



Health Reform Update – Week of March 3, 2014

By Mark Hobraczek

CONGRESS

GAO agrees to investigate flawed rollout of several state Marketplaces

The Government Accountability Office (GAO) announced this week that it will investigate the continued failure of the Marketplace web portal created by Oregon, as well as the flawed rollout of other state Marketplaces under the Affordable Care Act (ACA).

Rep. Greg Walden (R-OR) was joined by Senators Ron Wyden (D-OR) and Jeff Merkley (D-OR) in seeking the audit of \$304 million in federal exchange establishment grants received by Oregon, which still lacks any online enrollment capability. House Energy and Commerce chairman Fred Upton (R-MI) and health subcommittee chairman Joe Pitts (R-PA) also signed-on.

GAO did not specify what other state-based Marketplaces would be audited. However, Maryland and Massachusetts were two glitch-plagued Marketplaces targeted by the Congressional request (see Update for Week of February 17th) while Hawaii and Minnesota are other state-based Marketplaces that have struggled to enroll applicants online.

GAO has already begun a similar audit of the federally-facilitated Marketplaces being operated in 36 states, which were severely hampered by technological issues before being overhauled in November (see Update for November 18th-December 6th).

President's budget fully funds ACA, repeats other Medicare and Medicaid reforms

The fiscal year 2015 budget proposed this week by President Obama would fully fund implementation the Affordable Care Act (ACA) while repeating earlier calls to increase beneficiary and provider shares of Medicare costs and expand the availability of biosimilar drugs (see Update for Week of April 8, 2013 and Week of February 13, 2012).

The budget seeks \$629 million specifically to fund Marketplace operations, including information technology, outreach, in-person assisters, and call-center operations, while collecting roughly \$1.2 billion in user fees for insurers participating in the federally-facilitated Marketplaces. It also would spend \$5.5 billion on the temporary reinsurance payments under the ACA intended to compensate Marketplace insurers for any exceptional losses resulting from a sicker and more costly pool of subscribers than anticipated—a program that Republican lawmakers have already termed a “bailout” (see Update for Weeks of January 20th and 27th).

President Obama also proposes several tweaks to certain ACA provisions. This includes speeding-up the closing of the Medicare Part D coverage gap under the ACA by increasing manufacturer discounts from 50 to 75 percent starting in 2016 (instead of 2020) and extending for one year the ACA provision that provides Medicare payment rates to primary care providers under Medicaid.

The President also seeks to strengthen the controversial Independent Payment Advisory Board (IPAB) created by the ACA to recommend Medicare payment cuts whenever spending exceeds a pre-determined target. These recommendations automatically go into effect unless Congress enacts equivalent offsets. His proposal would reduce this target from gross domestic product (GDP) plus one percent to GDP plus 0.5 percent, making it easier for IPAB recommendations to be triggered.



The budget renews the President's earlier calls to prohibit "pay-to-delay" settlements where generic drug companies agree to keep lower cost copies of brand-name drugs off the market for negotiated number of years (saving \$9.1 billion over ten years). It also would reduce the exclusivity period for biosimilar copies of brand-name biologic drugs from 12 years under the ACA to the seven years initially sought by his Administration (saving \$4 billion over ten years).

The remainder of the budget shies away from any major Medicare or Medicaid reforms and removes a controversial proposal in earlier budgets for a chain consumer price index (CPI) formula that would reduce the growth in Social Security payments. The chained CPI was intended to facilitate a "grand bargain" with Republicans on deficit reduction but drew the ire of Democratic constituencies.

President Obama does include roughly \$402 billion in Medicare and Medicaid savings in ten years, mostly through piecemeal changes that were part of his previous two budgets. These cuts would heavily-weighted toward future years, with only \$3.5 billion occurring in 2015.

The biggest change for Medicare enrollees would be an increase in Part B and D premiums for the wealthy, which are projected to save \$52.8 billion over ten years. In addition, new enrollees who buy supplemental Medigap plans with low cost-sharing requirements would pay a new surcharge, a change advocated by the Medicare Payment Advisory Commission (MedPAC) that is estimated to save \$2.7 billion over ten years (see Update for Week of January 6th).

Starting in 2016, drug manufacturers would be required to give Medicare the same rebates it now must extend for drugs furnished to Medicaid enrollees, for a projected \$117.2 billion in savings over ten years. Reimbursement for physician-administered Medicare Part B drugs would also be reduced from 106 to 103 percent of average sales price (ASP).

Funding for health-related agencies would remain largely flat under the FY 2015 budget proposal, with the Food and Drug Administration seeing only \$0.4 billion increase once accounting for user fees on drug reviews. The Centers for Disease Control and Prevention budget would be cut by about six percent.

The President's requests may be largely symbolic. Congressional Republicans, who have tried to defund all or part of the health law, balked before at adding money for the health law and are highly unlikely to approve an administration request for additional implementation funding. In addition, Congress already agreed earlier this year to a two-year budget deal that slightly raised federal government spending caps imposed by the ongoing sequester (see Update for Week of January 13th). Neither Republicans nor Democrats appear anxious to undo that agreement.

CBO reduces cost of ACA coverage expansion due to flawed Marketplace rollout

The Congressional Budget Office (CBO) has once again lowered its estimate this week of the cost of expanding coverage under the Affordable Care Act (ACA).

The non-partisan scorekeeper had reduced its initial cost projections last year, when it predicted that roughly eight million fewer Americans would be Medicaid-eligible after the U.S. Supreme Court let states opt-out of the Medicaid expansion without penalty (see Update for Weeks of May 20 and 27, 2013). At the time, it estimated that the ACA's coverage provisions would cost \$1.363 trillion over ten years. However, it reduced that figure this week by \$9 billion due to Marketplace enrollment that is likely to be one million consumers less than previously anticipated (see Update for Week of February 3rd).

CBO blames the lower enrollment on "significant technical problems" with the online web portal for the federally-facilitated Marketplaces and several of the state-based models. According to its estimates, the one million fewer enrollees will translate to \$11 billion in lower subsidies and other costs in fiscal years 2014 and 2015.



The costs of the ACA provisions will rise each year as more uninsured Americans gain coverage. For example, CBO estimates that 24-25 million people will enroll in the Marketplaces, starting in 2017. If 80 percent are eligible for ACA subsidies (as expected) total subsidy spending will steadily rise from only \$15 billion in 2014 to more than \$143 billion by 2024.

However, these costs will partially be offset by \$517 billion collected in ACA penalties under the individual and employer mandates, as well as the taxes on high-cost health plans, health insurers, device manufacturers, etc. Expanding Medicaid coverage to will also expand coverage to 12-13 million people per year starting in 2017, further mitigating the ACA costs.

CBO predicts that 31 million Americans under 65 will still remain uninsured by 2024. Roughly 45 percent of that group will choose to pay the penalty under the ACA instead of buying coverage they can afford. Another 30 percent will be unauthorized immigrants, 20 percent will be Medicaid-eligible but not enrolled, and five percent will be ineligible for Medicaid because their state opted-out of the expansion.

Most Senate Finance members ask CMS to scrap controversial Medicare Part D changes

New Senate Finance committee chair Ron Wyden (D-OR) was joined last week by ranking member Orrin Hatch (R-UT) and all but four of the 24 panel members in condemning the Medicare Part D changes recently proposed by the Centers for Medicare and Medicaid Services (CMS).

CMS has already been under increasing pressure from a broad group of over 200 stakeholders seeking to scrap or scale back the proposed rule (see Update for Week of February 17th), forcing the agency to issue a “fact sheet” last week insisting that the changes would protect Part D enrollees and provide them with “more meaningful choices” while promoting transparency and market competition. The agency also claims they will save \$1.3 billion from 2015-2019.

In Congressional testimony last week, CMS Administrator Marilyn Tavenner defended the removal of protected class status for three types of drugs—the primary concern of Senate Finance members--insisting that it would protect from overutilization that could be harmful to Part D enrollees. She also insisted that requiring Part D plan sponsors to work with “any willing pharmacy” would broaden access for enrollees, while limiting them from issuing more than two Part D plans in the same service would reduce enrollee confusion.

The provisions of the proposed rule requiring all price concessions from pharmacies be reflected in negotiated prices has increasingly come under attack, including from members of Senate Finance. However, CMS maintains that such transparency is necessary to “allow beneficiaries to find the best deal for them and ensure they actually benefit from lower costs if they used preferred pharmacies.”

Rep. Renee Ellmers (R-NC) followed by introducing legislation this week (H.R. 4160) that would prohibit CMS from finalizing the proposed rule.

House passes 50th bill to repeal or part of the Affordable Care Act

House Republicans voted for the 50th time this week to repeal all or part of the Affordable Care Act (ACA). However, 27 Democrats joined with them this time to approve a measure that would suspend the tax penalty for not buying minimum essential coverage (the “individual mandate), at least until the employer mandate goes fully into effect (see Update for Week of February 24th).

The Congressional Budget Office (CBO) estimated that H.R. 4118 would save \$9.4 billion over 11 years due to reduced ACA subsidies and fewer Medicaid enrollees. However, as with the previous 49 bills, it is expected to be largely ignored by the Democratically-controlled Senate.



House Republicans are rejecting permanent “doc fix” proposal due to cost

Several media outlets reported this week that many House Republicans recently have informed the American Medical Association (AMA) and other physician groups that they will not back the bipartisan framework to permanently replace the Medicare physician payment formula that would have resulted in a more than 21 percent cut every year if not continuously deferred by Congress.

Though they reached agreement last month on a new formula (S.2000, H.R. 4015), Democrats and Republicans have been unable to come together on how to offset the \$121 billion that the Congressional Budget Office estimates the latest plan will cost over ten years (see Update for Week of February 3rd). House Republicans have thus far balked at the most likely offsets being discussed, which include cuts in Medicare payments for other providers (such as post-acute care) and extending the cuts in federal Medicaid payments for safety-net hospitals that serve a disproportionate share of indigent patients.

These offsets have been part of the proposed budgets introduced by President Obama over the past two years (see above). New Senate Finance Committee Chairman Ron Wyden (D-OR) refused to rule out these offsetting cuts this week.

House Republicans are instead planning to bring to the floor next week a bill that would pay for the “doc fix” by tying it partly to a delay in the individual mandate under the ACA (see above).

Congress must either pass a permanent or temporary fix by March 31st to avert a 24 percent Medicare physician payment cut for this year.

FEDERAL AGENCIES

HHS extends ACA-deficient plans until 2017, expands open enrollment for 2015

The Department of Health and Human Services (HHS) confirmed persistent rumors this week that certain individual health plans will not need to comply with new Affordable Care Act (ACA) consumer protections until 2017.

President Obama had given state insurance commissioners discretion to allow ACA-deficient plans to be extended through 2014 in order to quell the political controversy that erupted after individual health insurers chose to cancel substandard plans for more than five million subscribers instead of upgrading them by January 1st to comply with the ACA (see Update for Week of November 11th). To date, 27 states (plus Puerto Rico and Guam) have done so, although California has not (see below).

HHS will now extend this discretion for plans that start no later than October 1, 2016, effectively pushing the continuation of ACA-deficient plans past the 2014 mid-term elections and 2016 presidential election and into the start of 2017. According to the RAND Corporation, roughly 500,000 subscribers are currently in ACA-deficient plans though the Kaiser Family Foundation expects that number to dwindle by 2017 even with the extension.

The announcement came as part of a broad set of regulatory changes (see below) that includes broadening the open enrollment period for 2015. The flawed rollout of the Marketplaces already forced HHS to delay and expand the 2015 enrollment period until November 15, 2014-January 15, 2015 (see Update for November 18th-December 6th). HHS will now add one month to this timeframe, so that consumers can enroll in individual health plan coverage from November 15, 2014-February 15, 2015.



White House officials insisted on a conference call with stakeholders this week that it has no plans to extend the March 31st deadline for the inaugural open enrollment period, nor does it anticipate any other major changes relating to Marketplace enrollment.

However, other minor changes announced this week include giving states until June 15th to decide whether they want to operate their own Marketplace for 2015. A handful of states including Idaho and New Mexico have already stated their intent to transition from a federally-facilitated Marketplace to a state-based Marketplace next year.

HHS also set annual out-of-pocket limits for 2015 at \$6,600 for individuals and \$13,200 for families (up from \$6,400 and \$12,700 in 2014). These out-of-pocket limits restrict what plans can charge subscribers for cost-sharing (deductibles, copayments, and coinsurance) on covered services but are typically lower for gold and platinum level plans that have higher premiums than the lower-end bronze and silver plans.

HHS insists that broader reinsurance payments to insurers will not be a “bailout”

In order to compensate insurers that may now have fewer Marketplace consumers than initially projected for the first three years, the Department of Health and Human Services (HHS) will further broaden the reinsurance payments under the Affordable Care Act (ACA) intended to minimize any “rate shock” caused by exceptional losses. The threshold at which reinsurance payments would be triggered will be lowered for 2014 from \$60,000 to \$45,000 in claims per person, then rise to \$70,000 next year, with a reinsurance cap of \$250,000 per person.

The changes were announced concurrent with the Obama Administration’s two-year extension of ACA-deficient plans (see above). President Obama also proposed \$5.5 billion in reinsurance payments for 2014 as part of his latest budget (see above).

Republican lawmakers have largely attacked these reinsurance payments as a “bailout” (see Update for Weeks of January 20th and 27th), forcing HHS officials this week to stress that they will only be implemented in a “budget neutral fashion” requiring matching revenue flows through user fees paid by insurers participating in the Marketplaces and other sources. Senator Marco Rubio (R-FL) has already introduced legislation to repeal the reinsurance payments and scoffed this week at claims that taxpayers would not be on the hook for some or all of these payments.

However, the Congressional Budget Office (CBO) concluded earlier this month that the risk corridors and reinsurance program under the ACA would actually earn the government \$8 billion over the 2015-2017 period, as the \$8 billion in costs would be more than offset by \$16 billion in user fees and other revenues.

HHS permits further delay in consumer choice requirement for small business Marketplace

As part of the broad regulatory changes for the Affordable Care Act (ACA) Marketplaces announced this week, the Department of Health and Human Services (HHS) will give state insurance commissioners the discretion to further delay an ACA requirement that small business version of the Marketplace offer consumers a choice of more than one plan.

The “employee choice” option has already been delayed until 2015, although several states operating their own Marketplaces (including California and Minnesota) elected to put it into place for 2014 (see Update for Week of April 1st). However, HHS indicates that later guidance and rulemaking will delay making it mandatory for an additional year (until 2016).

The Small Business Majority and other advocacy group criticized the delay calling it a “major letdown” as “the employee choice option is crucial to the success of the small business marketplaces.”



Online enrollment in all federally-facilitated Small Business Health Options Program (SHOP) Marketplaces had likewise been delayed until 2015 (see Update for November 18th-December 6th) and several state-based SHOPS (including California, Maryland, and Oregon) still lack any online capability.

HHS insists that online enrollment functions for FFMs will still be ready by the November 15th start of open enrollment for 2015.

CMS issues final rule on Basic Health Plan option under ACA

The Centers for Medicare and Medicaid Services (CMS) finalized regulations this week that allow states to create a Basic Health Plan (BHP) alternative for their lowest-income Marketplace consumers.

The Affordable Care Act provides states with additional federal funding should they choose to exercise the BHP option for those earning 138-200 percent of poverty that do not qualify for Medicaid but would still have trouble affording any Marketplace plan even with the ACA's premium and cost-sharing subsidies. BHPs can offer enrollees lower out-of-pocket costs and avoid the requirement that they repay any extra subsidies that they improperly received because of a change in income during the year. However, few states have expressed interest to date, mostly due to fears that BHPs would siphon away enrollment needed to keep their Marketplaces financially viable (see Update for Week of February 10th).

As a result, CMS delayed implementing the BHP until 2015 in order to focus on the rollout of the Marketplaces (see Update for Weeks of January 28 and February 4, 2013). The delay drew vociferous criticism from Senator Maria Cantwell (D-WA), the lead author of the BHP provision, and forced CMS to commit to finalizing regulations in early 2014 (see Update for Week of March 25, 2013).

The final rule and accompanying payment bulletin made some changes to rules and guidance issued late last year that outlined a proposed methodology for BHP payments and the parameters for states to operate these programs (see Update for December 16th-January 3rd.) This includes an option for continuous enrollment, so that BHP subscribers would not have to reapply within 12 months as long as they do not move out-of-state, lack minimum essential coverage, and do not turn age 65.

In response to public comments concerned about network adequacy, CMS will require that plans follow Medicaid managed care rules or Marketplace rules to make sure that the number, mix, and geographic distribution of providers will meet the needs of consumers in the area. They also will have to follow the same rules dictating the types of providers that must be included.

The final rule also clarifies that states must offer a choice of plans from at least two standard plans. Rural states that may not have enough plans to allow this can request an exception.

The final rule further outlines how states can be certified to operate a BHP, how states should regulate and certify a BHP, and the eligibility criteria for individuals. CMS will not allow monthly BHP premiums to exceed the monthly premiums that Marketplace enrollees would have paid under the second-lowest cost silver plan (to which premium tax credits are tied).

The BHP option will be available to states starting January 1st. However, the final rule allows states to start the program during any point in 2015 so long as CMS approves their blueprint.

Commerce department says ACA increased personal income and spending

The Affordable Care Act (ACA) contributed to slight increases in personal income and consumer spending in January, according to a Department of Commerce report released last week.

Researchers specifically found that personal income increased by 0.3 percent (or roughly \$23.7 billion) compared with a decrease of \$15 billion in December 2013. The report concluded that the



increase resulted primarily from \$19.2 billion in expanded Medicaid benefits and another \$14.7 billion in premium subsidies and tax credits offered by the Affordable Care Act (ACA). These factors also helped boost consumer spending by 0.4 percent (or about \$48.1 billion).

STATES

States opting-out of ACA Medicaid expansion will leave 60K HIV/AIDS patients uninsured

Researchers from drug manufacturers AbbVie and Bristol Myers Squibb, as well as the University of Southern California, predicted this week that roughly 60,000 Americans with HIV/AIDS will likely remain uninsured in states not participating in the Medicaid expansion under the Affordable Care Act (ACA).

According to the study, roughly 115,000 individuals with HIV/AIDS would have gained coverage if all states expanded Medicaid to everyone earning up to 138 percent of the federal poverty level (FPL), as initially required by the ACA. However, the U.S. Supreme Court's decision to allow states to opt-out without penalty will leave more than half this group uninsured, because about 70 percent of all HIV/AIDS patients live in one of the 23 states that have currently decided not to expand and earn less than 100 percent of FPL, leaving them ineligible for the ACA's premium tax credits or cost-sharing subsidies.

More than half of the 60,000 that will be left uninsured reside in just three opt-out states (Florida, Georgia, and Texas).

Arkansas

House renews Medicaid expansion on fifth try

The House finally provided the three-fourths majority this week required to reauthorize Arkansas' private-sector alternative to the Medicaid expansion under the Affordable Care Act (ACA).

Arkansas was the first state given federal approval to use ACA matching funds for the Medicaid expansion to instead coverage those made newly-eligible for Medicaid under private Marketplace plans. However, the House had previously voted four times to strip coverage from the roughly 96,000 Arkansans that have already enrolled (see Update for Week of February 17th).

Under state law, the expansion required an annual reauthorization. However, conservatives in both the House and Senate sought to leverage the reauthorization to place additional restrictions on the program, including enrollment limits and bans on marketing and outreach (see Update for Week of February 24th). Ultimately, the reauthorization received pass by one vote in both the House and Senate.

California

Senator sues to reinstate canceled plans

State Senator Ted Gaines (R) announced this week that he is suing Covered California for refusing to allow plans to do not meet Affordable Care Act (ACA) standards to be extended past January 1st after the President Obama gave them discretion to do so (see Update for Week of November 11th).

Covered California's decision caused more than one million individual health plan subscribers to lose ACA-deficient coverage, a move that Senator Gaines insists violates both federal and state laws. His lawsuit in the Los Angeles County Superior court also alleges that Covered California has wasted hundreds of millions of dollars in marketing and outreach to boost Marketplace enrollment, including \$10 million to contract with a public relations firm.

Covered California has been among the most successful of Marketplaces, enrolling more than 829,000 consumers and already meeting its target for March 31st (see Update for Week of February 17th).



It is not clear how many of the one million of those with canceled policies ultimately enrolled in a Covered California plan.

Senator Gaines owns an insurance agency and is currently campaigning to take the seat of Insurance Commissioner David Jones (D).

Colorado

Colorado gets federal approval to expand dual-eligible demonstration

The Centers for Medicare and Medicaid Services (CMS) notified Colorado state officials this week that they can add 48,000 people eligible for both Medicare and Medicaid to their demonstration program to coordinate care for such dual-eligibles.

Colorado was one of nine states approved to operate the three-year demonstration authorized by the Affordable Care Act (see Update for Week of October 28th). Seven of the nine do so through managed care plans. Colorado and Washington are the only two that use a more coordinate type of fee-for-service model where enrollees are assigned to a primary care medical provider.

Only selected Medicaid beneficiaries were eligible to participate in Colorado's demonstration. However, CMS will now allow Colorado to expand beyond the initial 352,236 that have already enrolled.

Georgia

House passes two anti-ACA measures

The Republican-dominated House overwhelmingly passed two measures this week seeking to bar implementation of provisions in the Affordable Care Act (ACA).

The first bill (H.B. 990) was sponsored by House speaker pro tempore Jan Jones (R) and would prohibit any state official from participating in the Medicaid expansion without legislative approval (see Update for Week of February 17th). The second bill (H.B. 707) sponsored by Rep. Jason Spencer (R) goes even further by barring the insurance commissioner from implementing any of the ACA's market reforms and specifically prevents the University of Georgia from operating the navigator program for which it received a federal grant to help facilitate Marketplace enrollment. Any employee of state government would also be prohibited from spending state funds to advocate for the Medicaid expansion.

House Minority Leader Stacey Abrams (D) insisted the latter measure was unconstitutional.

Hawaii

Resolution would require impact study of specialty tier coinsurance limits

Senator Josh Green (D) introduced S.C.R. 64 this week, which would direct the state auditor to study the social and financial impact of his related legislation (S.B. 2173). That bill would require health insurers to cover prescription drugs while limiting any coinsurance or copayments for the highest-cost specialty tier drugs to only \$150 per a thirty-day supply (see Update for Weeks of January 20th and 27th).

The findings and recommendations of the auditor would have to be submitted no later than twenty days prior to the end of the 2014 regular legislative session.

Kentucky

New bill would limit cost-sharing for specialty tier drugs

Rep. James Kay (D) introduced H.B. 578 this week, which would limit coinsurance or copayments for specialty drugs to no more than \$100 per month for up to a 30-day supply, or \$200 per month in the aggregate. The bill also requires an exceptions process for tiered formulary plans and would prohibit



plans from placing all drugs of the same class in a specialty tier, a practice occurring in Affordable Care Act (ACA) Marketplace plans in states like Alabama and Florida (see Update for Week of January 6th).

Maine

Health commissioner disputes cost estimate for Medicaid expansion bill

A plan to expand Medicaid coverage to more than 70,000 low-income Mainers for three years would cost the state practically nothing, according to a preliminary analysis provided to the Health and Human Services Committee this week by the Office of Fiscal and Program Review (OFPR).

L.D. 1487, proposed this week by two moderate Republican Senators, would accept Affordable Care Act (ACA) funds to expand Medicaid up to 138 percent of the federal poverty level (FPL), at least until full federal funding starts to phase down to 90 percent in 2016. The OFPR study found it would save Maine roughly \$3.4 million in the first year and cost just under \$290,000 in the second year and \$3.8 million in the third year—at which point the legislature could choose to continue it for \$1.9 million per year.

Governor Paul LePage (R) staunchly opposes any Medicaid expansion. His Department of Health and Human Services Commissioner called the findings “nonsense” and predicted that the expansion would actually cost 123 times the amount the nonpartisan office says or \$84 million by 2017.

New Hampshire

Senate clears way for Arkansas-style Medicaid expansion alternative

The Republican-controlled state Senate voted 18-5 this week to pass a “private sector” alternative to the Medicaid expansion under the Affordable Care Act (ACA).

S.B. 413 is expected to become law as it has the backing of Governor Maggie Hassan (D) and a similar version already cleared the Democratically-controlled House. It largely follows the model already federally-approved for Arkansas, Iowa, and Michigan (see Update for Week of January 6th). However, instead of using ACA funds to cover the newly-eligible population in the state partnership Marketplace, about 12,000 adults earning up to 138 percent of the federal poverty level would be covered instead through an existing state program that subsidizes employer-based coverage. Another 38,000 would be covered first through Medicaid managed care plans and then transition to private Marketplace plans when federal funding starts to phase down from 100 percent to 90 percent.

The state must obtain federal waivers for each stage of the expansion. It will sunset in 2017 without additional legislative approval.

Oregon

Legislature passes bills addressing failed Marketplace as lead contractor still gets paid

The House and Senate passed H.B. 4122 this week, which would require independent quality assurance oversight on contracted technology projects that cost more than \$5 million, as well as other projects that meet certain criteria. They also passed H.B. 4154, extending state whistleblower protections to Cover Oregon employees and allowing the governor to remove all Cover Oregon board members in a single year. It would also direct Cover Oregon to seek a federal waiver to extend the enrollment deadline to April 30th and to seek federal tax credits for small businesses.

Governor John Kitzhaber (D) applauded passage of both measures and is expected to sign them shortly. They are part of a series of bills intended to correct or compensate for continued flaws in the Covered Oregon web portal that has prevented online enrollment throughout the entire inaugural open enrollment period, resulting in a federal audit (see above).



Governor Kitzhaber acknowledged this week that the state had no choice but to pay Oracle Corporation nearly \$44 million in withheld payments despite the continued technological glitches with the web portal. Oracle has threatened to walk away from the project leaving Covered Oregon with no chance of completing repairs on the failed web portal before the March 31st end of open enrollment.

Health committee approves study of basic health plan option under ACA

The House and Senate passed H.B. 4109 this week, which calls for the Oregon Health Authority to study whether Oregon should exercise the Basic Health Plan (BHP) option under the Affordable Care Act (ACA) for those earning 138-200 percent of the federal poverty level (FPL). Despite enhanced reimbursement under the ACA for this population, several states have considered but rejected the BHP option for fears it would siphon away enrollment critically needed to ensure the viability of the new health insurance Marketplaces (see Update for Week of March 25, 2013).

The Obama Administration delayed the BHP option until 2015 and finalized regulations this week (see above).

South Dakota

Obama Administration rejects Governor's partial Medicaid expansion proposal

For the second time, the federal Centers for Medicare and Medicaid Services (CMS) has rejected a waiver requested by Governor Dennis Daugaard (R) to expand Medicaid under the Affordable Care Act (ACA) only for those earning less than 100 percent of the federal poverty level (FPL).

The head of CMS' Medicaid division has made clear that states can only receive ACA matching funds if they expand all the way to the 138 percent of FPL threshold set by the ACA (see Update for Weeks of August 6 and 13, 2012). Democratic leaders in South Dakota had joined with their Republican counterparts in urging CMS to compromise and allow partial expansions. However, the agency made clear in a conference call with state officials this week that while CMS will negotiate on "private sector" expansion alternatives such as those it already approved for Arkansas, Iowa, and Michigan (see Update for Week of January 6th), the ACA statute allows it no flexibility to grant partial expansions.

Democrats are expected to introduce another full expansion bill next week, but Republican leaders have shown no interest in supporting an expansion beyond the 100 percent of FPL threshold, as those earning above this threshold are eligible for premium and cost-sharing assistance under the ACA. House Republicans rejected an Arkansas-style model just last week, as it would have covered those earning up to 138 percent of FPL in private Marketplace plans (see Update for Week of February 24th).

Tennessee

House and Senate pass bill barring Medicaid expansion without legislative approval

The Senate voted this week to approve H.B. 937, a House-passed measure that prevents Governor Bill Haslam (R) or other state officials from expanding Medicaid without legislative approval (see Update for Week of February 24th). The Governor has repeatedly indicated that he does not object to the measure and will not make any decision on participating in the Medicaid expansion under the Affordable Care Act without legislative support.

Utah

Governor backs special session on Medicaid expansion

Governor Gary Herbert (R) stated this week that he was likely to call a special session to debate Medicaid expansion legislation if the House and Senate fail to reach a consensus on one of four competing versions by the March 13th end of the regular session.



Governor Herbert backed a “private sector” alternative last week similar to the model federally-approved for Arkansas, Iowa, and Michigan (see Update for Week of February 24th). That plan would use Affordable Care Act (ACA) matching funds to move newly-eligible Medicaid enrollees into private Marketplace plans.

House Speaker Becky Lockhart (R) insists that accepting any ACA funds remains “toxic” and is pushing a limited expansion with only \$35 million in state funds. Senator Brian Shiozawa (R) sponsored a separate alternative this week under which Utah would use only a portion of ACA funds to cover only those earning up to 100 percent of the federal poverty level (FPL), instead of the 138 percent threshold set by the ACA. However, the Obama Administration has consistently refused to approve such partial expansions (see South Dakota above).

A Democratic plan to pursue the full Medicaid expansion under the ACA emerged this week. However, S.B. 272 sponsored by Senate Minority Leader Gene Davis (D) is not likely to receive much support in the Republican-dominated legislature.