Health Reform Update – Week of May 27, 2013

CONGRESS

House Republicans seek feedback on draft "doc fix" bill

Republican leaders on the House Energy and Commerce health subcommittee released an updated version this week of their plan to replace Medicare's sustainable growth rate (SGR) formula that threatens each year to cut physician payments by nearly 27 percent.

A permanent "doc fix" has bipartisan support as Congress has had to pass temporary delays every year since the SGR was enacted. CBO gave competing proposals momentum by recently lowering the projected cost of eliminating the SGR from $260 billion over ten years to only $139.1 billion (see Update for Weeks of January 28th and February 4th).

Despite the lower price tag, Republicans and Democrats have been unable to agree on how to offset this cost and the draft bill released this week by committee Republicans avoids the subject. Instead, it simply solicits comments from stakeholders by June 10th on the bill's plan to replace the SGR with an enhanced fee-for-service system, in which doctors and medical specialty organizations would work with the Department of Health and Human Services (HHS) to develop quality measures for specific provider groups. Physicians' performance would be assessed based on those quality measures, and they would get incentive payments for good performance. Future payment updates would be based on physicians meeting those quality measures.

The draft legislation would require HHS to provide Congress a biannual report on the incentive payment program, as well as report on alternate payment models such as accountable care organizations. In addition, the Government Accountability Office would study the adequacy of the performance measures and evaluate the program's initial phase.

Republicans on the Energy and Commerce Committee and the Ways and Means Committee released this framework earlier this year (see Update for Week of April 1st). Both committees have held hearings on the issue, and the subcommittee is planning an additional hearing for June 5th. The Senate Finance Committee has also held a hearing on their proposal (with comments due this week). However, Senate Democrats have yet to release any draft legislation.

Three House Republicans push back against bipartisan support for Medigap premium surcharges

At least three House Republicans are strongly resisting proposals by President Obama, Republican leaders, and the Medicare Payment Advisory Commission (MedPAC) to increase cost-sharing amounts for those who purchase Medicare supplemental (or Medigap) plans.

Reps. Lee Terry (R-NE), Marsha Blackburn (R-TN) and Tom Latham (R-IA) urged lawmakers in a "Dear Colleague" letter last week not to "punish" Medigap subscribers until other Republican-sought Medicare reforms are fully enacted. They dispute MedPAC claims that Medigap subscribers have little incentive to consider the cost of their care and tend to overutilize services and drive up costs for all other beneficiaries. The three lawmakers insist that Medigap subscribers have already shown they are "prudent" purchasers by making sure they have supplemental coverage.

MedPAC has proposed a 20 percent surcharge coupled with a redesigned benefit package, while President Obama's proposed budget for the next fiscal year includes a 15 percent surcharge (for a projected savings of $3 billion) (see Update for Week of April 8th).

The House Energy and Commerce Committee has already held a hearing on imposing a surcharge on Medicare Part B premiums for those who purchase Medigap plans that have limited cost-sharing. The Ways and Means health subcommittee plans to hold a series of similar hearings.

About 90 percent of Medicare beneficiaries have some type of supplemental coverage through Medigap, employer-retiree health, Medicaid, Tricare, or Medicare Advantage programs. However, the three lawmakers point out that 46 percent of Medigap subscribers have less than $30,000 in annual income and would be especially burdened by a 15-20 percent premium surcharge.

Taxing employer-sponsored health insurance remains off-the-table, despite massive savings

A new analysis from the Urban Institute and Robert Wood Johnson Foundation finds that capping the tax deduction for employer-sponsored health insurance at the 75th percentile would raise more than $264 billion in federal revenues from 2014-2015.

The tax exemption reduced federal revenues by more than $286 billion as recently as 2011 and will cost $3.6 trillion over the next decade, by far the single largest federal expenditure. Capping the deduction has often been proposed by both Democratic and Republican lawmakers, but gained little traction and was not included as part of the Affordable Care Act or ongoing deficit reduction negotiations.

The study acknowledges that a 75 percent cap would increase taxes, but only for nearly 16 percent of filers in 2014 and 20 percent by 2023. Researchers also emphasize that the tax break benefits high wage earners far more than lower-income employees. For example, an untaxed $10,000 premium saves workers in the 35 percent tax bracket about $3,500 but only $1,500 in the 15 percent bracket.

The study did not recommend eliminating the deduction entirely for fears it could destabilize the market for employer-sponsored coverage.

GAO says formula for Medicaid matching funds is unfair

The federal Medicaid matching rate formula fails to account for high healthcare costs and demand in some states and should be revised, according to a report released last week by the Government Accountability Office (GAO).

The Federal Medical Assistance Percentage is currently based on each state's per capita income in comparison to the national per capita income. On average, it matches 57 percent of state costs but ranges up to 75 percent for poorer states.

GAO did specify how states should revise their formulas, but did recommend that instead of using per capita income, the formula should instead evaluate state resources by measures that include other types of taxable income within a state, including corporate profits. It also should account for geographic variations in healthcare costs and utilization.

Total number of drug shortages remains constant, despite new legislation

According to the University of Utah Drug Information Service, the total number of active drug shortages has remained constant nearly a year after Congress passed legislation enhancing the authority of the Food and Drug Administration (FDA) to alleviate shortages.

The database showed 300 "active" drug shortages at the end of April or roughly the same number as the end of 2012 and slightly above September 2012 (282 shortages). However, there are only 54 new shortages in 2013, which is well off the pace from prior years.

The *FDA Safety and Innovation Act* incorporated provisions of the President's 2011 executive order by requiring manufacturers to notify the FDA as soon as possible when a production interruption

occurs in a "life-supporting" or "life-sustaining" drug and at least six months in advance if such a product is being discontinued. The FDA insists that the executive order enabled it to prevent 150 shortages and that the number of manufacturer notifications per month has more than doubled since the bill was signed into law (see Update for Week of June 25th).

Several senators led by Sen. Al Franken (D-MN) wrote the FDA earlier this month urging the agency to take additional action to curb shortages. However, the agency continues to blame manufacturers for the production and quality issues that are causing most shortages, although House Republicans cite regulatory actions for causing plant shutdowns (see Update for Week of June 18th). Other advocacy groups such as Physicians Against Drug Shortages identify squeezed profit margins by group purchasing organizations as the primary culprit.

A Government Accountability Office on drug shortages is expected to be released next year.

FEDERAL AGENCIES

Trustees extend Medicare solvency by two years, while Social Security remains constant

The annual report released this week by the Medicare Trustees projects that the program's trust fund will remain solvent until 2026, or two years long than last year's projection.

The Centers for Medicare and Medicaid Services (CMS) attributed the extended life largely to lower-than-expected Part A spending and Medicare Advantage (MA) costs in 2012. (The lower growth in MA was directly related to the Affordable Care Act.) The 1.7 percent growth in Medicare spending per beneficiary also played a role (see Update for Week of May 6th).

The trust fund for Social Security retirement payments is still expected to become insolvent by 2033, at which point only 75 percent of benefits will be paid. However, the trust fund that funds disability programs will be insolvent by 2016 without Congressional intervention, meaning only 80 percent of benefits will paid after that date.

CMS finalizes regulation and application for small business health insurance marketplace

The Centers for Medicare and Medicaid Services (CMS) issued final regulations this week governing the Small Business Health Options Program (SHOP) marketplace created by the Affordable Care Act (ACA).

The rule finalizes the application that small employers and their workers must use to enroll in the marketplace starting October 1st. It also retains the one year delay in implementing the "employee choice" model. As a result, just one qualified health plan (QHP) will be offered in 2014.

States creating their own exchanges such as Minnesota have largely elected to still offer multiple plans in the SHOP exchange next year (see Update for Week of March 11th). However, the rule does not specify if partnership exchanges also have this option.

CMS issues final rule imposing profit caps on Part D and Medicare Advantage plans

The Centers for Medicare and Medicaid Services (CMS) finalized regulations last week that require Medicare Part D drug plans and Medicare Advantage (MA) managed care plans to spend at least 85 percent of premium revenue on medical care.

The Affordable Care Act (ACA) has applied the identical standard to large-group plans since the 2011 plan year, and imposed a lower 80 percent threshold on individual and small group plans. These new medical-loss ratios (MLRs) forced insurers to rebate more than $1.1 billion to consumers last summer (see Update for Week of June 18th).

The final rule imposes "several levels of sanctions" for Part D and MA plans that fall short of the MLR. These include remitting payment to CMS and for repeated violations can result in a ban on enrolling new members or contract termination.

The final rule largely follows the proposed rule (see Update for Week of February 18th) with the exception of altering the reporting period for plans that fail to meet the MLR for two straight years. CMS also refused to accede to industry demands to exempt Part D plans from the MLR, but did agree to exempt the Part D offerings of PACE organizations.

HEALTH CARE COSTS

Cancer diagnosis leads to higher rates of medical bankruptcy

People diagnosed with cancer are 2.5 times more likely to file for bankruptcy than those without cancer, according to a new study released last week by the Fred Hutchinson Cancer Research Center.

Researchers found that of the nearly 200,000 people in western Washington state that were diagnosed with cancer from 1995-2009, 2.2 percent had to declare personal bankruptcy due to high medical costs. The rate for younger cancer patients was 2-5 times higher, as overall bankruptcy filings increased as more time passed following diagnosis, with the bankruptcy rate for the youngest age groups being ten times more than older patients, many of whom are likely to have Medicare, other health insurance, or more extensive savings and assets.

Thyroid and lung cancer were most likely to cause medical bankruptcies, compared to other forms of the disease.

STATES

More states release figures on exchange participation, premiums

Most exchanges are showing healthy competition for qualified health plans (QHPs); although several largely rural states continue have only a handful of dominant insurers willing to participate.

Connecticut was one of the first to solicit QHPs and announced this week that four of the state's largest insurers (Aetna, Anthem Blue Cross and Blue Shield, United Healthcare, and ConnectiCare) have been approved to participate in the "clearinghouse" exchange that will accept any plan meeting minimum federal and state standards. The Healthy CT non-profit insurance cooperative created by the Affordable Care Act (ACA) will also participate.

Maryland's "clearinghouse" exchange will have a similar level of plan participation. The state's dominant insurer, CareFirst Blue Cross and Blue Shield will compete with Coventry, Kaiser Permanente, and United Healthcare, as well as the Evergreen cooperative. Aetna, CareFirst, Kaiser, and United will also offer 34 different plan options to individuals and 259 for small businesses in the "clearinghouse" exchange for neighboring District of Columbia.

California, Colorado, Oregon, and Washington have already announced double-digit numbers of QHPs in their respective state-based exchanges (see Update for Weeks of May 13th and 20th) and Florida will have ten in its federal marketplace (including three affiliated with the state's largest insurer Florida Blue). Rhode Island's state exchange will have the highest number of QHPs at 28.

By contrast, rural states already dominated by a single insurer will have very limited exchange participation. Only three QHPs will participate in Montana's federal marketplace, one of which is a cooperative. Only two will participate in Vermont's state-based exchange, after that state rejected an

application from a cooperative and Anthem Blue Cross will be the lone QHP in the federal marketplace in New Hampshire.

The Centers for Medicare and Medicaid Services (CMS) announced last week that more than 120 plans nationwide have applied to participate in the federal marketplaces that will be operated in 35 states (including partnership exchanges) starting January 1st. Federal marketplaces will average 15 plans per state. CMS emphasized that one out of every four plans will be a new entrant to the individual marketplace. Nearly two-thirds of these new entrants are in states where only one insurer currently dominates the individual market.

According to CMS, 90 percent of subscribers in federal or state exchanges will have a choice of at least five insurers.

Georgia became the latest state this week where proposed exchange premiums came in lower than expected. However, unlike California, Maryland, Oregon, Rhode Island, Vermont, and Washington (see Update for Weeks of May 13th and 20th) Georgia defaulted to the federal marketplace and is not operating a state-based exchange (it will have seven QHPs).

The lower premiums for California, Oregon, Rhode Island, and Vermont were largely attributed to the "active purchaser" exchange model those states chose to follow, where the board can selectively contract only with the most affordable plans. New York only other state currently pursuing this model, although it was considered but rejected in Hawaii, Maryland, New Mexico, and Washington.

The "active purchaser" model is likely to result in consumers having a more limited choice of plans and network of providers as compared to the "clearinghouse" model in most states. However, insurers like Health Net have found a growing acceptance for these narrower networks. The California-based insurer said enrollment among employers in California, Arizona and Oregon in those smaller networks has grown 37 percent in the last year.

California is also the only state thus far to also make its exchange a voter registration agency.

ACA boost in Medicaid primary care payments still delayed in all but six states

Primary care physicians in most states have yet to receive the temporary increase in Medicaid reimbursement authorized by the Affordable Care Act (ACA).

Under the final rule issued last fall, Medicaid payments for physicians practicing in family medicine, general internal medicine, pediatric medicine, and related subspecialists will be raised to Medicare levels, but only for calendar years 2013 and 2014 (see Update for Week of October 29th). This will increase reimbursement by an average of 73 percent nationwide, as Medicaid programs in states like Rhode Island, California, and Florida pay only 30-40 percent of Medicare rates.

The Centers for Medicare and Medicaid Service (CMS) gave states until March 31st to submit state plan amendments to enact the increase, which must be federally-approved within 90 days. States then set their own deadlines for physicians to submit forms proving they are eligible for the increase.

However, CMS has only approved 17 state plan amendments to date and does not expect to finish reviewing the rest before the end of June. The delay has allowed the increase to go into effect in only five states (Florida, Maryland, Massachusetts, Michigan and Nevada) while Alaska was allowed to keep its current Medicaid rates because they were already higher than Medicare reimbursement in order to attract and retain physicians to such a rural state.

States set their own deadlines for physicians to send in their eligibility forms in order to qualify for retroactive raises. Those deadlines have passed in many states, and physicians there can only start getting the higher Medicaid reimbursements after they send in their eligibility forms.

Delaware, Hawaii, Illinois, New Hampshire and New York are among the states where physicians can still receive retroactive payments going back to January as long as submit proof of eligibility by this summer (Florida's deadline expired this week).

Ballot referendums may ultimately decide Medicaid expansion in large Republican states

Republican governors in Arizona, Florida, Michigan, and Ohio are facing the prospect of having to put the issue of expanding Medicaid before voters after their expansion plans have been stymied by opposition from conservative lawmakers.

The long-sought "middle ground" appeared to come together in Arizona last week as Senate Majority Leader John McComish (R) was able to cobble together the five Republican votes needed to pass the budget plan by Governor Jan Brewer (R) that participates in the Medicaid expansion under the Affordable Care Act (ACA), despite the opposition of Senate President Andy Biggs (R) (see Update for Weeks of April 22nd and 29th). However, House Speaker Tobin (R) remains adamant that the Senate plan will not get the seven Republican votes needed to pass the House, even though it likewise accepts the ACA funds to expand Medicaid for everyone earning up to 138 percent of the federal poverty level (FPL).

The Speaker's plan has some material differences. The Senate would impose a $240 million tax on hospitals to pay for the state share of the expansion, which is capped at ten percent of total costs for 2020 and beyond. Speaker Tobin wants provision barring hospitals from passing along the cost of that tax to consumers and health plans.

However, the key difference is that Tobin's plan would require voter approval for the expansion. Although polls continue to show the ACA is supported by a majority of voters, especially in southern Republican-led states with high rates of uninsured, Republican leaders nationwide continue to believe that putting any Obamacare provision on the ballot will drive voter turnout.

As a result, Governor Brewer opposes letting the issue go to the voters. Even though Arizona voters did approve a Medicaid expansion in 2000 that included childless adults, the ACA itself is overwhelming unpopular in Arizona, whether voters were the first to approve a symbolic ballot referendum declaring that their state could opt-out of the law's controversial individual mandate.

A voter referendum does have several potential advantages for Governor Brewer as it would circumvent the state constitutional requirement that the legislature others need a two-thirds vote to impose any new tax. However, the Governor's plan already argues that the hospital tax is a "fee" and gives the Medicaid director discretion to impose it without legislative approval. She has pledged to veto all other legislation unless the House approves her plan.

Expansion bills already died in Florida (see Update for Weeks of May 13th and 20th) and appear unlikely to pass Republican-led legislatures in Michigan and Ohio. The Michigan Senate narrowly approved a budget bill last week that, just like the House, dropped the proposal by Governor Rick Snyder (R) to participate in the ACA expansion. Republican supporters are pursuing separate legislation, however the House version would limit the number of years that enrollees can remain on Medicaid, a provision the Obama Administration has rejected (see Update for Week of May 6th).

Ohio Rep. Barbara Sears (R) also resurrected the plan by Governor John Kasich (R) to expand Medicaid under the ACA that was stripped out of his proposed budget (see Update for Week of April 8th).

Ohio Governor Kasich and Florida Governor Rick Scott (R) are openly weighing putting the issue on the ballot. Ohio voters have previously passed a ballot referendum similar to Arizona's that opposed the ACA's individual mandate, while Florida voters rejected it (see Update for Week of November 5th).

North Dakota remains the only state where a Republican legislature approved a Republican Governor's request to expand Medicaid under the ACA (see Update for Weeks of April 22nd and 29th).

Urban Institute study finds Medicaid managed care plans can accommodate expansion

An Urban Institute survey of Medicaid managed plans in eight states found that they are prepared to accommodate a 23-102 percent expansion in enrollment starting January 1st.

Each of the eight states surveyed in the report released this week (Maryland, Michigan, Minnesota, New Mexico, New York, Oregon, Rhode Island and Virginia) are expand Medicaid either through the traditional Affordable Care Act (ACA) expansion or a federally-approved private sector alternative. Researchers found that the long-standing relationships with Medicaid managed care plans in these states, stable and mature" managed care structures, and familiarity with the newly-eligible populations will help them quickly adapt to the expanded enrollment. They emphasized that states like New Mexico and New York already cover childless adults in the newly-eligible income range.

The projected increases through 2022 could be substantial, ranging from an estimated 23 percent in New York to 102 percent in Oregon.

The "predominant" concern for these states' is the ability of information technology systems to handle the influx of new enrollees and transform to the seamless eligibility determination and enrollment process required by the ACA. However, researchers note that each state has used federal exchange establishment grants to make significant progress over the past two years in upgrading their IT systems to coordinate health insurance exchange enrollment with Medicaid and other health programs.

California

Federal appeals court will allow ten percent Medi-Cal rate cut from 2011

The full U.S. Ninth Circuit Court of Appeals will allow California to cut Medi-Cal payments to hospitals, doctors, pharmacists and other providers by ten percent, as it sought to do in 2011 before an injunction was issued by a lower court.

The Obama Administration approved the cut, which was to save $623 million per year. However, advocacy groups immediately sought to block it as the state had already instituted dramatic cuts in years prior. The lower court ruled that further cuts would threaten access to care for enrollees and thus violate federal Medicaid law. However, a three-judge panel for the Ninth Circuit reversed that decision, insisting CMS has the authority to make that call (see Update for Weeks of December 3rd and 10th).

President Obama had sided with California in urging the full Ninth Circuit to reject any appeal of the panel's decision (see Update for Week of March 11th). His 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 Administration efforts to lure reluctant governors into expanding Medicaid under the Affordable Care Act.

Governor Jerry Brown (D) has hinted that he may reinstate the ten percent cut even though 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 5th). If so, it would be retroactive to June 1, 2011.

Provide and consumer groups pledge to appeal again to the U.S. Supreme Court, even though it already declined to resolve the issue last year (see Update for Week of February 20, 2012). The high court would have to stay the cut pending a hearing in order for it not to go into effect.

Florida

Governor to decide whether to veto bill that suspends review of health insurance premiums

The Republican-controlled House and Senate have sent a bill to Governor Rick Scott (R) that would temporarily suspend the state's review of health insurance premiums so that unreasonable increases can be blamed on the Affordable Care Act (ACA).

S.B. 1842 would deny the Office of Insurance Regulation its existing authority to approve, modify, or reject proposed rate hikes in the individual and small group market, at least for those policies that are not "grandfathered" from certain ACA market reforms in 2014 and 2015. The measure requires insurers to then break-down for subscribers how much of the resulting spike in premiums is due to specific provisions of the ACA.

The most conservative members of the legislature sought the rate review suspension so that consumers will know the full impact of the ACA upon premiums. U.S. Senator Bill Nelson (D-FL), a former state insurance commissioner, warned that the temporary suspension could cause rate hikes of 70 percent or more and criticized Republican lawmakers for using individual and small group subscribers as a political pawn in their stated effort to impede any implementation of the ACA. House Republicans recently blocked bills passed by their Senate peers that would have accept ACA funds to expand Medicaid, even if the newly-eligible populations was covered under private plans instead of Medicaid.

It is not yet clear if Governor Scott will veto the legislation by the June 5th deadline or let it become law. He has generally adhered to the goal of conservatives not to "legitimize Obamacare" but did support accepting $52 billion in federal funds to expand Medicaid under the ACA. The Governor may also not wish to impose such dramatic hikes on subscribers in a year in which he is up for re-election.

In addition to suspending rate review, S.B. 1842 imposes certain registration, training, and certification standards on navigators that will facilitate enrollment in the federal marketplace to be operated in Florida starting January 1st. It also terminates the state high-risk pool on that date.

Illinois

Governor to sign legislation expanding Medicaid, licensing exchange navigators

The Democratically-controlled House and Senate sent legislation this week to Governor Pat Quinn (D) that allows Illinois to participate in the Medicaid expansion under the Affordable Care Act.

The Governor is expected to shortly sign S.B. 26, which he supported. At least 342,000 uninsured Illinoisans with incomes up to 138 percent of the federal poverty level (FPL) are expected to enroll in Medicaid by 2017.

A handful of Democrats including Rep. Sue Scherer (D) joined with Republicans in voting against the measure, insisting that the federal government could not be trusted to live up to its commitment under the new law to fund 100 percent of the expansion through 2016 and at least 90 percent of the expansion in 2020 and beyond. S.B. 26 does include an automatic termination clause should the promised level of federal funding fall below 90 percent (see Update for Week of February 25th).

The Governor is also expected to sign S.B. 1194, which sets licensure standards for navigators that will help facilitate enrollment in the new health insurance exchange. Illinois will initially partner with the federal government, but intends to assume full control over the new online marketplace in 2015 (see Update for Week of February 11th).

Louisiana

House and Senate panels reject Medicaid expansion or private sector alternatives

House and Senate health panels have rejected bills over the last two weeks that would have forced Governor Bobby Jindal (R) to participate in the Medicaid expansion under the Affordable Care Act (ACA) or seek federal approval for a private sector alternative.

The Governor was among the first to opt-out after the U.S. Supreme Court gave all states the flexibility to do so without penalty (see Update for Week of June 25th). He has adamantly refused to participate despite the decision of eight Republican governors to do so and support for the expansion by U.S. Senate Mary Landrieu (D-LA) and hospital, physician, and business groups. The Department of Health and Hospitals also released a study showing that the ACA expansion would save Louisiana up to

$368 million over ten years. (The non-partisan Legislative Fiscal Office has upped this estimate to $544 million over just the next five years).

Governor Jindal has also refused to embrace the private sector expansion that the Obama Administration approved for Arkansas, where the state accepts federal funds for the ACA expansion but instead covers the newly-eligible population under private plans offered through the federal health insurance marketplace (see Update for Week of March 25th). He has insisted that the alternative does not provide states with enough flexibility, as recent federal guidance clarified that states still must provide wrap-around services and apply Medicaid cost-sharing limits (see Update for Week of April 1st).

Jindal has indicated that he will only accept the ACA funds to expand if the Obama Administration allows for partial expansion to only 100 percent of the federal poverty level, something they have previously been unwilling to do (see Update for Week of December 3rd and 10th).

The Senate Committee on Health and Welfare voter to defer the private sector alternative (S.B. 125), which included a sunset clause in 2017 and automatic termination if promised federal funding did not materialize. The move effectively killed the measure for the session. Committee staff estimated that it would have saved Louisiana $311-323 million per year.

Maine

Democrats fail to override Medicaid expansion veto, CMS rejects Governor's alternate plan

The Democratic House and Senate passed legislation last week to expand the Medicaid program pursuant to the Affordable Care Act (ACA), but were unable to overcome the promised veto this week from Governor Paul LePage (R).

The Senate fell two votes short of the two-thirds majority needed to override the veto of L.D. 1546, which attached the expansion to a plan for the state to repay its Medicaid debt to hospitals. The Governor insisted that he would only support a private sector alternative that would resemble the plan that was conditionally-approved for Arkansas (see Update for Week of March 11th). However, L.D. 1546 included only a traditional expansion for everyone earning up to 138 percent of the federal poverty level (FPL), instead of using the ACA expansion funds to instead cover some or all of that newly-eligible population under the new federal marketplace to be operated in Maine.

The Governor is continuing to negotiate the terms of a private sector alternative with the Obama Administration. However, the federal Centers for Medicare and Medicaid Services (CMS) has rejected his demands to extend 100 percent federal funding for a full decade, at least for adults.

LePage's Democratic predecessor had made Maine the most generous state in the nation for parents for Medicaid-eligible children and one of the few to also cover childless adults. The Governor thus argued that Maine was effectively being "punished" for previously expanding, since it will only receive its regular 62 percent federal matching rate for those who already qualify for Medicaid. CMS offered to grant the Governor's request for full federal funding for childless adults, since Maine would have to expand childless adult coverage from 100 percent of to the federal poverty level (FPL) to 138 percent under the ACA expansion. However, CMS insisted that federal law prohibits it from extending the same offer to adults with children, as Maine already covers that group up to 200 percent of FPL or more broadly than the ACA expansion would require.

The House Health and Welfare Committee promptly re-sent a stand-alone Medicaid expansion bill to the House floor with an amendment that would allow for a special session to repeal the expansion should promised federal funding fail to materialize. However, the change attracted the support of only one committee Republican.

According to the Maine Department of Health and Human Services, the traditional expansion is expected to add only 70,000 Mainers to Medicaid but cost the state $75 million per year after the federal match drops to 90 percent in 2020 and beyond. However, the Maine Center for Economic Policy, it has

estimated that 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 (see Update for Week of March 11th).

New Hampshire

Insurance exchange may default to federal control with only one individual market participant

The Republican-controlled Senate Commerce Committee blocked legislation this week that would have allowed the Insurance Commissioner to begin implementing parts of the Affordable Care Act (ACA).

Republicans had impeded nearly all ACA implementation prior to losing control of the House last fall (see Update for Week of November 5th). However, the full Senate, which will take up H.B. 668 next week, still rests narrowly in Republican hands.

The measure would let the Insurance Commissioner partner with the federal government on the new health insurance exchange that will begin operating January 1st. Republicans had passed a law last year banning state officials from participating in any exchange creation, which H.B. 668 sought to relax to allow for the federal-state partnership (see Update for Week of February 25th). The measure also aligns state insurance law with the new ACA market reforms such as guaranteed issue and community rating.

Republicans on the Commerce Committee, including Senate Majority Leader Jeb Bradley (R), insisted that H.B. 668 would simply let New Hampshire ultimately create a state-based exchange and thereby violate state law. Governor Maggie Hassan (D) stressed that if the full Senate likewise kills the bill, New Hampshire will have to default to full federal control not only of the federal marketplace, but enforcement of the ACA, something that would be antithetical to "state rights" proponents.

The Department of Insurance confirmed to the Associated Press this week that only one carrier has thus far sought to participate in the individual exchange, whether it remains a partnership or a fully-federal marketplace. However, that carrier, Anthem Blue Cross and Blue Shield, already controls more than 90 percent of the individual market in New Hampshire.

Oklahoma

Governor discontinues premium assistance program instead of upgrading to comply with ACA

The federal Centers for Medicare and Medicaid Services (CMS) notified Governor Mary Fallin (R) that it has rejected her request to continue the Insure Oklahoma premium assistance program without changes, as it does not comply with the higher standards under the Affordable Care Act (ACA).

Since 2005, Insure Oklahoma has covered nearly 30,000 Oklahomans that are unemployed or working in companies with less than 250 employees with state-subsidized health insurance that provides limited benefits. Under the program, the state pays 60 percent of the premium costs, employers pay 25 percent, and individuals pay 15 percent.

Governor Fallin sought to extend Insure Oklahoma's federal demonstration waiver, which expires December 31st. However, CMS refused to do so unless the state removed the program's enrollment caps and offered the full range of products that the ACA requires for the individual and small business markets. As a result, the Governor has decided to eliminate the program for 2014.

Rep. Doug Cox (R) and other Republicans sought to use Medicaid expansion funds under the ACA to move all Insure Oklahoma enrollees into the federal marketplace to be operated in the state starting January 1st. However, legislation effectively creating the private sector alternative already federally-approved for Arkansas (see Update for Week of March 25th) failed to pass before the session ended. Governor Fallin and the state's most conservative lawmakers have adamantly opposed accepting any ACA funds (see Update for Weeks of November 19th and 26th).

Texas

Legislature passes ban on expanding Medicaid under the Affordable Care Act

The Republican-controlled House and Senate approved a Medicaid reform bill last week that would prohibit Texas from expanding the program pursuant to the Affordable Care Act (ACA).

Senate conferees for S.B. 7 retained an amendment by Rep. Jeff Leach (R) that bans any future legislature or governor from accepting ACA funds to expand Medicaid for everyone earning up to 138 percent of the federal poverty level (FPL). Governor Rick Perry (R) has adamantly opposed the expansion, despite intense pressure from the state's hospital and physician groups, as well as the leaders of counties with high rates of uninsured who are seeking federal permission to separately participate (see Update for Week of March 4th).

More than a quarter of Texans are uninsured, by far the highest rate in the nation. The ACA expansion is projected to add $7-12 billion over the next decade to some of the nation's poorest counties along Texas' border with Mexico, where the uninsured rate approaches 40 percent.

The legislature also sent the Governor bills to abolish the state's high-risk pool coincident with the ACA's new market reforms on January 1st (S.B. 1367) and regulate navigators that will help facilitate enrollment in the federal marketplace that will begin operating in Texas on that date (S.B. 1795). Several other states have recently enacted similar measures (see Update for Weeks of April 22nd and 29th).

Vermont

Proposed rules implement key ACA provisions for exchange eligibility, enrollment, and coverage

The Vermont Agency for Human Services published proposed rules last week that implement several provisions of the Affordable Care Act (ACA) related to eligibility, enrollment, and coordination of benefits across multiple programs including Medicaid, SCHIP, and the new health benefits exchange. Public comments are due by June 21st.

The rules define the roles of navigators, as well as insurance agents and brokers, in facilitating exchange enrollment and help determine applicant eligibility for premiums and cost-sharing tax credits offered by the ACA, as well as other health care programs. It also clarifies how the tax credits will be calculated, how premiums will be processed, and what essential health benefits must be provided.