NAHU Newswire

Prepared exclusively for members of NAHU National Association of Health Underwriters

in affiliation with BulletinHEALTHCARE

Today's News for the National Association of Health Underwriters from Newspapers, TV, Radio and Journals

Customized Briefing for Kimberly Barry-Curley **February 4, 2013**

Leading the News

HHS Offers Contraception Mandate Compromise.

A proposed rule offering a compromise to opponents of the Affordable Care Act's so-called "contraception mandate" received extensive coverage in print and on network television over the weekend. Most pieces characterize the regulation as a step forward, but one that did not completely satisfy the opposition.

The AP (2/1, Zoll, Alonso-Zaldivar) reported that Friday, HHS "proposed a work-around for religious nonprofits that object to providing health insurance that covers birth control." The "new regulation attempts to create a barrier between religious groups and contraception coverage, through insurers or a third party, that would still give women free access to contraception. It wasn't immediately clear whether religious leaders would accept the new approach, or whether it would stem the tide of lawsuits by Roman Catholic charities and other faith-affiliated nonprofits nationwide challenging the requirement to provide such coverage." HHS Secretary Sebelius "said in a statement the compromise would provide 'women across the nation with coverage of recommended preventive care at no cost, while respecting religious concerns.'"

On its front page, the New York Times (2/2, A1, Pear, Subscription Publication) called the proposal "yet another compromise" designed to "to address the concerns of religious organizations that object to its policy requiring health insurance plans to cover contraceptives for women at no charge." Under the compromise, "female employees could get free birth control coverage through a separate plan that would be provided by a health insurer. The institution objecting to the coverage would not pay for the contraceptives. The costs would instead be paid by the insurance company, with the possibility of recouping the costs through lower health care expenses resulting in part from fewer births."

USA Today (2/1, Kennedy) reported HHS Secretary Kathleen Sebelius' full statement, in which she said, "Today, the administration is taking the next step in providing women across the nation with coverage of recommended preventive care at no cost, while respecting religious concerns. We will continue to work with faith-based organizations, women's organizations, insurers and others to achieve these goals."

The Los Angeles Times (2/2, Levey) reports that in making the compromise, HHS was "trying to defuse one of the most contentious issues in its healthcare law."

Bloomberg News (2/1, Wayne) reported that the rules are "designed to dispel concerns of religious groups haven't appeased critics who say the policy violates employers' rights."

The Washington Post (2/2, Kliff, Boorstein) noted that "some religious groups criticized the proposed rules. For more than a year, they have mounted a high-profile protest and filed dozens of lawsuits against the contraceptive mandate, arguing that it is a violation of their religious freedom." However, reproductive rights groups like Planned Parenthood praised the rules.

Reuters (2/1, Morgan) reported further on the negative reaction of the religious community, including Cardinal Timothy Dolan of New York.

The Washington Times (2/1, Howell) added, "No federal funds will be expended under the plan, although ostensibly federal and state governments will be losing out on the fees that would normally paid to participate in the exchanges, officials said. The plan will be open to comments from interested parties through April 8."

In network TV, the CBS Evening News (2/1, story 2, 2:05, Pelley) and NBC Nightly News (2/1, story 6, 0:25, Williams) covered the

new rule Friday night.

Other sources covering the rule included the Financial Times (2/2, Kirchgaessner, Subscription Publication), The Hill (2/1, Baker) "Healthwatch" blog, Politico (2/1, Brown), McClatchy (2/2, Kumar, Clark), the Wall Street Journal (2/2, Radnofsky, Subscription Publication), CQ (2/2, Norm, Subscription Publication), LifeHealthPro (2/1, Bell), the NPR (2/1, Rovner) "Shots" blog, Kaiser Health News (2/1, Gold), Modern Healthcare (2/1, Subscription Publication), Alabama Live (2/4, Garrison), and HealthDay (2/4, Reinberg).

NYTimes Praises Contraception Mandate Compromise. In an editorial, the New York Times (2/2, A22, Subscription Publication) welcomed the Obama Administration's update to proposed contraception coverage, saying it "modifies the definition of a 'religious employer' and certain affiliated organizations to follow a section of the Internal Revenue Code more closely. And for the first time, it provides guidance for the large religiously affiliated institutions that self-insure, or pay their own medical costs rather than buy insurance coverage." While the updated proposal may require close accounting to handle the payment process in the short term, contraceptive coverage, in the long run, "should save money by improving women's health and reducing the number of unwanted pregnancies, abortions and medical complications from pregnancy."

Columnists Look Into HHS Rule About Contraception Mandate. E.J. Dionne, in his Washington Post (2/2) column, wrote that "America's Big Religious War ended on Friday. Or at least it ought to," after HHS produced new regulations that apply to contraception coverage under the ACA. Dionne said the Roman Catholic Church should recognize that extending "a bitter and unnecessary clash" between it and the Obama Administration over the issue would be counterproductive, calling "the final HHS rules...the product of a genuine and heartfelt struggle over the meaning of religious liberty in a pluralistic society." Dionne also credited HHS Secretary Sebelius for "a becoming humility" when she said the original rules "really caused more anxiety and conflict than was appropriate." Dionne said her critics should act as gracefully.

In his Los Angeles Times (2/1) column, Jon Healey wrote of the rule, "Critics don't believe the exemption will function the way the administration has said it will." He concluded, "I think they're wrong, but I also think the administration should have taken a much different tack to resolve the dispute." He described his plan, but acknowledged that Congress was unlikely to take up the issue.

Representative Says Contraception Mandate Rule Violates Constitution. In a Washington Times (2/1, King) op-ed, Rep Steve King (R-IA) used the contraception mandate as an example of the Obama Administration violating the Constitution. He wrote, "The rule published by Health and Human Services Secretary Kathleen Sebelius directing even religious institutional health care providers to offer abortifacients, sterilizations and contraceptives free of charge was unprecedented. This violated the religious convictions of the Catholic Church as well as many other religious institutions."

From NAHU

Access NAHU's latest information on PPACA, including a timeline, through our Compliance Corner by clicking here. This section of the website is constantly being updated, so be sure to check in often!

Legislation and Policy

CMS Releases Final Rule On Sunshine Act.

CMS' release of the Physician Payments Sunshine Act final rule received moderate coverage online. Much of the focus was on the rule having been "long-delayed" or "overdue." CQ (2/2, Bunis, Subscription Publication) reported, "The Centers for Medicare and Medicaid Services issued a long-awaited final rule late Friday that governs how the manufacturers of drugs, devices and other medical supplies have to report some payments they make to doctors and hospitals." This "rule requires manufacturers of drugs, devices, biologicals and medical supplies covered by Medicare, Medicaid or the Children's Health Insurance Program to report to CMS payments or other transfers of value that they make to physicians and teaching hospitals; officials say CMS will post the data on a public website." Additionally, "the final rule...requires manufacturers and group purchasing organizations to disclose to CMS physician ownership or investment interests."

The Hill (2/2, Viebeck) "Healthwatch" blog reported that "pressure had been mounting for the Obama administration to release the final 'Sunshine Act' regulations, which are more than one year overdue. Critics blamed the wait on election-year politics."

Bloomberg News (2/3, Wayne) reported that in a statement, Peter Budetti, deputy administrator for program integrity at CMS, said, "You should know when your doctor has a financial relationship with the companies that manufacture or supply the medicines or medical devices you may need." He added, "Disclosure of these relationships allows patients to have more informed discussions with their doctors." Meanwhile, "Jeremy Lazarus, president of the AMA, said his group would 'carefully review' the rule."

Modern Healthcare (2/1, Subscription Publication) reported that in a statement, Sen. Chuck Grassley (R-Iowa), co-author of the legislation, said, "The lack of transparency regarding payments made by the pharmaceutical and medical device community to physicians has created a culture that this law should begin to change substantially."

CardioSource (2/3) reports, "The ACC is in the process of reviewing these regulations and will provide a more detailed analysis and additional resources in the coming days and weeks. Stay tuned to CardioSource.org and The ACC Advocate for updates."

MedPage Today (2/2, Frieden) also covered the story.

LA Times Calls On Obama Administrator For Sunshine Act. The Los Angeles Times (2/2) editorialized that the Obama Administration's regulations to implement the Physician Payment Sunshine Act "are 15 months overdue" and should be released by OMB promptly. The Times said the act, which provides "new transparency" about payments and gifts to physicians, "isn't as strong as it should have been." Still, it said "the Administration should release rules that fully reflect the spirit of the law, and it should do so soon."

Illegal Immigrants Facing Longer Wait For Health Insurance.

The print edition of Modern Healthcare (2/2, Barr, Subscription Publication) reported, "For now, at least, it appears that the estimated 11 million illegal immigrants living in the U.S. will not get federally subsidized access to health insurance coverage as a result of planned legislation that would allow many illegal immigrants to live in the country legally." According to the article, "one major objection to giving federal health insurance assistance to illegal immigrants would be the extra costs. And while a broad consensus has emerged in Washington to create a path to citizenship for these immigrants, immigration remains a hot-button issue for many Americans." Obama's plan "would create a new class of resident" for immigrants, although "some had hoped he would leave the door open to giving the newly legal immigrants assistance with paying for health insurance."

In a seperate report, the print edition of Modern Healthcare (2/2, Zigmond, Subscription Publication) reported healthcare experts on Capitol Hill "said they were not surprised" that the proposals did not offer Federal help in some form to the illegal immigrants, "primarily because lawmakers already addressed the issue in the run-up to the Patient Protection and Affordable Care Act, which made it clear that provisions in the 2010 law would not apply to anyone not 'lawfully present' in the country. It's also because Congress and the Obama administration are gearing up for a series of budget battles, making it difficult for any lawmaker to suggest policies that would add to the nation's large federal deficit."

Part-Time Insurance For Employees A Rarity Under ACA.

The Huffington Post (2/4, Young) reports, "Just 8 percent of part-time workers are enrolled in their company health insurance plans, according to a report released Monday that underscores the reasons for and the challenges created by President Barack Obama's health care reform law." The report, conducted by the payroll and benefits manager Automatic Data Processing's ADP Research Institute, "analyzed data from about 300 large employers" and determined that "23 percent of their workers are part-time but only 8 percent get company-sponsored health benefits." Meanwhile, "seventy-seven percent of workers at the companies studied in the report are full-time. Among those full-time employees, 88 percent were eligible for health benefits, and 77 percent of those who were offered health insurance signed up."

However, the Minneapolis Star Tribune (2/2, Spencer) reported, "most experts say the collective impact won't be measurable for a few years because many provisions of the law do not take effect until January 2014."

Sequester Cuts May Have Significant Impact On Health Reform Implementation.

The print edition of Modern Healthcare (2/2, Daly, Subscription Publication) reported, "It appears increasingly certain that providers and insurers will see a 2% Medicare cut go into effect March 1." Although "providers and insurers have focused on the 2% cut in their Medicare payments," the sequester will take about 5% to 8% out of the CMS' administrative budget. "Everybody in the health IT industry and the health transformation area, which includes payment and delivery reforms that come out of the ACA, are really pretty worried," said Jeff Smith, assistant director of advocacy for the College of Healthcare Information Management Executives. According to Smith, "a cut of up to 8% in CMS administrative functions, as estimated by the Office of Management and Budget in September 2012, would have 'massive' effects on the rollout of initiatives, including accountable care organizations and patient-centered medical homes."

Shared Decisionmaking May Play Important Role In ACA Landscape.

The print edition of Modern Healthcare (2/2, McKinney, Subscription Publication) reported, "Driven by federal incentive programs and a growing body of research, providers are ramping up attempts to engage patients and promote shared decisionmaking." In fact, "many experts...believe that shared decisionmaking can lead to lower utilization of services and a possible antidote to ballooning healthcare costs." Modern Healthcare notes that patient engagement "is a cornerstone of the federal government's Medicare and Medicaid electronic health-record incentive program," which has Stage 2 meaningful-use requirements that "require providers to communicate with patients using electronic messaging and provide them with timely access to health information. Patient engagement and shared decisionmaking are also emphasized in other federal programs, including the Medicare Shared Savings Program."

Medicaid, CHIP Unlikely To Be Cut During Budget Negotiations.

The Los Angeles Times (2/3, Levey) reported that Medicaid and the Children's Health Insurance Program, "once viewed as especially vulnerable in this era of budget cutting," have "emerged as a surprisingly secure government entitlement with as much political clout as the Medicare and Social Security retirement programs." The two programs, "which together provide coverage to more than 1 in 5 Americans," seem to be "off-limits" in budget negotiations, "despite their huge price tag."

Republican Congressman Calls ACA Burdensome To Small Businesses.

The Washington Times (2/1, Howell) reported that Representative Sam Graves (R-MO), chairman of the House Committee on Small Business, "sent a critical letter to the Treasury on Friday to comment on the 'employer mandate'" within the Affordable Care Act. Graves argued that "the litany of calculations contained in a rule published by the department at the start of the year will burden small business owners who already have enough on their plates." The letter read, in part, "Simply put, compliance with the health care law could become a full-time job for them. Each year, they will be forced to make multiple decisions and calculations just to determine if one provision - the employer mandate - applies to them."

The Hill (2/2, Viebeck) "Healthwatch" blog quoted Graves' letter further, in which he wrote, "To speed our nation's economic recovery, we must encourage an environment in which small businesses can hire and expand. I encourage you to remember the concerns of small-business owners and minimize their burdens as you consider these regulatory alternatives."

Senate Finance Committee To Look Into Reducing Waste In Medicare.

In continuing coverage, Modern Healthcare (2/2, Carlson, Subscription Publication) reported that "the Senate Finance Committee will consider such nitty-gritty issues as patient observation status and the redundant overlap among CMS auditors when senators look at ways to reduce waste and abuse in federal healthcare spending." A summary report "from the committee on Jan. 31 outlined the results of 2,000 pages of public comments received by the Senators in response to a call for recommendations last May on ways to fix Medicare. Those responses, boiled down into a list of bullet points in the summary, will inform the bipartisan group of six senators as they draft legislation for the 113th Congress, which ends in January 2015."

NYTimes Questions IRS Interpretation Of ACA Provision.

A New York Times (2/3, SR10, Subscription Publication) editorial questions the IRS and the Congressional Joint Committee on Taxation for their "strict" interpretation of an Affordable Care Act provision that "says a worker cannot get taxpayer-subsidized coverage on the new health insurance exchanges, starting in 2014, unless the cost of employer-based health coverage for that worker exceeds 9.5% of the worker's household income." The IRS said the law should consider "only the cost of covering the individual employee in calculating the 9.5 percent, not the much higher cost for a family plan," but that "pinching approach" could leave "millions of Americans with modest incomes unable to afford family coverage under their employers' health insurance but ineligible for subsidies to buy coverage elsewhere."

Analysts Advise Investing In Hospitals Due To Coming ACA Changes.

In an edition of Health Reform Watch, the Washington Post (2/1, Kliff) "Wonkblog" looked into the best way to make money off the Affordable Care Act. Speaking with analysts and experts, the blog determined that one should invest in hospitals, due to an uptick in the number of insured Americans that will stem from the ACA. The blog also warned investors to "steer clear of post-acute care," because "one way the Affordable Care Act financed a coverage expansion for 30 million Americans was by reducing payments to Medicare providers."

OMB Reviews Final Rule On Rate Review.

CQ (2/2, Adams, Subscription Publication) reported that "the Office of Management and Budget is reviewing a final rule on rate review, according to a notice posted on the agency's website Friday." According to the article, "The rate review and market regulation spells out how insurance companies will have to change their operations in order to comply with the requirements for the new exchange markets, which are expected to start running on Jan. 1." CQ noted, "it outlines how insurers will have to offer coverage to everyone, with limits on the differences in rates that they can charge."

Michigan Governor Still Weighing Medicaid Expansion.

The Detroit News (2/4, Bouffard) reports, "Gov. Rick Snyder will fire the first shot in the next health care skirmish Thursday when he recommends in his budget presentation to the Legislature whether Michigan should open Medicaid to as many as half a million more residents." According to the paper, "The long-term addition of 400,000 to 500,000 Medicaid recipients would result in an additional $1.5 billion to $2 billion a year in federal health spending in Michigan." The governor "has said his biggest concern is whether Michigan's health care system can treat all of the newly insured Medicaid patient."

The Detroit Free Press (2/4, Gray) reports that although the governor "'hasn't made his final decision yet, he has definitely weighed and analyzed all the data and studies on the issue,' said Kurt Weiss, a spokesman for Snyder, adding that he's encouraged by studies on the capability of doctors to handle the increased patient load." Meanwhile, "House Speaker Jase Bolger, R-Marshall, said he and his caucus are 'cautiously skeptical' on Medicaid expansion." Bolger said that "we have significant concerns whether it's affordable in the long term."

Survey: Michigan Physicians Could Take More Patients If Medicaid Program Expands. MiBiz (2/4, Sanchez) reports that findings "from an Ann Arbor health care research group dispel the notion that if Michigan expands Medicaid, then the tens of thousands of people receiving coverage would have trouble getting in to see a doctor because of the influx of patients." According to the article, "The Center for Healthcare Research & Transformation survey results indicate that most doctors in Michigan have the ability to take more patients into their practices and that they would accept new Medicaid patients." The finding "counters a key question about expanding Medicaid: whether a physician shortage leaves the system unable to handle the thousands of people in Michigan who would gain coverage and have a better financial ability to access care."

New Regulations Could Make Insurance Less Affordable For Some Families.

In continuing coverage, the Nashville (TN) Business Journal (2/2, Boyer, Subscription Publication) "NashvilleBizBlog" reported that recently released regulations "by the U.S. Treasury Department could make health insurance less affordable for families with modest incomes and could have larger implications for the future of employer-sponsored health plans while saving the federal government money." The article explained, "the Affordable Care Act provides federal subsidies to workers who aren't able to get 'affordable' insurance through their employers, with 'affordable' defined as less than 9.5 percent of household income." According to the blog, the new rule "applies that 9.5 percent threshold to the cost of a worker's individual coverage - not what he or she must pay to cover an entire family, which is more expensive."

Utah Autism Groups Push To Mandate Coverage.

The Salt Lake (UT) Tribune (2/1, May) reported Utah's autism community is trying to "mandate coverage, but last year saw their efforts stymied by a bill that instead created three pilot programs treating about 300 children under the age of 6." Now, they are pushing for state lawmakers to "join 32 other states that require insurance coverage, according to the national advocacy group Autism Speaks, which endorsed the bill." The proposed bill "requires coverage of the diagnosis and treatment of autism, including speech, occupational and physical therapy, along with applied behavior analysis (ABA) for up to $50,000 a year for children under age 9 and $25,000 for children ages 9 to 18."

Bill Barring Tennessee From Expanding Medicaid Has Support Of Senate.

The Chattanooga (TN) Times Free Press (2/2) reported, "A bill barring the state from expanding the number of TennCare enrollees under the federal Affordable Care Act has 16 Republican sponsors, one vote shy of the 17 votes needed to pass the bill on the Senate floor." However, "Senate Speaker Ron Ramsey, R-Blountville, said he wants to delay action to give Gov. Bill Haslam, a fellow Republican, more time to study the issue and see whether it makes financial sense for Tennessee to participate." Meanwhile, the articles points out, "The governor said U.S. Health and Human Services Secretary Kathleen Sebelius last week 'indicated some flexibility on some things I haven't heard before,'" such as flexibility regarding Medicaid copays.

Georgia Medicaid Rule Would Limit Coverage For Elective Births.

The Augusta (GA) Chronicle (2/4, Corwin) reports on a new rule included in Georgia Governor Nathan Deal's proposed budget for fiscal year 2013 which would "end [Medicaid] coverage for elective births before 39 weeks of pregnancy, or what is considered full-term." The measure "would save the state $5.12 million, according to the budget, though others are skeptical about the savings." For example, "some obstetricians argue that making it a mandate hampers their ability to work with pregnant women, particularly in areas such as Augusta, where almost all of the surrounding counties lack birthing services and expectant mothers live hours from their provider."

"Bed Tax" Bill Passes Georgia House.

The Atlanta Journal-Constitution (2/2, Shenin, Williams) reported that the Georgia house "overwhelmingly approved" Senate Bill 24, which allows for the renewal of the "bed tax," which is "seen as necessary to avoid a loss of $700 million in funding" for Medicaid. The bill "will transfer the power to levy the fee...from the Legislature to the state's community health care agency." This, as the article explains, "solves a problem for many legislators who did not want to renew the 2-year-old fee...because they saw it as a tax increase."

The Atlanta Business Chronicle (2/1, Williams, Subscription Publication) added, "Despite objections from minority Democrats and anti-tax Republicans as the bill went through the legislative process, it passed the House overwhelmingly 147-18."

New HHS Poverty Guidelines May Lessen Cuts To MaineCare.

The Waterville (ME) Morning Sentinel (2/4, Bouchard) reports, "New federal poverty guidelines could reduce the number of people who will be cut from MaineCare, the state's Medicaid program, as a result of federal funding waivers granted recently to the LePage administration." HHS regularly "issues new poverty guidelines each year to account for increases in the Consumer Price Index," and the new guidelines, issued Jan. 24, "raised the poverty level 2.9 percent for a single person, from $11,170 in annual income to $11,490, and 2.2 percent for a family of four, from $23,050 to $23,550." However, it remains "uncertain" how many Maine residents "will retain MaineCare coverage because of the higher poverty guidelines and how it will affect Gov. Paul LePage's effort to balance the state budget."

Virginia Democrats Holding Up Budget To Push For Medicaid Expansion.

The Newport News (VA) Daily Press (2/4, Wilson) reports that Democrats in Virginia's Senate have "indicated they may hold up approval of the budget for the second year in row." This year, they have "said they could not vote for a budget that does not include expansion of the state's Medicaid program under provisions of the federal Affordable Care Act." Explained Sen. Janet Howell, "The budget has a fatal flaw. It does not include Medicaid expansion. I think that's morally wrong. We must not deprive over 300,000 Virginians of health care. For years we've known we have one of the most miserly programs in the country. We couldn't improve it much because we didn't have the money. Now that money is being offered us, and we shouldn't spurn it. Delaying Medicaid expansion is cruel and wrong." [Note: Paula wrote something similar]

Medicaid Officials Offer Higher Matching Rate For Preventive Services.

CQ (2/2, Adams, Subscription Publication) reported that on Friday, Medicaid officials told states that "as of Jan. 1, the health care law allows states to get a federal matching rate increase of one percentage point if they offer patients free preventive care." Further, "It doesn't matter whether the services are provided by a managed care plan or through a fee-for-service Medicaid system." The article explained, "The preventive services are those that the U.S. Preventive Services Task Force have graded an 'A' or 'B' as well as vaccines that are recommended by the Advisory Committee on Immunization Practices"

The Kaiser Health News (2/2, Galewitz) "Capsules" blog noted, "The provision of the Affordable Care Act was slated to take effect Jan. 1. States that implement the changes can apply for the funding retroactive to that date."

Scott Said To Leave Door Open For Medicaid Expansion In Florida.

The Palm Beach (FL) Post (2/3, Kennedy) reported on Florida Governor Rick Scott's apparent softening stance on the Affordable Care Act, writing, "Last week, after years of saying 'no,' Scott released a state budget proposal that has left many advocates hearing, if not a resounding 'yes,' at least a 'maybe' from the state's chief executive." In "the budget proposal that Scott released Thursday, he complies with several parts of the federal Affordable Care Act that are mandatory, apparently making the calculus that he didn't want to risk substantial penalties for non-compliance." Still, "Scott said Thursday that he was not ready to expand Medicaid coverage for Floridians not currently eligible, a step that state analysts say could add 900,000 people to a program already covering almost 3 million Floridians."

Similarly, the Huffington Post (2/1, Young) reported that "Scott issued a budget Thursday that doesn't provide money for the Medicaid expansion - but he didn't close the door on it either." As such, "the Obama administration and poor Floridians will have to wait longer to find out whether an estimated 1.3 million of the state's residents will become eligible for health care coverage."

The South Florida Business Journal (2/2, Subscription Publication) "Heard Along the Coast" blog added, "Legislators are

studying the issue and Scott has an upcoming meeting with Kathleen Sebelius, secretary of US Health and Human Services."

Kasich To Announce If Ohio Will Expand Medicaid Monday.

The AP (2/4, Seewer) reports that Ohio Governor John Kasich "will announce Monday whether he supports expanding the government-funded Medicaid program" under the Affordable Care Act. As the article explains, "Supporters say it will cut down on the costs passed on to those with health insurance and hospitals that treat the uninsured. Opponents argue that it will only add more to the national debt and that the costs to Ohio will be greater than predicted."

CQ (2/2, Subscription Publication) reported, "The pressure that business and some religious groups have been putting on Republican Ohio Gov. John Kasich to expand his state's Medicaid program increases the chances that he will throw his support behind expansion when he unveils his budget plan on Monday." The article adds, "If Kasich says Monday he does back expanding Medicaid, he will join a growing number of GOP governors who have decided to take the additional federal funding the law provides to offer coverage to more people."

Missouri Governor's Plan Could Encourage Physicians To Accept Medicaid Patients.

The AP (2/4, Lieb) reports that part of Missouri Gov. Jay Nixon's plan to expand Medicaid eligibility in his state is to let state Medicaid program "pay rates similar to private insurance - instead of the typically lower rates paid by Medicaid - for adults covered by the Medicaid expansion." The goal behind this is to "entice more physicians to accept Medicaid patients, thus hopefully improving the health of those people and potentially saving taxpayers money by avoiding the types of expensive, emergency care that arise when health problems go untreated until they are dire."

Alabama Considering Cuts, Changes To Cover Medicaid Costs.

The Montgomery (AL) Advertiser (2/3) reported that with increasing enrollment and Medicaid set to take up 35 percent of Alabama's $1.6 billion budget for the 2013 fiscal year, "and with a lack of willingness to find new revenue sources, lawmakers are looking at changes to the program." Dr. Don Williamson, the state health officer and chairman of the Alabama Medicaid Advisory Commission, said "Medicaid may look at changes to a pharmacy tax and reimbursements to Medicaid providers to keep the program afloat." He warned, "There are going to be serious and significant cuts and changes."

Alabama Live (2/2, Chandler) noted, "Despite Alabama offering a bare-bones program with one of the most restrictive income limits in the country, Medicaid enrollment and costs have increased. Enrollment jumped by nearly 200,000 people since 2008."

The Dothan (AL) Eagle (2/2, Tindell) added, "A proposal by an advisory commission advocates that the state reduce Medicaid costs by having community care systems. Under those systems, local hospitals, doctors and other health care stakeholders will work together to keep Medicaid costs down by treating Medicaid patients as efficiently as possible. Part of this will entail getting Medicaid patients quality primary care to help them avoid costly hospital visits."

Texas Doctors Group Supports Expanding State Medicaid Program With Conditions.

The Dallas Morning News (2/3, Garrett) reported the Trustees of the Texas Medical Association, the state's largest group of doctors, "conditionally endorsed expansion of the state's Medicaid program on Saturday after months of internal disagreement about a major piece of the federal health care overhaul." The article says the group "hinged its support" on "simultaneous actions by state officials to make doctors' participation in Medicaid more palatable and federal dispensations flexible 'to change the program as our needs and circumstances change.'"

Texas Business Board Votes Against Supporting Medicaid Expansion. The Tyler (TX) Morning Telegraph (2/3) reported as Texas Republicans "continue to posture against expanding Medicaid under the Affordable Care Act," lobby groups, "including the Texas Association of Business and Texas Hospital Association, are considering analyses by economists who believe accepting federal money to expand Medicaid rolls will be better than refusing the money." For example, Economist Ray Perryman, "in an economic forecast released in October, found expanding Medicaid coverage in Texas is the only rational choice." Nevertheless, the Texas Association of Business governing board voted against supporting Medicaid expansion "because there are too many questions regarding the health care act's cost for businesses."

Corbett Shown No Signs Regarding Support For Medicaid Expansion.

The Pittsburgh Post-Gazette (2/4, Toland) questions if Pennsylvania Gov. Tom Corbett will become the fifth Republican governor, and the 23rd governor overall, to support expanding Medicaid. Corbett has so far, "shown no signs that he will, but neither has he suggested that he will slam the door completely this week, when he unveils his proposed budget. If Mr. Corbett intends to expand Medicaid

eligibility in 2014, he may account for it in his 2013-14 budget - or he may hold back and use the Medicaid expansion as a bargaining chit during budget negotiations."

South Dakota Ad Focuses On Healthcare For Native Americans.

The AP (2/3) reports that North Dakota's "Insurance Department and Indian Affairs Commission are combining on" a video "campaign on an exclusive Native American TV network to talk about health care benefits." The videos are "meant to encourage Native Americans to access Medicare and affordable prescription drug benefits, which are available regardless of income or whether people are receiving Indian Health Service assistance," according to state officials.

Public Health and Private Healthcare Systems

Health Insurers Complain About High Out-Of-Network Charges.

The Los Angeles Times (2/1, Terhune) reported in its "Money & Co" blog that a "national survey released Friday by America's Health Insurance Plans is part of the industry's effort to show that some medical providers are overcharging consumers and unnecessarily raising healthcare costs." The survey found that 12 percent of "all medical claims were for out-of-network in 2011." Medical providers often claim Medicare rates are too low, arguing "they shouldn't have to accept an insurance company's deeply discounted rates to become an in-network provider." However, critics accuse the insurers of "paying these excessive charges for out-of-network care and then passing along those increased costs in the form of higher premiums for employers and consumers."

Medscape (2/1, Lowes) also explained that private insurers "don't pay thousands" for a hospital or office visit because they "reimburse out-of-network physicians based on a fee schedule that might be slightly more generous than Medicare's." The AHIP explains in its report that "physicians can bill patients for the balance of a visit, a privilege not afforded to network physicians. They generally must accept the insurer's allowable charge - which may include a co-pay and co-insurance - as payment in full." The article also lists several examples of when health insurers paid steep out-of-network fees.

Massachusetts Insurers Restricting Use Of In-Lab Tests For Sleep Apnea.

The Boston Globe (2/2, Conaboy) reports, "Researchers have found that the cheaper and often more convenient home tests are about as good at detecting the breathing interruptions that characterize obstructive sleep apnea." Now, "Massachusetts insurance companies looking to clamp down on the booming field of sleep medicine have responded by restricting use of the in-lab tests, which run about $650 to $1,000, in favor of home testing at about one-third the cost." While "sleep medicine physicians say the change, which is likely to spread to other states, has occurred too quickly for them to adjust their business models and that insurers have taken it to an extreme, cutting some patients off from tests their doctors think they need," one recent report indicated that more home testing could lead to millions in savings for "New England's health care system."

New York Insurers To Participate In Healthcare Exchange.

The Business Review (2/1, Pinckney) reported, "New York has officially invited health insurers to participate in its health benefit exchange." While the ACA does not require insurers to participate in the exchanges, "Albany-based CDPHP, MVP Health Care of Schenectady and other area carriers have already said they plan to" participate. The Business Review adds that "about 1.1 million New Yorkers - 615,000 individuals and 450,000 employees of small businesses - are expected to enroll in the state exchange beginning this October." New York joins 16 other states in setting up its own exchange; the remaining 33 states are referring people to the national plan.

Minnesota Experimenting With New Medicaid Payment Model.

The Minneapolis-St. Paul (MN) Business Journal (2/1, Grayson, Subscription Publication) reported that "the state of Minnesota will test a new model for paying health providers who treat Medicaid patients, an initiative it said could save about $90 million over a three-year period." Under the new model, "the state will offer incentives to providers based on how well patients fare following treatment and other measurements, rather than on a fee-for-service basis. Both the state and the health providers will share in the cost savings." The approach is modeled after the CMS' accountable care organizations.

Survey Highlights Insurers' Willingness To Alter Physician Pay.

American Medical News (2/4, Tel Maat) reports that a survey conducted by HealthEdge "highlights how eager health insurers are to have physicians participate in new models of paying for care." The article says that "in a poll of 170 health insurance executives, 69% percent said their organization is planning to participate in or support accountable care organizations during the next three years," and

"sixty-six percent said their company would participate in pay-for-performance programs."

Friday's Lead Stories

- **White House Adviser Speaks Out Against Cutting Medicaid.**
- **Baldwin Extols ACA In Families USA Conference Speech.**
- **Insurers Beginning To Challenge Overbilling From Outpatient Centers.**