

Health Reform Update – Weeks of December 12, 2011

CONGRESS

Congress set to approve fiscal year 2012 spending bill, payroll tax extension still up in the air

President Obama is set to sign a \$1 trillion omnibus full-year spending resolution for fiscal year 2012 that passed the House and is expected to clear the Senate before the temporary resolution expires this weekend.

The measure (H.R. 3671) includes nearly \$70 billion in funding for the Department of Health and Human Services (HHS), which is about \$700 million less than last year's allocation and \$3.4 billion below the level sought by the President. The National Institutes of Health would receive an increase of \$299 million, although this is still over \$750 million below the President's request.

Democratic and Republican leaders remain at odds over an extension of the President's payroll tax holiday that expires December 31st. The House voted this week to pass the Republican plan (H.R. 3630) which would stave off the nearly 30 percent in Medicare physician payments slated to take effect on January 1st. The measure would pay for the \$38 billion "doc fix" partly by increasing Medicare premiums for high-income enrollees and cutting Affordable Care Act (ACA) subsidies and prevention funds (see Update for Week of December 5th).

Although the measure is certain to be blocked in the Senate, a major obstacle was removed this week when Senate Democrats dropped their insistence on offsetting the tax break extension with surtaxes on the wealthy. However, lawmakers still appear about \$90 billion apart at week's end.

Senate Majority Leader Harry Reid (D-NV) and Minority Leader Mitch McConnell (R-KY) are debating a fallback plan that would extend the tax break and Medicare physician payment cut by two months while lawmakers continue to hammer out a longer-term resolution.

Softer Medicare privatization plan gains only one Democratic supporter

Rep. Paul Ryan (R) moved away this week from his controversial bill to convert traditional Medicare into a "voucher" program, instead offering a less severe plan that would give Medicare enrollees a choice between traditional Medicare or federal subsidies to buy private health coverage.

Ryan's latest proposal was based on the model recommended by the debt panel headed by former Senator Pete Domenici (R-NM) and former budget director Alice Rivlin (D) (see Update for Week of December 13th). It immediately gained one Democratic champion in Senator Ron Wyden of Oregon.

However, other Democrats and advocacy groups lambasted the "softer" proposal, as it would effectively mitigate a central campaign issue for Democrats in the 2012 elections. Ryan's earlier proposal became a political lightning rod when it was overwhelmingly passed by House Republicans last spring (see Update for Week of April 4th), and was largely blamed for a surprising election loss by Republicans in a traditionally conservative New York district (see Update for Week of May 23rd).

Despite the wholesale lack of support from his own party, Senator Wyden insisted that the latest Medicare "premium support" model would create safeguards to protect enrollee from having to "pick up the full tab" if Medicare cost increases exceed an annual cap on the annual amount they would receive

from the federal government to purchase private coverage. However, both Senator Wyden and Rep. Ryan have yet to flesh out details of how that would occur.

As with Ryan's initial version, the new Ryan-Wyden plan would not apply to those who are now at least age 55. However, premium support for others would not begin until 2022 and now give enrollees the option of using the assistance to enroll in private plans or remaining in traditional Medicare. The annual federal contribution would rise each year by no more than the increase in Gross Domestic Product plus one percent, and would be adjusted for inflation.

FEDERAL AGENCIES

New HHS guidance lets states define "essential health benefits" under ACA

The Department of Health and Human Services (HHS) released new guidance this week that will let states instead of the federal government define the minimum package of "essential health benefits" that the Affordable Care Act (ACA) requires all health plans to cover by 2014.

States and health plans have been anxiously awaiting the proposed rule on essential benefits that HHS pledged to issue by the end of 2011. Many had delayed a decision on whether to create or participate in the new health insurance exchanges authorized by the ACA until they knew what benefits HHS would require plans to cover (see Update for Week of October 3rd).

However, defining essential benefits is likely to incite a highly contentious political debate during an election year. As a result, the Obama Administration reportedly has been seeking a "middle ground" that would outline the parameters of coverage, while putting the political bulls-eye on both Republican and Democratic governors to define the benefit packages.

The initial guidance HHS released for public comment this week makes clear that forthcoming regulations will still place strict limitations on how states can define essential benefits. Specifically, the only existing plans that could serve as a state essential benefit "benchmark" are one of the state's three largest small group plans, one of its three largest state employee health plans, one of its three largest federal employee health plans, or the largest HMO plan offered in the state's commercial market.

Any plan selected by a state must also cover all ten required categories of care set forth in the ACA, or the state will have to select coverage of the uncovered categories from other benchmark health plans, such as the popular Federal Employee Health Benefits Plan (FEHBP). These categories include preventive, emergency, maternity, hospital, and physician services, as well as prescription drugs.

Plans can still modify coverage within a benefit category so long as they do not reduce the value of coverage. Future regulations will also require states to pay for any state-mandated coverage beyond their essential benefits package.

During a conference call to announce the new guidance, HHS officials noted that their benchmark model was based on SCHIP. At least one hemophilia advocate expressed concern with this approach, as SCHIP plans in New York are not covering critical clotting factor products in certain settings. HHS officials emphasized that states are under no obligation to use SCHIP as their benchmark plan. They also noted that each state's definition of essential benefits is not the ACA's "be all and end all" mechanism to ensure comprehensive coverage, citing other provisions like the network adequacy standards outlined as part of HHS' set of proposed exchange regulations.

HHS delayed discussion of cost-sharing limitations until later guidance. Recommendations furnished earlier this fall by the Institute of Medicine (IOM) urged HHS to take premium cost into account in making this determination, but did not suggest to the agency what specific benefits should be included (see Update for Week of October 3rd). Consumer groups like Families USA have urged CMS to consider all out-of-pocket costs, and not just premiums.

Study finds that Treasury regulations could deny ACA subsidies to one million Americans

Researchers at the University of California released a report this week criticizing Department of Treasury regulations for limiting working families' access to new federal premium subsidies.

The Affordable Care Act (ACA) offers tax credits individuals who are uninsured or working for small businesses, so long as their annual income is between 133 to 400 percent of the federal poverty level (FPL). Those who work for large employers may also be eligible if the cost of individual coverage offered by their employer exceeds 9.5 percent of their household income.

However, proposed regulations and guidance published last summer by Treasury would make family members ineligible for subsidized coverage in the new health insurance exchanges if an employee is offered affordable self-only coverage, even if the cost of family coverage exceeds this affordability threshold. Researchers concluded that if this provision is not amended, at least 144,000 Californians (more than half of them children) would be denied eligibility for the tax credits and unable to purchase more affordable coverage through their state's health insurance exchange. This translates to more than one million Americans "if California is representative of the United States as a whole."

Kaiser Family Foundation notes that the distinction is crucial. Premiums for family coverage under employer-based plans average \$4,129, compared to \$921 for single coverage. Therefore, far more employees will exceed the 9.5 percent affordability threshold if family premiums are used. According to Cornell University economists, using family premiums would add \$48 billion in federal subsidy payments to the cost of the ACA, making it politically unpalatable for the Obama Administration.

However, the higher price tag did not deter Rep. Pete Stark (D-CA) and most of California's Congressional delegation from immediately urging Treasury to fix this "glitch", as defining affordability only in terms of individual coverage will force "children and spouses [to] fall through the cracks."

The Treasury department previously sought public comments on whether they should create an affordability "safe harbor" that protects large employers from the \$2,000 per full-time employee assessment imposed by the ACA for failing to provide affordable coverage. Commenters asked Treasury to clarify whether employers must offer family coverage to avoid this penalty as earlier guidance (Notice 2011-73) indicated that "affordability" would be based on employee wages and not household income (see Update for Week of September 19th). Public comments were accepted through December 13th.

CMS [finally] issues physician payment sunshine rules required by Affordable Care Act

Two months past deadline, the Centers for Medicare and Medicaid Services (CMS) released proposed rules this week defining how drug and device makers will report payment made to physicians.

The Affordable Care Act (ACA) included the *Physician Payment Sunshine Act* legislation that was long-sought by Senators Herb Kohl (D-WI) and Chuck Grassley (R-IA). These provisions require manufacturers to report all payments to physicians. They also require CMS to publicly disclose on the internet the identity of the manufacturer, physician, and the drug or device associated with the payment.

Both Senators had repeatedly bashed CMS for missing the October 1st deadline for the agency to define how manufacturers are to submit the required information and how it will be disseminated. The delay caused great uncertainty as under the ACA manufacturers and group purchasing organizations had to start collecting payment data on January 1, 2012 and report it to CMS on March 31, 2013.

As a result, the proposed rule eliminates these deadlines and will not require the collection of data until final regulations are issued. Comments will be accepted through February 17, 2012.

Affordable Care Act has now extended coverage to 2.5 million young adults

The number of young adults lacking health insurance has shrunk by 2.5 million since passage of the Affordable Care Act (ACA), according to new figures released this week by the Department of Health and Human Services (HHS).

The ACA's "consumer bill of rights" allowed young adults to remain on their parents' health plan until age 26, starting with the 2011 plan year. This provision had been estimated by the federal government and private analyst to extend health coverage to one million Americans aged 19-25. However, the latest figures show 2.5 times as many young adults became insured since it went into effect, or over eight percent of all young adults aged 19-25.

Kaiser Family Foundation's tracking poll consistently shows that the young adult provision remains the single most popular ACA provision.

Enrollment in high-deductible health plans is at all-time high

More than one in five privately-insured Americans are now enrolled health plans with at least a \$1,000 deductible (or \$2,000 for families), according to a new study released this week by the Employee Benefit Research Institute (EBRI).

The survey of 4,703 showed that enrollment in such high-deductible health plans have surged to an all-time high. As recently as last year, only 14 percent of covered workers were in such plans.

EBRI researches note that the spike in enrollment is due largely to large employers increasingly refusing to offer any other coverage options. EBRI warns that while this trend may result in short-term savings for employers, the exceptionally higher cost-sharing under high-deductible plans is likely to cause enrollees to forgo needed care and result in higher health care costs down the road.

A new Kaiser Family Foundation study appears to confirm these findings (see article below). In addition, EBRI cites an earlier RAND study concluding that overall health spending by families in high-deductible plans dropped an average of 14 percent, when compared with similar families in traditional health plans. Families frequently avoided preventive care as their primary means of saving money.

Study shows that more than half of Americans are delaying needed care due to cost

A new study released this week by the Kaiser Family Foundation found that about half of Americans lack health insurance due to being unemployed and underemployed. Roughly 56 percent of this group acknowledged they are being forced to delay necessary care due to out-of-pocket costs, with one-third reporting that their health problems have worsened as a result of forgoing care.

The findings are consistent with earlier studies showing that Americans are increasingly going without needed medical care due to cost (see above).

GAO finds that manufacturing problems are to blame to shortages of life-saving drugs

A Government Accountability Office (GAO) report released this week by Senator Tom Harkin (D-IA) attempts to determine whether manufacturers or market economics are to blame for the tripling of drug shortages since 2006.

The study (GAO-12-315T) concluded that drug manufacturers are indeed the "primary cause of most shortages", especially among injectable drugs and cancer medications that make up the majority of shortages over the past three years. However, it also blamed Congress for restricting the authority and ability of the Food and Drug Administration (FDA) to even be aware of most shortages. GAO urged Senators to strengthen the reporting requirements imposed by the FDA, in order to force manufacturers to promptly notify the agency of any snafus that will limit or shut down production.

According to GAO, the FDA does not even maintain a database of drug shortages forcing researchers to turn to industry groups like the American Hospital Association, which found that 99.5 of hospital reported shortages as recently as last summer. However, GAO found that when the FDA does know of shortages, it has the discretion to alleviate them with steps such as allowing foreign-approved drugs into the United States.

By law, the FDA currently cannot force manufacturers to report supply disruptions unless they are the only maker of a drug and it is life-saving. According to the FDA, most shortages do not fall under that category, as there are at least two suppliers.

The GAO report was requested by Senate Democrats as part of hearings they have conducted into price-gouging by suppliers of scarce medications. Senators Harkin and Jay Rockefeller (D-WV) also joined this week with the investigation into such price-gouging that was opened last October by Rep. Elijah Cummings (D-MD) (see Update for Week of October 31st).

The Generic Pharmaceutical Association (GPhA) responded to the GAO report by announcing that it would work with those in the supply chain to create the advance warning system recommended by GAO and sought the President's executive order last October and Senate legislation introduced earlier this year (S.296). However, such a voluntary system needs prior approval by the Department of Health and Human Services and the Federal Trade Commission to make sure it does not violate anti-trust laws.

FDA issues final rule to help mitigate drug shortages

The Food and Drug Administration (FDA) issued an interim final rule this week to address findings by the Government Accountability Office (see article above) that the agency should clarify the regulatory meanings of a drug production "discontinuance" and "sole manufacturer" as it relates to a drug manufacturer's duty to inform federal officials about potential shortages.

The new regulation broadens the term "discontinuance" to include either a permanent or temporary disruption in the supply of a product. Manufacturers previously only had to inform FDA only when they permanently stopped making a particular drug product.

FDA will also now define "sole manufacturer" to mean that "an applicant that is the only entity currently manufacturing a drug product of a specific strength, dosage form, or route of administration for sale in the United States." This means that only the company considered a "sole manufacturer" will be subject to the requirement to report potential shortages to federal officials, even if other manufacturers are approved to market the drug but not actively manufacturing it.

FDA issued the rule pursuant to the President's executive order which directed the FDA and Justice Department "to take action to help reduce and prevent drug shortages, protect consumers and prevent stockpiling and exorbitant pricing of drugs in shortage" (see Update for Week of October 31st).

STATES

Despite cost containment efforts, state Medicaid spending continues to spike

A new report by the National Association of State Budget Officers (NASBO) found that state Medicaid spending soared last year and will likely continue to do so despite recent cost containment measures.

Total Medicaid spending, excluding administrative costs, reached nearly \$400 billion in fiscal 2011, an increase of over ten percent from the year prior. The biggest spikes were experienced in California (40.8 percent increase), Idaho (22.9 percent), and Hawaii (22.7 percent). Overall, Medicaid comprised nearly one-quarter of all state budgets, exceeding education as the top state expenditure.

The economic downturn is the primary cause of the spending increase, as high unemployment has increased Medicaid enrollment by an average of 5.5 percent in fiscal year 2011, with another 4.1 percent jump projected next year.

Despite severe cuts in Medicaid spending enacted by most states, NASBO notes that the Government Accountability Office has warned that spending is likely to continue escalating for the next 50 years due to rising health care costs.

California

Late economic improvement means mid-year health cuts are less than feared

Governor Jerry Brown (D) announced this week that lagging state revenues have triggered an additional \$980 million in mid-year spending cuts for state health programs.

The Governor's budget package signed last summer filled a record budget deficit with severe spending cuts, as well as unprecedented hikes in Medi-Cal premiums and benefit limits. However, it also included automatic across-the-board spending cuts to be triggered at year's end should projections of \$4 billion in higher revenue collections fall at least \$1 billion short (see Update for Week of November 14th).

Lagging tax revenues forced the Legislative Analyst's Office (LAO) to announce last month that the state would likely be \$3.7 billion short of budget expectations (see Update for Week of November 14th). However, slight economic improvements late in the year have greatly improved budget forecast for many states, including California (see Update for Weeks of November 21st and 28th). As a result, the Department of Finance calculated that the shortfall was \$1.5 billion lower than LAO anticipated.

As a result, the cuts that will be triggered on January 1st will be less severe than feared. However, they still include \$980 million in health cuts, including \$8.6 million in additional revenue through an extension of previous Medi-Cal reimbursement cuts and higher copayments.

LAO estimates that California will still face a \$12.8 billion deficit next fiscal year.

Florida

Unprecedented public opposition dooms Florida's request to phase-in insurer payout rules

Florida became the fifth state this week to be denied a temporary reprieve from the new federally-imposed caps on insurer profits.

The Affordable Care Act (ACA) required individual and small group plans to spend at least 80 percent of premium revenue on medical care as of January 1, 2011, or issue rebates to consumers starting in 2012. At least 17 states including Florida had sought a federal waiver allowing plans to phase-in these standards until 2014.

The six states that have received such waivers thus far were able to demonstrate that immediate enforcement could force destabilize the market. These states (Maine, New Hampshire, Kentucky, Nevada, Iowa and Georgia) are largely rural and have a health insurance marketplace dominated by 1-2 large plans that would become even more dominant if smaller plans were unable to comply with the 80 percent threshold (see Update for Week of November 7th).

By contrast, Florida's application was widely expected to be rejected, as it has a very competitive marketplace (see Update for Week of November 14th). As a result, the Center for Consumer Information and Insurance Oversight (CCIIO) within the Centers for Medicare and Medicaid Services (CMS) determined that Florida could not show a "reasonable likelihood" that immediate enforcement would

destabilize the market. CCIO also cited an “unprecedented amount” of public opposition, with over 20 advocacy groups and 3,000 Florida residents urged that CCIO reject Florida’s waiver request.

Florida Insurance Commissioner Kevin McCarty (R) has led the charge against the Affordable Care Act (ACA), returning the state’s \$1 million federal grant to strengthen its rate review process and urging the National Association of Insurance Commissioners (NAIC) to adopt resolutions seeking to weaken the 80 percent medical-loss ratio (see Update for Weeks of November 21st and 28th).

Requests to phase-in the new MLRs are still pending for six other states (Kansas, Michigan, Texas, Oklahoma, North Carolina and Wisconsin).

CMS to extend Medicaid managed care waiver, with new access to care safeguards

Officials with the Agency for Health Care Administration (AHCA) disclosed this week that federal officials are likely to approve an extension of Florida’s five county Medicaid managed care demonstration as early as next week.

Florida’s initial 2006 waiver was set to expire in August. However, the Centers for Medicare and Medicaid Services (CMS) has routinely extended the program while it considers whether to approve Florida’s request to expand Medicaid managed care to all Medicaid enrollees statewide (see Update for Week of August 1st).

The latest extension came with a list of new conditions that are likely to be part of any expanded waiver. CMS officials have consistently warned Florida that they would only approve a statewide expansion if additional safeguards were created that would protect against managed care plans saving money simply by rationing needed care. These concerns surfaced after studies by Georgetown University and the Urban Institute repeatedly documented access problems under the initial demonstration (see Update for Week of May 2nd).

The new safeguards include long-rumored stipulations requiring that Medicaid managed care plans spend at least 85 percent of premium revenue on medical care or quality improvement and offer benefit plans that meet the needs of at least 98.5 percent of enrollees. Participating plans also must refrain from imposing premiums or copayments that exceed traditional Medicaid and continue to serve a county through their contract term even if they are losing money.

These strings were widely praised by the large numbers of consumer advocates and medical groups who objected to the waiver (see Update for Week of July 18th), although they were adamant that the managed care demonstration will still harm beneficiaries and providers. Republican lawmakers have bitterly opposed the new safeguards, with the architect of the plan, Senator Joe Negron (R), accusing CMS of treating states like “beggars” (see Update for Week of September 19th).

CMS is likely to impose additional conditions on Florida’s expanded waiver request, as it seeks to impose premiums on all Medicaid enrollees, not just those earning above 150 percent of the federal poverty level (FPL) as allowed by the federal law. The latest study by Georgetown University’s Health Policy Institute warns that the \$10 monthly premium and \$100 copayment for non-emergency use of the emergency room sought by AHCA are likely to cause at least 800,000 enrollees to drop out of Medicaid. Georgetown notes that even nominal Medicaid copayments on lower income Medicaid beneficiaries have resulted in massive disenrollment in states like Oregon.

Although CMS has approved waivers in Arizona and California that allow for higher Medicaid premiums (see Update for Week of October 31st), they have consistently rejected efforts by Wisconsin and other states to go below the 150 percent of FPL threshold.

Idaho

Insurance department revises exchange-authorizing legislation

A panel of state lawmakers met this week to review draft legislation that would authorize the creation of a state-based health insurance exchange.

However, the bill proposed by the Department of Insurance is sure to stoke controversy over potential conflicts of interest, as it would give the insurance industry almost half of the voting seats on the proposed 13-member exchange oversight board. By contrast, only one member represents consumers.

The Idaho Main Street Alliance insisted that a revised provision in the legislation requiring members to disclose conflicts of interest and abstain voting on those matters was highly insufficient to ensure to insurance industry members are not voting to favor their own self-interest. However, at least 20 other states have introduced or passed similar legislation allowing insurance industry representation on exchange boards.

The draft legislation is being introduced pursuant to the executive order issued last spring by Governor Butch Otter (R). The Governor is one of roughly 11 who have sought to circumvent legislative opposition to exchange implementation through executive action. Republican lawmakers sought to prevent the Governor from accepting federal funds to implement any part of "Obamacare", but several have since supported the Governor's position to create a state exchange in favor of a federal fallback exchange (see Update for Week of August 22nd).

Michigan

Exchange legislation delayed until next session as Republicans split on whether to proceed

Legislation to create the health insurance exchange authorized by the Affordable Care Act (ACA) has been delayed until next session.

Despite the support of Governor Rick Snyder (R) and passage by Senate Republicans (see Update for Week of November 14th), action on S.B. 693 stalled in the Republican-controlled House, with Appropriations chair Chuck Moss (R) acknowledging that many Republicans would "rather be caught sacrificing to Satan than voting for [any part of] Obamacare." House Republicans instead voted to strip out \$9.8 million in federal grants that Michigan already accepted to create the exchange, which the Senate had included in a supplemental appropriations bill for fiscal year 2011 (H.B. 5014).

It was not immediately clear if Governor Snyder will follow the lead of his counterparts in 11 other states and attempt to circumvent legislative opposition through executive action (see Update for Weeks of November 21st and 28th). Many Republican lawmakers favor waiting to see if the U.S. Supreme Court will invalidate the entire ACA law next spring (see Update for Week of November 14th). However, Governor Snyder and the chair of the Joint Health Policy Committee, Senator Jim Marleau (R), warned that failing to pass Marleau's authorizing legislation until next session will likely cause a federal takeover of the exchange in January 2013.

New Hampshire

Executive Council reverses course, bars state agencies from creating health insurance exchange

The all-Republican Executive Council voted 3-2 this week to bar the Insurance Department from spending the last \$330,000 of the state's \$1 million federal exchange planning grant.

Governor John Lynch (D) had obtained the grant last year in order to begin implementation of the health insurance exchange required by the Affordable Care Act (ACA). The Council authorized the Insurance Department to begin spending the grant last April. However, they quickly changed their mind after tea party opposition to any part of "Obamacare" helped spur successful legislation barring any state expenditures to implement the new law.

The Insurance Department has already spent two-thirds of the grant studying how New Hampshire could best design and create their own exchange. However, they had intended to use the remaining \$330,000, as well as millions in future grants, to identify and develop the necessary information technology to operate the exchange.

Governor Lynch has not appeared inclined to follow the lead of at least 11 other governors and implement the exchange through executive action. In fact, Insurance Commissioner Roger Sevigny (D) stated that he expects New Hampshire will simply allow a federal fallback exchange.

Several Republicans including Councilor Dan St. Hilaire still favor creating a state exchange over a federal takeover. However, the majority including Councilor Chris Sununu (R) insist that a state exchange would not be any better than a federal fallback exchange, given the strings that are attached to the federal implementation grants.

New York

Governor signs bill prohibiting mail-order only prescriptions, but with a catch

Governor Andrew Cuomo (D) signed legislation this week that will prohibit insurers from requiring patients to get prescriptions through the mail. However, the Governor sought to strike a compromise between advocates and opponents of the measure by insisting in his signing statement that lawmakers pass their promised amendment to the law that requires retail pharmacies to accept the same insurance reimbursement rate as mail-order businesses.

The law will allow people to fill any prescription covered by mail order at an independent retail pharmacy as long as the pharmacy price is comparable.

The Pharmacists Society of the State of New York sought the legislation, arguing that it will help counter the rising numbers of community drugstores that are closing, causing \$4-5 billion per year in prescriptions to move out-of-state.

South Carolina

E-mails suggest Governor sought to scuttle exchange, despite accepting federal planning grant

Members of the exchange planning committee largely appointed by Governor Nikki Haley (R) sought to downplay media reports this week that the Governor worked behind the scenes to scuttle exchange progress, even while she was accepting federal grants to create the exchange.

E-mails obtained by several local newspapers through the state's *Freedom of Information Act* appeared to indicate that while the Governor was using the state's \$1 million federal exchange planning grant to study exchange options, she was privately directing her appointees to recommend against exchange implementation. In fact, the Health Planning Committee's ultimate findings last month mirrored Haley's exhortation that "the whole point of this commission should be to figure out how to opt out and how to avoid a federal takeover, NOT create a state exchange."

Governor Haley denied that she was attempting to pre-ordain the outcome of the 12-member committee she created via executive order, and her appointees insisted that Haley's e-mails were merely "distasteful" but not influential. However, at least one commission member, Rep. David Mack (D), believed Haley's appointees were pushing a preferred outcome instead of studying legitimate options. Rep. Mack was appointed by House Speaker Robert Harrell (R).

Even a physician appointed by Senate President Glenn McConnell (R) questioned whether Haley's e-mails caused him and others to backtrack on their initial support for a state exchange. Casey Fitts suggested that he was perhaps an "unwitting stooge through [a] process that was pre-determined."

Republican leadership in the House and Senate, as well as Governor Haley, had all publicly supported legislation (H.B. 3738) authorizing the create of a state-based exchange, until key members defected from the bill in the face of tea party opposition to implementing any part of Obamacare (see Update for Week of March 28th). Haley and her health director Tony Keck have since publicly declared their intention to allow a federal fallback exchange to be operated in South Carolina (see Update for Week of November 14th). The both refuse to seek any additional federal exchange grants (see Update for Week of August 29th).

Texas

CMS approves waiver allowing Texas to move nearly all Medicaid enrollees into managed care

The Texas Health and Human Services Commission (HHSC) received federal approval this week to expand Medicaid managed care statewide and establish funding pools to help providers recoup the cost of managed care.

The waiver was part of a comprehensive health reform bill (S.B. 7) signed into law last spring by Governor Rick Perry (R). It extends Medicaid managed care to those rural counties primarily in the Rio Grande Valley that had previously been excluded because Medicaid enrollees in those areas were typically sicker and more costly (see Update for Week of June 6th).

Washington

Governor appoints former insurance executive to chair health insurance exchange board

Governor Chris Gregoire (D) appointed nine members this week to serve on the new Health Benefits Exchange Board

The appointments may be somewhat controversial in that the Governor nominated only one consumer advocate, and also named a former executive of the state's dominant health insurance (Regence BlueShield) to chair the board. Authorizing legislation passed last session (S.B. 5445) does not bar insurance industry representatives from serving on the board, but does require board members not to have any conflicts of interest relating to the work of the board.

Funded by a \$23 million federal exchange establishment grant, the state Health Care Authority has taken initial responsibility for development of the exchange until the board assumes governance in March 2012. The board will ultimately be responsible for all exchange operations and provide input regarding any further funding or legislation that may be required.