

Health Reform Update – Week of June 6, 2011

CONGRESS

11th Circuit appears skeptical that Congress can mandate everyone to buy health insurance

Supporters of the new federal mandate that everyone buy health insurance appear to have tough sledding ahead of them in the most conservative of the nation's appellate courts.

A three-judge panel of the 11th U.S. Circuit Court of Appeals heard oral arguments this week on the most prominent of the 30 plus legal challenges to the constitutionality of the individual mandate. They are reviewing the decision by lower court Judge Roger Vinson, who invalidated the entire ACA after concluding that the individual mandate regulated "inactivity" and went beyond Congress' authority to regulate interstate commerce (see Update for Week of January 31st). At least 26 state attorneys general have already signed-on to the case, which was one of only two to find the mandate unconstitutional.

Each of the three judges appeared to reject Judge Vinson's conclusion that failing to purchase health insurance was "inactivity", as it forces other consumers to subsidize \$43 billion per year in unpaid medical bills. They also recognized flaws in the health insurance market cause millions of Americans to be denied needed care for costly conditions and curiously even forced the plaintiffs to concede that Congress can mandate individuals purchase health insurance once they are in the hospital.

However, they also sharply questioned whether it was appropriate for Congress to intervene in order to correct these flawed incentives. The panel was concerned that upholding the mandate would give Congress unlimited discretion in how it regulates interstate commerce and appeared far more inclined than other appellate panels to reign in their traditionally broad Commerce Clause authority.

The judges spent most of the hearing focused on whether the individual mandate could be invalidated without striking down the entire law, as Judge Vinson did. Although Judge Frank Hull, the lone Democrat on the panel, indicated she believed the mandate may be "severable" from the law, the other judges did not appear to tip their hand on how they would decide this critical issue.

In somewhat of a surprise, Chief Judge Joel Dubina also stated that the plaintiffs made a powerful argument supporting their original claim that the ACA mandate for all states to expand their Medicaid programs amounted to unlawful "coercion". Judge Vinson had dismissed this claim, noting that the expansion is largely federally-funded and concluding that states could simply opt-out of Medicaid if they believe the expansion to be too onerous.

The panel surprisingly did not address concerns by the Fourth and Sixth Circuit panels that the courts could review the individual mandate before it actually goes into effect in 2014 (see Update for Week of May 30th).

Although previous ACA rulings have followed the political affiliation of the judges, the ideological balance of the 11th Circuit panel is not clear cut. Chief Judge Dubina is a staunch conservative who was appointed by President George H.W. Bush. His daughter is Congresswoman Martha Roby (R-AL), who voted to repeal the ACA and supports "abolish[ing] the IRS", the federal agency that would enforce the individual mandate. However, even though Judge Frank Hull and Stanley Marcus were appointed by President Clinton, they were compromise nominees to break a Republican filibuster. Judge Marcus is actually a Republican who was originally appointed to the lower court by President Reagan.

Ninth Circuit will be the next appellate court to review Affordable Care Act challenge

The Ninth U.S. Circuit Court of Appeals announced this week that it will hear oral arguments on July 13th in a California case challenging the constitutionality of the new federal mandate that all Americans buy health insurance.

The case brought by the conservative Pacific Justice Institute and a former state Assemblyman was dismissed last summer by lower court Judge Dana Sabraw, who ruled that the plaintiffs lacked standing until the individual mandate actually goes into effect in 2014. Judge Sabraw became the first federal judge appointed by a Republican president to dismiss an Affordable Care Act challenge. Several Democratic and Republican appointed judges have followed his lead by also declaring individual mandate challenges to be premature.

Three-judge panels on both the Fourth and Sixth Circuits have already indicated that they may dismiss challenges to the individual mandate on the same basis, however the 11th Circuit did not address the issue. The D.C. Circuit has scheduled oral arguments for September.

The U.S. Supreme Court declined last winter to intervene in the California case, and ruled in April that they will not intervene in other cases until all appeals have been resolved.

New study says ACA will erode employer-sponsored coverage, despite previous findings

A new report this week published by McKinsey Quarterly found that over 30 percent of 1,300 surveyed employers plan to stop offering employer-sponsored health coverage once the Affordable Care Act (ACA) goes into full effect in 2014.

The White House was quick to point out that the findings conflict with several earlier studies that predicted only a “minimal” drop in employer-sponsored coverage once the ACA requires large employers to either provide coverage for all full-time workers or pay an additional \$2,000 per worker assessment. For example, RAND and the Urban Institute found most firms have little financial incentive to drop coverage and either already provide employee health benefits that meet the new federal standards or remain exempt from these standards (i.e. firms with less than 50 workers) (see Update for Week of March 21st). The Congressional Budget Office (CBO) also estimated in March 2010 that only about seven percent of employees would lose their employer-sponsored coverage as a result of the new law.

House Republicans support Medicare cuts, but want to repeal Medicare cost-cutting panel

The House Energy and Commerce health subcommittee will hold a June 14th hearing on the new bipartisan Medicare cost-cutting panel that has become a primary target of Republicans seeking to dismantle the Affordable Care Act.

The new law created the Independent Payment Advisory Board (IPAB) to identify specific Medicare payment cuts. Its recommendations will take effect automatically unless Congress offsets them with the same amount of cuts elsewhere in the federal budget.

Despite fervently pushing severe Medicare cuts in negotiations over next year’s budget, House Republicans are adamantly opposed to the cost-cutting panel which Rep. John Fleming (R-LA) has compared to “Soviet-style central planning.” Because it cedes control away from Congress, their bill to repeal the IPAB (H.R. 452) has also been able to garner a handful of Democratic supporters including Reps. Allyson Schwartz (D-PA), Shelley Berkley (D-NV), Larry Kissell (D-NC), Michael Capuano (D-MA) and Linda Sanchez (D-CA). The IPAB was also opposed by 72 House Democrats when it was included by the Senate in final legislation (see Update for Week of March 7th).

A key advocacy group, the National Committee to Preserve Social Security and Medicare, also came out this week in support of repeal. Advocacy giants including AARP, the American Medical Association, the American Hospital Association, and the Pharmaceutical Research and Manufacturers of

America already support repeal (see Update for Week of January 24th).

The Congressional Budget Office (CBO) has estimated that repealing the IPAB would increase Medicare spending by \$2.4 billion from 2018 through 2021 (see Update for Week of May 16th).

New Republican bill would repeal higher insurer payout standards in ACA

Rep. Tom Price, MD (R-GA) introduced H.R. 2077 this week, which would repeal the higher medical-loss ratios (MLRs) mandated by the Affordable Care Act starting for 2011 plan years.

The new insurer payout rules require small group and individual health plans to spend at least 80 percent of premium revenue on medical care (85 percent for large groups) or issue rebates to consumers.

House Republicans have largely supported repealing or weakening the standards, as they claim that the three temporary waivers already granted by the Administration are proof that the new MLRs will destabilize the market. However, the higher ratios are strongly supported by key Senate Democrats such as Jay Rockefeller (D-WV), who notes that they would have saved consumers over \$2 billion if they had been in place for 2010 (see Update for Week of May 23rd).

The Department of Health and Human Services (HHS) estimates that roughly nine million Americans will receive an average of \$164 in MLR rebates next year (see Update for Week of May 9th).

Senate Democrats solidly against GOP plan to block grant Medicaid, but may allow other cuts

Senator Jay Rockefeller (D-WV) announced this week that he has marshaled enough Senate votes to block the House Republican plan to convert Medicaid into a block grant program.

The fiscal year 2012 budget passed by House Republicans seeks more than \$700 billion in Medicaid cuts, mostly by replacing federal matching funds with an \$11,000 per beneficiary payment that states can use as they wish. However, the Congressional Budget Office and Kaiser Family Foundation promptly warned that such a low level of funding with “no strings attached” will drastically cut enrollment, reduce benefits, and lead to rationing of care for those with costly illnesses (see Updates for Week of April 4th and May 9th).

At least 41 Senate Democrats wrote letters this week to President Obama urging him not to accept the block grant plan as part of the ongoing deficit reduction negotiations led by Vice President Biden (see Update for Week of May 30th). They also opposed Republican plans to cap Medicaid spending. Senator Rockefeller emphasized that all 41 could filibuster any budget bill that included these proposals, thus preventing a floor vote.

However, notably absent from the letters were the signatures of Senate leadership or any mention of the “maintenance of effort” provisions in the Affordable Care Act that prevent states from reducing Medicaid eligibility to fill budget gaps. Republican Governors and members of Congress have urged the Administration to waive or eliminate this prohibition (see Update for Week of May 2nd). Consumer advocates fear that Senate Democrats may thus be signaling that they are open to negotiation on this particular issue.

FEDERAL AGENCIES

Administration seeks to prevent Medicaid providers and patients from suing over low payment

The Obama Administration filed a surprising “friend of the court” brief last week urging the U.S. Supreme Court (USSC) not to allow Medicaid providers and enrollees to seek judicial relief from low reimbursement.

The high court has agreed to hear a case next term about whether the 9th U.S. Circuit Court of Appeals erred in allowing Medi-Cal providers and enrollees to block a ten percent across-the-board payment reduction ordered by former California Governor Arnold Schwarzenegger (R). Existing federal Medicaid statutes prohibit states from reducing Medicaid rates to the point where beneficiaries no longer can access certain services due to a lack of participating providers. The USSC will not decide the validity of this law, but instead determine whether the Supremacy Clause of the U.S. Constitution allows providers and enrollees to file lawsuits to enforce it.

Consumer advocates warn that depriving providers and enrollees of this right to sue means that the Centers of Medicare and Medicaid Services can only ensure adequate reimbursement by withholding Medicaid matching funds—a move that would also harm access to care. They thought the Obama Administration also supported this position, since the acting Solicitor General opposed the USSC's intervention last winter.

However, the Administration reversed its position in its *amicus* brief, urging the USSC deny Medicaid providers and enrollees access to federal courts, since it would lead to a proliferation of Medicaid litigation that would clog up court dockets. Key Congressional Democrats vowed to file their own *amicus* briefs denouncing the Administration's position and advocating for the court to preserve the right of Medicaid providers and enrollees to seek judicial enforcement of federal Medicaid law.

FTC may issue expedited rules to stop anti-competitive generic drug settlements

According to a report this week in *Bloomberg*, the Federal Trade Commission (FTC) is seeking expedited rules to ban “pay-for-delay” deals between brand-name and generic drug manufacturers after legislative and judicial efforts to outlaw the practice have failed.

The FTC has been pushing for over a decade to outlaw the patent litigation settlements where generic drugmakers agree to delay introduction of lower-cost drugs into the market. The agency claims that the prevalence of these “pay-for-delay” deals costs consumers over \$3.5 billion per year.

The agency had previously declined to issue rulemaking banning “pay-for-delay” settlement absent specific authorization from Congress, because it would involve antitrust rather than consumer protection issues. However, the FTC has been rebuffed in its efforts to get the federal courts or Congress to act. The U.S. Supreme Court declined earlier this year to review appellate court rulings upholding the practice, while bipartisan Senate bills have stalled after key senators from states with some of the nation's largest drugmakers withdrew their support (see Update for Week of March 7th).

The recent proliferation of generic drugs (now accounting for 78 percent of all retail prescriptions) has also meant an unprecedented 60 percent increase in the number of “pay-for-delay” settlements from 2009 to 2010 (see Update for Week of May 2nd). Nearly 30 percent of all patent settlements filed with the FTC last year contained a “pay for delay” settlement, resulting in an average 17-month delay in getting the generic drug to market. The agency is worried that “pay for delay” deals are likely to spike even further over the next two years when six of the nation's ten highest-selling drugs will become available in generic forms.

As a result, the FTC is strongly weighing whether to rely on seldom-used expedited rulemaking to combat the practice. FTC rulemaking typically takes seven years, thanks to restrictions Congress placed on the agency in response to criticism that the FTC had over-reached in the 1970's in trying to regulate gasoline, television advertising, etc. However, the 1975 law does allow expedited rulemaking in less than a year, so long as it promotes competition.

The U.S. Chamber of Commerce decried any “unprecedented” FTC efforts to prohibit generic drug settlements through rulemaking. The Pharmaceutical Research and Manufacturers of America and Generic Pharmaceutical Association also blasted the agency's consideration of expedited rules.

Out-of-pocket costs for some cancer patients top \$700 per month

Duke University Medical Center and Dana-Farber Cancer Institute published a study this week showing that the monthly out-of-pocket costs for 216 cancer patients they surveyed averaged over \$700.

All but one of the mostly older females with breast cancer had insurance (mostly Medicare) and 83 percent had prescription drug coverage. Yet despite this level of benefits, 30 percent of respondents reported expenses that were a “significant burden” while 11 percent called them a “catastrophic problem.”

The \$712 in average monthly out-of-pocket expenses included insurance premiums and cost-sharing, as well as lost wages, and travel to appointments.

The findings were consistent with previous studies showing that more than 13 percent of cancer patient spend more than 20 percent of their income on medical care, while over 30 percent are burdened by medical debt.

The Duke study found that high out-of-pocket expenses are resulting in cancer patients increasingly choosing to abandon care, as at least 26 percent of patients surveyed had not filled a prescription because of cost.

STATES

States focus on Medicaid cuts, move slowly to create health insurance exchanges

As legislative sessions in most states have drawn to a close, the National Conference on State Legislatures reports that 43 have enacted new cuts in Medicaid spending or benefits, while fewer than one-fourth have taken any concrete steps to create the new health insurance exchanges authorized by the Affordable Care Act (ACA).

Louisiana is the only state that has refused to create any exchange and only 13 legislatures have yet to even consider exchange bills (most of whom are waiting for federal regulations later this summer before proceeding.) However, an orchestrated tea party campaign to block implementation of any ACA provision derailed exchange-authorizing legislation another dozen or so states, even those such as Alabama, Georgia, Idaho, Indiana, Mississippi, New Mexico, and Oklahoma where Republican Governors and lawmakers had planned to create an exchange even before the ACA became law or accepted federal grants to move forward.

Although Alaska, Florida, and Oklahoma have refused or returned their federal exchange grants, Republican Governors in Alaska and Oklahoma insist that they will still create insurance exchanges only with state-only funds. However, as with Wisconsin Governor Scott Walker (R), they acknowledge that their planned exchanges will not meet the new federal exchange standards under the ACA.

States have until January 2013 to prove to the U.S. Department of Health and Human Services that they will have an exchange operational by January 2014. Those states that were unable to pass legislation this session may have great difficulty meeting this deadline, even if they pass a bill in 2012. As a result, Republican Governors in at least Alabama, Georgia, Indiana, and Mississippi are trying to move ahead with exchange implementation through executive orders or other alternate means. (The insurance department in Texas is proceeding despite the opposition of Governor Rick Perry (R), insisting that it does not need legislative authorization to start using its federal implementation grant.)

California was the first state to pass an exchange law, followed by Maryland. Both states are far ahead of others, as their exchange boards have already held initial meetings. Governors recently signed exchange laws in Colorado, Vermont, Washington and West Virginia, while the Governors of Connecticut, Hawaii, Nevada, and Oregon are expected to do so shortly (see articles below). North Dakota, and Virginia have adopted a slower approach, passing laws to create a study committee that put the state on

a path to creating an exchange (The Illinois Governor has yet to indicate whether he will approve a similar approach, see below).

Massachusetts and Utah already had operational insurance exchanges prior to the ACA.

Alabama

Legislature sends constitutional amendment on federal health reform to voters

The Senate voted 24-9 this week to pass H.B. 60, which will allow voters to decide whether to amend the state constitution to explicitly prohibit any federal or state law mandating participation in a health care system or the purchase of health insurance.

The measure already passed the House with the necessary three-fifths majority (see Update for Week of April 4th) and now moves directly to the November 2012 ballot without the Governor's signature. Similar ballot referendums passed last year in Arizona, Missouri, and Oklahoma, but failed in Colorado. Several states including Florida have placed such a referendum on their 2012 ballot.

California

Blue Shield of California responds to rate hike fallout by capping profits, refunding reserves

One of California's largest insurers announced this week that it would cap future profits at two percent and rebate all of their \$180 million in excess 2010 income to consumers and providers.

Blue Shield of California created a firestorm earlier this year when it attempted to increase individual plan premiums by a cumulative average of 30 percent since last October (or up to 59 percent for some plans). Although the California Insurance Commissioner lacks the authority to reject or modify rate hikes without pending legislation, additional actuarial data sought by the Commissioner revealed that Blue Cross severely understated the rate hike, as premiums for some plans would have increased by 86 percent (see Update for Week of March 14th).

The revelations forced Blue Shield to withdraw the rate filing and acknowledge that its failure to anticipate higher medical costs was forcing the company to lose over \$24 million. Blue Shield's management also incurred heavily criticism for seeking such an onerous rate hike when it earned over \$180 million last year and paid its CEO over \$4.6 million.

The continued fallout has generated support for long-stalled state legislation that would give the Insurance Commissioner greater authority to modify rate hikes it deems "excessive". (A.B. 52 passed the Assembly last week and awaits a Senate vote).

Blue Shield is responding to the likelihood of greater insurance regulation by voluntarily taking steps to combat the rise in health care costs. The CEO pledged to rebate \$167 million of 2010 income to Blue Shield's 3.3 million customers and donate \$10 million to physician and hospitals that develop new ways to better coordinate care, as well as \$3 million to its own foundation for the uninsured. He also announced that the insurer will cap future profits at two percent of its revenues and rebate any profits over two percent, so long as it can remain "solvent" and "competitive".

The average individual subscriber will receive an \$80 credit in October, while an average family of four will see a \$250 rebate (small and large group subscribers will receive slightly higher rebates).

While Blue Shield's announcement was praised by federal regulators, state consumer advocates denounced it as a "publicity stunt" that was no substitute for the greater accountability and transparency A.B. 52 would bring to the rate review process. Editors for the *San Francisco Chronicle*, where the Blue Shield announcement first appeared, suggested the insurer focus more on limiting premiums instead of trying to prevent itself from being the "poster child for fast-moving [rate review] legislation".

Blue Shield was an early supporter of the Affordable Care Act and has consistently refused to blame its proposed rate hikes on the new federal consumer protections that went into effect last fall.

Connecticut

Governor to sign exchange implementation bill

The Democratically-controlled House sent legislation to Governor Daniel Malloy (D) this week that would create a health insurance exchange subject to the standards in the Affordable Care Act (ACA). (The Governor has indicated that he will sign the bill.)

S.B. 921 is a compromise that includes parts of three different exchange bills that cleared Senate committees this session. Senate Republicans and provider groups largely objected to a key provision that excluded anyone affiliated with insurers, brokers, providers, or provide trade associations from serving on the 11-member board that will govern the exchange. However, consumer advocates insisted that the prohibition was necessary to avoid the conflict of interest controversies that have beset exchange implementation in North Carolina (at least seven states are considering legislation that would allow health insurers to participate on exchange boards).

Governor expected to sign compromise bill that puts state on path to a true “public option”

The Senate passed compromise legislation this week creating the state SustiNet health plan and sent it to Governor Daniel Malloy (D) for his expected signature.

Created in 2009 over the veto of then Governor Jodi Rell (R), SustiNet is a state health insurance option that currently provides affordable coverage for the uninsured, underinsured, and certain small business workers. The board of directors had recommended that the legislature expand Sustinet to include all state health plans including Medicaid and ultimately offer coverage to large groups and any other state resident who wanted it, in order to meet SustiNet’s original goal of universal coverage by 2014 (see Update for Week of January 10th).

Supporters think that by incorporating these recommendations, H.B. 6308 would provide the “public option” that was left out of the Affordable Care Act (ACA). However, the broad expansion drew predictable opposition from Republican lawmakers, insurers, and business groups. Governor Malloy ultimately defected from the expansion after the Office of Fiscal Analysis warned it would cost far more than anticipated (see Update for Week of April 4th). The Governor also expressed reservations about handing over control of \$5 billion in state spending to the quasi-public Sustinet board.

The compromise measure passed this week scaled-back the expansion to add only municipalities to buy insurance through the state beginning in 2012, and non-profits that contract with the state in 2013. The state comptroller could join their coverage with the state employee health plan, which would require approval from state employee unions, or cover them in a separate plan.

H.B. 6308 also retains most control over the plan with the Governor’s office. The measure creates an advisory board, called the SustiNet Health Care Cabinet, which would make recommendations to the Governor on how to expand access to care and develop a business plan that evaluates private health insurance alternatives to a “public option”. It also establishes an Office of Health Reform and Innovation within the lieutenant governor’s office to coordinate state and federal reform efforts.

Supporters on both sides claimed victory. Opponents insisted that the compromise bill prevents the state from creating a “public option”. However, the Universal Health Care Foundation of Connecticut (created by Blue Cross and Blue Shield) praised it for putting the state on the path to a true “public option.” They emphasized that although the bill does not commit the state to offering health insurance to all, it explicitly does not rule it out should the cabinet and Governor choose to do so in the future.

Legislature passes bill mandating insurance coverage for clinical trial costs

The House and Senate reconciled different versions of S.B. 21 and sent it to Governor Daniel Malloy (D) this week for his signature. The measure sponsored by Senator Martin Looney (D) would require individual and group health plans to cover routine patient costs associated with clinical trials for disabling, progressive or life-threatening medical conditions (see Update for the Week of January 10th).

Delaware

Legislature rejects Governor's Medicaid cuts despite \$100 million budget gap

The Joint Finance Committee voted 8-4 this week to reject Medicaid benefit cuts sought by Governor Jack Markell (D). The committee restored \$5 million to the \$589 million program and removed the Governor's limits on emergency room visits, new copayments, and temporary physician payment cuts.

Members instead passed a measure that sets up a task force to study ways to cut Medicaid costs without harming delivery of services or placing an undue financial burden on patients and providers. The state budget director accused the committee of "stalling" and simply delaying hard decisions on Medicaid until next year, when they have to fill a \$100 million gap created by the loss of federal stimulus relief.

Georgia

Governor creates advisory committee to move forward on insurance exchange

Governor Nathan Deal (R) signed an executive order last week that partially circumvented the Legislature's opposition to establishing a health insurance exchange meeting the standards set forth in the Affordable Care Act (ACA).

An outspoken opponent of the ACA, the Governor has already signed legislation this session creating interstate compacts to defy the law (see Update for Week of March 14th) and allowing for the sale of substandard interstate health plans (see Update for Weeks of April 18th and 25th). Georgia also is one of 12 states seeking federal waivers from the ACA's medical-loss ratios and one of 26 states that joined a federal lawsuit challenging the constitutionality of key ACA provisions. However, the health insurance exchange is not one of those provisions, as the Governor has long supported the creation of such an exchange, calling it a "Republican-like idea."

Despite his support, tea party opposition to implementing any provision of "Obamacare" forced the Governor and Republican lawmakers to shelve exchange-authorizing legislation last session, even though the Governor already accepted a federal implementation grant (see Update for Week of March 21st). As a result, Governor Deal instead formed the Georgia Health Insurance Exchange Advisory Committee to design the exchange in accordance with "free market principles". He also appointed a member of the tea party to serve on the committee, in addition to state legislators, business leaders, health insurers.

The committee held its first meeting this week and was directed by the Governor to submit recommendations by September 15th. He urged them to "deal with reality" and not "ignore the law's existence" no matter how "undesirable" the ACA may be for most Georgians. The Governor emphasized the importance of creating their own exchange instead of defaulting to the federal government.

Illinois

Legislature adopts slower approach to exchange implementation

The legislature concluded its spring session last week by forming a bipartisan committee to study how an insurance exchange should be designed, taking a significant step back from the detailed implementation plan proposed by Governor Pat Quinn (D).

The Governor was disappointed that his more ambitious approach died without a Senate vote, as did legislation that would give the state insurance department greater authority to modify or reject excessive rate hikes. He has yet to indicate whether he will sign the slower approach passed by the House and Senate, which fails to create the consumer-oriented exchange board he envisioned.

Republican Governors in North Dakota and Virginia have signed similar legislation creating advisory committees that put their states on a path to an exchange, while Georgia's Governor issued an executive order last week to create an exchange task force (see above).

If signed, H.B. 1577 would require the committee of legislators to issue a report by September 30th, giving the fall session time to pass authorizing legislation that would satisfy the federal government's January 2013 deadline (see above).

Massachusetts

Support grows in Massachusetts for state's landmark universal health care law

Polling released this week by the Harvard School of Public Health revealed support for Massachusetts' landmark health reforms has increased ten percentage points over the past two years.

Signed into law in 2006 by former Governor Mitt Romney (R), the state's universal health care model ultimately was applied nationwide under the Affordable Care Act (ACA). However, despite blistering attacks on the ACA by Republican opponents, over 63 percent of Massachusetts' residents now support the law, with only 21 percent opposed.

Opposition to the Massachusetts' mandate that everyone buy insurance is predictably higher (44 percent), with only a narrow majority favoring it. However, that is far lower than nationwide opposition to the ACA's identical mandate, which now exceeds 54 percent.

Although the Massachusetts' law has been an overwhelming success in getting over 97 percent of state residents into the insurance pool and improving health outcomes (see Update for Week of January 10th), the state has only recently sought to add cost controls like global budgeting (see Update for Week of December 6th). As a result, health care costs in Massachusetts have continued to spike upwards. However, only 28 percent of state residents lay the blame for rising health costs on the new law instead of on medical providers and health plans.

Over four out of five residents believed the Massachusetts law has improved their quality of care, affordability of care, and time it takes to get an appointment with a physician.

Montana

Montana taking the lead on health insurance co-operatives authorized by ACA

Provisions allowing states to create "consumer oriented and operated plans" (co-ops) were inserted by Senate Finance Democrats into the final Affordable Care Act (ACA) law as an alternative to the public health insurance option that met with intense Republican opposition.

Former state auditor John Morrison is heading a group that is creating one of these non-profit health insurance co-ops to compete for part of \$3.8 billion in federal grants authorized by the ACA. The Montana Health Cooperative will be one of many co-ops nationwide that will be applying for ACA grants, but the group believes it is further along than others, as it already has an operating board of directors that include physicians and insurance executives.

While the co-op will offer insurance primarily to 40,000-80,000 individuals and small businesses, the board is awaiting federal regulations scheduled for release in a few weeks that will help it decide how to best apply for and use the federal funding. The board also must still decide how to contract with hospitals, what kind of rates it can reasonably expect, and what strategies can achieve the most insurance market penetration.

The U.S. Department of Health and Human Services has indicated that applicants that offer a statewide plan, use "integrated care models", and have "significant private support" will be given priority.

Nevada

Governor expected to sign exchange bill that unanimously cleared both House and Senate

The House unanimously passed legislation this week creating the Silver State Health Insurance Exchange, subject to the standards established by the Affordable Care Act (ACA). S.B. 440 now goes to Governor Brian Sandoval (R) after unanimously clearing the Senate last week (see Update for Week of May 30th).

Despite insisting that the ACA is "unconstitutional", Governor Sandoval has pledged to implement its provisions unless they are overturned or repealed. He is expected to sign S.B. 440 as his Administration has already agreed to pay consultants nearly \$626,000 to design the new exchange.

The bill prohibits members of the exchange board from being affiliated with insurers, thus avoiding the controversy surrounding exchange bills in other states (see Update for Week of May 30th).

Oregon

Maligned insurance exchange bill clears House, awaits Governor's signature

The House of Representatives overwhelmingly approved S.B. 99 this week, clearing the way for Oregon to create a health insurance exchange that meets new federal standards under the Affordable Care Act (ACA).

Supporters breathed a huge sigh of relief, as the measure appeared dead last month after key Republicans in the evenly-divided House demanded that the state first return the \$48 million "early innovator" reward from the federal government for being a leader in exchange implementation (see Update for Weeks of April 18th and 25th).

However, one of the bill's champions, Rep. Jim Thompson (R), successfully pleaded with his colleagues not to block exchange implementation and cause the federal government to instead assume control. Rep. Thompson has tried to create a health insurance exchange since 2004 and criticized fellow Republicans for "unfairly connect[ing] [the exchange] to Obamacare."

Governor John Kitzhaber (D) has pledged to sign the bill, despite disappointment that it does not bar the insurers from serving on the oversight board (see Update for Week of May 30th). Once signed, the measure directs the Oregon Health Authority to fill the nine board appointments and provide the legislature by February 2012 with a business plan for the public entity that will operate the exchange.

Texas

House and Senate pass comprehensive Medicaid reform bill that includes block grant waiver

The House and Senate passed major changes to Medicaid this week that includes moving enrollees in south Texas into managed care, allowing the formation of health care cooperatives, and seeking a federal waiver to block grant the entire Medicaid program.

The omnibus cost-control measure (S.B. 7) passed largely along party lines during a special session called by Governor Rick Perry (R) after lawmakers failed to act on separate stand-alone bills before the regular session concluded. The Legislative Budget Board estimates that the changes could save the state nearly \$470 million, a figure disputed by opponents who fear that the bulk of the savings may come from managed care plans rationing more care.

The primary bill sponsor, physician Rep. John Zerwas (R), assured fellow legislators that managed care would work in the Rio Grande valley, the state's largest Medicaid service area, since many enrollees in other poor Texas counties are already successfully enrolled in managed care.

The biggest change under the measure would be creating state-sanctioned health care collaboratives, which allow hospitals, doctors and insurers to work together to lower costs. These collaboratives would be similar to the accountable care organizations authorized by the Affordable Care Act (ACA), which have drawn intense opposition from provider groups (see Update for Week of May 9th).

However, the most controversial provisions were forced on the Senate by the House's chief health policy writer, Rep. Lois Kolkhorst (R). She had led the charge to allow Texas to ask for federal permission to create "interstate health care compacts" that can defy federal health care reforms like mandating the purchase of health insurance. Similar protest laws have been enacted in Georgia (see Update for Week of March 14th) and Oklahoma.

Senate Republicans were also reluctant to include Kolkhorst's amendment requiring the state to seek a federal waiver allowing Texas to use federal Medicaid matching funds however they wish. A similar Medicaid block grant plan by Congressional Republicans has caused a public backlash (see Update for Week of May 30th) as analyses from the Congressional Budget Office and others have found it would greatly reduce enrollment and benefits, as well as increase rationing of care for those with costly conditions (see Update for April 4th).

Other lesser provisions of S.B. 7 include the imposition of Medicaid copayments and abolishment of the State Kids Insurance Program (which will be assumed by SCHIP). It also creates an advisory committee to develop more efficient payment methods than fee-for-service for traditional Medicaid, such as reimbursing for hospital services under case-mix models like diagnosis related groups.