managed Care Plans Spend Less on Care:** On June 15, the **Commonwealth Fund** released a [brief](#) comparing publicly traded Medicaid managed care plans with their non-publicly traded counterparts. The authors examined plans' financial stability, administrative expenses, and quality of care, finding that publicly traded plans spent less of their Medicaid revenue on medical care than non-publicly traded plans. Additionally, the Commonwealth Fund determined that publicly traded managed care plans spent more of their Medicaid revenue on administrative expenses than non-publicly traded plans. Publicly traded plans were also more likely than non-publicly traded plans to have lower quality of care indicators. The authors highlight the importance of these findings, noting that publicly traded managed care plans stand to gain a considerable share of Medicaid business under health reform ([The Commonwealth Fund, 6/15](#); [Kaiser Health News, 6/15](#)).
- **MedPAC Recommends Payment Changes to Improve Quality and Efficiency:** On June 15, the **Medicare Payment Advisory Commission** (MedPAC) issued the June 2011 [Report to the Congress: Medicare and the Health Care Delivery System](#), offering recommendations for reforming Medicare's payment system to improve quality and efficiency. Among other recommendations, MedPAC suggests bundling payments for related health services and directly linking payments to health service quality. The authors also offer recommendations for incentives to reduce excessive provision of health services under the current fee-for-service (FFS) reimbursement model. Finally, MedPAC proposes improving dual eligibles' care quality through more integrated and coordinated health services ([MedPAC, 6/15](#); [Kaiser Health News, 6/16](#)).
- **GAO Finds Annual Benefit Limit Waivers Most Common in Cases of High Projected Premium Rate Increases:** On June 14, the **Government Accountability Office** (GAO) released a [report](#) outlining the criteria federal officials used in determining whether to award waivers exempting health plans from the national health care reform law's minimum annual benefit requirements. The GAO determined that **Centers for Medicare & Medicaid Services** (CMS) officials awarded waivers in cases where plans would otherwise have significantly raised health coverage premiums or limited access to care. Examining a sample of 58 approved applications, GAO officials found that most projected a premium increase of at least 10 percent under the law's annual benefit requirement, while nearly 75 percent of a sample of 65 denied applications projected premium increases of 6 percent or less ([Kaiser Health News, 6/15](#); [Benefits Management, 6/14](#)).
- **AP Analysis Notes States With Highest Per Capita Medicaid Populations Among those With Highest Deficits:** The **Associated Press** (AP) has released an [analysis](#) of state budgetary developments, finding that states' projected revenue for FY2012 totals \$734 billion, down 5 percent from the fiscal year before the economic recession began. The authors note that states with the largest per capita populations of Medicaid beneficiaries were among those with the highest deficits as a percentage of

general fund revenue. The analysis also highlights a concern over states' future action in light of the end of federal stimulus funding that totaled \$316 billion, including increased **American Recovery and Reinvestment Act** (ARRA) Federal Medical Assistance Percentage (FMAP) funding ([Kaiser Health News, 6/13](#)).

Around the Hill: Hearings on Health Financing

House Energy and Commerce Subcommittee on Oversight and Investigations: *Views of HHS on Regulatory Overhaul*

June 13, 2:00 p.m. 2322 Rayburn

House Veterans' Affairs Committee: *Veterans' Mental Health Care*

June 14, 10:00 a.m. 334 Cannon

House Energy and Commerce Subcommittee on Health: *Patient Protection and Affordable Care Act Overview*

June 15, 3:00 p.m. 2322 Rayburn

House Energy and Commerce Subcommittee on Health: *Impact of IPAB on Medicare*

July 13, 9:00 a.m. 2123 Rayburn

House Appropriations Subcommittee on Labor, Health and Human Services, Education, and Related Agencies:

Fiscal 2012 Appropriations: Labor, HHS, Education

July 26, Time TBA. 2358-C Rayburn

House Appropriations Committee: *Fiscal 2012 Appropriations: Labor, HHS, Education*

August 2, Time TBA. 2359 Rayburn