Health Reform Bulletin

Week of September 24, 2012

The Congressional Budget Office (CBO) released a report last week that revises upward the number of Americans expected to pay a penalty for not obtaining health insurance as required under the Affordable Care Act (ACA). The CBO estimates that as of 2016 nearly 6 million Americans will be on the hook for the penalty, an increase of 2 million over previous estimates. The increase is due to legislative changes made since 2010, changes in the economic outlook that are expected to mean a higher unemployment rate, and an increase in the projected rate of uninsured due to a relaxing of the ACA's Medicaid expansion requirement – related to the U.S. Supreme Court's ACA decision in June. The penalty is expected to result in the collection of about $8 billion per year in 2017 through 2022.

Federal

The Senate sent to the White House a fiscal 2013 spending extension that will fund the government for six months. With an October 1 deadline looming, the continuing resolution was the last must-pass measure for lawmakers to address before returning to the campaign trail. The measure, which the president is expected to sign soon, will extend spending through March 27 and increase levels for most programs and agencies by about 0.6 percent. Following this action, the House and Senate recessed for campaigning and will return the week of November 12 for the lame-duck session.

States

With the October 1 deadline approaching by which states must notify HHS of their **essential health benefits (EHB),** state activity on the EHB front has increased significantly. For example, in the Northeast/Mid-Atlantic states, we expect Connecticut, Washington D.C., Maryland, Massachusetts, New York and perhaps even New Hampshire, New Jersey and Pennsylvania to finalize their essential health benefits this week. Several states' exchange boards will be voting on the EHB recommendations this week. Finally, many of the states that are actively implementing a state-based exchange are working closely with HHS on their readiness preparations.

INDIANA: The Family and Social Services Administration (FSSA) has released an updated study on Medicaid expansion under the ACA that adds cost estimates to a version developed last October. The Milliman study projects state and federal costs for the following four scenarios: 1) no expansion ($612 million); 2) eligibility expanded to 100 percent of the federal poverty level ($1.7 billion), 3) eligibility expanded to 133 percent FPL ($2.04 billion), and 4) full ACA expansion ($2.5 billion). The cost projections are based on what will be incurred once federal matching funds decrease, capitation adjustments necessary to

offset new premium taxes, and projected enrollment. According to the data, full implementation of the expansion would increase the state's Medicaid population by 500,000 over what is expected to occur without expansion. The Health Finance Commission and Interim Study Commission on Insurance met last week to hear from the governor's administration on implementation options for a state exchange and the cost impact of the various Medicaid expansion scenarios. But no decisions are expected on these matters until after the election.

LOUISIANA: The Louisiana State Medical Society filed suit last week seeking an injunction to block the implementation of the Department of Insurance Emergency Rule 26, which suspends certain statutes and regulations pertaining to claim filings, non-renewals, cancellations, premium payments and other insurance matters. The rule was issued in the wake of Hurricane Isaac. The LSMS contends that the Commissioner used "a natural disaster as a guise to circumvent the legislative process."

MINNESOTA: Governor Mark Dayton reaffirmed his desire for a state-run health insurance exchange in a letter to legislative leadership last week, but he emphasized that critical policy decisions would be delayed until after the November elections. He also announced that he was shifting the responsibility for exchange development from the Department of Commerce to the Department of Management and Budget. Dayton wrote of his continuing goal for a state-run exchange with public/private governance. He also noted the urgency of acting to avoid being assigned to a "one-size-fits-all federal exchange." The governor said that Minnesota will meet the November 16 deadline for filing a state exchange "blueprint" with the federal government. He went on to note that the flexibility of the federal approval process will allow the state to request conditional approval in November, and then make important policy decisions concerning financing and governance early in the 2013 legislative session.

NEVADA: The Silver State Health Exchange Board voted unanimously to recommend three potential benchmark plans to Commissioner Scott Kipper for consideration as the state's Essential Health Benefits plan. The plans are Health Plan of Nevada, Public Employee Benefit high-deductible plan and the Hometown Health HMO. The board and the Plan Certification and Management Advisory Committee reviewed the benefits, riders, formularies, the federal employee dental and vision plans and the CHIP dental plan as part of the selection process. Key factors considered were the inclusion of state mandates, comprehensiveness of coverage, affordability and potential market disruption.

OKLAHOMA: Two months after a ruling from the U.S. Supreme Court seemed to strike down the state's challenges to the ACA, Oklahoma Attorney General Scott Pruitt has amended his lawsuit to raise new complaints. Pruitt said Oklahoma now has the only active lawsuit against the ACA seeking to hold the federal government accountable for how it implements the health care reform law. The amended lawsuit complains that the Internal Revenue Service has issued rules to implement the ACA that overstep and directly conflict with "unambiguous language" in the act itself – a reference to the health insurance exchange requirement. The amended suit challenges IRS rules that would make Oklahoma's large businesses liable to pay a penalty or tax if their employees sign up for health care through a federally established health care exchange. State officials have said they are unlikely to pursue establishment of

a state-based exchange. The challenge is now in federal court in Muskogee, Oklahoma.

WASHINGTON: The Office of the Insurance Commissioner (OIC) adopted a permanent rule last week designating the Regence Blue Shield Innova small group policy as the state's "benchmark plan" for defining "essential health benefits" under the ACA. For Washington, essential health benefits will be defined as every benefit contained in the Regence plan, those identified by Health and Human Services and all benefits mandated by the state on or before December 31, 2011. Numerous state-mandated benefits include the state's "every category of provider" law banning “discrimination” against health care practitioners by class as well as detailed standards for insurance coverage of diabetes services. Washington has a long history of enacting laws to promote access to particular health care practitioners.

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