



# HEALTH POLICY

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*By Matt Sundeen, Senior Program Officer for Health Policy, The Colorado Trust*

As an odd-numbered year, with no planned elections for national or state political offices, 2011 easily could have been an “off year” for political and policy issues likely to affect The Colorado Trust’s mission and vision. That was not the case as 2011 was marked by numerous state and national events that could have significant ramifications for the health and well-being of Coloradans. This brief summarizes key policy activity for October, November and December, including election results, Affordable Care Act (ACA) developments, the state and national fiscal debate and political events. It also provides a preview for events likely to shape health policy in the coming months.

### 2011 ELECTION RESULTS

In the November general election, Colorado voters overwhelmingly rejected a statewide ballot initiative that would have had implications for state revenues and could have affected state funding for health care. If it had passed, Proposition 103 would have returned sales and income tax rates to 1999 levels, raising state sales tax rates from 2.9% to 3% and state income taxes from 4.63% to 5% for a five-year period. It was estimated that the measure would generate nearly \$536 million a year to be used to support K-12 and higher education. Although the proposal was not directly linked to health care, in theory the extra money dedicated to education might have freed additional general fund resources for other programs, including those more directly linked to health care.

Although the primary organization backing Proposition 103, Support Schools for a Bright Colorado, raised nearly \$200,000 for its campaign and received several key endorsements from unions and nonprofit advocates, the initiative lost by a significant margin. Statewide, fewer than 36.8% of voters supported this measure, with 63.2% of voters against. In 63 of Colorado’s 64 counties, voters rejected the measure, with only Boulder County voters supporting it.

Among the factors that contributed to its demise was that Proposition 103 failed to gain traction with some of the key constituencies that worked together to successfully pass Referendum C in 2005 and defeat Amendments 60 and 61, and Proposition 101 in 2010. Most notably, the Denver Metro Chamber of Commerce remained neutral, and Governor John Hickenlooper maintained his campaign position that there was “no appetite” for new taxes in Colorado. Some more progressive organizations argued that Proposition 103 was regressive, creating an unfair tax increase for poor families. Others argued that the measure did not go far enough to solve the state’s fiscal condition. In the end, the lack of unanimity created a mixed message for voters. Although the approximately \$200,000 proponents raised for the campaign dwarfed amounts raised by the opposition, it was not nearly enough to mount a significant statewide campaign. By comparison, the campaign organized against the initiatives in 2010 spent well over \$2 million, and received support from a broad coalition of community leaders and organizations. Nationally, Proposition 103 was the only tax increase on a statewide ballot, and it was watched closely to gauge

voter interest and potential support for such measures. Although 2011 elections in other states did not directly affect health care policy for Coloradans, several elections were watched as possible predictors of the future. Most notable was a ballot measure in Ohio that challenged the ACA. Voters there approved Issue 3, a constitutional amendment that preserved the right to choose health care coverage. Although federal law preempts state law and the measure will not block implementation of the ACA in the state, some pundits viewed the victory as an indicator of voter opposition to federal health care reform.

Also significant were several special elections to fill vacated positions. Results in these elections were evenly split. Republicans won special elections for vacancies in the U.S. House of Representatives from districts in New York and Nevada. A Democrat won the special election for the West Virginia governor's office, and another won a U.S. House seat in New York. Although both political parties trumpeted their successes as precursors to next year's election, it's difficult to draw conclusions based on the results.

### AFFORDABLE CARE ACT UPDATE

As the ACA nears its two-year anniversary, its future continues to be shaped by vital policy work occurring nationally and in Colorado. Key developments in October, November and December included decisions in several significant ACA lawsuits and progress in Colorado's ongoing implementation of its health benefits exchange.

#### Legal Decisions

Since President Obama signed the ACA in 2010, opponents have filed approximately 30 lawsuits to challenge various components of the law. Collectively, the ACA lawsuits have provided a comprehensive challenge. They involve a variety of plaintiffs, including individuals, states, associations, universities, foundations and businesses, and were filed in federal courts located in 18 states and the District of Columbia. Although the lawsuits have attacked several different aspects of the ACA, the main focus has been the individual mandate provision. Plaintiffs have argued in most cases that Congress stepped outside its authority under the Commerce Clause of the U.S. Constitution by requiring individuals to purchase health care insurance under the law.

Many lawsuits have been withdrawn by plaintiffs or dismissed based on lack of standing or other procedural or jurisdictional concerns. When courts have reached decisions on the merits, most have ruled in favor of the ACA. The most recent decision on the merits was made in November. In the closely watched case of *Susan Sevensky v. Holder*, in which numerous interested parties filed amicus curiae briefs for both sides, the D.C. Court of Appeals upheld a district court opinion that the Act was constitutional. So far, there are two active cases where the current controlling opinion is that the individual mandate is unconstitutional. Both of those opinions are under appeal, and neither decision will block implementation before 2014. In the remaining cases, the most current judicial opinion favors the defense.

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Most legal experts have long-predicted that the U.S. Supreme Court ultimately would determine the ACA's fate. The Supreme Court resisted several early attempts to fast-track decisions about the law, preferring to allow the appellate process to unfold first. Now that federal appeals courts in the 3rd, 4th, 6th, 11th and D.C. circuits have issued opinions in six different ACA cases, with decisions also pending in the 8th and 9th circuits, the Supreme Court has decided it will hear two appeals of a case decided by the 11th Circuit, *Florida v. U.S. Department of Health and Human Services (DHHS)*.

Perhaps the highest-profile challenge to federal health care reform, *Florida v. DHHS*, was filed in a Florida District Court mere minutes after President Obama signed the Patient Protection and Affordable Care Act on March 23,

2010. The lawsuit includes as plaintiffs 26 states, including Colorado, the National Federation of Independent Business and two individuals. In January, the district court judge ruled that the individual mandate provision of the ACA was unconstitutional and, as a consequence, the entire Act was invalid.

In August, a three-judge panel for the 11th Circuit of the Federal Court of Appeals **agreed** (<http://www.uscourts.gov/uscourts/courts/ca11/201111021.pdf>) that the individual mandate portion of the ACA was unconstitutional. However, differing from the district judge, the panel also found that the individual mandate was severable from the remainder of the law. Both sides appealed the decision and on November 14 the Supreme Court announced it would consolidate both appeals and hear the case. In its orders, the court announced it would consider four key arguments about the law: the constitutionality of the individual mandate; its severability from the ACA; Medicaid expansions made under the law; and the applicability of the Anti-Injunction Act. Underscoring the importance of the case, the court announced it would devote five hours for oral arguments in March, departing from the standard one hour. A decision is expected in June 2012.

### Colorado Health Benefits Exchange Implementation

Several significant developments in the last quarter of 2011 likely will affect Colorado's continuing development of its health benefits exchange. On September 30, Colorado's Legislative Health Benefits Exchange Implementation Review Committee voted not to submit a \$22 million, Level-One grant application to the DHHS to support the continued growth of the exchange. The 10-member legislative committee is evenly split between Republicans and Democrats from the House and Senate, and requires a majority vote for approval of items under consideration. Republicans on the committee objected to language in the application they felt would bind the state more closely to the ACA, and bipartisan concern was voiced about the proposed compensation packages for exchange employees included in the application. The Health Benefits Exchange Board of Directors has reworked the application; it plans to resubmit it to the committee for approval this month. If the committee decides not to approve the new proposal, the exchange likely would have insufficient funding to continue operations next year. The committee will meet on December 7 and 15 to discuss the matter.

In October, Joan Henneberry left as the director of the health insurance exchange when the federal planning grant that funded her work expired. The board of directors started a search for an executive director; in November it announced it had selected Patty Fontneau as the finalist. The Legislative Health Benefits Exchange Implementation Review Committee will review the selection in December. If it gives its approval, the exchange board will finalize the terms of employment with the new executive director.

The Colorado Health Benefit Exchange Board of Directors also has elected officers, selecting Gretchen Hammer, who had been interim chair, as chair, Richard Betts as vice chair and Arnold Salazar as secretary.

## STATE & FEDERAL FISCAL DEBATE

Health policy in Colorado continues to be affected by both state and national fiscal issues. In November, the governor **submitted** (<http://www.colorado.gov/cs/Satellite?c=Page&childpagename=OSPB%2FGOVRLayout&cid=1251608971702&pagename=GOVRWrapper>) his proposed FY 2012-2013 budget to the legislature. The budget includes substantial increases for Medicaid and CHP+ spending to adjust to expanding caseloads. The proposed budget also makes cuts to other state health care services programs, including reductions in general fund spending for school-based health centers and cuts to the Colorado Department of Public Health and the Environment.

Nationally, in November, the "super committee" established by the Budget Control Act of 2011 announced it had been unable to identify recommendations for \$1.2 trillion in deficit reduction measures required by law. The committee's failure will trigger an automatic sequestration of \$1.5 trillion in spending cuts, evenly divided between defense and domestic programs. Although Medicaid officially is protected from the automatic

sequestration, the committee's failure and the potential effects on military spending have generated new discussions about federal entitlement programs that have included Medicare and Medicaid. Additional federal funding cuts also could affect ACA implementation, including funding for state health insurance exchanges, health insurance exchange subsidies, Medicaid expansions and community health centers.

### POLITICAL ISSUES

Two key political issues continue to loom over policy discussions in Colorado: the redistricting plans for congressional districts and the reapportionment process for state legislative districts. In theory, the state legislature is empowered to draw new maps for congressional districts following each census. Last session, however, with control of the General Assembly split between Republicans and Democrats, lawmakers were unable to agree to a redistricting map. Both parties filed lawsuits and submitted competing redistricting plans to the courts for a decision. After a trial in October, the chief judge of the Denver District Court selected a map drawn by Democrats that makes several districts more competitive, including most notably a normally safe Republican seat currently held by U.S. Representative Mike Coffman. After an appeal, the Colorado Supreme Court in December upheld that decision.

A second key political issue is the ongoing reapportionment process to define state legislative districts. The Colorado Constitution gives authority to draw state legislative districts after each census to an 11-member reapportionment commission. Four commission members are appointed by the state legislature, three are appointed by the executive branch, and four are appointed by the judiciary. No more than six members may be affiliated with the same political party. Colorado's 2011 reapportionment commission included five Democrats, five Republicans and one unaffiliated member. In November, the commission selected district maps considered favorable to Democrats. After a review, the Colorado Supreme Court rejected the commission's initial plan. Democrats and Republicans then submitted new plans to the commission. Late in November, in a contentious 6-5 vote, the commission selected new maps for reapportionment, which had been favored by Democrats. The plan was submitted to the Colorado Supreme Court for review on December 6.

Although redistricting and reapportionment do not directly affect Colorado's health policy, both processes will have short-term and long-term political implications for the state. In the short-term, the decisions could further exacerbate partisan tensions in the legislature and make it more difficult for either party to pass meaningful legislation in 2012. In the long-term, the decisions could influence party control of the state legislature and the composition of Colorado's congressional delegation.

### 2012 HEALTH POLICY ISSUES

While difficult to predict policy events far in advance, in 2012 it appears that significant issues with health policy implications will continue to surface, in Colorado and nationally. However, much of the health policy focus likely will be outside the state General Assembly or in Congress.

In Colorado, the initial deadline for state legislators to request bills for the 2012 session was December 1. According to legislative rules, members may not introduce more than five bills without approval from leadership. Of the five requested bills, no more than two can be introduced after December 1. From initial reports, it appears that few lawmakers are considering bill proposals with significant or direct repercussions for health care in the state. Many analysts believe that the legislature's focus will be primarily on the state general fund budget. These fiscal discussions will affect state health programs, and lawmakers may be forced to cut spending in areas important for the health and well-being of Coloradans. But it appears unlikely that the legislature will pass any new health-related programs in 2012 that might have negative budget implications for the state.

Nationally, 2012 is an election year with control of the U.S. House of Representatives, Senate and presidency at stake in November. In this highly charged partisan environment, it seems nearly impossible that Congress and the President would agree to new health care policies that could create positive outcomes for the health and well-being of Coloradans. However, because the ACA was highly partisan and has been a focal point of attacks against President Obama and Democrats in Congress, it is likely health care will be a topic for discussion by lawmakers and a subject for federal legislation throughout the election year. Additionally, ongoing debate about the federal budget deficit and budget will continue to have implications for federally funded health care programs.

Outside of Congress, other federal policy work will continue in 2012 that will have significant implications for Colorado. Although the future status of the ACA remains uncertain, federal agencies are continuing to develop new rules for key aspects of the law, including rules to guide the formation of the state and federal health benefit exchanges.

The U.S. Supreme Court, in addition to hearing ACA-related challenges, is expected to issue a ruling next year regarding the rights of providers and Medicaid recipients to sue states when they cut Medicaid payment rates to address budget concerns. States that participate in Medicaid agree to pay providers at rates that are sufficient to ensure that care available to Medicaid clients is similar to care available for other area residents. Under current practice, DHHS alone is to evaluate the sufficiency of state provider payment rates and take action when rates dip too low. In three California cases, providers and Medicaid recipients challenged whether the sole enforcement authority rests with DHHS, and argued that private entities have the right to sue to enforce federal law.

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The case could have significant implications for the provision of Medicaid in this country. If private entities can challenge state decisions to cut provider rates, it would open the door to multiple lawsuits and could force many states to increase provider payments or withdraw from the Medicaid program entirely. Many states and the Obama administration oppose the idea of private lawsuits to challenge the sufficiency of provider payments, but the U.S. Court of Appeals for the 9th Circuit disagreed, ruling that such lawsuits were constitutional.

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**NOTE:** *The Colorado Trust supports policies, systems and programs to achieve access to health for all Coloradans. To help inform work that is vital to its mission, The Trust monitors, analyzes and reports about key national, state and local policy issues, and current events that can affect the health and well-being of all Coloradans. As part of those efforts, this Health Policy Brief is produced throughout the year, and is available online at [www.coloradotruster.org/health-policy](http://www.coloradotruster.org/health-policy).*



**THE  
COLORADO  
TRUST**

1600 SHERMAN STREET  
DENVER, CO 80203-1604  
[WWW.COLORADOTRUST.ORG](http://WWW.COLORADOTRUST.ORG)

**PHONE** 303-837-1200  
**TOLL FREE** 888-847-9140  
**FAX** 303-839-9034