Health Reform Update –Week of August 18, 2014

CONGRESS

Bill to create lower coverage tier could decrease premiums by 18 percent

Avalere Health released a new study this week concluding that plans with an actuarial value of only 50 percent could be offered in Affordable Care Act (ACA) Marketplaces for an average premium that is 18 percent lower than bronze-level plans.

The bronze plans created by the Affordable Care Act (ACA) must cover at least 60 percent of the estimated health costs of subscribers (i.e. actuarial value), the lowest threshold currently allowed for non-catastrophic plans. However, Senator Mark Begich (D-AK) introduced legislation last fall (S.1729) that would allow for an even lower-level of coverage under so –called "copper" plans. This tier would offer lower premiums but fewer benefits and higher cost-sharing (see Update for November 18th –December 6th). (The bill is expected to receive a floor vote in September).

The Council for Affordable Health Coverage asked Avalere Health to estimate the impact of this legislative proposal. Avalere concluded that copper plans could be offered in 2016 for roughly $4,600 per year or 18 percent below premiums for the average bronze plan. As a result, about half of those currently enrolled in bronze plans would likely switch to the copper plans, while 75 percent of those who would have selected a bronze plan would also instead choose a copper plan.

In addition to lowering premiums, copper plans could reduce the federal budget deficit by $0.3 billion from 2015-2024, if it were implemented for the 2016 plan year. This reduction would be due to a net $5.8 billion decrease in ACA subsidies and $5.5 billion less in employer mandate penalties due to roughly 350,000 fewer workers with access to employer-sponsored plans seeking Marketplace coverage.

Ninth Circuit rejects premature challenge to Medicare cost-cutting board created by ACA

The U.S. Court of Appeals for the 9th Circuit dismissed a lawsuit this week seeking to block the controversial Independent Payment Advisory Board (IPAB) created by the Affordable Care Act (ACA).

The IPAB would propose Medicare spending cuts whenever pre-determined caps are exceeded—recommendations that would automatically go into effect if Congress fails to pass at least equivalent cuts. Republicans have been joined by at least 20 Democrats in seeking to repeal this ACA provision, insisting that it usurps the authority of Congress (see Update for Week of March 19, 2012).

A three-judge panel for the 9th Circuit (one of whom was Republican-appointed) rejected the lawsuit brought by a physician and uninsured patient in Arizona alleging that such a ceding of Congressional power is unconstitutional, holding that the challenge was premature because the IPAB is not yet in effect (see Update for Week of May 6, 2013). The court noted that its 15 members have yet to even be appointed, so the plaintiffs could not possibly identify any financial harm that they have incurred from speculative cuts that may occur in the future.

The panel did rule against the plaintiffs on two other challenges. It rejected their claim that the ACA's individual mandate violated their due process right to "medical autonomy", concluding that an uninsured person can opt to pay a tax penalty under the ACA instead of purchasing unwanted minimum coverage that he or she can afford.

It also nullified part of the Arizona Health Care Freedom Act—a ballot referendum passed in 2010 that claimed to exempt state residents from tax penalties under the ACA (see Update for Week of November 1, 2010). The panel found that the Act presents a “classic case of preemption” by federal law, which is always supreme to conflicting state laws pursuant to the U.S. Constitution. Several conservative states have passed similar measures, although they were rejected by voters in Colorado and Florida (see Update for Week of November 5, 2012).

MACPAC says most emergency room use by Medicaid enrollees is appropriate

The July report from the Medicaid and CHIP Payment and Access Commission (MACPAC) created by the Affordable Care Act (ACA), concludes that about 90 percent of emergency room visits by Medicaid enrollees are for urgent symptoms that require quick medical attention.

The findings appear to rebut the popular belief that most Medicaid use of emergency rooms is “inappropriate”. The congressional Medicaid advisers suggested that this “misconception” of emergency room abuse comes from studies that wrongly classify certain visits as “avoidable” because they fail to account for real-world conditions that Medicaid enrollees face, including the lack of access to primary care physicians. Instead, researchers found that when accounting for these factors, non-urgent visits by Medicaid enrollees occur no more frequently than the rate among those privately insured or uninsured.

MACPAC says it is too early if ACA provisions like the expansion of Medicaid will increase the necessary and unnecessary use of the emergency room, noting that studies after Massachusetts’ comparable coverage expansion in 2007 offer only conflicting results. However, MACPAC did note that studies of pre-ACA Medicaid expansion programs in 12 states “show no evidence of increased use of emergency services or erosion of perceived access to care among enrolled adults.”

FEDERAL AGENCIES

CMS provides guidance on recertification process for Marketplace assisters

The Centers for Medicare and Medicaid Services (CMS) released an enrollment assister bulletin last week explaining how navigators and other entities helping consumers enroll in federally-facilitated Marketplaces can become recertified for the 2015 open enrollment period that starts November 15th.

The guidance document emphasizes that navigators and certified application counselors (CACs) must undergo continuing education and be recertified annually. Those trained last year received certificates that expired August 14th and must have provisional certificates to continue assisting consumers until 2015 training is completed.

According to CMS, the updated training will be available in early September through the Medicare Learning Network, a training site that will be taken down for several weeks before a new curriculum is added. This will include more detailed instructions on how to verify immigration status and eligibility for Affordable Care Act (ACA) subsidies, a major weakness identified by the Government Accountability Office and Health and Human Services Inspector General (see Update for Week of July 21st).

CMS estimates it will take about 20 hours to complete navigator training and 5-10 hours to finish CAC training.

One-third of records in Open Payments website is erroneous and will not be released

The Centers for Medicare and Medicaid Services concluded last week that roughly one-third of entries in the new Open Payments website are not accurate and will not be released when the database becomes available to the public on September 30th.

The database has been collecting information on payments to physicians that drug and device manufacturers are required to disclose pursuant to the physician payment sunshine provisions of the Affordable Care Act (ACA). CMS recently took the database offline for ten days after physicians complained of erroneous and misleading data, and agreed to extend the physician review period until September 8th (see Update for Week of August 11th).

CMS will now return the erroneous records to the manufacturers "because of intermingled data" and is requiring that manufacturers resubmit the data for the next reporting cycle in June 2015.

One of the lead sponsors of the bipartisan sunshine provision, Senator Chuck Grassley (R-IA), criticized the agency's action and urged CMS to clarify for consumers what records are being withheld from release. However, the American Medical Association (AMA) and other physician groups have used the inaccuracies to renew their push for a six-month delay in public disclosure. To date, CMS has refused to budge on its September 30th release date (see Update for Week of August 11th).

CMS considers covering HIV screening for all Medicare enrollees

The Centers for Medicare and Medicaid Services (CMS) announced that it has accepted a request from HIV/AIDS advocates to consider paying for HIV screening of all Medicare enrollees without regard to perceived risk behavior, rather than only for pregnant women and those deemed to be high risk.

Advocates had argued that relying on enrollees to self-identify as high risk was problematic and caused the number of cases to be greatly underreported and undertreated. The change would bring Medicare policy in line with a recommendation by the U.S. Preventive Services Task Force in 2013 (although that recommendation applies those aged 15-65). Advocates insist that senior citizens should likewise be screened, even though only three percent of those living with HIV are estimated to be age 65 or older. They cited a study by the Centers for Disease Control and Prevention, which projected that more than half of those living with HIV will be 50 and older by 2017.

The broader screening policy is likely to also extend screenings to the roughly nine million Medicare enrollees under age 65 that qualify due to disability.

CMS will accept public comments through September 3rd and plans to release its initial coverage decision by February 4, 2015 (with a final decision by May 5, 2015).

Medicare spending on HIV totaled $6.6 billion in 2014 and CMS has requested an additional $400 million for fiscal 2015. However, Medicare spending on HIV drugs has come under federal scrutiny after a recent report by the Health and Human Services Inspector General found that Medicare Part D may have improperly paid $32 million for HIV drugs in 2012 (see Update for Week of August 4th).

Health care prices slowing despite coverage expansions

The Bureau of Labor Statistics announced this week that the price of medical commodities (including prescription drugs) grew by only 0.3 percent from June to July, well below the three percent growth rate for the same period last year and one of the slowest monthly increases for 2014.

Prices for medical care services (like health insurance and hospital care) grew over the same time at an even smaller rate (0.1 percent) and are up only 2.5 percent over the year.

However, the slow growth rates still represent an uptick from earlier this year. The Bureau of Economic Analysis had reported in June that total health care spending had actually declined during the first three months of 2014, representing the largest decline in the last 30 years (see Update for Week of June 23rd).

STATES

New studies continue to document economic benefits of Medicaid expansion

New studies released over the past two weeks are increasingly putting pressure on states to participate in the Medicaid expansion under the Affordable Care Act (ACA).

An analysis by The Urban Institute concluded that states opting-out of the expansion will forgo more than $423.5 billion in federal matching funds from 2014-2022, while hospitals in those states will lose nearly $168 million in revenue. In addition, 6.7 million residents will remain uninsured in those states, increasing the uncompensated care burdens on safety net hospitals whose federal indigent care payments will start to be phased down in 2016.

By contrast, Tenet Healthcare recently reported that its hospitals in five states that expanded Medicaid have seen "a 54% decline in uninsured admissions and a 27% decline in uninsured outpatient visits."

Urban Institute researchers cited other positive effects that would result from expansion, such as increased economic activity and job growth, stating that "every comprehensive state-level fiscal analysis that we could find concluded that expansion helps state budgets, generating savings and revenues that exceed increased Medicaid costs." They specifically disputed claims from officials in the 23 holdout states that the federal matching funds under the ACA are likely not to materialize, noting that of 100 federal Medicaid cuts since 1980, just one lowered the federal share of Medicaid spending.

A separate study from Families USA documented potential benefits of expansion for ten holdout states, including Alabama, Florida, Indiana, Missouri and Virginia. It found that had Indiana expanded its Medicaid program at the first opportunity provided by the ACA, the federal matching funds would "have supported 16,400 jobs and increased state economic activity by $1.9 billion."

<u>Arkansas</u>
Board delays request for federal grant to transition to state-based Marketplace

The Arkansas Health Insurance Marketplace Board announced this week that it has delayed its planned application for $100 million in additional federal exchange establishment grants until October, after the Obama Administration asked for a "firm plan" on the board's intent to transition from a state partnership Marketplace (SPM) to a state-based Marketplace (SBM).

There were 36 states that defaulted to either full or partial federal control of their Affordable Care Act (ACA) Marketplace for the inaugural open enrollment period. Insurance Commissioner Jay Bradford (D) had initially intended for Arkansas to have full state control over its Marketplace. However, the partnership model was far more politically palatable for the Republican-controlled legislature (see Update for Week of April 23, 2012).

Although Governor Mike Beebe (D) and the Insurance Commissioner have sought to ultimately move the Marketplace to full state control, it remains unclear when this transition would occur. The Board sought the additional $100 million since it still needs to design and build the software for a SBM, as well as create a call center, conduct the necessary outreach, and develop a system that can accurately verify eligibility for coverage and subsidies.

<u>California</u>
Governor signs bill eliminating health plan waiting periods

Governor Jerry Brown (D) signed a measure late last week that prohibits group health plans from imposing any waiting period on coverage. S.B. 1034 removes the prior 60-day period allowed under state law, which was already less than the 90-day waiting period permitted by the Affordable Care Act (see Update for Week of June 23rd).

Anthem sued again for narrow networks, erroneous provider directories

A group of 33 consumers filed suit this week against Anthem Blue Cross, alleging that the health insurance giant misrepresented the scope of the narrow provider networks offered in their Covered California plans.

Anthem garnered the largest market share in California's Affordable Care Act (ACA) Marketplace during the inaugural open enrollment period and remains the largest for-profit insurer in the state. However, complaints regarding narrow networks have already resulted in an earlier class action lawsuit by Consumer Watchdog and an ongoing investigation by the state Department of Managed Health Care (see Update for Weeks of June 30th and July 7th).

The latest suit filed in the Los Angeles County Superior Court claims that Anthem canceled more generous preferred-provider organization plans (PPOs) and moved subscribers to a more limited exclusive-provider-organization (EPO) options, which have little or no out-of-network coverage. The plaintiffs allege that misleading or incorrect provider directories for these plans further caused them to incur unforeseen medical bills out-of-network.

Covered California officials acknowledged multiple problems with erroneous provider directories and even took them offline at points during the inaugural open enrollment period (see Update for Week of October 21st). However, the lawsuits allege that Anthem failed to disclose these inaccuracies to subscribers.

State lawmakers are pursuing legislation to address problems with inaccurate directories and limited networks, including S.B. 964 that would expand state monitoring and enforcement of existing rules for network adequacy (see Update for Week of August 11th).

Covered California board members criticize ballot referendum to expand rate review

Covered California board members expressed concerns this week about a ballot initiative that could give the insurance commissioner his long-sought authority to reject or modify excessive rate hikes.

Consumer Watchdog and Insurance Commissioner Dave Jones (D) placed the Proposition 45 voter referendum on this fall's ballot in an effort to give the commissioner's office the same authority over health insurance premiums that it currently has for automobile and property rates. Jones has pursued similar initiatives while serving in the Assembly (see Update for Week of August 29, 2011).

However, Covered California officials continue to worry that the expanded authority could cause insurers to leave the individual market (see Update for Weeks of June 30th and July 7th), as well as result in delays and confusion that may impede its own rate negotiations with participating insurers. California is one of only five states that elected to follow the "active purchaser" model for its Affordable Care Act (ACA) Marketplace, giving it the ability to selectively contract only with insurers that offer the best value and exclude insurers that otherwise meet minimum standards (see Update for Week of May 27, 2013).

Several board members including a former secretary of the Department of Health Services (DHS) emphasized that they were not necessarily against expanding the commissioner's rate review authority, but simply believe that "now is not the right time to make the job we are in the middle of any harder." They urged the board to campaign against Proposition 45.

However, Executive Director Peter Lee and board chair Diana Dooley, the current DHS secretary, insisted that becoming embroiled in a political campaign against expanded rate review could harm Covered California's reputation.

The latest Field Poll published by the Sacramento Bee shows that nearly 70 percent of registered voters (including 58 percent of Republicans) back Proposition 45. However, the ACA overall receives far higher marks in California than the rest of the nation, with roughly 60 percent of respondents expressing a favorable opinion.

Connecticut

Connecticut's individual insurance market has grown by 55 percent under ACA

The number of state residents enrolled in individual health insurance plans rose by nearly 60,000 or 55 percent since Connecticut opened its own health insurance Marketplace pursuant to the Affordable Care Act (ACA), according to new figures released by the Department of Insurance. This increase has caused the state's uninsured rate to cut in half since October 2013, one of the ten largest gains in the nation (see Update for Week of August 11th).

The data show that ConnectiCare has been able to weaken the traditional dominance of Anthem Blue Cross and Blue Shield, nearly quadrupling its individual plan membership and increasing its overall individual market share to 32 percent (while selling more than 50 percent of all non-Marketplace plans to individuals). Anthem's market share dropped since October 2013 from 42 to 37 percent.

The AccessHealth CT Marketplace found that 52 percent of its new individual plan consumers were previously uninsured, defusing criticism from ACA opponents that insist most new enrollees were simply shifting from previous coverage.

However, the Department warns that nearly 60,000 individual market consumers are enrolled in ACA-deficient plans with coverage that started before January 1, 2014. All but just over 9,000 of these individuals are in non-grandfathered plans that came into existence after the ACA passed in 2010, and as a result they will not be able to keep their existing health plan for the 2015 plan year.

The Department is not allowing ACA-deficient plans beyond 2014, even though the Obama Administration has given states the discretion to continue them through 2016 (see Update for Week of March 3rd). The only exception is a one-month extension for those purchasing their coverage December 1, 2013. Both the Department and Governor Daniel Malloy argued that allowing ACA-deficient plans beyond 2014 would shrink the risk pool as healthier and less costly consumers are not pushed to buy Marketplace coverage.

Premiums will fall slightly for Anthem customers after proposed rate hike rejected

Individual market consumers for Anthem Blue Cross and Blue Shield will benefit from an 0.1 percent decrease in premiums for the 2015 plan year after the Department of Insurance rejected the dominant insurer's request for an average 12.5 percent rate hike.

The Department's actuary deemed the proposed rate hike "excessive" following a public hearing and more than 150 written comments. He directed Anthem to resubmit its filing with reduced estimates for medical inflation and higher federal reinsurance payments under the Affordable Care Act (ACA) for high-cost claims (see Update for Week of July 28th). The revisions resulted in the slight decrease.

However, actual premium changes will vary greatly by plan. Premiums for catastrophic policies offered in the ACA Marketplace for those under age 30 will fall by nearly 15.5 percent while consumers purchasing certain gold plans will incur a 4.23 percent increase (the highest approved rate hike).

ConnectiCare, whose individual plan enrollment has quadrupled since the ACA Marketplace opened (see above), will increase premiums by an average of 3.1 percent, a significant drop from its initial proposal. HealthyCT, the non-profit consumer-driven cooperative created with ACA loans, will lower premiums by an average of 8.5 percent, slightly less than it proposed.

Delaware

Commission releases new figures on Marketplace enrollment, plan options

The Delaware Health Care Commission announced last week that nearly 21,750 consumers have now enrolled in qualified health plans through ChooseHealth Delaware, the state partnership Marketplace created pursuant to the Affordable Care Act (ACA). An additional 7,350 individuals have enrolled through the Medicaid expansion under the ACA, an increase of 11 percent since June 30th.

The Commission emphasized that Delaware is not among those states experiencing a backlog in Medicaid applications (see Update for Week of July 14th), as all are being processed within the federally-required 45-day timeframe.

In addition, the Commission reported that ChooseHealth Delaware will have essentially the same three participating insurers for 2015. The state's dominant insurer, Highmark Blue Cross and Blue Shield, will continue to offer Marketplace plans to both individuals and small groups, as will Aetna Health. Aetna Life Insurance Company will offer plans only to individuals. (Both Aetna companies will replace their subsidiary Coventry Health that participated in the inaugural open enrollment period.)

The total number of individual plan options for Marketplace consumers will increase from 21 to 25 for 2015, as two bronze, two silver, and one gold option is added (while catastrophic options will be reduced from two to one). As with 2014, only one platinum plan option will be available to individual Marketplace consumers.

One bronze, three silver, and three gold plan options will be added for small group Marketplace consumers, as total overall options increase from 11 to 16. However, as with 2014 no platinum or catastrophic options will be offered.

The Department of Insurance submitted final rate recommendations to the Centers for Medicare and Medicaid Services (CMS) last week and is awaiting their approval in September.

Maryland

State officials insist rebuilt Marketplace portal will be operational by November

Governor Martin O'Malley (D) stated this week that he is confident that state officials can rebuild Maryland's state-based Marketplace (SBM) and complete needed testing by the November 15th start of open enrollment for the 2015 plan year.

Maryland's initial attempt at creating its own Marketplace pursuant to the Affordable Care Act (ACA) was so plagued with technological glitches that the oversight board ultimately elected to dump the entire software infrastructure and replace it was technology used for Connecticut's successful model (see Update for Week of July 14th). The rebuild is estimated to cost taxpayers at least $40 million.

Earlier this month, the federal Centers for Medicare and Medicaid Services (CMS) gave Maryland formal approval for the rebuild, provided they can prove by September that the web portal will be fully operational on November 15th.

Despite the Governor's confidence, the board acknowledged this week that they are preparing backup plans and manual processes that can be implemented if the portal is not functioning properly.

These contingency plans including limiting access to the web portal during the first few days of open enrollment to ensure the system can handle full capacity during heavy traffic periods.

However, the board also revealed that consumers who subscribed to Marketplace plans during the open enrollment period will be required to re-enroll starting in November, due to the new technology. The board insists that they will repeatedly contact all initial subscribers to ensure they re-enroll and ensure that subscribers will not lose any ACA subsidies for which they are eligible.

Insurance commissioner reduces proposed premium hikes for Marketplace consumers

The Insurance Commissioner announced this week that three participants in the state-based Marketplace (SBM) created pursuant to the Affordable Care Act (ACA) will lower premiums by an average of 10.4 percent for next year, while three others will increase rates by 14 percent on average.

Final approved premiums for All Savers Insurance Company, Evergreen Health Cooperative and Kaiser Foundation Health Plan of the Mid-Atlantic will fall by roughly 6.7 percent, 10.3 percent and 14.1 percent respectively. However, rates for the dominant carrier CareFirst BlueChoice will jump 9.8 percent, with a 16.2 percent increase for CareFirst of Maryland and Group Hospitalization and Medical Services are set to rise 16.2 percent.

The commissioner emphasized that her office reduced the proposed premiums sought by the two CareFirst insurers by 22.8 percent and 30.2 percent respectively.

Cigna and UnitedHealthCare will join the Marketplace in 2015.

<u>Oregon</u>
Attorney General sues Marketplace contractor for failed website

The Oregon Attorney General filed suit this week against software giant Oracle Corporation for its botched work on the Cover Oregon health insurance Marketplace created pursuant to the Affordable Care Act (ACA).

Oregon became the first state-based Marketplace (SBM) to default back to the federally-facilitated model for next year after state officials determined that it would be unable to rebuild and test the flawed technology infrastructure by the November 15th start of open enrollment (see Update for Week of April 21st). The SBM web portal was never operational during the inaugural open enrollment as consumers were able to enroll only through paper applications.

The Attorney General's lawsuit accuses Oracle of "fraudulently" inducing Oregon to enter into a contract to build the web portal by hiding the level of its undertraining and "shoddy performance". The suit insists that "Oracle's conduct amounts to a pattern of racketeering activity" by filing for more than $240 million of false claims for its work on the Marketplace, and threatening to walk away from the project during the open enrollment period unless it was fully paid for its non-performance (see Update for Week of March 3rd).

Oregon received over $300 million in federal exchange establishment grants for the botched rollout, resulting in ongoing investigations by the Federal Bureau of Investigation, Government Accountability Office, and Inspector General for the Department of Health and Human Services into potentially improper uses of the funds (see Update for Week of March 10th). Oracle continues to blame bureaucratic hurdles and micromanagement from state personnel for the failed website.

Despite no online capability, Covered Oregon was still able to manually enroll roughly 63,000 consumers in qualified health plans and nearly 154,000 in Medicaid before the end of open enrollment (see Update for Week of April 21st).

Texas
Judges join consumer advocates in pushing bipartisan Medicaid expansion compromise

The Senate Health and Human Services Committee met this week to hear testimony on potential "Texas solutions" that will provide a politically-palatable alternative to participating in the Medicaid expansion under the Affordable Care Act (ACA).

According to the Health and Human Services Commission (HHSC) and Department of State Health Services (DSHS), more than 1.9 million Texas remain caught in a "coverage gap" since they are not eligible for the bare-bones Medicaid program in Texas but do not earn enough to qualify for ACA subsidies that start at 100 percent of the federal poverty level (FPL).

Several consumer advocacy groups and judges from the state's six largest counties urged the committee to adopt a bipartisan compromise floated last session that would accept ACA matching funds for expanding Medicaid to everyone earning up to 138 percent of FPL, but instead cover the newly-eligible population in private Marketplace plans with required copayments and deductibles. The model would be largely similar to the federally-approved alternatives in place for Arkansas, Iowa, and Michigan (see Update for Week of January 6th), that are also being proposed in other conservative-leaning states like Indiana, Pennsylvania, Tennessee, and Utah.

The sponsors of last session's compromise, Reps. John Zerwas (R) (a physician) and Garnet Coleman (D) insisted that they would have had sufficient support to pass their bill (H.B. 1391) had Governor Rick Perry (R) not threatened a veto (see Update for Week of March 4, 2013). The legislature did enact a provision in a Medicaid reform bill preventing any future governor from expanding Medicaid without their approval (see Update for Week of May 27, 2013).

Wisconsin
Legislative bureau shows Wisconsin has lost more than $200 million by not expanding Medicaid

Governor Scott Walker (R) scoffed this week at claims by the nonpartisan Legislative Fiscal Bureau that Wisconsin taxpayers would have saved $206 million over two years (or $500 million over 3.5 years) had the state participated in the Medicaid expansion under the Affordable Care Act (ACA) starting in 2014.

The figures are 73 percent more than the bureau estimated last year. The bureau noted that the higher estimate is a result of more childless adults than expected enrolling in BadgerCare—coverage that would have fully been the responsibility of the federal government had Wisconsin participated.

Instead, Governor Walker proposed a partial expansion that was enacted by the Republican-controlled legislature (see Update for Week of November 11th). The Governor's plan expanded BadgerCare for about 97,500 childless adults earning up to 100 percent of the federal poverty level (FPL) while cutting eligibility for about 63,000 residents earning 100-250 percent of FPL that were previously covered under BadgerCare Plus.

The bureau notes that Wisconsin can still save $261-315 million through June 2017, if they elect to participate starting in January 2015 (while adding about 87,000 residents to Medicaid).

However, Governor Walker insisted this week that he is not wavering from his position that the promised level of federal matching funds under the ACA will not materialize.

Wyoming
Governor to resume push for Medicaid expansion next session

Governor Matt Mead (R) stated this week that he plans to renew his push for an alternative to the Medicaid expansion under the Affordable Care Act (ACA) when the legislature reconvenes in January.

The Governor has opposed participating in the traditional expansion, but previously supported floor votes for an expansion alternative modeled on federally-approved approaches in Arkansas, Iowa, and Michigan that allow the ACA matching funds to be used to purchase private Marketplace coverage for the newly-eligible population of nearly 18,000 residents (see Update for Week of January 13th). He was backed by a study from the Department of Health showing Wyoming would save up to $50 million per year from participating in some form of the ACA expansion, while the Wyoming Hospital Association estimated that it would avert $200 million per year in uncompensated care costs.

However, the Republican-dominated legislature has repeatedly rejected any consideration of an ACA expansion over the past two sessions, insisting that the promised level of federal funding would likely not materialize (see Update for Week of February 10th).

The Governor did pursue a federal waiver that will expand Medicaid to Native American populations residing in the state's Wind River reservation, all at the federal government's expense (see Update for Week of December 9th).