



Health Reform Update – Week of May 14, 2012

CONGRESS

Health insurers could lose \$1 trillion if Affordable Care Act is overturned

A study released this week by Bloomberg Government estimates that health insurers will lose \$1 trillion from the federal government over the next eight years if the U.S. Supreme Court overturns the entire Affordable Care Act (ACA).

The \$1 trillion figure comes largely from the law's subsidies for low-to-moderate income Americans to purchase affordable coverage in an exchange and dramatic expansion of Medicaid (creating more opportunities for Medicaid managed care plans). The former will cost \$557 billion through 2020 while the latter will cost \$669 billion. The two provisions account for 98 percent of new spending in the law, 58 percent of which would pass through insurers.

These payments also represent nine percent of the insurance industry's total revenue from 2013-2020, with large insurers like UnitedHealth Group receiving about \$174 billion (or \$22 billion a year). However, Bloomberg Government emphasized that the entire economy and not just the insurance industry would be adversely impacted if the entire ACA were struck down, as \$1 trillion also equals nearly one-half percent of the nation's estimated gross domestic product from 2013-2020.

Both the Government Accountability Office and Congressional Budget Office have likewise confirmed that overturning the ACA would explode the federal deficit (see Update for Week of April 2nd).

Senate Democrats block five Republican budget plans

The Senate rejected five competing Republican budget plans this week in a largely symbolic effort that was intended to put both parties on the record one more time before the fall elections.

The most prominent measure was the controversial House-passed budget plan sought by Rep. Paul Ryan (R-WI) that may play a pivotal role in deciding tight races. The resolution (H.Con.Res. 112) would give Medicare enrollees premium subsidies to use in the private market while converting Medicaid into a federal block grant program with no strings attached (see Update for Week of March 26th). Three moderate Republicans sided with Democrats in blocking the measure.

Democrats likewise blocked the remaining appropriations measures that passed the House (see Update for Week of May 7th), as they would violate the spending caps both parties agreed to as part of the last summer's contentious debt ceiling compromise. Majority Leader Harry Reid (D-NV) instead pledged to move ahead on a package of 12 bills passed by the Senate Appropriations Committee.

Senate prepares FDA reauthorization for next week, House to vote later this month

The Senate is set to debate and vote early next week on legislation reauthorizing user fees that fund Food and Drug Administration (FDA) product reviews, which the Congressional Budget Office projects will reduce the federal deficit by roughly \$363 million over ten years. The measure (S.3187) will ultimately have to be reconciled with the House bill (H.R. 5651) that is expected to pass in late May. A final version must be sent to the President before the current user fee program expires September 30th.

The House and Senate versions are fairly comparable, as both create new user fees for generic drugs and biosimilars. They also reflect the compromise reached by the Obama Administration with

manufacturers, who will voluntarily pay \$100 million more in user fees in exchange for faster reviews (see Update for Week of May 7th).

However, several key differences between the House and Senate versions may delay reconciliation in conference committee. For example, while both versions include legislation (H.R. 2182) that would provide incentives for the development of new antibiotics, the Senate bill would focus those incentives on new drugs that treat serious or life-threatening diseases.

The bills also differ on drug shortage language. Although both require manufacturers to report potential shortages to the FDA at least six months in advance (or as soon as possible), the House bill requires the FDA to keep a public, up-to-date list of all shortages, while the Senate version would not make that information public. The Senate also calls for a task force to help prevent drug shortages.

Another key difference is that the House measure prevents the FDA from issuing new guidance without first producing a report for Congress, which can often delay release by at least a year. The House also requires nullifies any draft agency guidance not finalized within two years.

Senator John McCain (R-AZ) plans to resume his persistent efforts to include bipartisan amendments to the Senate bill allowing cheaper drugs to be imported from Canada (see Update for Week of April 23rd). However, fellow Senators who support the effort (such as HELP Committee chairman Tom Harkin (D-IA)) fear it could impede prompt passage of the reauthorization.

A bipartisan amendment by Senators Jeff Bingaman (D-NM) and David Vitter (R-LA) would also include their *FAIR Generics Act* into the Senate bill, which would effectively circumvent the “pay-to-delay” settlement agreements that the Federal Trade Commission insists are anti-competitive and have long-sought to ban (see Update for Week of April 23rd). S.1882 would speed the introduction of cheaper generics by allowing other generic drugmakers to share some of the 180-day marketing exclusivity period given for the original generic patent holder if it enters into a “pay-to-delay” settlement with a brand-name manufacturer. However, the Generic Pharmaceutical Association immediately pledged to withdraw their support for the user fee reauthorization if S.1882 is attached.

Senator Sanders proposes “radical” prize fund to lower cost of HIV drugs

Senator Bernie Sanders (I-VT) held a hearing this week to push legislation creating a \$3 billion fund to reward companies who develop new HIV medications with monetary prizes instead of patents, so long as they agree to immediately let their products enter the generic market.

His measure (S.1138) would de-link research and development costs from the price of the drug. It would stop companies from setting prohibitively high prices during the drug’s monopoly phase in order to first recover research and development costs.

Patents awarded to new HIV drugs would instead qualify manufacturers for federal rewards that would replace profits earned during the monopoly phase. The awards would be funded by an assessment on health insurance and be based on the therapeutic value of the drug compared to the number of patients it will benefit.

Sanders, the chairman of the Primary Health and Aging subcommittee of the Health, Education, Labor and Pensions Committee, pointed out that patients are literally dying while drugmakers are waiting to recoup the cost of research and development for new and emerging medications. He insists that ending exclusive marketing rights for new HIV drugs and instead relying on rewards would reduce their price by at least 90 percent and help ensure that those in need more quickly get life-saving drugs.

Senator Sanders acknowledges that his proposal is “very radical” and not likely to move. However, he intends to use the bill to bring attention to the limited access that many HIV/AIDS patients have to life-saving drugs, noting that some like Atripla cost patients more than \$25,000 per year even though the generic version costs only \$200.

FEDERAL AGENCIES

CMS guidance says federal fallback exchange will follow “clearinghouse” model, for now

The Centers for Medicare and Medicaid Services (CMS) has released long-awaited guidance detailing how a federal fallback exchange will operate in those states that fail to make substantial progress towards creating their own state-based exchange by January 2013.

Most Republican governors have cited the lack of such guidance as justification for delaying the creation of an exchange that complies with the Affordable Care Act (ACA), at least until the U.S. Supreme Court resolves the constitutionality of the new law (see Update for Week of March 26th). The latest guidance seeks to resolve lingering questions relating to the final regulations issued earlier (see Update for Week of March 12th) and spur some reluctant states to move forward.

The guidance details the three options available to the states under earlier rules. For states that elect to create their own exchange, it creates a new November 16th deadline by which they must submit exchange plans, so that CMS can certify by January whether the state has made substantial progress. States can seek full approval, or conditional approval if they can show that any outstanding exchange development will be completed during 2013. However, they must follow the “exchange blueprint” set out in the guidance.

For states that will not be ready by January, CMS will allow them to temporarily partner with the agency so that the state can retain control over exchange functions like plan management and consumer assistance (Arkansas and Wyoming are among those exploring this option). Plan management includes such duties as certifying that a health care plan offers the required minimum benefits and has adequate provider networks. Consumer assistance includes the “navigator” role that helps make sure customers have the information they need to pick a plan. Under the partnership model, CMS will still carry out such functions as determining the eligibility and size of ACA tax credits.

States that fail to create their own exchange or get approval for a federal-state partnership will have a newly-named “federally facilitated exchange” (FFE) operated in their state. CMS has decided that at least for the first year, the FFE will follow the “clearinghouse” model already in place in Utah and favored by conservative lawmakers. Under this model, any plan that meets minimum federal (or additional state) standards may participate. The exchange cannot negotiate rates and selectively exclude plans as in the “active purchaser” model in place in Massachusetts.

The head of the Center for Consumer Information and Insurance Oversight (CCIO) within CMS declined in a news briefing to estimate how many states will likely require an FFE.

CMS releases another \$181 million in exchange establishment grants

Six more states will receive federal grants totaling \$181 million in order to establish the health insurance exchanges required by the Affordable Care Act (ACA).

The grants were issued concurrent with long-awaited guidance by the Centers for Medicare and Medicaid Services (CMS) on how the federal fallback exchange will operate in those that fail to get approval for state-based exchange or federal partnership by January 2013 (see above). The latest grants will go to Illinois, Nevada, Oregon, South Dakota, Tennessee, and Washington.

Three of these states (IL, SD, and TN) have made little or no exchange progress (see Illinois article below). South Dakota immediately announced that it will not use the latest grant until after the U.S. Supreme Court resolves the constitutionality of the ACA (see Update for Week of March 26th). By contrast, Nevada, Oregon, and Washington have made substantial progress.

Nevada Governor Brian Sandoval is one of the few Republican governors allowing exchange implementation to proceed. Only 15 states have passed legislation or issued executive orders authorizing exchange creation, with most Republican governors content to wait until the high court acts.

Washington will join with Rhode Island as the only state to receive a Level II establishment grant, meaning they are further along in exchange implementation than most other states. Four states (KY, MN, NV, and NY) have already received two Level I grants.

Previous guidance extended the final deadline for applying for Level II exchange establishment grant through November 3, 2014, instead of the final deadline that was to be this June (see Update for Week of February 27th).

Every state but Alaska accepted the initial \$1 million planning grants in 2010, though several states (led by Florida, Kansas, Oklahoma, and Wisconsin) have since returned all of their grants in order to make a statement of political opposition (see Update for Weeks of January 16th and 23rd).

Total exchange grants under the ACA now total more than \$1 billion. The head of the Center for Consumer Information and Insurance Oversight (CCIO) within CMS declined to answer during a news briefing whether states would have to return these grants if U.S. Supreme Court strikes down the ACA.

HHS revises final rule on consumer rebates required by the Affordable Care Act

The Department of Health and Human Services (HHS) finalized regulations late last week governing the premium rebates that roughly 16 million private plan subscribers will receive in August.

Starting with the 2011 plan year, the medical-loss ratio (MLR) provisions of the Affordable Care Act requires individual and small group plans to spend at least 80 percent of premium revenue on medical care or rebate the excess to subscribers each year. Rebates for last year are expected to total at least \$1.3 billion (see Update for Week of April 23rd).

The final rules require letters from insurers to rebate recipients to state "This rebate is required by the Affordable Care Act -- the health reform law" and be sent even to those 100 million subscribers who will not receive a refund this year. America's Health Insurance Plans (AHIP) and several Republican lawmakers Rep. Joe Pitts (R-PA) had objected these burdensome requirements which they claim will add \$200-300 million in unnecessary costs and amount to campaign "propoganda". However, consumer groups sought the language in order to ensure that the industry does not try instead to take credit for the rebates (see Update for Week of March 26th).

The final rules address issues that remain unresolved in interim final regulations on the medical-loss ratio requirements that CMS issued last year (see Update for Weeks of November 21st and 28th). Along with the notice requirements above, the final rule also compromises with insurers by requiring that those who meet the MLR target only report this fact to their enrollees after the first year. However, insurers must notify enrollees that MLR information for other years is available at www.healthcare.gov.

The notice requirement also does not apply to limited benefit, expatriate, or student health plans, or to insurers with fewer than 1,000 enrollees in a particular market and whose experience is thus not "credible" under the MLR regulations.

CMS revises guidance on consumer-friendly benefit summaries required by ACA

The Centers for Medicare and Medicaid Services (CMS) and two other agencies provided additional guidance last week on final regulations governing the "Summary of Benefits and Coverage" (SBC) created by the Affordable Care Act (ACA).

Starting in September, the final rules require that plans provide subscribers with a four-page "plain English" summary explaining what limitations or exceptions apply to their policies. They should

allow consumers to make “apples to apples” comparisons of different plans and prevent insurers from burying key coverage details in the fine print of plan documents (see Update for Week of February 6th).

Despite their popularity with consumers, the “coverage facts labels” required by these rules are fiercely resisted by plans and employers, who insist that their policies cannot be succinctly condensed into a single brief form in such a short timeframe. As a result, HHS, Labor, and the Treasury issued a new frequently asked questions (FAQ) document to address some of these concerns while not wavering on the September deadline.

The FAQ clarifies that benefit summaries can be provided electronically in certain circumstances and need only be provided when subscribers apply if no plan terms change by the time of enrollment. Health plans can also break-out elements of the benefit summaries for comparison purposes (for example comparing deductibles across plans) as long as the entire summary is also available.

To facilitate compliance (in response to complaints), the agencies reiterate their intention not to penalize plans that are making good faith efforts at compliance in the first year. The summaries also need not be provided the first year for expatriate plans and plans can delay providing the summaries until September 23, 2013 for enrollees in closed blocks of business.

AHRQ study says Affordable Care Act will save individual plan subscribers at least \$280 per year

A report released this week by the Agency for Healthcare Research and Quality (AHRQ) concludes that those covered under individual health plans from 2001-2008 would have saved an average of \$280 per year in out-of-pocket costs had the Affordable Care Act (ACA) been in place.

According to AHRQ, more than 11 million Americans under the age of 65 were covered by individual health plans during this period. The study compared 2,672 of these adults to those 60,000 adults with large or small group coverage. It determined that adults with individual coverage incurred an average of \$1,100 in out-of-pocket costs each year compared to only \$607 for small group subscribers and \$546 for those with large group coverage.

When applying the new consumer protections under the ACA, the federal agency found that these average out-of-pocket costs would have been \$589 lower for those individual subscribers aged 55-64, while even those who are younger or wealthier would still save a minimum of \$104. Overall, an adult with a chronic condition would have saved an average of \$252 per year.

FDA holds hearing on new biosimilar pathway created by Affordable Care Act

The nation’s largest biopharmaceutical companies used an agency hearing this week to continue to urge the Food and Drug Administration (FDA) to more strictly limit the ability of less costly biosimilar products to come to market.

FDA released its long-awaited guidance earlier this year defining how the agency intends to implement the new regulatory approval pathway for biosimilars created by the Affordable Care Act (ACA) (see Update for Week of February 6th). Generic biosimilars are expected to cost 25-45 percent less than existing biologics, which represent some of the most complicated and expensive drug products.

Public comments on the guidance largely objected to “risk-based, totality-of-the-evidence” approval protocol proposed by the FDA and recommended tighter standards for biosimilar reviews (see Update for Week of April 16th). Similar comments at the hearing hammered home the point that patient safety should remain paramount to getting less costly biologics to market.

For example, Amgen insisted that much remains unknown about these biosimilar products, amplifying the need for manufacturer accountability, accurate tracking of adverse events, and the

use of distinguishable and established names that facilitate prompt identification of product problems. The company also urged the FDA to conduct a media campaign educating stakeholders about the limitations of biosimilars, particular that they are not always substitutable with the reference product.

The Alliance for Safe Biologic Medicines echoed Amgen's comments and identified additional areas of concerns that the FDA still needs to resolve before allowing biosimilars into the U.S. market. These include more robust clinical testing than has been proposed, clear packing, labeling, and prescribing information, and very close and deliberate scrutiny of biosimilars before they are deemed interchangeable with the reference product.

Novartis, which is developing several biosimilars, focused instead on recent studies of cost savings from biosimilars in Europe, which are in line with Congressional Budget Office projections that the new biosimilar approval pathway could reduce total spending on biologics by \$25 billion over ten years.

Yale study shows that FDA approving drugs faster than Canadian or European counterparts

A study published this week in the *New England Journal of Medicine* refutes a "common belief" that drug approval process in the U.S. lags behind other advanced countries.

Yale University School of Medicine researchers reviewed Food and Drug Administration (FDA) approval decisions from 2001-2010 and found that despite the agency's far-higher proportion of applications requiring multiple reviews, the FDA completed reviews "over three months faster" than either Health Canada or the European Medicines Agency (EMA). In addition, 64 percent of medicines approved in both the U.S. and in Europe were approved for U.S. patients first, while 86 percent of medicines approved in both the U.S. and Canada were also approved first in the U.S.

NIH study refutes claims that genetic testing spurs utilization of costly medical services

A study released this week by the National Institutes of Health concludes that most people do not seek costly follow-up medical services after genetic tests reveal they are at risk for particular diseases

Published in the *Genetics in Medicine*, the research identified the amount of services that 217 healthy people (age 25-40) received in the 12 months before they received genetic test results and compared it to the medical care they received in the following 12 months. It also evaluated the care patterns of the group that had the genetic tests with a group of about 400 similar members of their health plan whose genes had not been tested.

Genetic tests have become increasingly available to consumers since the human genome was mapped in 2003. The testing done by the participants determined if they carried any of 15 different genes that would slightly increase their risk for eight common health conditions including diabetes, coronary heart disease, hypercholesterolemia, lung cancer, colorectal cancer, and skin cancer.

Critics have speculated that knowing this type of information would lead people seek further diagnostic tests or additional medical care. However, the NIH study appears to refute that notion.

The study is the first to use electronic health records to track the use of medical care and tests, instead of relying on the potentially-faulty memory of participants.

HEALTH CARE COSTS

Health care costs now exceed \$20,000 for families with employer coverage

A new report by employee benefit consultant Milliman affirmed that out-of-pocket costs continue to climb even for families covered by employer-sponsored health insurance.

For the first time, Milliman found that costs for a family of four with employer coverage will break \$20,000 in 2012. The \$20,728 projected average is \$1,335 or seven percent more than last year. Although the rate of increase was slower than past years, the total dollar increase was still a record.

A family of four is now expected to pay an average of \$5,114 in premiums for a preferred provider organization plan, along with \$3,470 in cost-sharing. However, Milliman emphasized that the Affordable Care Act (ACA) "has had only a limited effect" on these costs.

Health care costs also varied significantly among the 14 metro areas surveyed. Costs in Miami and New York City were about 20 percent higher than the national average, while Phoenix, Atlanta and Seattle were the only three cities where annual costs are projected to be less than \$20,000.

Consumer-directed health plans show mixed results

Employer health plans with low premiums and high deductibles could cut health costs significantly but not without significant risks for subscribers, according to a new study from RAND Corporation.

Published in this month's *Health Affairs*, the 2007 survey of 59 large employers found that the non-elderly would save four percent or \$57 billion per year by using these "consumer-directed" plans. Such plans typically have annual deductibles of at least \$1,000 per person and are often championed by Republican lawmakers as a "market-based" reform that instills efficiency by forcing consumers to have "more skin in the game".

According to RAND, consumer-directed plans already represent 13 percent of all employer coverage, but would reach 50 percent over the coming decade due to incentives in the Affordable Care Act. Cost savings for the nonelderly population would range from 1-2 percent if consumer-directed plans represent 25 percent of employer coverage and from 5-9 percent with 75 percent market penetration.

However, RAND warned that savings could be accompanied by serious quality issues "including poorer health and health emergencies" that could result from significant increases in up-front patient costs. The researchers emphasized that consumer-directed plans often eliminated coverage for preventive services like cancer screenings and caused subscribers to more frequently go without needed care due to the high deductible.

The findings are consistent with a recent study by the Robert Wood Johnson Foundation concluding that those enrolled in high-deductible health plans are 3-4 times more likely to report forgoing needed care (see Update for Week of January 30th). Previous studies by RAND and the Kaiser Family Foundation reached similar conclusions (see Update for Week of December 12th).

Most employers plan to curb employee use of costly specialty drugs

An Express Scripts survey of more than 300 large employers found that most are planning to implement measures that will more strictly control health insurance coverage of specialty drugs.

The annual survey by the nation's largest pharmacy benefit manager found that more than a third of all employers cited the use of specialty drugs by employees as their primary cost concern. This figure rose to nearly 60 percent of employers with 25,000 or more workers.

Overall spending on specialty drugs rose a staggering 17.1 percent last year, according to Express Scripts, as compared to a mere 2.7 percent increase in spending for all other drugs. Even though specialty drugs still constitute less than 30 percent of an employer's overall drug spending, it is by far the fastest-growing component.

As a result, the vast majority of survey respondents expect to institute “step therapy” programs within the next two years, which will require employees to first try the lowest-cost drug that is appropriate and available before starting on a more costly drug therapy.

Orphan drug market could hit \$6 billion in six years

A report released last week by GBI Research projects that the worldwide market for orphan drugs will increase from \$2.3 billion in 2010 to \$6 billion by as early as 2018.

There are currently more than 6,000 orphan diseases recognized in the U.S., which are defined as those affecting 200,000 or fewer Americans. The report found that the need for an improved and expanded selection of drugs would significantly boost research and development.

STATES

Arizona

Insurance Department to assume control of enhanced rate review under the ACA

Despite opposing the Affordable Care Act (ACA), the Administration of Governor Jan Brewer (R) proposed this week to at least strengthen its rate review process in accordance with the new law.

Effective last September, the ACA requires that individual and small group health insurers must publicly disclose their actuarial justification for any double-digit premium increase (see Update for Week of August 29th). States are required to review this data, determine whether the increase is “unreasonable”, and publish the data and decision on their websites.

Arizona is one of six remaining states where the federal government has assumed this role of “shaming” health insurers who seek “unreasonable” premium increases. However, the Department of Insurance held a hearing this week on their proposal to take over this responsibility, insisting that state-level reviews give both insurers and consumers easier access to insurance regulators.

The move was strongly supported by Blue Cross Blue Shield of Arizona, which insisted that state regulators are in better position to account for factors unique to the local market. Consumer advocates also largely did not object to the plan, so long as the Department improves the transparency of the process and gives a bigger voice to subscribers.

Insurance officials emphasized that the proposed rules just give them authority to carry out the “shaming” provisions of the ACA and that additional state legislation would be needed before they could actually reject or modify rate hikes. They also stressed that funding for the enhanced review is coming entirely from the \$1 million federal premium review grant that Governor Brewer obtained in 2010.

California

Health programs to be slashed again after deficit forecast nearly doubles

Governor Jerry Brown (D) and the Legislative Analyst’s Office (LAO) announced this week that lower than anticipated tax collections have nearly doubled California’s projected budget deficit, forcing the Governor to propose slashing health programs by another \$2.5 billion.

California’s structural deficit problems have resulted in \$15 billion in cuts to Medi-Cal, SCHIP, and other safety net programs over the past several years, even though ten percent cuts in Medi-Cal provider payments for 2008-2009 continue to be blocked by the courts (see Update for Week of February 20th). Health cuts already comprised more than one-third of the \$6.5 billion the Governor sought to cut in his proposed budget for fiscal year 2013, in order to fill a projected \$9.13 billion budget deficit. These

included slashing payments to SCHIP managed care plans by 25 percent, shifting many of the 875,000 SCHIP children into Medi-Cal, and moving all 1.4 million residents eligible for both Medicare and Medi-Cal into managed care plans (see Update for Week of February 20th).

The Governor's revised budget retains all of these cuts but also further slashes Medi-Cal by \$1.2 billion, primarily by cutting provider reimbursement and eliminating more optional benefits. He resurrected his plan to hike cost-sharing for Medi-Cal enrollees, albeit by imposing only \$15 copayments non-urgent emergency room visits and \$1-3 copayments on prescription drugs. The Governor sought last year to force Medi-Cal enrollees to pay \$200 for hospital stays, \$50 for emergency room care, \$5 for physician visits, and \$3-5 for certain prescription drugs, but such dramatic hikes were rejected by the federal government (see Update for Week of February 6th).

However, the Governor's latest spending cuts make up only \$8.3 billion of the projected deficit that now stands at \$15.7 billion. He is also proposing \$8.5 billion in new revenues, although nearly \$6 billion of that amount is contingent upon passage of a voter referendum this fall.

Recent U.S. Census data showed that revenues improved in all 50 states since 2011 (see Update for Week of April 9th). However, the growth in personal income tax collections has slowed significantly, up only 7.3 percent on average as compared to the 18.5 percent spike this time last year.

The LAO had warned as early as last fall that revenues in California were lagging far behind the improvement in other states (see Update for Week of November 14th). The mere 1.7 percent bump last quarter was well-below the Governor's \$9.4 billion projections and forced him to nearly double the forecast deficit for this year.

The Governor's proposed budget cuts will be considered by legislative committees in advance of the June 15th deadline to pass a budget. Last year's budget was only the second in 25 years that was passed on time (see Update for Week of June 27th and July 4th).

Delaware

Governor likely to sign mini-COBRA legislation

The Senate unanimously passed H.B. 170 this week. If signed as expected by Governor Jack Markell (D), it will allow qualified individuals covered by small employer plans to continue health benefits for up to nine months after termination of coverage. However, the measure will be nullified if the U.S. Supreme Court overturns the Affordable Care Act or the provisions of H.B. 170 are pre-empted by federal law on January 1, 2014 (see Update for Week of March 26th).

This "mini-COBRA" bill also unanimously passed the House after being introduced last year by Rep. Bryon Short (D), chair of the Economic Development/Banking/Insurance/Commerce Committee (see Update for Week of February 6th).

Illinois

Governor may rely on executive order to create health insurance exchange

Governor Pat Quinn (D) is considering using an executive order to establish the health insurance exchange required by the Affordable Care Act (ACA), according to health advisor Michael Gelder.

The announcement came as the legislative session is drawing to a close without any action on exchange-authorizing legislation. It was immediately opposed by Senator Bill Brady (R), who co-chaired an exchange study committee that failed to form a bipartisan consensus on how to proceed.

Earlier this month, Brady and fellow Republicans forced the legislature to suspend all efforts to pass authorizing legislation until the U.S. Supreme Court resolves the constitutionality of the entire law

(see Update for Week of March 26th). However, the Governor's office points out that waiting until the court's decision in June and trying to pass authorizing legislation during a subsequent special session would not allow Illinois to meet the January 2013 deadline to avoid a federal fallback exchange.

Despite Democratic control, the legislature was unable to pass exchange-authorizing legislation last year and wound up enacting a compromise bill that merely created a study committee. However, the "industry-friendly" measure angered consumer groups as it allowed insurers to serve on the oversight board and prevented the Governor from appointing voting members that represented consumers committee (see Update for Week of July 11th).

Quinn would become the third Democratic governor to circumvent legislative opposition to an exchange via executive order, although Kentucky Governor Steve Beshear (D) is likely to do so after the Supreme Court rules (see Update for Week of April 30th). However, consumer advocates like the Illinois Public Interest Research Group urged the Governor not to follow the lead of his fellow Democrats in Minnesota and New York, and instead issue an executive order similar to that of Governor Lincoln Chafee (I) in Rhode Island (see below). Chafee's order is "much more proscriptive" and specifically bars insurers from serving on the exchange governance board.

However, both the Governor and consumer advocates acknowledge that while the executive order could set-up the exchange, authorizing legislation will ultimately be required to make it operational.

Louisiana

Senate Finance Committee rejects bipartisan health insurance exchange bill

A last ditch effort by Democrats to create a state-based health insurance exchange received only one vote this week from the Senate Finance Committee.

New Democratic Party chair Senator Karen Carter Peterson (D) was pushing S.B. 744 as an alternative to the federal fallback exchange that will likely be operated in Louisiana starting in 2014. Governor Bobby Jindal (R) has steadfastly refused to even consider a state-based exchange, despite misgivings from some Republican lawmakers including Insurance chair Dan Moorish about defaulting to federal control.

S.B. 744 had cleared the Insurance Committee with Republican support (see Update for Week of April 23rd) but was flatly rejected by the Finance Committee. Even most Democrats on the panel sided with arguments that the state should at least wait until the U.S. Supreme Court resolves the constitutionality of the ACA in June (see Update for Week of March 26th).

The libertarian Pelican Institute also testified that "creating these exchanges [would be] a ratification of the Obama health care law."

Massachusetts

Senate amends and then passes landmark global budget bill

The Senate nearly unanimously passed landmark legislation this week that would save the Commonwealth an estimated \$150 billion over 15 years by transforming all third-party payer reimbursement to a system of prospective global budgets. S.B. 2260 now moves on to the House.

The House and Senate introduced similar measures last week that had long been sought by Governor Deval Patrick (D) (see Update for Week of May 7th). Both set a target growth for state health care spending and establish a new regulatory authority to enforce it on providers. However, the House bill sets a far lower spending target with tougher penalties.

The Senate bill initially would have allowed the spending target to start at a half-percent above gross state product (GSP) growth for 2015 and equal to GSP growth in 2016. However, the amended version is slightly more aggressive by limiting increases to GSP growth indefinitely, but still above the House target. Other minor changes relate to grants for primary care providers and community hospitals. However, Republican efforts to remove certain surcharges failed (such as the one to fund electronic health records and preventive care).

Former Commonwealth Connector official urges states to limit exchange participants

A former deputy director for Massachusetts' landmark health insurance exchange published an article last week in *Health Affairs* recommending that other states follow their example.

Federal regulations will allow states to follow one of two models for creating the health insurance exchange required by the Affordable Care Act (ACA) (see above). The first model put in place by Massachusetts in 2007 would allow the exchange governing board to directly negotiate prices with insurers and limit participation only to those that "play ball". It would also allow exchanges to impose standards beyond those mandated by the ACA. California, Hawaii, Maryland, New Jersey, Vermont, and Washington are among the states pursuing this "active purchaser" model.

Conservatives largely favor the model used by Utah since 2009, where every insurer who meets the minimum ACA standards will be allowed to participate. However, the former deputy director of the Commonwealth Connector, Rosemarie Day, insisted that based on her state's experience, consumers are typically "overwhelmed" by the vast number of insurance options under this "clearinghouse" model.

Instead, Ms. Day urged states to limit exchange insurance options to only low, medium, and high benefit plans offered by no more than 4-6 carriers. She emphasized that focus groups under the Commonwealth Connector showed that this was the optimal level to spur competition but ensure consumers could still sufficiently process the array of information to make rational purchasing decisions. While Connector consumers preferred value or quantity, they still demanded the ability to obtain detailed information from each plan and were very suspicious of hidden costs.

Rhode Island

Rhode Island soliciting bids to build health benefits exchange infrastructure

Prospective vendors are submitting letters of intent to build the technology infrastructure for the new online insurance marketplace required by the Affordable Care Act (ACA).

The health benefits exchange is being created pursuant to an executive order from Governor Lincoln Chafee (I) after authorizing legislation was blocked by Republican lawmakers last year (see Update for Week of September 19th). State agencies went ahead with issuing Requests for Proposals (RFPs) in late April, even though the exchange cannot begin operation until legislation is passed (see Update for Week of April 16th).

Final proposals are due June 8th, but interested companies must send a letter of intent by May 25th. The state intends to have a contract in place by August 20th so that Rhode Island can meet the January 2013 federal deadline for exchange certification.

Exchange implementation is being funded by nearly \$60 million in federal establishment grants that Rhode Island has already received. The state is one of only two to receive a Level II grant, indicating that they are further along than most states (see article above).

State officials estimate that up to 862,000 residents will participate in the exchange.