

Health Reform Update – Week of December 9th, 2013

CONGRESS

House passes bipartisan budget deal that includes temporary Medicare “doc fix”

Senator Patty Murray (D-WA) and Rep. Paul Ryan (R-WI) announced an \$85 billion budget agreement this week that sets federal spending levels for fiscal year 2014 and 2015.

The chairs of the 29-member conference committee created by the last temporary spending bill (see Update for Week of October 14th) elected instead to push the deal through straight legislation, eliminating the need for the panel to first vote on the plan. Though far from the “grand bargain” envisioned by the *Budget Control Act of 2011* that created the ongoing sequester, H.J. Res. 59 replaces \$63 billion in sequester cuts over the two years and trims an additional \$23 billion in long-term deficits. It extracts another \$28 billion in savings by extending the two percent cut to Medicare reimbursement imposed by the sequester for two additional years (see Update for Week of March 25th), which is now not slated to expire until 2023.

Despite the opposition of some House conservatives to raising the spending caps imposed by the sequester (see Update for Week of February 25th), the measure easily passed the House this week. It is also expected to pass the Senate despite protests from some Democratic lawmakers. However, actual funding levels for the Food and Drug Administration, Centers for Medicare and Medicaid Services, and other health-related agencies will be determined through by appropriations committees by January 15th.

H.J. Res. 59 removes the threat of another government shutdown at the end of the federal fiscal year in September. However, several Senate Democrats were upset that it does not pre-emptively lift the debt ceiling, which Republicans have sought to use the past two years to leverage measures that reduce the deficit or repeal all or part of the Affordable Care Act (ACA) (see Update for Week of October 14th).

It also attaches a three-month “patch” that would forestall the 24 percent cut to Medicare physician payments while House Ways and Means and Senate Finance continue to formulate a long-term replacement for the Sustainable Growth Rate (SGR) formula that Congress has delayed every year since it was enacted in 1997 (see below). The “patch” mollified the American Medical Association (AMA) and other proponents of a long-term “fix” by increasing current physician reimbursement rates by 0.5 percent over three months. According to the Congressional Budget Office, the “patch” will cost about \$8.7 billion.

However, the “patch” also contains several offsets that could result in \$300 million in overall savings over ten years. This includes:

- Altering the extension of the two-percent sequestration cut for Medicare providers so that the reduction would be 2.9 percent in the first six months and 1.1 percent in the last six months;
- Delaying Medicaid cuts to disproportionate-share hospitals for FY 2016, while increasing cuts at that time from \$600 million to \$1.2 billion and extending them another year through FY 2023.

Hopes for permanent Medicare “doc fix” spurred by second CBO revision to cost estimate

For the second time in a year, the Congressional Budget Office (CBO) has lowered its score of a the permanent fix in the Medicare physician payment formula, increasing the likelihood that Congress can pass the current replacement being marked-up in the House Ways and Means and Senate Finance committees. The CBO now says that the cost of repealing the sustainable growth rate (SGR) formula will be \$116.5 billion over ten years or nearly \$23 billion less than its previous estimate (see Update for Week of May 27th).

Both committees agreed to several industry-sought changes this week to the replacement plan it previously drafted. However, the main obstacle remains how to offset the cost of repealing the flawed SGR formula that would have cut Medicare physician payments by roughly 20-28 percent every year if Congress had not continually passed temporary “patches” every year since it was enacted in 1997.

There are several different versions of an SGR replacement being debated, including H.R. 2810 that the House Energy and Commerce Committee approved in July but CBO assigned a higher cost (see Update for July 15th-August 2nd). However, the bipartisan draft framework agreed to by Ways and Means and Finance would allow physicians to either stay in Medicare’s traditional fee-for-service model and have their payment rates frozen for ten years or receive bonus payments to transition to alternative payment models (see Update for Week of October 28th).

The committees agreed to change the bonus structure so that physicians would not be forced to compete against each other in order to receive the bonuses. It also gives physicians more time to adjust to the value-based purchasing program and ties less payment to performance for the initial years than under current law.

HHS Secretary calls for OIG investigation into failed launch of ACA marketplace portal

Department of Health and Human Services (HHS) Secretary Kathleen Sebelius announced this week that she has requested an Office of Inspector General (OIG) investigation into problems with agency contracting, management, and payment procedures that led to the failed launch of the federally-operated health insurance marketplaces under the Affordable Care Act (ACA).

The decision was timed to coincide with the Secretary’s testimony before the House Energy and Commerce Committee regarding improvements in the marketplace web portal since her appearance last month (see Update for Week of November 4th). In addition to the OIG investigation, Sebelius testified that new HHS rules seek voluntary concessions from marketplace insurers to ensure continuity of care during January (see below) and the agency will hire a new “chief risk officer” to oversee new programs created by the ACA and ensure needed technology works as advertised. She also ordered an agency-wide retraining in best practices for outside contracting, after HHS’ reliance on large contractors with long-term relationships to the agency was largely blamed for its inability to resolve technological glitches as promptly as state-based marketplaces (see Update for Week of October 21st).

The Secretary confirmed earlier testimony from HHS officials that many “back end” problems with the financial management systems have yet to be resolved and may prevent marketplace insurers from being reimbursed timely on January 1st, but assured the committee that they would be fully-functional by mid-January. She also insisted that the agency is making progress on electronically transferring Medicaid enrollment from www.healthcare.gov to states, which has been non-functional since open enrollment started October 1st.

Sebelius claimed that up to nine states may be able to receive Medicaid transfer data by week’s end. Once fully automated nationwide, this will greatly speed up the process of verifying that federal marketplace applicants are instead eligible for Medicaid (which is a state responsibility). HHS announced last week that in the interim it was providing states more cumbersome and labor-intensive “flat-file” data with identifying information on potential Medicaid eligible individuals that must be cross-matched with state records (see Update for November 18th-December 6th).

The National Association of State Medicaid Directors and National Association of Health Underwriters warned this week that the federal marketplace these “flat files” were frequently filled with errors and often incorrectly determined applicants to be Medicaid-eligible when they were not, including those earning more than \$80,000 per year.

FEDERAL AGENCIES

Federal PCIP enrollees get 30 more days to shop for other coverage

The Centers for Medicare and Medicaid Services (CMS) announced this week that the federally-operated Pre-Existing Condition Insurance Plans (PCIP) will be continued for 30 days past the December 31st termination set by the Affordable Care Act (ACA).

Several state high-risk pools that predate the PCIP program have already opted to extend their programs past December 31st because the initial non-functionality of most Affordable Care Act (ACA) marketplaces prevented many of their enrollees from smoothly transitioning to marketplace coverage starting January 1st. These states include Indiana, New Hampshire, New Mexico (see below) Texas, and Wisconsin that have postponed the planned termination of their programs until open enrollment for the marketplaces closes on March 31st (see Update for November 18th-December 6th).

Louisiana is one of the few states electing to still end their high-risk pool on December 31st due to improvements in the marketplace enrollment (see below).

Roughly 135,000 people enrolled in the PCIPs nationwide. The 30-day extension will automatically apply to those enrolled in the 40 PCIPs for which CMS has already assumed control (see Update for Weeks of May 13th and 20th). Ten states still control their own PCIPs (Alaska Connecticut, Maryland, Maine, Montana, New Jersey, New Mexico, Oklahoma, Rhode Island and Wisconsin) and will have to make their own decisions about whether to extend their programs. Oklahoma has already indicated that it will do so.

New rules allow for marketplace coverage to be retroactive to January 1st

The Centers for Medicare and Medicaid Services (CMS) issued an interim final regulation this week announcing additional extensions of Affordable Care Act (ACA) marketplace deadlines in order to facilitate enrollment following the failed rollout of the federal web portal.

The regulation codifies CMS' previous decision to allow consumers to purchase coverage by December 23rd for coverage effective January 1st, or eight days later than the initial deadline (see Update for November 18th-December 6th). However, CMS will also now require insurers to accept payment through December 31st.

The remainder of the changes gives marketplace insurers discretion to make voluntary concessions that would facilitate enrollment. HHS is "strongly encouraging" but not mandating that insurers allow coverage to be retroactive to January 1st for consumers that enrolled prior to the December 23rd deadline but pay their full premiums until January. At least one insurer, Aetna, promptly agreed to do so, but only if premiums are paid by January 8th.

HHS also wants marketplace insurers to refill prescriptions covered under previous plans during January in order to ensure continuity of care, as well as treat out-of-network providers as in-network, especially for marketplaces like California where online provider directories initially were inaccurate (see Update for Week of October 21st). The latter distinction could be significant as out-of-pocket limits in marketplace plans apply only to in-network care.

ACA marketplace enrollment quadrupled from October to November

Figures released this week by the Department of Health and Human Services (HHS) show that enrollment in state and federally-operated Affordable Care Act (ACA) marketplaces quadrupled during the second month of open enrollment, though remain far below initial projections.

Roughly 264,000 people signed-up for private marketplace coverage nationwide during November, bringing the two-month total to 364,682 enrollees. The overhaul of the federal web portal during November resulted in 137,000 now being enrolled through www.healthcare.gov, a dramatic

improvement over the less than 27,000 that were able to sign-up in October. However, the 15 state-based marketplaces (SBMs) continue to far outpace the 36 federally-facilitated marketplaces (FFMs), as they have enrolled 227,000 individuals (see breakdowns below). The more than 803,000 enrolled in Medicaid or SCHIP through the marketplace portal also continues to nearly triple private plan sign-ups.

HHS insists that enrollment is continuing to “surge” following the re-launch of the federal web portal on November 30th, with more than 29,000 signing-up the first two days of December (see Update for November 18th-December 6th). However, even including these numbers, total enrollment is still but a fraction of the 3.3 million that the Congressional Budget Office (CBO) had projected would enroll by December 31st and seven million by the end of open enrollment on March 31st. At its current pace, 3.5 million would enroll by March 31st (1.1 million in private coverage and 2.4 million in Medicaid).

HHS continues to predict that enrollment will jump shortly before the December 23rd deadline for January 1st coverage, as well as at the end of open enrollment, consistent with past experience in comparable marketplaces (see Update for Week of November 11th). The report emphasizes that 1.9 million of the 2.3 million determined to be eligible for private marketplace coverage have yet to select a plan much less pay the premium.

The number of applicants determined to be eligible for ACA tax credits and cost-sharing subsidies rose to 40 percent after the second month of open enrollment. However, this figure is still far below initial projections by Avalere Health, Urban Institute, and the Congressional Budget Office, which had predicted that more than two-thirds of applicants would be subsidy-eligible.

CMS discouraging further paper marketplace applications due to backlog caused by online flaws

The Centers for Medicare and Medicaid Services (CMS) acknowledged this week that about 25 percent of enrollment records submitted to participating insurers through the federal health insurance marketplace in October and November could contain errors.

The issue involves so-called 834 forms, which is a daily electronic file sent from www.healthcare.gov to insurers with the total number of enrollees for that day. Without those forms, insurers are unable to bill consumers, who are ultimately unable to make their first payment and risk being uninsured on January 1st.

The Secretary for the Department of Health and Human Services (HHS) insists that the recent overhaul of the federal web portal have lowered the error rate on these forms to about ten percent during December and are expected to be resolved by mid-January (see above). However, CMS acknowledges that the errors have resulted in a massive back-log of alternative paper applications that may not be able to be processed in time for coverage to be effective January 1st. This backlog is not limited to the 36 states with federally-facilitated marketplaces as Oregon has over 30,000 paper applications pending due to the continued non-functionality of its online enrollment (see below), California has over 25,000, and even tiny Vermont has over 1,200.

As a result, CMS is directing navigators and other consumer assisters to cease using paper applications to enroll applicants now that the federal web portal is functioning for “most” users (see Update for Week of November 18th-December 6th).

HHS launches delayed Spanish version of federal marketplace portal, but glitches remain

The Spanish language version of www.healthcare.gov went live with a “soft launch” last week after being repeatedly delayed since the October 1st start of open enrollment for the federal health insurance marketplace (see Update for Week of October 21st).

Consumer advocates were quick to point that several fixes are still required for www.ciudadadesalud.gov to function properly. For example, the site links applicants to the English version

of the new window shopping tool that was created last month to allow users to compare different plan benefits and costs before creating an online account (see Update for Week of November 4th).

Latinos are a crucial population that federal officials are trying to reach, given that they represent one in very three uninsured Americans. However, more than one-third of uninsured Latinos are not conversant in English and Latino marketplace enrollment has initially lagged far behind others even in states like California that have had success enrolling other populations (see Update for November 18th-December 6th).

HHS investigating whether specialty tier coinsurance for all HIV or HCV drugs is discriminatory

A coalition of 31 HIV/AIDS related organizations are urging the Department of Health and Human Services (HHS) to investigate whether some insurers participating in the Affordable Care Act (ACA) marketplaces are engaging in illegal discrimination by not covering the full range of available drugs or imposing “egregious” coinsurance on most of them.

The AIDS Institute and other organizations have been publicizing data from detailed analyses of marketplace plans showing that in states like Florida, most marketplace insurers are placing nearly all drugs for high-cost conditions like HIV/AIDS or hepatitis C (HCV) into specialty tiers where the beneficiary coinsurance can average 40 percent for the lowest-level bronze and silver level plans (see Update for Week of October 7th).

In their December 2nd letter to HHS, the coalition noted that Aetna required patients to pay at least half the cost for most HIV/AIDS drugs covered under their Florida marketplace plans, while Aetna subsidiary Coventry One placed all HIV drugs (including generics) into specialty tiers imposing a 40-50 percent coinsurance. Humana likewise covers only six HIV drugs on their marketplace formularies for Florida and Alabama, while others are on a specialty list imposing a 50 percent coinsurance.

The AIDS Institute noted that some insurers like Blue Cross and Blue Shield are able to cover HIV/AIDS drug with the same flat \$10-50 copayments they apply to most other drugs, and questioned why other insurers were unable to do the same.

The Affordable Care Act broadly prohibits discrimination based on health status. However, HHS has yet to issue guidance detailing specific actions that would constitution discrimination under the ACA.

The AIDS Institute has sought to focus attention on this issue through recent articles in *The Wall Street Journal*, *Forbes*, and *TIME*. In response, HHS spokespersons have indicated that the agency has agreed to investigate, though it has yet to formally respond to the December 2nd coalition letter.

The issue has particular resonance within the HIV/AIDS community as only about 17 percent of the estimated 1.1 million HIV-infected Americans are covered by private insurance plans, according to The AIDS Institute. Many will gain private coverage for the first time through the ACA marketplaces.

STATES

ACA marketplace enrollment continues to vary widely by state

Nearly one out of every three Americans that have enrolled in an Affordable Care Act (ACA) health insurance marketplace live in California, according to the latest figures released this week by the Department of Health and Human Services (HHS).

The Covered California marketplace signed-up 107,000 of the nearly 365,000 enrollees nationwide during the first two months of open enrollment, and racked up another 52,000 during the first week of December alone. It is now enrolling consumers at a rate of 7,100 per day or more than 15 times the pace during the first week the marketplace was launched.

The high level of private plan enrollment in Covered California makes it one of only a handful of states enrolling nearly as many in private plans as in their expanded Medicaid program (which added 182,000 through November 30th).

California's success hinges in large part on its ability to get eligible applicants to select a plan. Nearly half (47 percent) of applicants have done so in California, a figure matched only by Connecticut. By contrast, only ten percent of applicants in Minnesota or New Mexico and 18 percent nationwide (see above) have selected plans.

California's enrollment tally is rivaled only by New York's state-based marketplace (SBM), which also broke 100,000 enrollees in November. Three other SBMs are also meeting or exceeding initial projections including Washington with over 18,000 private plan enrollees (nearly 92,000 in Medicaid), Connecticut with over 11,600 private plan enrollees (22,700 in Medicaid), and Kentucky whose private plan enrollment jumped 32 percent since late November to more than 15,500 (nearly 56,500 in Medicaid).

Nearly 41 percent of Kentucky marketplace enrollees in either private plans or Medicaid are under age 35, an encouraging trend for the marketplace since initial enrollees nationwide were skewed towards older and more costly enrollees (see Update for Week of November 11th).

By contrast, enrollment in several SBMs continues to be hampered by troublesome glitches comparable to the federal marketplace. Oregon (see below) still has no online enrollment capability, while Hawaii's delayed start (see Update for Week of October 14th) has limited enrollment to only 444 individuals (although more than 3,200 were determined eligible for Medicaid). Minnesota and Colorado remain far below private plan projections with only 4,478 and 9,980 enrolled despite a larger population than either Connecticut or Kentucky. Maryland has enrolled less than 3,800 in private plans (see below), a very troubling number given that smaller states with similar glitches have exceeded it (Vermont's marketplace has nearly 5,000 private plan enrollees).

Florida far outpaces all other 35 states operated fully or partially by the federal government. It had more than 17,900 enrollees as of November 30th and nearly 165,000 determined eligible for Medicaid. Although these are below initial projections, they were a pleasant surprise to consumer advocates given the state's anti-ACA posture. By contrast, the larger state of Texas has only slightly over 14,000 private enrollees in their marketplace and below 16,770 determined eligible for Medicaid, despite having nearly a quarter of their state population uninsured.

California

Covered California insists that "robust" networks will include more than 80 percent of physicians

Covered California officials reiterated this week that more than 80 of the state's practicing physicians and another 360 hospitals will be available in health plans offered through the Affordable Care Act (ACA) marketplace in 2014. It insisted that the 58,000 doctors available to Covered California subscribers compares favorably to the 72,000 and 63,000 offered by the state's two largest commercial insurers. In addition, nearly two-thirds of the participating hospitals meet the federal definition of "essential community provider" serving low-income or previously uninsured populations.

The announcement responded to a week of public criticism over revelations that some of the participating insurers will narrow their provider networks even further in 2015 in order to keep premiums affordable. This includes Blue Shield of California, which will include just 50 percent of the physicians and 75 percent of the hospitals that are part of its provider network for 2014 marketplace plans.

Several studies have confirmed that provider networks in ACA marketplaces across the country are more limited than those available in non-marketplace plans (see Update for Week of September 30th). An analysis released this week by McKinsey and Co. found that two-thirds of hospital networks in ACA marketplaces are "narrow or ultra-narrow."

Iowa

Iowa becomes second state to receive federal approval for Medicaid expansion alternative

The Centers for Medicare and Medicaid Services (CMS) approved Iowa's request this week to use Medicaid expansion funds provided by the Affordable Care Act (ACA) to cover some of the newly-eligible populations in the federal health insurance marketplace.

Iowa's plan is largely-based on the model that CMS formally approved for Arkansas (see Update for Week of September 23rd). Under the plan, working-age adults earning from 100-138 percent of the federal poverty level (FPL) will be enrolled in private marketplace plans instead of Medicaid, unless they are considered "medically frail" in which case they will remain in traditional Medicaid. Pennsylvania (see below) and Tennessee are seeking federal approval for similar alternatives (Utah is formulating its plan).

CMS initially rejected the one provision in Iowa's waiver request that charges sliding-scale premiums for those earning from 50 to 138 percent of FPL, as its Arkansas approval limited premiums only to the newly-eligible population covered in marketplace plans (100-138 percent of FPL). About 40 states are allowed to charge premiums for Medicaid enrollees, but CMS had yet to permit any state to do so for those earning less than 100 percent of FPL.

However, Governor Terry Branstad (R) reached a compromise with CMS under which Iowa could charge premiums to those earning 50-100 percent of FPL, but could not eliminate coverage for those that failed to pay. Iowa can also create an incentive program to encourage the roughly 100,000 people that are gaining coverage through the Medicaid expansion to adopt healthy behaviors. Those that agree to do so will have their premiums waived.

Senator Jack Hatch (D), a gubernatorial candidate next year, pointed out that the dispute was largely moot for 2014 as premiums were not going to be charged anyway for the first year of the expansion under the compromise the Governor reached with Senate Democrats last session (see Update for Weeks of May 13th and 20th). He insisted that the only reason Democrats allowed the premiums to be part of the agreement was because CMS was certain to reject them for lower-income populations.

Louisiana

State high-risk pool will close December 31st

The Louisiana Health Plan (LHP) has elected not to follow the lead of several other states (see above) and extend the state high-risk pool past December 31st in order to ensure its 1,900 enrollees can smoothly transition to individual plans in or outside of the new Affordable Care Act (ACA) marketplaces on January 1st.

LHP officials had discussed postponing their planned shutdowns past December 31st due to the limited functionality of the federal marketplace portal during the first month of open enrollment (see Update for November 18th-December 6th). Louisiana is one of the 36 states using the federal marketplace portal; however LHP decided that recent improvements in the marketplace enrollment did not warrant an extension of the Plan. They pointed out that LHP has been informing members of the pending termination since 2012 and will continue to process 2013 claims and appeals of coverage denials through August.

Maryland

Marketplace enrollment continues to be hampered by technologic glitches, infighting

The most recent data released by the Maryland Health Connection shows that it continues to lag behind all but three of the other 14 states that elected to create their own health insurance marketplace pursuant to the Affordable Care Act (ACA).

As of November 30th, just 3,758 people had signed up for private marketplace coverage while 13,296 were determined eligible for Medicaid, a small fraction of the state's 700,000 uninsured residents

and far behind enrollment numbers for other state-based marketplaces with comparable populations, such as Kentucky and Washington (see Update for November 18-December 6).

Although other states had similar technological glitches during the first few weeks of open enrollment, Maryland Health Connection blamed disputes among two contractors for their failure to promptly correct the problems, which caused the web portal to crash on day one and remain crippled. The two firms, Noridian Healthcare Solutions and EngagePoint, now have dueling lawsuits in federal court after the latter was removed from the project by the former.

The infighting resulted in the resignation of the executive director who was on vacation when a website overhaul was underway and may prevent Maryland Health Connection from meeting the December 15th deadline set by Governor Martin O'Malley (D) to make the portal fully functional. Only three of the nine "fixes" identified by the Governor have been resolved, according to Maryland Health Connection's latest report.

New Mexico

High-risk pool board calls for federal government to assume cost of extension

By a 7-1 vote, the board overseeing the New Mexico Medical Insurance Pool voted to extend state high-risk pool coverage past December 31st for 1,200 of its 10,000 enrollees covered under plans that must be terminated because they do not comply with the Affordable Care Act (ACA).

The three-month extension was passed as the Superintendent of Insurance insisted that the web portal for the federal health insurance marketplace still had too many technological problems to allow these high-risk pool enrollees to purchase coverage by the December 23rd deadline for January 1st coverage.

However, the board also voted to send a letter to the Centers for Medicare and Medicaid Services (CMS) demanding federal reimbursement for the estimated \$9-10 million cost of extending coverage. If CMS refuses, this cost will be borne by carriers in the New Mexico Medical Insurance Pool such as Blue Cross and Blue Shield of New Mexico.

Ohio

Medicaid expansion website enrolls record number of Ohioans on day one

Nearly 1,200 Ohioans earning up to 138 percent of the federal poverty level (FPL) were able to enroll during the first day of online enrollment in the state's newly-expanded Medicaid program that will start January 1st.

Governor John Kasich (R) was able to implement the Affordable Care Act (ACA) expansion over the objections of a Republican-controlled legislature (see Update for Week of October 21st). According to the Governor's Office of Health Transformation, online enrollment went smoothly in marked contrast to the failed launch of the web portal for the federal version of the ACA health insurance marketplace used by Ohio and 35 other states. The 1,165 enrollees represent the largest number ever to sign-up for state benefits in a single day.

The Governor's office has projected that 600,000 Ohioans will be added to Medicaid in 2014 as a result of the expansion. The online system will not replace the paper applications that previously were being submitted by newly-eligible applicants, but will greatly shorten the amount of time needed to apply.

Oregon

Oregon remains last in marketplace enrollment, but near the top in Medicaid determinations

Despite being among the first states to create their own health insurance marketplace under the Affordable Care Act (ACA), Oregon has enrolled only 44 residents in marketplace plans through November 30th, according to data released this week by the Obama Administration (see above).

The figure ranks dead last among all states (the next closest state is North Dakota at 265). It is a result of Covered Oregon's failure to provide any online enrollment capacity to date (see Update for November 18th-December 6th) and reliance on paper applications. The state leads the nation with a backlog of over 30,000 paper applications (see above) that it must process by next week in order to ensure coverage can start on January 1st.

Covered Oregon officials insist that 686 residents have actually enrolled in private plans as of the first week in December. They also emphasize that the marketplace continues to have great success in enrolling more than 90,000 eligible applicants into Medicaid using a "fast track" process where pre-screened residents can sign-up without having to go through the marketplace web portal.

Pennsylvania

Governor's waiver provides new details on proposed Medicaid expansion alternative

Governor Tom Corbett (R) formally submitted his request this week for a federal waiver that will allow Pennsylvania to use Affordable Care Act (ACA) funds for the Medicaid expansion to instead cover some newly-eligible populations in the federal health insurance marketplace.

The waiver request included several new details from the outline the Governor previously released (see Update for Week of September 16th), including a premium structure that rewards prompt payment and healthy behaviors, and a work-related requirement that aims to improve health outcomes. Sliding-scale premiums would be limited to no more than \$25 for individuals and \$35 for households with two or more adults. Failure to pay premiums for three consecutive months would cause an enrollee to be excluded from benefits for at least the following three months.

However, the waiver request was immediately panned as "irresponsible" by consumer advocates and may be modified by CMS as it currently does not provide the wraparound benefits that CMS required of similar alternatives it approved for Arkansas (see Update for Week of September 23rd) and Iowa (see above). These wraparound benefits would ensure the newly-eligible enrolled in marketplace plans receive a comparable level of benefits to traditional Medicaid.

The state will hold eight public hearings on the waiver through January 9th.

House version of specialty tier resolution clears committee

The House Health Committee passed the House counterpart of a resolution that would direct the Legislative Budget and Finance Committee to study the impact of specialty tier prescription drug pricing upon access to care for Pennsylvanians. The House version (H.R. 348) requires the report to be submitted by June 30, 2014 compared to the Senate-passed version (S.R. 70) that sets the date at July 15, 2014 (see Update for Week of October 21st).

Wisconsin

New bill would let counties decide whether to participate in ACA Medicaid expansion

Rep. Melissa Sargent (D) announced this week that she will introduce a bill requiring the state to allow counties to fully expand Medicaid under the Affordable Care Act (ACA).

Governor Scott Walker (R) and the Republican-controlled state Legislature have rejected the traditional Medicaid expansion alternative under the ACA in favor of the partial expansion proposed by the Governor that does not meet minimum standards for federal approval. Under the Governor's plan, about 83,000 childless adults will gain coverage, but another 72,000 adults will lose coverage as the state's current Medicaid eligibility level would be sliced in half to 100 percent of the federal poverty level (see Update for November 18th-December 6th).

The bill by Rep. Sargent would let counties decide whether or not to participate in the traditional expansion, similar to a proposal offered by Texas counties (see Update for Week of March 4th) and a demonstration project federally- approved for Cuyahoga County in Ohio before that state agreed to participate in the full expansion (see above).

Dane County and 17 other Wisconsin counties have passed resolutions supporting the Medicaid expansion under the ACA, as has the Wisconsin Counties Association.

Wyoming

Governor rejects Medicaid expansion for all but Native Americans

Governor Matt Mead (R) reiterated last week that he still does not want his state to accept federal funding to expand Medicaid coverage, due to the flawed launch of the federally-facilitated Affordable Care Act (ACA) marketplace.

The Governor has opened the door at times to participating, as the Department of Health has concluded it would be the state's best financial interest to accept the \$750 million in federal funds over the next seven years. However, the Republican-dominated legislature has steadfastly refused to consider the issue (see Update for Week of January 28th and February 4th).

The Governor has instead opted to take a "wait and see" approach while agreeing to support a federal demonstration waiver that will expand Medicaid to Native American populations residing in the state's Wind River reservation, all at the federal government's expense. Governor Mead points out that the state's share of Medicaid costs for Wind River residents will not increase under the demonstration. By contrast, the state's share of an ACA expansion would gradually go from zero percent through 2016 to ten percent in 2020 and years after.

The demonstration proposal quietly passed the Select Committee on Tribal Relations last summer and will be heard in the legislature next session. Because of the political reluctance by conservatives to expand any federal program, it is not clear if it can get the needed votes to pass despite the backing of state hospital and physician groups.