



## Health Reform Update – Week of December 18, 2017

### CONGRESS

#### ***President signs tax bill that repeals individual mandate, cuts orphan drug tax credit***

President Trump signed tax legislation this week (H.R.1) that repeals the individual mandate under the Affordable Care Act (ACA) starting in 2019 while cutting the orphan drug tax credit in half.

Repealing the ACA's mandate that everyone purchase minimum coverage they can afford was a primary Republican goal since the ACA was enacted, even though it was first proposed by conservative economists with the Heritage Foundation in 1989 as a means to ensure individuals took responsibility for their health coverage and prevent "free riders" who forgo coverage and require others to subsidize their uncompensated care. The mandate became the centerpiece of the ACA as it helps ensure insurer risk pools are balanced between healthier and sicker consumers so private insurers can remain profitable.

Republican leaders acknowledge that repealing the individual mandate without a replacement mechanism (such as increasing premiums for those who fail to maintain continuous coverage) could destabilize the entire individual market via significant rate hikes and insurer departures. The Congressional Budget Office (CBO) predicts that it will increase Marketplace premiums for 2019 by an average of at least ten percent and cause 13 million Americans to become uninsured (see Update for Week of November 13<sup>th</sup>). Insurers, providers, and consumer groups remain unified in opposition to the repeal, with the American Academy of Actuaries warning that it would mean that "insurers would likely reconsider their future participation in the market [which would] lead to severe market disruption and loss of coverage"

Despite these dire projections, Republican leaders had little alternative but to include the individual mandate repeal as part of their tax reform package, as it was the only way they could show sufficient savings to use the budget reconciliation process and move H.R.1 through the Senate with only a bare majority. (The measure received zero support from Democrats).

Republicans were able to secure the support of key moderates like Senator Susan Collins (R-ME) by promising to separately pass legislation that would help stabilize the Marketplaces. This includes the compromise between Senators Lamar Alexander (R-TN) and Patty Murray (D-WA) that would restore the ACA's cost-sharing reductions, which the Trump Administration terminated in October (see Update for Week of November 6<sup>th</sup>). Senator Collins is also sponsoring legislation with Senator Bill Nelson (D-FL) (S.1835) that would create a \$4.5 billion reinsurance program to compensate insurers for exceptional claims, similar to the ACA program that expired after 2016 (see Update for Week of November 13<sup>th</sup>).

However, consideration of both the Alexander-Murray and the Collins-Nelson bill has been delayed until 2018 (see below). Even if enacted, CBO has already determined that neither measure would have a "significant" impact on mitigating the upward pressure on premiums that would be caused by repealing the individual mandate without a replacement. A subsequent analysis by Avalere Health consultants concluded that only 40 percent of the "premium rate shock" caused by the individual mandate repeal would be offset by both measures.

Senator Collins did succeed in removing provisions passed by the House that would have eliminated the tax deduction for medical expenses and replaced them with a provision that would temporarily lower the threshold for claiming the deduction from ten percent to 7.5 percent of income (where it was prior to the ACA). While this change is favorable to consumers, H.R.1 caps the orphan



drug tax credit at 25 percent of research costs instead of the current 50 percent threshold. Consumer groups insist that such a steep reduction will greatly slow the development of these drugs.

The new law remains one of the most unpopular pieces of legislation in history, with Quinnipiac and Gallup polling showing it is favored by less than 30 percent of adults surveyed. This appears to be due to analyses from CBO and other consulting groups showing that despite the dramatic reductions in tax rates for corporations and the wealthiest Americans, those earning less than \$75,000 per year would ultimately see their tax bills rise as the increase in their standard deduction would be lost by other popular deductions being capped or eliminated.

### ***Stopgap spending bill includes temporary CHIP funding but no market stabilization provisions***

Congress did succeed in averting a federal government shutdown this week before leaving for the holiday recess. The short-term continuing resolution (CR) signed by the President will provide funding through January 19<sup>th</sup>, when Congress will need to either pass a full-year spending bill for fiscal year 2018 or another short-term extension.

Senate Democrats agreed to provide the needed support to pass the measure even though it provided only \$2.85 billion of emergency funding for the Children's Health Insurance Program (CHIP), which Congress failed to reauthorize for FY 2018 (see Update for Week of November 13<sup>th</sup>). The limited funding through March 31<sup>st</sup> sparked an outcry from state officials, as 25 are already expected to run out of FY 2017 CHIP funding by the end of January, causing several (including Alabama, Colorado, and Virginia) to start sending termination warnings to CHIP families.

Senate Democrats also objected to the fact another \$750 million was cut from the Prevention and Public Fund under the Affordable Care Act (ACA), which ensures that certain preventive services including cancer screenings can be provided without any beneficiary cost-sharing obligations.

Republican leaders elected not to include several contentious provisions that could have prevented passage before the December 22<sup>nd</sup> deadline. This most notably included the market stabilization bills that Senator Susan Collins (R-ME) was promised in exchange for her support of the Republican tax plan (see above). Senate Majority Leader Mitch McConnell (R-KY) insists both her reinsurance bill and a bipartisan compromise to restore ACA cost-sharing reductions will be part of the spending resolution that is drafted in January (with the support of the White House), even though members of the conservative House Freedom Caucus staunchly oppose each measure.

### ***Temporary spending bill does not address cuts in Medicare payment for 340B drugs***

Despite the urging of a bipartisan group of Senators, the temporary continuing resolution (CR) passed this week by Congress (see above) failed to prevent the 27 percent cut in Medicare Part B payments for drugs that safety-net hospitals purchased through the Section 340B drug program.

The Centers for Medicare and Medicaid Services (CMS) implemented the \$1.6 billion reimbursement cut last fall as part of the final rule governing the Medicare outpatient prospective payment system (see Update for Week of November 13<sup>th</sup>). However, it has drawn strong opposition from both sides of the aisle and House legislation (H.R. 4932) to overturn the cut quickly drew 141 cosponsors (including 74 Republicans).

The Senators, led by John Thune (R-SD) and Patty Murray (D-WA), are hoping to include provisions in a full-year spending bill in January that will reverse the cuts. However, the issue may be decided before then by the U.S. District Court for the District of Columbia, which promised this week to promptly rule on the Trump Administration's motion to dismiss a lawsuit brought by the American Hospital Association and other plaintiffs seeking an injunction block the CMS rule from going into effect (see Update for Week of November 13<sup>th</sup>). The presiding judge, Rudolph Contreras (appointed by President



Obama), has previously sided with drugmakers on 340B litigation, twice invalidating a 2014 CMS rule in that would have required them to sell orphan drugs at the 340B discount to rural and cancer hospitals (see Update for Week of November 30, 2015).

### ***Ways and Means to consider bills delaying ACA taxes***

Key taxes imposed by the Affordable Care Act (ACA) would be delayed for several years under new legislation introduced last week by Republican lawmakers on the House Ways and Means Committee, with the support of chair Kevin Brady (R-TX).

The first of these measures (H.R. 4616) would delay the controversial 40 percent excise tax on high-cost or “Cadillac” health plans before it goes into effect in 2020 (see Update for Week of January 25, 2016). In addition, it would retroactively void any assessments to be imposed over the last three years under the ACA’s employer mandate and delay its effective date for another year (see Update for Week of November 13<sup>th</sup>).

H.R. 4617 would delay the ACA’s medical device tax for five years, while H.R. 4618 would temporarily (for two years) lift the ban on using health savings accounts (HSAs) to pay for over-the-counter medications.

H.R. 4620 would postpone the ACA’s current tax on health insurers in 2018, but only for insurers that must issue premium rebates for violating the law’s medical-loss ratios that limit how much premium revenue can go towards insurer profit and overhead. The tax would then be lifted in 2019 for all insurers.

The measures, which are rumored to be part of larger legislation such as the FY 2018 spending resolution (see above), notably do not propose how to offset the costs of the lost revenue. The lack of offsets may create major impediments in the Senate, as it has with the House bill reauthorizing the Children’s Health Insurance Program (see Update for Week of November 13<sup>th</sup>).

## **FEDERAL AGENCIES**

### ***Final Marketplace enrollment reaches 96 percent of 2017 totals despite Administration sabotage***

Data from the Centers for Medicare and Medicaid Services (CMS) released last week showed that 8.8 million consumers enrolled in coverage through federally-facilitated Marketplaces (FFMs) during the 2018 open enrollment period that ended December 15<sup>th</sup>.

The preliminary figures shattered expectations following efforts by the Trump Administration to depress enrollment. Because the Administration cut the 2018 enrollment period in half (from January 31<sup>st</sup>), consumers needed to sign-ups at twice the pace in order to reach the 9.2 million total for 2017, and as of last week enrollment was only 16 percent higher. However, a late surge in the final week increased enrollment by 4.1 million enrollees. That is more than double the number that signed-up in the final week of 2017 enrollment (see Update for Week of January 30<sup>th</sup>).

Enrollment in 11 FFM states actually exceeded their 2017 totals, and four states came within two percent. As usual, Florida led all FFM states with more than 1.7 million enrollees (coming within only 30,000 of last year.) Texas was second with 1.1 million (or 92 percent of 2017). Louisiana was the poorest-performing FFM state (only 78 percent of 2017 total). However, residents in hurricane-impacted counties for all three states can continue to enroll through December 31<sup>st</sup>.

Analysts had projected that Marketplace enrollment would be much lower for 2018 after the Trump Administration not only shortened the enrollment period, but slashed the marketing and outreach budget by 90 percent and eliminated the ACA’s cost-sharing reductions, causing premiums to spike by an



average of 29 percent (see Update for Week of November 6<sup>th</sup>). However, the threat of Congress repealing key provisions of the ACA spurred more than 2.4 million new consumers to enroll (including more than one million alone in the final week).

The CMS figures do not include enrollment in the 12 state-based Marketplaces (SBMs), which analysts unofficially estimate have enrolled an additional 2.8 million consumers. These Marketplaces have shown an even higher pace of enrollment than FFMs. Hawaii and Oregon already surpassed 2017 totals before their December 15<sup>th</sup> deadline, as did Minnesota and Washington, where enrollment remains open until mid-January.

Most SBMs previously extended their deadlines beyond December 15<sup>th</sup> (see Update for Week of November 6<sup>th</sup>), including California and New York, who have the same January 31<sup>st</sup> deadline as last year and are experiencing 12-15 percent higher rates of enrollment. Officials with the Maryland Health Benefit Exchange agreed this week to extend their deadline until December 22<sup>nd</sup> due to a late surge of enrollees.

Insurers that entered regions abandoned by large insurers like Aetna, Humana, and UnitedHealth Group did particularly well this enrollment period. For example, start-up insurer Oscar Health, which agreed to fill “bare” counties in Ohio and Tennessee (see Update for Weeks of June 12<sup>th</sup> and 19<sup>th</sup>) saw its Marketplace enrollment jump by 150 percent to more than 250,000 subscribers.

Despite the urging of several Democratic lawmakers, the Trump Administration refused to issue any extension of the December 15<sup>th</sup> FFM deadline. (Under the Obama Administration, brief extensions were typically granted in order to accommodate the typical last-minute surge in enrollment.) However, CMS will allow consumers who started their application prior to the deadline to be able to complete the process at a later date.

### ***Administration quietly reaches settlement on House lawsuit to invalidate cost-sharing subsidies***

The Trump Administration has reached agreement with House Republicans and 18 Democratic state attorneys general to settle a federal lawsuit filed by House Republicans in 2014 that potentially could have invalidated the cost-sharing reductions (CSRs) under the Affordable Care Act (ACA).

Their proposed settlement filed this week with the U.S. Court of Appeals for the District of Columbia would vacate a lower court ruling in which Judge Rosemary Collyer (appointed by President George W. Bush) held that the Obama Administration unlawfully paid the CSRs to insurers after Congress refused to appropriate funding (see Update for Week of May 16, 2016). The Court of Appeals allowed the Trump Administration to put the Obama Administration’s appeal of that ruling on hold, but in the interim also allowed the attorneys general to intervene in the case, meaning they could continue the appeal if it was ultimately dropped by the Trump Administration (see Update for Week of August 14<sup>th</sup>).

The settlement gets the Trump Administration out of the dilemma over whether to drop the lawsuit and permanently invalidate the CSRs or pursue an appeal that could compel the CSRs to be paid. However, it also helps the attorneys general, who will be allowed to continue their separate lawsuit filed in the U.S. District Court for the Northern District of California that seeks to reinstate the CSRs (see Update for Week of November 6<sup>th</sup>).

The settlement will not become final until and unless it is approved by the Court of Appeals.

The political debate over the CSRs remains unresolved as the Trump Administration stopped paying them in October but has supported a bipartisan compromise to restore them for at least two years (see Update for Week of November 13<sup>th</sup>).



## ***CMS moving forward on Medicaid work requirements despite legal concerns***

The Centers for Medicare and Medicaid Services (CMS) is expected to shortly issue guidance to state Medicaid directors on the type of work requirements that the agency will let states impose on most Medicaid enrollees

New Administrator Seema Verma expressed her support for the work requirements last month in a speech criticizing the Obama Administration's insistence that they would violated federal Medicaid law (see Update for Week of November 6<sup>th</sup>). She has pledged to begin approving work requirements early next year as part of federal Section 1115 demonstration waivers. However, according to *Inside Health Policy*, that process has been slowed by concerns expressed CMS' general counsel that the work requirements would create a "significant litigation risk moving forward."

Seven states (Arizona, Arkansas, Indiana, Kentucky, Maine, New Hampshire, and Wisconsin) have already submitted waiver requirements that include work requirements for Medicaid enrollees, with some applications (from Kentucky and Indiana) waiting more than one year for CMS to respond.

Administrator Verma has recused herself from the approval process because of her previous role in developing several of those waivers as a health care consultant (see Update for Week of January 9<sup>th</sup>).

## ***Pace of national health spending slowed dramatically last year***

A new analysis released last week by the Office of the Actuary at the Centers for Medicare and Medicaid Services (CMS) showed that even though national health spending rose to \$3.3 trillion for 2016, the growth rate slowed dramatically from 2014 and 2015 (when the Affordable Care Act coverage expansions were being fully implemented).

The slower spending pace was largely attributed to a much slower growth in prescription drug spending (only 1.3 percent in 2016 compared to 12 percent in 2014 and nine percent in 2015). Hospital spending growth also fell by a full percent last year (down to 4.7 percent) and Medicaid spending saw an even greater downturn (increasing by only 3.9 percent compared to 9.5 percent and 11.5 percent in 2014 and 2015).

As a result, overall health spending increased at only a 4.3 percent pace in 2016, after it had jumped 5.1 percent and 5.8 percent in 2014 and 2015 respectively. According to the chief actuary, the 4.3 percent rate of growth represents a return to the moderate pace that was set following the 2007-2009 recession.

Despite the good news, the report emphasizes that health spending still continues to far outpace overall spending for all other goods and services, which increased by only 2.8 percent in 2016.

## **STATES**

### ***States consider enacting their own "individual mandate" penalties***

Several states that have fully implemented the Affordable Care Act (ACA) are already considering implementing their own version of the federal law's mandate that everyone purchase minimum essential health coverage that they can afford.

Under Congressional tax legislation enacted this week (see above), penalties for the so-called "individual mandate" will be set to zero starting in 2019. Because the Congressional Budget Office and other consulting groups have warned that the lack of any comparable replacement would quickly destabilize the individual market (see Update for Week of November 6<sup>th</sup>), states have proactively been



examining either enacting their own version of the “individual mandate” or creating a similar mechanism to ensure risk pools remain balanced between sicker and healthier consumers.

Massachusetts Governor Charlie Baker (R), a former insurance executive, confirmed last week that the Commonwealth would immediately reinstate the “individual mandate” penalty under which the ACA penalty was modeled. The Massachusetts mandate was never repealed when the ACA was implemented. Because it imposed a far greater tax penalty, it was largely considered by insurers as more effective than the ACA version at incentivizing healthier consumers to purchase coverage before they got sick or injured, as less than one percent of Commonwealth tax filers chose to pay the penalty (see Update for Week of June 18, 2012).

The chairman of the House Insurance Committee in Connecticut, Rep. Sean Scanlon (D), announced that he had convened a “working group” to develop a state replacement to the ACA mandate, while lawmakers in California, Maryland, and Washington are also considering either a version of the ACA mandate or a requirement that consumers maintain continuous coverage or face higher premiums when they re-enroll.

#### Arizona

#### ***State officials seek federal approval to exclude certain drugs from Medicaid formulary***

Arizona became the second state last month to seek federal approval to exclude Medicaid coverage for certain prescription drugs.

Under federal law, Medicaid programs must cover any drug approved by the Food and Drug Administration (FDA). In return, drug manufacturers must provide rebates to states based on a set formula that typically results in at least a 23 percent rebate on the brand-name price and a 13 percent for generic drugs. States can negotiate for additional rebates if they agree not to attach restrictions to new prescription drugs.

In October, Massachusetts became the first state to seek the Trump Administration’s approval to refuse Medicaid coverage for certain drugs, arguing that covering all FDA-approved therapies creates an incentive for patients to enroll in Medicaid even when employer-sponsored coverage may be available to them. In order to prevent this, Massachusetts wants to use a Section 1115 federal demonstration waiver to exclude coverage for those drugs it determines do not have a significant, clinically meaningful, therapeutic advantage in terms of safety, effectiveness, or clinical outcome over another drug on the state’s formulary, so long as at least one medicine for every “therapeutic class” or group of medications designed to treat specific conditions (such as HIV or hepatitis C).

The request is modeled after Medicare Part D and the Veterans Health Administration, which both used closed formularies (although Part D requires at least two drugs be covered for each “therapeutic class”). Arizona’s waiver request follows the Part D model, instead of Massachusetts’ more restrictive proposal.

It is not clear whether the Trump Administration will approve either the Arizona or Massachusetts waiver proposals, as they are strongly opposed by the Pharmaceutical Research and Manufacturers of America (PhRMA) as well as some consumer groups like the American Cancer Society.

#### California

#### ***Covered California extends deadline for January 1<sup>st</sup> coverage in face of record gold plan sign-ups***

Covered California officials are giving consumers an extra week to sign-up for coverage that will be effective January 1<sup>st</sup>.



The extension from December 15<sup>th</sup> to 22<sup>nd</sup> is intended to accommodate the “huge influx of consumers”, as the Affordable Care Act (ACA) Marketplace has already enrolled more than 220,000 new consumers and 1.2 million renewals (or 15 percent more than at the same point last year). The enrollment surge is occurring even though California is one of only a handful of state-based Marketplaces that have maintained the same three-month open enrollment period as 2017 (through January 31<sup>st</sup>).

The executive director for Covered California pointed out that 2018 enrollment is being spurred not only by the threat of Congress repealing the ACA, but premiums that are actually an average of ten percent lower than 2017 for the 85 percent of enrollees that receive ACA premium tax credits. This is because the Trump Administration’s elimination of cost-sharing reductions caused silver-plan premiums to jump by 25 percent, leading to a higher level of premium tax credits (see Update for Week of November 6<sup>th</sup>).

Because Covered California loaded most of the premium increases from the loss of CSRs onto silver-tier plans, coverage under more generous gold-tier plans suddenly cost 78 percent less on average for those receiving ACA tax credits. As a result, enrollment in gold plans has been 300 percent higher than 2017, by far a record for Covered California.

More than three million consumers have enrolled in Covered California since the ACA was fully implemented in 2014, reducing the state’s uninsured rate from 17 percent in 2013 to a record low of 6.8 percent over the first half of 2017.

### ***Pharmaceutical industry files suit to block new drug price transparency law***

The Pharmaceutical Research and Manufacturers of America (PhRMA) filed a lawsuit last week in the federal court in Sacramento that seeks to block California’s new drug pricing transparency law.

Governor Jerry Brown (D) signed S.B. 17 into law earlier this fall over the strong objections of the pharmaceutical industry, who had spent more than \$17 million to defeat it over the past two sessions (see Update for Week of November 6<sup>th</sup>). The measure is billed as the most comprehensive in the nation, going further than a comparable law enacted last year in Vermont by requiring drug manufacturers to notify health insurers and government health plans at least 60 days before increases in drug wholesale acquisition costs (WAC) that would exceed 16 percent over a two-year period (see Update for Week of September 18<sup>th</sup>).

The measure applies to drugs with a WAC of \$40 or more, starting January 1<sup>st</sup>. In addition, manufacturers must explain the reasons for those increases and post them online in a manner that allows consumers to access it on a per-drug basis and shows the overall impact of the drug cost on premiums.

Other provisions would set new disclosure requirements for health insurers in both the large and small group markets, who would be required (starting in October 2018) to annually notify state agencies about the 25 most frequently prescribed drugs, the 25 most costly drugs, and the 25 drugs with the highest year-over-year increase in annual spending.

PhRMA argues that because the advance notification requirement is tied to a national measure of drug prices, it could effectively restrict the ability of manufacturers in other states and also cause pharmacies and other purchasers to stockpile and thus create shortages for critical medications. The lawsuit also claims that forcing manufacturers to publicly justify price increases violates the First Amendment to the U.S. Constitution.

### Colorado

### ***Colorado becomes latest state to cease rationing Medicaid coverage for HCV drugs***



The Department of Health Care Policy and Financing (HCPF) announced last week that it would no longer ration Medicaid coverage for hepatitis C antiviral medications only to those with an advanced stage of liver disease.

As of January 1<sup>st</sup>, all Medicaid enrollees with the hepatitis C virus will be eligible for coverage, regardless of the stage of illness. State officials insisted that the move was due to a steep drop in the cost of new HCV “cures”, which have fallen from \$84,000 for an eight-week course of treatment when first introduced to roughly \$14,000 last year. However, HCPF currently faces a class-action lawsuit from the American Civil Liberties Union alleging that the current restrictions violate federal Medicaid law.

Following the lead of Oregon and Illinois, Medicaid programs in at least 34 states took steps to ration the availability of the costly HCV “cures” over 2014 and 2015 (see Update for Week of January 4, 2016). The National Association of Medicaid Directors insisted that states had no alternative given that the cost covering those drugs for every Medicaid enrollee with HCV was more than 300 percent of the total pharmacy budget in several states, including Colorado which spent \$26.6 million treating only 326 HCV patients in 2016 (or roughly \$82,000 per patient).

However, the Centers for Medicaid Services (CMS) warned Medicaid agencies in 2015 that such rationing of care violates federal Medicaid law and at least one federal court concurred, forcing them to be rescinded in Washington (see Update for Week of June 20, 2016). As a result, most states followed by voluntarily lifting their restrictions.

HCPF officials state that by lifting the restrictions, Medicaid will be able to extend coverage to roughly 20 percent more enrollees with HCV, based on the experience of those other states.

#### Massachusetts

#### ***Committee hears three bills to increase affordability of prescription drugs***

The Joint Committee on Financial Services held hearings last week on measures that would help make the cost of prescription drugs more transparent and affordable for Massachusetts consumers.

S.B. 542 sponsored by Senator Eric Lesser (D) would require insurers to limit cost-sharing for covered prescription drugs to no more than \$100 for a 30-day supply. It would also prohibit them from moving all drugs in a given class into the highest cost-sharing tier under a drug formulary, a practice the federal Centers for Medicare and Medicaid Services (CMS) and several state insurance commissioners have previously determined to be discriminatory (see Update for Week of February 23, 2105). At least 15 states have enacted similar measures relating to specialty tier cost-sharing.

H.B. 513 sponsored by Rep. Marjorie Decker (D) would require that insurers establish a separate maximum out-of-pocket limit for prescription drugs (including specialty drugs). This limit may not exceed the minimum annual deductible for high-deductible health plans set by the federal government.

H.B. 491 sponsored by Rep. Jennifer Benson (D) would make Massachusetts the latest state to require greater transparency in prescription drug prices. It specifically would compel manufacturers to file a report with the Department of Health to justify any increase in the wholesale acquisition cost (WAC) that equals or exceeds 15 percent within the previous 12 months.

Similar legislation has been considered in 25 other states this year. California enacted the nation’s most comprehensive prescription drug price transparency law this fall, which went beyond the law passed last year in Vermont (see Update for Week of November 6<sup>th</sup>). The Puerto Rico legislature is currently reconciling different transparency bills passed by each chamber.





New Hampshire

***House committee to consider prescription drug price-gouging prohibition***

Rep. Rebecca McBeath (D) has pre-filed legislation for next session that would make New Hampshire the second state to prohibit price-gouging for essential off-patent or generic drugs.

H.B. 1780 is modeled after comparable legislation that was enacted earlier this year in Maryland (see Update for Weeks of May 29<sup>th</sup> and June 5<sup>th</sup>). It would require the commissioner for the Department of Health and Human Services to notify the Attorney General whenever three or fewer manufacturers are actively manufacturing and marketing the drug, the wholesale acquisition cost (WAC) increases by 50 percent or more in one year, or if the WAC for a 30-day supply exceeds \$80.

H.B. 1780 was referred to the House Commerce and Consumer Affairs Committee.

Virginia

***Governor and Governor-elect disagree on path forward for Medicaid expansion***

Outgoing Governor Terry McAuliffe (D) has made expanding Medicaid under the Affordable Care Act (ACA) the centerpiece of the two-year budget plan he proposed this week.

Governor McAuliffe was elected in 2013 largely on a pledge to expand Medicaid but his efforts to do so over Republican objections resulted in a government shutdown in 2014 that was resolved only when the Senate shifted to Republican control due to a party switch by one Senator (see Update for Week of September 15, 2014). Since then, the Governor has made only symbolic efforts at Medicaid expansion as Republicans gained supermajority status in the House of Delegates.

However, Republicans may have lost control of the House during last month's electoral sweep by Democrats, with the current 50-50 split in the House to be resolved by a random drawing after the remaining race was tied following a recount. Even if Republicans prevail, their one-seat margin in both chambers has provided momentum for expansion proponents who expected McAuliffe's successor, neurologist and Lt. Governor Ralph Northam (D), to pursue the expansion early next year (see Update for Week of November 6<sup>th</sup>).

McAuliffe's proposal builds upon his earlier plan, which would fund the ten percent state share of expansion costs via a hospital assessment he negotiated with the state hospital association (see Update for Week of December 7, 2015). It would accept federal matching funds to extend Medicaid coverage to roughly 300,000 Virginians at a projected savings of \$421 million.

Despite his similar campaign pledge to expand Medicaid, Governor-elect Northam angered Democratic leaders this week with comments that appeared to suggest he would at least initially pursue the Republican-favored goal of overhauling Medicaid prior to any expansion. The outcry forced him to later reaffirm that expanding Medicaid remained his priority. However, his expansion strategy once he assumes office in January remains unclear.