

Health Reform Update – Week of February 25, 2013

CONGRESS

Sequester goes into effect as Republicans insist that bad cuts are better than new revenues

President Obama signed an order this week canceling \$85 billion in budgetary resources across federal agencies for the rest of fiscal year 2013 after Congress made little more than symbolic efforts to avoid the automatic sequester that began on March 1st.

The spending caps and automatic cuts were imposed by the *Budget Control Act of 2011*. They were intended to be so onerous that Congress would be forced to compromise on an alternative package of spending cuts and/or new revenues that would reduce the federal deficit by \$1.2 trillion over ten years. However, in the end Republican leaders decided that bad spending cuts were preferable to any additional revenues, apart from their concession at year's end to allow the Bush-era tax cuts for the wealthy and payroll tax holiday to expire (see Update for Weeks of December 24th and 31st).

The sequestration requires a nearly eight percent reduction each year in discretionary and mandatory funding for non-exempt defense spending, compared to roughly five percent for nondefense spending. However, because these cuts must be achieved over the remaining seven months of the fiscal year, the effective reductions will be approximately nine percent for agencies like the Centers for Medicare and Medicaid Services (CMS).

Although spending for Medicaid and Social Security programs and key parts of the Affordable Care Act (ACA) are exempt, Medicare will see a two percent reimbursement cut (though not until April 1st.) Other federal health programs will not be spared however. The National Institutes of Health will lose \$1.55 billion, dramatically impacting research programs, while the Food and Drug Administration (FDA) will lose \$209 million, causing drug safety reviews to be scaled back, and 15,700 people will lose access to AIDS Drug Assistance Program services.

The Congressional Budget Office has estimated that the across-the-board cuts will cause 750,000 job losses in 2013 and trim economic growth by 0.7 percent (see Update for Week of February 11th). An iVantage Health Analytics study this week predicted that more than 4,200 hospitals nationwide would lose nearly \$3 billion this year just from the two percent Medicare payment cut, which will likely result in 73,000 fewer hospital jobs.

However, the exact impact of the sequester will depend on how each agency carries out the cuts. According to the Office of Management and Budget, agency heads have some flexibility in how much is cut from each "program, project, and activity." Agencies could also apportion cuts so that most occur in later months, in order to see if Congress is pressured to compromise now that the sequester is a reality.

CMS has pledged to use this flexibility to protect non-exempt ACA funding and keep implementation on track. This includes funding for the new federal health insurance marketplace (see below) and the federal data hub that is critical to determine applicant eligibility for premium and cost-sharing tax credits. However, funding for the tax credits and Medicaid expansion is already exempt.

Most commentators do not anticipate a resolution until later this month when the latest temporary spending resolution that funds the federal government is set to expire and the Medicare reimbursement cut goes into effect. House Speaker John Boehner (R) has pledged not to seek a government shutdown at that point, which would occur if no agreement is reached on an extension or upcoming budget.

GAO says ACA will increase budget deficit if cost-cutting provisions are phased out

A new report from the Government Accountability Office (GAO) concludes that the Affordable Care Act (ACA) impact on the federal deficit depends entirely on whether the cost-savings provisions in the new law remain intact past 2019.

Republican lawmakers have vociferously objected to several of these measures, most notably the independent Medicare cost-cutting board, restrained growth in Medicare Advantage payments, and productivity adjustments to Medicare. However, if these measures were repealed or phased-out by or after 2019, GAO found that the federal deficit would increase by 0.7 percent of the nation's gross domestic product (GDP) over the next 75 years, instead of declining over that time by 1.5 percent.

Senator Jeff Sessions (R-AL) promptly used the study to declare that the ACA will increase the deficit by \$6.2 trillion over 75 years, though GAO auditors were quick to note that they did not come up with that figure. However, they did acknowledge that "[m]ore needs to be done to change the fiscal path," noting that even if the cost-containment measures in the ACA remain in place, the deficit as a share of GDP will reach a historical high just one year later than estimates completed before the ACA was passed.

CMS gives Senate Finance Committee its timeline for meeting ACA deadlines

The Centers for Medicare and Medicaid Services (CMS) has provided a timetable outlining the steps the agency will take to ensure the federal marketplace begins enrollment in October 2013 as required by the Affordable Care Act (ACA).

The timeline requested by Senate Finance Chairman Max Baucus (D-MT) (see Update for Week of February 11th) shows that CMS plans to conclude policy rulemaking by April. Essential health benefit and market rules were already released (see below and Update for Week of February 18th), while Medicaid federal matching rate rules will come out in March and rules on eligibility (including the federal marketplace and Medicaid/SCHIP appeals) are slated for April.

CMS intends to finalize its streamlined application for consumers coincident with the eligibility rule (see Update for Week of February 11th.) It will re-launch its website and establish a call center in June, open a web portal for exchange navigators in July, and complete navigator and broker training by August.

On the operations side, CCIIO plans to finalize qualified health plan (QHP) rating and benefit data in July, preview QHP plans for federally-facilitated and partnership exchanges in August, and complete information development and integration testing in September.

The Health and Human Services Secretary (HHS) will make final federal marketplace decisions in March, the same time that QHP designs are expected to be completed. State insurance departments will approve QHPs in July, when state partnership reviews of QHPs will also be completed.

FEDERAL AGENCIES

CMS issue final rules to tame premium hikes, set premium subsidies, and delay MLR deadlines

The Centers for Medicare and Medicaid Services (CMS) finalized regulations this week governing the risk adjustment, risk corridors and reinsurance programs that are intended to stabilize premiums and cushion health plans against early financial losses in the unfamiliar exchange market.

The "risk adjustment" payments are a permanent feature that compensates plans for covering a large number of sicker and more costly subscribers. Insurers with lower-risk patients would provide payments to those with higher-risk subscribers once the guaranteed issue mandate goes fully into effect in 2014. They will be used when a state elects not to use its own risk adjustment program.

The related reinsurance and risk corridor programs are temporary and expire in three years. These help to prevent premium spikes as a large number of people with pre-existing conditions transition into the individual market. According to CMS, they should lower premiums by 10-15 percent for 2014. However, because payments are greater in 2014 than subsequent years, states may more quickly move high-risk pool enrollees into exchange plans (see below).

America's Health Insurance Plans praised the \$63 per subscriber fee that funds the \$25 billion reinsurance program. This fee will be assessed on all "major medical" insurers, including individual and employer plans (large employers pay it directly), but will phase down each year until it expires in 2017.

The final rule is largely the same as the proposed rule (see Update for Weeks of December 3rd and 10th). It amends prior medical-loss ratio (MLR) regulations to specify how issuers are to account for payments or receipts for risk adjustment, reinsurance, and risk corridors. It also delays from June 1st to July 31st the deadline for insurers to report how much they spend for medical care versus administration. Insurers will also have until September 30th (instead of August 1st) to make annual rebates.

The rule likewise proposes standards for advanced payments of the ACA's premium tax credit and cost-sharing reductions. It will allow a health insurance exchange to make advance determinations of tax credit eligibility for individuals. Advance payments will be made monthly to the issuer of the qualified health plan in which the individual is enrolled.

Congressional Republicans continue to balk at the 3.5 user fee created by the rule to fund the federal marketplace. Commenters had particularly objected to the fee being imposed on all individual and small group plans, even if they are not participating in the health insurance exchange. However, CMS stressed that creating a "single risk pool" was imperative to prevent the kind of adverse selection that would make the marketplace a "less attractive" repository for higher-risk subscribers.

The wave of new regulations comes only weeks before health plans are scheduled to begin filing bids for the state and federally-operated exchanges on April 1st. Plans will have 30 days to submit their bids and policy forms and related data templates for approval.

ACA reinsurance program has states reconsidering when to end high-risk pools

According to *POLITICO*, a recent change in how the Department of Health and Human Services (HHS) plans to run the three-year, \$20 billion reinsurance fund under the Affordable Care Act (ACA) is forcing states to reconsider their timetable for shifting high-risk pool enrollees into the exchanges.

More than 200,000 uninsurable are covered by state high-risk pools, with another 100,000 enrolled in the pre-existing condition insurance plans (PCIPs) created by the ACA. PCIP enrollees were set to move into the newly-created health insurance exchanges as soon as they became operational in January 2014. However, most states had planned on gradually transitioning their state high-risk pool enrollees in order to prevent a surge in premiums from flooding exchanges with high-cost enrollees.

According to several state high-risk pool officials, new federal regulations are likely to speed-up that transition. The ACA created a reinsurance program funded by insurer assessments that was meant to compensate plans that are forced to take on a large share of sicker and more costly enrollees from high-risk pools (see above). States thought they would have a voice in what plans would receive those payments. However, the final regulations would give the money only to plans with enrollees that cost more than \$60,000 per year, while making state high-risk pools ineligible.

As a result, the chief executive for Wisconsin's state high-risk pool indicated that the board has decided to start moving enrollees into the exchanges far more quickly than the 1-3 year transition they initially approved, due to fears that they will miss out on the \$20 billion allocated by the ACA. Texas is moving in a similar direction.

The Montana Senate unanimously passed legislation last week (S.B. 233) requiring a plan for terminating the Montana Comprehensive Health Association (MCHA) in fiscal year 2015 once the federal marketplace begins operating in the state. However, pending legislation in Washington (S.B. 5449) would maintain state high-risk pool coverage through 2017.

The reinsurance program is front-loaded so that plans will receive \$10 billion in 2014, but only \$6 billion and \$4 billion in subsequent years.

Estimates vary on the impact of suddenly shifting 200,000 people from the state pools into the exchanges. Some actuaries project that it will not make much difference, while others claim premiums will jump by as much as 45 percent. By contrast, HHS predicts that the reinsurance program will keep premiums on the individual market 10-15 percent lower than they would be without it.

However, some commenters to the proposed rule such as the American Academy of Actuaries suggest that it could be “unfairly discriminatory” to keep sicker populations in high-risk pool once the exchanges are in place. It would also just kick the premium problem down the road, when the reinsurance subsidies will not be available to help minimize the impact.

Final OPM rules decline to specify which states will offer multi-state exchange plans next year

The Office of Personnel Management (OPM) finalized regulations this week on the Multi-State Plan Program (MSPP).

The Affordable Care Act (ACA) requires that OPM contract with at least two multistate health plans (at least one of which is a non-profit) that will be offered to exchange consumers. These multi-state plans (MSPs) must be offered in every state by 2017, but only at least 60 percent of states starting next year. However, the final rules fail to identify these 31 states.

Under the final rule, OPM will determine will certify MSPs in each marketplace and ensure a “level playing field” between MSPs and other exchange plans. They also will ensure that families or small businesses are offered MSPs from the same issuer even if they reside or operate in more than one state.

OPM is required to implement the MSPP “similar to the manner” that it operates the Federal Employees Health Benefits Program (FEHBP). However, the final rule recognizes that the MSPP creates additional challenges for OPM, especially in preserving the traditional state regulation over their insurance markets. As a result, OPM announces that they will pursue a “memoranda of understanding” with each state that establishes a process to informally resolve disputes that may arise between OPM and states.

The final rule also establishes standards related to how OPM will coordinate with states and the Centers for Medicare and Medicaid Services (CMS) to approve rates, rating standards, medical loss ratios, and an MSP’s participation in reinsurance, risk adjustment, and risk corridor programs (see above).

The rules finalize the flexibility previously given to MSPs for covering essential health benefits (EHBs) (see Update for Weeks of December 3rd and 10th). As with all non-grandfathered individual and small group plans, MSPs must cover minimum EHBs starting in 2014. However, because the Obama Administration gave states latitude to define their own EHB package (see Update for Week of October 1st), multistate plans potentially would have been required to vary their package in every state.

To avoid this predicament, OPM will allow multistate plans to offer an EHB package that either substantially follows a state’s EHB benchmark plan for the state in which it is operating or any EHB benchmark chosen by OPM that is based on one of the three largest FEHBP plans. However, the rule does not allow an issuer to use a state EHB benchmark plan in some states and an OPM-chosen benchmark in others. The issuer’s benefits package, including its prescription drug list, must be submitted to OPM to be approved.

OPM previously relaxed its standards so that an insurer can offer multi-state plan coverage in part of a state but not necessarily the entire state (see Update for Week of September 24th). The final rules clarify that MSPs must provide a path to expand statewide in order to be certified by OPM. During each year of the phase-in, an issuer also only need be licensed in the states where it is offering coverage during that year. Eventually, they must be licensed in every state.

OPM is currently accepting applications from MSPP issuers, which are tentatively due by March 29th. It projects that up to 750,000 people could be covered by MSPs in 2014.

Industry attacks proposed rule implementing ACA tax on health plans

The Internal Revenue Service (IRS) released proposed rules this week implementing the annual assessment that the Affordable Care Act (ACA) imposes on health plans starting in 2014.

The agency expects to raise about \$8 billion through the fee in 2014 and \$100 billion over ten years. The fee was intended by Congress to help fund the new subsidies under the ACA that helps low-to-moderate income Americans purchase affordable health insurance through the new exchanges.

Reps. Charles Boustany (R) and Jim Matheson (D) have sponsored industry-backed legislation to repeal the annual fee (H.R. 763), which will partly be the focus of a March 5th hearing that Boustany has scheduled in his Ways and Means oversight subcommittee. The IRS will also hold a June 21st public hearing on their proposed implementation of the fee.

Under the IRS proposal, insurers with aggregate net premiums of over \$25 million will be subject to the sliding-scale fee, which is based on their level of premiums and due every September 30th. Insurers with less than \$25 million in premiums must report them to the IRS but will not pay the fee.

America's Health Insurance Plans blasted the fee as a "new sales tax" that health plans will be forced to impose on struggling families and employers.

STATES

New guidance appears to allow states to carry-out some functions for federal marketplace

The Centers for Medicare and Medicaid Services (CMS) has decided that states do not need to submit an exchange blueprint in order to retain control other certifying whether health plans meet standards for the new federal marketplace, as well as other plan management activities.

CMS had required states to submit their plans for creating a state-based exchange that complies with the Affordable Care Act (ACA) by December 14th, or apply for an initial partnership with CMS by February 15th. However, the latest guidance says that CMS remains willing to share some exchange responsibilities with states that elected to simply default to the federal marketplace.

Even though these states do not need to submit official blueprints, the guidance still urges them to "submit to [CMS] a letter as soon as possible....attesting that the state will perform all the plan management activities" listed by CMS in the model blueprint. The attestation must assure CMS that the state has the legal authority to support certification for qualified health plans, collect and analyze data on plan rates, help ensure ongoing plan compliance and resolve consumer complaints, provide insurer technical assistance as needed, help manage decertification of insurers and appeals, and participate in a one-day review of operational plans.

Ohio and Virginia have already submitted this attestation despite defaulting to the federal marketplace. However, the guidance emphasizes that this arrangement is distinct from a partnership exchange, since CMS and not the state retains all enforcement authority.

Recently-enacted legislation in Virginia (H.B. 1769) sought to allow the commonwealth to retain control over certifying health plan participation and rates, despite not applying for a partnership exchange (see Update for Week of February 11th). However, the ultimate decision is up to CMS.

Federal marketplace to be strained by unexpected number of opt-out states with high uninsured

Enroll America released a study this week showing that the federal government will be responsible for operating health insurance exchanges in states with the majority of the uninsured.

The analysis shows that over two-thirds of the nation's uninsured reside in just 13 states. However, only two of these states (California and New York) have sought to create a health insurance exchange for the uninsured that complies with the Affordable Care Act (ACA).

Of the remaining 11 states, only two (Illinois and Michigan) have sought an initial partnership with the federal government, while the other nine all defaulted to full federal control (Arizona, Florida, Georgia, New Jersey, North Carolina, Ohio, Pennsylvania, Virginia, and Texas.)

Researchers noted that the Centers for Medicare and Medicaid Services (CMS) has never revealed its budget for the federal marketplace, leading to concerns that it will be underfunded and able to mount little more than a bare-bones effort to cover far more uninsured than anticipated. These concerns were amplified when the Office of Management and Budget requested a \$949 million increase in the administrative budget for CMS under the next continuing spending resolution being negotiated by Congress before March 27th (see above).

Enroll America data also show that five of these 13 states (Georgia, North Carolina, Virginia, Pennsylvania, and Texas) also do not plan to expand their Medicaid programs for 2014.

Alaska

Governor rebuffed in effort to partially expand Medicaid

Governor Sean Parnell (R) announced this week that he will not ask the legislature this session for funding or authorization to participate in the Medicaid expansion under the Affordable Care Act (ACA). However, he did leave the door open to participating when he submits his next budget in December, should cost estimates justify the expansion.

The Governor met with the U.S. Health and Human Services Secretary to ask for permission to partially expand Medicaid up to 100 percent of the federal poverty level, the point at which the ACA makes premium tax credits available. However, she reiterated her earlier position that HHS has no authority to release federal funding to any states that does not fully expand up to 138 percent of FPL (see Update for Weeks of December 3rd and 10th). As a result, the Governor has decided not to expand Medicaid until he can be assured that the federal government will fulfill its commitment to fully fund the expansion through 2016, and then provide at least 90 percent of funding for subsequent years.

Parnell was the only governor to reject federal exchange planning grants, and has elected to default to a federal marketplace instead of creating a state-based exchange.

Arkansas

Governor strikes surprise deal to move newly Medicaid eligible groups into partnership exchange

Governor Mike Beebe (D) struck a deal with the Obama Administration this week that could pave the way for future Medicaid expansions in other reluctant states.

The U.S. Department of Health and Human Services (HHS) has agreed to allow Arkansas to use the federal funding for the Medicaid expansion under the Affordable Care Act (ACA) to instead move the newly-eligible population into the partnership exchange that will be operated in Arkansas starting in 2014.

The move perplexed many analysts as the Congressional Budget Office has estimated that it will cost \$9,000 to cover each newly-eligible Medicaid enrollee in the exchanges compared to only \$6,000 if the enrollee had been covered by Medicaid as the ACA intended (see Update for Weeks of July 23rd and 30th). However, insurers welcomed the deal, as it would dramatically boost exchange enrollment. Providers likewise would benefit, as exchange plans will reimburse more highly than Medicaid.

Consumers will incur greater out-of-pocket expenses in the exchange, although the Governor insisted that they and state officials would benefit from not having to be bounced between Medicaid and an exchange plan whenever income fluctuated.

Just as with the Medicaid expansion, the federal government will foot the entire cost through 2016 for this population to be served by the exchange. Starting in 2017, Arkansas will gradually start paying up to ten percent of the premium. However, Governor Beebe emphasized that the deal includes a “sunset provision” allowing Arkansas to move the enrollees back into Medicaid should the exchange plans become too costly an alternative for the state.

The deal is still subject to legislative approval. However, Governor Beebe is far more likely to get Republican support for moving Medicaid enrollees into private exchange coverage than he was for a straight Medicaid expansion, which faced stiff opposition even before both chambers fell into Republican hands this session. A key Republican in Missouri has already proposed a similar model (see below).

California

Exchange board approves bridge plan to coordinate with Medi-Cal managed care

The board governing the Covered California health benefits exchange approved a “bridge plan” this week that will seamlessly allow the lowest-income Medi-Cal managed care beneficiaries to choose a health plan offered by the exchange.

The goal of the “bridge plan”, which will start in April 2014, is to allow beneficiaries to easily move without disruption between Medi-Cal and Covered California whenever their circumstances change. The board projects that 840,000 enrollees with incomes below 200 percent of the federal poverty level (FPL) may be eligible for the plan.

California is the first exchange to implement such a “bridge plan”. The chair of the exchange board notes that California is seeking federal approval to broaden it to those above 200 percent of FPL.

Insurance Commissioner opposes Democratic plan to vary premiums by six geographic regions

Lawmakers in the special session on health reform have still been unable to resolve how to allow health insurance premiums to vary by geography under the Affordable Care Act (ACA).

Health insurers typically set their own rating regions. However, the ACA will allow states to set the map. The Assembly and Senate passed bills this week on party-line votes that would initially split the state into six rating regions, following federal guidance that recommends states use seven or fewer.

The provisions, part of larger bills (ABX1-2 and SBX1-2) that implement ACA market reforms like guaranteed issue and community rating. However, bill sponsors Richard Pan (D) and Ed Hernandez (R) acknowledged that the six region provision is likely to change as additional federal guidance is released.

The bills already increase the number of regions from 6 to 13 in 2015. However, that falls far short of the 19-region map supported by the Covered California health benefit exchange and California Association of Health Plans, which was adopted by lawmakers last year for the small group market.

Insurance Commissioner Dave Jones (D) strongly objected to setting only six premium zones, insisting that it would cause “rate shock” and drive-up premiums for smaller coverage by up to 23 percent

in Los Angeles and San Francisco because of the large and costly hospital systems in those areas. He is instead proposing to split the state into 18 premium zones.

A Department of Insurance Analysis found that the average premium increase under Jones' proposal would be only 3.5 percent, compared to 9.1 percent under the six region proposal.

According to the final market reform regulation issued last week by the Centers for Medicare and Medicaid Services (see Update for Week of February 18th), states only have until March 29th to set the geographic rating areas that will apply in 2014 (as well as the uniform curve used for age-rating bands).

Florida

New bills would limit out-of-pocket expenses for high-cost drugs

Two bills filed this month in advance of the legislative session would limit the out-of-pocket expenses that health plan subscribers must pay for the high-cost prescription drugs.

Rep. Janet Cruz (D), a health care executive and ranking member of the Insurance and Banking subcommittee, pre-filed H.B. 1003 this week. The measure would impose a specialty tier prescription drug moratorium and require the Agency for Health Care Administration to report to the Governor and Legislature on the impact of specialty tier coinsurance upon access and patient care.

Senator Jeremy Ring (D), chair of the Governmental Oversight and Accountability Committee, pre-filed S.B. 1010 earlier this month. The measure would prohibit higher copayments, deductibles, coinsurance, or similar charges for non-preferred prescription drugs as compared to preferred prescription drugs. It would also require the Agency for Health Care Administration, with the assistance of the Office of Insurance Regulation, to conduct a study and submit a report to the Governor and Legislature.

Illinois

Senate passes Medicaid expansion bill

The Senate approved a bill this week that would accept federal funds to expand Medicaid under the Affordable Care Act (ACA). S.B. 26 has the support of Governor Pat Quinn (D) and is expected to pass the Democratically-controlled House. It would automatically terminate the expansion within three months should the share of federal funding ever fall below 90 percent.

Indiana

Senate votes to expand Medicaid, but only if health savings accounts are allowed

The Senate voted 44-6 this week to approve the proposal by new Governor Mike Pence (R) that Indiana only expand Medicaid under the Affordable Care Act (ACA) if it is allowed to move the newly-eligible population into its existing Medicaid demonstration program requiring health savings accounts.

Governor Pence is one of several Republicans trying to condition their support for the ACA expansion on additional concessions from the Obama Administration (see Update for Weeks of January 28th and February 4th). However, the Centers for Medicare and Medicaid Services (CMS) has recently granted similar concessions to Arkansas (see above), Florida (see Update for Week of February 18th), and Virginia (see below).

The state's actuary estimates that using the state's Healthy Indiana Plan for the expansion would cost Indiana about three percent less than using traditional Medicaid.

Iowa

Governor rejects Medicaid expansion, pushes CMS to expand state demonstration program

Governor Terry Branstad (R) met with U.S. Health and Human Services (HHS) Secretary Kathleen Sebelius this week to reiterate his opposition to participating in the Medicaid expansion under the Affordable Care Act (ACA).

Several governors have been conditioning their participation on HHS approval for other Medicaid reforms (see Update for Week of February 18th). Governor Branstad appeared to be taking the same posture as he used the meeting to push for a federal waiver to continue IowaCare, a state-subsidized program that provides limited benefits to 70,000 low-income adults that is set to expire on December 31st.

Branstad's position is at odds with the Democratic majority in the Senate, who have made expanding Medicaid their top priority and already passed needed legislation out of a subcommittee. They emphasized that continuing IowaCare is not an acceptable alternative, as it is more costly than accepting the ACA funding to expand Medicaid and limits coverage to two hospitals.

Both the Governor and state lawmakers were surprised that HHS has expressed a willingness to continue IowaCare, even if Iowa opts-out of the expansion. However, the Governor and HHS still need to work out how to broaden the limited benefits provided by that program, which both parties appear to want.

Senator Jack Hatch (D), chair of the Health Committee, insists that Senate leaders will not approve any negotiated extension of IowaCare, calling it a "stopgap" that is no substitute for Medicaid.

Michigan

Exchange resistance thawing among House Republicans

The House Appropriations Committee lifted its prohibition this week on state agencies using the \$31 million federal exchange establishment grant obtained last month by Governor Rick Snyder (R) (see Update for Week of January 14th).

The Governor was one of five Republicans in favor of creating a state-based exchange that complies with the Affordable Care Act (ACA). However, House Republicans not only twice blocked exchange-authorizing bills passed by the Senate and supported by the Michigan Chamber of Commerce, they also barred the Governor from using the previous \$11 million in federal exchange grants, forcing him to instead pursue an initial federal partnership (see Update for Weeks of November 19th and 26th).

Approval of the grant money signals a thawing in resistance to Obamacare by several key Republicans such as Rep. Anthony Forlini (R), chair of the House appropriations subcommittee on licensing and regulatory affairs, who urged fellow Republicans to face the political reality that the ACA cannot be repealed. His support will be needed if the legislature is to approve the Governor's plan to accept ACA funding to also expand Medicaid (see Update for Weeks of January 28th and February 4th).

Polls by the American Cancer Society Cancer Action Network show that Michigan voters largely favor both a state-based exchange and the Medicaid expansion (see Update for Week of January 21st).

Missouri

House Republicans block Medicaid expansion under ACA, offer "market-based" alternative

A key House Republican unveiled his plan this week to expand Medicaid mostly just for childless adults while moving roughly 44,000 children into the federally-operated marketplace created by the Affordable Care Act (ACA).

The bill introduced by Rep. Jay Barnes (R) was touted by House Republicans as a "market-based" alternative to the Democratic bill that would expand Medicaid for everyone earning up to 138 percent of the federal poverty level (FPL). That measure (H.B. 627) was supported by Governor Jay Nixon (D) but blocked this week by the government oversight committee chaired by Barnes.

While H.B. 627 sought to add more than 300,000 Missourians to Medicaid, H.B. 700 takes largely the opposite approach. Although the bill would add nearly 180,000 childless adults and those just above Missouri's very low eligibility threshold of only 19 percent of FPL, it would dramatically slash eligibility for children from 300 to only 100 percent of FPL. The 44,000 children that would lose Medicaid coverage would instead receive subsidized private coverage in the federal marketplace, saving Missouri an estimated \$741 million over the next eight years according to Barnes.

H.B. 700 would also follow Florida's lead and move all Missouri Medicaid enrollees into capitated plans (instead of just half of Medicaid enrollees that are now in managed care).

Republican leaders acknowledge the bill's chances of passing are slim, as it would also require the approval of federal waivers. However, the Obama Administration did grant Arkansas similar permission to move newly Medicaid eligible populations into the federal marketplace, despite the greater cost (see above). It likewise tentatively agreed to allow all Florida Medicaid enrollees to be moved into managed care, subject to strict safeguards (see Update for Week of February 18th).

Montana

New Governor proposes legislation to expand Medicaid under the Affordable Care Act

Governor Steve Bullock (D) unveiled more details this week about his plans to accept federal funding under the Affordable Care Act (ACA) to expand Medicaid to 70,000 low-income Montanans.

House Minority Leader Chuck Hunter (D) will introduce legislation currently drafted by the Governor's office that will bring an estimated \$750 million in federal funds over the next two years while creating more than 5,000 jobs during the first year alone. In addition to expanding Medicaid, the set of reforms, dubbed Access Health Montana, will create a "health trust account" that the legislature would use to improve health-care delivery and access, and increase the rates that Medicaid pays to health-care providers by two percent each year for the next two years. It also includes provisions to encourage the use of preventive care and increase the supply of in-state physicians.

Leaders of the Republican-controlled Legislature pledged to give the Governor's proposal a "fair hearing", though House Speaker Mark Blasdel (R) acknowledged it will take a lot of convincing for Republicans to "rely so much on federal spending".

House-passed bill would expand review of health insurance rate hikes

The House passed legislation this week that would require the State Auditor's Office (SAO) to contract with actuaries to review rate filings for each health insurance insurer that issues, delivers, or renews any health plan in the individual or small group market. H.B. 87 now goes to the Senate.

New Hampshire

Democrats try to lift Republican ban on state-based health insurance exchange

House Commerce and Consumer Affairs Committee chairman Ed Butler (D) held a hearing this week on his legislation that would lift the Republican-imposed ban on New Hampshire creating a health insurance exchange that complies with the Affordable Care Act (ACA).

Previous Governor John Lynch (D) signed the ban last year only after House Republicans allowed him to still pursue a federal partnership exchange that would at least allow New Hampshire to retain control over plan management, consumer assistance, and Medicaid eligibility functions (see Update for Week of June 18th). Republicans controlled both chambers last year and voted not only to prohibit Governor Lynch or his successor from creating the exchange via executive order, they also sought to return the unused portion of the state's \$1 million federal exchange planning grant (see Update for Week of April 30th).

Current Governor Maggie Hassan (D) ultimately decided to pursue the federal partnership model at least for this year, after being urged to do so by the state Insurance Commissioner and Health and Human Services Commissioner (see Update for Weeks of January 28th and February 4th). However, Democrats that now control the House (see Update for Week of November 5th) remain intent on removing the ban that would prevent the creation of state-based exchange in subsequent years.

Department of Insurance counsel acknowledged during the hearing that even if H.B. 544 were enacted this session, it would be too late for the state to establish its own exchange before 2016. The committee held off making a recommendation on the bill, but must do so by March 6th.

State and federal officials overseeing the design and implementation of the partnership exchange will hold a March 8th hearing to solicit public comments.

New Jersey

Governor will accept federal money to expand Medicaid

Governor Chris Christie (R) became the eighth Republican governor this week to support his state's participation in the Medicaid expansion under the Affordable Care Act (ACA).

Even though the Governor refused to create the state-based health insurance exchange authorized by the ACA, he was largely expected to back the Medicaid expansion given his state's already broad Medicaid eligibility. He is running for re-election and faced intense pressure from provider, consumer, and business groups to expand (see Update for Weeks of January 28th and February 4th). A majority of state voters also backed the expansion (see Update for Week of January 21st).

The Governor emphasized that he remains "no fan of the Affordable Care Act" and would "end [the expansion] as quickly as it started" if the Obama Administration makes any "adverse" changes.

If approved as expected by the Democratically-controlled legislature, the expansion will only add a projected 104,000 uninsured residents to Medicaid. However, the Governor stressed that it would save the state over \$227 million just in the first year.

North Dakota

House approves Medicaid expansion bill

A key part of the Affordable Care Act (ACA) continues to attract support this week in highly-conservative North Dakota, as the full House approved participating in the law's Medicaid expansion.

Governor Jack Dalrymple (R) surprised many Republican colleagues by becoming the third governor to support his state's participation in the Medicaid expansion under the Affordable Care Act (ACA) (see Update for Week of January 14th). However, his proposal has received significant Republican support due to the uncompensated care costs that hospitals would bear if the state opted-out.

The House Human Services Committee did amend H.B. 1362 to ensure that the program would automatically sunset in 2017 without additional legislative approval. This would prevent the state from bearing all or most of the costs of expanding if the federal government does not shoulder at least 90 percent of the costs after the full federal match ends in 2016.

Other amendments would allow the Department of Human Services to bid out administration of the program through private insurance carriers or the federal health insurance marketplace and would require the state to study the effects the expansion has on North Dakota residents and providers.

Pennsylvania

Republican lawmakers pressuring Governor to expand Medicaid

Under pressure from Republican lawmakers, Governor Tom Corbett (R) agreed this week to meet with the Obama Administration to explore ways in which Pennsylvania can participate in the Medicaid expansion under the Affordable Care Act (ACA).

Several states have cut deals with the U.S. Department of Health and Human Services (HHS) over the past two weeks that condition their participation upon federal approval of other Medicaid reforms. Most recently, Arkansas Governor Mike Beebe (D) appeared to circumvent Republican opposition by getting federal funds for the Medicaid expansion to be used instead to put newly-eligible enrollees into the more costly federal marketplace (see above).

However, the pressure on Governor Corbett is coming from leaders within his own party. Rep. Gene DiGirolamo (R), chairman of the Human Services Committee, is urging the Governor to reconsider his earlier decision to opt-out of the expansion (see Update for Weeks of January 28th and February 4th), as it would impose dramatically higher uncompensated care costs on safety net providers by leaving 700,000 Pennsylvanians uninsured and reliant on hospital emergency rooms for primary care. He emphasized that most of this group earn less than \$10 per hour and will be ineligible for ACA subsidies to purchase exchange coverage that only start for those earning at 100 percent of the federal poverty level.

Senate Appropriations Committee chair Jake Corman (R) even hinted this week that his panel may condition funding for the Governor's other priorities on his eventual support for the expansion.

Tennessee

House Republicans fail to get enough support for bill to opt-out of Medicare and Medicaid

AARP is applauding the failure last week of legislation that would have let Tennessee join with other states and seek federal waivers to opt-out of any federal health care programs.

The House Insurance Committee remained deadlocked on health care compact legislation (H.B. 536), as four Republicans joined with Democrats in questioning why the bill was even needed and raising concerns about problems it would create with federal funding for the state's Medicaid program. Several Republicans also questioned whether Tennessee would run the federal Medicare program.

The legislation is a favorite of conservative groups since 2011 and has been enacted in Oklahoma, South Carolina, Texas, and a handful of other "red" states. As the bill sponsor Rep. Ted Pody (R) acknowledged, it is largely a symbolic statement of opposition that "does zero for health care policy", as it merely allows the state to ask for waivers that Congress would likely deny.

Rep. Pody did not say if the bill would be resurrected in an attempt to secure the one additional vote needed. The Senate version (S.B. 407) remains pending.

Vermont

Green Mountain Care standardizes cost-sharing for exchange and non-exchange plans

Vermont became the second state this week after California (see Update for Week of February 11th) to standardize the cost-sharing to be applied to individual and small group plans starting in 2014, both in and outside of the new health insurance exchanges created by the Affordable Care Act (ACA).

The deductible and out-of-pocket (OOP) limits set by Vermont are identical to those that will be allowed by the ACA for earning up to 200 percent of the federal poverty level (FPL). However, Vermont dramatically lowers cost-sharing for those earning from 200-350 percent of FPL. For example, while the maximum deductible under the ACA is \$1,900 for those at 200-250 percent of FPL Vermont is proposing to set it at only \$700. The OOP max in Vermont would also be \$1,600 instead of \$3,200.

While these amounts are much less than ACA maximums, they are still significantly more than uninsured Vermonters at those income levels currently pay through the state-subsidized Catamount Care

program. These could also be the cost-sharing limits that remain in place when Vermont plans to move to a single-payer system in 2015 (see Update for Week of May 23, 2011).

Virginia

Lawmakers open door to Medicaid expansion, but only if feds first approve program reforms

The House and Senate passed a two-year budget bill over last weekend that keeps open the door for Virginia to participate in the Medicaid expansion authorized by the Affordable Care Act (ACA).

Democrats in the evenly-divided Senate had vowed to hold up the entire budget if Republicans blocked the expansion (see Update for Week of February 18th), which would add roughly 400,000 Virginians to the Medicaid rolls and save more than \$584 million by 2022 according to the Department of Medical Assistance Services (see Update for Week of January 14th). The stalemate was broken when lawmakers accepted a controversial compromise by creating a commission that will decide when Virginia has received sufficient federal concessions to proceed with expanding Medicaid.

Ten voting members (five each from the House and Senate) will serve on the Medicaid and Innovation Reform Commission. At least three members from each chamber must approve any commission action, which will meet every over month starting in June.

A dozen Senator Republicans lodged a “document of protest” against the compromise, while other Republicans serving on the new commission like Rep. James Massie (R) are already on record as having “serious concerns about the costs of Medicaid expansion.” However, it has the support of Senate Finance leaders Walter Stosch (R) and Emmett Hanger (R) who authored a similar provision in the initial Senate-passed budget bill (see Update for Weeks of January 28th and February 4th). Del. Riley Ingram (R), chair of the House Appropriations health subcommittee, also urged lawmakers not to fall to the “bottom of the pack” by rejecting the expansion (see Update for Week of February 18th).

Governor Bob McDonnell (R) informed leaders of the budget committees last week that he will not drop his opposition to the Medicaid expansion until the Obama Administration formally allows Virginia to hike Medicaid cost-sharing, redesign benefits, and simplify program administration and the reforms are fully implemented. Unlike his counterpart in Florida, the Governor did not agree to expand Medicaid based solely on the “agreement in principle” issued last week by the Centers for Medicare and Medicaid Services (see Update for Week of February 18th).

The Governor may still veto or modify the commission provision, which the Assembly can override with a simple majority vote when they return on April 3rd.

Health and Human Resources Secretary Bill Hazel, who will serve as a non-voting commission member along with the Finance Secretary, has urged lawmakers to reach a “quick decision” on the Medicaid expansion, as delaying past January 1st would cost Virginia roughly “\$5 million a day in federal spending and \$400,000 a day in state-budget savings” (see Update for Weeks of January 28th and February 4th). The bill (H.B. 1500) already will not allow Virginia to expand before July 1, 2014, meaning that Virginia will miss out on at least six months of the full federal funding provided by the ACA.