

Health Reform Update – Week of July 11, 2011

CONGRESS

House Republicans hold hearings to push repeal of Medicare cost-saving commission

The House Budget Committee and Energy and Commerce Committee held lengthy hearings this week on whether to repeal one of the most controversial provisions in the Affordable Care Act (ACA).

The new health insurance reform law creates a 15-member Independent Payment Advisory Board (IPAB) to make recommended cuts whenever Medicare spending exceeds certain targets after January 2014. The recommendations would automatically go into effect if Congress fails to implement them or pass equivalent offsets.

The IPAB has become a political lightning rod as House Republicans claim it is a form of “Soviet-style central planning” that would ration care to those on Medicare. They immediately made repealing the IPAB a legislative priority upon assuming control of the House last January.

However, a handful of Democrats have signed-on to their repeal legislation (H.R. 452) as they also are concerned about Congress ceding control over Medicare spending cuts to a non-elected commission and claim that the ACA already sufficiently restrains rising costs. Rep. Allyson Schwartz (D-PA), a former health care executive, even testified in support of repeal, though she emphasized that the panel would not ration care as Republicans claim. Many of the nation’s most powerful lobby groups for seniors, physicians, providers, and pharmaceuticals are also supporting the measure.

Health and Human Services Secretary Kathleen Sebelius was the featured witness at both hearings and staunchly defended the IPAB as a critical tool to curb costs. Republicans and business groups insisted that unelected bureaucrats on IPAB would have an “unrelenting focus” solely on spending cuts, without taking into consideration issues like the high up-front costs of new technology that need to be reflected in Medicare payments. They claimed that Congress would often be unable to stop IPAB recommendations, which would disrupt and reduce access to care if not responsive to “outside concerns.”

The Secretary emphasized that IPAB was needed specifically to insulate the rate-setting process from partisan politics and “outside concerns”, stressing that the 60 votes needed to move Senate bills now renders Congress unable to make necessary cuts to sustain Medicare viability. She also noted that the ACA explicitly bars IPAB from cutting benefits and eligibility, or raising premiums and cost-sharing.

The Secretary insisted that the IPAB was merely a “safeguard” and “backstop mechanism” to encourage Congress to act, and still gives Congress the final say over any Medicare spending cuts. However, Republicans warned that it would morph into a “Terminator” that Congress would be powerless to stop, noting that President Obama has already proposed expanding the IPAB’s authority in his fiscal year 2012 budget by lowering the spending targets that would trigger IPAB recommendations.

Sebelius and committee Democrats also used the hearing to criticize Republicans’ plan to convert Medicare into vouchers that would give private insurers instead of Congress control over Medicare spending and benefits, as well as the ability to greatly increase out-of-pocket costs for enrollees.

Negotiations on debt ceiling, fiscal year 2012 spending remain at an impasse

President Obama and Congressional leaders plan to continue negotiations through the weekend on a compromise that would raise the nation’s debt ceiling and reduce the federal deficit.

The negotiations grew especially contentious this week as the President was unable to secure any Republican support for this \$4 trillion deficit reduction package, which includes spending cuts, entitlement reforms, eliminating certain corporate tax breaks and subsidies, and a one percent tax hike for the wealthiest Americans.

However, Republicans were adamantly opposed to any compromise that included additional tax revenues and Democrats including former Speaker Nancy Pelosi (D-CA) objected to the President's plan to slowly increase the Medicare eligibility age to 67 by 2036 (a move that would save nearly \$125 billion by 2021 according to the Congressional Budget Office). As a result, by week's end it appeared the only potential compromise was a short-term procedural deal that would allow the President to incrementally increase the debt ceiling over 18 months while allowing all Republicans to vote on a "measure of disapproval" that the President could veto.

Senate Majority Leader Harry Reid (D) asked Minority Leader Mitch McConnell (R-KY) to reconsider the Republicans' earlier rejection of the President's proposal to form a joint bipartisan committee that would draft their own deficit reduction plan. However, Republican leaders continue to push a package that would cut Medicare and Medicaid by \$334-353 billion (as compared to the \$80 billion in cuts proposed by Senate Democrats). The Republican cuts would include raising premiums for higher-income Medicare enrollees and cut prescription drug spending for military dependents covered under TriCare by \$17 billion.

Lawmakers face an August 2nd deadline to raise the \$14.3 trillion debt ceiling or risk defaulting on federal government obligations, a move that could increase interest rates, tighten credit markets, and limit critically-needed federal funding to states.

NAIC will not endorse bill to protect broker fees under new insurer payout standards

The executive committee for the National Association of Insurance Commissioners declined this week to follow a task force recommendation to endorse Congressional legislation that would preserve the role of insurance agents and brokers under the Affordable Care Act (ACA).

Led by Florida Insurance Commissioner Kevin McCarty (R), the task force had voted to recommend that NAIC support H.R. 1206, which would define commissioners and fees paid to brokers as medical expenses instead of administrative expenses (see Update for Weeks of June 27th and July 4th). The distinction is significant as the ACA requires that individual and small group plans spend at least 80 percent of premium revenue on medical care as of the 2011 plan year (85 percent for large groups). Task force members had insisted that H.R. 1206 was necessary, since insurers were already eliminating or trimming broker fees in order to limit their administrative expenses under the new law.

However, Commissioner McCarty acknowledged that H.R. 1206 has "no realistic chance" of passing the Democratically-controlled Senate and agreed to table the measure. NAIC typically does not endorse specific legislation.

Bipartisan legislation would repeal ACA limits on flexible spending accounts

House and Senate lawmakers introduced bipartisan legislation this week to remove unpopular restrictions on tax-exempt health spending accounts imposed by the Affordable Care Act (ACA).

The bill would repeal Section 9003 of the new law, which since last January has barred the use of medical savings accounts for non-prescription medications. The prohibition was added in order to keep the overall price-tag of the ACA under \$1 trillion, as it was estimated to save \$5 billion over ten years.

However, the prohibition has proven very unpopular with those who frequently use Flexible Spending Arrangements and Health Savings Accounts. Initially introduced by Senator Olympia Snowe

(R-ME), it also has had the unintended effect of increasing health service utilization as patients are increasingly seeing physicians solely to obtain a prescription for over-the-counter (OTC) medications.

Senators Ben Nelson (D-NE) and Pat Roberts (R-KS) sponsored the Senate version (S.1368), while Reps. Lynn Jenkins (R-KS) and Shelley Berkley (D-NV) sponsored the House version (H.R. 2529). The White House is currently not opposing either bill. Previous Republican-backed legislation to repeal the identical provision (S.312/H.R.605) has not moved since being introduced last February.

Over 35 million Americans rely on medical saving accounts, while roughly 19 million use them to purchase OTC medications.

Bipartisan legislation would give states share of Medicaid savings for using generic drugs

Senators Scott Brown (R-MA), Ron Wyden (D-OR), and John McCain (R-AZ) introduced bipartisan legislation this week that would give Medicaid programs incentives to take advantage of the savings that can be achieved through greater use of generic drugs.

The Generic Pharmaceutical Association (GPhA) immediately praised the *Affordable Medicines Utilization Act of 2011*. Because the federal government pays states a portion of the cost of prescription drugs they purchase through Medicaid, they annually save hundreds of millions of dollars as the use of less costly generic drugs increases. S.1356 would give states a share of these savings.

According to GPhA, Medicaid paid on average of roughly \$200 for each monthly brand-name prescription in 2010, compared to just \$20 for a month's prescription in the generic version. By increasing generic utilization in Medicaid by just one percentage point, they estimate that the government would save more than \$500 million.

Generic pharmaceuticals currently represent 75 percent of the prescriptions dispensed in the United States, but consume just 22 percent of total drug spending.

SSA Commissioner testifies that ALJs are approving too many disability claims

Social Security Administration (SSA) Commissioner Michael Astrue urged the House Judiciary Committee and Ways and Means Committee this week not to cut funding for his agency, despite investigations revealing that overly lenient administrative law judges (ALJs) were costing taxpayers over \$1 billion per year.

Successful applications for federal disability benefits have surged since the recession with Social Security Disability Insurance (SSDI) paying over \$124 billion in benefits to 10.2 million people in 2010. Trustees for the Social Security program warned last month that the SSDI program will run dry in 2018 if Congress does not act to shore up the trust fund.

SSA's Inspector General conducted an investigation into the rate of approval for SSDI claims shortly after a May article in the *Wall Street Journal* identified at least one ALJ who awarded benefits to every single applicant that requested a hearing during the first six months of fiscal year 2011. The Inspector General found that while 1,500 ALJs nationwide only approved benefits for an average of 60 percent of claimants, certain judges were awarding benefits in more than 85 percent of cases at a cost of over \$1 billion.

Commissioner Astrue, a Republican holdover from the Bush Administration, insisted that federal law prevents him from taking any action against ALJs who approve a disproportionate number of claims. However, Judiciary chairman Howard Coble (R-NC) and Rep. Sam Johnson (R-TX) both recommended new legislation to "prevent abuses" in disability approvals.

Rep. Hank Johnson (D-GA) claimed that committee Republicans were using ALJs as "whipping boys" in a "backdoor attempt...to dismantle the Social Security program."

Commissioner Astrue insisted that Republican efforts to cut funding for the agency would backfire, as it would prevent his agency from reducing the lengthy backlog of pending cases that can often force applicants to wait at least 18-24 months for a hearing.

FEDERAL AGENCIES

Obama Administration eases requirements for state-based health insurance exchanges

The Centers for Medicare and Medicaid Services (CMS) has issued long-awaited proposed regulations governing the health insurance exchanges required by the Affordable Care Act (ACA).

The exchanges are the lynchpin of the new federal law, as they will initially provide the uninsured and small business workers with affordable coverage options that guarantee a comprehensive set of benefits. Those earning up to 400 percent of the federal poverty level will be eligible for federal subsidies to purchase exchange coverage.

The set of proposed rules were largely praised for giving states greater flexibility. However, consumer groups were dismayed that CMS did not prohibit insurers from serving on exchange oversight boards, a source of controversy in at least seven states (see Colorado and Illinois articles below). CMS instead will only bar insurers from constituting a board majority, insisting that the decision on excluding insurers altogether should be left to the states. Republican lawmakers and insurer groups were also concerned that CMS retains extensive oversight over future changes that states make to their exchanges.

The most prominent change provides states with some “breathing room” by removing “absolute deadlines” in the event their exchange infrastructure is not in place by the initial January 2013 deadline. States will now be able to qualify for “conditional approval” if they can simply show they are on pace to operate the exchange by January 2014 and can even partner with CMS to share the implementation workload. States with federally-operated exchanges in 2014 could still transition to a state-based exchange but only after giving CMS at least 12 months notice.

Many states are struggling to pass enabling legislation and feared that the delay would force a permanent federal government “take-over” of their exchange (see New York and Rhode Island articles below). Only 14 states have enacted some form of authorizing law, with a handful merely creating advisory committees to make recommendations. While most states were awaiting CMS proposed rules before moving forward, tea party opposition to implementing any provision of “Obamacare” blocked legislation in roughly 15 states despite solid Republican support for the “market-based” exchange concept (see Update for Week of June 6th).

Consistent with CMS guidance last summer, the proposed rules will not require states to act as “active purchasers” and negotiate prices and benefits with exchange plans. The decision whether to follow this Massachusetts model preferred by consumer groups will remain with the states, which can use a competitive bidding process to limit the exchange only to plans that provide the best benefits at the lowest cost. However, states can also follow Utah’s more limited clearinghouse model, which admits any health plan that meets minimum standards.

The proposed rules did not define the “essential health benefits” that exchange plans must provide, which will be addressed by CMS after the agency receives recommendations from the Institute of Medicine in September. CMS will respond to many unanswered questions in later rulemaking, including whether those exchanges operated by CMS will follow the Massachusetts or Utah model. The agency also did not specify what other benchmarks states must meet to certify they will be ready by 2013, apart from having some form of governance structure and information technology system in place.

Separate proposed rules aim to provide states with some premium stability by creating a three-year reinsurance program to help offset the costs of high-risk enrollees. A non-profit entity will provide

participating insurers with additional federal funding to insurers whose claims are three percent higher than projected, while giving fewer federal dollars to insurers whose claims are three percent lower.

The Congressional Budget Office estimates that nearly nine million uninsured and small business workers will participate in the exchanges in 2014 and 23 million will join by 2018. Most will be eligible for federal subsidies which are projected to initially average \$4,600 per person.

CMS will accept public comments on the new rules through September 28th, and specifically asked for input on whether additional conflict of interest requirements should be placed on board members and outside entities contracted with the exchanges.

SSA adds 12 disorders to list of those afforded expedited review for federal disability benefits

The Social Security Administration announced this week that it has added 12 new medical diagnoses to the Compassionate Allowances program that expedites the review of applications for federal disability benefits.

The move was praised by the National Organization for Rare Disorders as the majority of the 100 diagnoses on the Compassionate Allowance list are rare disorders. The program was started in 2008 with a list of only 50 diagnoses, but expanded each year based upon input from medical experts.

Loss of private health insurance significantly increases uninsured rate, except for children

The National Center for Health Statistics within the Center for Disease Control and Prevention (CDC) reported last week that Medicaid and SCHIP are continuing to act as a critical safety net for increasing numbers of uninsured children.

The number Americans who were uninsured rose by nearly two million during 2010 as private plan coverage continued to erode by 1.7 percent to only 61 percent of non-elderly adults. However, a greater percentage of children lost private plan coverage (1.9 percent) but did not become uninsured as they increasingly became eligible for Medicaid and SCHIP, which saw a two percent bump in enrollment.

Overall, those with annual incomes between 100 and 200 percent of the federal poverty level were hit the hardest, as their rate of uninsured increased by nearly four percent in a single year. CDC notes that the Affordable Care Act will greatly expand coverage to this group of non-elderly adults, who are ineligible for Medicaid in most states.

Study shows that health insurance does not prevent medical debt

A new study published this week in the *American Journal of Public Health* finds that having health insurance is no guarantee against incurring significant medical debt.

The authors cite several reasons why health insurance subscribers are far more susceptible to catastrophic expenses than for other lines of insurance. Rapid increases in deductibles and out-of-pocket expenses, as well as more limited prescription drug coverage have caused Americans to now pay eight times as much for health coverage as for car, auto, home, or life insurance. In addition, health insurance subscribers have seven times the out-of-pocket exposure.

However, perhaps the biggest difference is that health insurance is often tied to employment. Those with employer-based health insurance often face no insurance or drastically higher premiums if they lose your job.

STATES

Colorado

Exchange board urged to improve transparency during first meeting

The newly-appointed Colorado Health Benefits Exchange Board held its first meeting this week to outline how to create the health insurance exchange required by the Affordable Care Act.

The appointment of four insurance executives to the nine-member board ignited controversy last week (see Update for Week of June 27th and July 4th), especially after it was revealed that one of the five non-industry appointees had previously contracted with the state's largest insurers. Authorizing legislation (S.B. 200) explicitly prohibits more than four board members from having direct links to the insurance industry. As a result, the Colorado Public Interest Research Group and Colorado Consumer Health Initiative promptly called for Eric Grossman's resignation, noting that members of the board for his health information technology company were insurance representatives who would directly benefit from the decisions of the exchange board.

Governor John Hickenlooper (D) stood by his decision to appoint Grossman after Grossman insisted that his TriZetto Company no longer has insurer contracts and pledged to recuse himself from any vote that could potentially violate the exchange's conflict of interest standards. However, prior statements by Grossman continue to fan opposition to his appointment, as he advised clients last fall that there was "gold in the exchanges" and denounced attempts to create a competitive exchange marketplace.

Although conflict of interest was not a specific agenda item, the sponsor of the authorizing legislation, Senator Betty Boyd (D), criticized the board's lack of transparency, as did hemophilia advocate and board member Nathan Wilkes. The board was urged in the future to put meeting documents online and allow more access to the public, since only 30 of the 100 attendees were allowed in the meeting room.

Georgia

Department of Community Health to increase Medicaid and SCHIP co-pays

The Department of Community Health outlined its plan this week to increase Medicaid and SCHIP copayments effective September 1st, in an effort to fill a \$180 million program deficit.

Medicaid copayments would double to \$25 under the Department's proposal, while children age six or older in the PeachCare for Kids program would begin paying copayments for the first time. Medicaid copayments for prescription drugs and other services would also climb to \$3.74 depending on the service. The Department expects the state to save roughly \$4.2 million from the higher copayments.

Consumer advocates and the non-partisan Georgia Budget and Policy Institute emphasized that even though the increases are relatively small, even nominal hikes in copayments have caused massive disenrollment in other state's health programs, especially Oregon. They point out that PeachCare children over age six already pay up to \$70 per month in premiums.

The higher copayments must be approved by the board. Even though members approved a 0.5 percent cut in Medicaid and PeachCare reimbursement earlier in the week, some members already expressed concern about the negative impact of further reimbursement cuts and cost-sharing increases.

The changes were approved by the state legislature earlier this year.

Hawaii

Governor signs bill creating health insurance exchange

Governor Neil Abercrombie (D) signed S.B. 1348 this week, which establishes the Hawaii health connector to create a health insurance exchange that complies with the Affordable Care Act (ACA).

The law allows health insurance representatives to serve on the exchange board, a provision that has generated intense controversy in at least six other states (see Colorado article above). However, it prevents board members from having any financial interest in participating plans.

New law protects Hawaii's unique employer mandate from federal reforms

Governor Neil Abercrombie (D) signed H.B. 1134 this week, which protects Hawaii's unique universal health care system from being altered by federal health insurance reforms.

Hawaii is the only state to receive an exemption from federal ERISA law that allows it to mandate that employers provide minimum health coverage for full-time workers. Its Pre-Health Care Act pre-dates the 1974 federal law and has enabled Hawaii to consistently lead the nation in access to care.

The state law contained a provision repealing Hawaii's employer mandate should federal law ultimately provide better coverage. H.B. 1134 eliminates that repeal provision. Governor Abercrombie had threatened to veto H.B. 1134, arguing the Affordable Care Act (ACA) protections went beyond state law as it did not limit mandated coverage only to full-time employees. However, he agreed to sign the measure after receiving opinions from the U.S. Departments of Health and Human Services and Labor affirming that Hawaii's law did not conflict with the ACA.

Illinois

Governor signs "industry-friendly" law authorizing health insurance exchange

Governor Pat Quinn (D) signed legislation this week that is intended to ensure Illinois is on the path to creating the health insurance exchange required by the Affordable Care Act (ACA).

S.B. 1555 is a more "industry-friendly" version of exchange-authorizing legislation than sought by the Governor. It creates an Illinois Health Benefits Exchange Legislative Study Committee to make recommendations by September 30th on how the state should design and implement the exchange. It also directs state agencies to apply for and accept federal implementation grants and requires the state to create an exchange by the October 1, 2013 deadline set under federal law.

As in seven states including Colorado (see above) and North Carolina, S.B. 1555 has drawn the ire of consumer groups for allowing insurers to participate on the oversight board regulating plans within the exchange. It also does not allow the Governor to appoint voting members of the exchange board or provide any mechanism to ensure that consumers and small business groups are aptly represented within the governance structure of the exchange (see Update for Week of May 28th).

Kentucky

Governor turns to managed care to balance Medicaid deficit

Governor Steve Beshear (D) announced this week that the Cabinet for Health and Family Services has selected four of the managed care plans that will start serving more than 560,000 Medicaid enrollees on October 1st

The Governor's long-awaited plan to transition over two-thirds of Kentucky's Medicaid enrollees into managed care is estimated to save the state \$375 million over the next three years and \$1.3 billion overall. His re-election opponent, Senate President David Williams (R) has insisted that these figures are unrealistic and that actual savings may not even fill the Medicaid program's nearly \$140 million deficit. Senator Williams instead sought to shift money to Medicaid by cutting all other government programs.

The four plans selected are Coventry Health Care of Maryland, WellCare Health Plans of Illinois and Centene Corporation of St. Louis. Passport Health Plan was already contracted with the state and will continue to serve about 170,000 Medicaid recipients in the Louisville area.

House Speaker Greg Stumbo (D) acknowledged that Medicaid managed care has achieved “mixed” results in other states and pledged that House leaders will closely monitor the program to ensure savings are not resulting solely from private rationing of care. Kentucky’s plan still must be approved by the Centers for Medicare and Medicaid Services, which has indicated it will not approve Florida’s plan to expand Medicaid managed care statewide unless additional safeguards are enacted to prevent the erosion of care that occurred under that state’s demonstration (see Update for Week of June 20th).

Maine

New law outlaws anti-competitive “most favored nation” clauses in insurer contracts

Governor Paul LePage (R) signed L.D. 1583 this week, which bans the inclusion of so-called “most favored nation” clauses in the participation agreements between providers and health insurers.

The prohibition takes effect on September 28th and represents part of the new Governor’s effort to make Maine more “business friendly” to health insurers. He has already successfully pursued legislation to cut the state’s universal health care plan, repeal state law against unfair practices by pharmaceutical benefit managers, eliminate community rating and other popular consumer protections against insurer discrimination, and allow out-of-state insurers to sell bare-bones health plans to Maine residents (see Update for Week of June 20th).

The Governor’s latest accomplishment is intended to level the playing field by preventing large insurance companies from gaining an “unfair advantage” over small and often rural Maine health providers. It allows the Superintendent of Insurance to waive the ban upon finding that the inclusion of a “most favored nation” clause will not be anti-competitive. This bill also prohibits carriers from discriminating against providers who object to insurer demands for such clauses.

The U.S. Department of Justice opposes the use of “most favored nation” clauses in insurer contracts and has been conducting a nationwide investigation into whether Blue Cross and Blue Shield (BCBS) plans are forcing hospitals to charge rival insurers premiums that are up to 40 percent higher than those charged to BCBS (see Update for Week of March 28th). DOJ contends that this practice violates federal antitrust law if used to hobble competitors.

Minnesota

“Universally disappointing” compromise reopens state government

Governor Mark Dayton (D) became the first to blink this week in the showdown with Republican lawmakers that caused a two-week state government shutdown. Dayton backed off his insistence that a budget deal must include increase taxes on the wealthy, in exchange for Republican concessions that Democratic lawmakers complain are relatively minor.

The Governor will get new revenue in the compromise, but not in form of any new taxes. Instead, Republicans merely agreed to shift future revenue from schools, bonds, and tobacco settlements into the state general fund, a move that will exacerbate budget deficits in the coming years. Republicans also decided to drop the “social issues” they had tried to force into the budget, including stricter voting laws, bans on stem-cell research, cuts to school integration programs, and a reduction in state workforce.

However, the key Republican concession may have been their willingness to no longer demand that the Governor rescind his executive order expanding Medicaid before the 2014 deadline in federal law in exchange for enhanced federal funds (see Update for Weeks of June 27th and July 4th).

Former Vice President Walter Mondale (D) and former Governor Arne Carlson (R) criticized the Governor for “kick[ing] the can down the road” and ignoring their bipartisan panel’s recommendations for a mix of new revenues and spending cuts (see Update for Weeks of June 27th and July 4th).

The budget compromise must still be approved by a special session to be called by the Governor.

New York

Tea party politics stall insurance exchange legislation until next session

The Republican-led Senate failed to pass legislation creating the health insurance exchange required by the Affordable Care Act (ACA) prior to the July 1st close of the legislative session.

An identical bill proposed by Governor Andrew Cuomo (D) had already passed the Democratic-led Assembly with bipartisan support (see Update for Weeks of June 27th and July 4th). However, Republican leaders pulled S.5849 before a scheduled floor vote after a handful of “tea party” Senators insisted that the Senate should not marry the state to “Obamacare” on the same day that it passed a new law allowing gay marriage.

Democratic lawmakers urged Governor Cuomo to call a special session to pass the authorizing legislation, as New York has already received over \$28 million in federal exchange grants and applied last month for an additional \$10 million. The state also faces a January 1, 2013 deadline by which they must have a governance structure and information technology system in place or allow the federal government to take over the exchange. While proposed rules released this week by federal regulators may somewhat relax this deadline (see above), it remains unclear whether New York could have an operational exchange by January 1, 2014 if it does not pass authorizing legislation until next summer.

Rhode Island

Governor urged to create health insurance exchange after legislative inaction

Members of the bipartisan Rhode Island Healthcare Reform Commission are urging Governor Lincoln Chafee (I) to issue an executive order creating the health insurance exchange required by the Affordable Care Act (ACA).

The move comes after lawmakers failed to pass authorizing legislation before the July 1st close of the legislative session. The bill had bipartisan support and was expected to pass the Democratically-controlled Senate after clearing the House. However, the Senate version (S.B. 87) added controversial abortion restrictions that go well beyond federal law and were opposed by the House and Governor.

The state faces a September 30, 2011 deadline to apply for the next round of federal exchange grants, as well as a January 1, 2013 deadline to have at least a governance structure and information technology system in place. Commission chair Lt. Governor Elizabeth Roberts (D) fears that the state will miss both these deadlines without prompt legislative or executive authorization, causing the federal government to take over the exchange.

Republican Governors in at least Alabama, Georgia, and Indiana have already issued executive orders to circumvent legislative inaction on the health insurance exchange (see Update for Week of June 6th). However, state law in Rhode Island would prohibit Governor Chafee’s executive order from establishing an exchange as broad as the proposed legislation. For example, it cannot create the quasi-public corporation envisioned by the bill and would have to adopt a different governance structure. The order would also not remain in effect after he leaves office.

Despite these limitations, the Commission met this week to develop several proposed executive orders that would establish the exchange within the Department of Health, create a new division within an existing state department, or establish a not-for-profit agency regulated by the Health Director.

Proposed rules released this week by the Centers for Medicare and Medicaid Services would give Rhode Island some “breathing room” on the January 1, 2013 deadline (see article above). However, it is not clear that Rhode Island could even be ready to operate an exchange by 2014 if authorizing is not passed until next summer.

South Carolina

Governor’s planning committee meets to debate feasibility of health insurance exchange

The South Carolina Health Planning Committee held its first meeting this week to debate whether the state should move forward to create a health insurance exchange, even if it does not comply with the Affordable Care Act (ACA).

Governor Nikki Haley (R) created the committee after an orchestrated tea party campaign blocked exchange authorizing legislation that she and Republican leaders supported (see Update for Week of March 28th). The panel will use the state’s \$1 million federal exchange grant to make recommendations to the Board of Health and Environmental Control by October 28th on whether the state should still create an exchange and what design should be used.

After the exchange legislation failed, the Governor had pledged that any administratively-created exchange would use only state funds. The Director for South Carolina’s Department of Health and Human Services and committee chairman indicated this week that the relaxed exchange standards under the federal government’s proposed rules (see article above) were unlikely to change her position. He suggested that any exchange will be funded largely through insurer assessments, though employers and individuals should contribute some of the funding since they will benefit from lower premiums.

The chairman also instructed panel members to assume that the Affordable Care Act (ACA) will be legally upheld, even though South Carolina is one of 27 states challenging its constitutionality.