
Health Reform Update – Weeks of Jan 28 and Feb 4, 2013

CONGRESS

CBO adjusts estimates for Medicare spending, ACA expansion, and penalties

New estimates from the Congressional Budget Office (CBO) found that Medicare outlays grew by just three percent in fiscal year 2012, the slowest rate in more than decade, and are expected to grow by only four percent in 2013. As a result, the overall federal budget deficit will shrink from over \$1 trillion last year to \$845 billion in fiscal 2013, its lowest level as a percentage of the economy since 2008.

These estimates downgrade figures released last summer that already showed a decline in Medicare and Medicaid spending growth for the third straight year (see Update for Week of August 22nd). CBO continues to attribute the slowdown to an overall decline in the utilization of health service during and since the recession that started in late 2007. However, they also speculate that changes in how providers have paid have kept spending growth down since the recession ended in 2009.

The slowdown is likely to lower Medicare spending by \$126 billion and Medicaid spending by \$78 billion, as compared to 2010 estimates. These numbers are likely to lead Democrats to press for smaller Medicare reductions as part of the ongoing negotiations to avert across-the-board budget cuts slated for March 1st (see above). However, CBO noted that adding expenses for the premium and cost-sharing subsidies under the Affordable Care Act (ACA) to national health outlays will still likely cause them to exceed six percent of gross domestic product by 2023.

CBO also now projects that as a result of states opting out of the Medicaid expansion under the ACA, only 12 million uninsured will gain Medicaid coverage, down from 17 million last summer (Kaiser Family Foundation has estimated that over 21 million would gain Medicaid coverage if all states expanded). In addition, CBO predicts many exchanges will not be ready by January 1st, forcing two million fewer than anticipated to gain coverage through the exchange in 2014. However, it still estimates that roughly the same number (26 million) will purchase coverage from an exchange by 2022.

CBO also now predicts that more employers will opt to pay \$13 billion more in penalties for not providing minimum essential coverage that is affordable. This will in turn cause three million more workers to lose their employer-based coverage and be instead be eligible for premium subsidies to purchase coverage in the new health insurance exchanges.

Premium tax credits under the ACA could be huge, per CBO

According to a report issued last week by the Congressional Budget Office (CBO), premium tax credits offered under the Affordable Care Act (ACA) could amount by 2021 to roughly 13 percent of the \$864 billion in total health insurer revenue for 2011.

Congress made the premium tax credits “refundable”. This is a key distinction from ordinary tax credits that are subtracted directly from what a taxpayer owes the government. If an ordinary tax credit results in a negative number, the taxpayer does not pay taxes or could apply the amount to next year’s tax bill. However, when “refundable” credits produce a negative tax obligation, the government pays that negative amount to the taxpayer.

Because “refundable” tax credits are more politically palatable than “handouts” such as the Food Stamp or Medicaid programs, Congress has increasingly relied upon them. For example,

the Earned Income Tax Credit program and child tax credit program will generate about \$125 billion in “refundable” tax credits this year, according to CBO. The report found that “refundable” premium tax credits under the ACA could lead to about \$35 billion in credit costs in 2014 and \$110-213 billion in total refundable credit costs in 2021.

Private health insurers are expected to generate much higher premium revenue in 2021 than in 2011, but, if consumers had spent an additional \$110 billion in health insurance in 2011, that would have increased their revenue by about 13 percent.

The ACA lets individuals request an advance on the premium assistance tax credit that they expect to collect, so that they can use the amount to pay for health coverage in 2014. The Internal Revenue Service will send the advance payments directly to health insurers, while the ACA limits how much individuals have to pay back if tax credit amount winds up being larger than credit for which the individual actually qualified during the year.

Latest “doc fix” legislation buoyed by dramatically lower cost estimate from CBO

House Democrats and Republicans renewed their push this week for a permanent repeal of the Sustainable Growth Rate (SGR) formula, which cuts Medicare physician payment by nearly 27 percent.

The high cost of a permanent repeal has sidelined past efforts to eliminate the 1997 SGR formula, which has instead been delayed every year by Congress through short-term fixes, the most recent of which will expire at year’s end (see Update for Weeks of December 24th and 31st). However, the latest estimate released this week by the Congressional Budget Office (CBO) slashed the ten year cost by nearly half (down to \$138 billion).

Reps. Allyson Schwartz (D-PA) and Joe Heck (R-NV) reintroduced past legislation this week (H.R. 574) that would replace the SGR formula with a temporary system of physician pay raises, followed by a transition to a more efficient payment methodology. Leaders from the Energy and Commerce Committee and Ways and Means Committee also released similar frameworks, reflecting broad bipartisan agreement that physician reimbursement needs to move away from inefficient fee-for-service.

AARP slams Republican bill to loosen Affordable Care Act limits on age rating

The nation’s largest senior citizen lobby is fighting back this week against legislation that would relax new limits on how much insurers can vary premiums based on age.

Under the Affordable Care Act (ACA), plans can charge older subscribers no more than 300 percent the amount charged for young subscribers, or a 3:1 age rating band. However, Rep. Phil Gingrey (R-GA) insists that the 5:1 ratio most commonly used by states better reflects the difference in health costs by age groups and would prevent premiums from spiking for younger subscribers.

As a result, Rep. Gingrey introduced H.R. 544 this week, which would allow states to determine their own age rating band. If states fail to do so, the legislation would impose only a 5:1 band. It has already attracted one Democratic cosponsor, Rep. Jim Matheson, whose state of Utah has the youngest median age in the nation.

Gingrey cited the study circulated last month by America’s Health Insurance Plans showing that a 3:1 age rating band would increase individual plan premiums for those aged 21-29 by 42 percent, as insurers will have to make up losses on older subscribers by hiking rates for younger populations (see Update for Week of January 7th). He noted that even the Congressional Budget Office projected a 10-30 percent hike for younger populations prior to passage of the ACA.

AARP called the measure a “huge step backwards”, emphasizing that it would impose “astronomical” premiums on those age 50-64 who do not qualify for Medicare and lose employer coverage. They countered with a Kaiser Family Foundation brief demonstrating that for more than 80

percent of younger subscribers, the costs imposed by the 3:1 age rating band would be more than offset by the benefits the ACA provides, such as broader, more comprehensive coverage and new premium and cost-sharing tax credits to help low-to-moderate income Americans afford coverage.

Because any legislation to relax the age rating band is unlikely to pass the Senate, insurers have instead focused on pushing the Centers for Medicare and Medicaid Service (CMS) to phase-in the lower 3:1 band to minimize the spike in premiums for younger subscribers. At a conference attended last week by PSI Government Relations, the Center for Consumer Information and Insurance Oversight (CCIIO) within CMS stressed that the proposed rules from the agency had already allowed insurers to increase premiums for every year of a person's life, instead of only every five or ten years (see Update for Week of November 21st and 28th). As a result, the agency stated that any further concessions were unlikely.

Senate Democrats renew effort to protect consumers from medical debt

A group of Senate Democrats are renewing legislation that would protect the credit scores of consumers from being harmed by medical debt that has been satisfied.

Senator Jeff Merkley (D-OR) introduced S.160 last week, which would require credit bureaus to delete reports of any delinquent medical debt not exceeding \$2,500 within 45 days after it is resolved. This is the third time the bill has been introduced. It languished last year both the Senate Banking Committee and House Committee on Financial Institutions and Consumer Credit, despite the support of the American Medical Association, Consumers Union, and other prominent stakeholders.

FEDERAL AGENCIES

Proposed rules expand exemptions from individual mandate

The departments of Health and Human Services (HHS) and Treasury issued proposed regulations last week that will expand the number of individuals exempt from the new federal requirement that everyone buy health insurance they can afford.

The Affordable Care Act (ACA) provides nine categories of exemptions from the individual mandate (see Update for Week of January 21st). The rule seeks to minimize the number subject to the tax penalty for non-compliance largely by expanding the exemption for economic hardship, which is defined by regulation and not the statute.

The rule would most dramatically reduce this number by codifying HHS' earlier commitment that those earning below 133 percent of federal poverty level who do not qualify for Medicaid in their states would qualify for the hardship exemption. The U.S. Supreme Court decision allowing states to opt-out of the Medicaid expansion under the ACA without penalty had created a huge subset of people who would not qualify for Medicaid in opt-out states but would be ineligible for the law's premium and cost-sharing subsidies to help them comply with the mandate (see Update for Week of June 25th).

However, HHS did ask for public comment on whether this exemption should only be lowered to 100 percent of FPL, which is the level at which ACA subsidies are available.

HHS and Treasury will also allow individuals to satisfy the individual mandate for an entire month, even if they only had minimum essential health insurance for a single day within that month. Similarly, anyone that meets an exemption for one day of a month will be exempt for the entire month. (The tax penalties are calculated on a month-by-month basis starting January 1st).

Contrary to claims by many conservative opponents, Treasury also emphasizes that the Internal Revenue Service (IRS) will not be allowed to file a notice of lien or levy on a taxpayer's property for failing to comply with the individual mandate, nor can taxpayers be subject to any criminal penalties. The rule also allows HHS and the IRS flexibility to grant further exemptions for economic hardship "on a case-by-

case basis for individuals who face other unexpected personal or financial circumstances that prevent them from obtaining coverage."

Under the rule, the exchanges will bear the responsibility of verifying whether an applicant meets one of the nine ACA exemptions. It clarifies that those enrolled in self-funded student health insurance, state high-risk pool coverage, Medicare Advantage plans, or foreign health coverage will not be deemed to have minimum essential coverage and not be subject to the individual mandate.

HHS noted in the rule that the broader exemptions are likely to lower the Congressional Budget Office (CBO) estimate last fall that six million people (or less than two percent of Americans) would actually be subject to the tax penalty. However, CBO predicted this week that IRS will collect \$11 billion less in tax penalties from the individual mandate due not only to the broader exemptions under the proposed rule but lower incomes for most Americans.

Consumer advocates insist that IRS definition of affordability will leave 1.7M children uninsured

The Internal Revenue Service (IRS) issued a final rule last week that greatly disappointed consumer advocates who believe it severely limited the number of large group subscribers who can qualify for the premium and cost-sharing subsidies under the ACA.

The law makes employees eligible for these subsidies if the cost of coverage offered by a large employer exceeds 9.5 percent of their annual income. IRS was deluged with public comments urging them to allow this affordability standard to be based on family income and not just the income for the employee. However, they insisted in the final rule that the ACA gives them no latitude to do so.

The Government Accountability Office has found that at least 1.7 children may remain uninsured due to this "overly-restrictive" definition of affordability (see Update for Weeks of July 23rd and 30th).

CMS releases overdue regulation governing drugmaker payments to physicians

The Centers for Medicare and Medicaid Services (CMS) released long-awaited final regulations this week that implement the physician payment "sunshine" provisions of the Affordable Care Act (ACA).

Proposed regulations from 2011 outlined procedures for how drug and device manufacturers will have to disclose all consulting fees, travel reimbursements, research grants and other gifts with values over \$10 that they give to physicians and teaching hospitals. Those that fail to comply could face up to a \$1 million fine (see Update for Week of December 12, 2011).

However, Congressional authors of the bipartisan provision have been irate that CMS has repeatedly missed the statutory deadlines for both proposed and final regulations (see Update for Week of January 7th). As a result, manufacturers will not have to start collecting payment data until August 1, 2013, instead of the January 1, 2012 sought by Congress. In addition, the final rule delays until March 31, 2014 the date that such data must be reported to CMS.

The final rules make clear that manufacturers are required to report all payments for services covered by any federal health program. They also explicitly state that the ACA "sunshine" provision pre-empts any similar state laws. A 45-day "review and correction" period will allow physicians time to ensure the accuracy of any disclosures to CMS. Data reported to CMS will ultimately be posted on a public website to ensure full transparency.

While groups like Pew Charitable Trusts praised the new rules, the American Medical Association (AMA) and other physician groups have been far less enthusiastic. A survey released this week by MMIS Inc. showed that 63 percent of the 1,000 physicians fear the public disclosure of these payments, while at least half were still unaware of that the new rules were forthcoming. The survey also showed that more than half financially benefit from some kind of industry-sponsored program.

CMS delays Basic Health Plan option under the Affordable Care Act

The Centers for Medicare and Medicaid Services (CMS) announced this week that the Basic Health Plan (BHP) option under the Affordable Care Act (ACA) will not be available to states until one year before the full law goes into effect on January 1, 2014.

The ACA provides states with additional federal funding should they choose to create a Basic Health Plan for those earning between 133 and 200 percent of the federal poverty level (FPL) that do not qualify for Medicaid but would still have trouble affording any exchange plan even with the ACA's premium and cost-sharing subsidies. The BHP would also give this population the advantage of not having pay back part of these subsidies should their income and eligibility change during the year. However, only a handful of states have explored this option due to fears that shifting this population away from the exchange will make it more difficult for exchanges to be financially self-sustaining by 2015, as the ACA requires (see Update for Week of July 25, 2011).

CMS officials acknowledge that the backlog of ACA regulations has left it short of time to get the BHP program up and running before 2014. The agency still intends to issue BHP rules later this year and start the program on January 1, 2015.

The delay puts states like Iowa, Massachusetts, Minnesota, New York, and Washington in limbo because their existing versions of the BHP that do not comply with ACA standards were scheduled to end before the ACA fully kicks-in. Minnesota Governor Mark Dayton (D) has negotiated a preliminary waiver with CMS that would allow his state to continue its MinnesotaCare program until 2015.

Tavener re-nominated to be permanent CMS administrator

President Obama nominated Marilyn Tavener for a second time this week to serve as the permanent administrator for the Centers for Medicare and Medicaid Services (CMS).

If confirmed as expected by the Senate, Tavener would be the agency's first permanent administrator since 2006. She has served as the agency's acting administrator since late 2011, when the recess appointment of Donald Berwick expired. Dr. Berwick was a political lightning rod who never received a confirmation hearing from the Finance Committee due to previous comments that Republicans claim endorsed rationing of health care (see Update for Weeks of November 21 and 28, 2011).

Tavener likely never received a confirmation hearing since assuming the post due to the certain politicization any nomination to head the Medicare and Medicaid agency would draw in an election year. However, the former hospital industry executive has the support of several key Republican Senators including Orrin Hatch (R), and is not likely to stoke the same flames of opposition as Berwick.

ACA deadline extended for required employer notices

The Employee Benefits Security Administration (EBSA) announced last week that employers will not be required to notify employees by March 1st of the existing of state health insurance exchanges and premium tax credits, as initially required by the Affordable Care Act (ACA).

These notice requirements will instead be delayed until the necessary federal regulations and guidance are issued by the departments of Treasury, Labor, and Health and Human Services. The EBSA also notes that it will consider allowing employers to satisfy the notice requirement by simply providing employees information based on the employer coverage template found in the preamble of recently-issued proposed regulations. That template would be available at relevant state exchange websites.

STATES

Six Republican governors will seek to participate in Medicaid expansion, eight others undecided

Governors in Ohio and Michigan became the fifth and sixth Republicans to break ranks this week and propose that their state participate in the Medicaid expansion under the Affordable Care Act (ACA), while several counterparts indicated that they would drop their opposition if granted key concessions.

Despite slightly retreating last month from his strident opposition (see Update for Week of January 14th), the decision by Ohio Governor John Kasich (R) still surprised conservatives since he initially claimed the expansion would “bankrupt” his state by imposing up to \$2.3 billion in new costs by 2018. However, he acknowledged this week that those claims were overinflated by assuming every newly-eligible citizen would actually enroll (see Update for Week of April 4, 2011) and that the \$1.4 billion the Ohio State University predicts the state will save by 2022 was simply too much to ignore (see Update for Week of January 14th). In addition, Governor Kasich agreed with hospital groups that they could ill-afford the higher uncompensated care costs that would result from opting-out.

While the expansion was part of the Governor’s two-year budget proposal unveiled this week, he has an uphill climb convincing his Republican-controlled legislature, as Medicaid already covers one in five Ohioans and is the single largest program in the state’s current budget. As a result, Kasich followed the lead of Arizona Governor Jan Brewer (R) (see Update for Week of January 14th) by including an automatic opt-out should the federal government fail to fulfill its requirement under the ACA to fund 100 percent of the expansion through 2016 and at least 90 percent thereafter. He also proposes to create a new cabinet-level Medicaid Department charged with furthering his two-year project to remove barriers that “impede innovation”, such as streamlining care coordination for the disabled and elderly, as well as collapsing the state’s 150 different Medicaid eligibility categories into only three groups.

Pennsylvania Governor Tom Corbett (R) used his annual budget address this week to join with a dozen other Republican governors in rejecting the expansion, despite studies by the Urban Institute and Kaiser Family Foundation projecting that Pennsylvania would receive a \$35 billion windfall by 2022 if it agreed to participate. Governor Corbett echoed the theme of the Republican Governors Association that the federal government can simply not be trusted to provide the promised funding.

However, several Republican governors have taken a different approach by trying to use the Medicaid expansion as leverage to extract concessions. Florida Governor Rick Scott (R) appeared to condition his decision to federal approval of the state’s Medicaid managed care expansion (see below). New Indiana Governor Mike Pence (R) stated this week that he would only seek to participate if Indiana was allowed to use health savings accounts for the expansion, even though Indiana’s House Ways and Means chairman is planning to include the expansion as part of next year’s budget. And Governor McDonnell was supported by his Senate in his position that Virginia’s participation be contingent on federal permission to hike Medicaid cost-sharing and redesign benefit packages (see below).

Tennessee Governor Bill Haslam (R) has taken a similar approach to McDonnell’s though he had to temporarily delay proposed legislation that would tie his hands by prohibiting any Medicaid expansion. South Dakota Governor Dennis Daugaard (R) was able to block similar legislation, although new North Carolina Pat McCrory (R) appears unable to do so (see below). The Wyoming Senate also rejected the expansion last week.

Eight governors remain undecided, although each is expected to announce their decision when scheduled later this month to present their budget plans to their respective legislatures. New Jersey Governor Chris Christie (R) and Scott Walker (R) are considered the most likely to support expansion given the relatively broad Medicaid eligibility in each state. However, each has refused to tip their hand despite intense pressure from state hospital and provider groups to expand.

Louisiana Governor Bobby Jindal (R) remained adamant this week that he would not reverse his decision to opt-out of the expansion, despite petitions from 44 consumer and provider groups.

Commonwealth Fund, CCIIO warn of state inactivity on consumer health reforms

Only 11 of states have implemented the new consumer protections under the Affordable Care Act (ACA), according to a new report released last week by The Commonwealth Fund.

The study found that 39 states have yet to enact laws or regulations on seven critical reforms, including definitions of essential health benefits, bans on pre-existing condition denials and coverage waiting periods, and limits on age rating, gender rating, and out-of-pocket costs. Only Connecticut has passed legislation addressing all seven of reforms, while California has enacted six of seven and is currently addressing the guaranteed issue requirement in special session (see Update for Week of January 21st.) Nine other states (Arkansas, Maine, Maryland, New York, Oregon, Rhode Island, Utah, Vermont and Washington) have enacted laws or regulations for at least one of these reforms.

Citing the report, the federal Center for Consumer Information and Insurance Oversight (CCIIO) warned states that this week that the ACA requires them to implement these provisions, regardless of whether they choose to create a state-based health insurance exchange authorized by the new law. At a conference attended by PSI Government Relations, the CCIIO director emphasized that federal regulators would assume the responsibility for enforcing the ACA's consumer safeguards in states that fail to act by January 1st.

Biotech firms lobbying for state legislation to limit cheaper biosimilars

Some of the nation's largest manufacturers of biologic drugs are lobbying state lawmakers for bills that will slow down the introduction of lower-cost biosimilar copies.

Food and Drug Administration (FDA) guidance issued last winter (see Update for Week of February 6, 2012) sought to implement the regulatory pathway for biosimilar alternatives created by the Affordable Care Act (ACA). However, at least two companies, Amgen and Genentech, as well as the Alliance for Safe Biologic Medicines, are proposing state legislation that would restrict the ability of pharmacists to substitute biosimilars under this guidance.

These bills have already been introduced in at least eight states this session, with Genentech-proposed bills clearing at least one committee in Indiana and North Dakota. An Amgen-backed bill also overwhelmingly passed at least one chamber last week (the Virginia House of Delegates). Generic drug companies and health insurers have countered with their own amendments or legislation.

While the bills proposed by brand name companies largely expand state substitution laws, they also impose restrictions that do not apply to non-biologic products and go beyond the FDA guidance. For example, several would require patient notification or consent for the substitution of a biosimilar product by the pharmacist (see S.B. 190 in Texas), as well as notification of the prescribing physician. They also would mandate that records of any switch be maintained for several years.

Sponsors of such legislation, such as Pennsylvania Senator Patricia Vance (R), a registered nurse, and Virginia Delegate John O'Bannon (R), a neurologist, insist that the additional restrictions are needed to ensure patient safety.

Generic drug groups generally do not oppose provisions that limit substitution to biosimilars declared interchangeable by the FDA. However, they insist that any restrictions imposed once FDA makes that determination are unnecessary and intended solely to deter substitution.

Consultants with Avalere Health noted that some of these substitution restrictions could run afoul of the ACA, as the law defines interchangeability to mean that a biosimilar can be substituted without the involvement of the prescribing doctor.

Connecticut

Committee passes bill to require selective contracting for health insurance exchange plans

The Joint Committee on Insurance and Real Estate narrowly passed legislation this week (S.B. 596) that would require the new Connecticut Health Benefits Exchange to follow the "active purchaser" model allowed by federal regulations.

Exchanges in several states including California and Maryland are seeking to be active purchasers that can exclude otherwise qualified health plans because of price. This form of selective contracting (already in place in Massachusetts) contrasts with the more passive "clearinghouse" alternative allowed by federal rules, where the exchange must allow any qualified plan to participate.

Florida

Governor hints that expanding Medicaid depends on federal approval of full managed care waiver

Governor Rick Scott (R) announced this week that the federal government has approved the first of two demonstration waivers related to Florida's expansion of Medicaid managed care to all enrollees.

The three-year waiver allows Florida to start transitioning its 87,000 elderly and disabled Medicaid enrollees into managed care as of July 1st. The Governor previously indicated that Florida Medicaid will move these long-term care beneficiaries in stages, adding 1-2 regions of the state each month through March 2014. Enrollees can choose from among at least two capitated HMOs in each region.

Three HMOs won most of the lucrative market (American Eldercare, Sunshine State Health Plan and United Healthcare), while two others (Coventry and Amerigroup) will compete only in some regions.

Florida moved all Medicaid enrollees from five counties into capitated HMOs under an initial demonstration waiver that expired in 2011. The state has been operating the five-county demonstration under an approved waiver extension while it awaits the Obama Administration's decision on whether to allow Florida to move all enrollees statewide into HMOs (see Update for Week of August 1, 2011). The Centers for Medicare and Medicaid Services (CMS) delayed a decision pending negotiations over additional safeguards that would prevent the access and quality problems that arose during the initial demonstration (see Update for Week of September 19, 2011).

Governor Scott fired off a letter this week to CMS urging prompt approval of the remaining waiver request. He also strongly hinted that his decision whether to participate in the Medicaid expansion under the Affordable Care Act (ACA) could hinge on whether CMS allows all Florida Medicaid beneficiaries to be enrolled in managed care plans.

Republican lawmakers have increasingly signaled a willingness to consider expanding Medicaid, as recent projections from Georgetown University's Health Policy Institute showed Florida could save up to a \$100 million per year by participating (see Update for Week of January 7th). Polls by the American Cancer Society also showed that over 63 percent of Florida voters support the expansion. House and Senate committees formed to study ACA implementation are scheduled to make their recommendations when the legislative session opens in March (see Update for Weeks of December 3rd and 10th).

Minnesota

Brokers could be paid directly by insurance carriers under exchange amendment

The Senate Commerce committee handed insurance brokers a victory last week in a long-simmering debate over their role in the new health insurance exchange.

The amended bill passed by the committee (S.F. 1), would allow brokers who sell exchange policies to be paid directly by insurance carriers, though brokers would have to disclose the payment arrangement to consumers. (The original bill withheld a portion of premiums paid and then decide how

much to pay the brokers.) Senator Tony Lourey (D), the bill sponsor, is also seeking to require that brokers get additional training about data security and tax provisions in the Affordable Care Act (ACA).

The exchange is being created pursuant to an executive order from Governor Mark Dayton (D) (see Update for Week of October 31, 2011). However, it ultimately will require authorizing legislation to be operational. The Governor must sign such legislation by March 31st in order for it to be enacted in time to start open enrollment as scheduled in October 2013.

S.F. 1 has already passed three committees since Democrats assumed control of both chambers last month. Republicans blocked two similar bills last session (see Update for Week of November 5th).

If enacted as proposed, the legislation would create a seven-member board to oversee the marketplace. They would be paid \$55 a day plus expenses, although the chair of the Local Government committee, is trying to increase compensation to \$30,000 per year. Another change in the bill would require all board members to be appointed by the governor and confirmed by the Senate. Republican lawmakers have previously refused to make their designated appointments (see Update for Week of November 5th). However, several now support both the Senate measure and its H.F. 5 counterpart, which has also cleared three committees.

Bill sponsors project that the exchange will serve one of every five Minnesotans, or more than 1.2 million residents, as well as nearly 200,000 small businesses. They also estimate that purchase exchange coverage will save the average family \$500 and a lower-income family \$1,800. Small employers would see roughly a 7.5 decrease in premiums.

The Budget Department launched a new website last week for the health insurance exchange at <http://www.mn.gov/hix>.

New Hampshire

Commissioners for insurance and health departments urge federal partnership exchange

The Insurance Commissioner and Health and Human Services Commissioner recommended last week to Governor Maggie Hassan (D) and the legislature that the state initially partner with the federal government on a health insurance exchange that complies with the Affordable Care Act (ACA).

Governor Hassan has thus far stuck with her predecessor's decision to default to federal control after Republicans passed legislation last session blocking any state implementation of the exchange (see Update for Week of April 30th). She can still apply for an initial partnership by the February 15th federal deadline (as have eight other states), although she may still have difficulty persuading the Senate, which remains under narrow Republican control (see Update for Week of November 5th).

The two commissioners are urging that she enter into either a plan management partnership or a consumer assistance partnership. Under the former, the state would simply regulate and resolve complaints about exchange plans. Under the latter, the state would help individuals and businesses learn about and access the exchange.

North Carolina

Senate Republicans vote to block Medicaid expansion, health insurance exchange

Despite the strong objections of new Governor Pat McCrory (R), Senate Republicans pushed through legislation this week that would bar the creation of a state health insurance exchange that complies with the Affordable Care Act (ACA), as well as participation in the law's Medicaid expansion.

If also enacted by the House with full Republican support, the measure will likely force the Governor to default instead to a fully-federal marketplace, as the Republican supermajority can override any veto. House Speaker Thom Tillis (R) supports the legislation, but has agreed to "take some time" in bringing the measure to a vote in order to address the Governor's concerns.

Governor McCrory had urged lawmakers not to tie his hands with the legislation (S.B. 4), which he warned could ultimately jeopardize federal funding not just for a future exchange but also for current Medicaid information technology upgrades. However, Senate Republicans wanted to send a strong message to the Obama Administration that the states and not the federal government should be able to best decide how to provide health care to its residents.

Former Governor Bev Perdue (D) had declared her intent to apply for an initial federal-state exchange partnership before she left office (see Update for Week of November 5th). It is not yet clear if Governor McCrory will be able to follow-through and submit the required partnership application by February 15th, as S.B. 4 prevents the state from even pursuing a partnership. The bill would also require North Carolina to return the \$74 million in ACA grants that Governor Perdue obtained.

Governor McCrory also warned of “serious financial ramifications” if North Carolina was unable to participate in any future expansion of Medicaid under the ACA. The North Carolina Institute of Medicine had projected that participating would bring the state 18 times more revenue than the \$138 million per year it would cost to expand (see Update for Week of November 5th). By contrast, opting-out could dramatically increase uncompensated care costs for North Carolina hospitals that will start losing federal payments for indigent care in 2014.

Utah

Governor seeks bifurcated exchange partnership, instead of fully ACA-compliant model

Governor Gary Herbert (R) withdrew Utah’s exchange blueprints this week that had sought to upgrade his state’s health insurance exchange in order to comply with the Affordable Care Act (ACA).

The outcome is not altogether surprising as the Governor had insisted up until the December 14th federal deadline that he would not upgrade the seven-year old exchange, called Avenue H (see Update for Weeks of November 19th and 26th). Utah’s version of an exchange does not comply with the ACA as it serves only small businesses and not individuals. It also does not automatically enroll applicants in other state programs for which they may be eligible, such as Medicaid.

However, Utah’s state exchange was federally-certified contingent upon the Governor’s blueprints that sought to fully upgrade the exchange instead of default to full federal control (see Update for Weeks of December 24th and 31st). He has been unable to win legislative support from the Republican-dominated legislature for a state-based exchange, and as a result has been negotiating with the Obama Administration on a split partnership, whereby Utah’s small business exchange would remain federally-certified and under state control, while the exchange would only be under federal control for those in the individual marketplace. The Governor is also proposing that all Medicaid eligibility determinations remain under the control of the state’s Department of Workforce Services instead of Avenue H.

Virginia

House and Senate seek to retain control over rate review in federal health insurance exchange

The Senate passed legislation last week that would give the State Corporation Commission the authority to certify health benefit plans that will participate in the federally-operated health insurance marketplace that will start operating in Virginia on January 1st.

The measure (S.B. 922) specifically seeks to allow Virginia to retain control over reviewing the rates charged by participating health plans. Its sponsor, Senator John Watkins (R), had sought to authorize Virginia to create a state-based exchange or enter into an initial federal partnership exchange. However, Governor Bob McDonnell (R) has thus far ruled out either option, choosing instead to default to the fully-federal model (see Update for Week of January 1st).

The Governor has yet to take a position on S.B. 922 or its counterpart (H.B. 1769) that passed the House this week and is now pending in Senator Watkin’s Commerce and Labor committee. It is not

yet clear that the Obama Administration would approve the arrangement, even if approved by the Governor. Both measures specifically do not authorize the Governor to apply for the federal exchange partnership by the February 15th deadline.

The House also passed several other bills directed at the exchange, which is estimated to serve up to 500,000 Virginians. H.B. 2138 would create a health insurance reform commission to monitor implementation of the ACA, determine whether and how to create an exchange, and define the essential health benefits package, while H.B. 1900 would align Virginia insurance law with new consumer protections in the ACA, such as guaranteed issue, essential health benefits, and limitations on premiums. Both the House and Senate also passed legislation that would the function that can be performed by navigators within the exchange (H.B. 2246 and S.B. 1261).

Virginia Senate clears way for expedited Medicaid expansion, with a catch

The Virginia Senate voted this week to allow the Department of Medical Assistance Services to proceed with expanding Medicaid coverage to 400,000 Virginians on January 1st, but only if the commonwealth can obtain federal waivers to reform how Medicaid delivers and pays for care.

The surprise move was the result of an amendment sought by Senate Finance health subcommittee chairman Emmett Hanger (R) to the budget bill (S.B. 800). The amendment was an effort to break a budget stalemate that Democrats in the evenly-divided Senate threatened to force if the chamber did not vote to participate in the Medicaid expansion under the Affordable Care Act (ACA).

However, Senate Finance chairman Walter Stosch (R), who authored the amendment, cautioned that it does not actually expand Medicaid, but instead merely provides a path forward. The measure creates a Virginia Health Reform and Innovation Fund, which would invest more than \$500 million in projected budget savings over the first five years of Medicaid expansion as a hedge against more than \$700 million in higher state costs in the following five years.

Governor Bob McDonnell (R) continues to resist the Medicaid expansion, but has left the door open to participating should the Obama Administration agree to grant Virginia more flexibility under a demonstration waiver to hike cost-sharing, redesign benefits, and simplify program administration. The approved budget amendment appears to reflect this position (see Update for Week of January 14th).

Recent estimates showing that participating in the expansion would bring Virginia more than \$584 million in savings by 2022 compelled Lt. Governor Bill Bolling (R) last week to drop his opposition so long as the Obama Administration allows other Medicaid reforms. Senator Hanger likewise stated this week that “the positives [of expanding] are beginning to significantly outweigh the potential concerns.”

Health and Human Resources Secretary Bill Hazel, MD and a coalition of health care advocates testified last week that delaying the expansion after January 1st would cost Virginia roughly “\$5 million a day in federal spending and \$400,000 a day in state-budget savings.” Hazel and Stosch sought to allay concerns that the federal funding would not materialize by recommending that Virginia follow the lead of Arizona and Ohio (see above) by including a “trigger”, which in this case would scale back the expansion if the federal match fell below 85 percent.

Budget bills would limit state employee hours to avoid ACA mandates and penalties

Embedded within the budget bills that passed both the Senate and House this week are provisions that limit part-time state employees to no more than 29 hours per week, in any effort to avoid the mandates and penalties under the Affordable Care Act (ACA) that apply to full-time workers. The move would save the commonwealth up to \$110 million per year according to the Governor’s office.