

Health Reform Update – November 18 – December 6, 2013

CONGRESS

CMS receives bipartisan criticism for delaying SHOP marketplace by one year

Lawmakers from both parties were angered by the Obama Administration's decision over the holiday recess to delay the Affordable Care Act (ACA) marketplace for small businesses by one year.

The Small Business Health Options Program (SHOP) was scheduled to begin open enrollment on October 1st coincident with the individual marketplaces. However, some states including California (see below) and all of the 36 federally-operated marketplaces were unable to meet that deadline.

The bulletin announcement that the Centers for Medicare and Medicaid Services (CMS) would delay the SHOP marketplace for these 36 states until the next open enrollment period in 2015 was met with swift displeasure in Congress. A bipartisan group of lawmakers including Senate Small Business Committee chair Mary Landrieu (D-LA), House Small Business Committee chair Sam Graves (R-MO), and House Ways and Means Committee chair Dave Camp (R-MI), as well as the National Federation for Independent Business (NFIB), criticized the Administration for the additional burden the delay will put on small businesses in 2014, who can now only enroll in marketplace coverage through agents or brokers.

Rep. Camp noted that this is the second time the Administration sought to bury a delay in a key provision of the ACA over a holiday weekend, having similarly postponed the employer mandate for large companies over July 4th (see Update for Weeks of July 1st and 8th). The Administration also previously delayed the requirement that all SHOP marketplaces offer a choice of plans until 2015, although several states including California and Minnesota have still elected to do so (see Update for Week of April 1st).

The CMS announcement insists that this choice option will be required when the federally-operated SHOP marketplaces start open enrollment in November 2014 (see below).

U.S. Supreme Court declines to hear challenge to ACA employer mandate

As expected, the U.S. Supreme Court has refused to hear an appeal of a lower court's decision upholding the constitutionality of the employer mandate under the Affordable Care Act (ACA).

The court's landmark ruling last year upheld the constitutionality of the individual mandate under the ACA but did not address the corresponding requirement that employers with 50 or more workers provide minimum essential coverage or pay a per employee assessment. However, the court did allow Liberty University in Virginia to proceed with a pending challenge to the employer mandate that had been put on hold until the constitutionality of the law's other provisions was resolved.

The U.S. 4th Circuit Court of Appeals rejected Liberty's claim last summer, holding that it was "simply another example of Congress's longstanding authority to regulate employee compensation offered and paid by employers in interstate commerce" (see Update for Weeks of July 1st and 8th). Even though the Supreme Court's decision on the individual mandate did put certain limits on Congress' exercise of the so-called commerce clause, it declined to comment on Liberty's appeal on those grounds.

The Supreme Court did agree this term to resolve a split among appellate courts regarding whether the ACA's requirement that insurers cover certain preventive services can be applied to employee coverage offered by religious institutions that object to any coverage of contraceptives.

Senate Democrat pushes for cheaper “copper plans” under Obamacare

Senator Mark Begich (D-AK) is proposing legislation to create a new “copper” level plan to supplement the metal tiers that all non-grandfathered health plans must provide starting in 2014.

Currently, the lowest-level bronze plans must cover 60 percent of the total average costs for covered benefits (known as actuarial value). S.1729 would add a lower tier copper plan with an actuarial value of only 50 percent. Premiums for copper plans would be lower, but cost-sharing would increase.

Senator Begich insisted that the lower level option is needed for adults that do not qualify for the limited-benefit catastrophic option that is only available to those under age 30 and for whom bronze coverage is still unaffordable.

Potential budget deal would provide no relief from ongoing sequester

House Budget chair Paul Ryan (R-WI) and Senate Budget chair Patty Murray (D-WA) released details this week of a potential fiscal year 2014 budget that would raise the spending caps imposed by the ongoing sequester by about \$1 trillion in exchange for an array of limited deficit reductions.

However, even the focused cuts that were proposed are likely to draw the ire of Democratic constituencies such as raising retirement and health care contributions for federal employees. It is also not clear if Republicans will approve the proposal to pass the plan through straight legislation instead of a budget resolution, which would eliminate the need for the 29-member conference committee created by the last temporary spending bill (see Update for Week of October 14th) to first vote on the plan.

Provider and consumer groups such as the Federation for American Hospitals were upset that the proposal will not provide any relief from the sequester that went into effect last spring, including the two percent reduction in Medicare payments (see Update for Week of February 25th).

FEDERAL AGENCIES

Marketplace enrollment surges after website overhaul, though “back end” problems remain

The Centers for Medicare and Medicaid Services (CMS) issued a report this week declaring that it has met its stated goal of ensuring the federal web portal is operational for at least 80 percent of users by November 30th.

The “front end” overhaul of the website that started in November fixed over 400 software bugs or hardware problems and upgraded or replaced the portal’s web servers. As a result, the site can now support more than 50,000 simultaneous users (or 800,000 users per day), up from only 17,000 just a few weeks ago (see Update for Week of November 11th) and only 1,110 when initially launched on October 1st. According to CMS, error message rates are now down to less than one percent per page (from six percent in October) and the website is operational 90 percent of the time instead of only 43 percent of the time as it during the first several weeks of operation.

Despite CMS claims that the web portal was now operating with “private sector velocity and effectiveness”, it did shut down when 250,000 users tried to simultaneous access it the first day of the “re-launch”, which coincided with “Cyber Monday”. However, CMS emphasizes that those the web portal cannot accommodate will now be placed in an online queue so they can be receive an email notification when traffic declines.

CMS officials acknowledge that many “back end” problems remain unresolved, including continued inaccuracies in applications that the marketplace sends to insurers to finalize payment. The House Energy and Commerce subcommittee was particularly distressed to learn from the agency’s deputy chief information officer that CMS 30-40 percent of the information technology system needed to

complete these “back end” tasks still needed to be built as of mid-November. While Henry Chao stressed that these outstanding issues will not impact consumers’ ability to shop for plans through the federal portal, they could prevent insurers from receiving payment for January 1st coverage. In order to avoid that scenario, CMS is requiring insurers to submit initial payment requests manually.

The CMS performance report largely blamed a lack of management oversight and coordination among different agency teams for their failure to adequately respond to initial bugs and glitches as they were found.

The marked improvements in the web portal has directly translated to a surge in enrollment as 29,000 people signed-up via www.healthcare.gov just on the first day of the “re-launch” and 27,000 enrolled the following day, exceeding the mere 26,000 that were able to enroll during all of October (see Update for Week of November 11th). According to the most recent CMS figures, over 100,000 consumers were able to sign-up through the portal for the entire month of November.

Republican lawmakers dismissed the surge, noting that CMS figures do not identify the number of enrollees that have actually paid premiums and will have coverage as of January 1st. In an effort to boost this number, CMS has moved back the deadline for payment from December 15th to the 23rd.

Nearly 1.5 million people determined eligible for Medicaid or CHIP in October

A report from the Centers for Medicare and Medicaid Services (CMS) shows that despite the limited functionality of the federal web portal during October, roughly 1.46 million applicants were still determined to be eligible for Medicaid or the Children’s Health Insurance Program (CHIP) out of the nearly 2.5 million applications received.

Application volume for the 26 states that are participating in the Affordable Care Act’s Medicaid expansion (or plan to do so shortly after January 1st) increased by 15.5 percent compared to their average volume for July-September. By contrast, the non-expansion states saw only a 4.1 percent increase.

The applications reflected in the report are those “submitted directly to Medicaid and CHIP agencies; applications submitted to Marketplaces that are operated by states; and Medicaid and CHIP eligibility determinations those entities have made.”

However, the federal marketplace remains unable to transfer these applications to individual state Medicaid or CHIP programs due to systems issues (see Update for Week of October 28th) and instead elected this week to send “flat files” listing names and other identifying data for those determined to be eligible.

HHS delays and lengthens 2015 open enrollment for federally-operated marketplaces

The Department of Health and Human Services (HHS) announced in late November that it will delay the start of the second open enrollment period for the new Affordable Care Act (ACA) marketplaces by one month, while extending the window by an additional week compared to 2014.

As a result, open enrollment for 2015 will now run from November 15, 2014 to January 15, 2015. The move is intended to give participating insurers more time to account for those individuals, particularly young adults, whose 2014 enrollment was delayed by the limited functionality of the federal web portal over the first month (see Update for Week of November 11th). Extending the amount of time that enrollees for the 2014 plan year are covered will help ensure that premiums more accurately reflect actual medical costs for the year.

HHS noted that health insurers will still have until May 2014 to decide whether to submit applications to participate in the 2015 marketplaces. The agency also emphasized that these changes

will not affect any coverage for the 2014 plan year. However, 2014 enrollees will be given eight more days (until December 23rd) to purchase coverage that will start January 1st (see above)

CMS makes additional reinsurance funds available to compensate for plan cancellation fix

The Centers for Medicare and Medicaid Services (CMS) have released proposed rules that will increase the amount of money the ACA makes available to health insurers that incur significant losses in the new health insurance marketplaces.

The move is intended to soften opposition from the insurance industry to President Obama's proposal to allow plans that do not comply with the ACA to be extended until October 2014 (see Update for Week of November 11th). The cancellation of over five million such individual market plans in recent months had created a political liability for the Administration given the difficulties that subscribers had in transitioning to marketplace coverage due to the initial non-functionality of the federal web portal.

However, marketplace insurers that based 2014 premiums on the expectation that large numbers of younger and less costly subscribers would transition from deficient coverage into the marketplaces faced unexpected losses as a result of the President's decision. As a result, CMS proposed to lower the threshold for which insurers could tap into the three-year \$25 billion reinsurance fund created by the ACA to compensate insurers that faced unexpected costs from large numbers of high-risk pool or previously uninsured consumers signing-up for marketplace coverage.

Under the proposed rules released November 25th, insurers can now receive reinsurance payments in 2014 at \$45,000 instead of \$60,000. For 2015, CMS also proposed paying half of the costs above \$70,000 for high-cost patients. However, CMS is retaining the \$250,000 reinsurance cap and 80 percent coinsurance rate set by previous regulations (see Update for Week of October 28th).

Republican lawmakers protested that the proposed rule will also exempt multi-employer plans used by labor unions, universities, and local and state governments from the \$63 per covered life fee that funds the reinsurance program. However, the proposed rule does freeze the "user fee" for the federal marketplace at 3.5 percent for 2015, the same level as 2014.

Subsidy-eligible applicants are far below ACA marketplace projections

The consulting firm Avalere Health released a new study showing that only 30 percent of October applicants for either federal or state-based Affordable Care Act (ACA) marketplaces were eligible for premium or cost-sharing subsidies offered by the law.

The figure is far below the 84 percent of enrollees that Avalere still predicts will ultimately turn out to be eligible for those subsidies. Researchers were particularly perplexed why subsidy eligibility was much higher among the limited numbers of consumers that were able to apply through the crippled federal web portal (34 percent) than state-based marketplaces (SBMs) that enrolled four times as many applicants (23 percent). Even in the largest SBM in California, only 30 percent of enrollees were subsidy eligible as of November 21st (see below). Avalere points out that most SBMs have engaged in more extensive marketing and outreach designed to target low-to-middle income Americans that will be subsidy eligible and expects the number to grow for all marketplaces.

OIG find that IRS ready to administer ACA tax credits but not prepared to prevent fraud

The Inspector General for the Department of Treasury reported this week that the Internal Revenue Service has successfully finished testing systems to accurately calculate Affordable Care Act (ACA) premium tax credits but lacks sufficient internal controls to prevent taxpayers from deliberately under-estimating their income in an effort to qualify for credits to which they not entitled.

According to the report, the IRS had failed to complete a "fraud mitigation strategy" as of last July. The findings provided additional fuel to claims by Republican lawmakers such as Senate Finance

Committee ranking member Orrin Hatch (R-UT) that the tax credits would be susceptible to fraud, given the high error rates experienced under other refundable tax credit programs administered by the IRS. Senate Governmental Affairs Committee ranking member Tom Coburn (R-OK) wrote to the IRS Commissioner just last month to warn that the earned-income tax credit fraud rate exceeded 25 percent.

Record-low growth in health care spending is reducing overall cost of Affordable Care Act

The White House released a report this week by its Council of Economic Advisers (CEA) showing that overall spending on health care grew by only 1.3 percent from 2010 to 2013.

The record low rate of growth is spread across all parts of the healthcare industry, including public programs like Medicare and Medicaid as well as private insurers. As a result, the CEA concluded that the slowdown was likely due to alternative payment delivery systems and well as other structural reforms instead of a brief drop due to a slow economic recovery from the 2007-2009 recession.

CEA also credited the Affordable Care Act (ACA) with reducing health care spending by trimming overpayments to private Medicare Advantage plans, curbing hospital readmission rates, and promoting more efficient, high-quality care through demonstrations like accountable care organizations (ACOs).

The report notes lower health care costs can dramatically impact the cost estimates for the ACA in the coming years, especially once the law is fully implemented in 2014. It points out that the Congressional Budget Office (CBO) has already downgraded its initial cost projections for 2020 by 15 percent (or \$137 billion) for Medicare spending, 16 percent for Medicaid spending, and nine percent from lower private health plan premiums.

STATES

States divided on whether to extend health plans that do not comply with the ACA

At least 21 of 30 states with Republican governors (including Florida, New Jersey, Ohio, and Texas) have indicated that they will let health insurers extend policies through 2014 that otherwise would be canceled because they do not comply with the higher standards in the Affordable Care Act (ACA), and many will allow renewals well into 2015.

President Obama proposed the administrative “fix” last month in an effort to alleviate the political fallout from over five million plan cancellations in the individual market. It allowed state insurance commissioner to choose whether to let subscribers of plans that have been or will be cancelled to remain or re-enroll in those plans without complying with the ACA (see Update for Week of November 11th).

However, Democratic-led states have been reluctant to go along, citing concerns from the insurance industry that allowing substandard plans would undermine the risk pool for the new health insurance marketplaces. Participating insurers based their 2014 premiums on the assumption that large numbers of younger and healthier consumers would be transitioned from “junk” plans into the marketplaces.

The Obama Administration acknowledged that insurers may lose money as a result of extending these plans and issued proposed rules last week that would adjust the ACA reinsurance program to compensate for these losses (see above).

Despite this concession, only nine Democratic-led states (including Illinois, Kentucky, Missouri, and Oregon) have agreed to extend the plans. California’s insurance commissioner has sought to do so, even though the Covered California board unanimously voted last week not to allow plan extensions for marketplace insurers.

At least ten other Democratic-led states, all of which created their own ACA marketplace, have decided not to allow insurers to extend deficient plans into 2014. This includes Connecticut, Massachusetts, Minnesota, New York, and Washington.

The District of Columbia's insurance commissioner was fired on November 15th for issuing an unapproved news release denouncing the President's plan for siphoning away marketplace consumers. However, his interim successor supported his decision not to allow deficient plans to be extended (without directly criticizing the Administration).

Less than five states remain undecided, including Republican-led Nevada whose insurance commissioner stated that state law prevents him from extending the plans. (The Office of Legislative Counsel in Oregon issued a similar finding even though the state agreed to extend deficient plans.)

Obama Administration details notice that insurers must provide to extend ACA-deficient plans

President Obama's decision to allow states to choose whether plans that do not comply with the Affordable Care Act (ACA) can be extended for one year came with the caveat that insurers must notify consumers in writing that their plans are substandard (see Update for Week of November 11th).

The Centers for Medicare and Medicaid Services (CMS) released a two-page sample letter in late November outlining how insurers must provide this notice, including eight specific ways that the extended plans are inferior to ACA-compliant plans offered in the new health insurance marketplaces. This includes explaining that tax credits and cost-sharing subsidies are only available within the marketplace, and that ACA-deficient plans can discriminate based on gender, health status, or other factors.

CMS provided three similar versions of the sample letter tailored for plans that have already sent cancellation notices but plan to reinstate coverage, those that had planned to cancel coverage but are changing course, and those that will not extend plans.

Initial enrollees in state-based marketplaces are skewing towards older age groups

Demographic data released by state-based Affordable Care Act (ACA) marketplaces in California, Connecticut, Kentucky, Maryland, and Washington and Maryland show that older consumers have largely been the first to sign-up for coverage.

After the first month of open enrollment, the proportion of marketplace consumers in the critical 18-34 age group ranges from only 19 percent in Kentucky and Connecticut to about 27 percent in Maryland. By contrast, over 36 percent of marketplace enrollees are age 55-64, the most costly group to insure.

The largest state marketplace, California, released its promised demographic data in late November showing that more than 56 percent of enrollees were over age 45, compared to only 23 percent aged 18-34 (see below).

Marketplace officials acknowledge that the figures are a concern, since they projected that about 38 percent of the seven million that will enroll in ACA marketplaces by March 31st will be age 18-34. However, they note that the younger demographic typically enrolls late in the open enrollment period, based on the experience in other health insurance marketplaces such as the Massachusetts Connector, Federal Employees Health Benefit Plan, and Medicare Part D (see Update for Week of November 11th).

California

Nearly 80,000 have enrolled in Covered California, but target populations lag

Covered California officials announced in late November that nearly 80,000 consumers have now enrolled in health coverage through the Affordable Care Act (ACA) marketplace.

An average of 2,700 residents enrolled every day during November, compared with only 700 per day during the first month of open enrollment in October. Anthem Blue Cross led the way with more than 8,650 sign-ups, while Kaiser Permanente and Blue Shield of California were close behind.

However, the long-promised demographic data that Covered California released (see Update for Week of November 11th) raised several concerns. In addition to skewing towards older populations (see above), only 60 percent were eligible for private marketplace coverage and just 30 percent qualified for ACA tax credits to help purchase coverage.

In addition, the marketplace attracted only three percent of Spanish speakers, compared with 29 percent of the state population for whom Spanish is the primary language. Latinos are one the primary populations targeted by the marketplaces given the high rate of uninsured among that demographic and executive director Peter Lee insisted this week that Latino enrollment would be boosted once Covered California works out some of the continuing glitches in providing consumer assistance in Spanish.

Covered California officials acknowledged that the website is still struggling with inaccurate premium estimates and other display errors, as well as call center times that average 25 minutes and enrollment counselors being periodically shut out from the portal (see Update for Week of October 14th).

Covered California opens online portal for small business marketplace

Covered California announced that online enrollment in the Small Business Health Options Program (SHOP) started on December 2nd despite the one-year delay the Obama Administration announced last week for the Affordable Care Act (ACA) marketplaces that are federally-operated (see above).

The SHOP marketplace is separate from its more familiar counterpart for individuals or families. Enrollment is open year round for companies with less than 50 workers, instead of limited to six months.

Covered California expects about 7,000 companies to enroll by the end of 2014, as about half of the 650, 000 small business in the state currently do not provide employee health benefits. The executive director emphasized that SHOP plans can also be purchased through licensed agents.

Anthem Blue Cross tiers facilities by cost

Insurance giant Anthem Blue Cross has introduced Tiered Networks into its Affordable Care Act (ACA) compliant plans that are being offered in several large counties in California, in an effort to steer subscribers to less costly facilities.

Los Angeles, Orange, San Diego, and San Francisco are among the counties where Anthem is separating contracted provider facilities like hospitals into tiered groups into two tiers based on cost. Tier 1 is the most favored status, which provides the member with smallest cost for procedures or services. Tier 2 facilities will cost the member more money for the same services, because they have not agreed to accept the deeper discounts sought by Anthem.

Minnesota

Marketplace applications more than double during second month of open enrollment

The board overseeing the MNsure health insurance marketplace that Minnesota created pursuant to the Affordable Care Act (ACA) announced this week that more than 71,000 consumers have applied for coverage as of November 30th—more than double the 31,000 that applied during October.

MNsure was one of a handful of state-based marketplaces (SBMs) that got off to a rocky start due to severe technological glitches in the online web portal that mirrored many of the problems encountered by the federal website (see Update for Week of September 30th). Although MNsure has

corrected many of the glitches, it still was unable to start transmitting applications to insurers for invoicing and payment until last week.

As a result, only 24,586 applicants have selected a payment method and only a small fraction of that group (4,478) have enrolled in the marketplace's qualified health plans instead of Medicaid or SCHIP.

Despite the lowest marketplace premiums in the nation (see Update for Week of September 23rd), actual MNsure enrollment remains far short of the 102,800 projected enrollees for 2014. However, MNsure officials are confident that an uptick in enrollment will result now that most technological issues have been resolved, similar to the recent surge occurring in federal marketplace states (see above).

Missouri

Navigators challenge Missouri law preventing them from fulfilling duties under ACA

Several non-profit groups that received federal grants to serve as navigators for the federally-operated health insurance marketplace in Missouri have filed suit against the state for imposing onerous licensure and testing requirements that are preventing them from performing the consumer assistance functions required by the Affordable Care Act (ACA).

The lawsuit is the first in the nation to be filed against a state for practicing what Health Care for America Now has termed "navigator suppression" (see Update for Week of September 23rd). It seeks to invalidate provisions of a Missouri law that they claim will "prohibit them from providing information about health insurance altogether" and prevent Missourians "from receiving information about health insurance from the person or source of their choosing."

Plaintiffs in the lawsuit include the St. Louis Effort for AIDS, Planned Parenthood of the St. Louis Region and Southwest Missouri, the Consumer Council of Missouri and Missouri Jobs with Justice.

New Hampshire

State high-risk pool will remain open until federal marketplace glitches are resolved

New Hampshire became the latest state last month to postpone the planned closure of its state high-risk pool in response to the failed launch of the federally-operated marketplaces under the Affordable Care Act (ACA) (see Update for Week of November 11th and Wisconsin article below).

Roughly 2,750 high-risk pool enrollees would have been required to transition to ACA marketplace or other individual market coverage after the December 31st. However, the Insurance Commissioner issued an order in late November indefinitely extending the high-risk pool until enrollment problems in the federal marketplace are fully resolved (see above).

Only 269 state residents were able to enroll in New Hampshire's partnership marketplace during October, which requires consumers to use the error-plagued federal web portal.

The Texas Department of Insurance issued similar emergency rules this week extending their high-risk pool until the March 31st end of open enrollment for all marketplaces.

Ohio

Full Senate to vote on bill to require parity in oral and IV cancer medications

The Senate Insurance and Financial Institutions Committee passed legislation this week that seeks to make Ohio the 28th state to require parity in health insurance coverage of oral cancer medications and intravenous chemotherapy.

While S.B. 99 is strongly supported by provider and consumer groups, similar versions have stalled the past three years in the face of opposition by the Ohio Association of Health Plans and Ohio Chamber of Commerce, which insist it will raise premiums and make it harder for companies to offer

health insurance. However, committee chairman Jim Hughes (R) and bill sponsor Scott Oelslager (R) joined with other Republicans and Democrats in noting that comparable laws in other states have not had such an effect.

Similar legislation was also introduced last week in the New Jersey legislature (A. 4520).

Oregon

Online marketplace portal will not be ready for January 1st enrollment

Cover Oregon officials acknowledged in late November that online enrollment in their Affordable Care Act (ACA) marketplace will not be possible until after December 15th. As a result, consumers wanting coverage to start January 1st had to submit paper applications by December 4th.

Oregon remains the only state or federal marketplace still lacking online enrollment capability (see Update for Week of October 21st). Cover Oregon officials had set a December 15th deadline for fixing errors that prevent the web portal from correctly determining applicant eligibility for the marketplace or premium and cost-sharing subsidies.

However, Cover Oregon's main contractor Oracle has been unable to complete the needed testing by the state-imposed deadline. As a result, Cover Oregon is operating under the assumption that Oracle may not have the portal operational even through December and has already lowered its projections for first-year enrollment from 128,000 to 114,000 consumers.

Governor John Kitzhaber (D) recently appointed the retired CEO of Providence Health Systems and the Oregon Health Authority director to oversee paper-based enrollment so that Cover Oregon can focus on repairing the web portal.

Pennsylvania

Senate panel approves legislation limiting biosimilar substitution

The Senate Public Health and Welfare Committee unanimously passed legislation in mid-November that will place restrictions on when pharmacists can substitute lower-cost biosimilars that the Food and Drug Administration (FDA) has approved as interchangeable.

S.B. 405 is comparable to legislation pushed by brand-name manufacturers like Amgen and Genentech in at least 15 states that would impose additional steps such as a physician notification before a biosimilar copy can be substituted (see Update for Week of September 3rd). Although five states already enacted comparable industry-backed restrictions (Florida, North Dakota, Oregon, Utah, and Virginia), ten states have rejected them including California (see Update for Week of October 14th).

The Affordable Care Act (ACA) created the new approval pathway for biosimilar generic copies that can cost up to 40 percent less than their brand-name counterparts (see Update for Week of February 6th). However, final regulations have yet to be issued by FDA, whose commissioner has denounced the industry "efforts to undermine trust in these products" through "worrisome" restrictions that "represent a disservice to patients who could benefit from these lower-cost treatments" (see Update for Week of September 3rd).

The Generic Pharmaceutical Association, which opposes S.B. 405, insisted that the measure would only increase the costs for brand-name biologics, noting that they already cost Pennsylvania Medicaid an average of \$1,650 per prescription in 2012.

South Dakota

Governor opens door to future Medicaid expansion

In his annual budget address this week, Governor Dennis Daugaard (R) indicated for the first time that South Dakota may participate in the Medicaid expansion under the Affordable Care Act (ACA) in the future.

The Governor had staunchly opposed expanding Medicaid (see Update for Weeks of January 28th and February 4th) and continued to exclude participation from this year's budget plan despite pressure from state provider and consumer groups. However, he did previously convene a state task force to study private-sector alternatives similar to the model federally-approved for Arkansas (see Update for Week of September 23rd), and acknowledged that he was informally negotiating a similar plan with the Obama Administration so that South Dakota could accept future ACA funds for expanding.

The expansion would add roughly 48,000 South Dakotans to the Medicaid rolls, although about half that amount will currently be eligible to purchase coverage in the new ACA Marketplace.

Texas

Insurance department proposes background checks, additional training for ACA navigators

The Department of Insurance released proposed rules on December 3rd that would require navigators that help facilitate enrollment in the Affordable Care Act (ACA) marketplace to undergo background checks and 40 hours of additional training beyond federally-required minimums.

Governor Rick Perry (R), Attorney General Greg Abbott (R), and Insurance Commissioner Julia Rathgeber (R) insisted the measures were necessary to prevent identity theft and privacy violations by the 200 plus navigators in Texas that have received nearly \$11 million in ACA funding. However, consumer advocates were quick to decry the proposed rules, noting that the additional requirements of surety bonds and malpractice insurance go far beyond the registration or training standards imposed by any other state, much less the requirements for any other form of community-based enrollment assistance in Texas such as Medicare counselors.

Senate Democratic leader Kirk Watson estimated that the additional training alone would cost as much as \$800 per navigator and cripple efforts to educate the 25 percent of Texas' population that lacks health insurance.

Prior to the latest rulemaking, Texas was already identified by Health Care for America Now as one of 13 states engaging in "navigator suppression" by imposing overly burdensome requirements (see Update for Week of September 23rd).

Wisconsin

Assembly approves three-month delay in Medicaid terminations, high-risk pool closure

A special session of the Republican-controlled Assembly has approved the request by Governor Scott Walker (R) for a three-month delay in his plan to eliminate Medicaid coverage for 92,000 low-income residents and force 20,000 uninsurable residents to transition off state high-risk pool coverage.

The delay was necessitated by the limited functionality of the federal marketplace, which threatened to prevent many of those who would lose coverage from being able to transition to a marketplace plan without uninterrupted coverage. However, it will also postpone until April 1st the date by which roughly 83,000 childless adults would gain coverage under the Governor's limited alternative under the Medicaid expansion (see Update for Week of November 11th).

It remains very unlikely that the Governor can gain the needed federal approval for his plan, as it only partially expands Medicaid to 100 percent of the federal poverty level for previously-uncovered groups while reducing eligibility from 200 to 100 percent for others (see Update for Week of August 12th).