

## Health Reform Update – Week of April 9, 2012

### CONGRESS

#### ***Oral arguments eroded public opinion of Supreme Court, Affordable Care Act***

A new poll from the Pew Research Center and *The Washington Post* shows that the recent U.S. Supreme Court hearings regarding the constitutionality of the Affordable Care Act (ACA) have damaged public support for both the court and the law.

While the Supreme Court has been deeply divided for decades along ideological lines, the overtly “partisan tone” of the oral arguments surprised both liberal and conservative commentators, including President Reagan’s former solicitor general Charles Fried. It also appears to have caused more than half of those surveyed to now expect that the high court will decide the case based upon partisan political views, while only 40 percent predict it will act according to legal precedent. Another 21 percent have a less favorable opinion of the Supreme Court after the hearings, with the biggest drop (32 percent) coming among Democrats.

The hearings also appear to have caused overall support for the ACA to slide to 39 percent, the lowest level recorded since the law’s passage. At least 23 percent of respondents said that they now have a less favorable opinion of the ACA, while only seven percent have a more favorable view.

The oral arguments revealed that any decision to uphold the ACA mandate that everyone buy health insurance or pay a tax penalty would likely require Chief Justice John Roberts to side with the court’s four liberal justices. Moderate Anthony Kennedy, whom the Obama Administration had expected to provide the critical swing vote, appeared deeply skeptical of the constitutionality of the “individual mandate” (see Update for Week of March 26<sup>th</sup>). The court is expected to rule in June.

#### ***IOM calls for tax on medical transactions in order to boost public health spending***

A new report from the Institute of Medicine (IOM) urges Congress to impose a new tax on health care transactions in order to double the nation’s investment in public health programs.

The report by IOM’s Committee on Public Health Strategies to Improve Health notes that while overall health care spending per person was \$8,086 in 2009, only a mere \$251 per person was devoted to public health. It cited this discrepancy as a reason why the U.S. lags behind most industrialized nations and even some third-world countries in terms of life expectancy and infant mortality.

IOM specifically recommends that a “broad-based tax” be levied on private health plans that would apply to physician visits and prescription drugs. It considered but rejected other alternatives, such as new taxes on sugary beverages, estates and life-insurance proceeds.

Although the authors noted that a two-percent tax would raise about \$50 billion and help transition the clinical care-based system to one that focuses on preventive care, the report did not recommend an exact amount of tax.

The Obama Administration did not respond immediately to IOM’s recommendations. However, several Republican lawmakers including Senate Finance Committee ranking member Orrin Hatch (R-UT) called such a tax “an absurd and misguided proposal”.

## FEDERAL AGENCIES

### ***More than one million Medicare beneficiaries now enrolled in accountable care organizations***

The Centers for Medicare and Medicaid Services (CMS) announced this week that 375,000 Medicare beneficiaries in 18 states will be covered by 27 accountable care organizations (ACOs) that have already signed contracts with the agency.

The Affordable Care Act (ACA) authorized and funded the use of ACOs, which are networks where hospitals and physicians share in Medicare savings by collaborating to limit duplicative tests, needless procedures, and other inefficiencies caused by Medicare's fragmented payment system. Congress intended ACOs to provide the benefits of managed care without the severe restrictions on patient freedom of choice that spurred a backlash during the 1990s. While patients must be notified that their physician is in an ACO, the ACO cannot restrict their choice of provider.

CMS is currently reviewing another 150 applications from ACOs seeking to enter the program in July. It previously announced contracts with 32 "pioneer" ACOs, which differ from entities in the standard program in that they are willing to incur financial penalties if they do not meet specific standards for controlling spending and improving quality. Between the two types of ACOs, about 1.1 million Medicare beneficiaries either are or will receive care under the new arrangements.

The ACO "shared savings" program initially faced intense pushback from hospitals that balked at overly "rigid" proposed rules that favored urban providers (see Update for March 28, 2011). The Congressional Budget Office also found that at least six similar programs over the last two decades have failed to lower costs.

However, final rules modeled on recommendations by the American Medical Association generated "phenomenal" interest, according to CMS officials. The revised rules allowed providers to avoid penalties if they fail to meet savings targets, reduced the number of measurements to ensure ACOs are not saving money simply by skimping on care, and gave physicians and rural providers access to an average of \$3.5 million in start-up costs through an "Advanced Payment" program (funds that would be recovered through future savings) (see Update for Week of October 17<sup>th</sup>).

CMS estimates that the program will save up to \$940 million over four years and ultimately provide care to about two million Medicare beneficiaries under 270 ACOs. It is unclear what will happen to ACA funding for existing contracts if the entire law is struck down by the U.S. Supreme Court, a possibility raised by several justices during hearings last month (see Update for Week of March 26<sup>th</sup>).

### ***CMS issues proposed administrative simplification rule***

The Department of Health and Human Services (HHS) released proposed regulations this week that are expected to save health insurers and providers up to \$4.6 billion over the next ten years by simplifying insurance billing in accordance with the Affordable Care Act (ACA).

The primary change would establish a unique health plan identifier to standardize the billing process. Currently, when health plans and third-party administrators bill providers, they are identified using a wide range of different identifiers that do not have a set length or format. As a result, providers frequently run into time-consuming hassles, such as misrouting of transactions, rejection of transactions due to insurance identification errors and difficulty determining patient eligibility.

In addition, the proposed rule delays required compliance with the new International Classification of Diseases system by one year (until October 2014.) Many of the nation's largest provider groups had expressed serious concerns about their ability to meet the October 2013, compliance date for the ICD-10 codes that are used to bill according to diagnoses and symptoms.

A Commonwealth Fund study published earlier this year in *Health Affairs* found that each physician in the United States spends nearly \$83,000 per year just on administrative costs related to insurance billing. By contrast, physicians in Ontario, Canada spend only 27 percent of this amount. It noted that administrative costs are a primary difference between the United States and single-payer systems like Canada, which spends 87 percent less than the United States every year on medical care.

The proposed rule is the third in a series of administrative simplification rules required by the ACA. Future rulemaking will address the adoption of operating rules for healthcare electronic funds transfers, a uniform standard for claims attachments, and certification of health plan compliance with all standards and operating rules under the Health Insurance Portability and Accountability Act (HIPAA).

### ***Consumer groups urge greater federal oversight state definitions of “essential health benefits”***

Over 100 consumer groups sent a letter this week to the Secretary for the Department of Health and Human Services (HHS) urging the agency to adopt “strong federal oversight mechanisms” that ensure state definitions of “essential health benefits” do not deprive patients of medically necessary care.

The letter was critical of HHS guidance last winter that would require plans to cover only one prescription drug per therapeutic category or class covered by designated benchmark plan selected by each state (see Update for Week of December 12<sup>th</sup>). The groups insist that this “wholly inadequate” standard does not comport with the Affordable Care Act (ACA) mandate that “essential health benefits” should reflect the typical employer plan, as it is lower than the current standard in the private plan marketplace and contrary to the minimum prescription drug coverage standards under Medicare Part D.

As a result, the letter recommended that HHS ensure patients have adequate access to needed medication by meeting the breadth of the formulary offered by the state-selected benchmark plan.

HHS is currently formulating final regulations after accepting comments on their earlier guidance. The comments were largely critical of the decision by HHS to “punt” the contentious definition of “essential health benefits” to the states (see Update for Week of January 30<sup>th</sup>). The highly-varied level of state ACA implementation has caused many consumer groups to remain concerned about inadequate protections against discrimination by private health plans that may result in states that are refusing to move forward with all or most implementation efforts until the U.S. Supreme Court resolves the constitutionality of the ACA (see Update for Week of March 26<sup>th</sup>).

### ***Young adult provisions of ACA may have reached “saturation point”***

According to a Gallup poll released last week, the uninsured rate among those aged 19-25 has leveled off at 24 percent since early 2011, suggesting that the provision of the Affordable Care Act (ACA) allowing young adults to remain on their parents’ health plan may have reached its “saturation point.”

The young adult provision took effect for the 2011 plan year and within the first six months it reduced the uninsured rate from 28 to 24 percent as 2.5 million young adults gained coverage. However, those figures have since remained steady.

The Department of Health and Human Services plans to step-up education and outreach during the spring graduation season, partly in an effort to determine if significant number of young adults have not taken advantage of the provision due to lack of awareness.

### ***IRS rules define how ACA fees will fund cost-effectiveness research***

The Internal Revenue Service (IRS) released a proposed rule this week that defines how it will impose the new insurer fees that will create the Patient-Centered Outcomes Research Trust Fund under the Affordable Care Act (ACA).

Starting in 2012, the ACA requires that health plans pay a new fee to fund \$3 billion in research that will test whether various drugs, tests, and treatments work better than lower cost alternatives. Such comparative effectiveness research has become a political lightning rod as many Republican lawmakers claim it will lead to government “death panels” that determine whether the sick or elderly should be denied life-saving care. These 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 his past praise for the British system, which does link funding decisions to comparative effectiveness data (see Update for Weeks of November 21<sup>st</sup> and 28<sup>th</sup>).

As a result, the IRS rules repeatedly emphasized that the ACA prohibits the Patient-Centered Outcomes Research Institute (PCORI) created by the fee from using their research to make Medicare and Medicaid coverage determinations. The PCORI will instead merely present evidence on effectiveness to physicians and doctors and allow them to continue making treatment decisions.

Republican lawmakers and health insurers remain unconvinced. Even though insurers like Blue Cross and Blue Shield have long conducted their own effectiveness research (with bipartisan support), they claim that the credibility and influence of a government-backed institute will in actuality dictate coverage decisions by Medicare, Medicaid, and other private plans (see Update for Week of January 2<sup>nd</sup>).

Under the proposed regulations, the \$1 per covered person fee in 2012 will double to \$2 the second year and rise with inflation in subsequent years. Stakeholders have 90 days to submit public comments, while IRS will hold a public hearing on August 8<sup>th</sup>.

The Institute released its draft research agenda last month, but it did not single out any specific diseases, treatments or procedures to study. Instead, it identified a set of questions and topics in five broad categories, including medical treatments, improving the health care system and communication of research findings, and addressing health disparities.

The Institute’s 21-member board includes drug and device makers, insurers, consumers, researchers, and government officials.

## HEALTH CARE COSTS

### ***New survey confirms that premiums are declining as subscribers postpone needed care***

Average annual costs for all types of health plans are expected to increase by 9.9 percent in 2012, according to a new survey released this week by Buck Consultants. The projection marks the first time since 2001 that Buck has estimated rate hikes of less than ten percent for any plan.

The consultancy firm surveyed 129 insurers and found that most rate hikes are expected to decrease by a percentage point since last year, when they increase by at least 11 percent. As with several prior studies, Buck attributed the smaller premium increases to lower than expected utilization during the economic slowdown, as subscribers are attempting to mitigate increasing out-of-pocket expenses by postponing elective medical services (see Update for Week of April 2<sup>nd</sup>).

However, Buck stressed that health care costs will continue to outpace both inflation and wage increases in the near-term.

## STATES

### ***Census figures affirm economic recovery in all 50 states***

New figures released this week by the U.S Census Bureau showed that total tax revenues increased in all 50 states during fiscal year 2011.

Overall state tax revenues increased nearly nine percent, a huge jump from fiscal years 2009 and 2010 when declining revenues opened up record budget deficits in most states. Total revenues of \$764 billion were second only to the peak of \$781 billion in fiscal year 2008, shortly before the impact of the economic downturn.

Nine mostly energy-rich states enjoyed double-digit hikes in revenue collections during fiscal 2011, with North Dakota spiking at over 44 percent thanks largely to high oil prices and the nation's lowest unemployment rate. Despite continued deficit woes, even California and Illinois jumped by over 15 percent, mitigating severe budget cuts in both states.

While the figures affirm that the economy is recovering nationwide, the Rockefeller Institute of Government and Center for Budget and Policy Priorities warned that several states are "still in a deep hole" and have a "long way to go" before revenues return to pre-recession levels. For example, tax collections in only 17 states are now above previous highs, while 33 states are still below peak levels. Overall revenue gains remain seven percent below pre-recession levels when adjusting for inflation.

### ***Uninsured rates have improved in only a handful of states***

A new Gallup Inc. survey released this week showed that Massachusetts continues to lead the nation with the lowest percentage of uninsured residents (4.9 percent), as it has since implementing landmark health reforms in 2006 that became the model for the Affordable Care Act (ACA).

The figures show there has been relatively little improvement in the uninsured rates across most states. However, five states (California, Florida, New Jersey, New York, and Rhode Island) have significantly improved.

Texas continues to have the highest rate of uninsured at 27.6 percent, followed closely by New Mexico and Oklahoma.

### Arizona

#### ***Arizona receives federal approval to expand SCHIP coverage***

Nearly 22,000 children will gain SCHIP coverage under a deal Arizona worked out with the federal Centers for Medicare and Medicaid Services (CMS) last week.

Since 2009, Arizona remains the only state that froze SCHIP enrollment, causing more than 120,000 children to be placed on waiting list for coverage. The Affordable Care Act (ACA) prevented similar enrollment freezes starting in 2010.

Under the agreement with CMS, Arizona will partially restore SCHIP coverage for 22,000 children with incomes below 175 percent of the federal poverty level on the SCHIP waiting list or aging out of Medicaid. Starting May 1<sup>st</sup>, the state will create a Kids Care II program that will expire when all states are required by the ACA to expand Medicaid up to 133 percent of FPL in 2014.

### Arkansas

#### ***Insurance Commissioner fails to get approval to use federal exchange establishment grant***

Insurance Commissioner Jay Bradford (D) came up one vote short this week in his effort to get a key legislative panel to approve a partnership with the federal government on implementing a health insurance exchange.

Arkansas has received a \$7.7 million federal grant to create the exchange required by the Affordable Care Act (ACA). Governor Mike Beebe (D) had been content to simply allow a federal fallback exchange after the legislature blocked exchange-authorizing legislation last year. However, Commissioner Bradford has lobbied vigorously for a state-federal partnership allowed by the U.S. Department of Health and Human Services (see Update for Week of January 9<sup>th</sup>).

Republican lawmakers have largely remained adamant that exchange implementation should cease until the U.S. Supreme Court resolves the constitutionality of the ACA in June (see Update for Week of March 26<sup>th</sup>). As a result, the Commissioner was unable to get the 11 of 15 votes he needed from the Performance Evaluation and Expenditure Review Subcommittee to use the \$7.7 million grant to implement the exchange. The approval measure failed 10-4 in a straight party line vote.

The rejection will likely prevent the awarding of two state contracts to develop plans for regulating the sale of exchange plans and set the criteria for navigators that would use to help uninsured and small business workers purchase affordable coverage through the exchange (see Update for Week of April 2<sup>nd</sup>).

### California

#### ***Senate Health Committee passes bills implementing key Affordable Care Act provisions***

The Senate Health Committee held hearings this week at the outset of the new legislative session on several measures relating to implementation of the Affordable Care Act (ACA).

The committee passed S.B. 951, which identifies the Kaiser Permanente Small Group HMO as the baseline for the "essential health benefits" that all plans sold in the individual and small group health markets (including the new health benefits exchange) must cover. Guidance from the U.S. Department of Health and Human Services required states to select such a baseline plan in defining "essential health benefits" (see Update for Week of December 12<sup>th</sup>). A.B. 1453, the counterpart to S.B. 951 was also heard this week in the Assembly Health Committee (see Update for Week of January 9<sup>th</sup>).

The committee also passed S.B. 970, which would ensure "horizontal integration" between all health programs. This means individuals who apply for coverage in the new health benefit exchange, Medicaid, SCHIP, etc. would automatically be screened for eligibility in all of these programs.

Both measures now move to the Senate Appropriations Committee. The Senate Health Committee also plans to hear two other bills next week:

- (1) S.B. 96, which implements provisions of the ACA that prevent insurers from denying coverage due to pre-existing conditions, limits age rating to a 3:1 ratio, and otherwise conforms state insurance law to the ACA.
- (2) S.B.1431 sponsored by the Department of Insurance, which prohibits small employers from "self-insuring" in order to evade new ACA requirements in the small group market.

The Assembly Health Committee will hear legislation (A.B. 1800) on April 24<sup>th</sup> that limits out-of-pocket costs for subscribers of individual or small group plans and creates a single deductible in place of separate deductibles for health care, pharmacy, etc. Similar legislation by Speaker Pro Tempore Fiona Ma (D) (A.B. 310) that prohibited the use of specialty tier coinsurance died last session (see Update for Weeks of April 18 and 25, 2011).

### Connecticut

#### ***House to vote on measure adding consumer representation to exchange governing board***

The Government Administration and Elections Committee voted 9-2 this week to expand the Connecticut Health Insurance Exchange Board by two members in order to include consumer representation.

The board appointed by Governor Daniel Malloy (D) and legislative leaders came under heavy criticism last summer for selecting former executives from three of the nation's largest insurers to serve on the board, while failing to appoint a single consumer advocate as a voting member (see Update for Week of August 22<sup>nd</sup>). The Universal Health Care Foundation of Connecticut (UHCFC) had even demanded that the Office of State Ethics investigate whether the appointments violated exchange-authorizing legislation from last session (S.B. 921) that bars board members from being affiliated with health insurers (see Update for Week of February 13<sup>th</sup>).

The outcry forced the Governor to propose legislation that would add one small employer representative and one consumer representative. S.B. 5013 would also change the State Healthcare Advocate's status from a non-voting to a voting Board member.

UHCFC and Rep. John Hetherington (R) opposed the measure, which did not fulfill their goal of adding two consumer representatives. While adding the State Healthcare Advocate was a "step in the right direction", they did not believe that it sufficed for a second consumer voice on the board.

The measure was previously approved by the Insurance and Real Estate Committee and now moves to the House floor.

#### Delaware

##### ***Health care commission recommends restricting the use of specialty tier coinsurance***

The findings of a Delaware Health Care Commission Report to the General Assembly recommended last month that the legislature act to restrict the instances in which health plans can require coinsurance payment structures for high-cost specialty drugs.

Mandated last year by S.B. 137 (see Update for Week of October 10<sup>th</sup>), the study incorporated input received at two public meetings, letters from consumer groups like the National Hemophilia Foundation, and research into other state and federal initiatives to reduce out-of-pocket costs for prescription drugs. It urged state lawmakers to ensure that the proliferation of specialty tier coinsurance, where patients can be forced to pay 25-30 percent or more of the total cost, does not deny access to life-saving medications simply because the required cost-sharing is too expensive.

In order to ensure access while still retaining such tiered cost-sharing, the Commission proposed that lawmakers restrict the use of specialty tier coinsurance only when "therapeutically similar drugs are available in lower cost tiers" and "specific measures to assure affordability are in place." It also recommended uniform and fully transparent application of specialty tier coinsurance.

Among its suggested means to accomplish these goals, the Commission relied on measures being considered in at least 20 other states, such as caps for out-of-pocket expenses and reinsurance programs to share cost and risk. New York remains the only state to have passed a law prohibiting the use of specialty tier coinsurance (see Update for Week of March 26<sup>th</sup>).

#### Georgia

##### ***New law interstate health plan law has failed to attract out-of-state insurers***

The Insurance Commissioner acknowledged this week that Georgia's new law allowing the sale of out-of-state policies has yet to attract a single out-of-state insurer.

H.B. 47 was heralded last year as a means to allow low-income Georgians to afford “bare bones” individual health plan coverage (see Update for Week of May 9<sup>th</sup>). It permits the sale of health plans in Georgia that need not comply with state coverage mandates (including those for cancer screenings).

The new law effective July 1<sup>st</sup> was pushed by the Georgia Chamber of Commerce and the National Federation of Independent Business. However, consumer groups strongly opposed the measure, arguing that it would lead to a “race to the bottom” and stick individual subscribers with junk insurance that does more harm than good.

A similar law was enacted by Wyoming in 2010 but vetoed by Arizona Governor Jan Brewer (R) (see Update for Week of May 16<sup>th</sup>) and rejected this session by the Arizona legislature (see Update for Week of February 6<sup>th</sup>). It was also included as part of the traditional health reform proposals advanced by Congressional Republicans.

### Maine

#### ***Republican-controlled legislature passes streamlined version of exchange-authorizing legislation***

The House and Senate passed a Republican version of legislation this week that would create a health insurance exchange compliant with the standards of the Affordable Care Act (ACA).

Sponsored last year by Rep. Jonathan McKane (R), the amended L.D. 1497 was a “bare bones” counterpart to exchange-authorizing legislation put forward by Rep. Sharon Treat (D) that was tabled last month in a straight party line vote (see Update for Week of March 19<sup>th</sup>). Rep. Treat’s version (L.D. 1498) would have allowed the exchange board to act as an “active purchaser” and negotiate premiums. By contrast, L.D. 1497 follows the clearinghouse model in place in Utah under which all plans that meet minimum federal standards must be allowed to participate.

L.D. 1497 also allows two insurer representatives to serve on the ten-member board appointed by Governor Paul LePage (R), whereas Rep. Treat’s version followed the lead of most states in excluding insurers. L.D. 1497 does require that one board member be a purchaser of individual health insurance.

Governor LePage has yet to indicate whether he will sign the legislation. He previously supported creating the exchange as an executive state agency (see Update for Week of October 31<sup>st</sup>). However, he has since taken the position that Maine should “wait and see” whether the U.S. Supreme Court will strike down the entire ACA law (see Update for Week of March 5<sup>th</sup>).

### Maryland

#### ***Medicaid faces \$100 million automatic cut after Assembly fails to agree on budget***

Medicaid providers will bear the brunt of \$100 million in emergency cuts if lawmakers cannot reach agreement on a budget deal during a special session to be held before July 1<sup>st</sup>.

Senate and Assembly leaders had reach a tentative deal on a package of tax increases for the wealthy that would have averted the “doomsday” budget that will automatically impose deep budget cuts on July 1<sup>st</sup>. However, a stalemate over unrelated amendments blocked the budget from passing before the regular session expired this week, marking the first time since 1992 that the Assembly has failed to timely act on a budget.

### New York

#### ***Governor issues promised executive order implementing new health insurance exchange***

Governor Andrew Cuomo (D) became only the second Democratic governor this week to use an executive order to circumvent legislative opposition to creating the health insurance exchange required by the Affordable Care Act (ACA).

Despite the support of several key Republicans, the Governor's exchange authorizing bill (A.8514/S.5849) has remained blocked in the Republican-controlled Senate since passing the Assembly last summer. Governor Cuomo pledged to issue the executive order last month after Republican leaders left the exchange authorization out of a budget deal for the next fiscal year, warning that New York could not afford to risk falling further behind if the U.S. Supreme Court upholds all or most of the ACA (see Update for Week of March 26<sup>th</sup>). The move was widely praised by New York hospitals, health insurers, and consumer groups.

The executive order creates the exchange with the Department of Health, making New York only the second state besides West Virginia to house the exchange within a state agency (Maine Governor LePage (R) has also proposed doing so, see above). It also authorizes DOH, in conjunction with the Department of Financial Services and other state agencies, to begin using the \$40 million the Governor has obtained in federal exchange establishment grants to "effectuate the Exchange" including the creation of regional advisory committees comprised of health providers, consumer advocates, and other stakeholders to develop recommendations on exchange design and operation.

At least 12 other Governors have used executive orders to implement all or part of their exchange. However, several including Minnesota Governor Dayton (D) acknowledge that legislative approval will ultimately be necessary to begin exchange operations (see Update for Week of March 5<sup>th</sup>).

### Pennsylvania

#### ***House passes bill to reduce size of nation's second largest legislature***

The House passed a proposed constitutional amendment this week that would reduce its membership from 203 to 153 representatives, while reducing the number of Senators from 50 to 38.

H.B. 153 still has to pass the Senate this session, pass both chambers again in a subsequent session, and be approved by the voters before its 2022 effective date. However, if enacted, it would make Pennsylvania only the second state in the last decade to cut the size of its legislature.

The proposed changes are intended to reduce legislative costs for the General Assembly. Pennsylvania's legislature trails only in New Hampshire in size. However, unlike New Hampshire where part-time legislators earn relatively little, the \$82,026 average salary for Pennsylvania's legislature is second only to the California legislature. According to the National Conference of State Legislatures, Pennsylvania also leads the nation in number of legislative staff, which is a primary reason that it spends \$300 million per year on its legislature, the second most per capita behind Alaska.

Most Republican lawmakers backed H.B. 153, while Democrats were split. House Speaker Sam Smith (R) insisted that the prevalence of social media would counter concerns about increasing the size of the districts that each lawmaker must cover. The measure is believed to have the support of Senate Majority Leader Dominic Pileggi (R).

### Rhode Island

#### ***House bill would let Rhode Island exercise Basic Health Plan option under Affordable Care Act***

Deputy Majority Leader Frank Ferri (D) introduced legislation this week that would make Rhode Island the latest state to create a Basic Health Plan (BHP).

The bill (H.8056) will be heard in the House Finance Committee. It would provide coverage to roughly 31,000 of the 140,000 uninsured in Rhode Island. As with other programs administered by the

Executive Office for Health and Human Services (HHS), premiums and cost-sharing would be limited to five percent of income.

The Affordable Care Act (ACA) offers states enhanced federal funding if they choose to cover those earning from 133-200 percent of the federal poverty level (FPL) under the BHP option. It was inserted into the law by U.S. Senator Patty Murray (D-WA) as an alternative to the controversial “public option” in the exchange.

Consumer groups promoting this option argue that it will be difficult for those with incomes who fluctuate just above and below the new standardized Medicaid eligibility limit after 2014 (133 percent of FPL) to identify and pay for exchange coverage. They would prefer a state-run BHP that has the same design and network of health care providers as Medicaid. However, exchange governing boards already in place in states like California have expressed concern that the BHP would draw so many applicants away from the new health insurance exchange that it would threaten the ability of the exchange to remain financially self-sustaining, as the ACA requires by 2015 (see Update for Week of July 25<sup>th</sup>).

California, Connecticut, Hawaii, Illinois, New Jersey, and Washington are among the states that are already considering the creation of a BHP (see Update for Week of March 12<sup>th</sup>).

#### Virginia

#### ***Hemophilia advisory committee to be eliminated under bill awaiting Governor’s approval***

Governor Bob McDonnell (R) appears poised to sign into law his reorganization plan passed last month by both the House and Senate.

The Governor’s Commission on Government Reform and Restructuring recommended last fall that lawmakers eliminate the Hemophilia Advisory Committee in favor of issue-based workgroups convened by the health department (see Update for Week of January 9<sup>th</sup>). The committee currently assists the department in administering the Children with Special Health Care Needs Hemophilia Program.

S.B. 678 would eliminate language continuing this committee and replace it with the following:

“The State Board of Health shall provide for the development, implementation, and sustainability of a process for the receipt and consideration of advice and policy recommendations at least annually from, and on behalf of, persons suffering from hemophilia and other related bleeding diseases, for the purpose of informing programs and services established under this section.”

The Governor did not appear to have any objections to this provision, as it was not among his recommend changes that were received this week by the Senate.