

Health Reform Update – Week of August 15, 2011

CONGRESS

Key Republican on “super committee” opposes entitlement cuts for current enrollees

Most of the members of the new Joint Select Committee on Deficit Reduction spent this week either declining comment on the ultimate debt reduction recommendations by the “super committee” or fanning partisan divisions. However, many lawmakers were encouraged by remarks by panel member Rep. Fred Upton (R-MI). The powerful Energy and Commerce chairman emphasized that he would not support any benefit reductions for those currently enrolled in entitlement programs.

Rep. Upton’s position is not exactly a change in party position, as he would not rule out endorsing cuts in future entitlement benefits. House Republicans passed a budget earlier this spring that dramatically reduces benefits for future Medicare enrollees (see Update for Week of April 4th).

Drug makers “vigorously oppose” additional spending cuts as part of debt reduction plans

Leading drug makers warned the Obama Administration this week that they will not accept any new mandated discounts or rebates that cut the price of prescription drugs supplied through Medicare.

Chief executives from industry giants like Pfizer, Merck, and Eli Lilly insisted that they would vigorously oppose any further “price controls” apart from the 50 percent discount within the Medicare Part D “doughnut hole” that they voluntarily agreed to as part of Affordable Care Act (ACA) negotiations. This early \$112 billion concession by the Pharmaceutical Research and Manufacturers Association (PhRMA) became very unpopular with PhRMA members eventually leading to the ouster of its executive director.

Drug makers were alarmed by the recent debt reduction compromise signed into law by President Obama, which calls for cuts in prescription drug spending as part of an additional \$1.5 trillion in spending reductions over the next ten years (see Update for Week of August 1st). Congressional Democrats have also started to renew efforts to extend Medicaid rebates to “dual eligibles”, as well as give the federal government authority to negotiate Medicare drug prices.

Pfizer chief executive Ian Read insisted that targeting pharmaceuticals was misguided, because they represent “only 10 percent of the health care spending in the U.S.” and are the “most efficient part of that.” PhRMA also denounced personal efforts by President Obama during the debt ceiling negotiations to continue pushing for further cuts in drug spending, suggesting that it would “destabilize the successful Medicare Part D program and have a devastating effect on American jobs.”

Senators seek to combat emerging “gray market” for life-saving drugs

A shortage of often life-saving drug therapies is producing a “gray market” in which drug middlemen are forcing hospitals and pharmacies to pay exorbitant markups for the highest-demand products.

An analysis released this week by Premier’s alliance of hospitals and health-care systems studied more than 1,700 offers made by “gray market” vendors to hospital pharmacists over a two-week period earlier this year. It demonstrated an average mark-up of 650 percent higher than the manufacturer’s price for prescription drugs in short supply.

Even higher markups were found for back-ordered drugs needed for cancer treatment, heart conditions, and surgery. For example, the Labetalol drug for high blood pressure was marked up 4,533

percent to \$1,200 for a single dose. Cytarabine, prescribed to treat certain types of leukemia, had a 3,980 percent markup. In all, Premier recorded 18 vendors who offered “gray market” items to 42 acute-care hospitals, all of them medicines back-ordered or in short supply.

Two Senators have been highly-critical of this “gray market”. Senator Amy Klobuchar (D-MN) co-sponsored legislation in February (S.296) that would require drug makers to notify the Department of Health and Human Services (HHS) of possible drug shortages that result from discontinuances or other changes or problems in manufacturing. Senator Richard Blumenthal (D-CT), a former state attorney general, joined with other Senators in directing the Government Accountability Office (GAO) last May to investigate the “price-gouging” by sellers seeking to take advantage of desperate hospitals and providers.

The Food and Drug Administration (FDA) is also expected to hold a September 26th public workshop to address the problem.

FEDERAL AGENCIES

IOM could miss September deadline for guidance on essential health benefits

Guidance from the Institute of Medicine (IOM) on how federal regulators should define “essential health benefits” under the Affordable Care Act may not be released in September as planned.

An 18-member IOM committee recently signed-off on its report, which now is being reviewed by experts who will advise IOM before the final recommendations are sent to the Department of Health and Human Services (HHS). The agency plans to incorporate IOM’s recommendations in regulations to be promulgated later this year.

IOM’s recommendations will define the basic coverage standards to be provided through the state-based health insurance exchanges and ultimately all commercial health plans. They will not outline specific benefits to be covered, but instead recommend criteria and methods for HHS to use in setting and updating the essential health benefits package.

Many states have been awaiting the IOM guidance before designing their exchange, which was scheduled to be released by the end of September. However, an IOM spokesperson indicated this week that the report “could slip a little later” past this target date.

Insurers seek delay in new rules requiring consumer-friendly labeling, benefit summaries

Health insurers wasted little time seeking delay in long-awaited regulations issued this week by the Departments of Health and Human Services (HHS), Labor (DOL), and Treasury that would force plans to provide subscribers and prospective consumers with standardized “easy-to-understand” benefit summaries and labels.

HHS relied upon templates designed by the National Association of Insurance Commissioners (NAIC) on how insurers should design the new summaries and labels (see Update for Week of May 2nd), which were required by the Affordable Care Act (ACA) for individual and group plans starting next March. These new “coverage facts labels” (modeled after nutrition labels on food products) will for the first time give prospective consumers the ability to better predict their out-of-pocket costs, as well as identify the average costs for a wide array of treatments or prescription drugs. (The ACA does not limit the number of conditions for which HHS can eventually require such information.)

The proposed rules allow 60 days for public comment. HHS and DOL specifically are soliciting feedback on whether to bend the law’s March 23rd deadline for distributing the NAIC forms, whether to phase-in the use of the forms, and whether they should be modified for self-funded employer plans.

The National Business Group on Health (NBGH) and America's Health Insurance Plans (AHIP) immediately called for a delay in implementation. They insisted that health plans need more time to make the operational and administrative changes needed to create the forms, especially since HHS was five months late in issuing proposed rules. NBGH noted that many employers are already required to provide similar information on different forms, and would thus need time to develop "two sets of plan information."

Consumer groups also emphasized that HHS has yet to adequately test the forms with consumers, especially those who do not speak English.

Affordable Care Act fails to fund default health insurance exchange

An article this week in *POLITICO* pointed to an apparent omission in the Affordable Care Act (ACA) that fails to provide necessary funding for the Centers for Medicare and Medicaid Services (CMS) to assume control of health insurance exchanges in states that do not create one by 2013.

While the ACA appropriates \$1 billion for helping states create their own exchanges, it is "sort of silent" on the federal default exchange to be created by CMS, according to the director of the Massachusetts exchange advising CMS. Additional funding from Congress is a non-starter given Republican control of the House. As a result, CMS will have to "get creative about the financing"; perhaps by tapping funds from other ACA programs or enticing contractors to perform for free in the expectation that they would get paid once the exchange started collecting fees.

CMS will also face the challenge of paying for the functions of state exchanges, such as the infrastructure for doing risk adjustment, which it has indicated it will be willing to assume under partnerships with states. CMS proposed the partnerships in initial regulations in order to create an alternative to an all-federal exchange in a state that may not meet all of the requirements on time (see Update for Week of July 11th).

The agency has already distributed a quarter of the \$1 billion in implementation funds, according to Congressional testimony by the Health and Human Services Secretary last March. It awarded another \$185 million in exchange grants to 13 states last week (see Update for Week of August 8th).

HHS awards \$40 million in grants to enroll eligible children in Medicaid or SCHIP

The Department of Health and Human Services (HHS) released \$40 million in grants this week for efforts to identify and enroll children eligible for Medicaid and SCHIP.

Grants were awarded to 39 state agencies, community health centers, school-based organizations, and non-profit groups in 23 states. Half of the money will fund initiatives to improve the technology that's used for enrollment and renewal. The two-year grants are authorized under the Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009.

The grants were released concurrent with an Urban Institute and Robert Wood Johnson study that documented significant progress in the agency's effort to get eligible children enrolled in these federal programs. According to researchers, outreach efforts directly contributed to a three percent decline in the number of eligible but uninsured children, despite an overall increase in eligible children.

The study specifically found that almost 85 percent of eligible children were covered by Medicaid or SCHIP in 2009, compared with roughly 82 percent the year before. However, roughly 4.3 million children are eligible for Medicaid or SCHIP but remain uninsured.

Some states have experienced an even greater decrease. For example, Oregon used a prior CHIPRA grant to cut its percentage of uninsured children in half from 2009 to 2011. Oregon was able to enroll 94,000 eligible children in Medicaid and CHIP by reducing paperwork for families, establishing a cost-effective online application process, providing direct enrollment assistance to families, and conducting vigorous outreach activities throughout schools.

Both CHIPRA and the Affordable Care Act allocate a total of \$140 million for enrollment and renewal outreach, including \$112 million in grants to states, community groups and health care providers. This week's award supplements \$40 million already issued in 2009 and 2010.

OIG says Medicare pays more than Medicaid for prescription drugs

Medicaid receives much deeper discounts on many prescription drugs than Medicare, thanks to steep rebates mandated by federal law. That was the primary conclusion of a new report mandated by the Affordable Care Act (ACA) and released this week by the Office of the Inspector General (OIG) for the Department of Health and Human Services.

Both Medicaid and Medicare receive discounts in the form of rebates, which are paid by drug manufacturers when their products are dispensed to enrollees. However, the OIG survey of 100 widely used brand name drugs found that rebates reduced prices by only 19 percent in Medicare, as compared to 45 percent in Medicaid. After taking account of the rebates, Medicaid paid significantly less than Medicare for the same drugs.

Federal law specifies how the discount or rebate is calculated under Medicaid. The minimum rebate for a brand-name drug was increased last year to 23 percent of the average price that manufacturers receive for sales of the product to retail pharmacies.

Drug makers must pay additional rebates to Medicaid if a drug's price rises faster than inflation. The OIG found that these added rebates are the "primary reason Medicare rebates are substantially higher", as they account for slightly more than half of all rebates paid to Medicaid on the top 100 drugs. In fact, for 68 of the 100 drugs the Medicaid rebate was at least twice as large as the Medicare rebate.

Medicare's prescription drug program has cost less than originally predicted by the Congressional Budget Office (CBO), thanks largely to private insurers aggressively negotiating with pharmaceutical manufacturers. However, insurers have not obtained discounts or rebates as large as those secured by Medicaid. (The 50 percent rebate for brand-name drugs within the Part D "doughnut hole" mandated by the ACA did not go into effect until this year.)

CBO estimates that the cost of Medicare's outpatient drug benefit will still increase an average of nearly ten percent a year, up to \$175 billion in 2021 from \$68 billion this year. As a result, Rep. Henry Waxman (D-CA) and Senator Jay Rockefeller (D-WV) recently introduced bills that would require drug manufacturers to pay the higher Medicaid rebates for drugs provided to Medicare beneficiaries who are also eligible for Medicaid (see Update for Week of June 13th). President Obama's deficit-reduction commission recommended a similar approach, estimating that it would save \$49 billion over ten years (see Update for Week of December 6th).

Most Part D enrollees routinely fail to switch to plans with lower cost-sharing

A study released this week by PlanPrescriber found that the typical Medicare enrollee is in the wrong Part D prescription drug plan, thanks to Medicare's confusing array of plan offerings that constantly change from year to year.

The survey of 22,000 Part D enrollees who provided their plan and medication information during last year's Medicare annual enrollment period concluded that at least 90 percent of them could have saved money by switching to a plan that better met their medication needs (or as high as 94 percent in Florida). Enrollees on average could save \$546 by moving to a plan with the lowest out-of-pocket costs.

PlanPrescriber attributed a large part of the problem to the fact that most enrollees stay in the same plan each year, regardless of changes to benefits or cost-sharing. They cited a Robert Wood Johnson Foundation study that found that each year only ten percent of enrollees change their Part D plan. Researchers blame the enormous "homework" required of enrollees for this trend.

NAIC urges OPM not to exempt multi-state plans from additional state exchange rules

The National Association of Insurance Commissioners (NAIC) sent a letter this week to the Office of Personnel Management (OPM) warning that a “loophole” in the Affordable Care Act (ACA) could allow multistate insurance plans to operate under more favorable rules than smaller plans in the new state-based health insurance exchanges.

The commissioners said they have “serious concerns about the potential for market disruption and adverse selection” as a result of this disparate treatment. While all health plans are subject to the same basic regulations under the ACA, the law allows states to go further if they choose. NAIC is worried that this language may be interpreted to exempt multistate plans from additional consumer protections that states may impose, even though NAIC argues that Congress clearly intended a level playing field.

NAIC is asking federal regulators to clarify that there “should be no distinction between a multistate plan and any other carrier offering coverage in an exchange”, in order to prevent the nation’s largest insurers from gaining “significant market advantages.” They addressed the letter to OPM because the ACA directs the agency to contract with health insurers to offer at least two multistate health plans that will be sold on every state’s exchange beginning in 2014 (at least one has to be a non-profit entity.)

OPM also runs the Federal Employee Health Benefits Program (FEHBP), but these national plans will be sold and administered separately by the agency.

OPM has not yet offered any contracts for multistate plans and is at the stage of making a “request for information” from health insurance providers about how the agency should proceed. The request asks a number of questions about products offered, interest in offering a multistate plan, and possible partnerships with other health plans.

OMB directs all federal agencies to cut budgets by ten percent

Citing fiscal pressures and the recently enacted deficit reduction package that raised the debt limit (see Update for Week of August 1st), the Office of Management and Budget Director sent a memo this week to all federal agencies instructing them to plan a 2013 budget that is at least five percent below their 2011 spending level. Agencies also should identify additional savings that would bring their 2013 budget requests to at least ten percent below their current enacted appropriation.

It is not immediately clear what impact these reductions would have on agencies like the Department of Health and Human Services that have required additional staff and resources to implement provisions of the Affordable Care Act (ACA).

Large employers expect seven percent premium hike next year

The annual survey of large employers by the National Business Group on Health (NBGH) found that nearly two-thirds plan to increase employee health costs next year, due to an anticipated 7.2 percent jump in overall health benefit expenses. The findings appear consistent with a study earlier this year by PriceWaterhouseCoopers (PwC) predicting that employers will see roughly a seven percent increase in health care costs for 2012 as they shift more costs to workers (see Update for Week of May 16th).

The PwC study found only a “minimal” impact on this cost increase to Affordable Care Act (ACA) provisions. However, employers in the NBGH survey attribute one full percentage point of the increase to the ACA requirement that they allow young adults up to age 26 to remain on their parents’ group plan. They also blame the ACA tax on “Cadillac” health plans for some of the cost shift to employers, even though the tax does not go into effect until 2018.

NBGH said the survey of 83 employers covering four million workers showed a “sharp increase” in employers who plan to offer at least one “consumer-directed health plan” in 2012. These are typically high-deductible health plans with a health savings account. The percentage offering such a plan next year will reach 73 percent, up from 61 percent this year.

However, the survey did provide some good news, as it showed that the rate of growth in overall costs has begun to slightly decline from last year’s average increase of 7.4 percent. (PwC found that the rate of growth has decreased for three consecutive years.)

Health care prices rose another two percent over the past year

The Bureau of Labor Statistics (BLS) announced this week that overall health care prices in the United States jumped by another 0.4 percent last month. The BLS Producer Price Indices across the range of health care industries are now a full two percent higher than a year ago. The higher prices are all attributable to increase for hospital, physician, and long-term care services, as indices for other health care sectors (such as home health care and labs) were largely stable.

STATES

ADAP crisis continues unabated

The latest data from the National Alliance of State and Territorial AIDS Directors shows that waiting lists for AIDS Drug Assistance Programs (ADAPs) are continuing to swell as funding becomes scarce. At least 9,217 individuals are now on ADAP waiting lists in 12 states, as of August 11th. This represents a 20 percent increase from the 7,674 waiting list clients last April.

At least 19 ADAPs, including 11 with current waiting lists, have now instituted cost-containment measures since April 2009. In addition, 10 ADAPs, including two with current waiting lists, reported they are considering implementing new or additional cost-containment measures by the end of ADAP’s current fiscal year on March 31st. Four states expect to add waiting lists in fiscal year 2012 (HI, TN, WA, WY).

A whopping 41 percent of the total waiting list comes from Florida with another 19 percent from Georgia. Louisiana has 11 percent, with South Carolina and Virginia each at 10 percent. No other state exceeds three percent.

Florida has nearly 3,800 people on its waiting list as of August 11th. This number could jump dramatically as the state is considering cutting ADAP eligibility in half (see Update for Week of May 2nd).

California

Opposition mounting to landmark rate review bill

Long-sought legislation that would give the insurance commissioner authority to reject or modify unreasonable premium increases appears to be in peril in the Senate.

The Department of Finance report released last week spurred on critics of A.B. 52, as it opposed passage of the bill due to costs that exceeded Assembly estimates (see Update for Weeks of June 27th and July 4th). The analysis estimated that the additional staff needed to complete the massive number of reviews under the measure would cost the Department of Insurance and Department of Managed Health Care roughly \$31 million in one-time costs and \$27 million per year in on-going costs. They note that the bill goes far beyond the minimum federal requirements under the Affordable Care Act (ACA), and would likely result in costly litigation.

The measure passed the Assembly and Senate Health Committee with no Republican support (see Update for Weeks of June 27th and July 4th). However, despite Democratic control of the Senate, it

may not even reach a floor vote as it was promptly suspended by the Senate Appropriations Committee upon receipt of the Finance report.

A.B. 52 is strongly supported by Insurance Commissioner Dave Jones (D), who authored an unsuccessful version of the bill as an Assemblyman. However, it is staunchly opposed by the state's insurance, hospital, and physician groups. The California Health Benefit Exchange has also already come out in opposition to the measure, fearing it could undermine rates they negotiate with participating insurers (see Update for Week of July 25th). (Governor Jerry Brown (D) has yet to take a position.)

Bipartisan Ninth Circuit panel affirms dismissal of ACA challenge

A bipartisan three-judge panel for the U.S. Ninth Circuit Court of Appeals last week unanimously affirmed a lower court's dismissal of a constitutional challenge to the Affordable Care Act (ACA).

A former Republican Assemblyman and the conservative Pacific Justice Institute had brought suit last year, arguing that the U.S. Constitution did not give Congress the authority to require individuals or employers to purchase health insurance. A lower court appointee of President George W. Bush dismissed the case on the basis that the plaintiffs did not allege any specific injury and lacked standing. Judge Dana Sabraw held that the Assemblyman could not speculate that he would become uninsured when the individual mandate goes into effect in 2014, nor did the employer mandate apply to the Institute since it employed less than 50 workers.

The Ninth Circuit likewise concluded that the plaintiffs all lacked standing, as their complaint made general allegations without showing specific injury. They upheld the dismissal without ruling on the constitutionality of the individual or employer mandate.

Florida

Florida Supreme Court says Governor does not wield "supreme executive power"

The Florida Supreme Court ruled this week that Governor Rick Scott (R) over-stepped his authority when he suspended all agency rulemaking upon assuming office last January.

The Governor's Executive Order was part of his campaign pledge to eliminate "burdensome" and "job-killing" regulations that hinder economic growth. It was intended to ensure that agencies only promulgated regulations that received his prior approval through his newly created Office of Fiscal Accountability and Regulatory Reform.

The Supreme Court held that the Governor's action violated the separation of powers doctrine under the Florida constitution, because the "Legislature retains the sole right to delegate rulemaking authority to agencies." It specifically rejected Governor Scott's claim that the constitution gives him "supreme executive power" that gives him final say over any executive agency action.

The case was brought by a blind woman whose food stamp applications were delayed by the suspension of rulemaking. Her complaint ridiculed the Governor's claim of "supreme executive power", comparing it to an infamous line in a Monty Python movie.

It is unclear what impact the Supreme Court's decision will have rulemaking relating to the Affordable Care Act (ACA). The Governor had used his order to block agencies from moving forward on any ACA Act provision while legal challenges are pending (see Update for Week of February 7th).

Florida is leading the multi-state lawsuit joined by 26 state attorney generals. The 11th Circuit U.S. Court of Appeals agreed with the states that the federal mandate to buy health insurance was unconstitutional. However, it denied the remainder state claims (see Update for Week of August 8th).

Georgia

Advisory panel endorses legislative action on health insurance exchange

An advisory panel created by Governor Nathan Deal (R) voted this week to pursue legislation authorizing the creation of a health benefits exchange that complies with the Affordable Care Act (ACA).

Stating that a federal government “takeover” of the exchange was not an option, Governor Deal appointed members of the advisory panel after exchange-authorizing legislation he supported (H.B. 476) was blocked by local tea party opposition to implementing any provision of “Obamacare” (see Update for Week of June 6th). However, despite his support for the exchange concept, the Governor directed his Attorney General to join multi-state litigation seeking to overturn key provisions of the law.

As a result, the panel chose to create a subcommittee that will focus on alternative plans if a portion or all of the law is thrown out by the courts. The panel took this action despite last week’s decision by the 11th U.S. Circuit Court of Appeals in Atlanta to uphold the entire law except for the individual mandate.

The panel is expected to decide upon several recommendations by the Governor’s initial September 15th deadline, including who should run the exchange, how to make the system financially self-sustaining, and its impact on the overall insurance market. It must issue final recommendations to the Governor by December.

Maryland

Former insurance executive to head the Maryland Health Benefit Exchange

The Board of the Maryland Health Benefit Exchange voted this week to appoint a former executive as its new executive director.

Authorizing legislation creating the Board (H.B. 166) specifically prohibited insurers from serving. However, that did not deter members from appointing Rebecca Pearce to the position starting in September, despite her prior work for both CareFirst Blue Cross and Blue Shield and Kaiser Permanente.

Maryland was awarded a \$27.7 million federal exchange establishment grant last week to supplement the initial \$1 million grant it received last fall.

Minnesota

Republican lawmakers threaten lawsuit to block health insurance exchange

Republican lawmakers continue to be furious with Governor Mark Dayton (D) for reversing his predecessor’s ban on creating the insurance exchange authorized by the Affordable Care Act (ACA).

Despite seizing control of both the House and Senate for the first time in decades, Republicans have been unable to overcome the Governor’s consistent vetoes or threatened vetoes of legislation to block or hinder ACA implementation. Dayton’s predecessor, former Governor Tim Pawlenty (R) had barred all state agencies from implementing any part of the ACA, and made Minnesota one of only two states not to seek an initial \$1 million exchange establishment grant.

Republicans insisted that the Governor overstepped his authority in promptly reversing Pawlenty’s executive order the day after his inauguration (see Update for Week of January 3rd). Senate Health and Human Services Chairman David Hann (R) even held a news conference this week that threaten litigation to block the Dayton Administration from accepting the additional \$4.2 million exchange establishment grant awarded last week by the U.S. Department of Health and Human Services.

However, not all Republican lawmakers are on board with Hann's position. Representative Mary Franson eliminated language blocking the exchange from a budget bill passed by the legislature, and the issue was eventually dropped as part of the compromise to end a government shutdown that resulted from the budget stand-off with Governor Dayton (see Update for Week of July 11th).

The Department of Commerce, the lead agency on the health insurance exchange, maintains that it is aggressively moving forward consistent with the authority granted under the approved budget law. It has already sent out RFPs seeking bids for the information technology needed to operate the exchange and continues to solicit input from stakeholders.

Business groups within Minnesota are also split on the exchange, with some supporting the exchange as "market-based" reforms that will enhance competitiveness and participating in planning meetings to ensure favorable implementation. However, others are echoing the tea-party line that creating an exchange would marry the state to other objectionable provisions of "Obamacare"

Nebraska

Insurance Commissioner, Medicaid director warn that state may not meet exchange deadline

Nebraska Insurance Commissioner Bruce Ramage (R) expressed concern this week that the state will not meet the 2013 federal deadline to develop plans for the health insurance exchange required by the Affordable Care Act (ACA).

At a briefing before state lawmakers, Ramage insisted that the recent federal regulations and guidance has still not answered the questions Nebraska needs to resolve in order to forward. The Nebraska Medicaid Director affirmed that many issues remain unanswered, but stated that her agency was more concerned with state budgetary constraints and the lack of necessary information technology systems to operate the exchange. She insisted that not a single Medicaid director nationwide is confident that they can meet the deadline.

Proposed regulations released last month by the U.S. Department of Health and Human Services afforded states greater flexibility in meeting this deadline (see Update for Week of July 11th). However, both officials were adamant that the state agencies would be unable to comply even with this flexibility if Nebraska's unicameral legislature again failed to pass authorizing legislation next session. However, lawmakers like Senator Kathy Campbell, chair of the Health and Human Services Committee, appeared more focused on the constitutionality of the new federal law, insisting that she did not want to waste state resources implementing reforms that would ultimately be overturned by the U.S. Supreme Court.

North Dakota

Insurance commissioner backs off support for health insurance exchange

Insurance Commissioner Adam Hamm (R) made waves earlier this month when he told lawmakers that he was reconsidering his earlier opinion that the state should create a health insurance exchange, and suggested that North Dakota would be better off letting the federal government at least initially operate the exchange.

However, Hamm's position was not supported by the legislative panel created to prepare recommendations on implementation of the new exchange. Panel chairman Rep. George Keiser (R) insisted that states could "do a better job" than the federal government of creating an exchange that best meets their needs.

North Dakota became the first Republican-controlled legislature to pass legislation putting the state on a path to creating an exchange, even though the authorizing bill (H.B. 1126) did not specifically commit to doing so. It specifically directed the commissioner to use a portion of the state's \$1 million

initial federal exchange grant to hire a consultant to recommend exchange designs (see Update for Weeks of April 18th and 25th).

Hamm has been on the fence throughout the health reform debate. Though publicly opposing the new law, he proposed or supported legislation eventually signed by Governor Jack Dalrymple (R) to conform state insurance law to the ACA and move forward on the exchange.

Wisconsin

Governor pledges not to return federal exchange grant

Wisconsin Governor Scott Walker (R) reaffirmed his commitment this week to using the state's federal "Early Innovator" grant to create a health insurance exchange.

The U.S. Department of Health and Human Services awarded \$241 million earlier this year to seven states that had taken the lead in building the technology infrastructure to operate the new health insurance exchanges authorized by the Affordable Care Act (ACA). More than half of these dollars went to Kansas, Oklahoma, and Wisconsin—three states whose governorships changed from Democrat to Republican since they applied for the grants last year (see Update for Week of February 14th).

Local tea party opposition against implementing any provision of "Obamacare" forced the Republican Governors of Kansas and Oklahoma to return the grants, despite their prior support for exchange-authorizing legislation (see Update for Week of August 8th). Governor Walker insists that he will not follow their lead despite similar opposition in his state, and intends to use the full \$49 million grant to create an exchange. However, Walker had pledged earlier this year that Wisconsin's exchange would be more limited than required by the ACA and not include the full consumer protections under the law.

The Governor has also pledged more cooperation with Democratic lawmakers, only a week after Democrats came within one seat of re-taking the Senate through recall elections. The Governor himself faces a recall effort in the wake of his controversial and successful initiative to strip state employees of their right to collectively bargain for health benefits. The same legislation gave him unprecedented authority to make Medicaid cuts without legislative approval (see Update for Week of June 20th).

Wyoming

Exchange committee tables key decisions until next meeting

The Wyoming Health Benefits Exchange Steering Committee voted this week to gather more information about state and regional programs and defer any decisions about recommendations for the design of the exchange until its September 14th meeting.

The Committee asked a consultant to develop a cost model for a state-run program and identify other states that may want to participate in a regional exchange. Committee member Rep. Elaine Harvey (R) disclosed that she has engaged Utah lawmakers in discussions about joining their existing exchange, which is an information clearinghouse where all plans can participate. Members generally disfavored the broader exchange model in Massachusetts where the state is an "active purchaser" and negotiates rates with plans that meet certain consumer protections.

An interim report must be completed by October, with a final report due to the Legislature by January. However, committee members were not ready at this point to make any firm decisions, apart from a general consensus that they do not to simply let the federal government administer the program.

Legislation authorizing the committee (H.B. 50) was signed into law by Governor Mead (R) last spring. The creation of an exchange would require a two-thirds majority to pass the Republican-dominated legislature during the 2012 budget session.