

Health Reform Update – Week of October 22, 2012

CONGRESS

Urban Institute study says Affordable Care Act will contain costs

A new study released this week by the Urban Institute specifically takes on critics that claim the Affordable Care Act (ACA) ignores cost containment.

Researchers agree that “more could have been done” under the new law, but note that as with the landmark Massachusetts reforms upon which the ACA was based, lawmakers sought to leave the strongest cost containment measures for later legislation. This includes a transition away from fee-for-service reimbursement to global budgets, which states like Massachusetts, Rhode Island, and Vermont have sought to put into effect over the past year (see Update for Weeks of July 23rd and 30th). However, the study notes that global budgets on the federal level may not be “politically tenable”, nor would ending the tax deduction for employer-sponsored coverage, which the Senate Finance Committee considered but declined to include in the ACA.

Despite the absence of stronger cost containment measures, the Urban Institute identifies many provisions in the ACA that it believes will reduce costs. These include the new medical-loss ratios that cap insurer profits and require consumer rebates for excessive administrative spending. In addition, the study notes that the new health insurance exchanges have the discretion to negotiate with insurers and exclude those that refuse to lower premiums and cost-sharing (even though only a handful of states have thus far elected to create this “active purchaser” model).

Researchers noted that the exchanges themselves are an example of the “managed competition” concept long sought by conservative economists. They agree that exchanges will ensure “strong competition” in the insurance marketplace but concede that it is difficult to predict the overall impact on spending as the presence of more small insurers will not automatically reduce costs if they lack the market share to force large hospital chains and other providers to lower their prices. Prior studies by The Commonwealth Fund have shown that higher provider prices (and not greater utilization) are the primary reason why U.S. health spending far exceeds all other nations (see Update for Week of May 7th).

The study points to the slower rate of growth in Medicare provider payments as another key cost containment provision in the ACA. This includes lower annual increases for private Medicare Advantage plans, in order to eliminate the 14.2 percent overpayment identified by the Congressional Budget Office in 2009, which are expected to save \$145 billion over nine years.

In addition, Medicare hospitals will receive smaller increases while disproportionate share payments for indigent care will be phased down starting in 2014 to reflect the lower uncompensated care burden that hospitals should face once 32 million uninsured Americans gain health insurance coverage. Researchers noted that the chief actuary for the Centers for Medicare and Medicaid Services (CMS) has predicted that these provisions will cut



Medicare spending by ten percent over ten years.

The study also claims that the 40 percent excise tax on high-cost employer plans will have a “significant effect” by reducing national health spending by up to 1.5 percent. The tax (which starts in 2018) will reduce the number of employers that provide more comprehensive plans than the threshold employer plan, in order to correct “perverse incentives” associated with the tax break that workers receive for employer coverage. The threshold premium level for single coverage will be \$10,200 in 2018, but \$27,500 for families, and adjusted upward in later years based on premium growth in the Federal Employees Health Benefits Plan.

Other cost-saving provisions cited by the Urban Institute include demonstrations to improve care coordination for the nine million dual eligibles that are enrolled in both Medicare and Medicaid are often receive the most costly care, as well as the accountable care organization experiment where providers can collaborate and share in the cost savings if they stay below a preset global budget.

Researchers also identified two controversial provisions that fund comparative effectiveness research and create an Independent Payment Advisory Board (IPAB) to make recommendations on Medicare payment cuts. Republican lawmakers have claimed that these provisions would lead to “rationing” although the study emphasized that the ACA statute bars either from being used to alter Medicare benefits, cost-sharing, or eligibility.

The Urban Institute did not refer to three of other cost-saving provisions touted by Congressional Democrats. The first is the new regulatory pathway for biosimilars, which for the first time will allow the Food and Drug Administration (FDA) to approve lower-cost generic alternatives to some of the nation’s highest-cost biologic drugs (see Update for Week of April 16th). The second are the new rules requiring public disclosure of manufacturer payments to physicians. The third is the enhanced rate review provisions that the Kaiser Family Foundation found this week to have reduced insurer premiums by about one-fifth since they went into effect last year (see article below).

Overall, the study concludes that while it is debatable whether “more should have been done....it is simply not accurate to argue that the law’s cost containment provisions are weak or non-existent.” It emphasizes that the ACA will save money “through a large number of different provisions related to private and public insurance.”

As it has done since 2004, Urban Institute researchers specifically refuted the claim advanced by Republican lawmakers that capping medical malpractice awards would dramatically lower health care costs. To the contrary, they found that medical liability system accounts for only 2.4 percent of all national health spending and that the \$250,000 cap on non-economic damages sought by House Republicans would only reduce spending by 0.3-0.4 of a percent. Furthermore, strict caps are outlawed by four state constitutions and have been overturned by the courts in 11 other states (see Update for Weeks of July 23rd and 30th).



Earlier Urban Institute studies have affirmed that the ACA will not lead to the job losses (see Update for Weeks of May 28th and June 4th) or decline in employer-sponsored coverage predicted by Republican lawmakers (see Update for Weeks of August 6th and 13th), nor will it increase Medicaid costs as greatly as many Republican governors have claimed (see Update for Week of July 2nd). It will also cut costs for small businesses (see Update for Week of October 8th).

House Republican budget would cut near record low Medicaid spending by 38 percent

A new study released this week by the Urban Institute and Kaiser Family Foundation found that the House Republican plan to block grant Medicaid and repeal the Affordable Care Act (ACA) would cut federal Medicaid spending by 38 percent or \$1.7 trillion from 2013-2022.

The House twice overwhelmingly passed the budget sought by vice presidential nominee Rep. Paul Ryan (R-WI) that would convert Medicaid into a lump-sum block grant with no strings attached (see Update for Week of April 2nd). However, the study predicts that it would result in 31-38 million Americans losing Medicaid eligibility while eliminating \$363.8 billion in hospital funding. Of the \$1.7 trillion overall cut in Medicaid spending, \$810 billion would result just from the block grant program.

Additional data released this week by Kaiser showed that state Medicaid spending is now at near-record lows, thanks to an improving economy. The foundation's annual Medicaid survey found that state spending grew only two percent in 2012 and states are budgeting for an average increase of only 3.8 percent in 2013, one of the lowest rates over the past 15 years.

Kaiser attributes the low growth rates to far fewer people enrolling in Medicaid than the spike that occurred during and immediately after the recession. Enrollment for all states grew by 12.7 percent from June 2009-June 2011, but was down to 4.4 percent last year and 3.2 percent this year. Provisions under the federal stimulus act and ACA also forced states to take severe measures to curb Medicaid spending as they were prevented from simply scaling back eligibility.

The low rate of Medicaid spending growth combined with unanticipated jumps in tax revenue collections continue to greatly improve strained Medicaid budgets (see Update for Week of June 11th). Only one-third of state Medicaid officials are now projecting a Medicaid shortfall in 2013, down from half who made the same projection in 2012. Ten states are even budgeting for an overall decrease in Medicaid spending next year.

A separate study released last week by Kaiser found that the House Republican budget would have increased Medicare premiums for 59 percent of enrollees had it been in effect in 2010. The Commonwealth Fund Public hospitals urge Congress to block ACA phase-down of indigent care funds

The National Association of Public Hospitals and Health Systems (NAPH) urged Congress this week to prevent the scheduled phase-down of disproportionate share (DSH) funding under the Affordable Care Act (ACA).



Public hospitals urge Congress to block ACA phase-down of indigent care funds

The National Association of Public Hospitals and Health Systems (NAPH) urged Congress this week to prevent the scheduled phase-down of disproportionate share (DSH) funding under the Affordable Care Act (ACA).

DSH payments are the only Medicaid funding stream through which states are allowed to reimburse hospitals for the money they lose in treating Medicaid and uninsured patients. However, NAPH emphasizes that these DSH payments only reimburse about half of a hospital's uncompensated care costs and have already failed to keep pace with the soaring costs of treating indigent populations.

The ACA will start to phase-down Medicaid phase-down DSH payments in 2014 until they are reduced by about half in 2019 (or \$14.1 billion). Congress put this phase-down in place under the expectation that all state Medicaid programs would be required to expand eligibility to 133 percent of the federal poverty level in 2014, thereby reducing the uninsured and the need for DSH payments.

However, at least a dozen states have already indicated that they will “opt-out” of this expansion after the U.S. Supreme Court gave them discretion to do so without penalty (see Update for Week of July 9th). The Congressional Budget Office (CBO) has estimated that this will cause 6-10 million more Americans to remain uninsured than initially anticipated (see Update for Weeks of July 23rd and 30th).

Using these CBO estimates as well as data from the U.S. Census Bureau and American Hospital Association, NAPH is now estimating the Supreme Court decision will also result in uncompensated care costs for hospitals increasing by \$53.3 billion more than expected when the ACA was enacted. For hospitals in states that “opt-out” of the Medicaid expansion, the net effect will be that the ACA actually increases instead of decreases their uncompensated care burden.

NAPH insists that this nightmare scenario will have “disastrous consequences for safety net hospital patients” in states that elect not to participate in the Medicaid expansion. State hospital associations have intensely lobbied Republican governors that are seeking to opt-out. However, NAPH is pursuing a federal legislative fix to avoid access to life-saving care from being jeopardized in those states.

House Republicans threaten third subpoena this month over ACA funds

House Republicans on the Ways and Means committee threatened to subpoena the Centers for Medicare and Medicaid Services (CMS) this week if they do not provide documents by the end of October relating to contracts awarded to firms promoting the Affordable Care Act (ACA).

The threat is the third this month from Republicans. They previously demanded documents related to the demonstration program providing bonuses to high-performing Medicare Advantage programs (see Update for Week of October 15th) as well as oversight of federal exchange establishment grants (see Update for Week of October 1st).



Rep. Charles Boustany Jr. (R-LA), chairman of the House Ways and Means oversight subcommittee, had sought documents last spring showing how CMS has spent taxpayer funds since 2008 for all “public relations, advertisements, polling and message testing” immediately after it signed a \$20 million contract with Porter Novelli to promote the benefits of the ACA. (see Update for Week of May 21st). Congressional Republicans were further annoyed when California and most recently Hawaii used funds from their federal exchange establishment grants to promote the ACA through popular television shows and CMS paid \$3 million for another public relations firm to market the federally-facilitated exchange (see Update for Week of October 1st).

The demand letter that Rep. Boustany and Rep. Dave Camp (R-MI) sent this week to CMS referred to such tactics as a “big guerrilla campaign splash.”

President insists that sequester “will not happen”, provides more specifics on “grand bargain”

President Obama flatly stated during a presidential debate this week that the across-the-board budget cuts slated for January 2nd will not happen and later pledged to pursue a “grand bargain” during the lame duck session in December that will include \$2.50 in spending cuts for every \$1 in new revenues and include reductions to federal health care programs.

The sequester was triggered after the “super committee” created by the Budget Control Act of 2011 failed to propose much less pass any recommendations for reducing the federal budget deficit by \$1.2 trillion over ten years (see Update for Week of November 7th). Congress would have to pass an equivalent deficit reduction package to avert the sequester, which will automatically cut Medicare reimbursement by two percent (though spare Medicaid and Social Security programs).

Tea-party backed Republicans scoffed at the notion that they are prepared to cave on their long-held demands that any deficit reduction package not included any tax revenue increases, noting that the President’s \$2.50 spending cut to \$1 tax hike proposal was already part of his FY 2013 budget that was rejected by both the House and Senate. However, if Congress fails to act by year end, the Bush-era tax cuts will expire and automatically impose a tax increase on all Americans.

FEDERAL AGENCIES

Enhanced rate review has curbed double-digit premium increases

A new report released this week by the Kaiser Family Foundation concludes that health insurers have made fewer “unreasonable” rate hike requests since the enhanced rate review provisions of the Affordable Care Act (ACA) went into effect last year.



Regulations implemented by the Centers for Medicare and Medicaid Services (CMS) pursuant to this part of the ACA required all individual and small group plans seeking a double-digit rate hike to publicly disclose the actuarial justification for the increase. Starting in September 2011, states were required to publish this data on their insurance department website. CMS initially assumed this role for the ten states that did not have an effective rate review process in place (see Update for Week of August 29, 2011).

Kaiser's preliminary review of this data found that one out of every five requests submitted to states in 2011 resulted in a lower rate increase or no increase at all. The average rate change requested would have led to a 6.8 percent increase in premiums. However the average increase actually implemented was only 5.4 percent, meaning that the enhanced rate review resulted in about a one-fifth reduction in premiums.

Although states can get federal approval to create their own thresholds for review should medical costs rise, CMS will not adjust any state-specific thresholds until after August 30, 2013 (see Update for Week of June 11th).

Affordable Care Act has saved Part D enrollees nearly \$5 billion in prescription drug costs

Medicare enrollees under Part D have now saved \$4.8 billion in prescription drug costs thanks to the Affordable Care Act (ACA), according to the most recent figures from the Department of Health and Human Services (HHS).

Over 5.6 million have now benefited from the drug discounts or rebates required by the new law, including over 2.3 million this year. Those who entered the Part D coverage gap or "doughnut hole" have saved an average of \$657 this year, up from the \$629 average last summer (see Update for Weeks of July 23rd and 30th).

Savings for 2012 will likely exceed last year because the discount on generic drugs provided within the coverage gap doubled from seven to 14 percent. Part D enrollees have been receiving a 50 percent discount on brand-name drugs within the "doughnut hole" since 2011.

Discounts for both brand name and generic drugs in the gap will continue to increase until 2020, when enrollees will pay the same coinsurance in and out of the "doughnut hole". CMS predicts that enrollees will ultimately save an average of \$4,200 from 2011 to 2021, thanks not only to the reduction in the "doughnut hole", but also elimination of cost-sharing for certain preventive services and restricted growth in Medicare Advantage premiums (see Update for Week of January 30th).

Nearly 21 million Medicare enrollees have now benefited from the free cost-sharing for preventive services under the ACA.



New CMS innovation center “thrilled” with interest in State Innovation Model grants

The head of the federal innovation center created by the Affordable Care Act (ACA) stated this week that he was “thrilled” with the response to a grant program announced this summer that aims to transform state health care delivery systems.

The Center on Medicare and Medicaid Innovation will award \$275 million in grants to foster collaboration among health care purchasers, employers, and government programs. The application period for the first round of grants State Innovation Model grants closed on September 17th. Up to 25 states will each get \$2 million, while the remaining \$225 million will be divided among the five states with the most promising “ready to go” state transformation models.

States that have already submitted system transformation proposals include Arkansas, Colorado, Maine, Minnesota, Ohio, Oregon, Vermont, and Washington.

The Center is using the \$10 billion allocated by the ACA to oversee the accountable care and primary care coordination demonstrations created by the new law (see Update for Weeks of May 28th and June 4th). House Republicans have consistently sought to defund the Center (see Update for Week of July 16th).

HEALTH CARE COSTS

Increasing use of generic drugs accounts for nearly all of lower health spending during recession

A new study published this week by Health Affairs documents that the percent of working age adults with medical cost burdens hardly changed during the 2007-2009 recession as families compensated for lower incomes by reducing their health care spending.

The Center for Studying Health System Change (CSHSC) defined medical cost burden as more than ten percent of annual household income being spent on out-of-pocket health care expenses. Intuitively, this number should increase dramatically during periods of high unemployment when workers lose employer coverage. However, the study found those with medical costs burdens actually declined slightly from 19.2 percent in 2006 to 18.8 percent in 2009 even though annual household incomes dropped by an average of \$4,000 over this time..

Researchers attribute this unexpected outcome solely to a change in consumer behavior during the recession. A long list of studies have documented that consumers have dramatically curbed their utilization of health services during and after the recession (see Update for Week of September 17th). CSHSC confirms this trend, noting that average out-of-pocket spending fell from \$1,454 in 2006 to \$1,231 in 2009 while national health spending growth slowed to 3.8 percent.

However, CSHSC concluded that a shift to generic drugs “accounted for virtually all of [this] decrease.” It found that out-of-pocket spending on prescription drugs fell from \$258 to \$162 per person during this period, but did not change significantly for any other health care service. Likewise, the percentage of all prescriptions filled with generic drugs increased from 35 percent in 2003 to almost 55 percent by 2008.

CSHSC also was surprised to find that average out-of-pocket spending on health insurance premiums remained steady during this time at around \$1,800 per year, reflecting that consumers increasingly switched to lower cost plans, either voluntarily or because their employer changed to more limited coverage.

These figures are in stark contrast to the acceleration in out-of-pocket spending, premiums, and medical cost burdens that occurred over the first two-thirds of the decade. Only 14.4 percent of households experienced medical cost burdens in 2001.

STATES

Health insurers resume sales of child-only coverage after state intervention

A new study published this week by the Georgetown University Health Policy Institute and The Commonwealth Fund found that 22 states and the District of Columbia have taken legislative or regulatory action to successfully restore child-only coverage to the individual health insurance market.

Individual health plans in those 22 states stopped writing child-only policies in response to the Affordable Care Act (ACA) mandate requiring guaranteed issue for children went into effect for the 2011 plan year (see Update for Week of September 20, 2010). Most states responded by enacting laws or regulations that allowed plans to offer child-only coverage only once or twice per year during open enrollment periods. This prevented parents from waiting to enroll until their children were sick or injured and thus more costly.

Although child-only coverage represents only ten percent of the individual market, at least 20 states were left without any insurer willing to offer a child-only plan. Several states like California, Kentucky, Oregon, and Washington had to rely on a stick instead of a carrot to resolve this access problem, after limiting enrollment to set periods proved to be an insufficient carrot for individual health plans to return to the child-only market. This included barring health plans from the entire individual market if they refused to write child-only coverage. Others added a reinsurance mechanism that compensated plans that incur exceptionally high costs for child-only coverage.

Only one state, California, limited the amount that insurers can charge for child-only coverage. During the open enrollment period, designated as a child’s birthday month, insurers can charge rates no more than twice as high as the “standard risk rate” that a typical healthy child would be charged. Alabama



Alabama

Governor creates new commission to reduce Medicaid costs

Governor Robert Bentley (R) issued an executive order this week creating the Medicaid Advisory Commission to evaluate how Alabama can reduce Medicaid costs that consume one-third of the state budget.

State Health Office Don Williamson, MD will chair the commission, which will consist of at least 25 lawmakers, physicians, hospital representatives, and other stakeholders. Alabama Arise will be the lone consumer advocate on the panel.

While the commission is directed to study greater efficiencies like moving Medicaid enrollees into capitated managed care plans, it also is expected to recommend that the legislature appropriate additional funding to the program. Alabama has one of the leanest Medicaid programs in the nation, excluding coverage for childless adults and most optional benefits. However, it covers 40 percent of all children in the state.

Illinois

Governor seeks approval for initial federal partnership on insurance exchange

Governor Pat Quinn (D) submitted his formal request last week to the Centers for Medicare and Medicaid Services (CMS) seeking approval for a federal-state partnership for a new health insurance exchange.

The Governor intended to create a state-based exchange that complies with the Affordable Care Act (ACA). However, he was unable to get the Democratically-controlled legislature to approve authorizing legislation last session. Given the delay, he ultimately decided that even through an executive order, the state would simply be unable to meet the January 2013 federal deadline to make “substantial progress” on a state exchange or default to a federally-facilitated exchange.

As a result, Governor Quinn decided last summer to pursue the federal-state partnership option under CMS regulations (see Update for Week of July 16th). This will allow Illinois to retain control over key exchange functions like plan management and consumer assistance until it can operate the exchange on its own in 2015.

Arkansas, Michigan, Montana, New Hampshire, and Wyoming are among the other states that are considering a federal-state exchange partnership (see Update for Week of July 2nd).

Minnesota

Governor seeks up to \$80 million in additional exchange establishment grants

Governor Mark Dayton (D) announced this week that he will seek an additional \$60-80 million more in federal exchange establishment grants to create the state-based health insurance exchange authorized by the Affordable Care Act (ACA).

The Governor became the first to attempt to circumvent legislative opposition to the exchange via executive order (see Update for Week of October 31, 2011) and is adamant that state agencies can meet the January 2013 federal deadline to make “substantial progress” and avert a federally-facilitated exchange (see Update for Week of October 8th). However, Republican lawmakers have refused to authorize any part of the exchange, including the use of the \$42.5 million federal grant that the Governor obtained last month (see Update for Week of September 24th). As a result, the Governor has been forced to postpone key exchange decisions until the November elections determine the make-up of the next legislative session (see Update for Week of October 1st).

State budget officials have estimated that the exchange will cost Minnesota between \$40-50 million to operate by 2015 but will produce savings for taxpayers (see Update for Week of October 8th).

Mississippi

Study shows economic benefit of Medicaid expansion even if most newly-eligibles enroll

A study released this week by the University Research Center concludes that the benefits of expanding Medicaid pursuant to the Affordable Care Act (ACA) would outweigh the costs to the state.

Governor Phil Bryant (R) has adamantly opposed the expansion despite the urging of state hospital associations who will face higher uncompensated care costs if he does not participate (see above). However, the Governor has repeatedly insisted that despite the 100 percent federal match through 2016 (and at least 90 percent the reafter) the expansion would cost Mississippi hundreds of millions of dollars in administrative costs.

The study confirms that Mississippi could indeed lose \$95.8 million by expanding, but only if 95 percent of the newly-eligible population actually enroll. Both the Urban Institute and Kaiser Family Foundation have criticized Republican governors for relying on such unrealistically high participation rates, insisting that past expansions demonstrate that only about 57-70 percent of newly-eligible populations actually enroll (see Update for Week of July 2nd).



Although the study claims that the 95 participation rate is “likely”, even under that scenario it concludes that the state would ultimately save money in the long term through lower uncompensated care costs and greater productivity. In addition, the expansion could create up to 9,000 jobs by 2020 in the state’s health care sector. This positive economic impact would greatly increase if only 75 percent of the newly-eligible population enrolls.

A 95 percent participation rate would expand Medicaid by nearly a third in a state where the program already covers one out of every five residents. However, researchers also point out that Mississippi traditional has one of the nation’s highest poverty and uninsured rates and is seventh in the nation in emergency room visits per 100,000 people. All of these negative figures would be greatly reduced by expanding.

Ohio

Urban Institute disputes Ohio claims that “woodwork” effect will cost Medicaid \$940 million

The administration of Governor John Kasich (R) insists that the Affordable Care Act (ACA) will add 400,000 new Medicaid enrollees in 2014 and 2015, even if the state does not participate in the Medicaid expansion under the new law.

Medicaid director John McCarthy insists that the federal mandate for everyone to buy health insurance they can afford or pay a tax penalty will force many Medicaid-eligible residents to avoid the penalty by finally enrolling. This “woodwork” effect will cost the state an estimated \$940 million over the first two years.

However, the Urban Institute and state consumer groups scoffed at the claims, noting that neighboring states of Michigan and Indiana are estimating that only 15,000 and 92,000 residents respectively will “come out of the woodwork” and enroll in Medicaid. They noted that Ohio also has a relatively low Medicaid eligibility threshold at only 90 percent of the federal poverty level.

The non-profit Michigan Center for Healthcare Research and Transformation also noted that based on Urban Institute figures, Michigan is expected to see only a “woodwork” effect of 10-15 percent, while Ohio officials are estimating 40-50 percent. The Center insisted that Ohio’s figures were not consistent with projections in other states as well.

Spokespersons for the Governor claimed that Ohio’s figures are higher because they are accounting for the number of employers who will dump health coverage for their employees in order to avoid the assessment on employers. However, the Urban Institute cited prior studies (affirmed by the Government Accountability Office and Deloitte consulting) concluding that employers would not simply drop coverage for competitiveness reasons and would more likely replace employee coverage with a subsidy for them to instead purchase coverage in the new health insurance exchanges (see Update for Weeks of August 6th and 13th).



The Urban Institute also discounted the likelihood that those who qualify for Medicaid in many states would have sufficient income for the individual mandate to apply. The ACA specifically exempts anyone who does not earn enough income to file a tax return, or for whom minimum acceptable coverage would cost more than eight percent of their annual income.

The Urban Institute and Kaiser Commission on Medicaid also insist that Governor Kasich is overinflating the costs of the Medicaid expansion, which he claims would run at least \$365 million over the first two years. (Kaiser estimates it would be \$515 million over five years). However, the Governor has decided to wait for the outcome of the November elections before making a formal decision on expanding.

Policy Matters Ohio and state hospital associations have advocated for him to participate in the Medicaid expansion, claiming that as many as 789,000 residents could otherwise be too poor to qualify for the ACA health insurance subsidies but not eligible for Medicaid. This would greatly increase uncompensated care costs for Ohio hospitals as the ACA phases-down federal disproportionate share payments starting in 2014 (see above).

Pennsylvania

Medicaid agency settles eligibility dispute with more than 130,000 residents who lost benefits

Pennsylvanians who were wrongly kicked off the Medicaid rolls last year can reapply within the next 30 days and be compensated for their medical bills, thanks to a settlement agreed to this week by the Department of Public Welfare (DPW).

The Obama Administration had intervened after DPW terminated benefits for over 130,000 Medicaid enrollees (including 89,000 children) from August 2011 to January 2012 after the agency determined that they had not promptly sent the proper documentation to prove they were still Medicaid eligible. The federal government demanded evidence that DPW had done their due diligence in ensuring that those who were terminated truly were no longer eligible, while Community Legal Services and other advocacy groups threatened a lawsuit on behalf of those whose benefits were cut.

Under the terms of the settlement, DPW will send letters to all residents who lost benefits and give them 30 days to submit an appeal form. Although these residents always had the right to appeal, they were not previously informed of this right by DPW.

South Carolina

Medicaid director claims ACA will add 205,000 enrollees, even if state does not expand program

The Medicaid director warned state lawmakers this week that the number of already-eligible residents enrolling in Medicaid in 2014 could exceed estimates and available funding.



Tony Keck blamed this surge in enrollment on the “woodwork” effect from the Affordable Care Act (ACA). He insisted that about \$70 million of the \$194 million in additional revenues projected for 2013-14 will go to cover at least half of the people now eligible for Medicaid who will choose to enroll in order to avoid the tax penalty under the ACA for not buying health insurance that they can afford.

However, as with other Republican administrations (see Ohio article above), he claimed that the number of already-eligible residents enrolling in Medicaid could be much higher and use-up available funding if more than 75 percent do so. While Keck estimated that roughly 205,000 already-eligible residents would enroll, he insisted that this number could balloon if employers drop worker coverage altogether in order to avoid the ACA assessment under the new law. The Urban Institute has concluded that most employers are not likely to do so (see article above).

Keck’s figures do not include the number of residents who would be added to Medicaid if the state participated in the ACA expansion. Governor Nikki Haley (R) has already indicated that South Carolina will exercise the discretion the U.S. Supreme Court granted to states and “opt out” of the expansion without penalty (see Update for Week of July 2nd). Senator Yancey McGill (D) used the hearing to urge the Haley Administration to reconsider, given the additional uncompensated care costs that would be imposed on hospitals in states that refuse to expand (see article above).