

### Health Reform Update – Week of March 11, 2013

#### CONGRESS

##### ***Senate spending bill includes sequester and Medicare “doc fix”, but no extra ACA funds***

Majority Leader Harry Reid (D) has postponed consideration of the Senate’s continuing resolution (CR) bill that will fund the government through September, after Senators were unable this week to reach agreement on more than 100 amendments to the stopgap bill (H.R. 933).

The CR must be enacted by March 27<sup>th</sup> to avoid a federal government shutdown, an outcome that leaders from both sides have pledged to avoid. Sizeable differences must be ironed out between the House-passed version and the Senate measure negotiated by Appropriations chair Barbara Mikulski (D-MD) and ranking member Richard Shelby (R-AL). However, in an effort to ensure both sides pass something, the Senate measure sought to remove some of the major sticking points by agreeing to the lower spending levels set by the House bill, which reflects the sequester that went into effect March 1<sup>st</sup>.

To the further consternation of many Democrats, the Senate version also fails to include the additional \$949 million sought by the Office of Management and Budget for Affordable Care Act (ACA) implementation. Rep. Nita Lowey (D-NY) had warned that excluding the supplemental funding will delay progress of the exchanges set to begin enrollment on October 1<sup>st</sup> (see Update for Week of March 4<sup>th</sup>).

Amendments sought by Senator Tom Harkin (D-IA) to restore this funding, as well as new funds for the AIDS Drug Assistance Program, have already been rejected, as were the promised attempts by tea party-backed Senators led by Ted Cruz (R-TX) to prohibit any funding for the ACA until the economy is growing at the “historic” level of at least 3-4 percent.

As with the House version, the Senate proposal also would rescind \$10 million for the controversial Independent Payment Advisory Board (IPAB) created by the ACA, the same level cut under last year’s continuing resolution.

##### ***Democrats try to pre-empt Republicans on dueling budget proposals***

The House budget proposal released this week by Rep. Paul Ryan (R-WI) largely mirrors his previous proposal to Medicare enrollees premium support to enroll in private plans starting in 2024 and convert Medicaid into block grants with no strings attached (see Update for Week of April 2<sup>nd</sup>). It likewise would increase Medicare Part B and D premiums for the wealthiest enrollees, similar to President Obama’s proposal last year (see Update for Week of February 13, 2012), as well as fully repeal the Affordable Care Act (ACA) while retaining the law’s \$716 billion in Medicare savings.

The Senate version unveiled this week by Senator Patty Murray (D-WA) attempted to pre-empt Republican arguments on entitlement cuts by proposing more than double the amount of cuts to Medicare, although the details of those cuts would be left to the Budget Committee. However, it also would permanently reverse the Medicare sustainable growth rate formula (SGR) that would dramatically cut physician payments. House Ways and Means Republicans had pledged to eliminate the SGR this year, as it has been postponed by Congress every year since implementation. However, the House did not include such a proposal in last week’s CR or their proposed budget this week, even though the Congressional Budget Office recently lowered the projected cost of elimination from \$260 billion over ten years to only \$138 billion (see Update for Weeks of January 28<sup>th</sup> and February 4<sup>th</sup>).

### ***Health savings in President's "grand bargain" targets pharmaceuticals***

President Obama proposed over \$400 billion in health savings this week as part of a "grand bargain" that would permanently lift the sequester by reducing the deficit more than \$1.2 trillion over ten years, more than \$140 billion of which would come from drug manufacturers. These savings would come principally from eliminating the provision of the 2003 law creating Medicare Part D that reimburses at Medicare rates for drugs provided to those eligible for both Medicare and Medicaid. Drugmakers fought hard for that provision, but the President has repeatedly sought to require that dual eligibles be reimbursed instead at Medicaid rates (see Update for Week of February 13, 2012).

Other proposed health saving would come from reducing hospital payments, increasing fraud and abuse preventing, and banning "pay-to-delay" generic drug settlements, should the U.S. Supreme Court uphold them following oral arguments on March 25<sup>th</sup> (see Update for Week of January 21<sup>st</sup>).

The President reiterated his demands that any "grand bargain" include higher revenues from wealthier Americans, but also warned Democrats they would have to accept changes to Medicare.

### ***White House urges Congress to allow FDA to spend user fees***

The White House is urging Congress to allow the Food and Drug Administration (FDA) to spend the \$41 billion in prescription drug and biosimilar user fees it has collected, despite the nine percent automatic cut to its fiscal year 2013 budget that took effect March 1<sup>st</sup>.

The fees were collected under the reauthorization of Prescription Drug User Fee Act (see Update for Week of June 18<sup>th</sup>). However, they were not exempted from the sequester, which will reduce FDA spending by \$210 million through September 30<sup>th</sup>.

President Obama is now seeking to exempt user fees from the sequester, in the event that ongoing negotiations fail to shut it off entirely (see above). FDA commissioner Margaret Hamburg stressed last week that these new fees have greatly reduced the backlog of generic drug applications that had pushed the median time for FDA review and approval to 31 months. Exempting user fees would give the FDA an additional \$36 million for the rest of this fiscal year.

The White House and FDA commissioner warn that without the exemption, drug approvals will again be greatly delayed and the agency will have to reduce operational support.

### ***Democrats resurrect effort to allow Medicare to negotiate drug prices***

New bills from Rep. Peter Welch (D-VT) and Sen. Amy Klobuchar (D-MN) would require federal regulators to negotiate drug prices under Medicare Part D, a move that could save an estimated \$156 billion over ten years.

Progressive groups have been calling for the change since the enactment of Medicare Part D legislation in 2003. However, the White House dropped its support for the measures in order to secure pharmaceutical industry support for the Affordable Care Act (ACA).

## **FEDERAL AGENCIES**

### ***CCIIO acknowledges for first time that exchanges may not meet ACA deadline***

The Centers for Medicare and Medicaid Services (CMS) division overseeing exchange implementation acknowledged for the first time this week that contingency plans are being developed in the event states are not ready to being enrollment on October 1<sup>st</sup>.

The Center for Consumer Information and Insurance Oversight (CCIIO) has conditionally-certified exchanges to be operated by 18 states and the District of Columbia, while it will oversee the federal marketplace for 26 states. Another seven states will operate as an initial federal-state partnership.

At recent industry functions and before Senate Finance, the CCIIO director was adamant that the exchanges will meet Affordable Care Act (ACA) deadlines (see Update for Week of February 11<sup>th</sup>). However, members of Congress and the industry have remained largely skeptical, given the huge tasks that states and the federal marketplace must still complete in less than 200 days. The Congressional Budget Office even revised their cost estimates under the assumption that many exchanges will not be ready, leaving two million more uninsured than initially projected (see Update for Week of January 28<sup>th</sup> and February 4<sup>th</sup>).

Members of America's Health Insurance Plans (AHIP) grilled the CCIIO director this week, who eventually conceded that CMS was developing contingency plans that may scale back the initial scope of the exchanges in order to assure that all states can meet the deadline. However, he declined to provide any details other than to stress that a separate division of CMS would prepare the plans so that CCIIO can remain focused on implementation.

While several "early innovator" states including California, Colorado, Connecticut, Maryland, and Washington are on track to start October 1<sup>st</sup>, many lag far behind and have yet to even receive legislative authorization to move forward despite being conditionally-approved. It is not yet clear that the federal marketplace will be able to step in for those states on day one, since it has yet to complete testing of the federal data hub and premium data will not be released until July (see Update for Week of February 11<sup>th</sup>).

Health and Human Services (HHS) Secretary Kathleen Sebelius met behind closed doors this week with the Senate Finance Committee to discuss implementation concerns and is expected to do likewise next week with the House Ways and Means health subcommittee.

### ***Proposed rule on exchange navigators awaiting final OMB clearance***

The Office of Management and Budget (OMB) is reviewing a proposed rule that will govern the role of navigators in the new federal marketplace.

The OMB paperwork clearance is the last step before a rule is published. Although the process can still take weeks or months, the navigator rule is likely to move quickly as the Centers for Medicare and Medicaid Services (CMS) is under pressure to start accepting marketplace applications from prospective plans on March 28<sup>th</sup>, release premium data in July, and begin enrollment on October 1<sup>st</sup>.

The rules will spell out what training and certification will be required for non-profits, insurance brokers, etc. to help facilitate exchange enrollment. States will assume this process for their own exchanges. However, several states that have defaulted to the federal marketplace are debating bills that would keep navigator training under their control (see Update for Week of March 4<sup>th</sup>). (Georgia legislation was sent to the Governor this week). It is not yet clear if CCIIO will allow states to do so, although it wrote letters to four states this week (KS, MT, NE, OH) stating that it may consider their requests to retain control over certification of participating plans.

Marilyn Tavenner, acting CMS director, told hospital executives earlier this month CMS will begin to roll out its navigator program from April through July and may allow for navigators to be stationed in hospital emergency rooms. The director of the Center for Consumer Information and Insurance Oversight with CMS told the Senate Finance Committee that funding opportunities for navigators would be made available soon, with the first grants to be awarded in June (see Update for Week of February 11<sup>th</sup>).

### ***Federal marketplace will only offer one small business plan in 2014***

Proposed rules published by the Department of Health and Human Services (HHS) this week will not require that small business workers in the new federal marketplace have a choice of plans until 2015.

Under the Affordable Care Act (ACA), the exchange in each state will include a Small Business Health Options Program (SHOP) as well as offer plans for individuals. However, CMS had not resolved how many health plan choices will be offered the SHOP exchanges, as small businesses typically offer just one plan for workers.

The rule proposes that for plan years from January 1, 2014 to January 1, 2015, HHS will delay an “employee choice” model as a requirement for the SHOPs in the federal marketplace. That means just one qualified health plan (QHP) will be offered.

States with their own exchanges could opt for a SHOP that offers just one plan, or one that would offer multiple plans. However, the rule does not specify what would happen in states that have opted for a federal-state partnership exchange.

The proposed allows applicants to enroll outside of the open enrollment period if they have a triggering event such as marriage, divorce, childbirth, adoption, etc. That special enrollment period had been set at 60 days after the event, but HHS now proposes to reduce it to 30 days so that it aligns with HIPAA-established special enrollment periods for the group market. As part of this effort, HHS will also make employee or dependent eligibility for premium assistance under Medicaid or the Children’s Health Insurance Program (CHIP) a triggering event.

A separate final rule also tweaked a controversial policy that required QHPs in the federal marketplace to also participate in the SHOP exchanges. That policy will now only apply to QHPs with a least 20 percent share of the small group market.

### ***CMS reportedly will revamp single, streamlined application in face of criticism***

The *Associated Press* (AP) reported this week that the Centers for Medicare and Medicaid Services (CMS) is revamping its draft of the single, streamlined application that the Affordable Care Act (ACA) requires for the new health insurance exchanges, Medicaid, and other health care programs.

Public comments due to the agency this week were highly critical of the 21-page online application and 15-page paper version for being overwhelming and confusing. CMS officials had emphasized in training sessions that most applicants with three or fewer members in their household would not be completing all of these pages, which should take 30 minutes to complete on average (or 45 minutes for the paper version), however they have acknowledged that applicants would still need “significant help” filling out the forms (see Update for Week of February 11<sup>th</sup>), as it will seek detailed information on income in order to ascertain eligibility for premium and cost-sharing assistance under the ACA as well as Medicaid or SCHIP eligibility.

Comments from the Center for Budget and Policy Priorities recommended that the application should first rule out the latter, so all applicants do not needlessly have to answer the lengthy questions relating to premium tax credits. Consumer advocates were also very concerned about confusing questions relating to an applicant’s current access to “lowest cost self-only health plan” offered at their jobs, the cost of premiums for that plan and whether it meets the “minimum value standard.” America’s Health Insurance Plans also insisted that consumers should be able to pick their preferred plan online and enroll in coverage.

CMS plans on finalizing the application in April. The agency predicts that more than 90 percent of the applications submitted in 2014 will be online, although the Georgetown University Health Policy Institute warned that as few as ten percent of applicants may submit online applications in some states.

House Energy and Commerce Republicans seized on the AP report to demand why CMS sought confusing answers that would not be known to most applicants “outside of their tax filings”.

### ***Expatriate plans get temporary reprieve from Affordable Care Act compliance***

The departments of Labor, Health and Human Services (HHS), and the Treasury released new guidance last week granting temporary transitional relief from the Affordable Care Act (ACA) for expatriate health plans covering employees working outside their home country. The agencies are inviting public comments through May 8<sup>th</sup>.

The so-called “Expat FAQ” clarifies that for plan years starting before 2016, such plans will not be subject to new ACA standards so long as they continue to comply with the federal health plan mandates under the pre-ACA versions of federal ERISA law and the Internal Revenue Code. These include provisions governing mental health parity, HIPAA nondiscrimination, and claims and appeal procedures.

The Expat FAQ also confirms that the agencies will treat coverage provided under an expatriate group health plan as a form of minimum essential coverage under the ACA and thus not be subject to the individual mandate penalty for not having adequate health insurance. Additionally, such an individual will not be eligible for premium tax credits under the ACA so long as the expatriate coverage offered by their employer is affordable, nor will the company be subject to a penalty under the ACA’s employer mandate.

Expatriate plans are defined as group health plans where “enrollment is limited to primary insureds who reside outside of their home country for at least six months of the plan year and any covered dependents.” This definition will not extend to all health coverage provided for employees of American companies working outside the United States. For example, self-insured coverage for expatriate employees does not qualify.

## **STATES**

### ***States that refuse to expand Medicaid may cost employers \$1.3 billion in ACA penalties***

Business groups amplified their calls this week for states to expand Medicaid under the Affordable Care Act (ACA), after a Jackson Hewitt study found that opting-out will impose substantial costs on large employers.

Starting in 2014, companies with at least 50 full-time (FT) workers must offer minimum and affordable health coverage or pay a penalty of up to \$3,000 for each FT employee that thus becomes eligible for the ACA’s premium tax credits or \$2,000 for every FT employee (after the first 30).

Companies are exempt from these penalties for workers earning from 100-138 percent of the federal poverty level (FPL) in states that expand Medicaid. However, with as many as 17 states opting-out or leaning in that direction (and another five undecided), Jackson Hewitt found that employers in these states could be subject to \$876 million to \$1.3 billion in additional penalties each year, depending on how many workers receive the premium tax credits that start at 100 percent of FPL.

Nationwide, the study found that roughly 42 percent of all workers in this group may qualify for the ACA tax credits. Thus would subject employers in Texas, the largest opt-out state, to as much as \$448 million in fines if all of the more than 149,000 workers eligible for tax credits actually receive them. Employers in the second largest opt-out state of Florida (see below) could be liable for up to \$219 million.

These figures have led the U.S. Chamber of Commerce and other business groups to call for the Obama Administration to exempt this group from the employer mandate, similar to the exemption granted from the individual mandate for those not eligible for tax credits who live in opt-out states (see Update for Weeks of July 23<sup>rd</sup> and 30<sup>th</sup>).

#### Arizona

***Health committee chair backing Governor’s bill to expand Medicaid under the ACA***

Governor Jan Brewer (R) unveiled a draft budget bill this week detailing her plans for expanding Medicaid under the Affordable Care Act (ACA) (see Update for Week of January 14<sup>th</sup>).

The measure faces an uphill battle among skeptical Republicans that control the legislature. However, House Health Committee chair Heather Carter (R) was among six Republicans joining with the Governor during her second public rally to engender support for the bill.

The draft includes the Governor's promised "circuit breaker" that automatically rolls back coverage for those between 100-133 percent of the poverty if the promised ACA funding falls below 80 percent of expansion costs. This provision is viewed as critical to the bill's prospects, as the federal government is supposed to cover all of the cost through 2016, then at least 90 percent thereafter.

The Governor also wants to give the Arizona Health Care Cost Containment System (AHCCCS) the authority to "establish, administer and collect" a hospital assessment that will raise an estimated \$256 million to pay for the state's share of expansion. Other provisions intended to give Republicans some "political cover" include requiring AHCCCS to develop proposals to increase cost-sharing for Medicaid enrollees. However, the Obama Administration has already approved limited AHCCSS copayments after higher cost-sharing was thwarted by the courts (see Update for August 22, 2011).

Despite broad support from provider, consumer, and business groups, the Governor's bill faces intense opposition from conservative think tanks like the Goldwater Institute that oppose any ACA implementation. House Speaker Andy Tobin (R) has already stated that the bill cannot pass unless significant problems are fixed and assigned the bill to the House Appropriations Committee, which is more hostile to the legislation than Rep. Carter's committee.

#### California

#### ***Obama Administration again sides with states in dispute over Medicaid payment cuts***

California Governor Jerry Brown (D) is praising the Obama Administration's recent support for an appeals court decision that allows California to reinstate across-the-board Medicaid cuts.

A three-judge panel for the Ninth U.S. Court of Appeals reversed a lower court decision that had barred a ten percent cut to Medi-Cal rates in 2011, even though it was federally approved (see Update for Weeks of December 3<sup>rd</sup> and 10<sup>th</sup>). The panel held that the U.S. Department of Health and Human Services (HHS) has the authority to decide whether a rate cut will threaten access to care for Medicaid beneficiaries and thus violate federal Medicaid law.

The rate cut was expected to save \$623 million annually, but bitterly opposed by providers, physicians, and consumers who had experienced similar cuts in years prior. However, the Obama Administration is opposing their appeal to the full 9<sup>th</sup> Circuit panel, urging the court to uphold the cuts and affirm the "wide discretion" that states need in setting appropriate Medicaid payment rates for their states.

The Administration's prior support for the cuts surprised provider and consumer groups (see Update for Week of 6, 2011) and may now be based to a large extent on their efforts to lure reluctant governors into expanding Medicaid under the Affordable Care Act (ACA).

The U.S. Supreme Court declined to resolve the issue last year, remanding earlier decisions that blocked earlier Medi-Cal cuts back to the Ninth Circuit since they had yet to be approved by HHS (see Update for Week of February 20, 2012).

It is not yet clear that Governor Jerry Brown (D) will actually reinstate the 2011 cuts as California's budget crisis is projected to be alleviated by the two statewide tax initiatives approved last month by voters (see Update for Week of November 5<sup>th</sup>).

#### ***Governor and legislature at odds over Medicaid expansion***

Governor Jerry Brown (D) and Democratic lawmakers continue to disagree over how to expand Medi-Cal under the Affordable Care Act (ACA).

The Governor's fiscal year 2013-2014 budget proposal earmarked \$350 million to cover the increased enrollment. Although the Assembly and Senate passed companion bills to expand Medi-Cal (SBX1-1 and ABX1-1) and simplify the Medi-Cal enrollment process (see Update for Week of March 4<sup>th</sup>), the measures are at odds with the Governor's approach to fund the expansion by transition some existing Medi-Cal enrollees into the new Covered California exchange (including newly documented immigrants and those with HIV/AIDS), scale back additional benefits, and reduce the roughly \$2 billion per year that the state provides counties to pay for treatment of uninsured individuals. The Governor also wants an automatic "trigger" that will terminate the expansion if the federal share of the expansion cost ever drops below the 90 percent minimum stipulated in the ACA.

Democratic lawmakers oppose the "trigger" and instead would give the legislature up to one year to re-evaluate and amend state laws if federal funding changes. They also insist that the Governor's program cuts are currently unnecessary because the ACA fully funds the expansion through 2016.

#### Connecticut

##### ***Regulators to focus on health benefits exchange, place other ACA regulations on hold***

The director of the new health benefits exchange in Connecticut announced this week that state regulators have stopped implementing other parts of the Affordable Care Act (ACA) effective March 1<sup>st</sup> in order to ensure that the exchange can begin user testing June 4<sup>th</sup> and open enrollment on October 1<sup>st</sup>.

Connecticut, along with California and Maryland, are far ahead of other states in exchange progress and one of only six states that have received five federal exchange implementation grants. It has already created a user website and contracted with Maximus Inc. to run a new call center.

However, state officials acknowledge that building the exchange is simply too big a task to balance with other ACA regulations. They also fear that any late changes to the exchange could delay user testing of the online marketplace and prevent them from ironing out any bugs prior to the October 1<sup>st</sup> start date required by the ACA.

#### Florida

##### ***Senate panel joins House in rejecting Medicaid expansion, promotes "Not Medicaid" alternative***

The Senate Select Committee on Patient Protection and Affordable Care Act (ACA) Implementation joined with its House counterpart this week in rejecting the Medicaid expansion proposed by Governor Rick Scott (R) (see Update for Week of February 18<sup>th</sup>).

The straight party-line vote signaled Republican disapproval for any expansion of entitlement programs, despite the massive influx of \$51 billion in federal funds over ten years. However, House Speaker Will Weatherford (R) and other Republicans appeared very uncomfortable with simply saying "no" to the expansion given the broad support from provider, consumer, and business groups in the state, as well as 63 percent of voters in American Cancer Society polls (see Update for Week of March 4<sup>th</sup>).

As a result, chairman Joe Negron (R) quickly floated a "Not Medicaid" alternative, agreeing that Florida could not simply leave nearly 1.3 million of Florida's four million uninsured without Medicaid or premium tax credits under the ACA. Though it has yet to be drafted, Negron suggested it could follow the alternate plan that the Obama Administration already approved for Arkansas, where the state used the ACA funds for the expansion to instead cover newly-eligibles in their partnership health insurance exchange (see Update for Week of February 25<sup>th</sup>) or give them vouchers to purchase private coverage.

The Congressional Budget Office has projected that it would cost an additional \$3,000 per person to cover uninsured individuals in the new ACA exchanges versus traditional Medicaid (see Update for

Weeks of July 23<sup>rd</sup> and 30<sup>th</sup>). However, Negron cited a Milliman study commissioned by the Agency for Health Care Administration claiming it would actually cost 3-4 percent less because of higher copayments in the exchange (assuming out-of-pocket costs would be capped at five percent of family income).

### Idaho

#### ***House passes Governor's health insurance exchange bill, Senate expected to follow***

Governor Butch Otter (R) appears to have won his battle with the legislature over creating a state-based health insurance exchange that complies with the Affordable Care Act (ACA).

The Governor was one of only five Republicans to support a state exchange instead of ceding control to the federal government. However, House Republicans had been intent for years on blocking any implementation of "Obamacare" and even threatened to defund exchange efforts or prohibit the Governor from creating it through executive order (see Update for Weeks of December 3<sup>rd</sup> and 10<sup>th</sup>).

Senate passage last month of Otter's bill and cost estimates showing the state exchange could charge fees that are three times lower than the federal exchange (see Update for Week of February 18<sup>th</sup>) ultimately persuaded half of the House Republicans to join with all 13 Democrats and pass the measure after a feisty day-long debate. However, the sudden exchange support may not translate to the Medicaid expansion, which the Governor continues to oppose despite the recommendation of the advisory council he assembled (see Update for Week of January 7<sup>th</sup>).

At least one Republican, Rep. Tom Loertscher, announced this week that he will introduce and support bills authorizing the expansion under the ACA and dissolving the state's Catastrophic Health Care Fund that spends over \$60 million in to care for low-income childless adults that do not qualify for Medicaid. He emphasized that these bills would follow the recommendations of the panel and save the state \$284 million through 2024 (see Update for Week of November 12<sup>th</sup>). However, Governor Otter has hinted that he may propose an alternative plan modeled after those federally-approved in Arkansas and proposed in Indiana (see Update for Week of February 25<sup>th</sup>).

### Louisiana

#### ***Senate probes health department on "hidden tax" on employers for Medicaid expansion opt-out***

The joint Senate and House Insurance Committees held a hearing this week to gather information on whether Louisiana should expand Medicaid under the Affordable Care Act (ACA) or seek alternatives.

Governor Bobby Jindal (R) and health secretary Bruce Greenstein have remained adamant that Louisiana should opt-out of the "massive entitlement expansion" that would be "too costly" and "weaken the private insurance market." However, committee chair Senator Dan Morrish (R), insisted that lawmakers have a duty to explore to first explore potential costs and benefits, as well as test whether Louisiana could use the federal funding to cover newly-eligible Medicaid enrollees in the federally-facilitated health insurance exchange, similar to the alternate plan the Obama Administration recently approved for Arkansas (see Update for Week of February 25<sup>th</sup>).

Senator Morrish also grilled Greenstein on whether opting-out of the expansion would increase penalties that employers must pay under the ACA. Greenstein acknowledged that the Administration has not forecast what the impact on employers, even though a Jackson Hewitt study released this week showed that nearly 26,000 Louisianans earning from 100-138 percent of the federal poverty level would become eligible for ACA premium tax credits if the state opted-out (see above). It showed that large employers in Louisiana could thus be forced to pay an additional \$51.8 to \$77.6 million in penalties as a result of this group not being covered by Medicaid and not being offered affordable employer coverage.

Rep. Barbara Norton (D) filed legislation this week (H.B. 110) that would authorize Louisiana to participate in the AC expansion. The measure is supported by AARP Louisiana, Louisiana chapters of the National Multiple Sclerosis Society and AIDS Advocacy Network, the American Cancer Society, and several other consumer advocates that waited for hours to testify. They were buttressed by estimates

from the Louisiana Budget Project that the expansion could reduce the uncompensated care costs for Louisiana hospitals by \$1.1 billion by cutting the number of uninsured by 60 percent. One in four working age adults in Louisiana currently lacks health insurance.

### ***Several House Republicans seek to protect prescription drug assistance for seniors***

Several House Republicans came out in opposition this week to a proposal by Governor Bobby Jindal (R) that would eliminate the state's Senior Rx program.

Senior Rx was created in 2006 as a means to help the elderly navigate manufacturer patient assistance programs that provide some free or low-cost medicine to those the low-income uninsured. The program has saved over 100,000 residents roughly \$145.4 million.

At a hearing this week on the Governor's proposed budget, Rep. Johnny Berthelot (R) argued that the \$1 million budget for Senior Rx pales in comparison to the savings, while Rep. Pat Connick (R) insisted that "it's unfair to keep dumping on the charities [that] are just being overwhelmed." However, the director for the Office of Planning and Budget claimed that Senior Rx duplicated other resources that are available from the Department of Health and Hospitals or non-profit organizations.

### Maine

#### ***Governor seeks deal on Medicaid expansion***

Governor Paul Le-Page (R) and the Democratic-controlled Legislature appear to be moving toward a consensus that would expand Medicaid under the Affordable Care Act (ACA).

The Governor was among the first to openly opt-out of the Medicaid expansion after the U.S. Supreme Court gave all states the flexibility to do so without penalty (see Update for Week of June 25<sup>th</sup>), insisting that it was a "degradation" of the health care system that would lead to a single-payer model. However, recent deals cut by other governors with the Obama Administration and the loss of Republican control over both legislative chambers in Maine have compelled the Governor to signal this week that he is now open to participating if he can secure the "best deal for Mainers".

Governor LePage would not stipulate what he expects from the Obama Administration in exchange for expanding. Republican governors in Florida and Virginia recently received federal approval to expand Medicaid managed care or hike enrollee cost-sharing as an inducement to participate, and the Democratic governor was allowed to use the federal Medicaid expansion dollars to cover newly-eligible individuals in the state's partnership health insurance exchange (see Update for Week of February 25<sup>th</sup>)—a model that several Republican governors and legislatures are now likewise seeking (see below).

Rep. James Campbell (I) introduced L.D. 1049 this week, which would add 55,000 Mainers to Medicaid by expanding eligibility to 138 percent of the federal poverty level, consistent with the ACA. According to the Maine Center for Economic Policy, it would stimulate \$350 million in economic activity, create more than 3,100 jobs, and generate as much as \$18 million in state and local taxes per year.

### Missouri

#### ***House and Senate panels reject Medicaid expansion....again***

Lawmakers in the Republican-dominated legislature delivered a resounding no for the fourth and fifth time this week to proposals that Missouri expand Medicaid under the Affordable Care Act (ACA).

The rejection comes despite support of Governor Jay Nixon (D), as well as the Missouri Hospital Association and the Missouri Chamber of Commerce and Industry, who released a new study this week showing that uncompensated care costs will nearly triple to \$3.5 billion annually by 2019 if the Medicaid expansion is not enacted. Only one member of the public spoke against the Democratic-backed measure during a Senate Appropriations Committee hearing this week.

Both Senate Appropriations and the House Budget Committee defeated expansion bills on a party-line vote, insisting that it was not “politically-feasible” to follow the lead of Republican governors in Arizona and Florida and include an automatic termination clause should the promised federal funding not materialize in subsequent years. Republicans also largely insisted that the public demonstrated their skepticism of the expansion when voters enacted a ballot referendum barring the Governor for implementing the expansion without legislative approval (see Update for Week of November 5<sup>th</sup>).

Neither panel has yet to consider alternates, such as the partial expansion pending in the House Government Oversight and Accountability committee (H.B. 700) (see Update for Week of February 25<sup>th</sup>).

#### New Mexico

##### ***Senate passes legislation authorizing more passive health insurance exchange model***

The Senate overwhelmingly passed compromise legislation this week that would create a state-based health insurance exchange that complies with the Affordable Care Act (ACA).

S.B. 221 passed with bipartisan support as it followed the model sought by Governor Susanna Martinez (R), which creates the exchange within the New Mexico Health Insurance Alliance, a nonprofit corporation established in 1994. However, it agreed to Democratic demands to add a consumer advocate to the 13-member oversight board and limit insurers to only one member. The Governor also dropped her insistence that authorizing legislation was unneeded (see Update for Week of February 18<sup>th</sup>).

The Senate version also follows the passive “clearinghouse” model where any plan that meets minimum federal standards can participate. The measure now moves to the House, where a bill to instead follow the “active purchaser” model failed last month after eight Democrats defected. Democratic lawmakers had largely preferred this more competitive model where the governing board can selectively contract only with the most affordable plans and exclude others even if they meet minimum standards.

#### Ohio

##### ***Governor’s Medicaid expansion plan runs into stiff House opposition***

House Republican leaders pledged this week that the proposal by Governor John Kasich (R) to expand Medicaid under the Affordable Care Act (ACA) would not pass without substantial amendments.

Governor Kasich surprised many by becoming one of eight Republican governors to support the Medicaid expansion, despite staunch opposition to “Obamacare” and previously inflated estimates of the expansion’s cost (see Update for Weeks of January 28<sup>th</sup> and February 4<sup>th</sup>). The expansion has the support of state hospital and physician associations, as well as business and consumer groups. However, it has drawn the ire of conservative groups intent on blocking any ACA implementation.

Two of these groups, the Cato Institute and Buckeye Institute for Public Policy Studies, railed against the expansion during House subcommittee hearings this week. Cato argued that it is “wildly unrealistic to assume the federal government will maintain the Medicaid expansion’s 9-to-1 matching rate” as they could change the matching rate at any time. The Buckeye Institute warned that states effectively could not opt-out of the expansion if it becomes financially unsustainable, despite Obama Administration assurances to the contrary (see Update for Weeks of August 6<sup>th</sup> and 13<sup>th</sup>).

House Speaker William G. Batchelder (R) and Rep. Barbara Sears (R) echoed these themes and are instead developing alternatives similar to what the Obama Administration approved for Arkansas, where the state can use ACA funds for the Medicaid expansion to instead cover newly-Medicaid enrollees under private health insurance exchange plans (see Update for Week of February 25<sup>th</sup>).

#### South Carolina

##### ***House rejects Medicaid expansion bill***

The House rejected legislation this week that would expand Medicaid under the Affordable Care Act (ACA). The move was expected as Governor Nikki Haley (R) was among the first Republicans seeking to opt-out of the expansion after the U.S. Supreme Court gave states the flexibility to do so without penalty (see Update for Week of July 2<sup>nd</sup>). However, Democrats were intent on getting Republicans on the record in their nearly unanimous opposition to expanding coverage for 500,000 uninsured South Carolinians.

House Minority Leader Todd Rutherford (D) tried to make expansion a “moral obligation”, while others including Rep. Mandy Powers Norrell (D) provided statistics showing how those earning up to the 138 percent of poverty must choose between health care and other essential expenses and are often forced to into medical bankruptcy. Democrats even sought an amendment that would require lawmakers voting against the expansion to forfeit their own state employee health benefits.

House Republicans all stood against the expansion while instead voting to include \$80 million of state and federal funds into the budget, which will pay hospitals that steer the uninsured away from costly emergency rooms and towards free or subsidized health clinics for primary care.

Even though Republicans have a slimmer majority in the Senate, President pro tem John Courson (R) indicated this week that Medicaid expansion was very unlikely to pass so long as the Governor pledges to veto it.

#### Tennessee

##### ***Governor still waiting to decide on Medicaid expansion***

Governor Bill Haslam (R) acknowledged this week that he is increasingly being pushed towards expanding Medicaid under the Affordable Care Act (ACA).

The Governor is one of only a handful that has yet to decide whether to support the expansion, but is expected to do so by the end of March. He has previously expressed concern about the state costs of expanding Medicaid for more than 161,000 Tennesseans, even though the non-partisan Fiscal Review Committee within the General Assembly predicts that it would inject more than \$418 million into the state's budget in 2013-2014 and \$1 billion more in the next budget year.

Governor Haslam has warned lawmakers that both urban and rural hospitals alike may go under if Tennessee forgoes the federal funds forces higher uncompensated care costs upon them once federal indigent care funds start to phase down in 2014. He also stressed that even if the state does not expand, it will still face \$203 million in additional Medicaid costs just in 2018-2019, as the ACA will force roughly 60,000 of those already eligible but not enrolled to seek Medicaid coverage. However, unlike the newly-eligible population, Tennessee will receive only the state's standard 65 percent federal matching rate for these 60,000 enrollees, instead of the 100 percent federal match under the ACA.

The Governor conceded this week that a new Jackson Hewitt study (see above) may be a pivotal factor in his decision, as it showed opting-out of the Medicaid expansion would increase ACA penalties on Tennessee employers by \$59.5-89.4 million each year.

The legislature held its first hearings this week on Medicaid expansion legislation (H.B. 290/S.B. 604). However, despite calls House Speaker Beth Harwell (R) to leave the decision up to the Governor's good judgment; multiple bills have been introduced in the House and Senate to prohibit any Medicaid expansion. Senate President Ron Ramsey (R) previously agreed this week to the Governor's request to delay action on one of these measures (S.804), even though it was only one vote shy of passage.

Governor Haslam is attempting to negotiate with the Obama Administration on additional flexibility to hike Medicaid copayments for prescription drugs and emergency room visits, in exchange for agreeing to expand, similar to those preliminarily approved for Virginia (see Update for Week of February 18<sup>th</sup>).

#### Utah

***Senate blocks House bill that would bar Medicaid expansion in favor of charity care***

Senate Republicans voted this week to strip a House-passed bill of provisions that would prohibit Governor Gary Herbert (R) from accepting Affordable Care Act (ACA) funding to expand Medicaid.

House Republicans had sought to bar the expansion, arguing that increased funding for "charity care" was an acceptable alternative. However, Senators had no appetite for such a restrictive measure, even though similar bans have been enacted in other conservative-leaning states like Missouri (see Update for Week of November 5<sup>th</sup>).

A substitute bill for H.B. 391 would allow Governor Hebert to decide whether add 131,000 Utahns to Medicaid by expanding eligibility to 138 percent of poverty, subject to funding approval by the Legislature. However, he must first publicly release a twice-delayed cost study by the Department of Health and wait for the Health System Reforms Task Force to complete a "thorough analysis" of the charity care alternatives supported by House Republicans.

The Legislative Fiscal Analyst has already estimated that the Medicaid expansion would save Utah about \$6 million in the first year and nearly \$16 million in the second year. Senate Republicans specifically rejected the conclusion of the initial House-passed bill that these savings could just as well be realized by boosting charity care. Senator Brian Shiozawa (R), an emergency room doctor, pointed out that more than 25 percent of patients at certain Utah hospitals are already uninsured and receiving charity care, which society ultimately pays for through rising health costs and premiums. Uncompensated care costs among the state's four major hospital chains have already more than tripled since 2003 to nearly \$700 million, an amount that will dramatically rise if Utah does not expand Medicaid because hospitals will start to lose federal indigent care funding starting in 2014.