

Health Reform Update – Week of November 12, 2012

CONGRESS

President and Congress resume negotiations to forestall “fiscal cliff”

The President and Congress resumed negotiations this week on a compromise package of new revenues and spending cuts that will avert the so- called “fiscal cliff”.

This “fiscal cliff” is the combination of expiring tax cuts, automatic across-the-board budget cuts, and the Medicare physician payment cut that all go into effect at year’s end without Congressional action. While the President has pledged that the government will not go over the cliff (see Update for Week of October 22nd) it appears that any “grand bargain” will not be reached during a lame-duck session and that a temporary extension will ultimately “kick the can” on some measures to the next Congress.

However, the President has also promised not to forestall the sequester if Congress cannot agree on a package that at least reduces the deficit by \$1.2 trillion over the next ten years. If a compromise or extension is not reached before January 2nd, agency funding for many health programs will be slashed by 8.2 percent (see Update for Week of September 17th). Although Medicaid and Social Security are exempted, Medicare payments will fall by two percent. Hospital, nursing, and physician groups warn that the cuts will result in over 500,000 job losses next year alone (see Update for Week of October 8th).

Although last week’s election softened the tone between the parties, the path to any “grand bargain” remains unclear. House Speaker John Boehner (R-OH) signaled a willingness to increase revenues, the main sticking point in the failed negotiations last year that resulted in the sequester. However, Boehner insists that these come from eliminating loopholes and deductions instead of higher tax rates, and must be contingent upon Democrats accepting major entitlement cuts.

Senate Majority Leader Harry Reid (D-NV) pledged that Democrats would not “draw any lines in the sand” apart from higher taxes for the wealthy. He also remained open to discussing entitlement reform, although Democrats remain divided on the scope of these cuts.

Democrats appear to have early leverage as a result of the election. Polling released this week by the Pew Research Center also shows that Americans largely support the President’s position, and slightly more than half would blame Republicans if negotiations fail and taxes jump across the board.

President Obama is initially insisting on \$1.6 trillion in new revenues or double the amount from prior negotiations. His plan largely follows the \$4 trillion deficit reduction package he proposed last winter, which would raise the Medicare eligibility age to 67, impose higher premiums for wealthy enrollees, and reduce Social Security cost-of-living adjustments which are already at their lowest level since 1975 (see Update for Week of October 15th).



Kaiser Health News and others reported last week that some Affordable Care Act provisions long-targeted by Republicans may be included as part of the negotiations. These include:

- Repealing the Independent Payment Advisory Board (see Update for Week of November 5th).
- Adjusting the age-rating limit from 3:1 to 5:1 as sought by the Blue Cross and Blue Shield Association.
- Broadening the terms of the Medicaid expansion (i.e. can states expand only to 100 percent of the federal poverty level instead of 133 percent?).
- Limiting amount of the federal tax credits to help low-income individuals purchase health insurance.
- Eliminating new taxes on health insurers, drug and device manufacturers, and “Cadillac” health plans.

Public support fades for repealing Affordable Care Act

The latest monthly tracking poll from the Kaiser Family Foundation found just 33 percent now support repealing the Affordable Care Act (ACA), the lowest level since the law was signed.

The survey of 1,223 adults was completed only days after last week’s election reinforced the inevitability of the ACA being fully implemented. Those polled now favor the law by 43 to 39 percent, a complete inverse of the results obtained before the election.

The poll also affirmed that health care issues were largely a wash in the Presidential election, as voters for whom the ACA was the dominant issue equally split on their preference of candidate. However, President Obama came out nine points ahead among the 70 percent of voters who said the future of Medicare was their top priority.

More surveys confirm large employers will not drop employer coverage due to the ACA

A survey released last month by the nonprofit Midwest Business Group on Health (MBGH) found that the vast majority of large employers plan to adapt to the Affordable Care Act (ACA) and continue to offer employee health benefits. However, the results did warn that up to 41 percent of employers will reduce their benefit levels by 2018 in order to respond to the new consumer protections mandated by the ACA.

Only about nine percent of companies surveyed plan to participate in state-based health insurance exchanges that will begin operating in 2014. While many expressed interest in private health insurance exchanges, only four percent believe they will use these for active employee coverage in 2014-2016, while 11 percent indicated they will move toward private exchanges for post-65 retirees.

The survey affirmed earlier findings by the Congressional Budget Office, Urban Institute, Avalere Health, etc. that employers believe health benefits are “vital to attracting talented employees” and stay competitive (see Update for Weeks of August 6th and 13th). MBGH also found “little indication that employers plan to drop health care coverage” in favor of providing employees a set amount to buy exchange coverage.



A Mercer study released this week confirmed this trend, as it showed that only seven percent of large employers expect to drop employee coverage in the next five years. Mercer also found a slight uptick in the share of employers that offered coverage in 2012 (from 55 to 59 percent) reversing declines from the previous two years.

Researchers pointed to employer success in curbing health costs as one reason that they may be comfortable continuing to offer coverage. Costs grew by only 4.1 percentage points in 2012, the smallest increase in 15 years.

However, Mercer did warn that a much higher number (22 percent) of small employers were likely to drop coverage. A separate report released last week by The Commonwealth Fund documents that this trend is already occurring as just under half of small business workers were offered health insurance by their company last year, a nine percent drop from 2003. This was especially pronounced for those earning less than \$15 per hour, only about one-third of whom were offered coverage, compared to 42 percent just nine years ago. Small business employees were also twice as likely to be uninsured compared to employees of companies with at least 100 workers.

The surveys come during a week in which the CEOs of three large restaurant chains (Applebee's, Denny's, and Papa John's) all announced they would raise food prices in response to "Obamacare".

FEDERAL AGENCIES

GAO says hemophilia clotting factor is most costly Medicare Part B drug

A new report from the Government Accountability Office (GAO) found that Factor VIII recombinant for hemophilia A had the highest average annual cost per Medicare Part B beneficiary of the 55 drugs they studied.

The study (GAO-13-46R) commissioned by Congress analyzed trends for the highest-cost drugs paid under Part B, which are commonly administered by a physician or under physician supervision in physician offices and outpatient hospital departments. Part B spent \$19.5 billion on these drugs in 2010. However, over 85 percent of this amount went towards 55 drugs (42 percent of which were biologics), while only ten drugs were responsible for 45 percent.

Factor VIII recombinant led all of these 55 drugs with an average annual cost of \$217,000 for each of the 660 beneficiaries who were treated with it in 2010. The 660 beneficiaries were the fewest number receiving any of the 55 drugs, but had the largest increase in utilization since 2008. GAO notes that high average per beneficiary costs for Factor VIII result from the complexity of the production process and have not decreased despite the availability of several brand name products.

Two drugs for pulmonary hypertension, Remodulin and Ventavis, followed with average annual per beneficiary costs of about \$131,000 and \$84,000 respectively. Aside from a heart failure drug (Primacor), no other drug cost more than \$26,000 per beneficiary per year in 2010.



STATES

Republican governors receive extension of all health insurance exchange deadlines

Virginia Governor Bob McDonnell (R) and Louisiana Governor Bobby Jindal (R) successfully lobbied the U.S. Department of Health and Human Services (HHS) this week to extend the November 16th deadline for states to declare their intention to create a health insurance exchange that complies with the Affordable Care Act (ACA).

HHS had agreed last week to give states an extra month until December 14th to submit their blueprints for a state exchange (see Update for Week of November 5th). States also now have until February 15th to apply for an initial federal-state partnership if they are not prepared to move forward on a state exchange but do not want to default to a federally-facilitated exchange (FFE).

However, HHS still required states to notify them by the original November 16th deadline of their intentions. Governors McDonnell and Jindal sent a letter this week on behalf of the Republican Governors Association (RGA) insisting that this simply did not give states ample time to fully evaluate their options, especially since HHS has yet to respond to the RGA's request last summer for additional guidance. The governors claim that this lack of information has create a "virtual roadblock" for states and urged HHS to push back all deadlines until they respond to RGA's questions and promulgate final rules that are waiting for Office of Management and Budget clearance (see Update for Week of November 5th).

According to Governor McDonnell, HHS has indicated that the exchange regulations will be released next week. The governors will also participate in a conference call with the Vice President and HHS Secretary to discuss further details.

Because HHS did not extend the deadline until late in the week, most states had already declared their intentions. Nineteen states and the District of Columbia have now confirmed that they will create their own state exchange, while seven will likely pursue an initial federal partnership. However, at least one of the partnership states (North Carolina) will change from a Democratic to Republican governor, which may alter their decision. At least 15 states will default to an FFE, while several states including Arizona, Florida (see below), New Jersey, Oklahoma, Pennsylvania, and Tennessee remain undecided

Both McDonnell and Jindal elected to default to federal exchange control in their states at least until HHS guidance clarifies their share of the exchange costs. Iowa Governor Terry Branstad (R), Indiana Governor Mitch Daniels (R), and Texas Governor Rick Perry (R) made similar decisions. However, several other Republican governors included former RGA chairman Dave Heineman in Nebraska, Rick Perry of Texas, and Scott Walker of Wisconsin already concluded in the absence of this guidance that a state or partnership exchange will impose unreasonable costs on their state.



Mississippi Insurance Commissioner Mike Chaney (R) (over the objection of his governor) and New Mexico Governor Susanna Martinez (R) are two Republicans who have elected to move forward on a state exchange (see below).

All states now have until December 14th to formally declare their intentions and submit exchange blueprints. It is not yet clear if the additional month will coax undecided states not to default to the FFE.

Alabama

Governor will not create health insurance exchange, participate in Medicaid expansion

Despite pressure from state hospital associations and some Republican lawmakers, Governor Robert Bentley (R) notified the Obama Administration this week that Alabama will not implement two key provisions of the Affordable Care Act (ACA).

Governors initially had until November 16th to inform the Centers for Medicare and Medicaid Services (CMS) of their intent to either create a state-based health insurance exchange, opt for an initial partnership with the federal government, or default to a federally-facilitated exchange (FFE). Rep. Greg Wren (R), the sponsor of exchange-authorizing legislation last session, had urged the Governor not to simply allow federal control. However, the Governor insisted he had no other recourse as the state or partnership exchange would “create a tax burden of up to \$50 million on the people of Alabama.”

Defaulting to a FFE was somewhat of a surprise as the Governor, a physician, had initially supported a state exchange before threatening to veto Rep. Wren’s House-passed exchange bill if it passed the Senate (see Update for Week of May 7th). Tea party opposition to implementing any part of Obamacare had earlier forced the Governor to postpone any exchange decision until after the election.

However, the Governor’s decision this week to decline federal funds to expand Medicaid was fully expected, as elected to do so shortly after the U.S. Supreme Court gave states the flexibility to opt-out without penalty (see Update for Week of July 2nd). The Governor claimed that administrative costs not covered by the ACA funds could ultimately cost state taxpayers more than \$470 million.

Governor Bentley recently issued an executive order creating a commission to evaluate how to reduce Medicaid costs that currently consume one-third of the state budget (see Update for Week of October 22nd). Alabama already has one of the leanest Medicaid programs in the nation as it does not cover childless adults or most optional benefits.

Alaska

Governor affirms his opposition to any state control of health insurance exchange

Governor Sean Parnell (R) announced this week that the Obama Administration's extension of the deadline for states to create a state-based health insurance exchange or partner with the federal government will have no effect on his earlier decision to default to a federally-facilitated exchange (FFE).

The Governor decided last summer not to pursue any form of the exchange authorized by the Affordable Care Act (see Update for Week of July 16th). He had previously made Alaska the only state to refuse the initial \$1 million exchange planning grant provided by the ACA.

U.S. Senator Mark Begich (D-AK), who is up for re-election in 2014, had urged the Governor to let Alaska create a regional exchange with other rural states to broaden their risk pool. State Senator Hollis French (D), the sponsor of failed exchange-authorizing legislation, also was adamant that Alaska knew better than the federal government how to tailor the exchange to the needs of their unique state.

However, in the end the Governor insisted that an exchange would impose costs on Alaska taxpayers that in his view should be borne entirely by the federal government mandating the exchange. He rejected the recommendation of his consultants that the state pursue an initial federal-state partnership (see Update for Week of July 16th).

The Governor is soliciting cost estimates on the Medicaid expansion under the new law, but has already indicated that he is strongly leaning against participating (see Update for Week of October 15th).

Arkansas

Despite Republican control, Governor still seeks exchange partnership and Medicaid expansion

Governor Mike Beebe (D) informed the U.S. Department of Health and Human Services this week that he intends to seek approval for to initially partner with the federal government on the state-based health insurance exchange authorized by the Affordable Care Act (ACA).

The Governor decided last spring to pursue the federal-state partnership allowed under federal regulations (see Update for Week of April 23rd) and remains undaunted by the last week's takeover of the legislature by Republicans for the first time since Reconstruction (see Update for Week of November 5th). However, Governor Beebe may have a very difficult time securing the three-fourths vote he needs to move forward on the partnership, as Republican leaders remained adamant this week that they will force the state to instead default to a Under the extension granted last week by HHS, Arkansas now has until February 15th to submit its application for a partnership (see Update for Week of November 5th). The state has already received \$27.7 million in grants from the federal government for creating the exchange, including an \$18.6 million grant that is still awaiting



Under the extension granted last week by HHS, Arkansas now has until February 15th to submit its application for a partnership (see Update for Week of November 5th). The state has already received \$27.7 million in grants from the federal government for creating the exchange, including an \$18.6 million grant that is still awaiting legislative approval before it can be used.

The Governor also supports participating in the Medicaid expansion under the ACA after his Department of Human Services projected that it would save Arkansas over \$372 million in the first six years (see Update for Weeks of July 23rd and 30th). However, Republican lawmakers largely oppose participating, although a handful have not ruled approving a smaller expansion if the Governor agrees to substantially reform Medicaid (such as instituting copayments for new enrollees). HHS has yet to respond to questions from the Republican Governors Association inquiring whether they can receive the full federal match under the ACA if they only expand to 100 percent of the federal poverty level instead of those earning up to 138 percent (see Update for Week of July 2nd).

Republican leaders are rejecting any consideration of the Medicaid expansion this session as the Arkansas Medicaid is currently facing a projected \$358 million shortfall.

California

Governor submits exchange blueprint for federal approval

Governor Jerry Brown (D) submitted the blueprints for the new Covered California health benefit exchange to the U.S. Department of Health and Human Services.

Stating the “we don’t need more time”, the oversight board approved the plans well in advance of the new December 14th deadline set by HHS (see Update for Week of November 5th). California was the first to pass exchange-authorizing legislation in 2010 and is among the handful of states that are far ahead in exchange implementation. The exchange blueprint even included an approved plan for self-sufficiency by 2015 (as required by the ACA) and requests an additional \$706 million in exchange establishment grants to cover expenses for the next two years.

California is pursuing the “active purchaser” model in which the board can negotiate rates and excludes plans that are not affordable. It has already solicited bids for participating health plans (see Update for Week of October 29th), as well as contracted with vendors to design the infrastructure and promote the exchange through popular television shows (see Update for Week of October 1st).

Colorado

Health plan rate hikes are at their lowest level in ten years, but still exceed national average

According to Lockton Co.’s annual survey, health insurance premiums in Colorado will rise next year at their lowest level in a decade.



While rate hikes are still increasing faster than inflation or any other commodity, the average health plan increase of 7.4 percent is far less than the 9.4 percent rate of growth in 2012 and double-digit jumps in years prior. However, it is far above the national average increase of only four percent for 2013.

Lockton attributed most of the decline to lower utilization and the increasing prevalence of high-deductible health plans. Over 53 percent of Colorado companies now have plan deductibles of at least \$1,000, far higher than the national average of 34 percent and last year's Colorado average of 46 percent. (A separate study by the Kaiser Family Foundation found that average deductibles for employer plans nationwide have doubled to nearly \$1,100 since 2006).

However, consumer advocates like the Colorado Consumer Health Initiative (CCHI) insist that such a large drop can only be explained by the enhanced rate review authority implemented last fall by the Affordable Care Act (ACA). These provisions allowed states to publicly shame health plans that impose "unreasonable" double-digit rate hikes that are not justified by medical costs (see Update for Week of August 29, 2011). The fact that so many increases are exactly at 9.9 percent is further evidence that the lower rates are in direct response to this provision, according to CCHI.

CCHI has started taken advantage of state law allowing anyone to publicly comment on proposed rate hikes. However, the organization is urging the state to follow Oregon's lead and require a public hearing for every rate increase, not just the most substantial.

CCHI is also warning that the Lockton figures confirm many companies are moving to self-insured plans in order to exempt themselves from certain ACA provisions. They pointed out that the number of companies offering fully insured plans dropped for the first time last year from 58 to 46 percent.

District of Columbia

Exchange board receives public comments on standards for participating plans

The public comment period ended this week for health plans and stakeholders to provide guidance to the Insurance Subcommittee on the requirements for qualified health plans (QHPs) that will participate in the new Health Benefits Exchange. The October 29th bulletin specifically sought comments on whether the oversight board's standards for certification of QHPs are overly burdensome, sufficiently captures the needed data, and what QHP requirements would help improve plan certification.

The board used the list of QHP application elements suggested by the Obama Administration as a starting point for the exchange. It will incorporate the recommendations from stakeholders in the QHP application forms, which will ask plans to document their licensure, accreditation and financial condition, as well as applicable quality ratings, benefit designs, and cost-sharing structures.



The exchange model chosen by the oversight board follows the “active purchaser” model already in place in Massachusetts, where board can negotiate rates and exclude plans that are not affordable. However, the District’s model also eliminates the insurance market outside the exchange and requires all small employers and individuals to purchase coverage via the exchange. Massachusetts and Vermont are the only states to have taken similar approaches (see Update for Week of May 7th).

Florida

Governor signals he may back down on exchange opposition, legislature asks for more time

Only days after insisting the election results would not alter his opposition to implementing any part of “Obamacare”, pressure from Republican lawmakers has apparently caused Governor Rick Scott (R) to at least open the door to compromise.

Several Republicans openly acknowledged last week that the loss of their legislative supermajorities and inability to repeal the Affordable Care Act (ACA) on the national level meant that they would “take a long hard look” next session at moving forward on some provisions (see Update for Week of November 5th). Senate President Don Gaetz (R) joined the chorus late last week, stating that “I don’t like this law...but this is the law, and I believe I have a constitutional obligation to carry it out.”

Republicans still maintain sizeable majorities in both chambers and could certainly override gubernatorial vetoes with some Democratic support. As a result, the Governor put out a media statement agreeing that “just saying no [to the ACA] is not an answer” and that he is at least willing to consider having the state initially partner with the federal government on a health insurance exchange.

The Obama Administration gave states until February 15th to submit their proposals for a partnership exchange (see Update for Week of November 5th). Florida no longer has the option of submitting plans for a state-based exchange by December 14th as Governor Scott returned the federal exchange grants obtained by his predecessor and has allowed state agencies to do little but study the issue of creating an exchange (see Update for Week of May 7th).

Senator Gaetz and incoming House Speaker Will Weatherford (R) circumvented the Governor this week by informing the Obama Administration that even with this extension, the legislature will need more time to decide whether to create a state or partnership exchange, or simply default to a federally-facilitated exchange. Senator Gaetz denied rumors that he was preparing to call a special session to debate exchange legislation.

Despite the Governor’s retreat, consumer advocates were not convinced that he is prepared to move forward on the exchange, as he had earlier pledged to do so if the U.S. Supreme Court upheld the law, only to reverse his position shortly after the court’s ruling (see Update for Week of July 2nd).

Despite prodding from some Republican lawmakers and stakeholders, the Governor continues to rule out participating in the Medicaid expansion under the ACA. However, new studies released this week by the Florida Center for Fiscal and Economic Policy (CFEP) and Georgetown University Health Policy Institute provided further support for the expansion, concluding that service-based employers in Florida would receive a “significant and disproportionate benefit” if the Governor participated.

According to the CFEP study, the health coverage provided to Florida workers through expanding would be valued at roughly \$14.3 billion for mostly service-related employers over ten years. However, the state’s contribution over that period would be only 4.6 percent of that total, or \$67 million per year. Georgetown’s findings meshed with this study, predicting that Florida would save up to \$100 million per year by expanding, mostly through lower uncompensated care costs.

Idaho

Governor’s working group says that case for Medicaid expansion is “overwhelmingly compelling”

The 15-member working group commissioned by Governor Butch Otter (R) recommended this week that Idaho “do something right” by expanding Medicaid pursuant to the Affordable Care Act (ACA).

The panel unanimously rejected claims that the expansion would “bankrupt” the state and instead sided with projections by two consultants commissioned by the Governor (see Update for Week of October 15th) that the state would save roughly \$284 million by participating. This includes the Idaho Catastrophic Health Care Fund that spends over \$60 million in to care for low-income childless adults that do not qualify for Medicaid.

The Spokesman-Review newspaper and Kaiser Family Foundation found earlier this fall that Idaho would save roughly \$300 million, causing several Republican lawmakers to urge the Governor to reconsider his initial opposition to expanding (see Update for Week of September 10th). A comparable analysis by the Idaho Hospital Association and University of Idaho also estimated total tax savings over the next 10.5 years at \$407.4 million. They emphasized that this would negate the need for up to \$90.3 million in local property taxes to be levied

The panel did add one caveat to their recommendation, namely that Idaho only expand Medicaid if it also designs an appropriate benefit plan that provides incentives for newly covered patients to take responsibility for their own health. The Medicaid director noted that his program already varies benefits for different populations through a federal waiver, which fits in with the approach suggested by the panel.

Medical providers on the panel insisted that this data created an “overwhelmingly compelling” case for Idaho to participate in the Medicaid expansion. While the Governor has the final call, his decision must be approved by the legislature.

Indiana

New Governor will default to federally-facilitated exchange, but will not rule out partnership

Outgoing Governor Mitch Daniels (R) informed the Obama Administration this week that he will allow a federally-facilitated exchange (FFE) to be operated in Indiana.

Daniels had agreed to leave the exchange decision to his successor after Governor-elect Mike Pence (R) urged him to oppose a state exchange prior to his election (see Update for Week of August 20th). Pence insisted again this week that Indiana should not move forward given the cost to the state and potential for the ACA to be repealed. However, now that repeal is no longer an option given the election results last week, Pence and other Republican governors are under pressure from local providers and even lawmakers within their party to create the exchange as well as expand Medicaid.

Even though Indiana's dominant health insurer, Anthem Blue Cross and Blue Shield, has remained neutral, the nation's largest lobby group for health insurers is not. America's Health Insurance Plan came out in favor this week of states creating their own exchange, arguing that they have far more "experience, infrastructure and local market knowledge to ensure exchanges are able to meet the unique needs of the populations in each state."

Pence's claims that the costs of "setting up our own exchange could be at least \$50 million per year and perhaps higher" has been refuted by the Urban Institute, Kaiser Family Foundation, and others. However, the Governor-elect remains adamant that "there is no evidence that this investment will improve the lives of Hoosiers, or will lower the cost of health insurance." Despite this opposition, he specifically did not rule out partnering with the federal government at a future date.

Nearly 638,000 people are expected to enroll in the exchange, according to estimates from the Indiana Family and Social Services Administration.

Maine

Governor refuses to budge on ACA opposition despite losing legislative control

Governor Paul LePage (R) officially refused this week to create the state-based health insurance exchange authorized by the Affordable Care Act (ACA), ensuring the Maine will default to a federally-facilitated exchange in 2014.

Despite his early support for an exchange (see Update for Week of October 31, 2011), the Governor flatly rejected the urging of some Republican lawmakers as well as provider and business groups to move forward

on at least a partnership exchange with the federal government, stating “I’m not lifting a finger...we’re going to let Mr. Obama do a federal exchange. It’s his bill.” However, Democrats now control both chambers and need the support of only a handful of moderate Republicans to override any gubernatorial vetoes of exchange-authorizing legislation (see Update for Week of November 5th).

The Republican-controlled legislature did pass legislation last session authorizing an exchange that does not comply with the ACA (see Update for Week of April 16th).

Mississippi

Insurance commissioner defies Governor, submits blueprint for state-based exchange

Insurance Commissioner Mike Chaney (R) submitted his plan this week for Mississippi to operate the state-based health insurance exchange authorized by the Affordable Care Act (ACA).

An advisory board created by former Governor Haley Barbour (R) designed the exchange, which will follow the more passive “clearinghouse” model already in place in Utah. The commissioner has long supported a state exchange over defaulting to a federally-facilitated exchange (FFE), arguing that it would ensure state input and control over exchange functions and help Mississippi consumers secure the information necessary to make intelligent purchasing decisions.

The move was opposed by current Governor Phil Bryant (R), who insists that the online marketplace for the uninsured and small business workers is just a “large entitlement program” that would allow a federal government “takeover” of state healthcare programs. The Governor also refuses to participate in the Medicaid expansion under the new law, even though the Kaiser Family Foundation has estimated that Mississippi would only have to spend \$1 on the expansion for every \$23 it receives in federal matching funds. Senator Hob Bryan (D) decried the Governor’s decision this week, pointing to studies by the University of Mississippi and Center for Mississippi Health Policy showing that it would not only deny coverage to 300,000-400,000 residents but cost the state at least 9,000 in new health sector jobs that would be created by the expansion (see Update for Week of October 22nd).

Commissioner Chaney, who also complied with the federal government’s essential health benefits directive over the Governor’s objections, insists that despite a lack of authorizing legislation or executive order, he has the authority to create the exchange within the non-profit agency administering the state high-risk pool. Senator Buck Clarke (R), who authored the provision cited by the commissioner, supports this decision (see Update for Week of October 8th).



New Mexico

Governor moves forward on state exchange she previously vetoed

Governor Susana Martinez (R) notified the Obama Administration this week that New Mexico will create a state-based health insurance exchange that complies with the Affordable Care Act (ACA).

The Governor's exchange blueprint, which must be submitted for federal approval by December 14th, seeks to create the exchange within the New Mexico Health Insurance Alliance, a non-profit public corporation created in 1994 to provide coverage for small businesses and some uninsured individuals. The Alliance is funded by an assessment on health insurers.

The Governor had already pledged to create the exchange after the U.S. Supreme Court upheld the ACA (see Update for Week of July 2nd). However, her exchange support has previously wavered.

Governor Martinez vetoed exchange-authorizing legislation last spring (see Update for Week of April 11th) even though she initially supported the bill and had directed the Department of Human Services to use the state's \$34 million federal exchange establishment grant to design the exchange in consultation with the Office of Health Reform (OFR). She also abruptly suspended the bidding process, resulting in the resignation of her OFR director (see Update for Week of March 26th)

The Department of Human Services Secretary insisted this week that the Martinez Administration has remained committed to creating a state-based exchange and just wanted to ensure that their efforts would not be in vain should the law be overturned or repealed.

The state Attorney General is currently reviewing whether the Governor can create the exchange within an existing non-profit without authorizing legislation and avoid a battle with Democrats who now control both chambers. Senator Dede Feldman (D) has already objected to the lack of consumer and employee representation on the Alliance's governing board. She also questioned whether the limited number of uninsured served by the Alliance would comply with ACA standards.

Over 250,000 New Mexicans are expected to purchase coverage in the exchange by 2020, as nearly 20 percent of the state remains uninsured.

Ohio

Governor will default to federally-facilitated exchange, opt-out of Medicaid expansion

Lieutenant Governor and Department of Insurance director Mary Taylor (R) announced this week that Ohio will not create a state-based health insurance exchange authorized by the Affordable Care Act (ACA) or participate in the law's Medicaid expansion.

The move comes as little surprise given her strident opposition to the ACA. Governor John Kasich (R) was also one of the first Republicans postpone all implementation and “wait and see” if the new law would be overturned or repealed (see Update for Week of September 12, 2011).

Ohio has little choice at this stage but to default to a federally-facilitated exchange as it did not apply for any federal exchange establishment grants in 2011 or 2012 and has done little but study the issue over that time. Governor Kasich did use the initial \$1 million federal exchange grant obtained by his predecessor to contract with both Milliman and KPMG consultants to assess the costs of implementation. However, these studies were criticized for using unrealistic estimates to claim that a state exchange would increase individual plan premiums by up to 85 percent (see Update for Week of September 19th) and impose up to \$63 million in start-up costs (see Update for Week of October 10th).

Governor Kasich was also one of the first Republican governors to announce he would “opt out” of the ACA Medicaid expansion shortly after the U.S. Supreme Court gave states discretion to do so without penalty (see Update for Week of July 2nd).

South Carolina

Medicaid director seeks \$194 million in additional funds, but not for ACA expansion

The Medicaid director issued a preliminary budget request this week seeking nearly \$194 million in additional funds for next fiscal year in order to pay for the costs of the Affordable Care Act (ACA) and adjust for inflation and the loss of tobacco settlement funds.

According to Director Tony Keck, the new federal health insurance reforms will cause Medicaid rolls to jump by nearly three percent as those who are eligible but not enrolled come out of the “woodwork”, along with individuals seeking to escape the new federal tax penalty for not buying health insurance they can afford. Combined with higher medical costs, he estimates that this will increase the Medicaid budget by \$70 million.

Keck's figures do not reflect costs of creating a state-based health insurance exchange or expanding Medicaid. Governor Nikki Haley (R) has insisted since last summer that she will not move forward on either provision of the ACA.

South Dakota

Governor defaults to federally-facilitated exchange, delays decision on Medicaid expansion

Governor Dennis Daugaard (R) notified the Obama Administration this week that South Dakota will default to a federally-facilitated exchange (FFE) instead of creating a state health insurance exchange that complies with the Affordable Care Act (ACA).

The move came as little surprise, as the Governor has hinted since early fall that he believed the exchange would impose unnecessary costs on the state. However, his decision on participating in the ACA's Medicaid expansion remains very much in doubt as he faces pressure to expand from the South Dakota State Medical Association as well as the Association of Health Care Organizations.

These physician and hospital groups insist that at least 48,000 uninsured residents would be left behind if the Governor opts out of the expansion, as allowed by the U.S. Supreme Court (see Update for Week of June 25th). These uninsured would impose even greater uncompensated care costs on South Dakota hospitals (which exceeded \$89 million in 2010), as federal disproportionate share payments will be phased down under the ACA starting in 2014.

Governor Daugaard says that he remains open to expanding Medicaid, but only after the Obama Administration responds to letters from the Republican Governors Association detailing how much flexibility they will be afforded, especially for partial expansions (see Update for Weeks of August 6th and 13th). His Administration is also conducting its own study on how much the expansion will cost the state. As a result, he has ruled out participating in 2014, but indicated that he may opt in by 2015 or 2016.

Neighboring Wyoming, which considered both a regional exchange with South Dakota and a federal partnership, has also elected to default to a FFE. Although Wyoming lawmakers have formed a committee to consider a partnership exchange at a later date, Governor Matt Mead (R) has already ruled out any Medicaid expansion (see Update for Weeks of August 27th and September 4th).

Texas

Senate Democrats introduce bills to expand rate review and Medicaid

Senator Rodney Ellis (D) introduced S.B. 85 this week, which would require prior approval by the Department of Insurance of any double-digit increase in health plan premiums. The Department would have the authority to reject proposed rate hikes that are excessive, inadequate, or unfairly discriminatory.



Senator Ellis also filed S.J.R. 8 calling for a constitutional amendment that would require Texas to expand Medicaid to all populations eligible for federal matching funds under the Affordable Care Act (ACA). A separate bill introduced by Rep. Lon Burnam (D) (H.B. 59) would amend state law to allow local hospital districts, counties, or other local government entities to apply directly to the federal government for approval to expand Medicaid contingent on their ability to use local tax funds for the state's share. Several Texas counties have previously expressed an interest in doing so if Governor Perry (R) holds to his pledge to opt-out of the ACA expansion (see Update for Weeks of August 27th and September 4th).