

Health Reform Update – Week of July 9, 2012

CONGRESS

House votes for second time to repeal entire Affordable Care Act

The House voted 244-185 this week to repeal the entire Affordable Care Act (ACA). Five Democrats from Republican-leaning districts joined with every House Republican in supporting the measure (H.R. 6079). Three Democrats had supported an identical repeal measure (H.R. 2) that Republicans passed upon assuming control last year (see Update for the Week of January 17, 2011).

The vote was largely viewed as political theater, as it was the 33rd time that the House has voted to repeal all or part of the new law and the first opportunity for Republicans to register their disapproval of the U.S. Supreme Court decision upholding its provisions (see Update for Week of June 25th). House Republicans offered no proposed replacement for the ACA should the law be repealed if Republicans gain control of the Senate and White House next year.

Senate Majority Leader (D-NV) stated this week that he is not likely to allow a vote on either the House repeal measure or an amendment by Senate Minority Leader Mitch McConnell (R-KY) to small business legislation (S. 2237) that would repeal the entire ACA.

However, 80 of the most conservative House Republicans signed onto a letter this week spearheaded by Reps. Jim Jordan (R-OH) and Michele Bachman (R-MN) that urged House leaders to vote this year on defunding specific provisions of the ACA. Former Senate Majority Leader Tom Daschle (D-SD) acknowledged that the defunding initiative presents a far more realistic threat to ACA viability.

More legal challenges to the Affordable Care Act are still working their way through the courts

Republican strategists emphasized this week that the recent U.S. Supreme Court decision upholding the constitutionality of the Affordable Care Act (ACA) will not resolve all of the legal challenges to the health insurance reform law.

The landmark decision rejected the most prominent lawsuit brought in the 11th Circuit Court of Appeals by 26 state attorneys general that challenged only the individual mandate and Medicaid expansion (see Update for Week of June 25th). Three other appellate courts had upheld or postponed adjudication of similar lawsuits, all of which are now resolved by the decision last month.

However, there are already another 23 lawsuits filed nationwide that challenge the ACA mandate that health plans offered by religiously-affiliated institutions provide free preventive services such as contraceptives. The first of the cases brought by Notre Dame University and several Catholic archdioceses allege that the mandate violates their “religious freedom” and are expected to be heard later this year.

The conservative Goldwater Institute also filed a lawsuit in 2010 challenging the Independent Payment Advisory Board, the independent entity created by the ACA that ensures Medicare spending growth stays within federal targets. The case, which was joined by Reps. Jeff Flake (R-AZ) and Trent Franks (R-AZ) was put on hold pending the U.S. Supreme Court resolution of the 11th Circuit case. It can now proceed.

A far lesser known pending lawsuit is challenging whether the ACA ban on physician-owned hospitals participating in Medicare violates the physicians’ equal protection rights under the U.S.

Constitution. The plaintiffs insist that the law unfairly singles out physicians and does not ban others from owning and running a hospital.

The case generated some controversy during oral arguments last April when one of the conservative judges on the 5th Circuit Court of Appeals bristled at President Obama's suggestion that overturning the entire ACA would be an act of "judicial activism". The judge made Department of Justice lawyers write a memo acknowledging the federal court's authority to do so. The decision by the three-judge panel is expected shortly.

Conservative think tanks such as the American Enterprise Institute and Cato Institute are also promoting lawsuits to block the tax credits offered under the law from being offered to low-to-moderate income participants in federally-facilitated health insurance exchanges (FFE). Republican lawmakers are claiming that the ACA statute specifically does not allow tax credits in anything but a state-based exchange. Both IRS and HHS regulations insist otherwise (see Update for Week of July 2nd).

Such a lawsuit theoretically could be brought by employers in states that default to a FFE instead of creating their own exchange. Under the ACA, employees can qualify for tax credits in an exchange if their employer coverage is too costly, subjecting their employer to a mandatory per employee assessment. Employers could argue that the employee is not entitled to the credits in an FFE, hence they would have standing to bring suit to void the employer assessment. However, no employer could file such a suit until they were actually harmed after the employer mandate becomes effective in 2014.

Most physician leaders support Supreme Court decision to uphold ACA

A poll released this week by the American College of Physician Executives (ACPE) found that more than 61 percent of physician leaders surveyed support the U.S. Supreme Court upholding the constitutionality of the Affordable Care Act (ACA) (see Update for Week of June 25th). The survey of more than 9,500 physicians that lead hospitals, health systems, and large group practices was a striking difference from similar polls before the court decision, which showed that over two-thirds of physician leaders gave the new law a grade of "C" or below.

One of the most prominent physician groups, the American Medical Association, support passage of the ACA although several of its state chapters did not (see Update for Week of August 16, 2010).

A separate poll this week by the Pew Research Center found that Americans remain about evenly divided on the ACA. However, a whopping 30 percent of those surveyed claimed to be unaware that the U.S. Supreme Court had ruled while another 15 percent incorrectly believed that most provisions were struck down. These findings mesh with a Kaiser Family Foundation survey showing that 41 percent of respondents were unaware of the Supreme Court decision (see Update for Week of July 2nd).

FEDERAL AGENCIES

Accountable care organization "shared savings" program continues to grow under Medicare

The number of accountable care organizations (ACOs) in Medicare continues to grow faster than either the Department of Health and Human Services (HHS) or industry leaders anticipated when regulations were finalized last fall.

As of July 1st, 89 new ACOs started serving another 1.2 million people in the "shared savings" demonstration authorized by the Affordable Care Act (ACA). Over 2.4 million Medicare beneficiaries are now enrolled in 154 ACOs across 40 states and the District of Columbia, up from one million last spring (see Update for Week of April 9th).

ACOs are intended to bring groups of doctors and other medical providers together to coordinate care for Medicare patients. Those that cut spending growth while meeting 33 different performance measures for quality of care can share in the Medicare savings.

The chief Medicare actuary expects the program to save up to \$940 million over four years from the initiative, while the Congressional Budget Office (CBO) projects savings of up to \$4.9 billion through 2019. Almost half the ACOs are physician-driven groups serving fewer than 10,000 beneficiaries.

According to HHS, the interest from medical providers who want to participate in 2013 is even greater than those participating this year. Over 400 groups that want to join the shared-savings program next year filed the required notice of intent last month and must complete their applications between August 1st and September 6th.

At least 32 of the 154 groups now participating have agreed to change the way Medicare pays them within three years. The groups will abandon the traditional fee-for-service practice in favor of a fixed-rate system for some Medicare beneficiaries.

The ACO “shared savings” program initially faced intense pushback from hospitals that balked at overly “rigid” proposed rules that favored urban providers (see Update for March 28, 2011). CBO also found that at least six similar programs over the last two decades have failed to lower costs.

However, final rules modeled on recommendations by the American Medical Association have since generated the “phenomenal” interest in the program, according to CMS officials (see Update for Week of October 17th). However, publicly traded hospital chains (such as HCA or Community Health Systems) have declined to participate, as have many of the nation’s highest-profile nonprofit health systems such as the Mayo Clinic and Kaiser Permanente.

More than 16 million people with Medicare get free preventive services in 2012

The latest figures released this week by the Department of Health and Human Services (HHS) show that over 16 million enrollees in traditional Medicare have already received at least one free preventive service in 2012 while another 1.35 million took advantage of the annual wellness visit.

For plan years starting on or after September 23, 2010, the Affordable Care Act (ACA) required certain preventive care and annual wellness visits to be provided without cost-sharing. Over 32.5 million Medicare enrollees received at least one free preventive benefit during 2011.

STATES

Democratic governors affirm commitment to create state-based health insurance exchange

The Secretary for the Department of Health and Human Services (HHS) trumpeted letters this week from over a dozen Democratic governors affirming that they will create the state-based health insurance exchange authorized by the Affordable Care Act (ACA).

The letters are essentially the required responses from 11 of the 12 states that had already passed authorizing legislation and must inform HHS of their plans prior to the November 16th deadline set in HHS regulation (see Update for Week of May 14th). Only West Virginia Governor Earl Ray Tomblin (D), whose state was the second to enact authorizing legislation, has yet to respond.

Governor Mark Dayton (D) also wrote to confirm that Minnesota will create an exchange pursuant to his earlier executive order (see Update for Week of October 31st), although his state has yet to pass authorizing legislation. Kentucky Governor Steve Beshear (D) later reiterated his plans to soon issue an analogous executive order (see Update for Week of June 25th).

The majority of Republican governors have indicated that they will wait until the results of the November election to decide whether to move forward on exchange implementation. However, Michigan Governor Rick Snyder (R), Nevada Governor Brian Sandoval (R), and New Mexico Governor Susana Martinez (R) are among the handful of Republican governors seeking to meet the federal deadline to avert a federally-facilitated exchange (see Update for Week of July 2nd).

CMS says states have no deadline to decide on Medicaid expansion

The acting administrator for the Centers for Medicare and Medicaid Services (CMS) responded this week to some of the questions posed by the National Governors Association (NGA) in the wake of the U.S. Supreme Court decision upholding the Affordable Care Act (ACA).

Marilyn Tavenner assured the governors that there is no federal deadline by which states must decide whether they will exercise the new flexibility afforded by the U.S. Supreme Court to “opt out” of the 2014 expansion without a penalty (see Update for Week of June 25th). States also will not have to return federal exchange implementation grants if they ultimately decide not to create a state-based insurance exchange and instead allow a federally-facilitated exchange to be operate in their state.

NGA had posted several other questions to the Secretary for the Department of Health and Human Services, including whether states that “opt out” of the Medicaid expansion could later “opt in” and still be eligible for full federal funding through 2016 and at least 90 percent for years thereafter (see Update for Week of July 2nd). Tavenner indicated that these questions would be addressed in regulations or guidance that will be issued over the next 18 months.

California

Governor signs bleeding disorders legislation

Legislation establishing requirements for entities that provide blood clotting products for home use in the treatment of bleeding disorders is finally law after being signed this week by Governor Jerry Brown (D) (see Update for Week of June 25th). A previously-passed measure in 2010 was vetoed by then Governor Arnold Schwarzenegger (R) (see Update for Week of February 28, 2011).

Florida

Governor now pledges to implement any part of ACA that is “required” before January 1st

Governor Rick Scott (R) retreated slightly this week from his earlier proclamation that Florida would not “implement any part of Obamacare” until the November elections dictated whether Congressional Republicans could repeal all or part of the law (see Update of Week of July 2nd). In a statement released through his spokesperson, the Governor clarified that he would only direct state agencies to move forward on any provision of the Affordable Care Act (ACA) required to be implemented before January 1st.

The Governor and Republican leaders had steadfastly refused to implement any part of the new law pending the resolution of court challenges. However, Senator Joe Negron (R), chair of the Health and Human Services Appropriations subcommittee, did come out this week in favor of at least raising Medicaid reimbursement for primary care physicians next year in order to comply with the ACA after the health policy aide to the governor emphasized that the ACA does not provide states with any discretion to “opt out” of this provision, as they can do for the health insurance exchanges and Medicaid expansion.

The federal government will assume 100 percent of the costs for the higher reimbursement in 2013 and 2014. However, Florida will have to pay up to \$188.6 million in 2015 and subsequent years.

The increase could be substantial for primary care physicians in Florida, who are severely underpaid by Medicaid. According to the Florida Pediatric Society, pediatricians who accept Medicaid

patients receive only 56 percent of Medicare payments on average, resulting in access problems for enrollees in many areas of the state.

A Senate budget plan last session had tried to let state agencies use the \$438.5 million provided by the ACA to increase primary care payments in January. However, it was blocked by House Republicans who refused to legitimize any part of Obamacare.

Senator Negron insists that the state can still start making the higher payments in January, even though legislative authorization was left out of this year's budget. He suggested that the joint Legislative Budget Commission could authorize the payments later this year.

Hawaii

Governor signs measure creating Basic Health Plan under the Affordable Care Act

Governor Neal Abercrombie (D) signed H.B. 1276 this week, which directs the Division of Insurance to study the feasibility of the Basic Health Plan (BHP) option under the Affordable Care Act (ACA). Because of concerns expressed by the legislature about sustained federal funding for this option and the lack of guidance from the federal government, the bill also requires additional legislative approval before state agencies can create a BHP.

Several other states including California, Connecticut, Illinois, New Jersey, and Washington are considering exercising the discretion in the ACA to receive enhanced federal funding for creating BHPs (see Update for Week of April 23rd). However, exchange governing boards already in place in states like California have expressed concern that a BHP would draw so many applicants away from the health insurance exchange that it would threaten its ability to be financially self-sustaining, as the ACA requires by 2015 (see Update for Week of July 25th).

Idaho

Governor delays decision on health insurance exchange, Medicaid expansion

Governor Butch Otter (R) took a step back this week from the rush of several Republican governors to "opt out" of the Medicaid expansion under the Affordable Care Act (ACA).

The U.S. Supreme Court gave all state Medicaid programs the flexibility not to participate in the expansion without being penalized by the loss of all federal matching funds (see Update for Week of June 25th). At least 12 Republican governors have already indicated that will seek to exercise this option and turn down full federal funding for the expansion through 2016, which phases down to 90 percent federal funding in 2020 and subsequent years.

The Governor stated that he understood why his colleagues would not want to expose their states to billions of dollars in additional costs. However, he wanted to gather information on the exact cost of the expansion for Idaho before reaching a decision. The Urban Institute and others have disputed soaring cost projections by conservative governors in states like Florida, Indiana, Nebraska, and Ohio, which unrealistically assumed that every resident that would be newly-eligible for Medicaid after the expansion would actually enroll (see Update for Week of July 2nd).

Governor Otter also refused to back-off his earlier support for creating the state-based health insurance exchange authorized by the ACA, instead of defaulting to a federally-facilitated exchange in 2014. The Governor rejected attempts by the legislature to return federal exchange establishment grants and even took steps to implement initial parts of the exchange via executive order (see Update for Week of January 30th). However, the Governor's statement this week would only commit to further study of potential exchange costs before he makes a final decision.

An earlier AARP poll also showed that 73 percent of Idaho voters age 30-64 want the state to create their own exchange versus a mere nine percent that favor a federal fallback exchange (see Update for Week of January 30th).

Maine

Governor claims U.S. Supreme Court decision allows Maine to immediately cut Medicaid eligibility

Rep. Chellie Pingree (D-ME) publicly called on the Obama Administration this week to block the request from Governor Paul LePage (R) to cut Medicaid eligibility before 2014.

The U.S. Supreme Court gave all state Medicaid programs the flexibility not to participate in the expansion required by the Affordable Care Act (ACA) without being penalized by the loss of all federal matching funds (see Update for Week of June 25th). Governor LePage became the first of several Republican governors this week to insist that the court's decision likewise freed states from the maintenance of effort (MOE) provisions under the ACA which withdraws all federal matching funds from any state the cuts Medicaid eligibility before 2014.

In response, the Secretary of the U.S. Department of Health and Human Services sent a warning to all Governors this week that the Supreme Court's decision applied only to the Medicaid expansion and not the MOE provisions (see above). While HHS has been willing to allow limited cuts in Medicaid eligibility in Illinois and Wisconsin, the Secretary emphasizes that these cuts must be approved through a federal waiver of the MOE provision and will only be granted in cases of a severe budget crisis. States that cut eligibility without waiver approval still stand to lose all their federal matching funds.

Consumer advocates strongly supported the Secretary's decision, emphasizing that the Supreme Court did not reference the MOE provisions. However, many legal commentators suggested that because the court specifically found that depriving all federal matching funds to be unconstitutional, HHS may have to rely upon some other penalty or risk an additional court challenge.

Up to 27,000 Maine residents are projected to lose Medicaid coverage on October 1st if the state cuts Medicaid eligibility as sought by legislation enacted last spring, including eliminating coverage entirely for 19-20 year olds. The Governor stated that he would now seek federal approval to do so under a modified state plan amendment, requests that are traditionally granted, instead of the federal waiver that the HHS Secretary insists is still required.

Massachusetts

Governor signs bill relaxing nation's strictest gift ban

Governor Deval Patrick (D) signed legislation this week that will relax the Massachusetts Pharmaceutical and Medical Device Manufacturer Code of Conduct.

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

The "gift ban" faced heavy opposition from the Pharmaceutical Research and Manufacturers of America (PhRMA), claiming it forces pharmaceutical and biotechnology companies to leave Massachusetts (see Update for Week of July 12, 2010). The Democratically-controlled House agreed, citing conventions and events that have consequently been held in neighboring states as the basis for voting twice in the last three years to repeal the entire law (see Update for Week of April 30th).

However, the ban retains strong Senate support, especially from its author Senate President Therese Murray (D) and Joint Committee on Health Care Financing chairman Richard Moore (D). As a result, they modified the repeal under H.B. 4100 so that it only slightly softens the ban as follows:

- (1) Manufacturers can now provide “modest meals and refreshments” at certain presentations and events, although such gifts must still be reported quarterly to the Department of Public Health (DPH).
- (2) Device manufacturers may pay for a health care provider’s “reasonable expenses” necessary for technical training on the use of a medical device, prior to the sale of the device.
- (3) DPH can no longer require manufacturers to report payments already disclosed under the physician payment sunshine provisions of the ACA, although DPH will take the data disclosed to the federal government and make it publicly available on its website.

Mississippi

Insurance commissioner moves ahead with health insurance exchange implementation

Insurance Commissioner Mike Chaney (R) remained undeterred this week in his plans to create the state-based insurance exchange authorized by the Affordable Care Act (ACA), despite opposition from over 30 “tea party” members attending a public meeting of the Mississippi Health Insurance Exchange Advisory Board.

Former Governor Haley Barbour (R) had been one of the few Republican governors supporting the creation of a state-based exchange, instead of ceding control to a federally-facilitated exchange (FFE) (see Update for Week of February 28, 2011). Insurance Commissioner Chaney has continued with plans to design the exchange based on recommendations of the Advisory Board created by Barbour. He announced this week that the Board would be able to submit its plans for a state-based exchange to the federal government in 60-90 days, well in advance of the November 16th deadline (see Update for Week of May 14th).

However, Chaney is moving forward without authorizing legislation that stalled last session. Governor Phil Bryant (R) has also not made clear whether he will support the exchange, now that many Republican governors have elected to postpone implementation until the November elections (see Update for Week of July 2nd).

Chaney insists he has the administrative authority to establish the exchange, though legislative authorization will ultimately be needed to make the exchange operational. He also emphasized that Lt. Governor Tate Reeves (R) has urged Chaney to “proceed as if Obamacare is the law.”

Missouri

Republicans file lawsuit to block language for voter referendum on health insurance exchange

Lt. Gov. Peter Kinder (R) and Republican leaders filed a lawsuit this week to block Secretary of State Robin Carnahan (D) from using “blatantly false [and] deceptive” language on a Republican-backed voter referendum that could bar the creation of a state-based health insurance exchange.

The legislature had approved the statewide ballot measure for November that would prevent Governor Jay Nixon (D) from using an executive order to create the exchange authorized by the Affordable Care Act (ACA) without the assent of either voters of the Republican-controlled legislature. (Three Democratic or independent governors have already done so.) The referendum also would prohibit state agencies from using federal grants to create the exchange.

However, Republicans were incensed last week at the ballot summary approved by Secretary Carnahan, which asks if “Missouri law [shall] be amended to deny individuals, families, and small businesses the ability to access affordable health care plans through a state-based health benefit exchange unless authorized by statute, initiative or referendum or through an exchange operated by the federal government?” Republican leaders insist that the politically-biased language wrongly implies that approving the referendum would deny residents access to affordable health plans.

The Republican lawsuit suggests four alternative summaries that essentially ask whether state law should be amended to prevent the Governor from implementing provisions of the ACA unless authorized by a vote of the people or legislature. Carnahan ridiculed the proposed language as suggesting a duly-elected Governor could not exercise his authority under the state constitution.

Missouri was the second state after Arizona to pass a voter referendum to express opposition to the ACA mandate that everyone buy health insurance they could afford or pay a tax penalty (see Update for August 2, 2010). However, a similar ballot referendum in Florida was blocked by the Florida Supreme Court, which concluded that the Republican Secretary of State used a “manifestly misleading” ballot summary to suggest that the ACA was a government takeover of private health plans and physician practice (see Update for Week of August 30, 2010).

Republican lawmakers refuse to call special session to consider expanding Medicaid under ACA

House Speaker Steven Tilley (R) joined with other Republican leaders this week in rejecting calls from some Republican lawmakers for a special legislative session to formally “opt out” of the Medicaid expansion in the Affordable Care Act (ACA).

Senators Brad Lager (R), a candidate for Lt. Governor, and Bill Stouffer (R) had urged Governor Jay Nixon (D) to call the special session, after the U.S. Supreme Court gave the flexibility to “opt out” without penalty (see Update for Week of June 25th). Even though Republicans control both legislative chambers, Speaker Tilley did not see the need to expedite a vote on opting-out since the Medicaid expansion does not go into effect until 2014.

Oregon

CMS approves global budget plan for Medicaid that would save \$11 billion

The Centers for Medicare and Medicaid Services (CMS) has finalized its federal approval of Oregon’s request to transform all Medicaid spending into a system of “community care organizations” funded by global budgets.

The measure incorporates CMS’ earlier agreement to provide \$1.9 billion to federal funding over the next five years (see Update for Week of April 30th). In return, state officials pledged to curb cost increases for state and federal health programs. The approval will allow the state to implement the plan as scheduled next month.

Governor John Kitzhaber (D) pushed for the new law (S.B. 1580) enacted earlier this year, which would enable providers to collaborate on efficiencies and share in savings, similar to the accountable care organizations (ACOs) under the Affordable Care Act (ACA) (see Update for Week of February 20th). OHA officials project that the plan will save \$11 billion over ten years, as OHA will lower the percentage that the global budget is allowed to grow each year. OHA is committed to lowering the historical cost trend by two percentage points from the six percent annual rate of growth over the roughly the past five years.

Vermont and Massachusetts have already received federal approval for statewide global budget initiatives, although only the Vermont plan has been enacted (see Update for Week of April 23rd).

South Carolina

Governor vetoes funding for ADAP, Bleeding Disorders Premium Assistance Program

Governor Nikki Haley vetoed \$300,000 last week that was designated for the state AIDS Drug Assistance Program and Bleeding Disorders Premium Assistance Program.

The eliminated funding was among over \$1.4 million in line-item vetoes also intended for kidney disease, sickle-cell disease, and the Office of Rural Health. The controversial vetoes from the 2012-2013 budget (H.4813) angered consumer advocates but have the support of some key lawmakers including Senator Lee Bright (R), who insisted that “government is turning into a charity.”

Lawmakers will consider whether to override the vetoes when they return next week.

Texas

Governor officially opts out of Medicaid expansion, state-based health insurance exchange

In a terse letter to the U.S. Department of Health and Human Services (HHS), Governor Rick Perry (R) officially declared this week that he will not move forward on either the creation of a state-based health insurance exchange or the Medicaid expansion required by the Affordable Care Act (ACA).

Both actions were expected, as the Governor had already delayed implementation of the exchange and hinted that he would use the new discretion afforded by the U.S. Supreme Court to “opt out” of the expansion without penalty (see Update for Week of July 2nd). However, the strident opposition in his letter to a “power grab...under the Orwellian-named PPACA” surprised even some Republican lawmakers, as he had initially supported the creating a health insurance exchange that he now claims would “make Texas a mere appendage of the federal government when it comes to health care.”

According to the Kaiser Family Foundation, Texas traditionally leads the nation in the number of uninsured, much higher than national averages, and spends less per Medicaid enrollee than 41 other states and the District of Columbia (see Update for Week of September 5th). A separate study by the Urban Institute estimates that 2.5 million people in Texas would stand to gain Medicaid coverage under the ACA expansion.

Perry had been under pressure from Texas hospitals not to opt-out of expanding Medicaid, as the ACA will dramatically cut disproportionate share hospital (DSH) payments for low-income patients in 2014. According to the American Hospital Association, hospitals nationwide already provided more than \$39 billion in uncompensated care, amounting to six percent of their costs. These costs would significantly increase if Medicaid is not expanded as planned and DSH payment cuts go into effect.

Texas Health and Human Services Commissioner Tom Suehs also conceded to a House subcommittee this week that the actual costs to the state for expanding Medicaid would be 42 percent lower than he and the Governor originally claimed. Many Republican governors including Rick Scott of Florida have been widely criticized for overinflating the costs of the Medicaid expansion by presuming that every state resident who would be Medicaid-eligible would actually enroll. The Urban Institute had projected that a more realistic assumption would be that from 57-75 percent of newly-eligible residents would enroll (see Update for Week of July 2nd).

Suehs acknowledged that using such a lower baseline would reduce the costs of the expansion for Texas to \$16 billion over ten years instead of \$27 billion. He agreed that the additional \$100 billion in federal assistance over that period would be very attractive to Texas hospitals burdened with huge uncompensated care costs in a state where more than a quarter of the population remains uninsured.

However, both Suehs and the state Medicaid director advocated instead for the unfettered Medicaid block grant sought last year by Governor Perry. Under S.B. 7, the state is required to seek

federal approval to opt-out of both Medicare and Medicaid and use federal funds for the programs as they see fit (see Update for Week of June 6th).