

Health Reform Update – Week of September 24, 2012

CONGRESS

HHS assures Senate Finance that federally-facilitated exchange is on schedule

The Department of Health and Human Services (HHS) insisted this week that it will meet the January 2014 deadline to have a federally-facilitated exchange (FFE) operating in states that elect not to create the state-based health insurance exchange authorized by the Affordable Care Act (ACA).

HHS was compelled to publicly respond by a letter from Senate Finance Committee ranking member Orrin Hatch (R), who complained that states still lacked the federal guidance needed to decide whether to create their own exchange or default to a FFE. In particular, Senator Hatch chided HHS for not publishing any detail of what the FFE will require before the November 16th deadline imposed by their earlier guidance (see Update for Week of May 14th).

HHS has stated that the FFE will follow the “clearinghouse” model already established in Utah, where any plan that meets minimum standards can participate. However, the additional guidance promised by the agency has yet to materialize.

The letter from Senator Hatch details his specific concern that the delayed guidance will not adequately estimate the cost to states for operating the exchange, since the ACA requires state-based exchanges to be self-sustaining by 2015. However, HHS has yet to comment apart from assurances that the FFE will begin as scheduled in January 2014.

The Republican Governors Association also sent a follow-up letter this week to HHS demanding answers to their outstanding questions on the Medicaid expansion under the ACA, to which the agency has yet to fully respond (see Update for Weeks of August 6th and 13th).

Four in ten American adults still believe Affordable Care Act includes “death panels”

The latest Associated Press (AP)-GfK survey revealed that nearly 40 percent of adults still believe the Affordable Care Act (ACA) will create “death panels” to decide whether patients can access life-saving care—the same percentage as in 2009.

The widely-refuted notion was first espoused by Alaska Governor Sarah Palin (R), who coined the phrase to refer to a provision in the ACA that allowed physicians to receive Medicare reimbursement for counseling patients and family members about their options for end-of-life care. The provision was ultimately removed from the final draft of the legislation.

Even though the claim was dubbed the “Lie of the Year” by PolitiFact, it was resurrected by Governor Palin shortly before the U.S. Supreme Court upheld the constitutionality of the ACA (see Update for Week of June 25th). The former vice presidential nominee now claims that the law’s Independent Payment Advisory Board (IPAB) will make “life or death decisions about healthcare funding” for Medicare enrollees.

House Republicans have repeatedly voted to repeal the panel of “faceless bureaucrats” that is charged with making recommendations on Medicare cuts whenever Medicare spending exceeds a statutory target (see Update for Week of March 19th). Their recommendations will automatically go into effect if Congress does not pass equivalent cuts.

As with the “death panel” claims, opposition towards the new law remains largely constant, declining only by only four percentage points since the initial AP surveys following the ACA’s enactment. However, 88 percent of those surveyed believe the law will be fully enacted now that it has been upheld by the high court.

Confusion over the law’s requirements remains high, as only a mere 14 percent of surveyed adults could correctly identify its primary provisions.

The monthly tracking poll released this week by Kaiser Family Foundation showed that preserving Medicare trailed only the economy and federal budget deficit as voter priorities this fall. A majority of those surveyed (55 percent) want Medicare to remain in its current form, while only 37 percent favor the “premium support” model passed by House Republicans (see Update for Week of April 9th). Support for the status quo is strongest among those aged 55 and older (67 percent), even though this group would not be impacted by the proposal from the Republican presidential nominee to give Medicare enrollees premium subsidies to purchase private plan coverage.

FEDERAL AGENCIES

HHS awards exchange establishment grants to five more states

Five more states received federal grants this week to build the state-based health insurance exchanges authorized by the Affordable Care Act (ACA).

Federal regulations require that states make “substantial progress” towards an exchange by January 1st or default to a federally-facilitated exchange (see article above). Although only about 13 states have officially informed the Department of Health and Human Services (HHS) that they intend to create their own exchange, 34 states and the District of Columbia have now obtained exchange establishment grants. All but one state (Alaska) obtained the initial \$1 million exchange planning grant.

Arkansas, Colorado, Kentucky, Massachusetts, and Minnesota received the one-year grants (which exceeded \$40 million for Colorado, Massachusetts, and Minnesota). It was the second Level One grant for both Kentucky and Minnesota, whose governors are implementing the exchange via executive order in order to circumvent legislative opposition.

The \$72 million awarded to the District of Columbia was only the seventh Level Two grant issued by HHS. Connecticut, Maryland, Nevada, Rhode Island, Vermont, and Washington have previously received Level Two grants, which are given to those states that are the furthest along in the process of creating an exchange (see Update for Week of August 20th).

HHS emphasized that states may apply for grants through the end of 2014 and may use funds through the initial start-up year. The ACA requires all exchanges to be self-sustaining as of 2015.

OPM relaxes standard for multistate exchange plans in effort to generate more interest

The Office of Personnel Management (OPM) revealed this week that health insurers that agree to participate in multi-state exchange plans will initially be allowed to cover only part of a geographic area.

At least two multistate plans must be offered in each state-based health insurance exchange created by the Affordable Care Act (ACA), one of which must be non-profit. OPM, which administers the Federal Employee Health Benefit Program (FEHBP) exchange, released a draft application this week for multi-state plans that intend to participate.

OPM invited public comments on the application by October 22nd. In an effort to recruit several large national insurers, the agency has agreed to relax the ACA definition of a multistate plan, which requires the insurer to offer the plan “in all geographic regions”. So long as plans can provide a legitimate

rationale that is non-discriminatory and in the best interest of subscribers, the application states that they may be permitted to cover a smaller geographic area in 2014.

Although the FEHBP is a model of the exchange concept, the ACA explicitly says that insurers who participate in FEHBP are not required to offer a multistate plan.

Analysts suggest that insurers have shown little interest in multistate plans to date because regulations relating to some of the consumer protections in the exchange have yet to be published by HHS, such as essential health benefits, actuarial value, and other market reforms. The draft application itself acknowledges that four key sets of regulations needed by prospective plans are still “forthcoming”. For example, a proposed rule relating to multistate plans themselves has been awaiting paperwork clearance from the Office of Management and Budget since July.

ACA mandate for “plain English” insurance summaries goes into effect

Final regulations went into effect this week that require private health plans to provide subscribers with a Summary of Benefits and Coverage (SBC).

The four-page “plain English” summaries of plan limitations and benefits were mandated by the Affordable Care Act (ACA) and are now accessible at www.healthcare.gov for individual plan subscribers. Those in large and small group health plans can access them during their next open enrollment period.

The SBCs should allow consumers to make “apples to apples” comparisons of different plans and prevent key coverage details from being buried in the fine print of plan documents (see Update for Week of February 6th). They must also include “coverage facts labels” giving standardized examples of what each plan will cover for two of the most common covered benefits, maternity care and type 2 diabetes.

Initial versions of these labels were fiercely resisted by health plans and employers, who insisted that premium and out-of-pocket costs for their most common procedures cannot be succinctly condensed into a single brief form in such a short timeframe. As a result, the final rules watered down earlier requirements to make them less burdensome, much to the consternation of consumer advocates. However, the Health and Human Services did not budge on the ACA requirement that they apply to all plans, regardless of whether the new law allows them to be “grandfathered” from other reforms (see Update for Week of May 14th). The final rule also did not exempt companies that self-insure.

America’s Health Insurance Plans stated this week that they were pleased with the changes, including the six-month delay in the effective date until September 23rd. However, they continued to insist that the new rules are overkill that will only increase plan costs.

Polls conducted by the Kaiser Family Foundation and American Cancer Society Network continue to show that the user-friendly summaries are among the most popular provisions of the ACA.

No sign of promised regulations from CMS on essential health benefits

The Centers for Medicare and Medicaid Services (CMS) has yet to send promised regulations on essential benefits to the Office of Management and Budget, suggesting that the Obama Administration may be content to delay publication of the politically-sensitive rules until after the November elections.

The Affordable Care Act (ACA) requires individual and small group plans to cover a minimum set of “essential health benefits”, both in and outside of the new health insurance exchanges created by the new law. However, CMS made the surprise move last winter by “punting” the thorny task of defining essential benefits to the states (see Update for Week of December 12th).

Subsequent guidance required states to select a “benchmark” plan by September 30th for defining essential benefits, subject to certain criteria (see Update for Week of February 20th). An initial set of

proposed regulations indicating that CMS would designate the small group market plan and product with the largest enrollment for states that failed to do so (see Update for Weeks of May 28th and June 4th).

However, the Center for Consumer Information and Insurance Oversight within CMS had promised states as recently as July that additional proposed rules to further guide states in making this decision were imminent. Since the required paperwork clearance from OMB can take 30-60 days or more, the lack of any pending regulation with OMB appears to suggest that CMS may be holding off on publishing the new rules until the election has passed.

Colorado (see Update for Weeks of August 27th and September 4th), Connecticut (see Update for Weeks of July 23rd and 30th), Maryland and Michigan (see below), New Mexico, as well as Utah and Vermont (see Update for Weeks of August 6th and 13th) are among the states that are proceeding in the absence of these regulations—three of which have Republican governors. However, many other states like Kansas (see below) and West Virginia (see below) are opting instead to simply “wait and see” for the outcome of the November elections before making any ACA implementation decisions.

Medicare prescription drug plans to see sharp rise in premiums for next year

Seven of the top ten Medicare prescription drug plans will impose a double-digit increase in premiums for 2013; while Part D plans overall will increase by an average of six percent according to an analysis released this week by Avalere Health consultants.

Subscribers in the Humana Walmart Preferred RX Plan (with over 1.5 million Part D enrollees) will see the highest increase of 23 percent for an average premium of \$18.50. The second-highest increase among the top ten plans belongs to First Health Part D Value Plus, rising 17 percent to \$29.75.

Avalere did not speculate on the cause of the premium spike, although an unrelated study this week from the Health Care Cost Institute found that health care spending is again on the rise despite a two-year lull due largely to patients foregoing needed care during the recession (see article below).

The spike in Part D premiums contrasts with the Federal Employees Health Benefits Plan, which will see only a 3.4 percent average increase for 2013 (see Update for Week of September 17th). It is a reversal from a trend that saw overall health insurance premiums rise by only an average of four percent in 2012, down from a nine percent increase in 2011 (see Update for Week of September 10th).

HEALTH CARE COSTS

After two year lull, private health insurance costs are surging again thanks to higher prices

A report released this week by the Health Care Cost Institute found that spending on private health insurance grew at an accelerated rate in 2011, breaking a two-year trend of smaller cost increases.

Private plan spending surged 4.6 percent in 2011 as compared to only 3.8 percent growth in 2010. Per the Institute, subscribers spent an average of \$4,547 as compared to \$4,349 the year prior.

The Institute largely attributed the recession for the slowdown in spending growth, as Americans increasingly postponed needed care due to cost (see Update for Week of September 17th). However, its report emphasizes that the higher costs in 2011 are not due to increased post-recession utilization but rather price increases for hospitals and prescription drugs (the latter of which spiked by 17.7 percent).

The findings mesh with earlier studies by the Urban Institute and others showing that the United States leads the world in health care spending solely because of higher prices, not greater utilization.

Large firms drop health coverage in favor of exchange subsidies

Sears Holdings and Darden Restaurants announced this week that they will drop employee health insurance once the employer mandate under the Affordable Care Act (ACA) goes into effect and instead give employees subsidies to purchase coverage in the new health insurance exchanges.

Sears did not announce a start date for its 90,000 full-time workers. However Darden will not wait for the employer mandate to begin in 2014. As of January 1st, it will give its 45,000 full-time employees an annual contribution towards exchange coverage, which will increase as health care costs rise.

Prior analyses by the Urban Institute, Deloitte Consulting, and the Congressional Budget Office have all found that large employers like AT&T could save up to 75 percent of their health insurance costs by simply dropping employee coverage in 2014 and paying the \$2,000 per full-time employee assessment under the ACA. However, these studies all conclude that employers were not likely to do so for competitiveness concerns, as it would greatly harm their ability to attract and retain employees. Instead, they predicted that employers would follow the path chosen by Sears and Darden, which is to offer annual contributions so that workers could obtain more comprehensive and affordable coverage through an exchange (see Update for Week of August 6th and 13th).

The Urban Institute concluded that only those employers with a large number of workers earning below 250 percent of the federal poverty level would benefit from discontinuing employee coverage entirely (see Update for Week of March 12th).

Employers will not have to pay the ACA assessment so long as they offer employee coverage that meets ACA standards for affordability and minimum value. Employees who decline group coverage that meets these standards are also ineligible for the premium tax credits to help defray the cost of an exchange plan. As a result, the Urban Institute et al. have concluded that employees are not likely to simply drop company plans in favor of exchange plans, nor is the ACA otherwise expected to contribute significantly to the decade-long erosion of employer-based coverage (see below). However, the Employee Benefits Research Institute notes that other studies dispute this finding (see below).

Employment-based health insurance continues to decline

The latest report released this week by the Employee Benefits Research Institute (EBRI) confirms that employment-based insurance continues to decline as enrollment in public programs grows.

The study by the non-partisan private institute emphasized that employers continue to have strong incentives to provide employee coverage in order to remain competitive as health insurance remains the workplace benefit most sought by employees. However, it notes that conservative groups warn that the employer mandate under the ACA will cause employers to dump worker coverage en masse (see above).

EBRI's survey of census data found that employer-based coverage for working age adults fell to 58.4 percent in 2011, a dramatic drop from 69.3 percent in 2000. The downward trend occurred despite a drop in the uninsured for the first time since 2007 (see Update for Week of September 10th). (Only seven percent of working-age adults bought health coverage in the individual market as of 2011.)

Full-time employment remains the number one indicator of employer-sponsored coverage. The report found that nearly 72 percent of people in families with a full-time worker had some form of employer coverage compared to a mere 34 percent of those in families with no full-time workers.

The size of the employer is also a critical factor. According to EBRI, 61 percent of all uninsured workers are self-employer or work for companies with less than 100 employees.

The erosion in employer-coverage correlates directly to a spike in public plan enrollment. Over 22.5 percent of working-age adults are now enrolled in Medicare, Medicaid, or other government plan compared to only 14.1 percent in 1999.

STATES

Arizona

Non-partisan institute says Arizona would save billions; create jobs if it expands Medicaid

A report released this week by the non-partisan Grand Canyon Institute concludes that Arizona would save \$1.2 billion over the next four years and create more than 20,000 jobs if it participates in the Medicaid expansion under the Affordable Care Act (ACA).

Governor Jan Brewer (R) has not yet decided whether to exercise the flexibility afforded by the U.S. Supreme Court and opt-out of the Medicaid expansion without penalty, choosing instead to wait for further federal guidance before including her recommendation as part of her budget proposal next January (see Update for Week of July 23rd). However, the Institute's report strongly urges the Governor to accept the 100 percent federal funding through 2016, and at least 90 percent thereafter, emphasizing that the state will reap "huge economic benefits" as a result.

For example, the Institute projects that Arizona will bring in \$5 from the federal government for every \$1 it spends to expand Medicaid eligibility to those earning up to 133 percent of the federal poverty level, saving the state more than \$1.2 billion from its general fund over four years. It also estimates that the 21,000 jobs added by the expansion would reduce the state's unemployment rate by 0.7 percent in the first year alone, resulting in a full percent growth in the state economy.

The findings mesh with earlier analyses from the Urban Institute and Kaiser Family Foundation (see Update for Weeks of August 6th and 13th), as well as local state entity reports in Arkansas (see Update for Week of July 16th) Idaho (see Update for Week of September 10th), Nebraska (see Update for Week of August 20th), and New Mexico (see Update for Week of September 17th).

California

Business leaders launch website explaining ACA benefits for small employers

California business leaders launched a website this month that is intended to "cut through the political rhetoric" and provide an unbiased explanation of how the Affordable Care Act (ACA) will affect small businesses.

The www.healthguideforbusiness.org site was created with an \$180,000 investment by the California Endowment, a private foundation devoted to making health insurance affordable. It provides information on health plan enrollment, small business tax credits to buy employee health insurance, and wellness and prevention programs, as well as an entire text of the ACA.

The Pacific Business Group on Health, Small Business Majority, and various state and local chambers of commerce were among the business groups creating the site content.

Kansas

Governor refuses insurance commissioner choice of benchmark plan for essential benefits

Insurance Commissioner Sandy Praeger (R) publicly released her proposal this week to require health plans to offer at least the same benefit package as the small group plan provided by Blue Cross and Blue Shield (BCBS) of Kansas.

All states are required to identify their “benchmark” plan for defining the “essential health benefit” package required by the Affordable Care Act (ACA). Those that fail to do so by September 30th will have a default plan assigned for them by the U.S. Department of Health and Human Services (HHS) (see Update for Weeks of May 28th and June 4th).

Commissioner Praeger, a moderate Republican who chairs a National Association of State Legislatures (NCSL) taskforce on implementing the ACA, urged Governor Brownback to move forward on the essential benefit package as part of creating a state-based health insurance exchange. Although the default option selected by HHS is likely to be the identical BCBS plan recommended by Praeger, she emphasized that it was important for Kansas to ensure market stability to identify the level of benefits that plans must provide in and out of the exchange. She also stressed that failing to move forward on exchange implementation by November 16th will cause Kansas to cede all control over the exchange to the federal government (see article above).

Despite the Commissioner’s prodding, the Governor reiterated this week that he will not make any implementation decisions (on essential benefits, the exchange, or Medicaid expansion) until after the November elections indicate whether Republicans can repeal all or part of the ACA. As a result, he will not seek federal approval of the benchmark plan chosen by the Commissioner.

Louisiana

New Orleans wants to expand Medicaid even if Governor does not

City officials for New Orleans announced this week that they may follow the lead of Texas counties that are seeking to expand Medicaid even if their state does not.

Governor Bobby Jindal (R) is among the dozen governors that promptly announced they would exercise the flexibility granted by the U.S. Supreme Court and “opt out” of the Medicaid expansion required by the Affordable Care Act (ACA) (see Update for Week of July 9th). However, the Health Commissioner for New Orleans acknowledged that she was discussing with the federal Centers for Medicare and Medicaid Services (CMS) whether the city’s existing federal demonstration waiver could be amended and extended to allow it to expand Medicaid just for city residents with incomes up to 133 percent of the federal poverty level. New Orleans already provides free or reduced cost preventive care to uninsured residents under the waiver that is set to expire in 2014.

The Secretary for the Department of Health and Hospitals insisted that only his agency can approve such an expansion since it administers Medicaid for all state residents. However, the Health Commissioner points out that it is federal Medicaid law that requires all state counties operate under the same Medicaid eligibility standards and thus only the federal government can approve or reject a request to waive that provision.

The six most populous counties in Texas are already seeking an analogous waiver (see Update for Weeks of August 27th and September 4th).

Maine

Consumer advocates say that “free market” health insurance reforms are raising premiums

A report issued this month by Consumers for Affordable Health Care concludes that the rollback of consumer protections enacted by Governor Paul LePage (R) have increased health insurance premiums for Maine residents, although the Bureau of Insurance disagrees.

The Governor fulfilled a campaign pledge last year by successfully pushing through legislation to eliminate the state-subsidized universal health care plan (see Update for Week of June 20, 2011), as well as weakening the state’s rate review authority and community rating laws limiting how much premiums

could vary for age and health status (see Update for Week of May 16, 2011). He also repealed the ban on unfair practices by pharmacy benefit managers (PBMs) and the 15-year ban on insurers requiring rural residents travel only to Bangor or Portland for care (see Update for Week of June 13, 2011).

The “free market” reforms were intended to lower costs through increased competition. However, Bureau of Insurance rate filings showed that shortly after the new law (L.D. 1333) took effect, premiums soared by as much as 90 percent (see Update for Week of October 3, 2011).

Insurance regulators largely attributed this initial spike to the fact that Maine has the oldest population, and health plans could now charge the elderly more than 500 percent more than younger and healthier subscribers. However, the analysis by Consumers for Affordable Health Care argued that the jump in premiums was far from a short-term aberration among just the elderly. Over the course of the past year, the study found that 54 percent of individual policyholders and 90 percent of small groups experienced premium increases.

The law’s co-author, Rep. Les Fossel (R), insists that the analysis is premature because all of its provisions have yet to go into effect, most notably the allowance for out-of-state insurers to sell plans that need not comply with Maine insurance regulations. However, a similar law in Georgia has yet to attract any interstate health plans (see Update for Week of April 9th).

Rep. Fossel also cited Bureau of Insurance figures showing that “100 percent” of individual policyholders saw premium hikes in prior years and that the rate of increase has been more limited since the new law went into effect. Furthermore, he notes that over ten percent of small groups actually saw slight premium decreases, as compared to only three percent before the law was passed.

However, Consumers for Affordable Health Care pointed out the decreases only occurred in plans with large number of younger workers that were concentrated in the more populous southern part of the state. They used these figures to amplify the premium increases among older subscribers that occurred after age rating restrictions were relaxed.

Maryland

Health reform council selects state employee plan as essential benefit benchmark

The Maryland Health Care Reform Coordinating Council voted this week to choose the state employee health plan as the “benchmark” for defining the essential health benefits that all individual and small group plans must cover starting in 2014.

The Centers for Medicare and Medicaid Services (CMS) “punted” the politically-sensitive task of defining essential benefits under the Affordable Care Act (ACA) to the states, which are required to select a “benchmark” by September 30th or CMS will select a default plan for them (see Update for Week of February 20th). Most states have elected to move forward even though promised regulations on the process have yet to be published by CMS (see article above). The 16-member Council reviewed ten different health insurance options before deciding that the state employee plan offered the best balance between comprehensive coverage and affordability.

The selection stirred some controversy as it includes coverage for chiropractic and acupuncture services not included in the essential benefit packages chosen by other states. The state employee plan is also more costly than small group and HMO plans in Maryland because it includes coverage for expensive infertility procedures. However, the Council rejected competing alternatives because they did not adequately cover services they deemed more essential, such as hearing aids and speech therapy.

The Council did vote to allow health plans to substitute services of similar costs for in vitro fertilization. However, CMS guidance has yet to establish any standards for substituting services. In the interim, the Maryland Insurance Administration will do so.

Massachusetts

Temporary regulations relax gift ban even more than sought by legislature

The Department of Public Health (DPH) issued temporary regulations last week that go beyond the recent state law relaxing restrictions under the Massachusetts Pharmaceutical and Medical Device Manufacturer Code of Conduct.

The so-called “gift ban” enacted in 2010 imposed the strictest restrictions in the nation on drug and device manufacturer payments to physicians and providers. It went far beyond the new federal restrictions under the physician sunshine provisions of the Affordable Care Act (ACA).

The “gift ban” faced heavy opposition from the Pharmaceutical Research and Manufacturers of America, claiming it forces pharmaceutical companies to leave Massachusetts (see Update for Week of July 12, 2010). Some initial evidence caused the Democratically-controlled House to twice vote to repeal the entire ban (see Update for Week of April 30th). Senate Democrats ultimately agreed to slightly relax the ban last summer (see Update for Week of July 9th).

The H.B. 4100 law signed by Governor Deval Patrick (D) only allowed manufacturers to provide “modest meals and refreshments” at certain clinical events if they are fully disclosed. However, the new DPH regulations removed any restrictions on the cost of the meals, the setting in which they can be provided, or even whether alcohol can be served.

The DPH regulations would also end all disclosure requirements as well as the \$2,000 annual fee on companies that funded the database. Because the Affordable Care Act (ACA) requires manufacturers to make similar disclosures of payments to physicians and providers, H.B. 4100 had removed the requirement that manufacturers duplicate this disclosure. However, it had required that DPH publicize the data disclosed to the federal government on the DPH website.

Consumer advocates and the Prescription Reform Coalition criticized DPH for refusing to meet with them prior to issuing the temporary regulations or incorporating any of their recommendations.

Michigan

Consumer group seeks to modify proposed benchmark for essential health benefits

At least one consumer health group is dissatisfied with the benchmark plan that the Office of Financial and Insurance Regulation (OFIR) proposes to use to define the “essential health benefits” all individual and small group plans must cover starting in 2014.

Michigan Consumers for Healthcare (MCH) insists that the designated benchmark plan does not fulfill the categories of coverage required by the Affordable Care Act (ACA) because it fails to provide the same coverage for mental health services as for other care. They are urging Governor Rick Snyder (R) to adjust or reject the benchmark plan now that the public comment period on the proposal closed this week.

Under federal guidance issued last winter, states must select a benchmark plan for defining essential benefits by September 30th (see Update for Week of February 20th). However, the federal Centers for Medicare and Medicaid Services (CMS) can modify any benchmark that does not meet standards outlined in agency guidance or the ACA (see Update for Weeks of May 28th and June 4th).

Pennsylvania

House Republicans seek to ban Medicaid expansion under Affordable Care Act

Rep. Stan Saylor (R) introduced legislation this week that would prohibit any voluntary expansion of coverage authorized by the Affordable Care Act (ACA).

H.B. 2631 is targeted at the law's Medicaid expansion, which sought to require a uniform eligibility level for those with incomes up to 133 percent of the federal poverty level starting in 2014. The U.S. Supreme Court recently gave states the flexibility to "opt out" of this expansion without penalty, which at least a dozen Republican governors have already stated they would do (see Update for Week of July 9th).

Governor Tom Corbett (R) has indicated that he would first assess the costs of the Medicaid expansion before deciding whether to accept the enhanced federal funding to expand. However, legislative approval would ultimately be required should he decide to participate.

Rep. Saylor's measure was promptly cosponsored by 35 other House Republicans and assigned to the Health Committee.

South Carolina

Governor accused of pushing pre-determined decision on Medicaid expansion

Consumer advocates charged Governor Nikki Haley (R) this week with manipulating cost estimates in order to satisfy her intent not to expand Medicaid pursuant to the Affordable Care Act (ACA).

The U.S. Supreme Court granted states the flexibility to opt-out of the Medicaid expansion under the new law, without penalty (see Update for Week of July 25th). Governor Haley was among a dozen Republican governors who quickly announced that they would do so (see Update for Week of July 9th).

However, these Governors have been under pressure from hospital associations to accept the enhanced federal match to expand Medicaid, which according to the Congressional Budget Office will fund 93 percent of the expansion costs through 2020 and at least 90 percent thereafter. Because Congress expected the expansion to be mandatory for all states, the ACA gradually phases down the disproportionate share payments that hospitals receive for treating indigent patients, starting in 2014. Thus, uncompensated care burdens for hospitals will dramatically increase in states that do not expand.

To support their opposition, several Republican governors have attempted to cite cost estimates from Milliman Consulting and other groups that claim the costs of the expansion will "bankrupt" individual states. However, Kaiser Family Foundation, the Urban Institute, RAND, et al. have all documented that these studies rest on the faulty assumption that 100 percent of newly-eligible populations will enroll in Medicaid (see Update for Week of July 2nd). Based on past Medicaid expansion, the Urban Institute predicts that only 57-70 percent will actually enroll and that the enhanced federal match combined with lower uncompensated care costs will save South Carolina alone roughly \$59-678 million from 2014-2019.

As a result, safety net providers along with the South Carolina Small Business Chamber of Commerce are complaining that the Governor is playing "partisan politics" by refusing to expand. A state health care consultant went so far as to call the Governor's cost predictions "cheese and baloney" that are being used to satisfy a pre-ordained political objective.

Supporters of the expansion note this is not the first time the Governor has been accused of doing so. E-mails obtained last winter by local newspapers found that Governor Haley had similarly directed her own exchange task force to conclude that creating a health insurance exchange was too costly to implement, even before cost figures were obtained (see Update for Week of December 19th).

Virginia

Urban Institute says Virginia would save up to \$25 billion over eight years by expanding Medicaid

A recent report by the Urban Institute concludes that Virginia would save at least \$15-25 billion from 2014 to 2022 if it participates in the Medicaid expansion under the Affordable Care Act (ACA).

Governor Bob McDonnell (R), who heads the Republican Governors Association (RGA), was among the first of the governors to announce that they will exercise the flexibility afforded them by the U.S. Supreme Court to “opt out” of the Medicaid expansion without penalty (see Update for Week of July 2nd). He insists that states simply cannot move forward without additional federal guidance that the RGA has yet to receive (see Update for Weeks of August 6th and 13th).

However, according to the Urban Institute, Virginia would be among the prime beneficiaries of the Medicaid expansion, which will bring in up to \$28.2 billion in federal matching funds by 2022 while costing the state no more than \$2.8 billion. In addition, Virginia safety net providers would see greatly reduced burdens for uncompensated care as 400,000 new enrollees would be added to Medicaid, or roughly a 40 percent expansion of the program.

West Virginia

Governor playing it safe on essential health benefits, exchange, or Medicaid expansion

Despite pending federal deadlines, Governor Earl Ray Tomblin (D) has yet to play his hand on how West Virginia will define essential health benefits that all plans must cover under the Affordable Care Act (ACA) or if it will create the state-based health insurance exchange authorized by the new law.

As a Democratic governor in an increasingly conservative state, consumer advocates acknowledge that it would be politically difficult for the Governor to implement any provision of an unpopular “Obamacare” law in an election year. As a result, they anticipate that he will simply let the thorny decision of defining essential benefits default to the federal Centers for Medicare and Medicaid Services (CMS). Earlier CMS guidance indicated that the agency will designate the most popular small business plan for any state that fails to identify their benchmark plan by September 30th (see Update for Week of February 20th).

However, the Governor’s decision on the health insurance exchange is more problematic. West Virginia was among the first handful of states to pass legislation authorizing the creation of a state-based exchange, which the Governor signed. The Insurance Commissioner has also spent nearly \$1.5 million in federal exchange grants to undertake the initial steps in exchange design.

Republican lawmakers initially favored a state-based exchange over ceding all control to a federally-facilitated exchange if the state did not make substantial progress by January 2013. However, the exchange became increasingly unpopular last year among “tea party” backed lawmakers who oppose legitimizing any part of “Obamacare”. As a result, Governor Tomblin has delayed his appointments to the exchange oversight board, effectively impeding any governance decisions.

Governor Tomblin also attempted to buy himself more time to make an exchange decision by asking the federal government for more guidance on implementation issues. He must notify CMS by November 16th if West Virginia intends to move forward—only ten days after the election.

The Governor also refused to commit to participating in the Medicaid expansion under the ACA until additional federal guidance was received. However, CMS has not set a deadline for states to respond (see Update for Weeks of August 6th and 13th).

Wyoming

Lawmakers want more control over Medicaid eligibility

Seeking to avoid a situation where the Governor could unilaterally expand Medicaid, state lawmakers are drafting legislation that would require legislative approval for any change in eligibility.

Governor Matt Mead (R) has hinted that he is leaning against participating in the Medicaid expansion under the Affordable Care Act (ACA), as the U.S. Supreme Court has given all states the flexibility to “opt out”

without penalty (see Update for Weeks of August 27th and September 4th). However, he has not entirely ruled it out, stating only that he is still waiting for the Obama Administration's response to questions posed by the Republican Governors Association before making a decision (see Update for Weeks of August 6th and 13th).

Even though the Governor and Medicaid Administrator routinely seek legislative approval for eligibility changes as a matter of practice, it is not statutorily required. Fearing the Governor could choose to expand over legislative objections, Senator Charles Scott (R) announced that he will prefile legislation in November formally requiring legislative approval for any Governor to do so. Scott is the long-time chairman of the Joint Labor, Health, and Social Services Committee and insists that the legislature should have full control over a Medicaid program that constitutes the largest part of the state budget.