



Health Reform Update – Week of February 27, 2017

CONGRESS

House Republicans promise March vote on ACA repeal despite intraparty revolt

Momentum towards repealing and replacing the Affordable Care Act (ACA) hit a critical roadblock this week as both conservative House Republicans and moderate Senate Republicans refused to back the current plan being put together behind closed doors by party leaders.

Speaker Paul Ryan (R-WI) had indicated that a repeal and replace plan would be released the second week in March and marked-up in the House Ways and Means Committee shortly thereafter. However, details of the plan that has been submitted to the Congressional Budget Office (CBO) for a cost estimate and leaked to the press promptly created a furor across the party's ideological spectrum.

The draft bill was supposed to attract conservative support by eliminating all individual and employer mandate penalties, ACA taxes and subsidies, and Medicaid expansion funding. However, the House Freedom Caucus led by Rep. Mark Meadows (R-NC) immediately opposed its creation of new premium tax credits to replace those under the ACA. While both credits would be refundable, the House plan would base the amount of credit on a recipient's age instead of financial need. Even though at least one study has shown that this move would dramatically reduce the amount of credits paid (see below), the most conservative members of the House object to the creation of what they call "a new entitlement."

The Freedom Caucus also rejected the bill's plan to create a reinsurance program for insurers with exceptional claims, similar to the temporary reinsurance program under the ACA that conservatives led by Senator Marco Rubio (R) viewed as an "insurer bailout" and repeatedly sought to curtail (see Update for Week of December 15, 2014). The prohibitions on supplementary funding that Republicans successfully included as part of bipartisan deficit reduction agreements directly led to the insolvency or defection of many Marketplace insurers and premium spikes in 2017 (see Update for Week of October 24th). As a result, Republican lawmakers in Alaska were forced to create their own reinsurance program (see Update for Week of December 5th) and America's Health Insurance Plans (AHIP) has heavily lobbied the Trump Administration and Congressional Republicans to do the same, citing data from several groups including last month's study from the Brookings Institution documenting that Marketplace subscribers have been sicker and more costly than those outside the Marketplace (see Update for Week of April 18th).

Conversely, the draft bill's intent to repeal the Medicaid expansion also sparked a revolt from moderate Republicans. Senators Susan Collins (R-ME), Lisa Murkowski (R-AK), and Shirley Moore Capito (R-WV) have already stated that they are not planning to support the bill's plan to phase-out the Medicaid expansion by 2020. Alaska and West Virginia are among the 32 states participating in the ACA expansion who would lose hundreds of millions of dollars per year in ACA matching funds if it is repealed. Collins and Capito were also among the lead sponsors of an alternative ACA replacement bill that would let states decide whether to retain the ACA or opt-out (see Update for Week of January 30th). However, the House Freedom Caucus backed by conservative groups like the Heritage Foundation are demanding that any repeal bill also repeal the Medicaid expansion, creating a major impasse for bill drafters.

The defection of the three Senators means Republicans currently lack the 50 votes needed to pass a bill through reconciliation that would repeal key provisions of the ACA (see Update for Week of January 9th). Rep. Mo Brooks (R-AL) acknowledged last week that even in the House, Republicans currently do not have the votes to pass any repeal and replace legislation and blamed town hall protests from "liberal activists" for making it difficult for Republicans in swing district to support repeal efforts.



Other provisions of the bill are also creating angst among Republicans, including its reliance on high-risk pools. Prior to the ACA, at least 35 states attempt to segregate persons with costly conditions into their own market. However, studies from the Kaiser Family Foundation, the Urban Institute, and the University of Chicago showed that these efforts were largely a failure because the pools do nothing to address the cost of care which was prohibitive to all but two percent of consumers who were eligible.

The current Republican plan would allocate \$100 billion over ten years to pay for high-risk pools. While this is a substantial increase from the \$25 billion over a decade that was initially proposed (and comparable to pre-ACA levels), it remains well below the \$50-60 billion per year that would be required to fully fund them (or \$7,000-\$10,000 per enrollee). Both Republican and Democratic lawmakers pointed out that this level of funding is politically unrealistic as the entire space program only receives \$18.5 billion per year under the fiscal year 2017 federal budget.

Senator Rand Paul (R-KY) in particular was very critical of the high-risk pool approach. His replacement plan issued last month instead would keep persons with pre-existing conditions in the ACA Marketplaces but allow them to group together in association health plans, an idea resurrected from Republican legislation sponsored by Senator Michael Enzi (R-WY) in 2006.

The draft plan would also return to the pre-ACA scenario where only those with continuous coverage would be protected from insurer discrimination based on pre-existing conditions. The ACA's ban on pre-existing condition denials remains the most popular provisions of the law (see Update for Week of January 30th) and one which many Republican lawmakers are loathe to eliminate.

Other provisions sparking intraparty opposition are the proposed tax on overly-generous health plans (similar to the unpopular "Cadillac" tax in the ACA) and a cap on the tax deduction for employer-provided health insurance, which would dramatically increase plan costs for employees.

Senate Majority Leader Mitch McConnell (R-KY) acknowledged this week that the Senate was likely to wait for the House to act and consider their plan, instead of formulating their own alternative. The President also appears to change course on proposing his own plan, publicly coming out this week in favor of the main principles of the House bill.

House plans to replace ACA provide much less financial assistance for subsidy recipients

A new analysis released this week by the Kaiser Family Foundation estimates that the average premium subsidy received by consumers in the federally-facilitated Marketplaces will be cut by at least 36 percent under the current Republican proposals to repeal and replace the Affordable Care Act (ACA).

The study evaluates the two leading proposals released last year. The first is the *A Better Way* draft outline from House Speaker Paul Ryan (R-WI). The second is the *Empowering Patients First Act* introduced by Rep. Tom Price (R-GA) before he was named Secretary of the Department of Health and Human Services (HHS). Although the bills are not identical to those currently being considered by House Republicans, they contain many of the same elements, including premium tax credits that are based on age (instead of income as under the ACA).

Roughly 85 percent of FFM consumers currently receive premium tax credits. The average subsidy was projected to be \$4,615 in 2020. However, under the Republican plans evaluated, the average credit would only be \$2,957 for that year.

In addition, the new tax credits would be adjusted only by inflation instead of cost of coverage, making it far more difficult for consumers to obtain low-cost coverage, according to KFF researchers. Data from HHS concluded earlier this year that 72 percent of FFM consumers could find coverage for less than \$75 per month in 2017, thanks to the ACA premium tax credits. However, under the Republican plans, only about 46 percent could do so (a decrease of 36 percent).



The decline is even more precipitous in states like North Carolina, where 82 percent of FFM consumers can now find such low-cost coverage under the ACA but only 22 percent would have been able to do so under the Republican plans.

Governors want Congress to retain Medicaid expansion in exchange for “per capita” caps

Rep. Brett Guthrie (R-KY), the vice chairman of the House Energy and Commerce health subcommittee, confirmed that the ACA repeal bill currently under review by the Congressional Budget Office (CBO) will likely include a fundamental restructuring of the Medicaid program.

The measure would eliminate the Medicaid expansion under the Affordable Care Act (ACA) over the protests of Republican governors who have agreed to participate (see above). However, it would grant them their long-sought request for more flexibility by converting Medicaid into a lump-sum block grant with few federal strings attached. Specifically, it would cap federal Medicaid funding per each enrollee and put states on the hook if spending exceeds that amount.

However, a recent report from the consulting firms of Avalere Health and McKinsey and Co. that was presented during the recent National Governors Association meeting warned that such a proposal could dramatically reduce the amount of federal funding to states by 35-40 percent. Similar analyses by the Kaiser Family Foundation and Center for Budget and Policy Priorities found such a “per capita” cap as earlier advocated by Speaker Paul Ryan (R-WI) would result in 14-20 million fewer Medicaid enrollees by 2022 and \$1 trillion less in federal funding.

As a result, a group of ten Republican governors (from expansion and non-expansion states) issued their own proposal last week that urged Congress to limit the “per capita” caps only to those made newly-eligible for Medicaid by the ACA expansion, and give governors the discretion whether to apply them to the broader population. They also asked Congress exempt certain several Medicaid groups from the caps, such as children, pregnant women, the disabled, and the elderly.

The governors’ draft plan would not only retain the ACA expansion, but level out ACA matching funds for the expansion so that they are available to both expansion and non-expansion states. However, states that refuse to accept “per capita” caps would have their enhanced expansion funds frozen at the current rate and receive only their regular Medicaid matching rate for any new expansion enrollees.

The plan does include many of the new restrictions on the expansion population favored by conservative lawmakers including enrollment limits, work requirements, higher premiums, asset tests, mandatory managed care for all Medicaid populations, and eliminating the federal requirement that states cover every FDA-approved drug.

Republicans still undecided whether to appeal ruling invalidating cost-sharing subsidies

The Trump Administration and House Republican leaders jointly asked a federal appellate court last week to delay action on the House lawsuit seeking to invalidate the cost-sharing subsidies under the Affordable Care Act (ACA).

House Republicans filed the lawsuit in 2014 claiming that the Obama Administration was unconstitutionally paying roughly \$175 billion in cost-sharing subsidies over ten years without an appropriation from Congress. They obtained a favorable lower court order from a Republican-appointed judge, who allowed the cost-sharing subsidies to continue pending the appeal by the Obama Administration (see Update for Week of May 16th). However, the appellate court agreed to the House Republican request after the election to delay its decision until after the Trump Administration assumes office, allowing the President time to decide whether to simply drop the appeal and thus immediately terminate the subsidies (see Update for Week of December 5th).



However, the inability of Republicans to promptly agree on a plan to repeal and replace the ACA has forced them to ask the court to keep the appeal frozen for another three months (until May 22nd). Because the current bill to repeal key provisions of the ACA through reconciliation would also eliminate the cost-sharing subsidies, Speaker Paul Ryan (R-WI) insisted that the delay in the lawsuit was needed to allow time legislation to pass that would “obviate the need for judicial determination of this appeal.”

Despite current legislative plans to eliminate the cost-sharing subsidies, House Energy and Commerce Committee chairman Greg Walden (R-OR) pledged last month to continue to subsidies through at least 2017—even without the President’s approval—as federal contracts with Marketplace plans would allow them to cancel coverage mid-year if the subsidies are invalidated (see Update for Week of January 9th).

FEDERAL AGENCIES

Federal court says HHS must pay insurers for outstanding ACA risk corridors funding

The U.S. Court of Federal Claims ruled last week that the Centers for Medicare and Medicaid Services (CMS) must pay insurer Moda Health the full \$214 million to which it is entitled under the risk corridors program created by the Affordable Care Act (ACA).

The decision by Judge Thomas Wheeler somewhat contradicts an earlier ruling from the same court in which Judge Charles Lettow dismissed the lawsuit from Land of Lincoln Health seeking their unpaid risk corridor funding (see Update for Week of December 5th). While both judges concurred that there is no dispute that CMS is liable for the full amounts to be paid under the ACA, Wheeler concluded that CMS must make payments for each year that they were due (2014, 2015, and 2016) while Lettow ruled that CMS would wait until the temporary program expired in 2017 to make payments for all three years.

A third case brought in the same court by Health Republic of New Jersey was allowed to proceed by Judge Margaret Sweeney, who has yet to rule on its merits (see Update for Week of January 9th). (All three judges were appointed by President George W. Bush).

The risk corridor fund is one of three temporary risk mitigation programs created by ACA. They were meant to stabilize insurance markets during the initial three years of full ACA implementation by compensating insurers that incur an extraordinary number of high-cost claims.

Unlike the reinsurance fund where collections have largely aligned with expectations (see Update for Weeks of February 8th and 15th), the risk corridors program has a \$2.5 billion shortfall forcing insurers to receive only 12.6 percent of the payments they were due for 2014 (see Update for Week of September 28th). As a result, CMS is using all 2015 collections to pay outstanding amounts owed to insurers for 2014 (see Update for Week of September 12th).

The shortfall and subsequent losses are largely blamed for the insolvency and liquidation of all but four of the initial 23 Consumer Operated and Oriented Plans (CO-OPs) created with ACA loans, as well as by several major insurers to exit ACA Marketplaces for 2017 (see Update for Week of August 15th). As a result, at least four of the surviving CO-OPs (including Health Republic) and 16 other insurers are suing CMS to recover their 2014 costs (see Update for Week of August 15th).

The decision in favor of Moda Health (the dominant carrier in the Oregon Marketplace) is expected to set a precedent that may greatly complicate Republican replacement plans for the ACA (see above) as repealing the taxes in the ACA could limit the amount of available funding to pay the full risk corridor claims to insurers.



ACA Marketplaces signed-up more than 12.2 million consumers during open enrollment

More than 12.2 million consumers signed-up for health insurance coverage through all of the Affordable Care Act (ACA) Marketplaces during the 2017 open enrollment period, according to the latest figures tabulated by The Associated Press (AP).

Official figures will not be released by the Department of Health and Human Services (HHS) until later in March. However, the AP count showed that roughly three million consumers enrolled via the 12 Marketplaces created by states, on top of the 9.2 million enrollees in federally-facilitated Marketplaces (FFM) that HHS reported last month (see Update for Week of January 30th).

The 12.2 million figure is still well below the 13.8 million that the Obama Administration had projected would sign-up during open enrollment (which ran from November 1st through January 31st). FFM enrollment had been on a record pace until the latter half of January, when the Trump Administration pulled the plug on previously-paid advertising and outreach. That decision was largely blamed for suppressing the typical last-minute surge in enrollment from younger and healthier enrollees (see Update for Week of January 30th).

As a result, overall enrollment was four percent lower than 2016, despite higher than projected numbers from state-based Marketplaces (see below). For example, enrollment in Colorado's Marketplace jumped 12 percent in 2017 while Washington experienced a 13 percent spike, its largest single year increase since the Marketplaces opened.

The AP analysis also showed that nearly two-thirds of all Marketplace enrollees (64 percent) reside in states carried by President Trump and would lose their coverage if the ACA was fully repealed. Congressional districts with the highest numbers of Marketplace enrollees were all located in south Florida and held by Republicans (Reps. Ros-Lehtinen, Curbelo, and Diaz-Balart), while the district that enrolled the most new Medicaid enrollees through the ACA expansion belongs to House Energy and Commerce Committee chair Greg Walden (R-OR) who will lead House efforts on ACA repeal.

HHS extends Obama-era allowance for ACA-deficient health plans

The Department of Health and Human Services (HHS) announced last week that it would continue to allow transitional health plans that do not comply with the Affordable Care Act (ACA) to continue to be offered through the end of 2017.

The move is an effort to provide insurers with some flexibility as they base decisions on whether to participate in the 2018 Marketplaces upon their projected losses from 2017. It extends the transitional policy first offered by the Obama Administration in 2013 which gave states the discretion to continue limited benefit or "junk" coverage (see Update for Week of March 3, 2014). Since that time, at least a dozen states have outlawed transitional plans entirely but the others have been given extensions each year thereafter to continue them.

The transitional policy was intended to soften the political liability created by the mass cancellations that occurred in the individual market just as the ACA's consumer protections were fully being implemented (see Update for Week of November 11, 2013). Those cancellations appeared to contradict President Obama's pledge that "if you like your health plan, you can keep it."

HHS gives Marketplace insurers additional time to decide on 2018 participation

The Department of Health and Human Services (HHS) announced in February that it will give insurers an additional seven weeks to decide whether to submit plans to participate in the Affordable Care Act (ACA) Marketplaces for 2018.



The initial deadline was May 10th. However, insurers were increasingly concerned about committing to 2018 participation before knowing if and how the ACA was going to be repealed and replaced. In particular, insurers need to know whether the premium tax credits and cost-sharing subsidies will continue to be available. However, some Republican leaders have assured insurers that the cost-sharing subsidies will be available for 2018 even if the President elects to terminate them by no longer defending the Obama Administration's appeal of a House lawsuit that invalidated them (see above). (Insurers can exit their contracts mid-term if the cost-sharing subsidies are eliminated.)

As a result of the uncertainty, HHS agreed to extend the deadline for new submissions to June 21st and the final submission deadline to August 16th. Contracts must now be signed by October 12th.

HHS issued proposed rules last month that would shorten the 2018 open enrollment period by six weeks so that it will run only from November 1st to December 15th (see Update for Week of January 30th).

IRS will no longer withhold tax refunds from filers who ignore individual mandate question

The Trump administration took the first steps last week towards its expected decision to no longer enforce the individual mandate under the Affordable Care Act (ACA).

The mandate requires that consumers purchase minimum essential coverage that they can afford or pay a tax penalty of \$695 or two percent of income (capped at \$2,000). Less than two percent of all tax filers paid this penalty in the first two years of the mandate (when the penalty was lower) however polling consistently ranks it as the single most unpopular provision of the ACA.

Congress currently cannot repeal the mandate itself without the support of eight Senate Democrats (to break the 60 vote filibuster threshold). However, they can use the budget reconciliation process requiring to repeal the tax penalty itself with only a simple majority of each chamber and are widely expected to do so (see Update for Week of January 30th).

As a result, the Internal Revenue Service announced that it would no longer enforce the Obama Administration directive to withhold tax refunds from filers who do not respond to the tax form question about whether they maintained minimum essential coverage through year.

Federal hiring freeze likely to exacerbate 526-day backlog of disability claims

Former commissioners from the Social Security Administration (SSA) are warning that the freeze on federal hiring ordered by President Trump shortly after his inauguration is expected to force more than 1.1 million applicants for federal disability benefits to have to wait longer for benefits to be awarded.

Currently, Social Security Disability Insurance (SSDI) and Supplement Security Income (SSI) applicants appealing an adverse decision at the initial level must wait an average of 526 days for an administrative hearing. During that time, they are ineligible for the Medicare or Medicaid coverage that are linked to their disability benefits.

In order to accommodate this backlog, SSA had planned to hire 250 additional administrative law judges by the end of fiscal year 2018. However, the freeze ordered by the President via executive order will prevent those new hires and worsen the backlog of appeal cases, according to former commissioners from both parties. Kenneth Apfel, who served under President Clinton, echoed those concerns.

The President's nominee to head the Office of Management and Budget (OMB), Congressman Mick Mulvaney (R-SC), insisted during his confirmation hearing that hiring additional judges would not automatically "create more efficiency" and reduce the backlog of appeals.



Humana becomes first major carrier to pull out of all ACA Marketplaces

Humana became the first major insurer last week to decide to withdraw from all Affordable Care Act (ACA) Marketplaces for 2018, citing the uncertainty created by the prospective repeal of the health insurance reform law (see above).

Humana had already decided to limit its participation for 2017 to only 156 counties in 11 states (down from 1,351 counties in 19 states the year before), blaming higher than anticipated claims costs (see Update for Week of July 18th). After reviewing initial data from the 2017 open enrollment period, it predicted that it will lose more than \$45 million to the “unbalanced risk pool” that continues to attract sicker and more costly subscribers than non-Marketplace plans.

Without assurances that the risk pools would be better balanced for 2018, Humana elected to withdraw entirely, although it is not clear what impact its failed merger with Aetna had on that decision. (A federal judge previously blocked the merger and determined that Aetna’s exit from the 2017 Marketplaces was an effort to force the Department of Justice to approve it). Humana’s decision will most negatively affect 16 counties around Knoxville, Tennessee where Humana was the lone Marketplace carrier.

Arkansas

House approves new limits on Medicaid expansion enrollment

The House approved a measure this week that would freeze all enrollment in the popular private sector alternative to the Medicaid expansion under the Affordable Care Act (ACA) and limit eligibility.

The bill sponsored by Rep. Josh Miller (R) passed largely on a party-line vote and would cap enrollment at 330,000 starting July 1st. It will now be considered by the Senate although it is opposed by Governor Asa Hutchinson (R), who insists that an artificial cap is not needed if the Congress converts Medicaid to federal “per capita” caps as is currently proposed (see above).

Previous Governor Don Beebe (D) made Arkansas the first in the nation to receive a federal waiver allowing them to use ACA matching funds for the expansion to instead purchase private Marketplace coverage for those made newly-eligible (see Update for Week of September 25, 2013). Despite strong enrollment, the expansion has barely survived annual attacks from Republican lawmakers (see Update for Weeks of January 26 and February 4, 2015). Governor Hutchinson ultimately gained both legislative and federal approval to put new limits on the expansion program, including small copayments and voluntary work training referrals (see Update for Week of December 5th).

Because the Arkansas Works expansion is a demonstration program, Rep. Miller acknowledges that federal approval would be required to institute an artificial cap. However, he believes that the Trump Administration will approve the freeze due to the uncertainty over if and how the Medicaid expansion will be repealed and replaced (see above). He also expects approval to reduce eligibility for the program from 138 percent of the federal poverty level down to 100 percent (the threshold for ACA subsidies).

Democrats who opposed the measure pointed out that lower enrollment and eligibility levels now could ultimately reduce the amount of funding that the federal government will give Arkansas via “per capita” caps. However, Republican lawmakers insisted that the changes were necessary to limit the state’s exposure to higher expansion costs under ACA replacement proposals. Starting in 2017, the ACA requires that states only pay five percent of total costs for the expansion population, which will rise to no more than ten percent in 2020 and beyond.



California

Marketplace enrollment meets projections for 2017

Covered California officials announced last month that the Affordable Care Act (ACA) Marketplace met 2017 projections despite being lower than the same open enrollment period last year.

The Marketplace extended enrollment for one week after the initial January 31st deadline, in order to accommodate the typical surge in last-minute enrollees. More than 412,000 first-time enrollees signed up for coverage through February 4th, slightly above the 400,000 projection but six percent below 2016. When factoring in renewals, total enrollment is expected to reach 1.5 million (above the 1.4 million currently enrolled in Covered California.)

California and the other 11 state-based Marketplaces all experienced the usual late surge in enrollees that was absent from the federally-facilitated Marketplace, which canceled all advertising and outreach for the last half of January (see Update for Week of January 30th).

Threat of ACA repeal spurs renewed single-payer legislation

Senator Ricardo Lara (D) introduced legislation two weeks ago that would set California on the path towards a single-payer health care system, in response to the Congressional threat of repealing the Affordable Care Act (ACA) and its Medicaid expansion (see above).

California has flirted with a single-payer system on several occasions, most recently in 2006 and 2008 when bills passed by both chambers were vetoed by Governor Arnold Schwarzenegger (R). Voters also rejected a similar ballot referendum in 1994.

A study by the Lewin Group in 2005 estimate that single-payer health system would save California nearly \$344 billion over ten years through reduced overhead and bulk purchases of prescription drugs and medical equipment. It also predicted a significant economic boost for businesses that no longer had to purchase employee health coverage.

However, as with recent failed efforts in Colorado and Vermont (see Update for Week of December 5th), financing became the downfall as projections of double-digit payroll taxes needed to fund such a coverage expansion were politically unpalatable. As a result, Lara's bill (S.B. 562) leaves financing details for subsequent legislation or set forth a timetable.

The California Nurses Association is the primary sponsor of the new bill and is planning several rallies to engender consumer support. However, the California Association of Health Plans and other insurer groups have indicated that they are likely to oppose it.

Senator Lara acknowledges the bill faces long odds even in a Democratically-dominated legislature. However, he stated that the current proposal by Republican governors for Congress to reduce the federal share of the Medicaid expansion from 90 to 50 percent (and redistribute among the 19 states that have not expanded) should give lawmakers an additional impetus to consider single-payer (see above).

The former state senator who sponsored the earlier single-payer bills, Sheila Kuehl, is urging lawmakers to promote the latest reincarnation as "Medicare for All" so consumers associate it with a familiar program and insurers cannot portray the effort as a "government takeover of all health plans."

Florida

Committees approve bills to prevent midyear increases in drug cost-sharing or formularies



A Senate and House measure that would prevent health insurers from increasing prescription drug cost-sharing or removing formulary drugs during the middle of a plan year continue to move through committee with little opposition.

S.B. 182 has passed both the Senate Banking and Insurance Committee and Senate Health Policy Committee with only one dissenting vote. It is now in Appropriations. A House counterpart (H.B. 95) passed the Health Innovation subcommittee and is now in the Insurance and Banking subcommittee.

Currently, there is no state law in Florida that stops health insurers from making mid-year formulary or cost-sharing changes, which can cause great disruption for patients. As a result, consumer groups like The AIDS Institute back the “bait and switch” bills.

Senator Debbie Mayfield (R), the Senate sponsor, insisted that measure was a “consumer protection” bill and not an insurance mandate. She pointed out that it would still give insurers flexibility to add brand-name and generic medications to their formularies midyear or make any coverage changes necessary to respond to drug safety concerns announced by the Food and Drug Administration.

Georgia

Senate passes legislation to prevent surprise medical bills

The Senate unanimously approved legislation in late February that seeks to protect consumers from being billed for out-of-network services furnished by ancillary providers at in-network facilities.

The *Surprise Billing and Consumer Protection Act* (S.B. 8) had stalled in the Health and Human Services Committee over concerns by insurers and providers about the formula for reimbursing providers when out-of-network charges are disputed. The committee chair and bill sponsor, Renee Unterman (R), ultimately worked out a compromise that would reimburse providers 60 percent of benchmark charges for a particular procedure in the zip code where the service was delivered (based on the Fair Health database). However, two physicians that serve on the committee were able to amend the legislation to increase it to 80 percent.

Senator Unterman acknowledged that the bill may still face opposition in the House because insurers insist that payments in the Fair Health database are artificially high.

California, Connecticut, and Florida are among the states that have already enacted laws protecting consumers from surprise medical bills (see Update for Week of October 31st).

Kansas

House passes Medicaid expansion bill drafted by hospital association

By a surprising margin, the House voted 83-40 last week to expand Medicaid under the Affordable Care Act (ACA).

Rep. Susan Concanon, the vice-chair of the Health and Human Services Committee, had sponsored the initial measure drafted by the Kansas Hospital Association (KHA) that fully expanded Medicaid to 138 percent of the federal poverty level but include some elements favored by conservative lawmakers, including premiums (capped at two percent of income) and work referral requirements for the expansion population (see Update for Week of January 30th). The measure (H.B. 2064) was blocked by the committee on a partisan 9-8 vote before Concanon was able to successfully get it included as part of an unrelated health care bill (H.B. 2044) that went before the full House.

Passage of any Medicaid expansion measure was nearly unthinkable until pro-expansion Republicans made significant electoral gains last fall (see Update for Week of January 30th). A rash of rural hospital failures (with 31 additional hospitals on the brink of collapse) also caused KHA to throw its



full weight behind the expansion plan and more than 160 stakeholders voiced their support for the bill during committee hearings (with only five testifying in opposition). However, despite this overwhelming support, the measure is still expected to fail in the Senate or be vetoed by Governor Sam Brownback (R).

Maine

Medicaid expansion referendum will appear on election ballot

The Secretary of State confirmed last week that a referendum on whether Maine should expand Medicaid under the Affordable Care Act (ACA) has gained enough signatures to be placed on the November ballot.

The referendum is an effort by Mainers for Health Care to circumvent Governor Paul LePage (R), who has vetoed six Medicaid expansion bills that were passed by Democratically-controlled legislatures (see Update for Week of April 18th). Governor LePage has not only opposed the expansion but is continuing his long-sought quest to eliminate MaineCare eligibility for about 25,000 Mainers, including single adults age 18-19 (see Update for Week of December 1, 2014).

In response, the Governor immediately took to the airwaves to demand reforms to the referendum process, suggesting that voters “didn’t know what they were voting for” when they passed earlier referendums raising the minimum wage and imposing an education funding surcharge on the state income tax. He insisted the referendums were being funded by out-of-state groups and did not reflect the will of most citizens.

Oregon

New bills seek to extend Medicaid coverage to undocumented children

House and Senate committees will consider new bills next week that would extend Medicaid coverage to undocumented children under the age of 19.

The measures (S.B. 558 and H.B. 2726) have the backing of Governor Kate Brown (D) and House Speaker Tina Kotek (D). They would add roughly 17,600 undocumented children to the Oregon Health Plan at an estimated cost for \$55 million over the first two years. Families must earn less than 300 percent of the federal poverty level in order to be eligible for the expanded coverage—the same threshold that currently applies to children who are legal residents. Adults of undocumented children would not be eligible for coverage.

Despite Democratic control, passage is far from certain given the state’s \$1.8 billion budget gap that is due in large part to rising Medicaid costs. Voters in this progressive-learning state have also not always supported policies favoring undocumented immigrants, overwhelmingly rejecting a referendum in 2014 that would have granted them short-term driver licenses.

However, the measures do have the support of some Republicans, with Rep. John Huffman (R) stating that it “makes sense morally and economically [to cover undocumented] kids up front [and save] money down the road.”

California, Washington, New York, Illinois and Massachusetts have already implemented similar policies.

Virginia

House passes bill to return Virginia to pre-ACA standards following Congressional repeal

The House passed legislation last month on a straight party-line vote that would repeal all measures enacted by the General Assembly since 2011 to comply with the Affordable Care Act (ACA). The effective date would be contingent upon the ACA being repealed by Congress (see above).



Even if approved by the Republican-controlled Senate, H.B. 2411 is largely symbolic for this year as it faces a likely veto by Governor Terry McAuliffe (D). However, the governor is term-limited and the measure signals the intent of the legislature to return to the pre-ACA landscape should a Republican governor be elected this fall.