



Health Reform Update – Week of June 11, 2012

CONGRESS

Large insurers to keep some popular provisions of Affordable Care Act, even if struck down

Three major insurers pledged this week to retain several key provisions of the Affordable Care Act (ACA) if they are struck down by the U.S. Supreme Court later this month.

UnitedHealth Group, the largest health insurer by sales, led the way by announcing that popular provisions like the allowance for young adults to remain on their parents' group policies, free preventive care and wellness visits, strengthened external appeals, and even the bans on rescissions and lifetime caps will all remain in place for individual and small group plans regardless of the high court decision.

The Chief Executive Officer for UnitedHealth insisted that these parts of the new law all control rising health care costs by promoting greater access to quality care. However, critics noted that individual and small group policies were but a slice of the overall business for UnitedHealth, who primarily provides large employer plans for whom these provisions will not be extended.

Humana promptly matched UnitedHealth's pledge, while Aetna matched all but the ban on annual or lifetime limits. However, all three plans refused to extend one of the most popular parts of the ACA, namely the ban on pre-existing conditions for children under age 19. America's Health Insurance Plans (AHIP) insists that this guaranteed issue requirement cannot be preserved without the ACA mandate that everyone buy health insurance (with federal subsidies for those who cannot afford to do so).

By contrast, Republican Presidential candidate Mitt Romney insisted that any replacement to the ACA must include a ban on pre-existing condition denials. However, several House Republicans already oppose such a guaranteed issue requirement, with Rep. Tom Price (R-GA) insisting it is a "terrible idea" (see Update for Weeks of May 28th and June 4th). The Government Accountability Office found last month that the pre-existing condition protection would apply to as many as 112 million adults.

None of the continued provisions will be free for subscribers but will instead be factored into premiums. Nor did any of the insurers pledge to implement ACA provisions that had yet to go into effect.

The nation's second biggest health plan, WellPoint, has yet to decide whether it will continue any of the ACA provisions. However, several Republican lawmakers did indicate that all plans may be contractually bound to extend current ACA protections through the current plan year.

UnitedHealth Group announced later in the week that one of its divisions has hired the director for the Center for Consumer Information and Insurance Oversight (CCIIO), who heads ACA implementation for the federal Centers of Medicare and Medicaid Services.

Republicans target new innovation center created by Affordable Care Act

The chair of the House Ways and Means Committee questioned the appropriateness this week of the \$10 billion allocated by the Affordable Care Act (ACA) over the next ten years to test new models for lowering health costs and improving quality.

The Centers for Medicare and Medicaid Services (CMS) issued the first 26 Health Care Innovation awards last month to entities that best presented ideas on how to more efficiently deliver affordable health care to enrollees in Medicare, Medicaid and Children's Health Insurance Programs (see

Update for Week of May 7th). The final set of awards was released this week, providing funding for an additional 81 projects in all 50 states, the District of Columbia, and Puerto Rico.

The awards are expected to lower health care spending by \$1.9 billion over the next three years, according to CMS, and continue to save money in subsequent years. However, chair Charles Boustany (R-LA) suggested that the funds were likely going to waste, given the lack of transparency into how funding decisions are reached. He also was critical of the ACA's failure to allow for administrative or judicial review of the newly-created Center for Medicare and Medicaid Innovation within CMS, nor require Congressional approval of its determinations.

Senate Appropriations funds ACA implementation for FY 2013 over Republican objections

The Senate Appropriations Committee approved a spending bill (S.3295) this week that would increase FY 2013 funding for the Centers for Medicare and Medicaid Services (CMS) by 20 percent.

The \$547 million is largely intended to fund further implementation of the Affordable Care Act (ACA), which Republican lawmakers all insist is inappropriate until the U.S. Supreme Court resolves the constitutionality of the law later this month. Republicans accused Democrats of trying to preserve funding in the event the law is struck down, as it would be more difficult to block funds once appropriated.

Democrats defeated amendments from Senators Richard Shelby (R-AL), Ron Johnson (R-WI), and John Hoeven (R-ND) to prevent the Administration from hiring new employees to implement the ACA, block new funds for the Prevention and Public Health Fund created by the ACA, or bar the Fund from being used for advertising.

However, the amount appropriated to CMS was only half of what President Obama sought in his proposed budget (see Update for Week of February 13th). Other health-related funds largely mirrored the President's proposal, including a \$100 million increase for the National Institutes of Health and an additional \$30 million to fund cash-strapped AIDS Drug Assistance Programs.

CBO director says impact of upcoming sequester already being felt by federal agencies

The Director of the Congressional Budget Office (CBO) testified this week that the effects of the upcoming across-the-board cuts in discretionary are already being felt by federal agencies and contractors, even though the \$109 billion sequester will not begin until January 2nd.

Director Doug Elmendorf noted that because the federal fiscal year begins on October 1st, the impact of the sequester must be accounted for by agencies three months before it goes into effect. As a result, agencies and contractors need to make decisions about hiring, budget, and projects for the upcoming fiscal year under the assumption that Congress will be unable to avert the automatic cuts that were mandated as part of the *Budget Control Act of 2011* (see Update for Week of August 1st). He pointed out that even CBO has delayed hiring because of the impending cuts.

Former CBO Director Douglas Holtz-Eakin who now heads a conservative think tank similarly warned last month that the sequester would have significant repercussions on federal agencies well in advance of the November election.

The automatic cuts would continue to go into effect for each of the next ten years until federal spending is reduced by \$1.2 trillion. The "super committee" created by the *Budget Control Act* failed to reach consensus on an alternative plan last fall (see Update for Week of November 14th).

House and Senate Republicans are pushing the Office of Management and Budget to provide details of how the \$109 billion in automatic cuts would impact specific agencies. Several Senate

Republicans have also introduced legislation (S.3228) that would require such a report from the Obama Administration. They have not been satisfied with details that the White House has released to date.

Senator Carl Levin (D-MI) insisted this week that the sequester was unlikely to go into effect because “80 or 90 percent” of members of Congress believe it would have a devastating impact on economic recovery. He is proposing an alternative package of \$200 billion in discretionary spending cuts over ten years, \$300 billion in entitlement changes, and \$400-500 billion in new revenues. Senator Lindsey Graham (R-SC) became the first Republican Senator last week to support at least some new revenues as part of a deal to avert the automatic cuts.

FEDERAL AGENCIES

Medicare Advantage enrollment jumps a record ten percent on lower premiums

A new study released this week by the Kaiser Family Foundation found that Medicare Advantage (MA) enrollment jumped by a record ten percent this year, thanks largely to lower premiums.

The average monthly payment for the 13.1 million enrolled in private MA plans fell 11 percent to \$35, which is down from a high of \$44 in 2010. The total average premium MA plans with drug coverage is \$134.90 a month, \$5 less than the average for traditional Medicare plus a separate plan for drugs.

The Affordable Care Act (ACA) restrained the growth in MA spending starting this year, based on prior studies by the Congressional Budget Office and Government Accountability Office (GAO) documenting that MA plans were overpaid, as they received more than 14 percent per enrollee than under traditional Medicare.

The Secretary for the Department of Health and Human Services (HHS) used the Kaiser figures to refute claims by the chief Medicare actuary that the restrained payments will cut MA enrollment in half by 2017 as plans either cut benefits or leave the market. She noted that the chief actuary also found that the slower rate of growth in MA payments will also save \$68 billion through 2016 (see Update for Week of April 23rd). However, America’s Health Insurance Plans (AHIP) remained insistent that the ACA “cuts” will devastate MA plans, noting that the full impact will not be realized until 2014.

Kaiser acknowledged that a bonus demonstration to reward high-performing MA plans “may have helped to mitigate the effects of the [MA] payment reductions.” GAO recently recommended that HHS eliminate the bonus payments, which are expected to total \$8.6 billion through 2014—a cost that dwarfs all other Medicare demonstrations since 1995. GAO argued that the bonuses would effectively offset all of the projected savings from lower MA payments under the ACA (see Update for Week of April 23rd).

Threshold for enhanced rate review to remain at ten percent through August 2013

The Center for Consumer Information and Insurance Oversight (CCIIO) announced this week that it has rejected the first two state requests to adjust the threshold for enhanced scrutiny of “unreasonable” premium increases.

The Affordable Care Act (ACA) gave the Centers for Medicare and Medicaid Services (CMS) the authority to require health plans to publicly disclose the actuarial basis for any “unreasonable” increase in individual or small group premiums. Final regulations implemented by CMS required states to collect this data for any increase of at least ten percent, while CMS assumed this role for the ten states without an adequate rate review process (see Update for Week of August 29th).

However, the ten percent national threshold was intended to be replaced by appropriate state-specific thresholds after the first year. CCIIO within CMS has the authority to review state proposals to adjust the threshold and approve or reject them based upon specific criteria outlined in agency guidance. These include “analytically-oriented” or measurable factors that have “predictive validity” as well as

“policy-oriented” factors related to administrative burden or capacity. The CCIO guidance emphasized that the ten-percent default threshold would likely not be raised if medical costs in the state have not increased since the threshold was implemented last September 1st.

Alaska and Wisconsin were the only states that asked CCIO to adjust their threshold starting next September 1st. Alaska proposed a 17 percent rate threshold based on historical rate increases in the individual and small group markets. It argued that the ten percent threshold would have historically captured 25 of 30 rate increases sought in the state, placing a huge administrative burden on the state to review most rate filings. However, CCIO concluded that rates were only increasing an average of 8.9 percent per year in Alaska due to medical costs, well below the existing ten-percent threshold.

Wisconsin did not request a specific threshold but instead sought permission to set its own state-specific threshold based on "company-specific medical trend data and historical rate changes." CCIO rejected such blanket authority, noting that the guidance required states to propose a specific threshold. It also noted public comments urging CCIO to reject the request for a lack of public transparency.

As a result, the review threshold will remain at ten percent nationwide through August 30, 2013

HEALTH CARE COSTS

Latest figures show Americans continue to forgo medical care due to cost

Nearly 60 percent of Americans surveyed were forced to postpone or go without needed medical care over the past 12 months, according to results released this week by the Kaiser Family Foundation. The figures represent an eight percent increase from last summer, while the number of Americans reporting difficulties paying medical bills remained constant at 26 percent.

The survey found that the uninsured are predictably worse off than those with coverage, as over 81 percent of the uninsured went without needed care during the same time period while almost half reported difficulties paying medical bills. However, researchers also found that simply having coverage does not translate to affordable health care, as 55 percent of the insured who are under 65 reported forgoing care while 23 percent had trouble paying medical bills.

The figures correlated with the health status of respondents. Among the sickest people in the survey, 77 percent of both uninsured and insured respondents acknowledged going without needed care due to cost.

Similar findings were reported in a related poll conducted last spring by the Harvard School of Public Health in Massachusetts (see below), where 14 percent of those with chronic illnesses were unable to get needed care over the past 12 months, despite nearly universal coverage. Over 70 percent of this group cited cost as the primary reason they had to forgo care, despite insisting that quality of the care they receive has improved as a result of the universal coverage reforms enacted in 2006.

A wide array of studies have documented a nationwide decline in health care utilization since the recession, largely attributed to patients increasingly choosing to forgo needed care due to cost (see Update for Week of April 2nd and article below).

EBRI is latest to affirm that high-deductible plans result in greater rates of forgone care

A new report released this week by the Employee Benefit Research Institute (EBRI) confirms that consumers enrolled in high-deductible health plans (HDHPs) are far more likely to delay or forgo needed medical care due to cost.

EBRI specifically found that in 2011, 31 percent of those with traditional health insurance reported either not filling a prescription because of cost or skipping doses to make the medicine last longer. By contrast, 42 percent of a deductible of at least \$1,000 did so.

The survey also indicates that the longer an HDHP enrollee has a plan with either a Health Savings Account (HSA) or a Health Reimbursement Account (HRA), the less likely they are to skimp on medical care (a drop of 9-10 percent for those enrolled for 1-3 years). However, regardless of the type of HDHP, individuals with chronic health problems and those in households earning less than \$50,000 a year were also far more likely report access issues.

The EBRI findings mesh with the conclusion of earlier studies by the Kaiser Family Foundation, Robert Wood Johnson Foundation, and RAND, all of which found higher rates of forgone care among HDHP enrollees (see Update for Week of January 30th).

Employer-sponsored coverage declining rapidly for low-wage workers, but not for higher incomes

A recent report from the Urban Institute and the Robert Wood Johnson Foundation found that the decade-long decline in employer-sponsored health coverage is far more pronounced for the lowest paid employees.

Those earning less than 138 percent of the federal poverty level (FPL) experienced the sharpest decline, dropping from 38 to 29 percent over the last ten years. In stark contrast, 90 percent of the highest earners continue to be covered through their employer, a drop of only two percent during the same time period.

The researchers emphasized that the decline in employer coverage for the lowest earners means that premium assistance less of an effective option.

STATES

NGA affirms state budgets are improving, as revenues climb and Medicaid spending falls

Most states are continuing to collect more tax revenues than expected when they enacted budgets for the current fiscal year. However, the National Governors Association (NGA) warned this week that many state budgets are still far from pre-recession levels.

Dramatic cuts in state spending over the past year as created huge and unanticipated budget surpluses in several states, especially those benefiting from high energy prices. Overall, revenues are higher than projected in 31 states, with overall budget deficits being cut in half over the past 12 months. Only 19 states faced budget shortfalls this fiscal year (down from 27 last year), while only eight had to close mid-year budget gaps, the fewest since the recession ended in 2009.

State spending increased by a mere 2.2 percent, which is nearly half the 4.1 percent projected jump in their overall revenue. However, even severe cuts and improved revenues have not been enough to mitigate huge deficits in states like California (see below) and Illinois.

State Medicaid spending is expected to abate in FY 2013, as NGA projects only a 3.4 percent growth rate compared to nearly 11 percent in FY 2012 and 23 percent in FY 2011. However, even a 3.4 percent increase still exceeds the growth in spending for most other state programs.

Governors are planning to shift the emphasis of their Medicaid cuts in FY 2013. For example, 30 states reduced payments to providers in 2012, but only 15 plan to do so next year (though another ten plan to freeze rates). Instead, many states will focus on longer-term cost controls like accelerating the transition of enrollees into managed care plans (20 states), overhauling the delivery system (19 states),

imposing new limits on prescription drugs (18 states), hiking enrollee cost-sharing (18 states), or stepping-up program integrity and anti-fraud efforts (25 states).

Medicaid remains the single largest component of all state budgets, accounting for an average of 24 percent of state spending.

Bipartisan exchange model unveiled by partnership of 17 states and eight foundations

A group of 17 states have partnered over the past 14 months with private foundations to develop a bipartisan model that states can follow in implementing the health insurance exchanges required by the Affordable Care Act (ACA).

Called Enroll UX 2014, the model released last week demonstrated the interest of even conservative governors to pursue health insurance exchanges, which have long been considered a “market reform” favored by Democrats and Republicans. At least four of the participating states (Alabama, Kansas, New Mexico, and Tennessee) are headed by Republicans who are staunchly opposed to the new law and have refused to move forward on exchange implementation until the U.S. Supreme Court decides later this month on the law’s constitutionality. Alabama’s Governor has pledged to create the exchange via executive order if the law is upheld, while the New Mexico Governor vetoed exchange-authorizing legislation but allowed state agencies to continue implementation.

Other participating states include Arkansas, California, Colorado, Illinois, Massachusetts (partnering with Rhode Island and Vermont), Minnesota, Missouri, New York, Oregon, and Washington. Only Massachusetts already has an exchange in place. Despite being headed by Democrats, the other states are in widely varying degrees of preparation, with the governors of Rhode Island, Minnesota, and New York having to rely on executive orders to circumvent Republican opposition to legitimizing any part of “Obamacare”. The Illinois Governor is considering a similar move (see Update for Week of May 14th).

Vermont remains the only state to mandate that individuals and small business participate in its exchange. However, that requirement is due to the state moving to a single payer health care system and abolishing private insurers by 2015.

The eight foundations that provided \$3 million to fund the collaboration include the Atlantic Philanthropies, Blue Shield of California Foundation, the California Endowment, Colorado Health Foundation, Kaiser Permanente Community Benefit, New York State Health Foundation and the Robert Wood Johnson Foundation.

Most states taking advantage of ACA grants to improve Medicaid, though not to expand early

Although most states and the District of Columbia have taken advantage of funding under the Affordable Care Act (ACA) to upgrade technology systems or improve care within their Medicaid programs, only seven and the District of Columbia have exercised the option to expand Medicaid early.

The Medicaid expansion under the ACA requires that all states cover those with incomes up to 133 percent of the federal poverty level (FPL) by 2014. Despite the offer of additional federal matching funds, California, Colorado, Connecticut, Minnesota, Missouri, New Jersey, Washington, and the District of Columbia, are the only ones who have elected to do so.

The Kaiser Commission on Medicaid and the Uninsured notes that these states were already providing some optional coverage to low-income adults, making it “fiscally advantageous” for them to move forward early.

By contrast, 43 states and the District of Columbia have made progress on at least one of five options to improve their Medicaid programs under the ACA , with 28 deciding to upgrade Medicaid

eligibility information systems, 26 planning to test integrated care models for dual eligibles, and ten receiving five-year grant funding to help prevent chronic diseases.

California

House and Senate set to vote on scaled-down safety net cuts, cost-sharing hikes

The Senate Committee on Budget and Fiscal Review unanimously approved a budget plan this week (A.B. 1467) that preserves critical safety net programs, downgrades the Medi-Cal copayment proposal rejected by the federal government and also expands Medicaid managed care.

The Legislature last year passed more extensive cost-sharing hikes sought by Governor Jerry Brown (D) that were projected to save \$511 million per year by charging enrollees \$200 per hospital visit, \$50 for an emergency department visit, \$5 for physician visits, and \$3-5 for prescription drugs. However, the measure was rejected by the Centers for Medicare and Medicaid Services as it far exceeded copayments allowed under federal Medicaid law (see Update for Week of February 6th).

The current proposal would impose a copayment of \$3.10 for non-preferred drugs, with an exception for patients who receive those medications by mail, and a \$15 copayment for non-emergency use of the emergency room. The state estimates savings of only \$25 million per year from the downgraded plan, which still requires federal approval before being implemented in January 2013.

The lower copayments are part of the budget plan that the Assembly and Senate will vote on late this week. Democrats who control both chambers largely matched the latest round of severe spending cuts sought by the Governor in order to fill a \$15.7 billion budget deficit (see Update for Week of May 14th). However, the refused to go along with roughly \$300 million of the Governor's planned health cuts, insisting that safety net programs could not sustain deeper cuts than the \$15 billion already imposed in recent years. Democratic lawmakers specifically rejected the Governor's plan to again cut reimbursement for managed care plans participating in Healthy Families SCHIP and make those with HIV/AIDS pay more for their medications and related care.

Study finds that more small businesses will offer coverage once health benefit exchange opens

One-third of small businesses in California currently offer health insurance to their employees, while 44 percent are likely to do so once the California Health Benefit Exchange begins operating in 2014. That was the principal finding of a recent survey published this week by Kaiser Permanente and Small Business Majority, an advocacy group that supports the Affordable Care Act (ACA).

Roughly 4.4 million uninsured and small business employees are expected to participate in the exchange by the end of 2016. California is one of a handful of states that will follow the "active purchaser" model already in place in Massachusetts where the exchange board will accept only insurers who agree to negotiate the best rates. Roughly half of the 386 small businesses survey stated that this model presented an "attractive option" to purchase coverage for their employees.

Another 49 percent of respondents who were eligible for small business tax credits under the new law were unaware that they could receive such assistance. This meshes with a recent Families USA study concluding that only 360,000 of the 3.2 million small businesses eligible nationwide for the tax credits actually claimed them (see Update for Week of May 7th). The Government Accountability Office similarly found that small businesses have only claimed \$468 million of the \$2 billion in credits offered by the ACA, concluding that the amount of the subsidy was too small to incentivize most small employers to purchase coverage for their employees (see Update for Week of May 21st).

The board director reiterated this week that the exchange will continue even if the U.S. Supreme Court overturns the ACA later this month (see Update for Week of April 2nd). However, both Democratic and Republican lawmakers were skeptical that it could do so without continued federal grants or an

individual purchase mandate to ensure a broad risk pool. Governor Jerry Brown (D) has indicated that he will seek an individual mandate if it is struck down by the high court (see Update for Week of March 26th).

The board is planning to apply for an additional \$188 million federal grant this month. They are also in the process of defining who can serve as navigators that help facilitate exchange enrollment, as well as provide “modest” reimbursement to community-based organizations that fill this role.

Delaware

Key Senator seeks to limit use of specialty tier coinsurance

Senate Majority Whip Margaret Rose Henry (D), chair of the Health and Social Services Committee introduced legislation this week to restrict the use of specialty tier coinsurance for the highest-cost prescription drugs. Starting January 1st, S.B. 252 would limit copayment or coinsurance fees to \$100 per month for up to a 30-day supply of any single prescription drug, not to exceed \$200 per month per enrollee for all covered drugs.

The Delaware Health Care Commission recommended earlier this year that the legislature restrict the instances in which health plans can require coinsurance payment structures for high-cost specialty drugs (see Update for Week of April 9th), warning that forcing patients to pay at least 25-30 percent of the cost for high-priced drug can deny access to life-saving medications.

The Commission based its findings on similar measures considered in at least 20 other states, including California (see Update for Weeks of May 28th and June 4th). New York remains the only state to have passed a law prohibiting the use of specialty tier coinsurance (see Update for Week of March 26th).

Hawaii

Governor makes Hawaii the first state to declare it is on track to create ACA-compliant exchange

Hawaii became the first state last week to declare that it will meet the federal deadline for establishing a state-based health insurance exchange that complies with the Affordable Care Act (ACA).

The latest federal guidance issued by the Center for Consumer Information and Insurance Oversight (CCIIO) asked states to declare their intent to make “substantial progress” towards exchange implementation by the federal January 1st deadline and submit plans by November 14th on how their exchange will be structured (see Update for Week of May 14th). CCIIO will operate a federally-facilitated exchange (FFE) in states that fail to meet the January 1st deadline.

Governor Neil Abercrombie (D) sent a June 7th “declaration letter” to CCIIO verifying that the state has met all federal requirements and the Hawaii Health Connector will be operational by 2014. Authorizing legislation enacted in 2011 created the Connector as a quasi-governmental agency that will follow the “active purchaser” model in place in Massachusetts, where the oversight board negotiates rates and can exclude unaffordable plans.

Despite the Governor’s assurance, the Legislature still needs to pass supplemental legislation that authorizes the remaining functions needed to make the exchange operational, including the criteria for selecting navigators who can help facilitate the purchase of exchange plans by consumers. The eligibility and enrollment system for Medicaid and other state health plans also need to be integrated into the exchange. However, conferees were unable to reconcile competing versions of that legislation before the end of last session (S.B. 2434), due largely to the controversy over whether insurance representatives should be removed from the exchange oversight board (see Update for Week of March 19th).

Illinois

Governor signs dramatic spending cuts, tax hike in order to prevent Medicaid collapse

Governor Pat Quinn (D) signed a package of bills into law this week that will fill the state's \$2.7 billion Medicaid budget cap with \$1.6 billion in spending cuts and a \$1 per pack hike in cigarette taxes.

The casualties under S.B. 2840 and other measures include the entire Illinois Cares Rx program, which uses state subsidies to help seniors with prescription drug costs. Over \$350 million in savings is also expected to come from tighter screening protocols to remove enrollees no longer eligible for Medicaid, while another \$240 million will be generated by reducing provider reimbursement rates by 3.5 percent (less than half of that sought by the Governor).

The Governor, who had already hiked state income taxes by 66 percent to fill last year's deficit (see Update for Week of January 10, 2011), insisted that it was necessary to slash spending in order to keep the Medicaid program from collapsing. Unlike that dramatic tax hike, his current budget plan drew some Republican support (see Update for Week of May 21st).

New Hampshire

New Hampshire is latest state to exempt health care sharing ministries from state regulation

Governor John Lynch (D) signed legislation last week authorizing the establishment of health care sharing organizations.

Effective August 6th, S.B. 245 allows such organizations to operate as a 501(c)(3) tax-exempt charitable organization under the Internal Revenue Code. Participants may financially assist fellow participants with certain medical expenses, while the organization remains exempt from certain state insurance regulations.

State regulators such as the insurance commissioners in Connecticut and Washington have tried in past years to shut down such health care sharing organizations, which often operate as Christian ministries requiring participants to adhere to certain beliefs and practices. They insist that such organizations may often not have sufficient funds to pay claims, wrongly lead participants into believing they have health insurance coverage for all medical expenses, or otherwise defraud participants by using their contributions for non-medical purposes.

Since sharing organizations are not licensed, participants have little protection or recourse against fraudulent operators. The Washington Insurance Commissioner also warns that the organizations seldom can defray the expenses for costly medical conditions, often do not reimburse for treatment related to a pre-existing condition, and frequently apply very low lifetime maximums.

As of 2011, only about 150,000-200,000 people participated in such sharing organizations nationwide. However, legislation to exempt them from state insurance regulation has proliferated since the enactment of the Affordable Care Act (ACA) and was signed into law in at least 12 other states besides New Hampshire.

The ACA itself exempted some participants of ministries that share medical expenses as part of an established religious practice from the mandate that everyone buy health insurance or pay a fine (starting in 2014). However, only long-standing ministries are affected by this exemption because it applies only to sharing organizations that have Section 501(c)(3) tax-exempt status and have shared medical expenses continuously since at least December 31, 1999. They must also be audited annually by an outside accounting firm.

Rhode Island

House and Senate pass legislation to bring state insurance law in line with ACA

Over the strong objections of Republicans, the House approved legislation this week to bring Rhode Island insurance law into compliance with the Affordable Care Act (ACA).

The measure was requested by Governor Lincoln Chafee (I). A similar substitute measure S.2887 already passed the House and Senate and was transmitted last week to the Governor. They require a uniform summary of benefits and guaranteed issue for adults and children regardless of health status, prohibits annual and lifetime caps as well as rescissions, and applies the same medical-loss ratios and external appeals process as the new law. They also allow young adults to remain on the parents' group health plan until age 26 (an increase from age 25 under existing state law).

Minority Republicans were adamant that the measures should not move forward until the U.S. Supreme Court resolves the constitutionality of the ACA later this month.

The House and Senate also passed H.7892 that would create a joint oversight committee for health reform and require the Insurance Commissioner and the Executive Office of Health and Human Services to report to the legislature on state implementation of the ACA by October 1st.

South Carolina

Governor signs legislation making South Carolina sixth state to join interstate health compact

Governor Nikki Haley (R) signed S.836 into law last week, making South Carolina the sixth state to approve plans for an Interstate Health Care Compact that would use unrestricted federal block grants to provide services as they see fit to Medicare and Medicaid enrollees.

Republican Governors in Texas, Georgia, Louisiana, Oklahoma, and Utah (see Update for Week of March 5th) have already signed such laws. However, the measures are largely symbolic as they would require a federal waiver and may not pass constitutional muster without further Congressional legislation since both Medicare and Medicaid are governed by federal law.

Minnesota Governor Mark Dayton (D) vetoed analogous legislation last month (see Update for Week of May 7th).

Washington

Largest non-profit plans raise premiums despite \$1 billion surpluses

Insurance Commissioner Mike Kreidler (D) blasted two of the state's largest non-profit health insurers this week for seeking rate hikes at a time when they are sitting on record surpluses.

According to rate filings for the last three months, Premera Blue Cross and Regence BlueShield have amassed more than \$1 billion in surpluses, a cushion of about \$700 per subscriber. However, instead of refunding the excess to subscribers through lower premiums, each plan actually sought to increase premiums for the next year.

The health plans insisted that such a cushion was needed to provide a "safety net for members against unknown risks and costs", specifically the uncertainty surrounding implementation of the Affordable Care Act. However, the Commissioner used the rate hikes to renew his "top legislative priority" that would give him the authority to consider the surpluses as a basis to reject or modify proposed rate hikes, noting that premiums in Washington's individual market have more than doubled since 2005.

Kreidler noted that 11 states including neighboring Oregon give their commissioners that authority for individual and small group plans. However, a Senate bill that would give Kreidler the same power

failed to reach the floor last session after intense opposition from the insurance industry (see Update for Weeks of January 16th and 23rd). The Commissioner pledged to propose similar legislation next session.