



Health Reform Update – Weeks of July 23 and 30, 2012

CONGRESS

CBO says Supreme Court ruling will cause ACA to lower costs by covering less

The Congressional Budget Office (CBO) revised their cost estimate for the Affordable Care Act (ACA) last week in order to reflect the impact of the recent U.S. Supreme Court decision on the law.

The high court granted states flexibility to “opt-out” of the mandated Medicaid expansion in 2014 and forgo the full federal funding through 2016 and at least 90 percent federal match for years thereafter (see Update for Week of June 25th). Several Republican governors promptly announced they would do so, while others are waiting for the fall elections to decide (see Update for Week of July 16th).

CBO did not offer predictions about which states would “opt-out” of the Medicaid expansion, but instead made a “general forecast”. However, CBO does project that several states will do so and as a result the Medicaid expansion will cover six million fewer low-income Americans that initially anticipated.

Only about half of this group will be able to purchase coverage in the new health insurance exchanges, while the remainder will be uninsured. The ACA presumed the expansion would take effect for everyone with incomes up to 138 percent of the federal poverty level (FPL) and thus did not make premium tax credits available for those below 100 percent of FPL.

As a result of the lower participation in the expansion, the overall cost of the ACA will now likely fall by \$84 billion to \$1.168 trillion from 2012-2022. CBO projects that the federal government will save about \$289 billion because of states that opt-out but that it will have to spend about \$210 billion in subsidies for people that purchase coverage through the health insurance exchanges

However, hospitals will bear higher uncompensated care costs than anticipated because of the ACA’s phase-down of disproportionate share funding for indigent patients starting in 2014. States will also bear more costs from higher exchange participation, as it will cost them roughly \$9,000 to cover each enrollee that would have been covered by Medicaid, as compared to only \$6,000 had that enrollee been covered by Medicaid as intended.

CBO estimates that about one-third of “the potential newly-eligible population” with incomes below 138 percent of FPL live in states that will fully expand Medicaid, while 50 percent live in states that will partially expand eligibility. The remaining newly-eligible residents are in states that will not expand their programs.

However, it is not yet clear that the Centers for Medicare and Medicaid Services (CMS) will allow states to “partially expand eligibility” (i.e. to only 100 percent of FPL). The executive director of the National Governors Association (NGA) also noted this week that CMS has yet to respond to NGA queries about whether states that do not expand Medicaid could instead offer their own premium tax credits to help this “newly-eligible population” purchase exchange coverage.

The CBO report also predicted that private plan premiums will now increase by roughly two percent, because those who would have obtained Medicaid but instead will be covered through the exchanges are likely be in poorer health and consume more health care. In addition, it estimates that the Internal Revenue Service will collect about \$55 billion in tax penalties from those who can afford health insurance but refuse to purchase it and another \$117 billion from employers that fail to provide the minimum coverage mandated by the new law.

Repealing the entire ACA as sought by H.R. 6079 (see Update for Week of July 9th) would increase the budget deficit by \$109 billion from 2013-2022, according to CBO. The non-partisan budget scorekeeper had projected in March 2011 that the ACA would reduce the federal budget deficit by more than \$210 billion over this period, if all provisions were enacted.

Conservatives claim first victory in lawsuits to block preventive services mandate under ACA

The federal district court for Colorado became the first this week to rule that the Affordable Care Act (ACA) mandate that private plans cover contraceptives without cost-sharing may violate the religious freedoms guaranteed by the U.S. Constitution.

Judge John Kane, appointed by President Carter (D), granted a temporary injunction permitting an air-conditioning company in the state, Hercules Industries, not to comply with the mandate that went into effect August 1st. The business owner alleged that the mandate violates the tenets of his Catholic faith and is thus prohibited by the *Religious Freedom Restoration Act* of 1993, which says the federal government may not “substantially burden a person’s exercise of religion”. Judge Kane made clear that the injunction applies only to Hercules and that the full merits of the case will be heard later this year.

A new report released this week by the Assistant Secretary for Planning and Evaluation for the Department of Health and Human Services (HHS) insists that 47 million women will benefit from the free preventive services provided by the August 1st mandate.

HHS adopted guidelines for women’s preventive services last August, based on Institute of Medicine recommendations. However, the Secretary delayed the effective date until this week under a prior compromise that exempted plans covering employees of religious institutions like churches, but not church-affiliated private businesses like hospitals or schools. Although some religious groups were satisfied with this compromise, the National Association of Catholic Bishops has led a flurry of unsuccessful legal challenges to block its implementation (see Update for Week of July 16th).

Several Republican members of Congress actually compared this week’s implementation of the mandate to Pearl Harbor and 9-11. However, House Speaker John Boehner (R-OH) signaled he will not see any legislative action to block the mandate.

The Pacific Research Institute insisted last week at health reform conference attended by PSI Government Relations that conservatives have not lost momentum in their legal challenges to the new law, and that lawsuits seeking to block premium tax credits for federally-facilitated exchanges (FFE) represent a “serious challenge.” The Internal Revenue Service Commissioner took umbrage with such claims during his testimony this week before the House Oversight and Government Reform Committee, insisting that premium tax credits for FFEs are clearly authorized by the new law.

The National Federation of Independent Business, one of the losing plaintiffs in the multi-state challenge before the U.S. Supreme Court, indicated this week that it was refocusing its legal challenges to specific provisions of the ACA that are overly burdensome on small businesses. These include the employee mandate, the essential health benefits package, and the tax on “Cadillac” or high-cost health plans that could raise insurer costs by \$87 billion from 2014-2020.

Most Americans still hate the individual mandate; favor Medicaid expansion in neighboring states

The latest Kaiser Family Foundation monthly tracking poll confirmed that the recent U.S. Supreme Court decision upholding the constitutionality of the Affordable Care Act (ACA) did little to curb opposition to its singularly most unpopular provision.

The so-called “individual mandate” would require those that can afford to buy health insurance to either do so or pay a penalty. Nearly two-thirds of Americans opposed this provision since the law was

enacted, and the same percentage disapproved of it since it was upheld. Only a slightly lesser amount (61 percent) remain opposed when told that the Supreme Court defines the penalty as a “tax”.

Part of the opposition may be due to “exaggerated” fears that the mandate will apply to them. Nearly 20 percent of the over 1,200 respondents believed that they would have to pay the tax penalty. Kaiser previously estimated that no more than ten percent of Americans would have to decide between buying coverage and paying the tax penalty, while Urban Institute estimated that less than six percent would face this decision and less than three percent would pay the penalty (see Update for Week of July 2nd). Less than one percent of taxpayers under the same mandate in Massachusetts actually pay the penalty (see Update for Week of June 18th).

Over 56 percent of independent voters surveyed continue to urge lawmakers to “move on to other issues” and cease efforts to block implementation (see Update for Week of July 2nd).

Over two-thirds of those surveyed supported the Medicaid expansion under the ACA, although just under half said they would like their own state to participate.

MedPAC, AMA, and lawmakers urge CMS to slow down ACA demonstration for dual eligibles

The Medicare Payment Advisory Commission (MedPAC) joined a chorus of lawmakers and provider groups last week in urging the Centers for Medicare and Medicaid Services to “slow down” on its planned implementation of a demonstration program to test the use of managed care plans for the over nine million enrollees in both Medicare and Medicaid.

The dual-eligible demonstration was authorized by the Affordable Care Act (ACA) and set to launch this January. However, CMS has been surprised 27 states have already sought to participate in the pilot program, which could now wind-up enrolling over a third of all dual eligibles.

The demonstration was to create a “shared savings” program similar to the accountable care organizations created by the ACA where physicians and providers would have a financial incentive to improve the coordination of care for dual-eligibles, as that group often has multiple chronic conditions and complex health care needs. Although they make up only 15 percent of Medicaid, dual eligibles are very costly to treat and account for almost 40 percent of Medicaid expenditures according to the Kaiser Commission on Medicaid and the Uninsured.

Senator Jay Rockefeller (D-WV) called earlier this month for an immediate halt to the program, citing concerns that the financial incentives would lead to skimping on care. The American Medical Association, Federation of American Hospitals, Georgetown University Health Policy Institute, and Alliance for Health Reform have likewise urged that implementation at least be delayed.

However, it is the letter from the influential MedPAC that may be most persuasive. Since last spring, MedPAC has specifically cited the “passive enrollment” feature of the demonstration as an area of great concern, as it will automatically enroll dual-eligibles in a “shared savings” managed care plan and force them to opt-out—potentially violating their guaranteed “freedom of choice” (see Update for Week of May 7th). MedPAC emphasizes that the dual-eligible population is particularly difficult to reach through outreach efforts and may not even be aware that they are being automatically enrolled.

MedPAC recommended specific consumer protections for the demonstration in order to ensure that the financial incentives do not prevent dual eligibles from receiving the “highest-quality health care possible.”

However, some groups remain on board with the demonstration. The Medicaid Health Plans of America urged CMS to move forward during a health reform conference attended this week by PSI Government Relations, insisting that continuing to wait could do more harm than good for a population that is poorly-served under the traditional fee-for-service system.

Rep. Burgess offers bill to replace PCIPs with additional funds for state high-risk pools

Rep. Michael Burgess (R-TX) introduced legislation this week that would provide about \$25 billion for existing state high-risk pools and reinsurance programs to accommodate the 73,000 people now enrolled in pre-existing condition insurance plans (see PCIP Update for Week of July 16th).

Burgess had intended to introduce the bill once the Affordable Care Act (ACA) was struck down by the U.S. Supreme Court. He now wants to simply repeal the temporary federal high-risk pool program and let states use the \$25 billion either enhance their existing high-risk pools or create new ones.

Burgess insists that Republicans have plans in place to accommodate the newly-uninsured that would result from repealing the entire law should they gain control of the White House and Senate next year. Otherwise, he acknowledges that they will be “overwhelmed” with “negative press”.

Delaying the Medicare physician payment fix will cost \$271 billion over ten years, per CBO

Updated figures released this week by the Congressional Budget Office (CBO) projects that a continued delay in implementing the Medicaid physician payment cuts mandated by the Balanced Budget Act of 1997 would cost the federal government \$271 billion from 2013 to 2022.

Congress has repeatedly delayed these cuts every year since 2003. They would reduce physician reimbursement by 27 percent if the current extension expires next year. There is bipartisan support for repealing or revising the cuts but both parties continue to be unable to agree how to offset the enormous cost of doing so.

House and Senate leaders agree on six-month stopgap funding bill

Senate Majority Leader Harry Reid (D-NV) and House Speaker John Boehner (R-OH) announced this week that they have reached a deal to extend government funding through March 2013 and avert another polarizing debt-ceiling showdown in the weeks before the November elections.

The continuing resolution must still be voted on by both chambers when they return from the August recess. However, it would ensure that the government would not shutdown when the current fiscal year ends on September 30th if both parties cannot agree on raising the federal debt ceiling. The inability of Congress to compromise on raising the debt ceiling last summer resulted in the nation's first ever downgrade in its credit rating (see Update for Week of August 1, 2011).

The agreement would continue government funding at existing levels for six months. However, Democratic lawmakers immediately criticized the Majority Leader for not including any Medicare physician payment fix in the compromise (see article above). Medicare hospital supplemental payment extensions also are not included.

Senator Tom Harkin (D) favored a three-month extension that would expire coincident with the automatic sequestration going into effect in January 2013 as well as an expiration of the Bush-era tax cuts. He argued that these would put maximum pressure on “tea party” Republicans in the House, who held up any agreement last summer over demands that revenues not be increased. Other House Democrats wanted the Majority Leader to take a “hard-line” on a more progressive budget that raises taxes for the wealthy, eliminates certain corporate tax breaks, and takes cuts to entitlement programs off-the-table.

FEDERAL AGENCIES

GAO says 1.7 million children will remain uninsured under IRS definition of affordable insurance

A Government Accountability Office (GAO) report released this week concludes that many children may remain uninsured after full implementation of the Affordable Care Act (ACA), due to an overly-restrictive Internal Revenue Service (IRS) definition of affordable health insurance.

The ACA offers premium tax credits for those earning up to 400 percent of the federal poverty level to purchase coverage in the new health insurance exchange marketplaces. However, people will not be eligible for the tax credits if they are eligible for Medicaid, SCHIP, or affordable private coverage.

IRS regulations previously defined affordable coverage as that offered to an individual and not family coverage (see Update for Week of September 19th and Week of April 30th). The agency has finalized all parts of the rule except for the language defining how affordability should be measured.

GAO urged the IRS to “adopt an alternative approach that would consider the cost of insuring eligible family members.” The report emphasizes that the more limited definition is not only inconsistent with the primary goal of the ACA “to increase Americans' access to affordable health insurance” but would likely result in 1.7 million children remaining ineligible for premium tax credits and uninsured.

The report, which was requested by Senate Democrats, also notes that “for families in which one member has an offer of self-only, employer-sponsored health insurance”, they would actually be “less likely to obtain family insurance than if no employer insurance were offered, because of their ineligibility for the premium tax credit.”

Federal officials at the IRS and the Department of Health and Human Services have yet to comment on the GAO recommendations.

ACA has saved Medicare enrollees an average \$629 in prescription drug costs for 2012

The latest figures from the Department of Health and Human Services (HHS) document that over 5.2 million Medicare Part D enrollees have saved nearly \$4 billion in prescription drug costs since the Affordable Care Act (ACA) was enacted.

Already in 2012, Part D enrollees have saved \$687 million or an average of \$629 per enrollee. Savings for 2012 are expected to exceed last year because the discount on generic drugs provided within the coverage gap doubled from seven to 14 percent. Part D enrollees have been receiving a 50 percent discount on brand-name drugs within the “doughnut hole” since 2011.

Discounts for both brand name and generic drugs in the gap will continue to increase until 2020, when enrollees will pay the same coinsurance in and out of the “doughnut hole”. CMS predicts that enrollees will ultimately save an average of \$4,200 from 2011 to 2021, thanks not only due to the reduction in the “doughnut hole”, but also elimination of cost-sharing for certain preventive services and restricted growth in Medicare Advantage premiums (see Update for Week of January 30th).

NASTAD, AIDS advocates call for stable funding, more flexibility in Ryan White programs

The National Association of State and Territorial AIDS Directors (NASTAD), AIDS Institute, and other AIDS advocates are urging the the Health Resources and Services Administration (HRSA) not to make dramatic changes in the Ryan White HIV/AIDS program when it is reauthorized next year.

HRSA asked for public comments on the reauthorization, as the program is set to expire in September 2013. Coverage options for HIV/AIDS patients in some states are expected to change when

the Affordable Care Act (ACA) is fully implemented in January 2014, especially for those states that elect to participate in the law's Medicaid expansion.

Advocacy groups have feared that Ryan White funding would be cut under the assumption that many AIDS Drug Assistance Program (ADAP) patients would now be covered under Medicaid. However, several Republican governors have already indicated that they will exercise the new flexibility granted by the U.S. Supreme Court to "opt out" of the Medicaid expansion (see Update for Week of July 2nd).

Comments from The AIDS Institute stress that even in states that expand Medicaid, ADAP enrollees "will not automatically transfer to other coverage overnight." The group called for language that would "allow a reasonable period of time, of at least one year, to transition Ryan White clients to new payers and systems of care."

The activists also are concerned about the impact of potential across-the-board funding cuts for the program as part of sequestration, which is scheduled to begin early next year unless Congress intervenes. Advocates say that a potential 7.8 percent cut could have a dramatic impact on Ryan White treatment and other prevention programs.

Currently, 41 percent of people in the Ryan White program are uninsured, 34 percent have Medicaid, 13 percent have Medicare, and 12 percent have private insurance.

Advocacy groups also urged HRSA to adjust grant rules that require cities and states to spend 75 percent of grant funds on medical services and 25 percent on supportive services such as outreach, transportation, language services, and respite care for persons caring for individuals with HIV/AIDS. The consensus among the commenters was that cities and states should be allowed to focus more on support services, since many Medicaid or private plans impose limitations on prescription drug benefits.

The National Alliance of State and Territorial AIDS Directors (NASTAD) called for new expedited procedures for groups to apply for waivers from the 75 percent rule. The group also asked for more flexibility and technical assistance that would encourage community groups to pay premiums, deductibles and co-payments for patients.

STATES

Medicaid expansion improves health outcomes, lowers costs

A new study published last week in the *New England Journal of Medicine* counters claims by some Republican governors that expanding Medicaid as sought by the Affordable Care Act (ACA) will not improve health outcomes of enrollees or save money. By contrast, Harvard University researchers found that the savings from improved health outcomes in at least three states that previously expanded their Medicaid programs outweighed the costs of expanding.

The study examined Medicaid expansions Arizona, Maine, and New York as compared to four neighboring states that did not expand (New Hampshire, New Mexico, Nevada, and Pennsylvania). Data from the five years before and after the expansions found that those that expanded reduce their adults' mortality rates by more than six percent. Death rates declined most among minorities and residents in low-income counties.

The findings also showed that the expansions led to far lower rates of uninsured, fewer cases of delayed care due to costs, and an increase in those who reported their health status as "excellent" or "very good".

The research echoes a landmark 2011 study from Oregon that compared about 10,000 adult residents who became eligible for Medicaid through a lottery program with 68,000 who did not and found similar results.

Arizona

Governor delays decision on Medicaid expansion, health insurance exchange

Governor Jan Brewer (R) will wait until January to decide whether Arizona should accept the federal funding under the Affordable Care Act (ACA) to expand Medicaid.

Administration officials announced this week that the Governor's decision will be part of the fiscal year 2013 budget proposal she submits to the Legislature in January, as expanding Medicaid would require legislative approval. Although other Republican governors were quick to "opt out" of the expansion as allowed by the U.S. Supreme Court (see Update for Week of July 2nd), Governor Brewer has refused to tip her hand thus far, insisting that she needs more guidance from the federal government.

Arizona was one of a handful of states that already covered childless adults, thanks to a voter-approved expansion in 2000. However, Governor Brewer received federal approval last year to eliminate that expansion (see Update for Week of October 17th). The Governor now wants to know if the Obama Administration will let her simply reinstate that coverage and still receive the enhanced federal match under the ACA, instead of expanding all the way up to 138 percent of the federal poverty level (FPL).

Many Republican lawmakers in Arizona steadfastly oppose expanding Medicaid or implementing any part of "Obamacare". However, hospital groups are pressing the governor to do so in order to avoid the uncompensated care burden that would result from not expanding. Federal disproportionate share payments to hospitals will start being phased down in 2014, as the ACA anticipated that all states would expand Medicaid up to 138 percent of FPL.

Governor Brewer is not expected to make a decision until after the November election as to whether Arizona will create the state-based health insurance exchange authorized by the ACA. Because Arizona has made little progress towards exchange implementation, it appears that it will not meet the January 2013 federal deadline to avert a federal fallback exchange. The Governor has not entirely ruled out the federal-state partnership permitted by the Obama Administration (see Update for Weeks of November 21st and 28th), as long as the exchange does not become a "second de-facto regulator of the insurance industry."

Arkansas

Health board and Governor support Medicaid expansion, but legislative passage unlikely

Governor Mike Beebe (D) indicated this week that he is likely to seek legislative approval to accept the federal funding offered by the Affordable Care Act (ACA) to expand Medicaid for those earning up to 138 percent of the federal poverty level (FPL).

The Governor's decision came after the Board of Health voted in favor of the expansion, which would add about 250,000 mostly uninsured Arkansans to the Medicaid rolls. Board members cited a Harvard University study last week concluding that expanding Medicaid would save lives and improve health outcomes (see above). Their support was also bolstered by earlier estimates from the Department of Human Services that the expansion would cost the state only \$4 million a year instead of the \$200 million predicted by some conservative governors. In addition, the Department projected that the expansion would save Arkansas \$372 million over the first seven years, largely due to reduce uncompensated care burdens for hospitals (see Update for Week of July 16th).

However, despite Democratic control of both chambers, the governor will likely have great difficulty getting the three-fourths vote needed for legislative approval. Most Republican lawmakers have adamantly opposed implementing any part of "Obamacare" and the Governor was unable earlier this year to secure legislative approval for a state-based health insurance exchange, despite the support of several key Republicans.

Arkansas is the only southern state with Democratic control over the legislature. However, Republicans made significant gains last session and expect to gain control of one or both chambers this fall. As a result, Republican leaders are urging Governor Beebe to postpone any discussion of expanding Medicaid or creating the exchange until next session.

However, the Arkansas Hospital Association is putting significant pressure on key Republicans to support the expansion, as their federal disproportionate share payments will start being phased-down in 2014. As a result, not expanding Medicaid would place an even greater uncompensated care burden on hospitals than before the ACA was enacted.

Governor Beebe has already decided to seek federal approval for a federal-state exchange partnership, instead of defaulting to a federally-facilitated exchange (see Update for Week of April 23rd).

California

Insurance department releases data on insurer rebates required by Affordable Care Act

The Department of Insurance released figures showing the amount of rebates California insurers were required to send out this week to subscribers, pursuant to the new caps on insurer profits imposed by the Affordable Care Act (ACA).

Under the law's medical-loss ratios, individual and small group plans had to spend 80 percent of premium revenue on medical care (or 85 percent for large group plans) starting with the 2011 plan year or rebate the difference to consumers by August 1st.

About 1.8 million Californians have received a total of \$73.9 million in rebates for the 2011 plan year, with the average rebate coming to about \$65 per family. While most rebates for California subscribers were small, the average small-group rebate from Anthem Blue Cross totaled \$212 and United HealthCare's totaled \$173. Blue Shield's rebates to nearly 240,000 individual subscribers constituted the highest number of rebates for any single insurer.

Consumers nationwide stood to receive over \$1.1 billion in insurer rebates by August 1st (see Update for Week of June 18th).

Connecticut

Health exchange board goes beyond ACA in requiring more generous set of basic benefits

Connecticut's health insurance exchange board has selected a benchmark plan that will impose an "essential health benefits" package on individual and small group insurers that is more generous than required by the Affordable Care Act (ACA).

The Obama Administration has left the controversial decision of defining essential benefits up to each state, pursuant to federal guidance issued last winter (see Update for Week of January 30th). States must choose a "benchmark" plan subject to certain federal criteria outlined in the guidance.

The selection of the ConnectiCare HMO plan surprisingly stoked little controversy despite the fact it covers abortion services. However, the exchange board emphasized that the ACA and President Obama's subsequent executive order explicitly requires anyone purchasing coverage with federal premium tax credits to pay for abortion services out-of-pocket.

The state's consumer advocate and Connecticut Medical Society noted that the board effectively had no choice but to go with a benchmark plan that included abortion services. Every private plan in Connecticut covers abortion services, thus the only way to avoid the "hot-button" issue would be to use the Federal Employee Health Benefit Plan (FEHBP) as the state benchmark plan. However, board

members overwhelmingly rejected FEHBP as it does not include many of Connecticut's coverage mandates, such as in-vitro fertilization (IVF).

The board added coverage for prescription drugs and fertility treatments to the benefit package covered by ConnectiCare HMO.

The exchange board predicts that about 180,000 Connecticut residents will purchase coverage through the state's exchange within three years of operation. The board also estimates at least seven insurers will compete for customers in the exchange.

The board admits that it has no idea yet how much the benchmark plan will cost. However, it insists that because of ConnectiCare's prevalence in the private market, the benchmark plan should be affordable.

The board will officially vote on benchmark plan after the 30-day comment period concludes.

Massachusetts

Governor to sign "revolutionary" bill setting global budgets for health care providers

Governor Deval Patrick (D) is expected to shortly sign a reconciled bill laid before him this week that will transform all third-party payer reimbursement in the commonwealth to a system of prospective global budgets.

The Governor has tried over the past two sessions to push through global budget legislation as an adjunct to the landmark Massachusetts health reforms enacted by former Governor Mitt Romney (R) that became the model for the Affordable Care Act (ACA) (see Update for Week of May 7th). Although Governor Romney's reforms have been a resounding success in terms of expanding coverage, the lack of strict cost controls has been a leading criticism.

The measure aims to save at least \$200 billion over the next 15 years by linking health care cost increases to the growth of the state's economy—something no other state has ever attempted. It will require hospitals and physicians to cut their rate of cost growth by nearly half or down to only 3.6 per year.

In addition to setting a target growth rate for state health care spending, the bill establishes a new regulatory authority to enforce it on providers (see Update for Week of May 14th). However, proposed penalties for failing to do so have been relaxed under the final measure, causing some criticism from consumer groups who fear it does not have "enough teeth to keep overall costs" within the "soft targets".

The measure has wide support from the Massachusetts Hospital Association and insurers. It cleared the House with only 20 votes and unanimously passed the Senate.

Michigan

House Republicans continue to delay action on health insurance exchange

The House Health Policy Committee and Appropriations Subcommittee on Licensing and Regulatory Affairs held two joint hearings over the past two weeks to take testimony from stakeholders arguing for and against the creation of a state-based health insurance exchange.

Governor Rick Snyder (R) supports the exchange. However, House Republicans blocked exchange-authorizing legislation earlier this year, despite passage by the Republican-controlled Senate. As a result, the Governor secured the support of House Speaker Jase Bolger (R) to seek federal permission for a joint partnership that would allow Michigan to comply with the federal January 2013 deadline and still retain some control over key exchange functions (see Update for Week of June 25th). If

the state fails to get permission, a federally-facilitated exchange will instead be operate in Michigan starting in 2014.

Despite support for a state-based exchange from the Michigan Association of Health Plans, Blue Cross and Blue Shield of Michigan, and other leading health insurers, many House Republicans on the panel remained unconvinced that the exchange will not lead to higher costs for Michigan consumers and insist on delaying any implementation session until after the fall elections.

The Department of Licensing and Regulatory Affairs was directed last year by the Governor to begin preparations on the exchange. However, it still needs legislative authorization to begin using the \$9.8 million federal exchange establishment grant secured by the Governor.

Missouri

Missouri Supreme Court overturns cap on medical malpractice damages

The Missouri Supreme Court ruled this week that the state's 20-year old cap on non-economic medical malpractice damages is unconstitutional because it removes a citizen's fundamental right to a trial by jury.

Republican lawmakers have made tort reform a centerpiece of their federal and state health reform proposals and at least 30 states have instituted strict caps similar to the \$350,000 limitation in Missouri. However, the Missouri Supreme Court decision is the latest in a series of legal and political setbacks for these caps, which the Congressional Budget Office (CBO) found in 2003 to have reduced health care costs by less than two percent in states that have implemented them.

According to the American Medical Association, courts in 16 states have upheld such caps. However, they have been overturned by courts in 11 states while the constitutions in several others including Arizona, Kentucky, Pennsylvania, and Wyoming specifically outlaw them.

The Missouri State Medical Association condemned the decision, insisting that the caps have drawn more physicians to the state and greatly improved access to care. It urged Governor Jay Nixon (D) and the General Assembly to make restoration of the cap their "highest legislative priority in 2013."

The Supreme Court in neighboring Kansas is expected to soon rule on a similar challenge to that state's medical malpractice caps. The existing split in decisions nationwide will likely need to ultimately be resolved by the U.S. Supreme Court.

Nebraska

Uninsured jumped dramatically over past decade

A new study released this week by the University of Nebraska Medical Center found that the number of Nebraska residents under age 65 who lack health insurance grew over 67 percent from 2000-2010, with the uninsured rate in several rural counties exceeding 30 percent..

While the numbers seem alarming, they are actually in line with the jump in uninsured across all Midwestern states. The authors note that Governor Dave Heinemann (R) has steadfastly refused to participate in the Medicaid expansion or under the Affordable Care Act (ACA), both of which would dramatically reduce the number of uninsured Nebraskans (see Update for Week of June 25th).