

Health Reform Update – Week of August 26th, 2013

CONGRESS

Republicans remain divided over government shutdown as debt limit deadline moved-up

Treasury Secretary Jack Lew warned congressional leaders this week that the federal government will hit its borrowing limit by mid-October, setting up an earlier-than-expected showdown over raising the nation's debt ceiling to allow it to pay back debt it has already incurred.

Forecasters including the Congressional Budget Office (CBO) and Goldman Sachs had predicted that the limit would be hit around November 1st, although they cautioned that the deadline could vary depending on the strength of quarterly corporate income tax payments that are due next month. The Treasury Department has been using accounting maneuvers to avoid exceeding the borrowing caps since it was last increased in May. However, Lew insisted that such "extraordinary measures" will be exhausted by mid-October, meaning the federal government will only be able to pay its bills out of incoming tax revenues.

The revised deadline for the debt limit only heightens the internal debate amongst Republicans over whether to shut down the government after the September 30th end of the federal fiscal year if the Obama Administration does not agree to defund the Affordable Care Act (ACA). Republicans could also refuse to raise the debt ceiling if their demands are not met, a move that would likely harm the economy similar to the damage that resulted when the last debt ceiling stalemate caused a first-ever downgrade in the nation's credit rating (see Update for Week of August 1, 2011.)

Despite the support of roughly 80 of the House's most conservative Republicans, party leaders have thus far largely opposed or remained neutral on shutting down the government in a "Hail Mary" effort to block final ACA implementation (see Update for Week of August 12th). Instead, they are proposing to pass a two-month temporary spending extension while they target smaller changes to the ACA that have some Democratic support, like repealing the law's Medicare cost-cutting board and 2.3 percent tax on medical device manufacturers. They also may seek to include a House-passed proposal (H.R. 2009) that bars Treasury Department enforcement of key ACA provisions like the individual mandate.

Most Americans still do not understand ACA, but oppose defunding

Public opinion on the Affordable Care Act (ACA) remains largely unchanged according to the latest monthly tracking poll issued by the Kaiser Family Foundation. While 42 percent of Americans still hold an unfavorable view of the law as a whole (compared to 37 percent favorable), a majority of the 1,100 people surveyed (57 percent) continue to oppose efforts by tea-party backed Republicans to defund the law (see above).

The most commonly cited reason among those who oppose defunding is that "using the budget process to stop a law is not the way our government should work" (69 percent), followed by a belief that "without funding the law will be crippled and won't work as planned" (56 percent), and a feeling that the law will be "a good thing for the country" (49 percent). Another 35 percent say their main reason for opposing defunding efforts is that "we've heard enough about health reform and it's time to move on to something else." Kaiser has asked about "defunding" nine times since 2011 with disapproval of the idea consistently outweighing approval.

The latest poll also found that the more than half of respondents (51 percent) continue to lack needed information about the ACA, which rises to 62 percent among those without health insurance.

These figures have remained fairly steady since 2010 despite education and outreach campaigns. However, the number of respondents that say they have heard “a lot” or “some” about the new health insurance exchanges that will begin open enrollment in October has jumped by 22 percent since June.

The survey revealed that the most trusted source of information about the ACA is a patient’s doctor, nurse, or pharmacist, as well as federal or state health agencies. However, those are the sources that patients infrequently receive information regarding the ACA, as most (81 percent) turn to the news media even though only eight percent trust this source.

Starbucks will not end spousal coverage or cut hours in response to ACA

Stating that “Starbucks does not want to leave people behind”, the chief executive officer (CEO) of the large coffee chain announced this week that his company will not follow the lead of high-profile employers that are cutting spousal benefits or reducing employee hours in response to the employer mandate under the Affordable Care Act (ACA).

United Parcel Service (UPS) and the University of Virginia became the latest large employers last week to decide to slash spousal coverage in anticipation of higher costs imposed by the ACA (see Update for Week of August 19th). However, Starbucks CEO Howard Schultz emphatically stressed that his company will continue its commitment to providing coverage to their 160,000 full and part-time employees, even if “it may end up costing us more.”

Starbucks is unique in the service industry in that employee health benefits exceed more than the company spent on coffee in 2010. However, Schultz insisted that Starbucks has a “responsibility...to the people who do work and who represent us” and that such “an investment in your people is an investment in shareholder value.”

Several retail and restaurant chains, as well as other large employers that traditionally provide limited health benefits, announced plans earlier this year to roll back employee hours in order to stay below the threshold for ACA penalties (see Update for Week of April 8th). A Mercer consultant survey even reported that up to one-fifth of retailers would do so (see Update for Week of June 10th). However, Papa John’s and Darden restaurants promptly backed-off such plans after they sparked a consumer backlash (see December 17th).

Other restaurant chains have since downgraded their cost estimates of complying with the ACA. Wendy’s now estimates that the cost of providing minimum essential coverage will be roughly \$5,000 per store, dramatically lower than their \$25,000 per store projection last year (see Update for Week of June 10th). Industry consultants like People Report have also concluded that the benefits of ensuring workers have adequate coverage will largely offset these costs due to a healthier, happier, and more engaged workforce. They also stress that even though ACA compliance could force nearly 60 percent of restaurant chains to raise prices and 80 percent to hire more part-time workers, these adjustments will be no more disruptive than other types of regulatory issues to which restaurants routinely adapt.

A recent survey of private employers conducted by PriceWaterhouseCoopers also found little evidence of job cuts or major workplace changes likely to be caused by the employer mandate (see Update for Week of June 17th).

House Republicans step-up investigation of ACA navigators

House Republicans are intensifying their scrutiny of the navigators that will help facilitate enrollment in the health insurance marketplaces created by the Affordable Care Act (ACA).

Energy and Commerce Committee leaders sent a detailed records request to several entities that received federal navigator grants earlier this month, seeking copies of all contacts with the White House, any federal agency, or health insurers. The letter, which was not publicly released, reportedly seeks information on how the grant recipients will use the funds, train personnel, and ensure enrollee privacy. It

also asks whether organizations "may contact individuals who have utilized your services as a Navigator for the purposes of fundraising, voter registration efforts, campaign activities, or any other reason."

The Obama Administration awarded \$67 million in grants to 105 navigators (see Update for Week of August 12th) and issued final rules on navigator and non-navigator personnel last month (see Update for July 15th-August 2nd). Republican lawmakers have insisted that these funds were a target for fraud and identity theft (see Update for Weeks of May 13th and 20th).

House Democrats have accused Republicans of using their ongoing navigator investigation to tamp down enrollment in the new marketplaces. Georgia Insurance Commissioner Ralph Hudgens (R) amplified those criticisms when he told a group of state Republicans this week that Georgia's law requiring strict licensure standards for navigators in the federal marketplace (Act 253) was passed this year in order to do "everything in our power to be an obstructionist" (see Update for Weeks of April 22nd and 29th).

CBO says Medicare spending slowdown not tied to poor economy

The Congressional Budget Office (CBO) released an analysis last week concluding that the record slowdown in Medicare fee-for-service spending per enrollment was not a result of less demand for health care services during the recession. Instead, CBO concludes that much of the decline was caused by other factors affecting beneficiary demand for care and changes in provider behavior and incentives caused by delivery system reforms that shift from fee-for-service to other payment methods.

Harvard Medical School, PriceWaterhouseCoopers, and the Urban Institute concluded earlier this year that the slowdown in health care spending could be permanent due to structural changes in how providers are reimbursed (see Update for Week of June 17th). However, separate studies attributed up to 77 percent of the slowdown to the past recession (see Update for Week of May 6th).

FEDERAL AGENCIES

HHS delays finalization of marketplace plans until mid-September

The Department of Health and Human Services (HHS) notified insurers this week that it would not sign final agreements with the plans participating in the federal marketplace until at least mid-September, a slight delay from the September 5th deadline initially anticipated. Although the agency did not explain the reason for the postponement, it insisted that it would not impact open enrollment in the Affordable Care Act (ACA) exchange, which is slated to begin October 1st.

Media sources attributed the delay to technology problems involving the display of insurance products within the information technology system. At least two state exchanges (New Mexico and Idaho) have already had to default to a federal marketplace or partnership exchange in 2014 as a result of technology delays (see Update for Week of August 19th) and California and Oregon acknowledged this week that it will not have online enrollment capability for the first few weeks of open enrollment (agents and brokers will have to process applications).

The Government Accountability Office cautioned earlier that HHS could miss the October 1st open enrollment deadline for the federal marketplace because of delays in several areas (see Update for Week of June 17th) and the HHS Inspector General warned this month that the agency was months behind in testing data security for the federal data hub for the marketplaces (see Update for Week of August 5th).

RAND study finds no widespread premium increases due to Affordable Care Act

A study released this week by the RAND Corporation became the latest to refute claims by Affordable Care Act (ACA) opponents that the new health insurance reforms will result in widespread premium increases in the individual and small-group markets.

Backed by the Centers for Medicare and Medicaid Services, the nonpartisan research institution simulated the effects of the ACA on the health insurance markets for ten states and the United States as a whole. Although premiums could increase in several states, researchers concluded that rates would decrease for other states or markets or be offset by premium tax credits offered by the ACA. As a result, RAND found that overall premiums would remain largely unchanged nationwide.

For example, individual market premiums could jump by as much as 43 percent in states like Minnesota, North Dakota and Ohio, while actually falling in Louisiana and New Mexico, and remaining the same in Florida, Kansas, Pennsylvania, South Carolina and Texas. RAND also projected that premiums for companies with less than 100 employers would fall by six percent in 2016 (when the individual mandate penalties will fully be in effect) because of the ACA market reforms.

Previous studies by groups like the Urban Institute and Avalere Health have echoed RAND's findings that claims of "rate shock" are "overblown" (see Update for Week of June 3rd). Initial premiums for state-based health insurance exchanges created by the ACA have also come in well below projections (see Update for Week of August 19th).

HHS finalizes appeal process in rules for exchange oversight

The Department of Health and Human Services (HHS) finalized regulations this week outlining how the agency will ensure that qualified health plans (QHPs) comply with the rules for selling plans through the exchanges, as well as the department's plan for safeguarding privacy.

One outstanding issue addressed by the final rule is the appeals process for applicants that have been deemed ineligible for exchange coverage or premium and cost-sharing assistance. The "federally managed appeals process" created by the rule will allow individuals to first go through a preliminary review and receive an "informal resolution." They may request a formal hearing if still not satisfied.

Consumers in state-based marketplaces may first be subject to a state-specific appeals process, but can ultimately appeal to the federal government.

The rules also outline a separate appeals process for employers looking to appeal HHS' determination of whether their plans meet Affordable Care Act (ACA) standard for "minimum essential coverage." Under the new rules the employer may appeal that decision through either a state-run or federal process.

HHS also finalized a policy pertaining to oversight and privacy protection. While state insurance regulators will continue to provide primary oversight, the new rules allow HHS and the exchanges to monitor companies that offer QHPs in order to ensure they are in compliance with federal standards. The final rule retains the earlier requirement that QHPs must accept multiple forms of payment, including paper checks, cashier's checks, money orders, electronic transfers and prepaid debit cards, but clarifies that QHPs must "present all payment method options equally" (see Update for Week of June 17th).

IRS says coverage one day a month is sufficient to avoid individual mandate penalties

The Internal Revenue Service (IRS) finalized regulations this week relating to the Affordable Care Act (ACA) mandate that everyone purchase minimum essential coverage (MEC) they can afford.

The final rule rejects the industry recommendation that individuals must maintain coverage for a majority of a particular month to be considered covered for that time period. It instead sticks to the original provision requiring an individual be covered only for one day within that month (see Update for Week of June 24th), though it agreed to reconsider its policy if evidence shows the one-day timeframe is being abused (i.e. the same person is covered only for one day a month for several months in a row). The IRS says that it stayed with the one-day rule "because it provides administrative convenience for both taxpayers and the IRS."

Future guidelines detail how the government will collect the revenue raised from those that elect to pay a fine instead of purchase MEC. The IRS did decide that people who get insurance through their union or a temporary staffing agency will not be penalized. It also clarified that a taxpayer is responsible for ensuring MEC for his or her dependents whether or not the dependent is covered by the taxpayer's health plan. However, if a child is a legal dependent of a custodial parent, that parent is responsible for ensuring the child has MEC even though a non-custodial parent may be responsible for the child's health insurance under a divorce or separation agreement.

The rules reiterate that MEC includes government-sponsored coverage, an employer-sponsored plan (including self-insured and retiree coverage), individual or grandfathered coverage, and other coverage defined in statute and related regulations (see Update for Week of June 24th). However, it clarifies that a number of government programs do not provide full coverage for medical expenses, and thus do not qualify as MEC. This includes Medicaid programs that only provide pregnancy-related, family planning, or emergency services.

Full Medicaid assistance provided through Medicaid premium assistance programs and various Medicaid programs for disabled children and for home and community-based services is considered MEC. Medicaid coverage for the medically needy will be addressed in later guidance and may be problematic because spend-down requirements can result in frequent eligibility changes and provide less than comprehensive coverage. However, the medically needy will not be subject to the penalty for months in which they are covered in 2014.

The final regulation does not address whether coverage provided under a Medicaid Section 1115 federal demonstration waiver will be considered MEC, even though they allow states to provide benefits more narrow than traditional Medicaid. It also remains silent on arrangements in which an employer offers subsidies or funds a pre-tax arrangement for employees to purchase coverage in the individual market. IRS says it will issue future guidance clarifying those situations.

Future guidance will also address the extent to which limited benefit TRICARE programs for military dependents are not MEC, again with transition protection from penalties for 2014 for those determined not to have coverage.

Coverage provided by insurers located in U.S. territories is not MEC unless it is offered through an ACA exchange created by a territory. At this point none of the territories has established an exchange.

Taxpayers who are bona fide residents of U.S. territories are considered to have MEC, as are citizens who have tax homes outside the U.S. and are bona fide residents of another country for the entire year or for at least 330 full days during a one year period. Coverage provided by a foreign insurer to a U.S. citizen who does not qualify for one of these exceptions is not MEC. Neither is expatriate coverage offered to citizens of other countries residing in the U.S., although the Department of Human Services (HHS) provides a procedure under which an insurer may apply for recognition as MEC (see Update for Week of March 11th).

The final rule clarifies that application of the religious conscience exemption to the individual mandate will be determined by the ACA exchanges. However, it should apply narrowly to member of religious groups that have historically objected to all forms of insurance (such as the Amish). The exemption applies both to taxpayers and their children. Once a child reaches age 21 the child must reapply individually. Taxpayers who claim the health care sharing ministry exemption must prove membership for every month of the year.

An employee eligible to purchase employer-sponsored coverage is exempt from the individual mandate penalty if the lowest cost self-only plan offered by the employer costs more than eight percent of household income. Dependents of an employee for whom a personal exemption is claimed by the employee are exempt if the annual premium of the lowest cost family coverage that would cover the employee and all related individuals is unaffordable.

The IRS specifically notes that this rule is different than the rule that applies for determining eligibility for premium tax credits, where coverage for the family is considered to be affordable — and thus the family is ineligible for premium tax credits- — as long as self-only coverage is affordable, even if family coverage is not. The IRS regulations apply different rules to these two situations even though the premium tax credit provision defines affordability by referring to the individual responsibility provision.

IRS issues proposed rule on small business tax credits offered by ACA

The Internal Revenue Service (IRS) released proposed rules this week governing the tax credits offered under the Affordable Care Act (ACA) to small business that purchase employee health coverage.

The credits (that can be up to 50 percent of premium payments) are available to employers with 25 or fewer full-time workers that have average wages of less than \$50,000. The rules require that the employer pay a “uniform percentage” of at least half of the premium cost for a Qualified Health Plan (QHP) offered through the new small business health insurance exchanges (SHOPs) created by the ACA.

The IRS is proposing a “transition year” for 2014 since plan years for many eligible small employers may not coincide with taxable years. As a result, a small employer “will be treated as offering coverage through a SHOP Exchange for its entire 2014 taxable year for purposes of eligibility for, and calculation of, a credit” if it meets certain requirements, including:

- offering coverage in a plan year that begins on a date other than the first day of its taxable year;
- offering coverage “during the period before the first day of the plan year beginning in 2014 that would have qualified the employer for the credit under the rules otherwise applicable to the period before January 1, 2014”; and
- commencing coverage through the SHOP effective the first day of its 2014 plan year.

STATES

Medicaid expansion still up in the air in five states

Five states remain undecided about whether to expand Medicaid pursuant to the Affordable Care Act (ACA), over 14 months after the U.S. Supreme Court gave them the discretion to opt-out of the expansion without penalty (see Update for Week of June 25th).

While 23 states and the District of Columbia have decided to participate in the expansion, another 21 have opted-out due to cost concerns or political opposition. Michigan is poised to become only the third state this week that is fully under Republican control to approve participation in the ACA expansion once Governor Rick Snyder (R) signs the bill he supported, though it remains very unclear whether the private-sector alternative passed by the Legislature during special session will gain the necessary federal approval since it raises Medicaid copayments and seeks to move Medicaid enrollees into the new ACA marketplace after four years (see Update for July 15th-August 2nd).

However, Indiana, Ohio, Montana, Tennessee, and Utah continue to struggle with how to accept federal funds to expand Medicaid in a conservative-leaning state where political opposition to any ACA implementation remains high.

Indiana Governor Mike Pence (R) is awaiting the Obama Administration’s decision on whether to allow his state’s Medicaid demonstration program to be expanded using the Medicaid expansion funds offered by the ACA (see Update for Weeks of April 22nd and 29th). The Healthy Indiana Plan offers low-income, working adults subsidized coverage with premiums and copayments paid for through mandatory health savings accounts.

Despite the support of Governor John Kasich (R) for a traditional Medicaid expansion, conservative lawmakers in Ohio are continuing to block any votes on the expansion and seeking legislation that would instead pare back Medicaid eligibility (see Update for Week of May 27th).

Montana Governor Steve Bullock (D) continues to face pressure from provider and consumer groups to call a special session on Medicaid expansion. However, the Republican-controlled legislature rejected any Medicaid expansion legislation last session, including private sector alternatives (see Update for Week of April 15th).

Utah Governor Gary Herbert (R) has elected to put off any Medicaid expansion decision until next year, while undecided Tennessee (as well as non-expansion states like Alaska and Wyoming) are continuing to consider private-sector alternatives like the model that the Obama Administration previously approved for Arkansas (see Update for Week of March 25th).

Alaska

Federal marketplace will have competition in Alaska

The Division of Insurance announced this week that Alaska's dominant insurer Premera Blue Cross and Blue Shield will have competition in the new Affordable Care Act (ACA) marketplace that will begin open enrollment on October 1st.

The second participating plan in the federal version of the marketplace will be Moda Health, the new name of ODS Health Systems of Oregon, which has recently expanded across the region. Governor Sean Parnell (R) and state regulators had actively sought a second plan trying to avoid the situation in New Hampshire where only one insurer will have an effective monopoly on marketplace plans (see Update for Week of August 5th).

Premium data for the two plans remains confidential state law until the marketplace policies start operating on January 1st. However, neither the Obama Administration nor the companies are bound by this confidentiality provision and each can voluntarily release the rates earlier, if they so choose.

Illinois

Governor signs licensure standards for exchange navigators and assisters

Governor Pat Quinn (D) signed S.B. 1194 late last week, which sets licensure standards for navigators, in-person assisters, and certified application counselors that will help facilitate enrollment in the new health insurance exchange (see Update for Week of May 27th). Illinois will initially partner with the federal government, but intends to assume full control over the new online marketplace in 2015 once the legislature passes expected authorizing legislation this fall (see Update for Week of February 11th).

Massachusetts

ACA will have only a small impact on Massachusetts exchange premiums

The basic cost of qualified health plans offered in the existing Massachusetts individual and small group exchanges will increase only slightly next year, according to rates recently approved by the Division of Insurance.

Massachusetts was the first state to create a health insurance exchange in 2007, which became the model for the Affordable Care Act (ACA) marketplaces for which open enrollment will start on October 1st. As a result, Massachusetts only needed to make minimal changes to comply with ACA exchange standards (see Update for Week of January 30, 2012), which are reflected in the small premium increases approved for 2014 by the Division.

However, the Division was quick to credit other structural changes in health care delivery and payment over the past year for also holding down health care costs (see Update for Weeks of July 23 and 30, 2012). According to the Division, the average base rate for health insurance premiums in the

individual and small group market will increase by 1.9 percent in the first quarter of 2014. That is the third-lowest quarterly increase since mid-2011.

Blue Cross Blue Shield (BCBS) Massachusetts, the state's largest insurer, actually reported a drop of nearly 25 percent in health care costs, while Boston Medical Center Health Net Plan and Neighborhood Health Plan reported decreases of nearly ten percent. However, nine of the 14 insurers plan to increase premiums from 4-5 percent.

However, the Division stressed that the base rates do not reflect the new limitations on age rating under the ACA that could cause premiums for younger subscribers to rise while dropping rates for older subscribers. A study commissioned by the Massachusetts Association of Health Plans and BCBS, estimated that once all the factors are taken into account, the ACA will raise premiums for individuals and small groups by an average of 3.7 percent in 2014. The cost of premiums will vary widely, with some insurers showing a 20 percent decrease and others a 26 percent increase, with wider variations for individual buyers.

New York

Aetna pulls out of health insurance exchange for individuals

Aetna announced this week that it was pulling-out of the individual market health insurance exchange that New York is creating pursuant to the Affordable Care Act (ACA).

The nation's third largest insurer had earlier decided to withdraw its application to sell individual plans in state exchanges for Connecticut and Maryland, as well as federal marketplaces in Georgia and Ohio (see Update for Week of August 5th). It also will no longer offer policies in the entire individual market for California, although it is remaining in the non-exchange market for the other states (see Update for Week of June 17th).

Aetna and its newly-acquired Coventry Health unit, a low-cost provider that caters to individuals and Medicaid beneficiaries and provides private Medicare policies, still have applications to sell coverage in ten states, including Arizona, Florida, and Virginia. Aetna has indicated that its decision to opt-out of several exchanges was due to the presence of Coventry, though it also objected to rate reductions by exchange boards in Connecticut in Maryland (see Update for Week of August 5th). Coventry remains in the Ohio exchange, but opted-out of Tennessee earlier this month.

The New York Health Commissioner emphasized this week that 16 participating insurers will continue to offer policies in all four metal tiers created by the ACA (bronze, silver, gold, and platinum). The list includes industry giants like Blue Cross Blue Shield and United Healthcare, as well as smaller plans like Fidelis Care and Oscar Health Insurance Co. as well as one non-profit insurance cooperative created by the ACA (see Update for July 15th-August 2nd).

Approved exchange premiums released last month were surprisingly 32 percent below the national average projected by the Congressional Budget Office (see Update for July 15th-August 2nd). The NY State of Health exchange has received nearly \$370 million in federal exchange establishment grants—more than any other state—and is projected to serve more than one million consumers during its first three years.

New York becomes seventh state approved for dual-eligible demonstration under ACA

New York became the seventh state this week to receive federal approval to participate in a three-year demonstration to better coordinate care for people eligible for Medicare and Medicaid.

The Centers for Medicare and Medicaid Services (CMS) announced that about 170,000 dual-eligibles receiving long-term care services would start moving into managed care plans from July 1, 2014 through December 31, 2017. Under the terms of the memorandum of understanding (MOU) approved by CMS, New York will also create an integrated appeals system.

The Medicare Rights Center praised New York for implementing most of the consumer protections they sought, noting that it has gone farther than the six other states in addressing ongoing concerns about eroding quality and access to care under the demonstration. The state previously dropped plans to pursue only a capitated model (see Update for Weeks of May 13th and 20th).

At least 26 states initially submitted proposals to participate in the demonstration, which allows states to share in the savings from transitioning dual-eligibles into capitated plans. However, CMS has been forced to slow approval of the demonstrations, pushing most into 2014 after sharp criticisms from lawmakers, Medicare experts, and hospital groups that it was moving far too quickly to safeguard access and quality (see Update for Weeks of July 23rd and 30th). In response to the complaints, CMS has been denying requests to “lock-in” enrollees, forcing states to allow them to change plans or leave the demonstration whenever they please.

As a result, several states have withdrawn applications or scaled back proposals and California has been forced to twice delay the start of its demonstration until April 1st (see Update for Week of August 19th). Massachusetts is the first state slated to begin its demonstration in October.

North Carolina

North Carolina goes further than federal government in requiring price transparency

Governor Pat McCrory (R) signed legislation last week that will require hospitals to publish the prices that they negotiate with insurers starting next June.

The measure (S. 473) will allow consumer to more easily comparison shop for health care services and goes further than the Obama Administration’s release earlier this year of prices that hospitals charge for the most common inpatient and outpatient procedures (see Update for Week of June 3rd), as well as similar legislation in Arizona (see Update for Week of May 6th).

Hospital prices are typically “sticker prices” and the amounts charged to insurers provides a more accurate guide of what consumers will actually pay, according to bill supporters.

West Virginia

Medicaid can move-up date that ACA requires new eligibility criteria

The Centers for Medicare and Medicaid Services (CMS) approved a waiver submitted by the Bureau of Medical Services that will allow West Virginia to begin streamlining enrollment of certain eligible individuals into the state’s Medicaid program before the January 1st deadline required by the Affordable Care Act (ACA). Under the waiver, the state can start using a person’s modified adjusted gross income (MAGI) as of October 1st when enrolling applicants in Medicaid.