NC Get Covered
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NC GET COVERED BRIEFING
March 1, 2016

NC Get Covered is continuing its monthly briefings with the goal of bringing to its coalition partners state-specific information on the ACA, as well as national policies and trends that may have an impact on the following topics:

Consumers
- Special Enrollment Period, new rules and scrutiny
- Limited Coverage Plans

Insurance Carriers and Agents
- Actions appear to limit enrollment

Medicaid Coverage Gap
- State Scorecard—AK, GA, ID, IN, KS, NH, NC, SD, and UT

CONSUMERS

Clarifying, Eliminating and Enforcing Special Enrollment Periods
The Centers for Medicare and Medicaid Services (CMS) recently issued guidance eliminating six qualifying events for a special enrollment and clarifying the marketplace residency requirement and the special enrollment related to a permanent move. CMS took this step in response to insurer concerns about special enrollment periods (SEPs). Insurers argue that some consumers are taking advantage of special enrollment policies to enroll outside of open enrollment when they become sick and then rack up high medical claims.

<u>Elimination of Certain SEPs</u>
The following events will no longer trigger a SEP:
1. Consumers who enrolled with too much advance premium tax credit because of a redundant or duplicate policy
2. Consumers who were affected by an error in the treatment of Social Security income for tax dependents
3. Lawfully present non-citizens that were affected by a system error in determining their advance premium tax credits
4. Lawfully present non-citizens with incomes below 100 percent of the Federal Poverty level who experienced certain processing delays
5. Consumers eligible for or enrolled in COBRA and not sufficiently informed about their coverage options
6. Consumers who were previously enrolled in the Pre-Existing Condition Health Insurance

Program

The administration announced two additional measures related to special enrollment periods.

- First, it will review the most frequently used special enrollments – loss of minimum essential coverage and permanent moves – and try to determine whether people are using them legitimately. CMS stated it will provide additional information about this review and will use the results of its review to inform future policy.
- Second, it will review healthcare.gov call center scripts to ensure that they clearly inform consumers about penalties associated with providing false information on enrollment applications.

Clarifying the Marketplace Residency Requirement and the "Permanent Move" SEP

CMS also published a guidance document on the residency requirements for marketplace coverage and the special enrollment opportunity that accompanies a permanent move. CMS clarifies that moving temporarily to a state for medical treatment at a hospital or health system does not establish residency in that state, nor does it trigger a special enrollment right. Residency is established by meeting two requirements:

1. Living at a location and
2. Intending to live at that location or having a job commitment or looking for a job. The person does not need to have a fixed address or be employed.

"While this is an important first step, more needs to be done to validate special enrollment requests," said Clare Krusing, a spokeswoman for the lobby group America's Health Insurance Plans. "It's critical that there is a process in place to avoid potential abuse of special enrollment periods and to ensure a stable, affordable market for consumers."

New Special Enrollment Confirmation Process

On February 24, CMS announced another step that it says will enhance program integrity and contribute to a stable rate environment and affordability for consumers: a new Special Enrollment Confirmation Process in the 38 states using the HealthCare.gov platform. Under the new process, all consumers applying through the most common special enrollment periods will need to submit documentation to verify their eligibly to use an SEP. This represents a major overhaul of the SEP process. You can read more about the Special Enrollment Confirmation Process here: https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-02-24.html

CMS went on to state that Special enrollment periods are an important way to make sure that people who lose health insurance during the year or who experience qualifying life changes have the opportunity to enroll in coverage. We (CMS) are committed to making sure that special enrollment periods are available to those who are eligible for them. But it's equally important to avoid misuse or abuse of special enrollment periods.

CMS believes that this change in the special enrollment period process does not restrict anyone's access to a special enrollment period who is rightfully able to enroll in coverage. But consumers will need to be sure to provide sufficient documentation to establish their eligibility. If an individual doesn't respond to our notices, they could be found ineligible to enroll in Marketplace coverage and could lose their insurance.

Consumers cobble together separate Limited Coverage Plans

It's been reported that a growing number of consumers cut costs by combining limited coverage health plans, despite the penalty risks. Kaiser Health News related the story of a consumer who had been paying nearly $1,000 a month for a family health, dental and vision plan through her employer. The consumer decided to check out individual family plans on healthcare.gov. But their income was too high to qualify for subsidies and comparable Marketplace coverage wouldn't be any cheaper. So the consumer instead cobbled together three different policies that each provide limited coverage,

- For one spouse, an adult short-term plan with a $10,000 deductible that provides up to $1 million in coverage for just under a year;
- For the 2-year-old daughter, an identical, but separate plan, and
- For the couple, a critical illness plan that pays a $20,000 lump sum if one of them is diagnosed with invasive cancer, heart attack or stroke; and a dental plan that provides $1,000 in coverage.

The total monthly tab: $390.

Under the ACA, people without an exemption are required to have insurance that meets minimum standards or pay a penalty. Limited benefit policies such as short-term, critical illness, accident, dental and vision plans similar to those listed above don't qualify. Thus, this consumer will be subject to the penalty. In 2016, the penalty is $695 per adult and $347.50 per child, or 2.5 percent of household income, whichever is greater.

When faced with high premiums and high deductibles for traditional plans, it's not surprising that some people are looking at other options. "They may be making the best decision they can for themselves given their financial and health situation," said Sabrina Corlette, research professor at Georgetown University's Center on Health Insurance Reforms.

Another option is a short-term health plan. These plans last less than a year, have lower premiums than regular ones and often come with more extensive doctor and hospital networks. For some people — especially those who are young, healthy and don't qualify for a tax credit from a state or federal marketplace— short-term plans might make financial sense, even though they don't shield you from the ACA tax penalty. "Depending on your age and income level, you could get one of these plans, pay the uninsured tax penalty and still pay less than if you had purchased" a comprehensive plan, says Kev Coleman, head of research and data for HealthPocket, a health insurance comparison website.

The tax penalty hasn't deterred some people from signing up for short-term plans, especially the young and healthy. eHealth and AgileHealthInsurance.com stated that 18- to 34-year-olds accounted for more than half the buyers of short-term plans last year. Before enrolling in a short-term plan, a consumer needs to consider the pros and cons:

PROS

- You can buy them any time of year.
- Their premiums are generally lower than major medical insurance plans. The average premium for short-term plans sold by eHealth in California last year was $177 per month.
- They may have broader networks of doctors and hospitals than some plans available from exchanges.

CONS

- They won't accept you if you have pre-existing conditions, or if they do, they won't cover them.
- They may not cover benefits such as maternity care, preventive services or prescription drugs.
- They last less than a year and you have to reapply at the end of each term. There's no guarantee you'll be accepted again, especially if you got seriously ill while you had coverage.

CARRIERS

Insurers Actions appear to Limit Enrollment
Health policy analysts have raised the issue that it appears that major insurers are seeking to sharply limit how policies are sold to individuals in ways that consumer advocates believe may illegally discriminate against the sickest and could hold down future enrollment.

Recently, Anthem, Aetna, Blue Cross and Blue Shield of NC, and Cigna, told brokers they will stop paying sales commissions to sign up most customers who qualify for new coverage during the Special Enrollment Period. Last year, "special enrollment" clients were much more expensive than expected because lax enforcement by the Federal marketplace allowed many who didn't qualify to sign up, insurers said. Nearly a million special-enrollment customers selected plans in the first half of 2015, half of them after losing previous coverage.

In addition, Cigna and Humana, another big health insurer, have ceased paying brokers to sell many higher-benefit "gold" marketplace plans for individuals and families while continuing to pay commissions on more-profitable, lower-benefit "bronze" plans, according to documents and interviews. Gold plans typically enroll sicker members than do less comprehensive policies, say insurance experts.

By inducing brokers to avoid high-cost members — whether in gold plans or special enrollment — the moves limit access to coverage and discriminate against those with greater medical needs, said Timothy Jost, a law professor at Washington and Lee University and an authority on the health law.
"The only explanation I can see for them doing this is risk avoidance — and that is discriminatory marketing and not permitted," he said. "When people wonder why we're not getting millions more enrollees in Affordable Care Act health plans, one reason is, the carriers are discouraging it."

The insurance industry replies it is not discriminating but adjusting to market realities including higher-than-expected medical claims and the failure of a government risk-adjustment program called "risk corridors" to cover much of that cost. "Without making necessary changes to coverage and benefits, there was no way for health plans to remain in the market or to offer the kind of coverage as they had in the past without sustaining huge losses," said Clare Krusing, spokeswoman for America's Health Insurance Plans, an industry lobby.

Agents and brokers are critical to sign-ups and the success of the health law. For example, in 2014 44 percent of Kentucky enrollees bought through brokers, as did 39 percent of the California enrollees. However, no similar data is available from CMS on the percent consumers enrolled by agents and brokers in the 38 FFM states.

Aetna told HHS that a fourth of all its marketplace members joined through special enrollment last year and that many dropped out soon after receiving expensive care. Special-enrollment members used as

much as 50 percent more care than those who sign up before the deadline, said the Blue Cross and Blue Shield Association.

The risk corridor program was supposed to reimburse insurers with sicker-than-average members. In November, however, HHS said it had only enough money to pay 13 percent of what it owed under the program for 2014.

HHS to Review ACA Risk Adjustment Program

DHHS announced it will review problems with the ACA's risk adjustment program. The program is intended to compensate health insurers that cover sicker-than-average enrollees, but it has forced many smaller health insurers and nonprofit Consumer Operated and Oriented Plans (CO-OPs) created under the ACA to make large payments to other insurers, and some of them have called for a cap on payments. The administration will hold a public conference on the program March 25.

CMS Director Andy Slavitt recently stated that HHS is "committed to making sure risk adjustment works as intended to allow coverage of individuals with pre-existing conditions." He said that HHS will be providing early estimates of health plans' specific risk adjustment calculations, which will give plans "more timely information in order to facilitate informed rate-setting."

Slavitt said there are "four or five principal things" that have been suggested to the CMS to improve the risk adjustment program. Those include reflecting prescription drug costs and reflecting the fact that some people may only be in plans for part of a year.

MEDICAID COVERAGE GAP

Is Medicaid Expansion Near a Tipping Point?

At least one other state — South Dakota — is expected to extend Medicaid coverage this year. But, in the lead up to the November presidential election, supporters of the ACA aren't holding out much hope that more states will join in extending Medicaid coverage to more people — although the governors of Alabama, Virginia and Wyoming say they want to, as do key legislators in Maine and Nebraska.

After a new president is elected, the situation could change, predicted Joan Alker, executive director of Georgetown University's Center for Children and Families. With President Obama out of office, "The ideological opposition to the president will have to start fading," Alker said. "At that point, the facts and the evidence will start to matter more."

Historically, health care has been a bipartisan issue, George Mason University professor of health economics Len Nichols said. And it could be again. "Once President Obama leaves office, it's not 'Obamacare' anymore," Nichols said. "It's American law." At that point, he said, it will be hard for any state to reject a deal that is "good for their budget, good for their economy and good for the health of their residents."

Matt Salo, executive director of the National Association of Medicaid Directors, agrees. If a Democrat is elected president, the new administration could be expected to continue the Obama administration's approach of approving proposals from Republican-governed states to shape expanded Medicaid programs to fit their individual state needs and politics. Even greater flexibility could come if a Republican is elected president, Salo said. In that case, the GOP-led states that have so far shunned

expansion would likely seek authority to revamp their programs more radically than the Obama administration has allowed.

Hard to Take Back

So far, 31 states and the District of Columbia have taken the federal government up on its offer to fund all but 10% of the cost of providing health care to about 8 million low-income adults. Defunding or eliminating Medicaid expansion would mean taking away billions of federal dollars from the states and their ability to provide health care for their residents. It also would mean cancelling health coverage for millions of people, many of whom could be sick and in need of immediate care. That's not something any administration is likely to do, Salo said.

In general, the Obama administration has been lenient in approving state requests to modify traditional Medicaid rules. Six states — Arkansas, Iowa, Indiana, Michigan, Montana and New Hampshire — have expanded their Medicaid programs under so-called waivers to federal rules.

Facts and Evidence

Research shows that major fiscal and health benefits have accrued to states that have expanded Medicaid, and contrary to claims from opponents, job losses have not occurred. Hospitals also reported fewer unreimbursed expenses.

More than 6 million more people would become eligible to receive coverage under the health law's Medicaid expansion if all remaining states opt in to the program, according to an analysis by Families USA, which advocates for expansion. But states like Florida and Texas, with the highest uninsured rates and the most to gain, continue to reject federal funding.

Legislature's report rebuts GOP fears, outlines redesign ideas

A study, commissioned by **Alaska**'s Legislative Budget and Audit Committee at the request of state legislators who opposed the state's Medicaid expansion, concluded that none of the unintended consequences of expansion will materialize.

Among the Committee's findings are:

- Concerns about a "woodwork effect" — that expanding Medicaid could trigger more people to enroll — are unfounded.
- There's no basis for fears that expanding Medicaid could squeeze other patients out of the health care market, a phenomenon dubbed "crowd-out."
- The total state cost of expansion will be $24 million by 2020. The report goes on to state that there are "large-scale opportunities" to cut Medicaid spending over the long-term to offset the increased costs.
- It also says the state gets a $170 million annual net gain by expanding Medicaid, with more federal money coming into the state than is leaving in taxes.
- The impact of the federal money on the state's economy makes Medicaid expansion "a highly attractive policy change, financially," the report said. And when combined with other benefits to the health care sector and to low-income Alaskans — many of whom otherwise have no affordable way to get health insurance — expansion justifies a "considerable" state investment, the report said.

The Committee's report also included several recommendations that it said could lead to quick Medicaid savings for the state, including:

- Using more generic drugs, as Alaska's Medicaid costs-per-prescription are among the highest when compared to other states.

- Establishing more nursing homes and other services that can be run by tribal health care providers, which are fully reimbursed by the federal government for care given to Alaska Natives. Each Alaska Native Medicaid patient transferred to tribally run nursing homes could save the state $75,000 a year — or tens of millions of dollars, if hundreds of patients are moved, the report said.

A First Time Hearing

The **Georgia** Senate Health and Human Services Committee broke new ground recently by holding a legislative hearing, Senate Bill 368, that would create a Medicaid expansion alternative in Georgia. This is the first time an expansion bill gained a hearing at the General Assembly since the Affordable Care Act was passed in 2010.

The bill did not use the term "Medicaid expansion" but rather called for a premium assistance program for people who earn 138 percent of the federal poverty level or less. It's based on Arkansas' expansion alternative and is sponsored by state Sen. Michael "Doc" Rhett (D-Marietta). Those individuals gaining private health plan coverage through the current health insurance exchange, and would be responsible for paying up to 5 percent of their income toward the cost.

Ethan James of the Georgia Hospital Association told the committee that something must be done to address "a crisis of the uninsured in Georgia." Yet James also said his organization was committed to the current process of developing an independent study of health care access, sponsored by the Georgia Chamber of Commerce. "We don't want to rush to get this wrong," he said.

Hundreds turn out for Medicaid expansion plan

Hundreds of **Idaho** citizens turned out to express their support of Medicaid expansion as a recent meeting of the Senate Health and Welfare Committee. Although Medicaid expansion has been studied and was recommended by two succeeding governor-appointed workgroups, most of the Republican-dominated Legislature has opposed it. The hearing was the first time lawmakers have convened on an actual expansion bill.

There are actually two bills, introduced for comparison. The first proposes "straight" expansion as originally set forth under the ACA. The second includes certain waivers, pre-approved by the federal Centers for Medicare and Medicaid Services that address concerns about expansion and give the state some options for implementation.

With Medicaid expansion stalled, Gov. Butch Otter's administration this year proposed a state-funded plan to subsidize basic preventive care for people in the gap group. The $30 million cost of the plan would be covered by existing cigarette and tobacco taxes.

The state plan would add $30 million on top of the cost of keeping in place the state and county indigent care programs. County programs pay the first $11,000 of such cases; the state Catastrophic Health Care (CAT) fund pays the rest. CAT fund costs are dropping as more people have obtained health insurance under the ACA. Under the state plan, they could increase again as more people go to the doctor for preventive care, find out they're sick and need treatment that isn't covered.

Medicaid expansion plan would save the state $55 million by eliminating the need for the state and county indigent care programs. So the difference between adopting one program over the other is said to be $85 million.

Expansion is a boost to hospitals

As **Indiana** enters its second year of expanded Medicaid coverage created by the Affordable Care Act, hospitals around the state report it has helped patients gain needed coverage. But it's also helping hospitals. The Health and Hospital Corporation of Marion County (Indianapolis) operates the hospital with the largest amount of uncompensated care costs in the state. It has experienced a drop in patients without insurance from 35 percent to 25 percent. That translates to about a $15 million boost for the hospital's bottom line.

Preliminary data from a survey the state commissioned found that 55 percent of 270 health-care providers in the state reported a decline in the number of uninsured patients, and almost 40 percent have seen a decline in the request for charity care.

A spokesperson for the study indicated it's too early to draw conclusions on many aspects, such as how Medicaid expansion has improved health. But one of the clearest pictures emerging is how the expansion has helped hospital finances. For many communities, hospitals are the largest employer.

New Medicaid expansion plan introduced

The **Kansas** Hospital Association has engineered the introduction of a Medicaid expansion bill modeled after a so-called consumer driven plan implemented last year in Indiana. The measure, introduced in House and Senate committees, would provide coverage to approximately 150,000 low-income but non-disabled adults by making them eligible for KanCare, the state's privatized Medicaid program. Tom Bell, president and chief executive of KHA, said the proposal was written with input from Kansas lawmakers, who he said wanted something patterned after Indiana's more conservative approach to expansion.

The Kansas plan, which KHA is calling "The Bridge to a Healthy Kansas," also requires people earning above the federal poverty level to make monthly payments into personal health care accounts and, like the Indiana plan, terminates coverage for those who fall behind in their payments. It also would make participants responsible for a $25 co-pay if they go to the emergency room for non-emergency care.

Rep. Susan Concannon, a Beloit Republican, made the motion to introduce the bill in the House committee, which traditionally honors such requests from members without requiring debate and a vote. However, Concannon and others don't anticipate the bill will remain in the committee long enough for hearings. Rather, they expect House Speaker Ray Merrick, a Stilwell Republican and expansion opponent, to refer the bill to a new committee and work to keep it from coming to a vote on the House floor.

Gov. Brownback opposes expansion but has said he might be willing to discuss a plan that meets certain requirements. Among other things, he has said, it must be budget neutral.
Bell said the KHA plan meets that requirement. He said it includes funding mechanisms that would generate more than the estimated $55 million annual cost of expansion.
The proposal creates at least three special funds to pay for expansion.

- One would collect premiums from beneficiaries and total $16.4 million in 2017 and grow to $20.5 million by 2020.
- A second involves a drug rebate program that would collect between $7.9 million and $8.9 million a year.

- A third fund would capture a portion of the privilege taxes paid by the KanCare managed care organizations. The tax is expected to total $20.3 million in 2017 and average between $15 million and $15.8 million annually through 2020.

In addition to the new revenue sources in the bill, the hospital association estimates that expansion would create opportunities to save up to $113 million by reducing the need for KanCare services for which the state is now paying.

New Medicaid bill to offer 'private option'

After three attempts to expand Medicaid under the federal health care law, **Nebraska** lawmakers will soon unveil a new proposal that would offer private coverage to thousands of low-income residents. The newest bill is modeled after the so-called private option adopted by Arkansas, which received a federal waiver to spend Medicaid dollars on private insurance.

The proposal is expected to face opposition from Gov. Pete Ricketts and conservative lawmakers, who argue it's not sustainable. Ricketts spoke fervently against Medicaid expansion in his State of the State address last week, calling it "an unreasonable risk to Nebraska taxpayers."

Under Nebraska's upcoming plan, some recipients would still have to pay up to 2 percent of their incomes for premiums to ensure they share in some of the cost. If the federal government's share of funding ever dropped below 90 percent, the program would cease in Nebraska, said Republican Sen. John McCollister, who is expected to introduce the bill.

McCollister pointed to a 2015 University of Nebraska at Kearney study that found economic benefits to expanding Medicaid. The study predicted the state would see at least $1 billion in economic benefits if Medicaid was expanded, in addition to $2.1 billion in federal funding over five years.

The expected benefits included the elimination of so-called "silent taxes" paid through higher premiums to cover the cost of the uninsured, a reduction in medical related bankruptcies, and increased consumer spending because fewer patients would face financial hardship.

GOP leaders call for continuation of Medicaid expansion

New Hampshire's Republican lawmakers have presented their plan for reauthorizing Medicaid expansion. The outline of the proposal that includes work requirements for recipients and asks insurance companies and hospitals to help pay the state's share of the program's costs.
"This is an important debate to many of my constituents," said Republican Rep. Joe LaChance of Manchester, the bill's prime sponsor. LaChance said he's seen the positive effects of the program, which insures more than 45,000 New Hampshire residents, in his home city.

New Hampshire crafted a version of Medicaid expansion in 2014 that uses federal dollars to put people on private insurance plans. The program insures people who make up to 138 percent of the federal poverty line, or about $16,000 a year for an individual.

But federal funding for the expansion is set to start dropping next year, and the state's plan will sunset at the end of 2016 if lawmakers don't vote to reauthorize it. Republicans, who control the Legislature, have long said they won't make taxpayers pay the state's share of the bill.

LaChance's proposal, also backed by GOP Senate Majority Leader Jeb Bradley and House Speaker Shawn Jasper, relies on an insurance premium tax as well as voluntary contributions from insurance companies

and hospitals to pay the state's costs, estimated to be $25 million in 2018. The New Hampshire Hospital Association supports the plan, saying Medicaid expansion has decreased uncompensated care costs because fewer uninsured people are showing up in emergency rooms.

The Business and Industry Association of New Hampshire backs the program, too. A group of 15 business leaders signed on to a letter urging lawmakers to reauthorize the program. "A healthy workforce is a productive workforce," the letter reads. "The health of New Hampshire's residents is tied to the state's economic prosperity. NHHPP invests in the vitality of our growing workforce, begins to address the ever-increasing costs of coverage for all of us, and stimulates economic development in the Granite State."

Beyond the payment structure, the bill makes several other changes to the program that will need approval from the federal government. For example, it requires:

- Childless, able-bodied adults on Medicaid expansion to spend 30 hours per week working or performing other activities such as job training or community service. No other states have received federal approval to include such work requirements.
- An $8 copayment for people who unnecessarily visit the emergency room and $25 copays for every unnecessary emergency room visit thereafter.

Benefits of Medicaid expansion about equal in 2020

An assessment of Medicaid expansion, done by Mark A. Hall, director of Wake Forest law school's health law and policy program finds that the economic benefits and savings of Medicaid expansion would about equal the extra expense when **North Carolina** would have to pay its maximum share of the cost. Estimates are that Medicaid expansion in North Carolina would insure 300,000 to 500,000 people. About 1.9 million residents now have Medicaid. The study found that secondary benefits – job creation and economic stimulus, reducing the cost to treat uninsured people, and reducing costs of other state programs – would offset the state's 10 percent share of the total cost of expansion, when the state begins shouldering that portion.

"Undoubtedly, expanding Medicaid will incur some substantial cost to the state once its cost-sharing portion increases to 10 percent in 2020," they wrote. "However, based on expert economic forecasting and actual experience in other states, it appears that most or all of these direct state costs will be offset by financial benefits." They referred to a 2014 study by George Washington University researchers for the Cone Health Foundation and the Kate B. Reynolds Charitable Trust that put the state cost of expansion at $600 million in 2020, and the financial benefits at $556 million.

The Wake Forest review references economic studies done for North Carolina, for other states and for the nation. Some estimate Medicaid expansion would create 19,400 to 43,000 jobs or more in the state, about half of those in health care.

New jobs would lead to more sales and income taxes collected. The George Washington University study estimated that expansion would generate an economic stimulus that would produce an additional $266 million a year in state and county taxes by 2020.

Opposition Ad Campaign

A conservative group that opposes Medicaid expansion is campaigning against **South Dakota** Gov. Dennis Daugaard's plan to expand the program. South Dakota has been trying to work out a deal in

which the federal government would pay for 100 percent of all Indian health care. Currently, the state Medicaid program pays tens of millions a year for Native health care that occurs outside of Indian Health Services facilities. If the federal government were to pick up all of those costs, it would free up state money to expand Medicaid to working adults with incomes at 133 percent of the federal poverty limit.

The ad raises questions whether the federal government can be trusted to uphold its end of the bargain on Medicaid expansion. The ad quickly scrolls through a list of federal scandals to downplay the federal government's credibility.

Senate to Debate Expansion, while House has an alternative

The **Utah** Senate is soon expected to debate legislation that seeks to Medicaid Expansion in Utah. But SB77 — which would have Utah join more than 30 other states allowing full Medicaid expansion under the Affordable Care Act — likely will face a tough battle on the floor as several committee members said they would not support it without changes.

Sen. Gene Davis, D-Salt Lake City, said he's open to amendments but would never agree to a "cap" that would limit the number of people who could receive the benefit. Sen. Lyle Hillyard, R-Logan, expressed concern the state would be taking on too much with full Medicaid expansion, which is expected to provide coverage for about 110,000 residents. The fiscal note puts the bill's price tag at $50 million annually, beginning in 2020.

Davis countered that the bill would pay for itself, saying Utah is losing $625 million in revenue that should be coming back to the state. The University of Utah Hospital, he said, reports $100 million a year in uncollected bills — money he said would be recouped under SB77. The bill provides an opt-out if the federal government reduced the 90 percent match it has pledged for participating in the program. Utah's Episcopal bishop, the Rev. Scott Hayashi, also spoke of the human cost of rejecting Medicaid expansion. He said lawmakers have been debating for three years and always have a reason to delay action. Evelyn Everton, of the Utah chapter of Americans for Prosperity, spoke against the bill saying it would only increase the tax burden on families.

Over in the Utah House of Representatives House Majority Leader Jim Dunnigan, who is opposed to Medicaid Expansion has proposed HB437 to expand coverage to the poorest in Utah, specifically childless adults who are chronically homeless and who find themselves in and out of the justice system for various reasons, but never get proper treatment for recurrent mental health issues because of a lack of access to proper health care.

Dunnigan has said it is a starting point for the state, one that will yield helpful numbers to estimate further growth and potential expansion. House Speaker Greg Hughes, R-Draper, who supports Dunnigan's bill, said Wednesday there's no room for compromise. "If we can get it accomplished, it will be that bill," he said. "Politics is the art of the possible. I think what's possible is what Rep. Dunnigan has been working on. I think that stands as our best chance of doing something on that front."

Sources:

The information for this March 1, 2016 NC Get Covered Briefing was drawn from multiple sources, including:

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Associated Press
Bloomberg BNA
Casper Tribune
Chicago Tribune
CMS BLOG

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Idaho Statesman
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