Health Reform Update – Week of January 2, 2012

CONGRESS

President signs two-month reprieve on battle over payroll tax cut, Medicare physician payments

President Obama signed a last-minute measure before the holiday recess that extended the payroll tax holiday and Medicare physician payment cut until the end of February.

H.R. 3765 sets up a renewed showdown over reconciliation of competing House and Senate passed measures (see Update for Week of December 19th). It does not resolve any of the stalemate over how to offset the $150 billion in lost revenue (including whether to raise Medicare premiums for the wealthy). However, Republicans were able to get Senate Majority Leader Harry Reid (D) to move forward an appoint members to the conference committee that will try to hammer out a full-year extension of both the payroll tax cut and Medicare physician payment cut.

New fee in 2012 will fund comparative effectiveness research

Starting in 2012, the Affordable Care Act (ACA) requires that health plans pay a new fee to fund research comparing the effectiveness of various drugs, tests, and treatments.

The goal of such comparative effectiveness research is to evaluate whether expensive health services really work better than lower cost alternatives. However, it has become a political lightning rod since passage of the ACA, with several Republican lawmakers insisting that it will led to government rationing of care or "death panels" that determine whether the sick or elderly should be denied life-saving care. Such fears led Republicans to block the permanent appointment of Donald Berwick, MD to be the Administrator of the Centers of Medicare and Medicaid Services (CMS) due to past praise for the British health care system, which does link funding decisions to comparative effectiveness data (see Update for Weeks of November 21st and 28th).

The $1-per-person health plan fee goes into effect starting this year and will be used to fund the Patient-Centered Outcomes Research Institute, an independent, non-profit organization that will carry out the research. However, the Treasury Department notes that it likely will not be collected for another year (though insurers still owe the money). The fee doubles to $2 per covered person in its second year and thereafter rises with inflation. Treasury is expected to issue implementing guidance to insurers within the next six months.

The Institute will be headed by Joe Selby, MD, who insists that studies will merely present evidence on effectiveness to physicians and doctors and allow them to continue making treatment decisions. Insurers remain unconvinced. Even though many large health plans like Blue Cross and Blue Shield have long conducted their own effectiveness research (with bipartisan support), these studies lack the credibility and influence of a government-backed institute, which insurers claim could essentially dictate coverage decisions by Medicare, Medicaid, and other private plans.

Federal officials with Treasury and Health and Human Services emphasize that the ACA includes provisions barring Institute findings from being used for Medicare and Medicaid coverage determinations. The Institute also has complete autonomy to choose what health services to evaluate and compare.

The Institute will release its research agenda for 2012 in the coming weeks. Former Centers for Medicare and Medicaid Services (CMS) Administrator Gail Wilensky is one of few Republicans praising

its work, noting that the Institute will provide much-needed data on high-cost drugs and procedures, for which the exists little consensus among providers regarding their effectiveness. Wilensky has been an influential long-time member of the Medicare Payment Advisory Commission (MedPAC) and insisted that it was "shortsighted" to oppose federal funding to find "ways to treat better and spend smarter.""

The American Recovery and Reinvestment Act (ARRA) also provided $1.1 billion in stimulus funds for the National Institute of Health to conduct similar effectiveness research.

Chief justice compelled to defend integrity of fellow justices in Affordable Care Act review

The Chief Justice of the U.S. Supreme Court took the highly unusual step this week of using his year-end report to defend the decision by two justices not to withdraw from the high court's pending review of the Affordable Care Act (ACA).

Associate justices Elena Kagan and Clarence Thomas have been under intense partisan pressure to withdraw from the case (see Update for Week of November 14th). Conservative activists insist that Kagan's participation is improper given the fact that she served as the Solicitor General in the Obama Administration while the new law was being deliberated in Congress. Liberal groups oppose Thomas' involvement given his failure to disclose nearly $1.6 million in payments and gifts to his wife for working with conservative think tanks that seek to repeal or overturn the new law (At least 52 House Democrats have gone to the extreme of calling for impeachment proceedings against Thomas.)

One group, Alliance for Justice, had recently urged Roberts to impose the same code of conduct that applies to other federal judges, after Thomas and fellow associate Antonin Scalia attended a fundraiser held by ACA opponents. All federal judges except those on the Supreme Court explicitly "may not be a speaker, a guest of honor, or featured on the program" at a political fundraiser.

Roberts noted that only the justices can govern their own behavior or decide whether recusal is warranted, dating back to the precedent set as early as 1919. He noted that this ultimate discretion ensures that the chief justice cannot influence the outcome of the court's review simply by "selecting who among its members may participate" in a proceeding The Chief Justice insisted that he has "complete confidence" in the "exceptional integrity" of his colleagues to avoid any appearance of favoritism and determine when recusal is proper.

Both Justice Kagan and Thomas participated in all of the scheduling deliberations on the case. Neither has responded to demands for their recusal, keeping in line with Supreme Court tradition. A rare exception to this policy was Justice Scalia's memo defending his 2004 review of a case involving Vice President Cheney despite hunting outings with the Vice President.

House bill would allow FDA to expedite approval of "ultra-orphan" drugs

Representatives Cliff Stearns (R-FL) and Edolphus Towns (D-NY) introduced H.R. 3737 on December 20th. Called the *Unlocking Lifesaving Treatments for Rare-Diseases Act ("ULTRA")*, the bill would amend existing federal law to "improve access to the existing accelerated approval pathway for patients with life threatening ultra-rare genetic diseases." Specifically, it would allow the Food and Drug Administration (FDA) to approve an application for a drug designated both as an orphan drug and as a fast track product using a "surrogate endpoint" as defined in federal law. In addition, the orphan disease or condition must affect such a small number of patients in the United States that is considered an "ultra-rare" or "ultra-orphan" drug (commonly considered as afflicting less than 6,000 people).

A surrogate endpoint is an alternative measurement of the symptoms of a disease or condition that is substituted for measurements of observable clinical symptoms. Surrogate endpoints are expected to predict clinical benefit or harm. For more prevalent diseases, there may be independent clinical data that make a surrogate endpoint reasonably likely to predict clinical benefit. However, most ultra-rare diseases do not have the same pre-existing body of clinical management or historical study data currently required to utilize this accelerated approval pathway, according to the Kakkis EveryLife Foundation.

As a result, the Kakkis EveryLife Foundation worked with Rep. Stearns to build support for H.R. 3737, so that this pathway is also available for ultra-rare drugs.

FEDERAL AGENCIES

HHS rejects two more state requests to phase-in new caps on insurer profits

Kansas and Oklahoma became the latest two states this week to be rebuffed in their effort to temporarily avoid new federal caps on insurer profits.

The Affordable Care Act (ACA) requires individual and small group health plans spend at least 80 percent of premium revenue on direct medical care, as opposed to administration, salaries, and profits. Those that failed to comply in 2011 must issue refunds to consumers in 2012.

However, six states (Maine, New Hampshire, Kentucky, Nevada, Iowa, and Georgia) were able to persuade the Department of Health and Human Services (HHS) that immediate compliance with this new medical-loss ratio (MLR) in 2011 would significantly disrupt their marketplace, as smaller plans would be forced out in favor of dominant insurers. These states were allowed to gradually move up to the 80 percent standard by 2014.

Conversely, HHS has now rejected waiver applications from eight states (Delaware, North Dakota, Indiana, Louisiana, Florida, Michigan, Kansas, and Oklahoma) that failed to demonstrate that most existing individual and small group plans were not already profitable enough to meet the higher MLR or unable to adjust their business practices to do so. All but one of these states are led by Republican governors seeking to legally block implementation of the ACA.

Similar waiver requests remain pending from North Carolina, Texas, and Wisconsin. HHS announced this week that it has delayed a decision on the Texas waiver until late January. Congressional Democrats from Texas have urged the agency not to approve the waiver, which would deprive Texas consumers of millions in rebates from 2011.

At least one state is refusing to take “no” for an answer. Florida Insurance Commissioner Kevin McCarty (R) sent a letter to HHS last week urging the agency to reconsider last month’s rejection of his waiver request (see Update for Week of December 12th). He insists that applying the new MLR to the 2011 plan year will “cause permanent, irreparable harm to our market”, noting that not one new plan has sought entry to Florida’s individual market since passage of the ACA. However, HHS determined that Florida has a highly competitive insurance marketplace and cited an “unprecedented” level of public opposition generated by the Commissioner’s application.

McCarty recently became President of the National Association of Insurance Commissioners (NAIC) and led the unsuccessful charge last year to soften the new MLRs by removing fees paid to insurance brokers and agents from counting as administrative costs (see Update for Weeks of November 21st and 28th). He and Governor Rick Scott (R) have defiantly refused to implement any provision of the ACA and returned or refused to accept all federal implementation grants.

HHS rewards states with nearly $300 million for enrolling eligible children in SCHIP

The Department of Health and Human Services (HHS) awarded 23 states $296 million in bonus payments this week for exceeding enrollment targets in the State Children's Health Insurance Program (SCHIP). The awards comes on the heels of a new HHS report showing that 1.2 million children have gained coverage since the SCHIP program was reauthorized in 2009.

The 23 states are Alabama, Alaska, Colorado, Connecticut, Georgia, Idaho, Illinois, Iowa, Kansas, Louisiana, Maryland, Michigan, Montana, New Jersey, New Mexico, North Carolina, North Dakota, Ohio, Oregon, South Carolina, Virginia, Washington and Wisconsin.

New ACA program enlists medical professionals to help improve health care delivery

The new Center for Medicare and Medicaid Innovation (CMMI) announced this week that 73 doctors, health care executives, academics and other health professionals will each receive $20,000 this year to spend up to ten hours per week trying to change health systems in ways that will improve the delivery of health services.

The Innovation Center's advisor network was created by the Affordable Care Act (ACA). The 73 individuals selected are funded through an initial round of grants that are expected to eventually pay up to 200 professionals. Another round of applications will be accepted in the spring, with more advisors to be chosen by June. The initial advisors represent large and small hospitals and other health care centers from 27 states and the District of Columbia.

FDA drug approvals hit seven-year high

New drug approvals by the Food and Drug Administration (FDA) hit a seven-year high last year as pharmaceutical manufacturers responded to agency demands for better safety data and avoided last-minute requests for more information.

FDA cleared 30 new treatments in 2011 compared with 21 the year before, according to *Bloomberg*. The total was the most since 36 drugs were cleared in 2004.

Johnson & Johnson and GlaxoSmithkline each had three products approved after no company had more than one drug cleared in 2010. Pfizer leads all drugmakers with 85 products in development, followed by Roche AG with 83 and Sanofi with 79.

Highlighting the drug approvals in 2011 were Benlysta, the first lupus treatment approved in a half century, and Xarelto, the first drug to prolong lives of those with advanced skin cancer.

Although *Bloomberg* attributed the high rate of approvals partly to improvements in how companies respond to agency demands, it also noted that the pace may be influenced by Congressional efforts to renew the system that allows drug manufacturers to pay user fees for product evaluations. The drug industry and the FDA struck a deal last fall to extend reviews two months in exchange for additional discussions while a medicine is being tested (see Update for Week of November 14th).. Congress must pass the deal by October 1st, when the current user fee system expires.

HEALTH INSURERS

Large health insurers likely to thrive under ACA expansion of government health programs

A study released this week by *Bloomberg Government* shows that the nation's largest health insurers are profiting handsomely from participating in government health programs.

Researchers found that the share of revenues coming from Medicare and Medicaid increased by 36-42 percent since 2009 for Aetna, Cigna, Humana, UnitedHealth Group and Wellpoint. These dominant insurers also increased their combined operating margins (the share of company revenue left over after accounting for operating expenses) by 8.65%, even as revenue from traditional business remained flat.

As a result, *Bloomberg* concludes that profits will continue to increase for large insurers as participation in Medicare and Medicaid expand with full implementation of the Affordable Care Act in

2014. Commercial business already accounts for less than half of the companies' combined revenue for the first time in at least two decades.

Insurers like WellPoint (the nation's largest by membership) also recorded their highest combined quarterly net income of the past decade after the ACA was signed in 2010. Overall, profit margins for all of the insurers increased nearly 1.5 percent after the ACA was enacted. The S&P 500 Managed Health-Care Index also rose 36 percent since enactment, four times more than the S&P 500 index.

Bloomberg points out that the new study refutes insurer claims that the ACA would harm their bottom line. Researchers note that despite America's Health Insurance Plans' support for the individual mandate and other ACA market reforms, health insurance companies contributed $86.2 million to the U.S. Chamber of Commerce campaign to defeat provisions of the new law that are likely to benefit them.

STATES

States lose federal funding for consumer health assistance programs in 2012

Over the past year, 35 states have used $30 million allocated by the Affordable Care Act (ACA) to help them create offices that can respond to consumer questions about how to obtain affordable health insurance coverage or appeal denied claims.

However, the ACA left future funding was left to the discretion of Congress. As a result, many of these new programs such as the Texas Consumer Health Assistance Program will start to close shop during the first few months of 2012, as Congress left out consumer assistance funding in the short-term and full-year budget resolutions for the remainder of the federal fiscal year that ends September 30th.

The loss of funding comes as consumer confusion continues to increase as additional parts of the ACA continue to go into effect in advance of full implementation in 2014.

States like Connecticut, Maine, Maryland, Massachusetts, New York, and North Carolina are exploring whether other ACA funds like the millions in exchange establishment grants can be used to continue their consumer assistance programs. New York has been doing so since its consumer assistance funding was exhausted last October.

<u>Alaska</u>

Health department moves forward on state-funded health insurance exchange

The deputy director for the Department of Health announced this week that his agency plans to sign a contract with Public Consulting Group to evaluate the cost of a purely state-funded health insurance exchange and its potential impact on the marketplace.

Governor Sean Parnell (R) was initially the only state to refuse federal exchange planning grants (other Republican Governors had since returned their grants to signal their political opposition). As a result, Alaska is moving forward without the millions in federal assistance available to other states.

The Governor has yet to indicate whether he intends for the state-funded exchange to comply with the standards required by the Affordable Care Act (ACA). If Alaska fails to make substantial progress on an ACA-compliant exchange by January 2013, a federal fallback exchange will be operated in Alaska starting in January 2014.

State funding is no longer an issue for oil-rich Alaska, as high energy prices caused revenues to balloon nearly $1.9 billion more than projected, or four percent of the state general fund.

California

Federal judge blocks some of federally-approved Medi-Cal cuts

U.S. District Court Judge Christina Snyder issued a preliminary injunction blocking much of the ten percent cut in Medi-Cal reimbursement that had already been federally approved.

The Centers for Medicare and Medicaid Services (CMS) approved the across-the-board cut for most health care providers last fall that are retroactive to June 1, 2011, as well as new cost-sharing hikes and service limits for enrollees. However, Judge Snyder blocked the cuts from applying to pharmacies of managed care plans, agreeing that the severity of the cuts on top of similar reductions in prior years would likely restrict access to care for Medi-Cal enrollees.

Federal Medicaid law bars states from cutting Medicaid payments so severely that it will harm access to care, a nebulous standard that CMS often ignores in order to prevent states from otherwise cutting benefits or eligibility. Medi-Cal providers successfully sued to block an analogous cut in 2009, a decision that is currently being reviewed by the U.S. Supreme Court. California is challenging the constitutionality of the provision in federal Medicaid law that allows providers or enrollees from brining their own suits to enforce the "access to care" standard when CMS fails to do so.

California officials pledged to appeal Snyder's ruling, although the federal appeals court is likely to await the U.S. Supreme Court's decision later this term on whether to uphold the prior payment cut.

New health program cuts leaked by Governor's office

The office of Governor Jerry Brown (D) leaked details of the next round of fiscal year 2013 budget cuts to be proposed by the Governor at the outset of the legislative session.

The vast majority of the $4.2 billion in cuts are for health and human service programs, most notably Medi-Cal and the AIDS Drug Assistance Program (ADAP). The budget also optimistically assumes the passage of a November 2012 ballot referendum that will approve new sales taxes. If it fails to pass, additional cuts would be triggered.

The latest cuts come on top of $15 billion in health-related cuts since 2008, many of which have been held up in federal courts including the pending review by the U.S. Supreme Court (see article above). They include reducing reimbursement rates for SCHIP managed care plans by nearly 26 percent, shifting 1.4 million more dual eligible into Medicaid managed care plans, eliminating Medicaid coverage for services with "limited benefit", and increasing average cost-sharing for ADAP clients from only $28 to a whopping $385 per month.

The severity of the cuts was somewhat mitigated by the recent announcement from the Legislative Analyst Office that slight uptick in state revenues had trimmed the projected deficit for FY 2013 from $13 billion to $9.2 billion (see Update for Week of December 12th). They were met with immediate opposition from both parties, with Senate President Pro Tem Darrell Steinberg (D) and Assembly Speaker John Perez (D) insisting that the Governor focus on new revenues instead of inflicting more "significant damage" on vulnerable populations. Steinberg also refused to consider the cuts before May, when lawmakers will have a clearer picture on the status of the economic recovery in the state.

Blue Shield pays $2 million to settle remaining lawsuit over rescissions

Blue Shield of California has agreed to pay $2 million to resolve outstanding claims that the insurer improperly dropped policyholders once they required expensive treatment.

This practice of "rescission" was outlawed by state law in 2009 and the "patient bill of rights" under the federal Affordable Care Act (ACA) that went into effect for the 2011 plan year. However, Blue

Shield was among a group of large California insurers that have had to pay multiple settlements in order to resolve past claims that they left thousands of patients without coverage when they needed it most.

The settlements followed Blue Shield's previous $3 million settlement, and a $9 million judgment assessed against HealthNet in 2008, after a state court found that it paid bonuses to employees based on rescission volume. That case resulted in the new state law that cut rescissions in California from more than 5,000 a year to only a handful.

A rescissions lawsuit by the city attorney of Los Angeles remains pending against health insurance giant WellPoint.

Colorado

Record Medicaid enrollment not likely to subside as economy continues to improve

New figures provided by the Department of Health Care Policy and Financing to the Joint Budget Committee revealed that the number of Coloradans enrolled in Medicaid hit a record high in November.

The nearly 615,000 Medicaid enrollees represent a 57.7 percent spike since January 2007. State officials blame the record enrollment solely on the deep recession that started in late 2007 and not on recent expansions in Medicaid eligibility. Roughly 13 percent of all Coloradans are now covered by either Medicaid or SCHIP.

Governor John Hickenlooper (D) acknowledges that the state's Medicaid rolls are not likely to decline as the economy continues to improve, noting that his office currently predicts continued growth through fiscal year 2012-2013 as Colorado's population continues to swell.

Republican lawmakers immediately blamed Democrats for the enrollment explosion. Just last fall, state officials had to cap enrollment for childless adults at 10,000, after far more adults than expected applied. However, Democrats were quick to point out that both the childless adult coverage and expansion of Medicaid and SCHIP eligibility were fully paid for by a new fee on hospitals that was imposed with the consent of hospital associations.

State officials also noted that despite the skyrocketing growth, Colorado continues to operate one of the nation's least generous Medicaid programs.

Florida

Health subcommittee chair seeks to make Florida the latest state to allow interstate health plans

Rep. John Wood (R), chair of the Health and Human Services Quality subcommittee, pre-filed H.B. 1171 last week that would allow for the sale of interstate health plans that need not comply with state insurance regulations. It will be considered when the legislative session opens next week. Similar measures were enacted last year by several states including Georgia, Oklahoma, and Wyoming.

Indiana

New bill would make Indiana the latest state to allow interstate health plans

Rep. Tim Brown (R) filed legislation last week (H.B. 1043) that would allow for the sale of health plans by out-of-state insurers that need not comply with state insurance regulations. Similar measures were enacted last year by several states including Georgia, Oklahoma, and Wyoming.

Maine

Key Republicans defect from Governor's Medicaid overhaul

Republican lawmakers dealt a setback this week to the controversial overhaul of Maine's Medicaid program sought by Governor Paul LePage (R).

Rep. Patrick Flood (R), chairman of the House Appropriations Committee, declared his opposition to the Governor's plan to save $60 million by eliminating all funding for private non-medical facilities that serve the elderly, mentally and physically disabled, and those undergoing substance abuse.

The cut is among several Medicaid and social service cuts sought by LePage to close an estimated $220 million shortfall in the Department of Health and Human Services budget (see Update for Week of December 5th). However, the Governor's plan engendered an outcry from state residents at public hearings held last month, especially as they follow on the heels of the Governor's successful efforts last session to dismantle the state's landmark health plan (see Update for Week of June 20th) and many popular consumer protections (see Update for Week of May 23rd).

Rep. Flood insisted that the Republican caucus could not politically support the Governor's latest cuts, especially since the Governor acknowledged he was not able to get federal approval thereby putting federal Medicaid matching funds at risk. Flood instead pledged to work with the Appropriations and Health and Human Services committees to rework the proposal.

The remained of the Governor's Medicaid overhaul calls for dropping 65,000 Mainers from Medicaid (including 19,000 childless adults), cutting hospital reimbursement, placing service limits on hospital care, and eliminating entire categories of optional services. The Governor insists that without all of the severe reforms, MaineCare will run out of money on April 1st.

In addition to the defections by Republican lawmakers, the Governor's plan lacks support within his own health department. The director of the DHHS Office of Adult Mental Health Services warned this week that eliminating mental health funding would release roughly 1,000 severely mentally ill patients into the community without any supervision.

New bill would restrict use of specialty tier coinsurance for high-cost prescription drugs

Rep. Stacey Fitts (R) introduced new legislation late last month that would bar health plans from imposing co-insurance obligations for prescription drugs that exceed the dollar amount for non-preferred brand drugs or for brand drugs, if there is no non-preferred brand drug category. L.D. 1691 was referred to the Committee on Insurance and Financial Services.

Exchange legislation delayed until later this month

The Insurance and Financial Services Committee delayed consideration this week of two carryover bills relating to implementation of the health insurance exchange required by the Affordable Care Act (ACA).

Meeting for the first time in the second legislative session, the panel removed L.D. 1497 and L.D. 1498 from the agenda until at least January 18th, in order to give members sufficient time to review new federal exchange guidelines released November 30th.

Democrats including Rep. Sharon Treat (D) expressed dismay at what they viewed as delay tactics by Republican lawmakers who oppose implementing any part of "Obamacare". However, despite this opposition, the exchange concept has at least some support from Governor Paul LePage (R) and other key Republicans, who created an advisory committee last year via L.D. 1582 that will recommend how to create an exchange. However, the Governor has drawn bipartisan criticism for proposing to house the exchange oversight board within an existing state agency, something only West Virginia has done so far (see Update for Week of October 31st).

<u>Maryland</u>

Final exchange recommendations seek to go beyond federal minimum standards

The Maryland Health Benefit Exchange Board provided Governor Martin O'Malley (D) and the General Assembly a series of final recommendations last week that will support the successful creation of the health insurance exchange required by the Affordable Care Act (ACA).

As expected, the Board recommended that Maryland follow the "active purchaser" exchange model already in place in Massachusetts, where the Board can negotiate rates and selectively contract with plans that meet all state and federal standards for participation. The Board specifically wants the flexibility to impose standards above the minimum required by the ACA.

The additional standards would include a "minimum participation threshold". This would allow the Board to force any plan offering catastrophic coverage, small group plans with premium revenue above $20 million, and individual plans with revenue above $10 million, to participate both in and out of the exchange. The Board insists that such a threshold is necessary to ensure that the exchange does not effectively become a "high risk pool" due to "cherry-picking" of healthy subscribers by plans operating exclusively outside the exchange.

The Board prefers that the exchange be funded primarily by a broad-based assessment on the health care market, with additional funds coming from transaction fees on plans sold in the exchange. Federal regulations require all state-based exchanges to be self-sufficient by 2015.

The report also recommends that the exchange maintain separate navigator programs for the individual and small group markets (which will remain separate until at least 2016). The exchange would also integrate the navigator program with Medicaid outreach and enrollment, and develop a certification program limiting the number of entities or individual who can perform navigator functions, such as facilitating the enrollment of uninsured and small business individuals into exchange plans.

The Board estimates that up to 170,000 Marylanders will enroll in the exchange during the first year of operation, while 42 percent of those using the exchange will enroll in Medicaid. Essential health benefits that all plans must be provide should be defined no later than September 30th.

Lt. Governor Anthony Brown (D), who championed the new law authorizing the health benefit exchange, praised the board's work, which represents the culmination of input received from four advisory committees, 22 meetings, and numerous public hearings.

Massachusetts

High court says Massachusetts cannot limit state subsidized coverage for legal immigrants

The Massachusetts Supreme Judicial Court unanimously held this week that the Commonwealth must offer the same level of subsidized insurance to legal immigrants as to citizens. The decision affects roughly 40,000 residents and could cost Massachusetts at least $150 million per year.

Lawmakers opted in 2009 to fill a budget deficit by trimming state subsidized health coverage for legal immigrants who have not been naturalized as citizens, arguing that it did not need to offer them the same coverage as citizens since the federal government does not share in the cost of their care. Health Law Advocates sued after the Commonwealth instead created a limited benefit plan for legal immigrants that imposed significantly higher copayments and restricted their choice of providers.

Governor Deval Patrick (D) now must weigh whether to raise taxes or fees to cover the additional cost or reduce benefits for everyone, at least until 2014 when the Affordable Care Act will provide some federal assistance for coverage to legal immigrants.

Michigan

Insurance department will not challenge federal rejection of medical-loss ratio waiver

The Office of Financial and Insurance Regulation announced this week that it will not follow the lead of Florida (see article above) in seeking to appeal the federal government's refusal to allow it to phase-in new regulations capping insurer profits.

The Affordable Care Act (ACA) requires individual and small group health plans spend at least 80 percent of premium revenue on direct medical care, as opposed to administration, salaries, and profits. Those that failed to comply in 2011 must issue refunds to consumers in 2012.

Michigan was one of 17 states that sought a temporary waiver, arguing that it immediate compliance would destabilize the market. However, the U.S. Department of Health and Human Services determined last month that individual and small group plans in Michigan either already meet the new medical-loss ratio or are sufficiently profitable to adjust their business practices to do so (see Update for Week of December 19th).

HHS has denied similar waiver requests from seven other states (see article above).

New Hampshire

Republican lawmakers vote again to return federal grants to implement Affordable Care Act

The House Rules Committee voted 7-2 this week to allow the late entry of a bill that would return $333,000 in federal exchange implementation grants.

House Majority Leader D.J. Bettencourt (R) pledged to continue his effort to block any implementation of "Obamacare", even provisions such as the health insurance exchange that previously had bipartisan support. However, not all Republicans support the move, as the measure cleared the all-Republican Executive Council last month by only one vote (see Update for Week of December 12th). Some Republicans like Council member Dan St. Hilaire favor using the exchange grant to create a state exchange, in favor of simply allowing a federal fallback exchange to be operated in New Hampshire.

Governor John Lynch (D) had obtained the initial $1 million planning grant last year in order to begin implementing the exchange required by the Affordable Care Act (ACA). The Council authorized the Insurance Department to move forward last April, and it spent two-thirds of the grant before the Council changed course.

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The measure will likely be considered by the Republican-controlled House in March.

Ohio

Minority Democrats try to force Republican hand on health insurance exchange

Senator Michael Skindell (D) introduced S.B. 277 this week, which would create the Ohio Health Benefit Exchange Agency to oversee the creation and operation of the health insurance exchange required by the Affordable Care Act (ACA).

The measure would ban participate on the oversight board by any individual who worked for insurer or health provider in the past three years and ensure that at least one consumer representative serves on the board. However, insurance representatives can serve on an advisory committee that makes recommendations on board nominees.

Rep. John Patrick Carney (D) introduced companion legislation in the House as Democrats tried to force legislative action on the exchange prior to the January 2013 deadline to avoid a federal fallback exchange. However, the measures are certain to meet broad opposition from Republican leaders, who

have joined with Governor John Kasich (R) in taking a "wait and see" approach to see if the U.S. Supreme Court overturns the ACA before proceeding with exchange implementation (see Update for Week of September 12th). Ohio did not apply for any federal exchange establishment grants in 2011 and the Governor has given no indication that he intends to do so prior to the June 30th deadline for remaining grants.

Tennessee

Despite stakeholder urging, Republicans still seek to avoid exchange issue until December

Health insurers, physicians, hospitals, and other health providers overwhelmingly want Tennessee to create its own health insurance exchange instead of defaulting to a federal fallback exchange. That was the principal finding of a ""white paper" released this week by the Insurance Exchange Planning Initiative.

Tennessee was one of only 11 states that failed to introduce any legislation authorizing the creation of the exchange required by the Affordable Care Act (ACA). Despite the support by Governor Bill Haslam (R) for a state exchange, he has been joined by the Republican leaders in deferring any decision on the exchange until waiting to see if the new law is overturned by the U.S. Supreme Court (see Update for Week of December 19th).

In the interim, the Governor has accepted $2.5 million in federal exchange grants, which the Department of Finance and Administration used to create the Exchange Planning Initiative. The Initiative works with stakeholders in developing recommendations on implementation for the Governor and Legislature.

Feedback from a dozen listening sessions compiled by the Initiative demonstrated that stakeholders strongly oppose legislative inaction on the exchange, as it threatens to result in a federal fallback exchange instead of an exchange tailored to Tennesseans. This unsolicited opinion was provided by a majority of stakeholders even though the question was never asked of them. The responses came from insurers like BlueCross BlueShield of Tennessee, as well as the Tennessee Medical Association, the Tennessee Nurses Association and the Tennessee Hospital Association.

However, Lt. Governor (and Senate Speaker) Ron Ramsey (R) and House Speaker Beth Harwell (R) have acknowledged that moving forward on a state-based exchange may be politically untenable, as no Republican wants to incur the wrath of "tea party" voters opposed to legitimizing any part of "Obamacare". As a result, they have refused to consider the volatile issue before a special session in December 2012, which would be past both the U.S. Supreme Court resolution of the case and the mid-term elections. Such a delay would likely force the federal government to operate a fallback exchange in Tennessee, as the state will have made no progress towards an exchange by the January 2013 federal certification deadline.

Vermont

Bipartisan bill would go beyond minimum federal standards for health insurance exchange

Senators Vince Illuzzi (R) and Hinda Miller (D) used the opening of the legislative session this week to introduce bipartisan legislation that would give employers greater flexibility in the new health care exchange created pursuant to the Affordable Care Act (ACA).

The creation of state exchange was part of Vermont's landmark single payer measures signed into law last session. However, S. 208 will go beyond the federal standards and allow employers with up to 100 workers to initially participate in the exchange (instead of just 50), and all employers by 2017. The measure would also expand the choice of exchange plans to all five levels of coverage permitted by the ACA (instead of just three), and allow them to be sold both in and out of the exchange. It also requires a

study on the cost of Vermont supplementing the ACA's tax credit subsidies to those with incomes up to 400 percent of the federal poverty level who purchase coverage in the exchange.

Wisconsin

Governor urges states to delay exchange implementation until U.S. Supreme Court ruling

Governor Scott Walker (R) announced last week that Wisconsin would halt all work on the implementing the health insurance exchange required by the Affordable Care Act (ACA) and urged other states not to move forward until the U.S. Supreme Court resolves the constitutionality of the new law.

Despite being an outspoken opponent of the new law, Governor Walker had pledged not to return the $38 million in federal exchange implementation grants obtained by his Democratic predecessor. However, the Governor did transform former Governor Doyle's health reform implementation office into the Office of Free Market Health Care that used the exchange grants to commission studies concluding that the cost of creating an ACA-compliant exchange would be prohibitively expensive.

Consumer advocates and Democratic lawmakers strongly criticized the Governor's delay, as it means Wisconsin will likely be forced to accept a federal fallback exchange in 2014 should the Supreme Court not overturn the entire ACA. However, even if the law is upheld Governor Walker has suggested that Wisconsin could create a non-compliant exchange with state-only funds.

Even if he chose to create an ACA-exchange, Governor Walker would have to do so without the support of key Republicans including Senate Insurance committee chair Frank Lasee (R), who have pledged to block any exchange-authorizing legislation. This means he would have to follow the lead of at least 11 other governors and create an exchange via executive order.

The Governor's exchange announcement comes against the backdrop of a campaign to recall him later next year. Walker acknowledged this week that his opponents will have enough signatures to hold a recall election as early as next June. The Governor's successful passage last year of legislation stripping union workers of their right to collectively bargain for health care benefits sparked a backlash that result in recall initiatives against the Governor and several Republican lawmakers.