



Health Reform Update – Week of November 3, 2014

CONGRESS

Republicans target Affordable Care Act after seizing Senate control

Republicans appear to have swept all but one of the contested Senate elections this week, gaining at least seven seats to likely claim a 54-46 majority for the next two years.

Despite narrowly leading or running even in polls for five key races, low turnout from young adults, minority groups, and other largely Democratic constituencies doomed any chances for Democrats to retain control of the Senate chamber. (Roughly 35 percent of the electorate was over age 60, the highest in a decade). In the end, they were able to hold only the contested seat in New Hampshire, losing seats by fairly wide margins in Arkansas, Colorado, Montana, North Carolina, South Dakota, and West Virginia.

The race for the Louisiana Senate seat currently held by Senator Mary Landrieu (D) will go to a runoff next month. However, physician Rep. Bill Cassidy (R-LA) is expected to prevail in that head-to-head matchup. Republicans are also expected to pick-up the Alaska seat once all votes are counted.

The likely Majority Leader Mitch McConnell (R-KY) and House Speaker John Boehner (R-OH) immediately announced that the Senate and House will schedule new votes to repeal the Affordable Care Act (ACA) when the new Congress is sworn in this January. They also listed specific provisions that they will seek to individually remove, which included long-sought targets such as the medical device tax and controversial Medicare cost-cutting board, as well as increasing the threshold for the employer mandate from 30-40 hours per week. These measures all previously attracted some bipartisan support.

President Obama repeated his earlier declarations that he was “open” to negotiating some minor changes to the ACA. However, he insisted this week that he would veto any bills that repeal either the individual or employer mandates or terminate the ACA’s reinsurance provisions that compensate insurers for exceptional claims.

While the most immediate impact of a Republican-controlled Senate will be the ability to block most of the President’s executive and judicial nominations, Republicans can now significantly increase the noise level surrounding the ACA as well as limit new appropriations and increase legislative oversight. However, Republicans failed to gain the 60-vote threshold to pass legislation (apart from budget reconciliation measures) nor can they override a Presidential veto without significant Democratic support.

Initial ACA repeal measures are thus mostly viewed as an effort to solidify their base for 2016. Republicans are quickly expected to pivot towards pending legislation to reauthorize the State Children’s Health Insurance Program (SCHIP) and debate a permanent fix the Medicare physician payment formula that requires annual delays in order to avert deep cuts. The Centers for Medicare and Medicaid Services (CMS) announced this week that the physician payment cut for 2015 will be 21.2 percent if the existing Congress does not issue a temporary extension during the lame duck session next month.

After all recounts and challenges are resolved, Republicans are also expected to add at least 12 seats in the House of Representatives, where only 21 of 435 races were considered competitive. Republicans would now hold a 57-seat margin, their largest since World War II.



Supreme Court refuses to wait for appellate resolution of ACA subsidy challenge

The U.S. Supreme Court took the very rare step this week of intervening in a legal challenge to Affordable Care Act (ACA) subsidies, prior to any resolution or split in appellate opinions.

At issue are a series of lawsuits brought by conservative groups claiming that the ACA statute authorizes premium tax credits only for consumers in health insurance Marketplaces operated by states and not in the 36 federally-facilitated Marketplaces (FFMs). A three-judge panel from the Fourth Circuit U.S. Court of Appeals had rejected such a claim in King v. Burwell, concluding that the challenged provision could not be pulled out of context from the rest of the ACA, which clearly provided for tax credits to consumers in any type of Marketplace (see Update for Week of July 21st). Instead of seeking an *en banc* review from the entire Fourth Circuit, which is comprised mostly of judges appointed by Democratic presidents, the plaintiffs sought immediate review by the high court (see Update for Week of August 11th).

The Supreme Court's intervention surprised most observers because it typically does not do so until all appellate challenges are resolved and a split in opinions remains. At a minimum, the high court was expected to wait until the full District of Columbia U.S. Court of Appeals held oral arguments next month on an analogous lawsuit, after withdrawing a decision by a three-judge panel to invalidate the FFM subsidies (see Update for Weeks of August 25th and September 1st). That adverse decision was issued by two of the three panel judges that were appointed by Republican presidents.

Only one other lower court has agreed with the DC panel and invalidated the premium tax credits for FFM consumers. The Tenth Circuit U.S. Court of Appeals, which is controlled by Democratic-appointed judges, will soon hear an appeal of that decision from the U.S. District Court for the Eastern District of Oklahoma (see Update for Week of September 29th).

Court decisions on the FFM subsidies have thus far followed the partisan divisions of the judges. However, U.S. Supreme Court decisions on the ACA have not always followed that pattern, as conservative Chief Justice John Roberts previously-sided with the court's liberal wing in upholding the entire ACA (see Update for Week of June 25, 2012).

It takes votes from only four of the nine Supreme Court justices in order to intervene and the four votes on King could have come from the same four conservative justices that sought to overturn the entire ACA. However, the announcement of the court's decision to intervene in King was expected last week but apparently delayed by chief justice Roberts until after the midterm elections.

The loss of FFM subsidies would have a devastating impact on at least 4.5 million consumers that already enrolled in FFM coverage by last April, as it would increase FFM premiums by about 76 percent according to estimates from Avalere Health (see Update for Week of June 2nd).

Appellate court to hear origination clause challenge to ACA next month

The Fifth Circuit U.S. Court of Appeals announced this week that it will hear oral arguments December 2nd on whether the Affordable Care Act (ACA) is unconstitutional because it was first passed in the Senate instead of the House.

Despite the backing of Republican attorneys general from 20 states, a federal judge appointed by President Clinton rejected the claim last January brought by a Texas health services corporation, which rests on a provision of the origination clause in the U.S. Constitution that requires tax-related bills to first pass the House (see Update for Week of January 6th). A panel of three Democratic-appointed judges from the District of Columbia U.S. Court of Appeals unanimously rejected a similar origination clause challenge last summer, holding that "the origination clause only applies to bills whose primary purpose is to levy taxes and not those enacted for other purposes that "may incidentally create revenue" (see Update for Week of July 28th).



The U.S. Supreme Court has thus far declined to grant an expedited review of the challenges before all are resolved in the lower courts (see Update for Week of January 6th).

FEDERAL AGENCIES

Soft launch reveals defects in federally-facilitated SHOP Marketplace

The Centers for Medicare and Medicaid Services (CMS) announced this week that a “soft-launch” of the federally-facilitated Marketplace for small businesses revealed a number of technological glitches and software defects that need to be fixed before the online web portal is available in all states on November 15th.

The Small Business Health Options Program (SHOP) was launched last month in five of the 32 states that defaulted to federal control (Delaware, Illinois, Missouri, New Jersey and Ohio) in an effort to avoid the glitches that impeded the rollout of the Marketplace for individuals last fall (see Update for Weeks of October 20th and 27th). However, the SHOP portal for these states immediately experienced some similar problems, with available SHOP plans not being properly displayed on the site or incorrectly displaying percentages as dollar amounts (i.e. \$400 of the federal poverty level instead of 400%). For some households, the principal subscriber was also erroneously transposed with dependents.

CMS insisted the glitches would be resolved by the November 15th start of open enrollment for the individual Marketplaces. However, SHOP enrollment for small business workers is open year-round.

Treasury to close loophole allowing large groups to offer plans without hospitalization benefits

The Treasury Department issued notice this week that it will issue regulations in 2015 requiring large group health plans to provide “substantial coverage for inpatient hospitalization services” in order to meet the minimum value threshold under the Affordable Care Act (ACA).

The employer mandate under the ACA will require companies with more than 100 workers to meet the law’s minimum value threshold starting in 2015 or pay a per employee assessment. Minimum value is defined as an actuarial value of 60 percent (i.e. paying at least 60 percent of total average costs for covered benefits)—the same standard applied to bronze tier plans.

While large group plans must meet this minimum value threshold, they do not have to provide the essential health benefit packages required of individual and small group plans. The EHB packages include inpatient hospitalization.

In response to industry pleas, Treasury has decided to allow substandard plans that currently do not include inpatient hospitalization to continue being offered by large employers for one year, if the employer committed to them prior to November 4th. (Plans without inpatient hospitalization are often sold at half the cost of plans that include the benefit.)

However, any employee enrolled in a plan that lacks inpatient hospitalization will automatically be eligible for premium and cost-sharing subsidies to purchase Marketplace coverage—even if the coverage meets the ACA affordability standard. This is a key exception to the rule that only employees in unaffordable employer plans can be subsidy-eligible.

The American Hospital Association and other hospital groups praised the announcement.



New guidance confirms employers cannot reimburse workers for individual health plan purchases

The Departments of Labor, Treasury, and Health and Human Services issued joint guidance this week confirming that market reforms under the Affordable Care Act (ACA) now prevent employers from making cash reimbursement to employees for the purpose of purchasing individual health plan coverage.

Some employers had argued that contributing to employee health reimbursement arrangements or flexible spending plans in order to compensate workers that purchase individual coverage should be permitted because these are pre-tax contributions. However, the guidance makes clear that this practice is outlawed regardless of whether the reimbursement is paid to the employee on a pre or post-tax basis.

The guidance notes that HRA or other premium reimbursement arrangements do not violate the ACA if integrated with a group health plan that otherwise complies with the ACA. However, they can be subject to penalties if integrated with individual market policies.

OIG targets ACA subsidies in work plan for 2015

The 2015 work plan released this week by the Office of Inspector General (OIG) for the Department of Health and Human Services (HHS) shows that investigators could issue up to 16 reports on the premium and cost-sharing subsidies offered under the Affordable Care Act (ACA). Planned audits will determine whether the subsidies are being correctly calculated by Marketplaces and consumers are refunding amounts they were not due as a result of income changes during the year.

The OIG will also produce 5-10 reports identifying implementation problems that arose during the inaugural open enrollment period and whether they have been corrected for 2015. This includes the ongoing audit of how nine state-based Marketplaces that were plagued with technical glitches spent federal Marketplace establishment grants (see Update for Week of March 10th).

In addition, the OIG may examine issues surrounding the ACA reinsurance program for insurers with exceptional claims, Medicaid expansion coverage, and new Medicare payment delivery models being tested pursuant to the ACA.

The OIG released a separate audit this week showing that Medicare improperly paid more than \$292,000 in 2012 for HIV/AIDS drugs that were filled up to 32 days after 158 Medicare enrollees had died. Centers for Medicare and Medicaid Services officials pledged to rectify the erroneous payments.

RAND projects \$44 billion in savings from less costly biosimilar drugs

The RAND Corporation released a new report this week concluding that the United States could cut direct spending on biologic drugs by \$44.2 billion over the next ten years (or a four percent reduction) due to Food and Drug Administration (FDA) approval of cheaper biosimilar copies.

The Affordable Care Act (ACA) created the new approval pathway for the generic copies of brand-name biologic drugs. The report funded by the Swiss manufacturer of biosimilars in roughly 60 other countries (Novartis AG) emphasizes that the magnitude of actual savings is ultimately dependent on competition and final regulations to be hashed out by the FDA. RAND suggested the actual savings could range anywhere from \$13-66 billion.

The FDA's Center for Drug Evaluation and Research has received at least 78 requests for an initial meeting to discuss biosimilar development programs for 14 different reference products and already accepted 28 applications for biosimilar products.



Republican wave leads to greatest state-level control in more than a century

Republicans swept the vast majority of state-level races this week, greatly broadening their control of state legislatures and governorships. Although the final outcome of several contests have yet to be determined, by week's end Democrats retained unified control over only seven legislatures, their lowest level since 1860.

Despite pre-election polls showing Republicans could suffer a net loss of up to five governorships, Democrats flipped the governorship only in Pennsylvania and lost governorships in four other states (Arkansas, Illinois, Maryland, and Massachusetts).

Lack of Democratic turnout extinguished any chances of prevailing in Florida, Georgia, Kansas, Maine, or Wisconsin, all states that have resisted any form of Medicaid expansion and are likely to continue to do so. The most disappointing loss for expansion proponents was in Maine, where Democratic control of the legislature likely would have resulted in the state expanding Medicaid had the Democratic challenger prevailed. Re-elected Governor Paul LePage (R) has already vetoed five different bills to expand Medicaid and pledged to continue to do so during his second term.

The existing Medicaid expansion also appears to be in jeopardy in Arkansas and Illinois (see below). Republicans in Arkansas now enough votes to terminate the state's Medicaid expansion alternative while the new Republican governor in Illinois may convert the traditional expansion in the state to a similar private sector alternative.

The traditional Medicaid expansion in Kentucky will remain intact, after Democrats were able to maintain control of the House of Representatives. They also held the Iowa Senate, which may prevent Republican lawmakers from changing their mind about continuing that state's federally-approved Medicaid expansion alternative.

Both Colorado and Connecticut narrowly beat back Republican efforts to gain control of both chambers and the governorship, victories that could have ended the traditional Medicaid expansions in those states. Despite Democrats gaining the Pennsylvania governorship, that state's Medicaid expansion alternative is not likely to change to a traditional expansion as Pennsylvania Republicans increased their margins in both chambers.

Republicans gained new majorities for both chambers in Nevada and West Virginia, and also secured the House in Minnesota, New Hampshire and New Mexico, as well as the New York Senate.

Republicans also now hold a majority of state attorney general positions (26 to 24) by flipping both Arkansas and Nevada, either of which may now be expected to join or initiate legal challenges to the Affordable Care Act (see above).

Marketplace premiums to increase modestly for 2015, except for rural areas

The Urban Institute released its analysis this week of Marketplace premiums for 17 states and the District of Columbia, showing that most consumers in urban areas will see only "modest" premium increases for the second consecutive years.

Rate filings for only two of the 17 states showed average premium increases of five percent or more. The smallest increases (or even declines) will occur where competition is greatest, including the metro areas of Baltimore/Washington, New York City, Cincinnati and Cleveland, Denver, Detroit, Minneapolis, Portland (OR), and Seattle.



This contrasts sharply with premiums for rural counties in states like Tennessee that are expected to jump by an average of 21.4 percent of silver tier plans. Less populated counties in Michigan, New York, and West Virginia will also see average increases of nearly 7-9 percent.

The Urban Institute study was the latest of several to show modest increases in areas with significant competition among Marketplace insurers. Surveys by The Commonwealth Fund, Kaiser Family Foundation, and PricewaterhouseCoopers reflected similar results (see Update for Weeks of October 20th and 27th).

An unrelated survey by Reuters showed that at least six major insurers are expecting 20-30 percent gains in Marketplace enrollment next year due partly to the modest premium increases.

Arkansas

Republican gain needed votes to end Medicaid expansion for 205,000 enrollees

Arkansas' private sector alternative to the Medicaid expansion under the Affordable Care Act (ACA) appears to be in serious jeopardy after Republicans gained the needed votes this week to terminate the waiver program when it comes up for renewal this spring.

Arkansas was the first state to receive federal approval to use ACA matching funds to instead cover the newly-eligible Medicaid population in private Marketplace plans (see Update for Week of September 23, 2013). About 205,000 low-income Arkansans earning up to 138 percent of the federal poverty level are now enrolled in this private option or 91 percent of those that were projected to be newly-eligible (see Update for Week of April 21st).

The waiver was obtained by Governor Don Beebe (D) with the support of key Republican lawmakers as a more politically palatable alternative to a traditional expansion (see Update for Week of March 25, 2013). However, several of those Republicans have since been replaced by more conservative lawmakers that have refused to vote in favor of the required annual renewal.

Under state law authorizing the expansion, it must receive approval from three-fourths of the House and Senate to continue each year, a margin it secured by only one vote in each chamber last spring (see Update for Week of March 3rd). However, Republicans picked up two seats in the Senate with both lawmakers favoring termination, as well as several more seats in the House. Governor-elected Asa Hutchinson (R) has given only lukewarm support to the expansion in the past and appears to lack the authority to stand in their way if lawmakers vote to kick the new enrollees off Medicaid.

The federal Centers for Medicare and Medicaid Services (CMS) gave states the freedom to change their mind and terminate expansions under the comparable expansion alternative waivers it has approved for five states (including Arkansas).

Hospital association survey shows Medicaid expansion has dramatically cut hospital losses

The Arkansas Hospital Association released survey results this week showing that the state's private sector option to the Medicaid expansion under the Affordable Care Act (ACA) has decreased financial losses for responding members by \$69 million (or 56.4 percent) during its first six months.

According to the survey, which was conducted with the assistance of the Arkansas Chapter for the Healthcare Financial Management Association (HFMA), the private option reduced uninsured admissions by 46.5 percent and uninsured emergency room visits by 35.5 percent from January –June 2014. Overall emergency room visits increased by only 1.8 percent, while total utilization also increased only slightly as private option patients replaced uninsured volume.



Previous studies from the Governor's office have also shown dramatic drops in uncompensated care (24 percent) and uninsured hospital admissions (30 percent) since the private option was implemented (see Update for Week of June 16th). However, the success of the program has been somewhat mitigated by a Government Accountability Office audit concluding that the private option will cost Arkansas taxpayers \$778 million more than the state would have spent under actual payment rates for traditional Medicaid (see Update for Week of September 8th).

California

Insurance Commissioner loses rate review referendum but wins re-election

The ballot referendum to give Insurance Commissioner Dave Jones (D) his long-sought authority to reject or modify excessive hikes in health insurance premiums failed to pass this week, garnering only 40 percent of the vote.

The referendum had been placed on this year's ballot by Consumer Watchdog at the urging of the commissioner, who had also introduced legislation as an Assemblyman that would give the commissioner's office the same rate review authority over health insurers that it currently has for auto insurance (see Update for Week of August 29, 2011). However, it was vigorously opposed by the insurance industry and physician groups and failed to come close the 60 percent threshold for passage, despite early support in the polls.

Despite the referendum defeat, Jones was re-elected this week and pledged along with Consumer Watchdog to continue pursuing legislation and possible future referendums that would provide such authority. In its absence, he has used state law and Affordable Care Act (ACA) provisions to publicly shame insurers for roughly \$250 million in premium increases that lacked supporting justification (see Update for Weeks of October 20th and 27th).

Proposed SHOP premiums to increase by 5.2 percent average

Covered California announced this week that proposed 2015 premiums for plans purchased through the Small Business Health Options Program (SHOP) show an average increase of 5.2 percent.

The increase is slightly more than the 4.2 percent average rise in final premiums for the other Affordable Care Act (ACA) Marketplace for individuals and families (see Update for Week of July 28th). Covered California officials emphasized that some small business workers will see increases of less than two percent, while all small group consumers can select from additional coverage options in 2015.

California was among only a handful of state-based Marketplaces that went forward with their SHOP version last year after the Obama Administration delayed all federally-facilitated SHOPs until 2015 (see Update for November 18th-December 6th). The state also required more than one plan option to be available to small business workers, although they had federal discretion to let participating small employers limit coverage to only a single plan until 2016 (see Update for Week of June 2nd).

While small business employees could choose among several plans, all of the SHOP plans could only offer a single benefit level in 2014. However, starting October 1st three SHOP insurers (Health Net, Kaiser Permanente, and Western Health Advantage) will make two benefit levels available (see Update for Week of September 22nd).

The Covered California SHOP will have the same six participating insurers as last year. The remaining three are Blue Shield of California, Chinese Community Health Plan, and Sharp Health Plan.



Special enrollment in Covered California far exceeds disenrollment

Covered California released new enrollment figures last week, showing that average disenrollment from the health insurance Marketplace created pursuant to the Affordable Care Act (ACA) is only 1.6 percent, or nearly a full percent below initial projections.

The Marketplace recently announced that it would terminate coverage for nearly 10,500 consumers that failed to provide documentation of legal residency in the United States, in addition to the 150,000 that have disenrolled since the inaugural open enrollment period closed last spring. However, more than 200,000 consumers have used special enrollment periods to sign-up for Covered California coverage from June to September leading to an overall net gain since open enrollment.

Covered California officials acknowledge that special enrollment sign-ups are still slightly below initial projections. They attribute the lag to a continued backlog of 170,000 Medicaid applications, even though the logjam has been greatly reduced from 900,000 earlier this year (see Update for Weeks of April 28th and May 5th).

More than 1.12 million consumers are currently enrolled in Covered California plans.

Florida

Medicaid expansion appears dead as Republicans gain House supermajority, hold governorship

Governor Rick Scott (R) narrowly defeated former Governor Charlie Crist (D) this week by 66,000 votes (out of 4.75 million cast), after only about 40 percent of registered voters turned out in critical Democratic counties in south Florida.

Democrats nationwide had targeted Florida as their most high-profile opportunity to not only flip a governorship but expand Medicaid. More than 1.2 million Floridians are currently caught in the gap between Florida's extremely low Medicaid eligibility levels and the threshold for premium and cost-sharing subsidies under the Affordable Care Act (ACA).

Both Governor Scott and Senate Republicans had backed a private sector alternative to the Medicaid expansion last session similar to the model federally-approved for five other states (see Update for Week of March 31st). However, House Republicans remained adamantly opposed to accepting any of the federal matching funds to expand—a position not likely to change after Republicans gained eight House seats to now hold a supermajority in both chambers.

Governor Scott has stated that he will not push for the Medicaid expansion next year in the absence of House support.

Illinois

New governor says he may convert Medicaid expansion to private sector alternative

Private equity investor Bruce Rauner (R) narrowly defeated incumbent Governor Pat Quinn (D) this week and will assume public office for the first time in January.

Rauner's victory was largely viewed as a referendum on Governor Quinn, who had been dogged by ethics scandals and the nation's worst credit rating. Rauner pledged during the campaign to reduce the state's income tax and retain the popular expansion of Medicaid under the Affordable Care Act (ACA), which has enrolled roughly 470,000 Illinoisans since July 2013 (far more than the 200,000 that Governor Quinn projected would sign-up in year one).

Despite this pledge, it remains unclear whether the Medicaid expansion will remain in its current form. The Illinois legislature remains solidly under Democratic control making the odds of eliminating the



expansion improbable. However, Governor Rauner had told conservative activists last month that he would have vetoed the expansion if he were governor last year and may seek federal approval to convert the traditional expansion into a private sector alternative similar to those in place in five other states. This model would use ACA funds to instead cover those newly-eligible for Medicaid under private Marketplace or Medicaid managed care plans.

Governor-elect Rauner has also indicated that he would seek a wholesale restructuring of traditional Medicaid, which he insists is “filled with waste and fraud.”

Massachusetts

Voters elect health insurance executive as governor, mandate paid sick leave for workers

In one of the more surprising election results this week, former Harvard Pilgrim chief executive officer and state Health and Human Services secretary Charlie Baker (R) narrowly won the governorship this week and will replace term-limited Deval Patrick (D) in January.

Current Attorney General Martha Coakley (D) had been expected to succeed Patrick. However, her health reform record became clouded by her controversial agreement to let Partners HealthCare expand its hospital ownership. Similar to the Maryland governor’s race, her predecessor’s failure to successfully upgrade its health insurance Marketplace web portal to comply with the Affordable Care Act (ACA) also became a drag on her campaign (see Update for Week of March 10th).

Coakley had previously sought to replace the late Senator Ted Kennedy (D-MA) in Congress, but her unexpected defeat in that race cost Democrats a filibuster-proof majority and nearly derailed ACA passage in 2010. Her latest loss may be due in part to her lacking the health care experience of her opponent in a state whose recent transition to global budgets and landmark coverage expansion in 2007 became a national model.

Governor-elect Baker campaigned on a pledge to provide greater transparency into healthcare costs, including a promise to make average prices for the most commonly provided health services publicly available by 2016. He also will seek to reduce wait times for primary care physicians in Massachusetts (which lead the nation at an average of 45 days) largely by securing a federal waiver to raise Medicaid payments for primary care and craft state incentives for primary care physicians to coordinate care for patients with complex or chronic conditions.

Another federal waiver that Baker plans to seek would simplify the state’s health insurance Marketplace (that predates the ACA).

Massachusetts voters also passed a ballot referendum that would give the Commonwealth the nation’s strongest sick leave mandate, requiring employers with more than ten workers to provide one hour of paid sick leave for every 30 hours worked (capped at 40 hours). California and Connecticut are the only other states that mandate paid sick leave (although several cities have similar laws).

Ohio

Governor’s re-election does not ensure renewal of Medicaid expansion in 2015

Governor John Kasich (R) reaffirmed his commitment this week to Ohio’s expansion of Medicaid under the Affordable Care Act (ACA), following his re-election to a second term. However, it remains far from certain whether he can secure the legislative approval needed to continue the expansion past July, as both chambers remain firmly in the hands of Republican lawmakers opposed to its renewal.

Kasich was one of only 11 Republicans to back some form of an ACA expansion, but had to circumvent legislative opposition in order to get it enacted. He relied on the state Controlling Board,



which was a small group of bipartisan lawmakers overseeing adjustments to the Ohio's two-year budget cycle (see Update for Week of October 21, 2013).

However, the full legislature must approve a new two-year budget that will start July 1st, meaning that Governor Kasich must now secure renewed funding from the same group of lawmakers annoyed by his “end-around.” The Governor intends to rely on the popularity of the expansion for support, as more than 367,000 Ohioans have enrolled since January 1st, already exceeding the Governor’s projection for July 2015. Should the legislature fail to renew the expansion, these 367,000 will largely become uninsured and pushed on the backs of safety net hospitals just before the ACA starts phasing-down their federal indigent care funding in 2017.