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September 11, 2011

G.O.P. Senators in Albany Block Federal Aid to Fulfill Part of Health Law

By THOMAS KAPLAN

With 2.6 million uninsured residents, a popular Democratic governor and tens of millions of federal dollars at stake, New York would seem to be one of the least likely states to join a growing revolt in the nation's capitals against facilitating a federal overhaul of health care.

But several Republican lawmakers in New York, saying they do not want to have anything to do with what they call "Obamacare," have thus far succeeded in blocking the state from seeking large amounts of federal assistance to put into place a mandatory health insurance exchange — a state-run marketplace where individuals and small businesses can buy insurance.

State Senator Gregory R. Ball of Putnam County described his resistance as his duty as a Republican.

"I would fight very vociferously to make sure that we're not seen as implementing and expediting Obamacare," Mr. Ball said. And then, noting hopefully that President Obama could lose his re-election bid to a Republican who opposes the health care overhaul, he added, "We could be looking at a change of administrations."

Although Gov. Andrew M. Cuomo proposed creating the insurance exchange, and the State Assembly, with a Democratic majority, approved it, the Republican-controlled Senate refused to take it up before the Legislature adjourned its regular session at the end of June. Now, Republican lawmakers are balking at returning to Albany to consider the matter, as deadlines pass, and Mr. Cuomo, despite an unexpectedly harmonious relationship with Senate

Republicans, appears to be unwilling to force the issue at this time.

“The question isn’t whether to have a special session,” said Josh Vlasto, a spokesman for Mr. Cuomo. “The question is, do we reach an agreement? And that remains the question.”

Republicans in the State Senate have joined a chorus of conservative lawmakers in other states who are spurning millions of dollars in federal assistance rather than enacting legislation required to carry out the health care overhaul, known as the Affordable Care Act.

Since the act’s passage, only 13 states have approved legislation to set up exchanges, according to the National Conference of State Legislatures. Two additional states, Massachusetts and Utah, set up their own exchanges before the federal law was passed. In more than a dozen states, bills to that end were introduced this year but not acted upon.

In some places, governors have been blunt about their objections: Gov. Rick Scott of Florida, a Republican, has a general policy of rejecting federal grant money relating to the new health care law, which he does not plan to carry out. Several states have returned federal grants earmarked for use in setting up exchanges: Kansas last month gave back \$32 million, and Oklahoma returned \$55 million in April. And more than two dozen governors and attorneys general — all of them Republicans — have gone to court to challenge the law’s constitutionality.

Ross K. Baker, a professor of political science at Rutgers who has followed the development of the federal health care law, said it was important for the Obama administration to get exchanges up and running in large states like New York to show voters the fruits of the health care overhaul.

“This has got to set off some very loud alarm bells in the White House,” Professor Baker said of the objections in New York. “With a state as visible as New York, for the exchange to be obstructed is a very ominous sign for the ultimate implementation of the Affordable Care Act.”

New York has already received \$39 million in starter grants to begin planning a state health benefit exchange, which would function as a sort of one-stop shop for individuals and small businesses to compare the insurance plans that are available to them and enroll in one of them. The Congressional Budget Office estimates that, nationwide, 11.5 million people will get their

insurance through such exchanges when they start operating in 2014.

In the meantime, the federal Department of Health and Human Services has made available hundreds of millions of dollars to help states start up their exchanges, with quarterly deadlines this year for states to apply for the money and prove that they are proceeding with setting up their exchanges.

The next deadline is Sept. 30, and New York State is almost certainly going to miss it — to the chagrin of officials in the Cuomo administration.

In June, Mr. Cuomo and legislative leaders agreed to create the structure of the exchange. That would let the state seek more federal financing — perhaps \$50 million to \$100 million more. Mr. Cuomo said the state's exchange would "protect consumers and help bring down the cost of health care for families, businesses and taxpayers."

But the negotiated bill was tabled by lawmakers after several Senate Republicans insisted that carrying out the federal health care law deserved a more extended discussion than was possible in the final 48 hours of the legislative session. When the bill was discussed in a closed-door meeting of Senate Republicans, "people were starting to go, 'Oh, wait a minute, is this Obamacare?'" one lawmaker said.

The bill was also met with concern in the Assembly, which ultimately approved it. The floor debate featured a discussion about whether the federal health care law created "death panels," and several Republican lawmakers criticized the president.

"I will not support forcing a back-door form of Obamacare upon the people of this state," said Assemblyman Al Graf, a Republican from Suffolk County.

Now, health care groups and Democratic lawmakers are growing more nervous that the state could lose the chance to have the federal government shoulder the cost of setting up the exchange.

"What may end up happening here is, if you kick the can, you may end up kicking it off the cliff," said Blair Horner, a vice president of the American Cancer Society of New York and New Jersey, which says the exchanges will better enable cancer survivors to get insurance.

Lawmakers cannot duck the health care law simply by not setting up the exchange. If by 2013 the federal government does not believe a state is making adequate progress in building the health marketplace, it will set up the exchange itself. Some New York Republicans have argued that the so-called deadlines mean little, and do not justify taking action without more debate.

Democrats in the State Senate have urged the majority leader, Dean G. Skelos, a Long Island Republican, to call lawmakers back to Albany to enact the exchange bill before the next deadline. But a spokesman for Mr. Skelos said Sunday that the Senate had no plans to return to the capital this year.

If lawmakers do not return before the next legislative session begins in January, they will miss another federal deadline, Dec. 30. After that, they will have two more financing rounds to seek additional money, with deadlines of March 30 and June 29.



Appeals court shoots down Virginia's healthcare challenge

By Sam Baker - 09/08/11 12:11 PM ET

A federal appeals court on Thursday dismissed one of the highest-profile challenges to President Obama's healthcare reform law.

The 4th Circuit Court of Appeals said Virginia Attorney General Ken Cuccinelli (R) does not have a legal right to sue over the law's requirement that most people buy insurance. The court vacated a lower court's ruling in the case and instructed the lower court to dismiss the suit.

The Supreme Court is almost certain to have the final say on whether the coverage mandate is constitutional. Most legal observers expect the court to hear arguments during the term that begins in October, and rule in the summer of 2012.

The 4th Circuit's long-awaited decision isn't a huge surprise: those who attended oral arguments in the suits said the judges seemed skeptical of the mandate's critics, especially Cuccinelli. All three of the judges who heard the case were appointed by Democratic presidents, and two were appointed by Obama.

The mandate has a mixed record in federal appeals courts. The 6th Circuit upheld the requirement in a June decision, while the 11th Circuit — which heard the high-profile challenge filed by 26 state attorneys general — ruled that the mandate is unconstitutional.

Unlike those 26 states, Cuccinelli sued on the grounds that enforcing the mandate would violate Virginia law. As Congress moved closer to passing healthcare reform, Virginia enacted a law that says state residents can't be forced to purchase insurance.

But the 4th Circuit panel said Virginia does not have standing to sue over the mandate because it lacks a "personal stake" in the issue.

The judges seemed concerned during oral arguments that allowing his suit to proceed would essentially allow the states to exempt themselves from whatever federal laws they might choose.

Source:

<http://thehill.com/blogs/healthwatch/legal-challenges/180231-appeals-court-dismisses-key-challenge-to-healthcare-law->

THE HILL



Supercommittee's task makes healthcare advocates nervous

By Sam Baker - 09/12/11 06:00 AM ET

Months of intense lobbying (and rampant speculation) will reach its next level this week — the first full week back in Washington for the deficit-cutting supercommittee.

Healthcare interests are already making their pitches to the 12-member panel tasked with finding at least \$1.2 trillion in deficit reduction by Thanksgiving. Because healthcare was largely spared in the debt-ceiling deal and because the supercommittee's failure to perform its task would trigger an automatic Medicare cut, just about every sector of the health industry is at least a little bit scared of this process.

Some, of course, would benefit from the supercommittee's failure — Medicaid would be protected from the automatic cuts triggered if the panel can't reach an agreement. Others are far more afraid of the automatic 2 percent cut to Medicare. But no one wants to be cut, and everyone is at risk somehow.

Aside from the letters and other advocacy efforts that are likely to keep pouring in this week, the Alliance for Healthcare Reform will hold a briefing Monday on Capitol Hill to discuss what deficit reduction means for healthcare. Clinton administration healthcare adviser Chris Jennings and Bush adviser Gail Wilensky are among the speakers.

Also on the Hill, Sen. Orrin Hatch (R-Utah) and other lawmakers will join the U.S. Chamber of Commerce at a press conference Wednesday to criticize the healthcare law's employer mandate.

The Energy and Commerce health subcommittee has scheduled a hearing Thursday on the regulations issued under healthcare reform.

Off the Hill, America's Health Insurance Plans will keep folks busy with a full week of conferences. AHIP's Medicare conference runs Monday and Tuesday, followed by a Medicaid conference Wednesday and Thursday, and an exchanges conference Thursday and Friday.

Speakers over the course of the three events include Health and Human Services's Jonathan Blum and Melanie Bella, who leads the newly created office for dual-eligible beneficiaries, as well as a panoply of senior insurance industry executives. HHS's Tim Hill, who took over a big part of Joel Ario's portfolio implementing health exchanges, is scheduled to speak Friday.

The Healthcare Information and Management Systems Society is holding its annual conference this week in Washington. "Health IT Week" begins Tuesday with a press conference at the Capitol.

Source:

<http://thehill.com/blogs/healthwatch/health-reform-implementation/180695-supercommittees-task-makes-healthcare-advocates-nervous>

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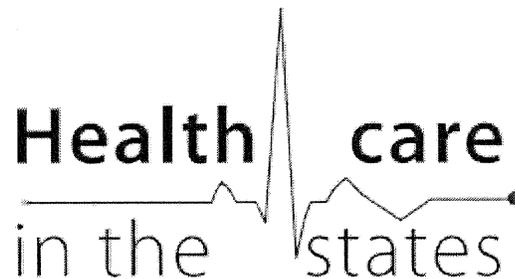
TOP STORY

TUESDAY, SEPTEMBER 06, 2011

High-risk health care plans fail to draw crowd

By Christine Vestal, Stateline Staff Writer

Throughout the rancorous public debate over the national health law, two provisions have maintained broad public support. One is the requirement that insurance companies let young adults up to age 26 remain on their parents' policies. The other is a federally subsidized insurance plan for people whose medical conditions make them uninsurable in the private market.



Covering young adults has been a resounding success. As of April 2011, more than 600,000 were included in their parents' health plans. The Obama administration predicts 1.2 million will be covered by year's end.

But the health law's lifeline for sick people who can't get insurance anywhere else has been a virtual nonstarter. A year into the program, only 21,000 out of an estimated 25 million uninsured people with "high-risk" conditions such as cancer, heart disease and diabetes have signed up. When the law was enacted last year, administration officials projected enrollment would reach 375,000 and many worried that funding would run out. So far, only 2 percent of the \$5 billion subsidy has been spent.

The high-risk program was intended to be a bridge to 2014, when state-run health insurance exchanges will offer affordable coverage for everyone, regardless of health status. Speculation varies as to why it has been slow to take off.

The biggest sticking point, according to a new report from the U.S. Government Accountability Office, is that only people who have been uninsured for at least six months are eligible. Congress added that provision to limit the number who would qualify. Others say the cost of premiums in the high-risk pool—though generally lower than for other available policies—is still too high for most patients to afford.

Cost is clearly the biggest deterrent, says Amie Goldman, chair of the National Association of State Comprehensive Health Insurance Plans. State officials who have run their own high risk insurance programs for decades continually struggle with the problem. Sick people cost more to cover, but you still have to offer benefits that they can afford, Goldman says.

Even in Pennsylvania's high-risk program, where monthly premiums of \$283 are among the lowest in the country, spokeswoman Rosanne Placey says nearly 10 percent of subscribers drop out of the state plan every month. "They call us and say they can't afford to keep making the payments." State officials who have had this experience are not at all surprised that the Obama administration's effort has attracted little interest.

State vs. federal

When the federal government announced its high-risk insurance program in April 2010, states were asked to choose whether they wanted to run their own plans or let the federal government do it. Pennsylvania and 26 other states elected to run their own programs and set their own rates; 23 states and the District of Columbia opted for the federal plan, in which rates are equal to the market price for healthy people. More than a year later, one thing is clear. The state-run plans have been more successful than the federal program, at least relatively speaking. States have garnered more than 15,000 subscribers; the feds have signed up just 6,000.

Pennsylvania—which has 3,700 subscribers, the biggest enrollment in any state high-risk program—offers a good example of why state-run operations have worked better than the federal effort.

The first thing Pennsylvania officials did was email some 20,000 individuals and groups who had previously participated in a state health insurance plan that had lost its funding. Next they produced low-cost radio and Internet advertisements and created print brochures that lawmakers and agency staff handed out when they appeared before audiences. They also worked with hospitals and other health care providers to spread the word. If someone showed up in an emergency room with a qualifying condition and no insurance, they were signed up.

Pennsylvania's plan is also one of the simplest. The premium is the same regardless of a person's age.

New York is the only other state with just one price. Most state-run programs have more than 20 different prices; North Carolina and Ohio have more than 50. Pennsylvania makes signing up easy. The application is online and it takes no more than 10 minutes to fill out.

“People thought we were some kind of marketing geniuses,” says Placey, of Pennsylvania's high-risk insurance program, PA Fair Care. “HHS (the U.S. Department of Health and Human Services) told states to call us for advice.”

But Pennsylvania had another advantage over other states. It was offering something new. Unlike 35 other states, Pennsylvania had never created a program for people whose medical conditions made them uninsurable.

Legacy plans

Wisconsin, for example, has run a high-risk insurance pool for nearly 35 years. With only slightly higher priced premiums, the state's old pool has 21,000 members and grew by 18 percent last year. The new pool—which Wisconsin runs out of the same office—has only 547 clients. Maryland also had a pre-existing pool with more than 20,000 subscribers. Even after hiring a marketing firm to help boost enrollment for the federally subsidized program this year, Maryland's new plan has only 348 subscribers.

States have been developing high-risk insurance programs for people rejected by private insurers since Minnesota launched the first experiment back in the 1970s. Premium costs for

New high-risk insurance plans: not many takers

Top states in enrollees:

1. Pennsylvania, 3,191
2. California, 1,858
3. Texas, 1,528
4. North Carolina, 1,302
5. Illinois, 1,261

Bottom states in enrollees:

1. Vermont, 0
2. Massachusetts, 1
3. North Dakota, 9
4. Maine, 14
5. District of Columbia, 21

Enrollment numbers as of April 30, 2011.
Source: U.S. Government Accounting Office

these plans vary widely from state to state and are higher than under the new plans funded by the Affordable Care Act. In most cases, states supplement revenue from premiums with insurance industry contributions to cover higher than average claims costs. A few states contribute general revenues and require medical providers to chip in.

Nationally, enrollment in the old state high-risk pools totals 223,000, with individual numbers ranging from 27,000 in Minnesota to 238 in Florida.

According to Goldman, the biggest reason the older state pools continue to grow is that they don't require people to have been uninsured for six months. Instead, people can sign up as soon as they lose coverage, but have to wait a number of months to get coverage for their high-risk conditions. Few people who are in an older state plan want to take the risk of leaving it, because they're afraid to wait six months to get federally subsidized insurance.

Another likely reason people are slow to join the new plans is that once they've waited for six months without insurance, they know they can get coverage as soon as they sign up. There's little reason to pay the premiums in advance of getting sick. That's why claims costs for the new plans have exceeded actuarial predictions in some states. Colorado, New Hampshire, Oregon and Washington, for example, have had low enrollment but excessive costs, because new enrollees have tended to need hospital stays right away and haven't put any money into the programs.

In May of 2011, HHS tried to fix some of the start-up problems. It dropped a requirement that applicants produce a rejection letter from an insurance company and opted for a simple doctor's note. HHS also reduced premiums by an average of 20 percent, with reductions as high as 40 percent in some states. Earlier in the year, grants were awarded to states, media outlets, consumer groups, health care providers, and others to increase awareness of the program.

HHS officials point out that other federally subsidized health plans—even free ones such as Medicaid and the 1997 Children's Health Insurance Program—took years to build enrollment.

But the difficulty in reaching people with serious medical conditions may signal a bigger problem. If sick people without insurance are slow to sign up for a subsidized health plan, how will states fare in 2014 when they try to entice 46 million healthy people to plunk down a portion of their paychecks for health insurance? The controversial "individual mandate" will require people to have a policy or pay a fine. But the cost of the fine will still be far cheaper than the premiums.

—Contact Christine Vestal at cvestal@stateline.org

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By Linda Lyons on Sep 7, 2011 4:50:21 PM

I am one of the high-risk people. I currently have health insurance but I will be laid off at the end of the month. My COBRA for my husband and myself will be \$1,700 a month. That is more than I make on unemployment. If I want to sign up for the High-risk plan instead of COBRA the payments will be \$1,792. How can I possibly afford that. In order for people to sign up for these plans, they have to be affordable to people who cannot get coverage through work or are unemployed. I believe that most people would rather have insurance than charity but it has to be within their reach. The high-risk plan in California at least is not within anyone's reach.

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POLITICO

Poll: Uninsured don't understand law

By: Jennifer Haberkorn
August 29, 2011 12:24 PM EDT

About half of the uninsured Americans who stand to benefit the most from the health care reform law aren't aware of how the legislation is designed to help them buy insurance, according to a new poll released Monday.

The Kaiser Family Foundation's monthly health tracking poll found that 47 percent of the uninsured said the law "won't make much difference" to them. Another 14 percent said the law would hurt them. Only 31 percent said they thought the law would help them.

Nearly half of the uninsured don't know about the law's tax credits for low- and middle-income people. Another 53 percent don't know about the law's Medicaid expansion.

"Experts who have advocated for expanded coverage for decades probably envision the uninsured sitting around the kitchen table anxiously awaiting the implementation of coverage expansions under the ACA," Drew Altman, president and CEO of the Kaiser Family Foundation, wrote in a column about the survey. "But surprisingly, only three in ten of the uninsured say the ACA will help them get health care."

The coverage expansion isn't due to go into effect until 2014, but Altman says people are unlikely to be truly aware of the benefits until up to two years later. The figures reflect the struggle supporters of the law will have in getting the word out to consumers who can benefit from it.

President Barack Obama and congressional Democrats focused much of their "pitch" for the health law on the benefits for the uninsured. They frequently cited the Congressional Budget Office estimate that the law would insure 32 million Americans. But since the law's passage, some have criticized that pitch, insisting that they should have focused instead on the benefits for the middle class and those who already have coverage.

Altman said the figures do not reflect a communications failure. He says busy people — particularly those struggling to afford insurance now — will only understand the law when it becomes tangible for them.

"When there is real insurance coverage available for people who don't have it, they will be more aware of it, and they will be able to render a judgment about whether coverage is affordable for them," Altman said.

The law's least popular provision — the requirement that nearly all Americans have to buy insurance — remains one of its most recognizable. About 65 percent of Americans know about the provision, the poll found.

The poll also found that public opinion of the law has fallen slightly.

Thirty-nine percent of Americans have a favorable view of the law — it's the first time the monthly poll has slid below 40 percent since the law's passage in March 2010. Forty-four percent of Americans have an unfavorable view of the law.

But the partisan undertones for and against the law may be softening slightly. Twenty-four percent of Republicans polled reported favorable views of the law — more than the poll has ever found. And 60 percent of Democrats reported favorable views — the lowest figure the poll has ever recorded. Thirty-three percent of independents have favorable views of the law, which is consistent with what the poll has recorded in the past.

This article first appeared on POLITICO Pro at 12:21 p.m. on August 29, 2011.

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McClatchy Washington Bureau

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Posted on Thu, Sep. 01, 2011

S.C. Gov. Haley to reject federal health insurance exchange funds

Gina Smith | The State (Columbia, S.C.)

last updated: September 01, 2011 07:49:24 AM

Gov. Nikki Haley said she will let federal deadlines slip by and not accept millions in federal funds to help South Carolina set up its own health insurance exchange.

Health insurance exchanges, the centerpiece of federal health care reform, are online marketplaces, to be set up by each state, where the uninsured could compare insurance plans from private insurance companies and buy the one that best fits their needs. Uninsured people who meet certain federal poverty guidelines could buy coverage using federal tax credits.

The exchanges are scheduled to open in 2014 when the health care law goes into full effect. If a state has not made progress by Jan. 1, 2013, the federal government will step in.

But Haley and Tony Keck, whom Haley appointed to head the state's Department of Health and Human Services, say the federal plan is not the right fit for South Carolina.

"The governor remains an equal opportunity opponent of ObamaCare, the spending disaster that South Carolina does not want and cannot afford," said Rob Godfrey, Haley's spokesman. "She and Tony Keck are focused on finding South Carolina solutions that provide our state with the most health at the least cost."

Democrats say Haley is playing politics with an important issue that affects millions of South Carolinians. Other Republican governors, including Texas Gov. and GOP presidential candidate Rick Perry, also are saying they will not accept the money.

"If South Carolina would put half the effort into figuring out how to do this versus being opposed to it, we would be light years ahead in making sure people could get health care coverage they need," said Rep. Gilda Cobb-Hunter, D-Orangeburg, who sponsored a bill this past session to set up a state health exchange.

"Governor Haley and all these people spouting the rhetoric have good health coverage," Cobb-Hunter said. "The people who don't have a place at the table, their voices are not being heard."

Twenty-one percent of South Carolinians under age 65 are not insured, according to a 2004 survey by the state Department of Insurance, meaning they do not have

private insurance or public insurance such as Medicaid or Medicare. An updated study is being conducted now for the department.

Keck said his opposition to applying for the money is that federal rules for the new exchanges are still not clear. And that's making officials in many states hesitant to accept money and agree to yet-to-be-determined rules and regulations.

To read the complete article, visit www.thestate.com.