

Health Reform Update – Weeks of December 3 and 10, 2012

CONGRESS

CBO confirms that ACA does authorize premium tax credits in federally-facilitated exchanges

The Congressional Budget Office (CBO) dealt a blow this week to Republican lawmakers' efforts to impede the employer mandate under the Affordable Care Act (ACA) by challenging the authority of federally-facilitated exchanges (FFE) to offer the same premium tax credits available in state exchanges.

Conservative groups and the Oklahoma Attorney General have filed several lawsuits insisting that the ACA statute does not allow for low-to-moderate income participants in FFEs to receive these tax credits (see Update for Weeks of July 23rd and 30th). Because penalties on employers are triggered if only one full-time employee enrolls in an exchange due to unaffordability of their employer plan, conservatives hope to negate these penalties in the 20 states that are expected to default to FFEs.

House Oversight and Government Reform Committee Chairman Darrell Issa (R) hounded the Internal Revenue Service commissioner all summer for concluding that his agency has the legal authority to offer FFE tax credits (see Update for Week of September 10th). However, CBO sided with the commissioner in concluding that earlier versions of the ACA that CBO scored had always made the tax credits available in every state, and that at no point did Congress ever indicate that it intended to limit the credits only to states that create their own exchanges.

CBO affirms that greater drug utilization is tied to lower health costs

A Congressional Budget Office (CBO) study released last week estimated that a one percent increase in the number of prescriptions filled by Medicare beneficiaries causes Medicare spending to fall by roughly 0.2 percent. CBO examined at least eight studies assessing the impact drug policies on medical expenditures before and after Medicare Part D came online in 2006, as well as the impact of drug policies outside of Medicare. Its findings agreed with drugmaker claims that a growing body of published evidence shows greater use of pharmaceuticals can reduce the use of medical services such as hospital care.

As a result, CBO now projects that Affordable Care Act (ACA) provisions closing the Part D coverage gap will cost only \$51 billion by 2022, instead of \$86 billion, as prescription drug use will increase by about five percent by 2018. It is not yet clear if this \$35 billion in net savings will be reflected in the ongoing negotiations to craft a deficit reduction package that averts the "fiscal cliff".

Senate Republicans, Chamber of Commerce seek delay in comment period for ACA regulations

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The lengthy rules implementing key provisions of the Affordable Care Act (ACA) such as essential health benefits (EHB), insurance exchanges, risk adjustment and reinsurance (see below), and other market reforms were all released within one week of each other. In separate letters to HHS, the lawmakers and Chamber point out that several of these rules were completed and formally approved by agency administrators 4-6 months ago, but deliberately held until after the November election.

The letters complain that releasing all of these regulations en masse “for political reasons” shortchanges the ability of stakeholders to properly analyze them and craft comprehensive response. They urge HHS to give stakeholders the same 4-6 month delay to submit comments.

The Director for the Center for Consumer Information and Insurance Oversight (CCIIO) within HHS stated this week that the agency was unlikely to grant the request.

FEDERAL AGENCIES

Supreme Court agrees to resolve constitutionality of “pay for delay” generic drug settlements

The U.S. Supreme Court announced this week that it will resolve this term whether “pay for delay” patent litigation settlements with generic competitors violate federal antitrust law.

The high court refused last term to intervene in a Second U.S. Circuit Court of Appeals decision upholding drug manufacturer settlements that pay a generic competitor to delay introduction of a cheaper alternative (see Update for Week of March 7, 2011). Both the Second and 11th Circuits found these settlements not to be anti-competitive so long as the generic drug was not delayed beyond the expiration of the patent. However, a contrary Third Circuit decision last summer created a split that can only be resolved by the Supreme Court (see Update for Week of July 16th).

The Federal Trade Commission (FTC) has sought for over a decade to ban “pay for delay”, which it insists cost consumers \$3.5 billion per year in unnecessarily higher drug costs. The Congressional Budget Office has estimated that banning the practice could save \$4.8 billion over the next ten years (see Update for Week of November 7th), as the number of such settlements have recently spiked (see Update for Week of October 24, 2011). However, legislation to outlaw the settlements has repeatedly been blocked by Republicans and Democrats from congressional districts with a heavy drug industry presence, despite the support of President Obama (see Update for Week of April 23rd).



CMS finally releases more key details on federally-facilitated exchange

The Centers for Medicare and Medicaid Services (CMS) has started to release long-awaited guidance on the operation of the federally-facilitated exchange (FFE) that will operate in states electing not to create their own health insurance exchange or enter into a federal partnership.

States now have until December 14th to submit blueprints for a state exchange and February 15th to seek approval for a partnership exchange. Many governors had complained that they were unable to make this decision without additional details from CMS on the structure of the FFE. Health plans likewise were unable to decide on whether to participate in the FFE.

CMS has released this information in “bits and pieces.” Agency officials confirmed this week that the FFE will initially follow the “clearinghouse” model enacted in Utah in which all plans that meet minimum federal standards may participate (see Update for Week of September 24th). A new “frequently asked questions” document also emphasized that the FFE’s role and authority will be limited to certifying and managing the participating qualified health plans that will be sold in the exchange. States will retain the lead role in “insurance regulation, oversight and enforcement.”

Proposed regulations released last week (see below) disclosed that health plans will have to pay a monthly user fee equal to 3.5 percent of premium charges to sell coverage in the FFE. The fees will support the federal exchange’s consumer assistance, outreach, and advertising, as well as enrollment operations. However, they will not count towards a plan’s administrative expenses, which are capped by the new medical-loss ratios (MLRs) imposed by the ACA.

Health plans will have until April to filing applications for the FFE, while CCIIO will assume responsibility for building a website and 24-hour call center to operate the online marketplace. The document does not indicate if the website and call center will be run by CCIIO staff or contractors.

CCIIO confirmed that they have finishing designing the federal data hub that state exchanges and the FFE will use to confirm the citizenship, income, and eligibility of applicants. States initially will not be charged for using this data hub, at least through 2014 (see Update for Weeks of November 19th and 26th).

CCIIO indicated that additional guidance on the FFE would be forthcoming, but would not commit to a deadline. They also did not indicate if FFE guidance would eventually be codified in regulation.

States that choose to provide some services to a federal exchange may in some circumstances be reimbursed for their costs, according to the document. They can seek funding if they develop a data system that works in tandem with the FFE, help transfer plan information from the state insurance department to the FFE, and perform other activities to support exchange operations.



Entities that receive federal grants to be FFE navigators must successfully take part in a CCHIO training and certification program. The number of navigators per state will depend on how many apply and how much grant funding is available. An announcement is expected early next year.

New ACA regulations seek to stabilize premiums through risk-adjustment payments

The Department of Health and Human Services (HHS) published three more proposed regulations in the December 7th Federal Register that build upon earlier regulations implementing the market reforms under the Affordable Care Act (ACA). They focus largely on the following areas:

Premium Stabilization Programs: The first set of rules govern the “risk adjustment” payments that protect health plans who have to cover a large number of subscribers who are sicker and more costly than average. Under the new proposal, insurers with lower-risk patients would provide payments to those with costlier, high-risk subscribers once the guaranteed issue mandate goes fully into effect in 2014.

These risk adjustment payments are a permanent feature. But the proposal also includes details on two temporary three-year reinsurance and risk corridor programs to help prevent premium spikes by health plans as a large number of people with pre-existing conditions transition into the individual market.

Even though a final rule last March laid out the regulatory framework for these programs, employers and insurers appeared caught off-guard by the amount of a “sleeper” fee under the new rule that would fund the \$25 billion reinsurance program. HHS announced that the fee works out to \$63 per subscriber in 2014 and will phase down each year until 2017 when it expires.

The fee will be assessed on all “major medical” insurers, including individual and employer plans (large employers will pay it directly). America’s Health Insurance Plans praised CMS’ effort to stabilize the market with the fee and mitigate dramatic cost increases for consumers. However, Republicans, insurers, and employers largely decried it as a “hidden tax”. During a House hearing this week, CMS officials emphasized that the fee is not a part of the Internal Revenue Code and thus not a tax.

HHS will maintain \$20 billion of the \$25 billion, while the remainder will go to the Treasury Department to shore up the ACA’s temporary reinsurance program for early retirees that went into effect in 2010.

MLR program: HHS wants to amend its prior medical-loss ratio (MLR) regulations to specify how issuers are to account for payments or receipts for risk adjustment, reinsurance, and risk corridors. The rules will also alter the timing of the annual report and distribution of rebates required of insurers who fail to meet the MLRs, in order to account for the premium stabilization programs.



Premium and Cost-Sharing Subsidies: The new rule proposes standards for advanced payments of the ACA's premium tax credit and cost-sharing reductions. It will allow a health insurance exchange to make advance determinations of tax credit eligibility for individuals. Advance payments will be made monthly to the issuer of the qualified health plan (QHP) in which the individual is enrolled.

OPM rule gives multistate health plans more flexibility on essential health benefits

The Office of Personnel Management (OPM) is accepting public comments through January 5th on proposed regulations issued last week that give multistate plans a choice in terms of the essential health benefits (EHB) they must offer starting in 2014.

The Affordable Care Act (ACA) requires that OPM contract with at least two multistate health plans (at least one of which is a non-profit). These plans must cover a minimum set of EHB, as is the case for all non-grandfathered individual and small group plans. However, because the Obama Administration gave states latitude to define their own EHB package (see Update for Week of October 1st), multistate plans potentially would have been required to vary their EHB package in every state.

To avoid this predicament, OPM will allow multistate plans to offer an EHB package that either substantially follows a state's EHB benchmark plan for the state in which it is operating or any EHB benchmark chosen by OPM that is based on one of the three largest plan options in the Federal Employee Health Benefit Program. In response to insurance commissioner concerns that multistate plans will have an advantage over other plans sold in state exchanges, OPM is specifically seeking comment on whether this allowance of an OPM benchmark option disrupts state level playing fields.

OPM's multistate plan proposal does not allow an issuer to use a state EHB benchmark plan in some states and an OPM-chosen benchmark in others. The issuer's benefits package, including its prescription drug list, must be submitted to OPM to be approved.

Per the ACA, multistate plans must be operating in 60 percent of states in the first year of an issuer's IRS issues final rule on new ACA fees for cost-effectiveness research

The Internal Revenue Service (IRS) issued final regulations in the December 5th Federal Register implementing the fee imposed on health insurers and self-funded plans to fund the Patient-Centered Outcomes Research Institute (PCORI) created by the Affordable Care Act (ACA).

Starting for plan years ending on or after October 1, 2012, health plans must pay the new fee to fund \$3 billion in research that will test whether various drugs, tests, and treatments work better than lower cost alternatives. The PCORI will use these funds to present evidence on effectiveness to physicians and doctors and allow them to continue making treatment decisions. Because such cost-effectiveness studies have become a political lightning rod inspiring fears of "government death panels", the final rule emphasizes that the ACA specifically prohibits the PCORI using their research to make Medicare and Medicaid coverage determinations.



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The final rule large follows the proposed rule (see Update for Week of April 9th) by setting the fee at \$2 (or \$1 for policy years ending before October 1, 2013) multiplied by the average number of lives covered under the policy or plan. For policy or plan years that end on or after October 1, 2014, the fee is increased based on increases in the projected per capita amount of national health expenditures.

The final rule applies the PCORI fee to retiree-only policies but not HIPAA-excepted benefits. IRS did not agree with commenter requests that PCORI fees apply only once with respect to individuals covered under more than one policy.

IRS proposes regulations implementing new Medicare taxes for high-earners

The Internal Revenue Service (IRS) published proposed regulations in the December 5th Federal Register that implement two new Medicare taxes under the Affordable Care Act (ACA) starting in 2013.

Under the new rules, employers will be responsible for collecting the 0.9 percent increase in the FICA payroll tax during the pay period in which annual wages exceed \$200,000. Unlike the general Medicare tax, there is no employer matching FICA amount on this Additional Medicare Tax.

The ACA also imposes a 3.8 percent non-payroll tax on investment income for those earning more than \$200,000 per year. As with the Additional Medicare Tax, this tax on investment income applies only to income in excess of the \$200,000 threshold and is not capped.

SSA adds 35 diagnoses to Compassionate Allowances Program

Rare diseases compromise the majority of the 200 conditions now under the Compassionate Allowance program, which started in 2008 with only 50 diagnoses but expands each year based upon input from the National Organization for Rare Disorders and other patient advocates and medical experts. It was last updated last spring when 52 conditions were added (see Update for Week of April 23rd).



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The fast-track review has enabled over 200,000 applicants to receive a decision within 10-15 days, instead of months or years. The new conditions published on the SSA website include Adult Non-Hodgkin Lymphoma, Malignant Gastrointestinal Stromal Tumor, and Phelan-McDermid Syndrome.

STATES

Obama Administration will not allow partial Medicaid expansions

The Centers for Medicare and Medicaid Services (CMS) issued a “frequently asked questions” document this week that responds to several questions posed by Republican governors in the wake of the U.S. Supreme Court decision allowing them to opt-out of the Medicaid expansion under the Affordable Care Act (ACA) without penalty (see Update for Week of July 2nd).

Many Republican governors had sought only to expand Medicaid to those earning up to 100 percent of the federal poverty level (FPL), instead of 133 percent as required by the ACA. Since premium tax credits under the ACA start at 100 percent of FPL, this would prevent a potentially huge subset of residents from being not only uninsured but ineligible for the premium assistance offered by the new law. This gap could be huge for roughly a dozen southern states that the Urban Institute identified as having “bare bones” Medicaid eligibility—as low as only 24 percent of FPL for working adults in Alabama (see Update for Weeks of November 19th and 26th).

However, CMS insisted that the ACA statute simply “does not provide for a phased-in or partial expansion” meaning that the Medicaid expansion is literally an “all or nothing” proposition for states. Those that expand to 133 percent of FPL will receive a full federal match through 2016, while those that expand to lower amounts will receive nothing but their standard matching rate.

CMS notably did not rule out partial waiver requests starting in 2017, when the federal match begins phasing-down to 90 percent by 2020. The guidance suggests that states may be able to get a higher federal match for partial expansions at that time, though less than the rate for full expansion states.

According to Avalere Health, nine states (all with Republican governors) have firmly declared that they will opt-out of the Medicaid expansion (AL, GA, LA, ME, MS, OK, SC, SD, TX). Republican governors in seven others (IN, IA, NE, NV, NJ, VA, WY) are leaning towards opting out while three others (AZ, FL, WI) have backed-off earlier pledges to opt out and are evaluating cost projections (see Update for Weeks of November 19th and 26th).



Republican lawmakers in Maine, Nebraska (below) and Texas hinted that they are reconsidering their Governor's opposition to the expansion and could have enough votes to override a veto.

Figures from the Kaiser Family Foundation show that Medicaid enrollment will increase by 4.3 million among the opt-in states, compared with 5.3 million who not be covered by Medicaid in the states that are currently opting out (roughly 1.8 million of which reside in Texas).

CMS has not set a deadline for a decision and will allow states to opt in or out at any time. However, states will not receive full federal funding for the expansion if they wait until the federal match starts to phase down in 2017 (see Update for Weeks of August 6th and 13th).

Six states are the first to receive federal approval to operate their own ACA exchanges

The Department of Health and Human Services (HHS) announced this week that the first six states to apply for exchange certification were conditionally approved.

These states (Colorado, Connecticut, Massachusetts, Maryland, Oregon, and Washington) are on track to meet all federal deadlines for creating the state-based health insurance exchange authorized by the Affordable Care Act (ACA). This includes enrolling participants in October 2013 and starting exchange operations in January 2014.

Massachusetts already had an existing exchange and simply needed to make additional changes to comply with the ACA version. Connecticut, Maryland, and Washington were among the six states that have already received Level Two Establishment Grants from CMS for being the furthest along in exchange design and infrastructure (see Update for Week of August 20th). CMS officials indicated that other states including California, Rhode Island, and Vermont were likely to soon be approved.

At least 19 other states and the District of Columbia declared their intent to create a state exchange in advance of the December 14th federal deadline, while six are seeking approval to initially partner with the federal government. Indiana, Ohio (see below), Pennsylvania, Tennessee, and Virginia joined the remaining states this week in opting to default to a federally-facilitated exchange.

Study finds that drug coverage varies widely under state benchmarks for essential benefits

Basic coverage of prescription drugs will vary greatly nationwide due to the different benchmark plans that states selected to define essential health benefits (EHBs).

The Obama Administration punted the politically-sensitive task of defining the minimum benefit package that all individual and small group plans must cover starting in 2014 pursuant to the ten broad categories set by the Affordable Care Act (ACA). States had until September 30th to identify one of four types of health plans as a benchmark to define their EHB package (see Update for Week of October 1st).

Although the deadline has since been extended to December 26th (see Update for Weeks of November 19th and 26th), a new report from Avalere Health shows that prescription drug coverage under the initial selection made by most states varies widely, from only 45 percent of available drugs in some states to as much as 99 percent in others. Some states will require health plans to cover all available FDA-approved drugs, while others will require coverage for only about half of such medications.

Arizona, Connecticut, New Hampshire and Virginia are among the states with the most generous coverage, while California, Maryland, Michigan and Wisconsin have benchmark plans that cover only 45-76 percent of available drugs.

California

Federal appeals court clears way for Governor to reinstate ten percent Medicaid payment cut

The Ninth U.S. Court of Appeals reversed a lower court decision this week that had barred California from cutting Medi-Cal rates, even though the reduction was federally approved (see Update for Week of January 30th). A three-judge panel determined that the U.S. Department of Health and Human Services has the authority to decide whether a rate cut would threaten access to care for Medicaid beneficiaries and thus violate federal Medicaid law.

The ten percent across-the-board cut in 2011 was expected to save \$623 million annually, but was bitterly opposed by providers and consumers who had already experienced similar cuts in years prior. It is not yet clear that Governor Jerry Brown (D) will reinstate them as California's budget crisis is projected to be alleviated by the two statewide tax initiatives approved last month by voters (see Update for Week of November 5th). In addition, the Affordable Care Act (ACA) will temporarily increase Medicaid reimbursement for primary care physicians starting January 1st (see Update for Week of October 29th).

Colorado

Exchange board pledges that costs will remain below federal exchange, other state exchanges

The new Colorado Health Benefit Exchange will cost \$22-26 million a year, according to estimates by the board that will oversee its operations.

Colorado is currently using \$62 million federal grants for start-up costs. However, all state exchanges created pursuant to the Affordable Care Act (ACA) must be self-sufficient by 2015. As a result, the board is debating whether to raise revenue through advertising, new taxes on insurers, or user fees charged to exchange participants.



Board members insist that because they have taken a “very conservative approach to the exchange regarding staffing and services”, the exchange will cost less to operate than other states with comparable populations. They note that Oregon’s exchange expects to spend \$34 million per year, while Maryland’s annual tab should be \$35 million (see below) while Minnesota projects at least \$54 million.

Even if the Colorado exchange does not impose user fees, board members pledged that exchange costs will be lower than the federally-facilitated exchange, which will charge a 3.5 percent user fee on monthly premiums according to recent federal regulations (see above).

Colorado was one of the first six states this week to receive preliminary federal approval for their exchange (see above).

Florida

Tea-party protests force Senate panel to solicit public input on ACA through website

After a raucous first meeting last week, the Senate Select Committee on the Patient Protection and Affordable Care Act has unveiled a new website to allow the public to more effectively voice their comments about Florida’s potential implementation of the Affordable Care Act (ACA).

Under pressure from Republican leaders, Governor Rick Scott (R) slightly moved away last month from his long-standing opposition towards ACA implementation. Senate President Don Gaetz (R) formed a legislative committee to debate two key decisions, namely whether to default to a federally-facilitated health insurance exchange or forgo billions in federal assistance to expand Medicaid (see Update for Weeks of November 19th and 26th).

The move drew the ire of tea-party activists who dominated the initial hearings with loud demands that the legislature continue to “nullify” the ACA by resisting all implementation. As a result, Senator Gaetz created the website at <http://www.flsenate.gov/topics/ppaca> to “ensure that citizens who cannot travel to Tallahassee are [also] able to play a meaningful role in the process.”

Idaho

Governor becomes fifth Republican to create an ACA-compliant exchange

Governor Butch Otter (R) notified the Obama Administration this week that Idaho will create a state-based health insurance exchange that complies with the Affordable Care Act (ACA).



The move makes Otter one of only five Republicans to create a state exchange. Republican governors in Iowa, New Mexico, and Nevada have done likewise, while the Republican insurance commissioner in Mississippi is creating a state exchange over the objections of Governor Phil Bryant (R).

The Governor has steadfastly opposed “tea party” efforts to “nullify” the ACA by resisting all implementation, insisting that simply defaulting to federal control was not in the best interests of Idaho. He has repeatedly threatened to implement the exchange via executive order after Republican lawmakers blocked authorizing legislation (see Update for Week of July 9th), and may need to promptly do so in order to make the “substantial progress” by January 2013 that is required for federal certification.

State consultants indicated last fall that Idaho had run out of time to meet this federal deadline. However, other consultants headed by a former Centers for Medicare and Medicaid Services Administrator Mike Leavitt insisted that Idaho could still use its \$30 million in federal exchange establishment grants to meet the deadline if it acted aggressively (see Update for Week of October 29th). Leavitt Partners and National Association of Insurance Commissioners consumer representatives stated this week that state could have a shell of the customizable online portal up and running in 90 days and the remaining technology infrastructure in place shortly thereafter.

A 15-member working group commissioned by Governor Otter overwhelmingly recommended that he take a “pragmatic approach” and create the exchange (see Update for Week of October 29th), as well as expand Medicaid (see Update for Week of November 12th).

Kansas

CMS approves transition to Medicaid managed care

Governor Sam Brownback (R) announced this week that federal officials have given Kansas the green light to move all Medicaid enrollees into three managed care plans starting on January 1st.

The Governor insists that the new KanCare plans will provide better health care more efficiently while about saving about \$1 billion over the next five years based on projected savings for similarly broad Medicaid managed care expansions in states like Arizona, Florida and Tennessee. However, his KanCare initiative has been beset by concerns from AARP and other consumer groups that it would erode quality of care, compelling the Governor to delay the transition of developmentally disabled enrollees by at least one year (see Update for Week of April 23rd). Kansas was also forced to withdraw its initial application last spring as the Centers for Medicare and Medicaid Services (CMS) found it did not get sufficient public input from impacted state agencies (see Update for Week of August 20th).

Each Medicaid consumer has already been pre-enrolled in one of the three plans, but they can switch to a different plan any time before April 4th.

Maryland

Council recommends user fees, higher tobacco taxes to fund new health benefit exchange

The Health Reform Coordinating Council recommended this week that the Maryland Health Benefit Exchange impose a combination of user fees and new taxes in order to fund the projected \$35 million annual cost of the new online marketplace (called Maryland Health Connection).

State exchanges created pursuant to the Affordable Care Act (ACA) must be self-sufficient by 2015. The legislature and Governor Martin O'Malley (D) must ultimately decide next session whether to create the new fees just for exchange participants or hike rates for all in-state consumers. They may also raise the state's tobacco tax by 18 cents, which the council predicts will cover \$21 million of the exchange's annual operating costs.

Though plans and providers likely would pass the new fees down to consumers, the exchange will increase competition and ultimately lower costs, according to the council report. An average of 198,000 individuals and small business workers are expected to purchase coverage in the exchange ever year, for a cost of roughly \$16.75 per person in 2015.

Maryland was one of six states to receive preliminary federal certification this week (see above).

Nebraska

Republicans may override gubernatorial veto of Medicaid expansion

Senator Jeremy Nordquist (D) pledged this week to introduce legislation at the January 8th outset of the next legislative session that will authorized Nebraska to participate in the Medicaid expansion under the Affordable Care Act (ACA).

The move is opposed by Governor Dave Heinemann (R), who promptly opted-out of the expansion after the U.S. Supreme Court gave states the flexibility to do so, claiming it would cost Nebraska \$766 million over ten years (see Update for Week for June 25th). However, Nordquist insists that he has enough Republican support to override the Governor's promised veto. Senator Kathy Campbell (R), chair of the Health Committee, has already backed Nordquist's bill.

Although Nebraska's unicameral legislature is technically non-partisan, there are 17 Democrats and two independents that caucus with Democrats. That means Democrats would need at least 11 Republican votes to get the 30 needed to override a veto.

Republicans did join with Democrats to override the Governor's veto earlier this year of SCHIP coverage of prenatal care for undocumented immigrants. Nordquist argues that if Republicans were willing to buck the Governor on an issue as controversial as immigration, they would certainly do so for legislation that will save Nebraska \$325 million in uncompensated care costs by 2019 and create 10,000 new jobs (see Update for Week of August 20th).

Nevada

Governor becomes first Republican to participate in Medicaid expansion under ACA

Governor Brian Sandoval (R) became the first Republican governor this week to agree to participate in the Medicaid expansion under the Affordable Care Act (ACA).

The Governor stated that while he remains opposed to the new law, accepting the federal funds to add 78,000 Nevadans to Medicaid will immediately save Nevada \$17 million that it would otherwise spend from the general fund on mental health programs. Over the first three years, Nevada will also receive \$712 million from the federal government while spending only \$67 million. According to the Urban Institute, Nevada is one of the states that will benefit the most from the ACA expansion due to its exceptionally high uninsured rate and relatively low Medicaid eligibility.

Sandoval is only one of only three Republican governors that are creating the state-based health insurance exchange under the ACA or seeking approval for a federal partnership.

New Jersey

Governor vetoes exchange-authorizing legislation for second time

Governor Chris Christie (R) vetoed renewed legislation this week that would have created a state-based health insurance exchange that complies with the Affordable Care Act (ACA).

The move comes as a slight surprise in that the Governor initially supported a state exchange and obtained \$7.6 million in federal grants to create one. Governor Christie also indicated that he would support a state exchange after the "screwy" U.S. Supreme Court decision upheld the entire law, only to later hint that he favored defaulting to a federally-facilitated exchange due to a lack of sufficient guidance (see Update for Week of October 1st).

However, the version twice passed by the Democratic-controlled legislature follows the "active purchaser" model from Massachusetts where the exchange board can selectively contract only with those health insurers who offer the best value. Conservatives largely favor the more passive "clearinghouse" model where any plan that meets minimum standards can participate.



The Governor initially vetoed the measure last spring (see Update for Week of May 7th). Democrats resurrected a modified bill that limited insurer representation on the exchange board and eliminating the option to create a Basic Health Plan under the ACA (see Update for Week of October 1st).

He insisted this week that he would not commit state taxpayers to an exchange that would likely be “extraordinarily costly”. As a result, New Jersey will default to a federally-facilitated exchange.

Ohio

Governor cedes exchange control to federal government, except for navigator function

The Republican-controlled House passed H.B. 613 last week, which authorizes the state to create a navigator program that will guidance individuals and small business employees through the health insurance exchange created by the Affordable Care Act (ACA).

Democrats questioned the move as Governor John Kasich (R) decided to simply default to a federally-facilitated exchange (FFE), instead of creating a state-based exchange. Republicans have blocked exchange-authorizing legislation (H.B. 412) from moving forward.

It is very unclear whether the Obama Administration will approve the arrangement since the navigator program is under federal control under the FFE. Governor Kasich has not sought approval for an initial federal-state partnership that would allow Ohio to retain control over certain exchange functions.

All state exchanges are required to create a navigator program, which will guide individuals and small business employees through the process of applying, enrolling, and selecting plans.