

Health Reform Update – Weeks of March 19, 2012

CONGRESS

“RyanCare 2.0” would slash safety-net spending, dramatically increase out-of-pocket costs

The House Budget Committee narrowly passed a FY2013 budget plan this week that would cut \$2.5 trillion in discretionary spending over the next decade, with over half the savings coming from federal health programs, as well as food stamps, Pell Grants, and other assistance for working-class Americans.

The severity of the plan, which included \$200 billion in mandatory spending cuts, caused two conservatives, Reps. Justin Amash (R-MI) and Tim Huelskamp (R-KS) to join with committee Democrats in opposing the measure, which passed by only a single vote. It is not yet clear if the plan has sufficient support to pass the House, since it violates the Budget Control Act, the contentious spending compromise that Speaker Boehner (R-OH) reached with Democrats last summer (see Update for Week of August 1st).

Crafted by Budget chairman Paul Ryan (R-WI), the plan cuts \$19 billion beyond the spending caps set by the Budget Control Act for FY2013, while increasing defense spending by \$8.2 billion more than allowed. It would also dramatically reform the tax code, condensing six brackets into two, removing loopholes, and extending the Bush-era tax cuts beyond their expiration in 2012. Eliminating tax loopholes have long been favored by Republican leaders and the Bowles-Simpson deficit reduction commission as a way to significantly boost federal revenues (see Update for Week of December 6, 2010). However, a Republican plan to do so as part of the Budget Control Act already failed after conservative freshman insisted it violates their pledge not to support any revenue increases.

Chairman Ryan’s latest plan slightly softens his House-passed bill last year that would force Medicare enrollees into the private market and convert Medicaid into federal block grants with no strings attached (see Update for Week of April 4th). Instead, it gives Medicare enrollees the option to remain in traditional Medicare if they do not want to accept premium subsidies to purchase private coverage.

Rep. Ryan was forced to include the traditional Medicare option last winter after a popular backlash was credited for a surprising Democratic victory in a special election last spring (see Update for Week of May 23rd). No other Democrat besides Wyden supported his revised plan (see Update for Week of December 19th) and Senator Wyden announced this week that he would not support Ryan’s latest version as it halves the amount that premium subsidies offered to Medicare enrollees would annually increase to reflect inflation.

Ryan’s latest plan would also increase Medicare eligibility to age 67. The Congressional Budget Office (CBO) concluded earlier this year that such a move would cut overall Medicare spending by five percent, but merely shift those costs to Medicare, new health insurance exchanges, and the uninsured (see Update for Week of January 9th).

While these provisions have broad Republican support, Rep. Ryan surprised conservative opponents of the Affordable Care Act (ACA) by proposing to create a health insurance exchange within Medicare. Even though exchanges have been long-supported by Republicans as a market reform, Tea Party opposition to legitimizing “Obamacare” have forced many Republican governors and lawmakers oppose any exchange implementation in their states.

According to CBO, Ryan’s plan would save \$205 billion over ten years from Medicare. However, CBO found that it would cut Medicaid spending by nearly four times that amount, or over \$40 billion more than Ryan first proposed last year

As it did last spring, CBO concluded that replacing the entire ACA with Ryan's proposed Medicare premium support and Medicaid block grant models would dramatically shrink Medicare and Medicaid benefits, increase out-of-pocket costs for enrollees, and escalate uncompensated care costs for far higher numbers of uninsured. (For example, CBO found that Medicare seniors could pay 68 percent of the cost of their health care by the year 2030.) CBO warned that the Ryan plan could also result in "reduced access to health care [and] diminished quality of care."

CBO estimated that the overall impact of the bill would reduce federal spending by more than 75 percent by 2050. House Appropriation Committee Republicans acknowledged that such a severe departure from previously agreed targets would create an even "bigger challenge" to find common ground, but Chairman Rogers (R-KY) agreed that he would work to meet Ryan's lower spending goals.

Democrats were quick to deride the plan, reiterating earlier claims that privatization will "end Medicare as we know it." Senator Max Baucus (D-MT) insisted that the Medicare premium support plan will put the program in a "death spiral" as sicker and costlier enrollees will be forced to remain in traditional Medicare. The Center for Budget and Policy Priorities deemed the plan "Robin Hood in reverse" while a commentator in *Forbes* opined that "the only way RyanCare makes any sense is if we are prepared...to let our elderly die because they have been priced out of the health care market."

House passes repeal of Medicare cost-cutting panel

Despite losing any appearance of bipartisan support, the House passed legislation this week that would repeal the panel created by the Affordable Care Act (ACA) to craft automatic cuts whenever Medicare spending exceed targeted growth rates.

The measure (H.R. 452) had attracted at least 20 House Democrats when it cleared committee, largely due to fears that the new Independent Payment Advisory Board (IPAB) would cede control away from Congress (see Update for Week of March 5th). However, it ultimately was attached to legislation (H.R. 5) that would enact the medical malpractice caps long-favored by Republicans.

The partisan move forced several key Democrats including Reps. Barney Frank (D-MA), Frank Pallone (D-NJ), and Allyson Schwartz (D-PA) to back-off their earlier support (see Update for Week of March 12th). Ultimately, only seven Democrats supported the bill (while ten Republicans opposed it).

President Obama immediately pledged to veto the bill, although the threat was largely symbolic since H.R. 5 appears all but dead in the Democratically-controlled Senate (where the IPAB originated).

Federal health reforms already slowing growth in Medicare spending

An article in the March 7th *New England Journal of Medicine* by the Center for Studying Health System Change concludes that recent federal reforms including the Affordable Care Act (ACA) have already substantially slowed the growth in Medicare spending and are likely to permanently do so.

Over the past four decades, the average growth in Medicare spending per enrollee has exceeded the growth in per capita gross domestic product (GDP) by 2.6 percent per year. If this trend continues, Medicare would consume all federal revenues by 2060. However, the researchers found evidence that Medicare spending growth has slowed substantially since 2005, to the point where per enrollee Medicare outlays in 2010 and 2011 were roughly in line with growth in the economy.

This reduction in spending growth has already been reflected in lower Part B monthly premiums (which were nearly \$7 less than estimated for 2012). The Congressional Budget Office (CBO) also downgraded its ten-year Medicare spending projection last January by \$69 billion.

Researchers attribute part of the decline in spending growth to less utilization of costly medical care during the recession, as well as greater numbers of young and healthier senior citizens going onto Medicare as “baby boomers” reach age 65. .

However, they conclude that the recent slowdown in Medicare spending growth is likely not a “fluke” but evidence of a long-term trend that began with tighter Medicare payment policies implemented under *Balanced Budget Act of 1997* and the *Deficit Reduction Act of 2005*, as well as the cuts in Medicare Advantage payments that started with the *Medicare Improvements for Patients and Providers Act of 2008*. All of these laws are but “pale previews” of the Medicare payment cuts in the ACA, which “permanently slows the growth in Medicare payment rates for almost every category of provider other than physicians.” As a result of the ACA, CBO projects that over the next decade Medicare spending per enrollee will grow substantially more slowly than the overall economy.

CBO predicts that less than three percent of taxpayers will pay individual mandate penalty

The most controversial provision of the Affordable Care Act (ACA) will likely impact relatively few Americans, according to the Congressional Budget Office (CBO).

The U.S. Supreme Court is set to hear oral arguments next week on whether Congress can force Americans to pay a tax penalty if they fail to buy health insurance that they can afford. Kaiser Family Foundation tracking polls consistently show that this “individual mandate” is opposed by nearly two-thirds of all Americans (see Update for Week of December 19th).

However, the latest cost estimate by CBO estimates that only about four million Americans will be hit with this tax penalty in 2016. That represents less than three percent of all tax returns received by the Internal Revenue Service (IRS).

CBO based its estimate on figures from Massachusetts, where former Governor Mitt Romney (R) signed a nearly identical mandate into law in 2006. Though Massachusetts imposes a higher penalty, less than one percent of Massachusetts tax filers were penalized for not buying health insurance, according to the most recently available figures in 2009.

By contrast, CBO projects that health insurance premiums would jump 15-20 percent for everyone if the U.S. Supreme Court were to strike down the “individual mandate”, given the political inability of Congress to pass any comparable mechanism to offset the higher uncompensated care costs that would result from 16 million additional uninsured.

CBO’s findings mesh with the conclusion of unrelated studies published this week in *Health Affairs*, as well as previous findings by the Robert Wood Johnson Foundation and American Academy of Actuaries that premiums would “skyrocket” by at least 20 percent if the “individual mandate” were severed from the ACA’s other market reforms (i.e. guaranteed issue, rating restrictions, essential health benefits, etc.) The *Health Affairs* study emphasized that health insurance premiums more than doubled in New Jersey when they instituted similar market reforms in 1993 but did not include a mechanism to ensure the risk pool was sufficiently broadened to include healthy and lower cost individuals. An Urban Institute analysis released this week also found that premiums in the new health insurance exchanges would jump 10-25 percent if the “individual mandate” was removed and 14 million more people remained uninsured.

Women continue to pay far more than men for health insurance

A report released this week by the National Women’s Law Center documents that women are continuing to pay far more than men for health insurance coverage in advance of the Affordable Care Act (ACA) ban on so-called “gender rating” that goes in effect in 2014.

Although 14 states including California, Massachusetts, New Jersey, and New York have already prohibited “gender rating”, more than 90 percent of the best-selling health plans in other states continue to charge women more than men. For example, Blue Cross and Blue Shield of Illinois premiums cost a

30-year old woman more than 31 percent more than a man of the same age, while health plans in Arkansas are charging comparable age women up to 81 percent more than men.

The deputy insurance commissioner in Florida confirmed that the findings are consistent with data from her state over the past four years. However, the Blue Cross and Blue Shield Association and other large insurers defended the disparity, claiming that women age 19-55 continue to use more health services than men.

The ban on gender rating is not among the provisions of the ACA that are at issue in the pending U.S. Supreme Court challenge. However, the entire law could be struck down if the high court finds just one provision to be unconstitutional (see Update for Week of January 2nd).

Democrats expand investigation into “gray market” sales of short-supply drugs

Democratic lawmakers have expanded their on-going investigation into prescription drug shortages by demanding new documentation from several pharmacies that bought and sold large quantities of scarce drugs at huge mark-ups.

Representative Elijah Cummings (D-MD) launched an investigation last fall after an analysis by Premier’s alliance of hospitals and health care systems found that middle-men were marking-up prescription drugs in short supply by an average of 650 percent (see Update for Week of August 15th). Similar investigations by the Food and Drug Administration (FDA) and the Government Accountability Office have found that this so-called “gray market” has greatly compounded record shortages of life-saving drugs in 2010 and 2011 (see Update for Week of October 31st).

Senators Jay Rockefeller (D-WV) and Tom Harkin (D-IA) joined with Rep. Cummings in sending letters this week to 22 pharmacies demanding extensive records by April 11th of how they acquired drugs in short supply and quickly profited from their sale. The three Democrats cited evidence obtained from earlier requests showing that a Maryland pharmacy purchased short supply cancer and seizure medications in 2011, yet transferred them to a related wholesaler in New Jersey on the very same day without dispensing them, in direct violation of Maryland law.

Drug shortages have tripled over the last five years causing more than 180 medications to be in short supply during 2011 (see Update for Week of October 31st). However, the White House claims that the President’s executive order last fall has prevented 114 drug shortages by giving FDA regulators more power to track shortages, quickly approve replacement manufacturing sites and punish price gougers (see Update for Week of February 20th).

FEDERAL AGENCIES

ACA has saved Medicare enrollees an average of \$610 in prescription drug costs

As part of their week-long campaign to extoll the virtues of the Affordable Care Act (ACA), the Department of Health and Human Services (HHS) announced this week that more than 5.1 million Medicare Part D enrollees have been helped by the law’s prescription drug discounts, saving them an average of \$610.

The ACA initially gave all Medicare Part D enrollees a \$250 rebate once they entered the coverage gap or “doughnut hole” in 2010. Starting in 2011, the ACA required brand-name drug manufacturers to discount their products by 50 percent within the “doughnut hole”, with an additional seven percent discount for generic medications.

The discounts saved Part D enrollees over \$2.1 billion last year but have already saved \$93 million for 103,000 enrollees who entered the “doughnut hole” in January and February. This is largely because the generic discount doubled to 14 percent for 2012.

HHS predicts that Part D enrollees will ultimately save an average of \$4,200 from 2011 to 2021, thanks not only due to the reduction in the “doughnut hole”, but also elimination of cost-sharing for certain preventive services and restricted growth in Medicare Advantage premiums. HHS reiterated that average premiums for Medicare Advantage dropped seven percent last year, while enrollment is up ten percent for 2012 (see Update for Week of January 30th).

ACA is ensuring young adults gain stable health insurance coverage

The Department of Health and Human Services (HHS) promoted an agency report this week showing that the ACA not only helped 2.5 million young adults gain health insurance coverage, but ensures they can keep it over time.

The new data timed to coincide with the second anniversary of the ACA this week shows that young adults up to age 26 were more than twice as likely to lose health coverage over time as compared to older adults. It found that nearly 31 percent of young adults aged 19-25 who initially had private health insurance in 2008 were uninsured for at least one month over the following two years

By contrast, the ACA ensures that young adults can remain on their parent's health plan until age 26, without having to worry about losing coverage if they change jobs, go to school, or get sick or injured.

All states but Arizona have taken steps to enforce the ACA “patient bill of rights”

A new Commonwealth Fund analysis timed to coincide with the second anniversary of the Affordable Care Act (ACA) documents that 49 states and the District of Columbia have already taken at least some form of action to enforce law's initial private market reforms.

For plan years starting on or after September 23, 2010, the ACA's “patient bill of rights” required guaranteed issue for children and dependent coverage for young adults up to age 26, as well as banning discriminatory practices like rescissions and lifetime benefit caps. Researchers from the Georgetown University Health Policy Institute found that only the state of Arizona has failed to take any legislative, regulatory, or administrative action to enforce at least one of these ten early reforms. At least 23 states and the District of Columbia have enacted a law or regulation to implement at least one of these reforms, while another 26 states have taken steps to promote compliance.

HHS shames two more insurers for excessive premiums, credits ACA for restraining rate hikes

The Department of Health and Human Services (HHS) used the second anniversary of the Affordable Care Act (ACA) this week to publicly shame two more health insurers for unreasonable hiking plan premiums.

Effective September 1st, state insurance departments are required to obtain and publicize the actuarial basis for any increase in private plan premiums of at least ten percent, while HHS oversee this task for the ten states that currently lack the ability to do so (see Update for Week of August 29th). While the ACA does not give HHS to power to reject or modify rate hikes, it can review this data to determine if the rates do not reasonably reflect increases in medical inflation.

The agency's Center for Consumer Information and Insurance Oversight (CCIIO) first used this new review authority to publicly shame Trustmark Life Insurance for unreasonably raising rates up to 27 percent (see Update for January 9th). Their latest determination likewise found that John Alden Life Insurance Company and Time Insurance Company excessively hiked rates 12-24 percent in both the individual and small group market across nine states (Arizona, Idaho, Louisiana, Missouri, Montana, Nebraska, Virginia, Wisconsin and Wyoming.)

The two companies, who both belong to Assurant Health, were unable to verify the accuracy of the medical inflation trend data they provided CCIIO. Based on the information they could verify, CCIIO

determined that neither company would meet the ACA requirement that individual and small group plans spend at least 80 percent of premium revenue on medical care. As a result, each company will have to rebate the difference back to consumers.

A concurrent HHS report documented that HHS has now reviewed 28 double-digit rate hikes and deemed 20 to be unreasonable. The report credited this new authority under the ACA with incentivizing seven more states to give their insurance commissioner greater authority to restrict unreasonable rate hikes. It also claimed that increases in health premiums have dropped by 4.5 percent since the new authority went into effect last fall.

However, a separate report by Epstein Becker Green noted that none of the rates HHS has deemed unreasonable have been adjusted or rescinded.

Final rule will apply most ACA standards to student health plans

Final regulations published by the Department of Health and Human Services (HHS) in the March 21st *Federal Register* will require student health plans to comply with most of the insurance market reforms in the Affordable Care Act (ACA).

In proposed rules published in February 2011, HHS exempted student health plans from any provision of the ACA that would have “the effect of prohibiting an institution of higher education from offering a student health plan otherwise permitted under Federal, State or local law.” They specifically did not impose guaranteed access and renewability requirements on student plans and barred them from applying an annual dollar limit on coverage that was less than \$100,000 for any policy year that began before September 23, 2012. The agency also solicited public comments on how other ACA provisions should apply to student health coverage.

In response, HHS has decided to continue banning annual limits of less than \$100,000 for the 2012-13 school year and increase that limit \$500,000 for the following year. No annual limits will be permitted starting in 2014.

Student health plans are defined as individual plans under the final rule and must start complying with most other individual plan requirements under the ACA, including the ban on lifetime caps and removal of cost-sharing for certain preventive services. Starting in 2013, they also must adhere to the new medical-loss ratios that require individual and small group plans to spend at least 80 percent of premium revenue on direct medical care instead of profit and overhead. While HHS may mitigate the impact of this provision for some student plans in 2013, all must comply by the following year.

The agency has yet to decide whether the temporary exemption for guaranteed access and renewability will continue past 2014. This will be addressed in subsequent rulemaking.

HHS continues to acknowledge that they “do not have the authority to regulate self-funded student health plans.” Thus, self-funded student plans need only comply with state laws, not the ACA.

CCIIO still resolving issues related to employer mandate under ACA

The Director of the Center for Consumer Information and Insurance Oversight (CCIIO) told lawmakers this week that his office is still debating how best to implement the employer mandate under the Affordable Care Act (ACA).

Starting in 2014, companies with 50 or more full-time workers will be required to provide affordable health insurance coverage or pay a per employee assessment. However, CCIIO has yet to issue regulations defining how to collect data from workers, employers and exchanges in order to assess whether workers are obtaining health insurance through their employer or on their own.

The Director did dispute Republican claims that the employer mandate would cause companies to drop coverage and force their employees into the new health insurance exchanges. He emphasized that both the Congressional Budget Office and Joint Committee on Taxation have concluded that while the exchanges will offer more attractive premiums, employers will still have major financial incentives to continue offering employer coverage in order to remain competitive (see Update for Week of March 12th).

STATES

ADAP waiting lists back on the decline

According to the National Association of State and Territorial AIDS Directors (NASTAD), Georgia now leads the nation with 1,102 people on a waiting list for the AIDS Drug Assistance Program (ADAP) with Virginia close behind at 996.

ADAP waiting lists nationwide reached their highest level in last September at 9,928 individuals, 43 percent of which belonged to Florida (over 4,000 individuals). However, \$885 million in federal relief last fall (see Update for Week of October 3rd) and an additional \$35 million pledged last winter (see Update for Week of December 5th) dramatically cut that total to only 3,840 individuals by March 15th.

Florida fell to 602 clients as of March 15th, a huge decline of 44.5 percent since February 24th when it led the nation and still had 26 percent of all waiting list cases nationwide. However, it is not yet clear if this is a permanent downward trend. Florida's ADAP waiting list had reached a low of 800 clients in December before spurting back up to over 1,200 clients one month later (see Update for Week of January 30th).

California

Once again, Anthem forced to backtrack on rate hikes

Responding to pressure from Insurance Commissioner David Jones (D), Anthem Blue Cross has again agreed to lower planned premium rate increases for individual subscribers in California.

Both Jones and his Republican predecessor have unsuccessfully lobbied for the statutory authority to modify or reject excessive premium increases (see Update for Week of August 29th). However, the Insurance Commissioner does have the authority to require an independent actuarial review to ensure rate filings comply with state and federal laws.

For the fourth time in less than two years, Jones' office has used this authority to document that rate increases sought by Anthem were based on erroneous calculations or otherwise failed to comply with state or federal laws mandating a minimum percentage of premium revenue be spent on medical care. As a result of the Insurance Commissioner's latest finding, Anthem has agreed to downgrade its average increase by 2.2 percent and limit maximum rate hikes to 20 percent (instead of 30 percent). The move saves individual subscribers for than \$41 million this year and emboldens proponents of a ballot referendum this fall that would give the Commissioner his long-sought authority to reject excessive hikes.

Anthem promptly halved its 16 percent average increase last spring (see Update for Week of March 21, 2011) and also slashed a 39 percent individual plan rate hike the year before that was frequently cited by the Obama Administration as an impetus for the expanded rate review authority under the Affordable Care Act (see Update for Week of August 23, 2010).

Hawaii

Amended bill would immediately remove insurers from interim health insurance exchange board

The House Committee on Consumer Protection and Commerce amended and passed legislation this week that would immediately strip the 11-member interim board governing the new health insurance exchange of six members who represent health insurers.

Exchange-authorizing legislation enacted last session (S.B. 1348) created an interim oversight board that will serve until a 15-member board is appointed by July 1st. However, the law allowed Governor Neal Abercrombie (D) to appoint representatives from the state's largest insurers (including Kaiser Permanente and the Hawaii Medical Service Association) to serve on the interim board.

As in the 20 states that have similarly allowed insurer representation, the presence of insurers has generated intense opposition from consumer groups. They successfully held protests during committee hearings last week that persuaded majority Democrats to immediately strip the board of the six insurance industry members.

The provision was attached to legislation (S.B. 2434) defining the criteria the board will use to establish the "navigator" program required by the ACA. According to federal regulations finalized last week, navigators can facilitate exchange enrollment and provide "fair and impartial" guidance to consumers on plan options, availability of federal tax credits for exchange premiums and cost-sharing (see Maryland article below).

Separate legislation (H.B. 2114/S.B. 2085) barring insurers from being appointed to the permanent exchange board has yet to clear committee (see Update for Weeks of January 16th and 23rd).

Kansas

Senate committee approves panel to oversee Governor's Medicaid managed care plan

The Senate Ways and Means Committee passed a measure this week that would create a joint legislative committee to oversee the implementation the plan by Governor Sam Brownback (R) to move virtually all the state's Medicaid beneficiaries into managed care plans.

The oversight panel under S.B. 459 would include six members from the House and five from the Senate and would be assembled prior to the January 1, 2013 of the KanCare initiative.

Several advocacy groups testified in support of the measure, citing concerns with lower quality and access to care that resulted when Florida began moving all Medicaid beneficiaries into managed care under a five-state demonstration (see Update for Week of August 1st). Committee chair Carolyn McGinn (R) acknowledged the concerns and pledged to leave the bill "open for some further work" before sending to the full Senate.

A hearing was also held this week on a companion bill (H.B. 2789) in the House Appropriations Committee. The primary differences between the versions rest on who can appoint the 11 members.

Maine

Committee blocks exchange-authorizing legislation

The Insurance and Financial Services Committee blocked legislation last week that would create the health insurance exchange required by the Affordable Care Act (ACA).

In a straight party line vote, Republican members all voted against L.D. 1498, insisting that Maine should "wait and see" whether the U.S. Supreme Court overturns the entire law before deciding whether to proceed. However, the committee did pass legislation that would allow only licensed insurance brokers to enroll people in exchange plans, should the ACA be upheld.

The move follows similar action in the Senate, where Republicans are preparing a “bare bones” exchange in the event the law is upheld (see Update for Week of March 5th). Governor Paul LePage (R) has supported creating a state-based exchange instead of defaulting to a federal fallback exchange should Maine fail to act by the federal January 2013 deadline. However, so far he has used only the initial \$1 million of the \$7 million in federal exchange establishment grants obtained by his Democratic predecessor.

Maryland

Exchange navigator bill clears first legislative hurdles

The House Health and Government Operations Committee and Senate Finance Committee passed H.B. 443/S.B. 238 this week. The measures would require the Maryland Health Benefit Exchange Board to implement the navigator programs within the new health insurance exchange, and set criteria defining what entities can serve as navigators (see Update for Week of January 30th).

The Affordable Care Act (ACA) requires exchange boards to award grants to “navigators” who can facilitate exchange enrollment and provide “fair and impartial” guidance to consumers on plan options, availability of federal tax credits for exchange premiums and cost-sharing, and questions about grievances, complaints, and appeals. The U.S. Department of Health and Human Services has just finalized rules from last summer that gave state significant flexibility in defining who could serve as a navigator, subject to basic federal standards (see Update for Week of March 12th).

Maryland was among the first states to enact exchange-authorizing legislation (see Update for Week of April 11th). However, Governor Martin O'Malley (D) has sought the additional legislation to implement remaining parts of the exchange not addressed in that law.

Expanded rate review legislation clears initial committees

The Senate Finance and House Health and Government Operations Committees passed legislation this week that would expand the authority of the Insurance Commissioner to review increases in health plan premiums and modify or reject any excessive rate hikes. The changes under H.B. 465/S.B. 456 are required to be consistent with the Affordable Care Act (ACA), which requires health plans to publicly justify any rate hike of at least ten percent (see Update for Week of August 29th). While the Maryland Insurance Commissioner already had the authority to reject or modify rate hikes, the standards varied for different types of health plans and did not include association health plans (as required by the ACA since November 1st).

Missouri

Republicans resolute in attempt to block exchange-authorizing bills or executive orders

Republican lawmakers have rebuffed another attempt by Democrats to create the state-based health insurance exchange required by the Affordable Care Act (ACA), holding firm to their decision to delay any implementation until the U.S. Supreme Court resolves the constitutionality of the new law.

Exchange-authorizing legislation initially had the support of key Republicans, but faltered last session after passing the House as tea-party backed Senators opposed implementing any part of “Obamacare” (see Update for Week of September 19th). H.B. 609 never cleared the Republican-controlled Senate and similar legislation this session has been a non-starter. The latest attempt by Senator Keaveny (D) to authorize the exchange through amendments to unrelated bills was also blocked.

Instead, Republican lawmakers have been focused on preventing Governor Jay Nixon (D) from following the lead of at least 11 other governors (including his Democratic counterpart in Minnesota) and circumventing legislative opposition to the exchange through executive order. The Senate passed legislation last month (S.B. 464) that would bar the creation of any exchange unless specifically

authorized by legislation or voter referendum, which will be heard by the House Health Insurance Committee next week.

Analogous measures have been introduced by Republican lawmakers in at least New Hampshire and South Dakota (see Update for Week of January 16th and 23rd).

New Hampshire

Senate Republicans decide that some insurance mandates aren't so bad...for now

The Senate voted 19-5 this week to preserve state laws mandating health insurance coverage for services such as bariatric surgery, hearing aids, autism treatment, and midwives.

House Republicans had passed legislation (H.B. 309) removing those mandates, arguing that they make health insurance more expensive for everyone. However, Senate Republicans were persuaded by a Department of Insurance report that concluded they increased premiums by less than five percent, as well as an outpouring of public support for minimizing the huge out-of-pocket costs associated with these services. They moved instead to table the legislation pending further study.

The Republican-controlled Senate has frequently rebuffed their more conservative counterparts in the House during the past session, especially on legislation opposing Affordable Care Act implementation (see Update for Week of March 5th).

Pennsylvania

New bills would limit cost-sharing to 30 percent of total cost per visit

Senator Donald White (R), chair of the Banking and Insurance Committee, sponsored legislation this week that would limit cost-sharing for insured medical services. The *Fairness in Copayment Act* (S.B. 2261) specifically would bar health plans in Pennsylvania from imposing a copayment or coinsurance that exceeds 30 percent of the total provider reimbursement for medical services rendered to the covered person per visit. Similar legislation was already sponsored by Senator Charles McIlhenny (R) last month (S.B. 1391) but has yet to proceed.

Senate debates constitutional amendment barring any mandatory purchase of health insurance

Republican lawmakers are trying again to make Pennsylvania the latest state to give voters a chance to express their disapproval of the individual mandate in the Affordable Care Act (ACA).

The Senate Appropriations Committee has started to consider a measure sponsored last session by Senate President Pro Tempore Joe Scarnati (R) that would amend the state constitution to bar any federal or state law penalizing those who elect not to buy health insurance when they can afford it. If passed by the Republican-controlled legislature and signed by Governor Corbett (R), S.B. 10 would then need to be ratified by the voters this fall.

Republicans are pushing similar legislation in at least 23 states. Voters in Arizona, Missouri, Ohio, and Oklahoma overwhelmingly approved an analogous constitutional amendment (though it was rejected in Colorado). Though largely symbolic due to the automatic supremacy of federal law under the U.S. Constitution, the measures are designed to keep the political spotlight on the single most unpopular provision the ACA (see Update for Week of December 19th).

Bipartisan legislation to implement key ACA provisions such as health insurance exchanges and new consumer protections has failed to advance in the House or Senate.