

Health Reform Update – Week of October 15, 2012

CONGRESS

Medicare premium support model would raise premiums for most enrollees

A study released this week by the Kaiser Family Foundation concludes that Medicare premiums would have increased for 59 percent of enrollees had the “premium support” model passed by House Republicans been in effect in 2010, even if they remain in traditional Medicare.

The latest incarnation of the “premium support” model advanced by the Republican presidential and vice presidential nominees would give Medicare enrollees the choice of using premium subsidies to purchase private coverage or staying in traditional Medicare (see Update for Week of April 2nd). This was a modification from the initial plan proposed by Rep. Paul Ryan (R-WI) that would have eliminated the traditional Medicare option and sparked a voter backlash (see Update for Week of May 23, 2011).

Kaiser found that more than half of Medicare enrollees who choose not to accept premium subsidies to purchase more costly private coverage would still have had their average premiums go up by \$720 per year. Likewise, 88 percent of those who already purchased private Medicare Advantage (MA) plans covering extra benefits would have paid an average of \$1,044 more in 2010 had the “premium support” model been in effect.

Altogether, the study predicted that premiums would increase for 59 percent of Medicare enrollees. However, if at least 25 of enrollees switched to cheaper MA plans as a result, only 35 percent would face higher premiums. The size of the premium hike would be the greatest for populous states like California and Florida.

Researchers acknowledged that the Kaiser study does not assess the long-term impact of the “premium support” model, but cautioned that strict rules and adequate risk adjustment will be needed to prevent traditional Medicare from becoming a repository for sicker and older enrollees and collapsing. They also emphasized that Medicare enrollees who accept the premiums subsidy and venture into the private market will be stuck with the difference if the second-cheapest bid in any region exceeds the amount of the subsidy or “voucher”. This is because the only way the “premium support” model can achieve cost savings is to limit the annual increase in the subsidy (which the Ryan plan proposes to be set at gross domestic product plus 0.5 percent).

Republican lawmakers criticized Kaiser for making an “apples to oranges” comparison, since their plan would not take effect until 2023. However, researchers insisted that the House-passed plan does not provide enough details to complete a long-term analysis.



Study finds Romney-Ryan plan would add 45 million to ranks of the uninsured

A new study published last week by The Commonwealth Fund predicts that the plan advanced by Presidential nominee Mitt Romney (R) would make 45 million more Americans uninsured as compared to the Affordable Care Act (ACA).

The landmark reforms enacted by the former Massachusetts governor expanded health insurance coverage to 97 percent of residents in his state and ultimately became the model for the ACA. However, as a Presidential candidate, Romney has adopted the House-passed budget plan proposed by his running mate Rep. Paul Ryan (R), which would repeal the ACA, privatize Medicare, and convert Medicaid to federal block grants with no strings attached (see Update for Week of April 2nd).

The Commonwealth Fund study predicts that the Romney-Ryan reforms would increase the nation's uninsured to at least 72 million, as compared to only 27 million once the ACA is fully implemented. This includes nearly 18 million children who would be uninsured under the former, compared to only six million under the latter.

According to the study, Romney-Ryan would also hit middle-income Americans hard, as more than one-third of Americans earning \$32,000-58,000 per year for a family of four (or 17.7 million Americans) would be uninsured by 2022. By contrast, only 3.3 million of this group would remain uninsured under the ACA. For those earning less than \$32,000 per year, 38.7 million would remain uninsured under the Romney-Ryan, compared to 17.2 million under the ACA.

CRS report shows 33 percent jump in federal anti-poverty spending since 2008

A new study by the nonpartisan Congressional Research Service (CRS) finds that spending on federal anti-poverty programs has increased 33 percent since 2008.

Senate Budget committee ranking member Jeff Sessions (R-AL) sought the report, which was intended to show how much spending for Medicaid, welfare, food stamps, Pell grants, and 80 other federal programs have jumped under the Obama Administration. He emphasized that CRS attributed most of the jump to the stimulus relief that Congress passed shortly after the President was inaugurated.

According to CRS, the \$1.03 trillion in anti-poverty spending far exceed amounts spent on Social Security (\$725 billion) and Medicare (\$480 billion). During this period, which included the latter half of the recession that began in late 2007, Medicaid costs grew by 37 percent while food stamp spending climbed 71 percent.

Senator Sessions insisted that the figures show the need to further reform and scale-back welfare programs, as President Clinton did in 1996.

House Republican seeks to alter Part B reimbursement for drugs in short supply

Rep. Bill Cassidy (R-LA) announced last week that he plans to introduce legislation during the lame-duck session after the November election that would alter Medicare reimbursement for Part B drugs that are in short supply.

The measure would be similar to a proposal last year advanced by Senate Finance committee ranking member Orrin Hatch (R-UT) that called for moving away from average sales price payment for shortage drugs, excluding them from Medicaid rebates and the 340B program, and granting them extended market exclusivity. Rep. Cassidy cites opinions from oncology market experts that the Medicare Modernization Act created a disincentive to manufacture certain drugs because transitioning reimbursement for physician-administered drugs from average wholesale price to average sales price (plus 6 percent) drove down generic drug prices.

Cassidy's effort comes as the Department of Health and Human Services Inspector General is initiating several studies relating to pricing for drugs experiencing shortages, which have tripled over the last five years causing more than 180 medications to be in short supply during 2011. However, the White House claims that the President's executive order last fall has prevented 114 drug shortages by giving FDA regulators more power to track shortages, quickly approve replacement manufacturing sites and punish price gougers (see Update for Week of February 20th).

Patient advocates seek to expand Medicare coverage for kidney transplant drugs

Advocates for patients with kidney disease are trying to push legislation through the lame-duck Congressional session after the election that would expand Medicare coverage for beyond the current three-year limit for individuals who are not elderly or disabled.

Immunosuppressive drugs are used to keep patients from rejecting transplanted organs. For patients with kidney disease, the drugs cost roughly \$11,000 per year, far less than the \$70,000 annual cost for patients that otherwise require dialysis.

Legislation introduced last year by Senator Richard Durbin (D-IL) and Rep. Michael Burgess (R-TX) have yet to advance (S.1454/H.R.2969) despite significant bipartisan support, as was this case in prior sessions. The primary objection is finding offsetting revenue that is acceptable to both parties.

The American Kidney Fund also plans to renew its push next Congress for broader legislation that would revise the Medicare secondary-payer policy for individuals with end-stage renal disease, allowing them to use their group health plan as the primary payer for an additional year (a total of 42 months) after they become Medicare-eligible. However, legislation introduced earlier this year (S.2163/H.R. 6011) by Senator Kent Conrad (D-ND) and Rep. John Lewis (D-GA) has yet to attract any cosponsors.



FEDERAL AGENCIES

More highly-rated managed care and drug plans will be available to Medicare enrollees next year

According to the Centers for Medicare and Medicaid Services (CMS), more four or five-star rated Medicare Advantage (MA) plans will be available to enrollees at the outset this week of the open enrollment period for 2013.

The private MA managed care plans are a voluntary option that enable enrollees to purchase coverage for benefits not covered by traditional Medicare. In 2011, about a quarter of all Medicare enrollees signed-up for MA plans.

The number of highly-rated MA plans will increase from 106 to 127 and serve 37 percent of all MA enrollees, as compared to only 28 percent in 2012. Overall, the number of MA plan choices is expected to grow by seven percent.

CMS officials also noted that the number of highly rated, stand-alone Medicare prescription drug plans will increase from 13 to 26 next year. The percentage of beneficiaries who are enrolled in these highly rated drug plans is likewise expected to double from nine percent to 18 percent.

According to a study by Avalere Health, 28 percent of Medicare Advantage plans and 49 percent of stand-alone Part D plans gained at least half a star over the past year on a scale of two to five stars (see article below). CMS insists that they will continue to aggressively move beneficiaries out of lower-rated plans and into higher-scoring ones. This includes preventing beneficiaries from enrolling in low-rated plans (less than three stars) through the www.medicare.gov website.

CMS officials acknowledge that monthly premiums for MA plans are expected to increase next year by 4.7 percent if most beneficiaries keep their plan or by 1.8 percent if beneficiaries switch to lower-cost plans at the same rate as in 2012. Average monthly premiums for Part D enrollees will increase slightly from \$29.67 to \$30.00, although a recent study by Avalere Health showed that monthly premiums for seven out of the ten most popular Part D plans will increase by an average of six percent (see Update for Week of September 24th).

Republicans subpoena HHS after studies show that Medicare Advantage bonuses are working

Republican lawmakers were quick to attack two studies this week that provided support for the temporary Medicare Advantage bonus program created by the Affordable Care Act (ACA).

The Government Accountability Office (GAO) had recommended that the three-year demonstration be canceled, claiming that the Centers for Medicare and Medicaid Services likely exceeded their authority under the ACA by unilaterally extending bonus payments for MA plans all the way down to those receiving only three



out of a possible five stars. As a result of giving bigger payments to more plans, not only will most MA plans receive a bonus, but the overall cost of the demonstration will soar to \$8.35 billion over ten years--an amount that is over \$5 billion more than anticipated and dwarfs federal spending on all other demonstration projects (see Update for Week of April 23rd).

GAO concluded that this level of spending would offset any of the “savings” Congress intended to achieve by reducing the rate of growth in MA reimbursement by \$145 billion over nine years, consistent with the Congressional Budget Office finding that MA plans were being overpaid by 14.2 percent in 2009. Republican lawmakers have insisted that these “savings” are actually cuts to the Medicare program that the Administration is seeking to conceal through the use of the bonuses.

CMS has refused to cancel the demonstration and used the studies released this week by Avalere Health and The Commonwealth Fund to bolster their argument that reducing overpayments is improving access and quality without harming plans, providers, or enrollees. In response, Republican leaders on the House Oversight and Government Reform committee threatened to subpoena the agency if it does not immediately comply with earlier requests for documents relating to the demonstration.

According to the Avalere study, 28 percent of MA plans gained at least half a star last year because of the bonuses and 99 plans will receive higher payments applied to their benchmarks for 2014. As a result, 68 percent of all beneficiaries will have access to a four or five-star MA plan in 2013, up substantially from only 51 percent last year.

Stars are awarded by CMS based on 50 measures of prevention, quality of care, and customer service. This gives plan financial incentives to reduce hospital readmissions, broaden coverage for preventive care, and increase consumer satisfaction. The average rating in 2013 will be 3.66 stars, up from 3.44 last year and 3.18 in 2011.

Avalere identified Humana as the first publicly traded insurer among the 11 that were given the top five-star rating. As a result, Humana will receive five percent more in MA reimbursement and achieve a competitive advantage by being able to enroll subscribers year round and not just during the open enrollment period that started this week. The other five-star plans are all nonprofits, with six belonging to Kaiser Permanente.

Social Security cost of living adjustment is lowest since 1975

The Social Security Administration (SSA) announced this week that beneficiaries will see only a 1.7 percent cost-of-living adjustment (COLA) next year as consumer prices rose by less than two percent in 2012. That amounts to only a \$21 monthly increase for the average beneficiary, less than half of the 3.6 percent hike they received last year.

The 1.7 percent increase is the lowest since 1975, during which time the COLA has averaged 4.2 percent. However, no COLA was issued in 2010 and 2011 when the recession limited inflation. The 2013 increase

could be largely offset by a 4.3 percent rise in medical costs and an increase in the Medicare premiums that are deducted from Social Security checks. The Part B monthly premium is expected to increase by seven percent to about \$107 in 2013.

The small increase renewed calls from Democratic lawmakers to raise the \$113,700 cap on income that is subject to the payroll tax. The issue is likely to be hotly debated during the lame duck Congressional session following the election when lawmakers must come up with a package that reduces the deficit by \$1.2 trillion over ten years or face an across-the-board sequester in January (see Update for Week of October 8th). However, Social Security payments are exempted from the automatic cuts.

Republicans oppose broadening the payroll tax and instead favor increasing the eligibility age to 67 and means-testing benefits so that wealthier beneficiaries receive less.

Census data shows that the median income for all American households fell 6.6 percent last year when inflation was taken into account. Even though the median income for households headed by someone 65 or older rose 13 percent, income for most seniors is still less than younger adults.

STATES

Alaska

Health department soliciting cost estimates for Medicaid expansion

The Department of Health issued a solicitation last week for cost estimates on the Medicaid expansion under the Affordable Care Act (ACA).

Governor Sean Parnell (R) has already indicated that he is likely to exercise the discretion afforded by the U.S. Supreme Court to “opt out” of the expansion without penalty. The Governor cited a state report from 2011 concluding that it will cost Alaska \$12 million per year in upgraded technology and administration to accommodate the influx of Medicaid enrollees if the state accepts the federal match under the ACA and expands to those earning up to 133 percent of the federal poverty level. He stressed that the full federal match through 2016 applies only to medical care for the expansion population and covers just 50 percent of the associated costs (see Update for Week of July 16th).

However, governors nationwide are under intense pressure from state hospital associations to participate in the expansion. States that do not expand will only increase the uncompensated care burdens on safety net providers as the ACA begins phasing down disproportionate share payments for the indigent in 2014.

As the result, the Department of Health has been directed to seek a more comprehensive actuarial analysis of the full costs of expanding Medicaid, including possible cost control measures. The agency will spend \$100,000 on the study, which is expected to be completed in December.



Arizona

Governor designates state employee plan as essential health benefits benchmark

Governor Jan Brewer (R) made Arizona the third state earlier this month to select a health plan for state employees as the benchmark for defining essential health benefits.

The Affordable Care Act (ACA) required all states to designate the benchmark plan that they will use to define the benefits that all non-grandfathered individual and small group plans must cover starting in 2014. States had until September 30th to do so or default to the most popular small group plan in the state (see Update for Week of February 20th).

Of the 23 states that selected a benchmark, Maryland and Utah were the only other states to designate a state employee health plan (see Update for Week of October 1st). The Governor indicated that her decision was based on the fact that the State Employee Benefit-United Healthcare EPO did not cover abortion services.

In her letter to the Centers for Medicare and Medicaid Services, the Governor maintained her opposition to the ACA but stated that she would not “abdicate” her responsibility to implement “the law of the land.” She also reiterated her position that it was better for Arizona to control ACA implementation that default to the federal government.

However, Governor Brewer did not indicate whether this signals that she will create a state-based health insurance exchange or participate in the Medicaid expansion. The Governor has deferred both of those decisions until after the November election (see Update for Week of September 24th). She has allowed state agencies to solicit bids for exchange design and is accepting cost estimates on the expansion.

California

Governor delays special session on health reform until January

Governor Jerry Brown (D) announced this week that he will wait until January to call a special legislative session to finalize outstanding implementation issues related to the Affordable Care Act (ACA).

The Governor had indicated that the special session of the newly-elected legislature would begin in December (see Update for Week of August 20th). The session was needed to pass legislation relating to the new health benefits exchange, which must be operational by October 2013. The Governor did not want to wait until the end of the next regular session in August for exchange bills to take into effect, preferring the special session so that they can instead be enacted in 90 days.



Lawmakers are expected to revise legislation vetoed by the Governor that would have conformed state law to the ACA ban on pre-existing condition denials that goes into effect in 2014. Governor Brown also vetoed bills that would have streamlined eligibility and enrollment in the exchange and other state programs and also required parity in health plan coverage between oral and intravenous chemotherapy (see Update for Week of October 1st).

In addition, the legislature will continue to weigh whether to create of a Basic Health Plan option as authorized by the ACA (see Update for Week of August 20th). The exchange board has opposed a Basic Health Plan option for those earning up to 200 percent of the federal poverty level, fearing it would siphon away exchange participants and threaten the financial viability of the exchange (see Update for Week of July 25, 2011).

State high-risk pool cuts premiums by 12 percent

The Managed Risk Medical Insurance Board (MRMIB) voted this week to decrease premiums for state high-risk pool enrollees by an average of 12 percent in 2013.

MRMIB officials were planning on a ten percent rate hike before Governor Jerry Brown (D) signed A.B. 1526 last month. The measure allows the MRMIB to subsidize premiums with tobacco tax revenue at no less than 100 percent of comparable rates for the individual market and prohibits the amount of subsidies from affecting the calculation of premiums. It is intended to prevent enrollees from having to leave the high-risk pool because of premium changes.

Per capita caps proposed as an alternative to Medicaid block grants

State officials, providers, and Medicaid managed care plans are pushing Congress to cap federal Medicaid spending per person as a way to avert Medicaid cuts in upcoming negotiations over entitlement reform, as well as boost Medi-Cal rates that are among the lowest in the nation.

The per capita caps were proposed earlier this month by former Senator Tom Daschle (D-SD) as an alternative to the House-passed plan advanced by vice presidential nominee Paul Ryan (R-WI) that would convert federal Medicaid matching funds into a no strings attached lump-sum block grant (see Update for Week of April 2nd). The Congressional Budget Office (CBO) warned that the lack of minimum federal standards would result in drastic cuts to Medicaid benefits, eligibility, and payments and make states even more susceptible to economic downturns (see Update for Week of April 4, 2011). Presidential candidate Mitt Romney (R) suggested during the first presidential debate that the federal government could still “step in” if states get in trouble, though he did not specify what such intervention would entail.

Daschle insisted that the per capita caps would give Republican governors the flexibility they seek while still guaranteeing minimum Medicaid benefits and eligibility. The per capita caps would vary by state or even by category of beneficiary and would be adjusted each year. He notes a handful of states including Missouri and Tennessee have experimented with the approach, which has some support among House Republicans including Mike Burgess (R-TX) and Bill Cassidy (R-LA).



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However, the Center on Budget and Policy Priorities (CBPP), a progressive think tank, released a study last week concluding that, as with block grants, federal Medicaid funding under per capita caps would still become inadequate over time and increasingly shift costs to the states.

Idaho

Governor commissions two studies to estimate costs of Medicaid expansion

The Department of Health and Public Welfare announced this week that it is spending \$195,000 for two out-of-state consulting firms to assess the full costs of expanding Medicaid under the Affordable Care Act (ACA).

An earlier analysis published by the Spokesman-Review predicted that Idaho taxpayers would save up to \$380 million over six years if the Governor accepts federal funds to participate in the expansion (see Update for Week of September 10th). The findings meshed with a recent Kaiser Family Foundation study, which also found that the state would reduce their Medicaid expenditures by \$300 million if it participated.

Governor Butch Otter had indicated that he was likely to follow the lead of at least a dozen other Republican governors and exercise the discretion afforded by the U.S. Supreme Court to opt-out of the expansion without penalty (see Update for Week of July 2nd). However, he agreed to wait for the recommendations of committee he created to analyze the potential cost or savings from expanding (see Update for Week of July 9th).

The Department hired two conservative-leaning consultant firms to complete the two studies. Leavitt Partners is headed by Michael Leavitt, a former Centers for Medicare and Medicaid Services Administrator under President George W. Bush. Analyses from Milliman consulting have frequently been used by Republican governors to show that the costs of the Medicaid expansion would “bankrupt” their states. However, the Urban Institute, Kaiser Family Foundation, and others have criticized Milliman for assuming that all newly-eligible populations will actually enroll, noting that past expansions have experienced only a 57-70 percent enrollment rate (see Update for Weeks of August 6th and 13th).

Several Republican leaders including House Majority Leader Mike Moyle (R) have been pushing the Governor to “get the facts” before opting-out (see Update for Week of September 10th).



Michigan

Study concludes Michigan would save \$1 billion over ten years by joining Medicaid expansion

A report issued this week by the Center for Healthcare Research and Transformation (CHRT) and two University of Michigan economists concludes that Michigan would save up to \$1 billion over ten years and expand coverage to 600,000 residents by participating in the Medicaid expansion under the Affordable Care Act (ACA).

Governor Rick Snyder (R) has yet to decide on whether to exercise the flexibility granted by the U.S. Supreme Court and “opt-out” of the Medicaid expansion without penalty. While at least a dozen Republican governors have already done so (see Update for Week of July 9th), Governor Snyder has not ruled out participating in the expansion. He is also one of only four Republican governors that have not refused to implement the health insurance exchange authorized by the new law (see Update for Weeks of July 23rd and 30th).

According to the report, the Medicaid expansion would impose only a minimal cost to Michigan starting in 2020, when the federal match phases down to 90 percent and the state assumes the other ten percent of the costs. However, even if the Governor is persuaded by these estimates, he may have difficulty securing legislative authorization. Senator Bruce Caswell (R) and three other Republican Senators have already proposed legislation barring the Governor from expanding Medicaid, and the legislature previously blocked all exchange-authorizing legislation despite the support of the Governor (see Update for Week of July 23rd and 30th).

Nebraska

Senator to pursue legislation barring elected officials from state employee health plan

Senator Jeremy Nordquist (D) announced this week that he will introduce legislation next session that will exclude elected officials from enrolling in the health plan for state employees.

According to the Senator, the move is intended to force the Governor and fellow lawmakers to gain a better understanding of how challenging it is for persons with pre-existing conditions to access coverage that is not provided through their employer. He emphasizes that it correlates to a provision in the Affordable Care Act (ACA) requiring members of Congress to enroll in the new exchange plans starting in 2014, instead of being covered through the Federal Employees Health Benefits Plan.

Senator Nordquist states that he was spurred to action by the recent decision by Governor Dave Heineman (R) to designate a health insurance plan with a whopping \$8,000 family deductible as the benchmark for the essential benefits that all individual and small group plans must cover in 2014 pursuant to the ACA. By contrast, the state employee health plan that covers the Governor and other lawmakers has family deductibles of only \$800-\$2,000. Nordquist insists the Governor’s decision demonstrated he was “disconnected...from the realities



of the health insurance marketplace.”

Senator Nordquist has previously been at odds with the Governor over his refusal to create an ACA-compliant health insurance exchange or participate in the ACA Medicaid expansion (see Update for Week of June 25th).

New Jersey

Legislature sends revived exchange-authorizing bill to Governor

The Assembly passed legislation this week on a 44-33 vote that would create the state-based health insurance exchange authorized by the Affordable Care Act (ACA).

The measure (A.3186/S.2135) now goes to Governor Chris Christie (R), who vetoed similar legislation last session that would have created the exchange authorized by the Affordable Care Act (ACA) (see Update for Week of May 7th). He immediately reaffirmed his commitment not to make any decisions on ACA implementation until after the outcome of the November elections dictate whether Republicans will be able to repeal all or part of the new law (see Update for Week of October 8th).

Republicans in both the Assembly and Senate unsuccessfully sought to delay the measure, arguing that states lacked sufficient federal guidance to proceed (see Update for Week of October 1st). However, bill sponsor Assemblyman Herb Conway (D) insisted that New Jersey could not afford to risk ceding control of the exchange to the federal government should they miss the federal January 2013 deadline to make “substantial progress” on the exchange. Conway is a physician who chairs a National Conference of State Legislatures task force on health reform.

However, even if the Governor should sign the authorizing legislation it is not clear that New Jersey could meet this deadline. State agencies have spent little of the \$7.6 million the Governor has obtained in federal exchange establishment grants, an amount that pales in comparison to the \$154 million and \$115 million that neighboring New York and Connecticut have respectively compiled for their exchange implementation.

Oregon

Insurance Division proposes rules to ensure plans cover bronze and silver benefit levels

The Division of Insurance filed proposed rules last week that establish the form, level of coverage and benefit design requirements for the standard bronze and silver health benefit plans required by the Affordable Care Act (ACA). Public comments will be accepted until December 7th.



The regulations will ensure that the bronze plan is actuarially equivalent to 60 percent of the full actuarial value of benefits included in the essential health benefits package that all non-grandfather individual and small group plans must cover starting in 2014. The silver plan must be actuarially equivalent to 70 percent of the full actuarial value of benefits.

Bronze and silver plans must be offered in and outside of the new Oregon Health Insurance Exchange that will begin enrollment in October 2013.

Pennsylvania

Pennsylvania will likely miss deadline for creating ACA health insurance exchange

Insurance Commissioner Michael Consedine acknowledged this week that movement on a state-based health insurance exchange has stalled and Pennsylvania would likely have to default to a federally-facilitated exchange (FFE) as a result.

Governor Tom Corbett (R) publicly opposes the Affordable Care Act (ACA), but had allowed state agencies to use federal exchange establishment grants and start designing the online marketplace while he awaited the outcome of the November election before deciding whether to proceed. However, the commissioner admits that, regardless of the election results, Pennsylvania will be unable to meet the January deadline to make “substantial progress” on a state exchange.

Consedine insists that Pennsylvania simply lacks adequate federal guidance, noting that the Centers for Medicare and Medicaid Services has yet to fully respond to a list of questions that were submitted by Republican governors nor issued regulations governing the FFE (see Update for Weeks of August 6th and 13th). He did not indicate whether the Governor would seek to initially partner with the federal government, as have several other states whose exchange implementation has lagged behind (see Update for Week of May 14th).

Even if the Governor decided to move forward, it is not yet clear that he could obtain legislative authorization for either a state-based or partnership exchange. The Legislature is currently under the control of Republican lawmakers, several of whom have signed on to legislation that would bar either model (see Update for Week of October 1st). However, all House seats and half of the state Senate are up for grabs next month.

Insurance Department consultants had estimated that an ACA-compliant exchange will serve over two million state residents. Pennsylvania is the 5th largest insurance market in the United States, in terms of premium volume.



Utah

Medicaid managed care plan gets green light after adding safeguards

The Utah Inspector General announced this week that he will not delay contract negotiations with new Medicaid managed care plans, after the Department of Health (DOH) added consumer safeguards to protect against capitated plans profiting by skimping on care.

DOH is currently negotiating contracts with the four health plans under which 70 percent of Medicaid beneficiaries will be enrolled starting in January. DOH officials had estimated that the transition would save the state \$700 million over seven years.

The Inspector General had expressed concerns last summer that the contracts lacked appropriate safeguards to ensure those savings would not come at the expense of access and quality of care, as has been the case in states like Florida (see Update for Week of August 1, 2011). However, the results of his audit revealed that DOH has since agreed to impose financial penalties against plans that go over budget or ration care, as well as provided a clear mechanism for the Inspector General to recoup misspent funds.

The Inspector General is still pressing for more direct oversight, but will allow implementation to proceed on schedule.