



Health Reform Update – Week of May 8, 2017

CONGRESS

House passes bill that would remove most ACA consumer protections

The House of Representatives passed an amended version of the *American Health Care Act (AHCA)* by one vote last week.

The measure (H.R. 1628) would eliminate funding for all ACA premium and cost-sharing subsidies and instead offer tax credits based on age instead of income, which are far more limited despite being more broadly available. In addition, it would phase-out Medicaid expansion funding and repeal the penalties for the individual and employer mandates while removing most of the law's new taxes on providers, insurers, drugmakers, and wealthy Americans.

The AHCA also would allow insurers to charge those age 50-64 five times more than younger consumers. While the Congressional Budget Office (CBO) acknowledged last March that this would lower premiums for younger groups, it warned that premiums would jump by roughly 66 percent for older consumers while their out-of-pocket costs would skyrocket by up to 750 percent. The non-partisan scorekeeper also predicted that the bill would slash coverage for up to 24 million Americans overall.

The adverse CBO score initially caused moderate Republicans to largely oppose the bill. However, the ultra-conservative Freedom Caucus also refused to support the first version, insisting that it was “Obamacare lite” and did not go far enough in repealing the ACA. As a result, the AHCA was pulled in March until additional amendments could garner sufficient support from both factions.

The most prominent amendment would let states seek federal waivers allowing them to opt-out of the mandated package of essential health benefits (EHB) and reduce premiums by resuming the sale of “skinny” or “junk” coverage. States could also again let insurers charge higher premiums based on health status for those whose coverage lapses by more than 62 days. (As under the initial bill, persons with coverage lapses would also face a 30 percent premium surcharge for one year.)

The *Wall Street Journal* also pointed to a little-noticed provision that would effectively allow large employers to default to the benefit standards of any state that opt-outs of ACA consumer protections, even if they are not located in the state.

In an effort to appeal to moderates, the amendments also boost the federal funding states can use to cover persons with pre-existing conditions through high-risk pools or reinsurance programs that compensate insurers for extraordinary claims (like those pursued in Alaska and Minnesota). The bill makes \$130 billion available over nine years with another \$8 billion over the first five for those subject to higher premiums based on health status.

In the end, the amendments garnered support from all but two conservatives and 70 percent of moderates. However, the AHCA faces a very different landscape in the Senate, where Democratic support would be required to advance any parts of the legislation that does not directly impact the budget deficit (see below).

The AHCA also faces broad opposition from nearly all provider and consumer groups (including AARP, the American Hospital Association, and the National Organization for Rare Disorders), as well as the nation's largest insurers like Blue Shield of California, whose CEO claimed it would allow for “unconscionable discrimination.” The American Medical Association (AMA) promptly warned that the



AHCA would “result in millions of Americans losing access to quality, affordable health insurance [while] those with pre-existing health conditions face the possibility of going back to the time when insurers could charge them premiums that made access to coverage out of the question.”

In addition to the bill’s failure to preserve the protection against health status discrimination (consistently the most popular provision of the ACA), critics largely focused on its reliance on high-risk pools to segregate patients with pre-existing conditions into separate marketplace. High-risk pools operated in 33 states prior to the ACA and never covered more than two percent of those eligible due to chronic underfunding. Studies from groups like the Kaiser Family Foundation, the Urban Institute, RAND Corporation, and the University of Chicago showed that high-risk pools would require \$30-50 billion per year to be adequately funded (or \$7-10,000 per enrollee), an amount that more than doubles the federal budget for the space program and is three times the amount allocated by the AHCA.

The House Rules Committee also passed an amendment to H.R. 1628 last week that would appropriate \$15 billion over eight years to create a federal reinsurance program, similar to the temporary reinsurance program under the ACA that Republican lawmakers refused to fund (see Update for Week of December 15, 2014). This Federal Invisible Risk Sharing Program would ultimately let states compensate individual market insurers who incur exceptional claims.

The revised AHCA still includes more than \$880 billion in cuts to Medicaid by converting it to a federal block-grant program (via per capita spending caps). This provision alone is responsible for most of the 24 million in coverage losses predicted by CBO.

Senate will draft their own ACA repeal and replace bill

Senate leaders confirmed last week that they will write their own legislation that would repeal and replace key provisions of the Affordable Care Act (ACA), regardless of the bill sent to them by the House.

The Senate will be forced to take a decidedly more deliberate approach than the House, which passed the *American Health Care Act (AHCA)* without public hearings or a Congressional Budget Office (CBO) estimate. None of the late AHCA amendments were part of the ACA repeal and replace legislation that the Senate passed in 2015, meaning that the Senate parliamentarian will first have to approve them for budget reconciliation in order for them to clear the chamber with a bare majority of 51 votes.

AHCA provisions that waive essential health benefit standards and allow insurers to again discriminate based on pre-existing conditions would typically not be expected to meet the reconciliation standard as they do not directly impact the budget deficit. As a result, they would require the support of Democrats to reach the 60 votes needed to break a filibuster. However, Senator John Cornyn (R-TX) made clear this week that Republican leaders will still try to repeal EHBs through reconciliation and Senator Ron Johnson (R-WI) insisted the entire ACA could be subject to reconciliation.

The parliamentarian cannot make her determinations until the new CBO score is issued the week of May 22nd. Meanwhile, Senate Republican working groups have been meeting behind closed doors to draft a version that can pass through reconciliation without losing more than two Senators, yet still satisfy both moderates and conservatives when the bill goes back to the House.

The delicate balancing act will hinge largely on whether Senators can compromise on the Medicaid expansion. At least seven Republicans already oppose the House plan to phase-out expansion funding starting next year, which would cause gaping budget gaps among expansion states (11 of whom are heading by Republican governors). Several others are staunchly against removing key ACA consumer protections, such as community rating which prevents premiums being raised based on medical history.



Even the AHCA's 30 percent one-year premium surcharge on those who have a lapse in coverage may not be part of the Senate bill. The American Academy of Actuaries found that the surcharge would actually be weaker than the ACA's individual mandate in terms of getting younger and healthier consumers into the risk pool and could dramatically depress Marketplace enrollment.

Tennessee Senators would let ACA subsidies be used to purchase non-Marketplace coverage

Senators Lamar Alexander (R-TN) and Bob Corker (R-TN) introduced legislation last month that would give individual consumers an additional option to the Affordable Care Act (ACA) Marketplace.

The uncertainty created by the potential ACA repeal (see above) has accelerated the already steady exodus of insurers from certain Marketplaces leaving 32 percent of counties only one insurer for 2018, including 16 counties around Knoxville, Tennessee (see below). This is likely to increase with Aetna's exit from four states this week (see below). The trend could spike further since insurers have only until June 21st to decide whether to participate next year and could also leave mid-year if Congress terminates the ACA's cost-sharing reductions (see below).

Under *The Health Care Options Act* (S.761), consumers eligible for premium and cost-sharing subsidies under the ACA could use them to purchase any state-approved plan on the private market if there are no insurers selling within their federally-facilitated Marketplace (FFM). The option would apply only to those in the 38 states defaulting to the FFM and remain in effect through 2019.

The measure would also waive individual mandate penalties under the ACA for consumers living in counties with zero FFM insurers.

According to the Center on Budget Policy and Priorities, S. 761 would "worsen the very problem it seeks to address" by encouraging insurers not to participate in the Marketplace. They note that the bill would specifically allow consumers with subsidies to purchase transitional plans that do not comply with the ACA's market reforms, benefit standards, or consumer protections (see Update for Week of February 27th), giving those insurers little incentive to become ACA compliant and enter the Marketplace in order to attract subsidy-eligible consumers.

Insurers nervous about Administration threat to end ACA cost-sharing subsidies

House Speaker Paul Ryan (R-WI) insisted late last month that the House will not drop its lawsuit seeking to prevent insurers from receiving cost-sharing reductions (CSRs) under the Affordable Care Act (ACA), even as House leaders including Ryan pledge to continue the subsidies through at least 2018.

A federal judge appointed by President George W. Bush had given House Republicans a temporary victory by ruling that the Obama Administration illegally continued to pay CSRs even after Congress refused to appropriate funds for them in 2014 (see Update for Week of May 16th). That decision was stayed pending the Obama Administration's appeal.

The Trump Administration has yet to decide whether to continue that appeal and asked the court for a delay until May 22nd (see Update for Week of February 27th). However, President Trump threatened twice in the past month to drop the appeal and immediately terminate the CSRs, a position that alarmed insurers seeking a resolution of the issue before deciding by June whether to participate in the Marketplaces for 2018.

At least four insurers have already withdrawn their participation for next year citing the uncertainty over CSRs (see below) and America's Health Insurance Plans (AHIP) made clear to Congress and the Administration this week that more would certainly follow. Florida Blue and Molina announced last month that it would "immediately" withdraw if the CSRs were not continued, while Anthem and Oscar Health Plan stated that a loss of CSRs would force them to promptly hike premiums by at least 20 percent.



The Centers for Medicare and Medicaid Services (CMS) also re-affirmed last week that Marketplace insurers have contingency provisions written into their contracts that would allow them to leave the Marketplaces at any point during the plan year if the CSRs are terminated.

The fiscal year 2017 spending bill passed by Congress included no CSR appropriations and the Office of Management and Budget Director indicated that they could be terminated by next month. However, Appropriations chair Tom Cole (R-OK), Ways and Means chair Greg Walden (R-OR), and other House leaders including Speaker Ryan have consistently promised since January that the budget bills would include CSR appropriations for both 2017 and 2018 (see Update for Week of January 9th).

Kaiser Family Foundation released an analysis last month showing the loss of CSRs would increase federal spending by \$31 billion over the next nine years and cause average premiums for benchmark silver plans (to which the subsidies are tied) to increase by at least 19 percent (in order to cover increased costs for insurers). The increase would be even higher (at least 21 percent) in the 19 states that have not expanded Medicaid and rise further (by 27 percent) in poorer states like Mississippi.

The CSRs are separate from the premium tax credits under the ACA and available only to those Marketplace consumers earning 100-250 percent of the poverty. Roughly 58 percent of Marketplace consumers received them for 2017.

Spending bill boosts NIH funding, postpones debate on spending cuts until October

President Trump signed a \$1 trillion omnibus spending bill this week that will fund the federal government through the September 30th end of the federal fiscal year.

The measure (H.R. 244) largely set spending levels within the discretionary caps set by the *Budget Control Act* (see Update for Week of August 1, 2011). However, nearly \$296 million in emergency relief allocated for Puerto Rico's Medicaid program was allowed to exceed these caps and increase the federal deficit (see below).

The bill reflected a rare bipartisan agreement to honor the funding levels set last year under the *21st Century Cures Act* that accelerated the approval of new drugs and boosted funding for the National Institutes of Health by \$2 billion over the next five months (see Update for Week of December 5th). The President had proposed to cut \$1.2 billion from the NIH budget for this fiscal year in addition to a 20 percent reduction (or \$5.8 billion) in fiscal 2018.

FEDERAL AGENCIES

Insurers receive greater flexibility under final market stabilization rule from CMS

The Centers for Medicare and Medicaid Services (CMS) finalized its first major regulations under the Trump Administration last month, which are intended to stabilize the individual and small group markets, including the Marketplaces created pursuant to the Affordable Care Act (ACA).

The rules largely mirror the agency's proposed regulation from February, which included a list of reforms sought by the insurance industry in an effort to boost the number of younger and healthier consumers in their risk pools. Public comments from insurers largely praised the changes as a "good first step" while they were opposed by consumer advocates who fear they would increase out-of-pocket costs.

The leading change cuts the open enrollment period for 2018 down to six weeks, so that it will now end on December 15th instead of January 31st. (This change was set to occur in 2019 and subsequent years.)



However, the rules attempt to limit eligibility for special enrollment periods (SEPs) by heightening documentation requirements that the Obama Administration first put into place last year (see Update for Weeks of February 8 and 15, 2016). This includes increasing pre-enrollment verification for all federally-facilitated Marketplaces (FFMs) from 50 percent to 100 percent of all new subscribers. These will be phased-in and focus initially on the most frequently used SEPs for loss of essential coverage, marriage, new dependents, and permanent changes of residence. (These new requirements can voluntarily be added by state-based Marketplaces).

In response to complaints from insurers, CMS will also now require individual and small group consumers who owe premiums from previous years to pay them in full before enrolling in new coverage.

The agency will also now let FFM states decide whether provider networks are too narrow, so long as the state has “a sufficient network adequacy review process...with the authority that is at least equal to the ‘reasonable access’ standard defined in [CMS regulation]. For states without the means to assess network adequacy, CMS will rely on an issuer’s accreditation (commercial or Medicaid) from an HHS-recognized accrediting entity.

The most controversial change will give insurers more flexibility in defining and meeting the actuarial value (AV) standards that the ACA sets for each metal tier. For example, silver plans must cover 70 percent of total average costs for covered benefits, though the actual figure could vary by plus or minus two percent (i.e. 68-72 percent). Under the final rule, insurers could come in four percent under the AV value, so that a silver plan only had to cover 66-72 percent. Because the consumer’s share of costs increases as the insurer’s goes down, consumer groups largely opposed this provision.

The final rules also codify CMS’ earlier decision to extend the plan filing deadline for 2018 by six weeks, giving insurers until June 21st to decide whether to participate in the Marketplaces.

Although insurers largely praised the final rule, America’s Health Insurance Plans warned that it did not go far enough to provide insurers with adequate certainty for 2018, causing several to already withdraw (see below). Kaiser Permanente and other insurers also expressed concern that the shorter enrollment window would depress participation, noting that nearly 71 percent of FFM consumers earn less than 250 percent of poverty and tend to have the most difficulty affording coverage during November and December. In addition, at least half of FFM consumers receive enrollment assistance from insurance brokers, who are more focused on helping more lucrative Medicare managed care consumers whose enrollment period from October 15th-December 7th will now overlap with most of the Marketplace period.

Enrollment consultants also predicted that the final rule will do little to stop insurers from exiting the Marketplaces, as it does not address their two greatest sources of uncertainty about whether the Administration will enforce the individual mandate and/or continue the ACA’s cost-sharing subsidies (see below). The Administration has already decided to allow tax filers not to voluntarily report whether they were uninsured during the year (see Update for Week of February 27th) and the President has repeatedly threatened last week to terminate the subsidies (see above).

HHS Secretary encourages states to create high-risk pools, reinsurance programs

The new Secretary of the Department of Health and Human Services (HHS) issued a letter last month to governors that “invite[s] states to pursue waiver proposals that include high-risk pool/state-operated reinsurance programs” to accommodate Marketplace enrollees with high-cost conditions.

The letter specifically refers to the Section 1332 State Innovation Waivers created by the Affordable Care Act (ACA) that allow states to experiment with non-ACA reforms so long as they cover a comparable number of residents without increasing the federal deficit. States are eligible for pass-through funding if the reforms reduce federal spending for ACA premium and cost-sharing subsidies.



The ACA allowed such waivers starting January 1st and Hawaii promptly received approval to drop the ACA requirement to operate a small-group Marketplace (see Update for Week of January 9th). However, the letter from Secretary Tom Price specifically refers to Alaska's Section 1332 application to create a state-operated reinsurance program so that Marketplace insurers can continue to be compensated for extraordinary claims following the expiration of the ACA's reinsurance program in 2016, noting that it is projected to significantly mitigate premiums (see Update for Week of December 5th).

Federal court dismisses second of two dozen lawsuits to force ACA risk corridor payments

The U.S. Court of Federal Claims has dismissed the latest lawsuit brought by an insurer seeking risk corridor payments due under the Affordable Care Act (ACA).

The court ruled that the suit from Blue Cross and Blue Shield of North Carolina (BCBSNC) was premature. BCBSNC was demanding payment for the \$147 million it was due for extraordinary claims incurred in 2014, that caused losses to exceed pre-set targets. The Centers for Medicare and Medicaid Services (CMS) has been able to pay only 12.6 percent of amounts due for 2014 due to a \$2.5 billion shortfall in revenue collections (see Update for Week of September 28, 2015). However, the court followed an earlier decision in the same court that held that CMS was not obligated to fill the shortfall until payment calculations were completed for the final year of the program, which will occur later this year (see Update for Week of December 5th).

Nearly two dozen insurers have filed similar lawsuits. Only a handful have been heard, with a single ruling obtained in favor of the insurer. That decision required CMS to make risk corridor payments to Moda Health (the dominant insurer in Oregon's Marketplace) for each year that they are due, which could potentially complicate Congressional efforts to repeal and replace the ACA since eliminating the law's tax revenues could prevent CMS from being able to pay the billions that are outstanding (see Update for Week of February 27th).

STATES

S&P says ACA Marketplaces are stabilizing and not in a "death spiral" despite defections

Standard and Poor's (S&P) released a new analysis last week showing that the financial performance of individual health insurance plans sold last year in Affordable Care Act (ACA) Marketplaces significantly improved from 2015.

Researchers caution that the findings do not mean the Marketplaces are on "stable footing", but stressed that they are also not in the "death spiral" claimed by proponents of an ACA repeal. It actually credited significant premium increases for minimizing the number of financial losses among plans and correcting the mistakes for those that greatly underpriced their products during the initial years.

S&P reiterated earlier projections that the ACA Marketplaces will take five years to stabilize (2017 is year four.) It concluded that "after starting on the wrong foot in 2014, and deteriorating further in 2015, we are seeing the first signs in 2016 that this market could be manageable for most health insurers."

The study focused on the average medical loss ratio (MLR) for Blue Cross and Blue Shield (BCBS) plans, which are the leading insurer in most Marketplaces. MLRs for these plans fell from 106 percent in 2015 (when claims costs outpaced premium collections) to 92 percent in 2016. Florida Blue has the lowest MLR at 75 percent, down from 90 percent in 2015.



Despite the improvement, the uncertainty over if and how Congress will repeal and replace the ACA has caused several high-profile exits in recent weeks. Aetna, which pulled out of 11 of its 15 Marketplaces last year (see Update for Week of August 15th) is withdrawing from the Delaware, Iowa (see below), Nebraska, and Virginia Marketplaces for 2018. The move leaves the first three essentially with only one participating insurer and makes Aetna only the second major insurer besides Humana to withdraw from all Marketplaces next year (see Update for Week of February 27th).

Anthem Inc. suggested last week that it may also exit all of the 144 rating regions in which it currently participates, due to the uncertainty over ACA repeal (see above). Anthem sells coverage under the BCBS brand in 14 states and its departure could leave consumers in parts of Colorado, Kentucky, Missouri and Ohio with no Marketplace insurers for 2018. The insurer lost more than \$374 million on individual health plans last year but is actually projecting a modest profit for 2017.

However, other leading insurers including Kaiser Permanente insisted they would remain in the Marketplaces for 2018 despite the instability created by the threat of repeal. Blue Cross and Blue Shield of Tennessee also agreed to return to 16 Knoxville-area counties that were left with no participating insurers after Humana's exit (see Update for Week of February 27th), but warned that premiums may be dramatically higher due to the "potential negative effects of legislative and/or regulatory changes."

Early rate filings show dramatic premium hikes are resulting from ACA uncertainty

Preliminary rate filings in at least three states revealed this week that Marketplace consumers may face another round of steep premium hikes due to the uncertainty over if and how Congress will repeal the Affordable Care Act (ACA).

The Council of Economic Advisers expected premiums to stabilize next year following a "one-time correction" in 2017 that resulted from the end of the ACA's risk corridor and reinsurance program (see Update for Week of January 9th). That three-year program provided additional payments for insurers with extraordinary claims and its expiration and the \$2.5 billion shortfall in payments for 2014 forced numerous insurers out of the Marketplaces and increased premiums by an average of more than 20 percent (see Update for Week of December 5th).

According to Center for Medicare and Medicaid Services (CMS) actuary, Marketplace premiums were expected to increase by an average of 7.2 percent next year. Insurers such as Kaiser Permanente concurred, projecting "single-digit" increases if the ACA were left alone.

However, insurers filing proposed premiums in Connecticut, the District of Columbia, Maryland, and Virginia have sought premium increases of 24-45 percent on average, with 15-40 percent of those hikes attributable directly to the uncertain regulatory climate surrounding the ACA. CareFirst Blue Cross and Blue Shield specifically blamed a "lack of clarity" about whether the individual mandate under the ACA will be enforced for a "significant" proportion of their average rate hike of more than 50 percent in Maryland, 35 percent in Virginia, and 29 percent in DC. The insurer pointed out that non-enforcement would "drive up the cost for everyone else" as "healthier, younger individuals will drop coverage."

The Internal Revenue Service (IRS) acknowledged earlier this year that it was no longer rejecting tax returns from filers who fail to report whether they were insured during the tax year, a move that analysts feared was a pre-text to dropping enforcement altogether (see Update for Week of February 27th). However, the agency claimed last week that it was continuing to impose tax penalties on 2016 filers who did not purchase coverage they could afford.

An even greater concern to insurers is the President's threat again this week to terminate the cost-sharing reductions (CSRs) under the ACA at any moment (see above). Insurers can exit



Marketplaces or increase rates mid-year if CSRs are eliminated and several including Anthem have indicated that at a minimum they would immediately hike rates by at least 20 percent to offset the loss.

Anthem did request an average rate hike of 34 percent for the Connecticut Marketplace, compared to the 15 percent average increase sought by their only competitor CTCare.

The uncertainty has led the California Insurance Commissioner David Jones (D) to direct insurers to submit two different rate filings for 2018. One would be “Trump rates” that assume major changes to the ACA and the other would be “ACA rates” that assume no changes.

The Center for American Progress projects average premiums will increase 34 percent (to \$7,572 per year) if the Administration stops issuing CSRs and enforcing the individual mandate—two changes it can make without Congressional action.

Arkansas

Republican lawmakers dramatically scale-back popular Medicaid expansion program

Governor Asa Hutchinson (R) signed legislation last week approving major limitations on the Arkansas Works program that expanded Medicaid to more than 320,000 Arkansans.

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

However, the bill signed by Governor Hutchinson (S.B. 3) goes even further by lowering eligibility for Arkansas Works from the ACA threshold at 138 percent of poverty down to 100 percent. The Department of Human Services acknowledges that this change will eliminate Medicaid for more than 60,000 enrollees that were made newly-eligible, while saving Arkansas up to \$93 million over eight years. S.B. 3 also establishes the work requirement previously sought by the Governor, which would force “able-bodied” adults age 19-49 to work at least 20 hours per week (or 80 per month) or participate in job training programs.

Because Arkansas Works is operated under a federal waiver, the Trump Administration must sign-off on the changes once they are formally submitted in June. The Obama Administration has consistently rejected partial expansions and work requirements that other conservative-led states have proposed as part of their Medicaid expansion alternatives (see Update for Week of November 30, 2015). However, the new Secretary for the U.S. Department of Health and Human Services has signaled a new willingness to consider both elements (see above).

California

Committee amends bill that would have banned patient assistance for prescription drugs

The Assembly Appropriations Committee amended legislation this week that would prohibit drug manufacturers from offering discounts or other reductions in an individual’s insurance cost-sharing expenses (including product vouchers or copay coupons) if a lower-cost brand or generic drug is covered under the individual’s health plan on a lower cost-sharing tier that is designated to be therapeutically equivalent by the Food and Drug Administration (FDA).

Groups like the Alliance for Patient Access and Patient Services, Inc. strongly objected to initial versions of A.B. 265 that appeared to broadly limit third-party premium assistance for all prescription



drugs. The amended version of A.B. 265 now specifically states that the “Prescription Discount Drug Prohibition. shall not prohibit or limit assistance to a patient provided by an independent charity patient assistance program...without regard to the pharmaceutical manufacturer’s interest and without regard to the beneficiary’s choice of product, provider, practitioner, supplier, or insurance plan.” PSI and other independent bona-fide charities operate under such a model that was established by the Office of Inspector General (OIG) for the U.S. Department of Health and Human Services (HHS).

The amended bill also specifically exempts single table drug regimens for HIV-AIDS from the drug discount prohibition, as well as drug rebates received by state agencies.

The sponsor of A.B 265, Assemblyman Jim Wood (D), cites a *Los Angeles Times* article last December as the basis for his bill. That article referred to studies from Harvard University, Northwestern University, and the University of California-Los Angeles as evidence that drug manufacturer coupons “propelled companies to charge ‘the highest price possible’” as spending for 23 popular medications for which coupons were offered were up to \$2.7B higher than if the coupons had not been used. However, a Stanford study in 2015 found that patient out-of-pocket costs did not change when Massachusetts lifted their ban on drug coupons (though the number of prescriptions did jump by 16 percent.)

Similar discount prohibitions have shown up in a measure carried over from last year in the New Jersey Senate (S.2769), as well as one introduced earlier this session in the New Hampshire House (H.B. 443) (see Update for Week of January 9th).

At least 25 states and Puerto Rico have introduced drug cost transparency bills this session (see below) and most would require manufacturers report on their use of drug coupons. Such coupons are now offered for nearly half of all brand name drugs after the HHS OIG relaxed kickback restrictions on their use in 2012. However, Medicare and Medicaid still prohibit them.

Colorado

Governor signs health care price transparency measure into law

Governor John Hickenlooper (D) signed S.B. 65 into law last month, requiring certain health care providers to make a single document available to the public listing the direct pay prices for their most common health care services, as well as the approximate cost-sharing responsibility.

The *Transparency in Health Care Price Act* applies only to those payments made directly rather than by a third party. It was sponsored by Assistant Majority Leader Kevin Lundberg (R). It does not mandate disclosure of pricing to any government agency.

Senate kills premium relief bill for those earning above threshold for ACA subsidies

A Senate committee appears to have blocked a House-passed bill that sought to create a temporary financial assistance program for Connect for Health Colorado consumers who earn too much to qualify for premium subsidies under the Affordable Care Act (ACA).

Under H.B. 1235, relief would have been limited to those earning 400-500 percent of poverty, for whom the cost of individual plan premiums exceeds 15 percent of their household income. The individual or family must also be ineligible for coverage under federal or state health care programs (such as Medicare or Medicaid), as well as affordable employer-sponsored coverage. Relief would have been available only through December 31, 2018 and was to be equal to the cost of the least expensive bronze plan available through the Marketplace, less the amount equal to 15 percent of household income.

The bill planned to allocate \$5.7 million in state funds for Connect for Health Colorado to provide the temporary relief. It would be immediately terminated if Congress repeals the premium tax credits provided under the ACA (see above).



The measure passed the Democratically-controlled House with the support of five Republicans. However, the Senate is narrowly under Republican control and the Committee on State, Veterans, and Military Affairs committee to which it was immediately assigned promptly tabled the bill indefinitely.

Florida

Feds let Florida continue Low Income Pool in place of Medicaid expansion

Governor Rick Scott (R) announced this week that the U.S. Department of Health and Human Services has agreed to dramatically increase funding for Florida's Low Income Pool (LIP).

Florida has operated the LIP under a federal Section 1115 demonstration waiver since 2006. It was created by former Governor Jeb Bush (R) in an effort to provide supplemental uncompensated care funding for safety net hospitals during Florida's transition to full Medicaid managed care.

However, the Obama Administration had refused to approve an extension of the waiver beyond 2015 unless Florida agreed to participate in the Medicaid expansion under the Affordable Care Act (ACA), a move that would have caused Florida to immediately lose \$1 billion in federal funding (see Update for Weeks of June 8 and 15, 2015). Governor Scott filed a lawsuit against HHS for seeking to unlawfully coerce the state to expand Medicaid in a manner that the U.S. Supreme Court prohibited.

The suit was dropped after HHS agreed to phase-out the termination by providing Florida \$1 billion through June 2016 and \$600 million through June 2017 (see Update for Week of June 22, 2015), but the Obama Administration barred the state from using the funds to provide charity care for the nearly 900,000 uninsured Floridians caught in the "coverage gap" between current Medicaid eligibility and the threshold for ACA premium tax credits. It argued that it was inefficient to compensate Florida for this group when the ACA had already earmarked \$51 billion over ten years for the expansion population.

According to Governor Scott, the Trump Administration has agreed extend the LIP waiver and provide Florida with nearly \$1.5 billion in additional funding, as well as remove the restrictions on its use. The funds enabled Republican leaders to follow through with \$521 million in hospital spending cuts in the fiscal year 2018 budget that was finalized before the legislative session ended this week.

House refuses to consider bill to prevent midyear increases in drug cost-sharing or formularies

A measure that would prevent health insurers from increasing prescription drug cost-sharing or removing formulary drugs during the middle of a plan year died in the House this week despite being unanimously passed by the Senate.

Currently, there is no state law in Florida that stops health insurers from making mid-year formulary or cost-sharing changes, which can cause great disruption for patients. As a result, consumer groups like The AIDS Institute and Patient Services Inc. had strongly backed the "bait and switch" bill.

At least six other states (including California and Texas) have already enacted similar protections. The Nevada Assembly passed its own version last month (A.B. 381), which is currently being considered in their Senate. Comparable bills failed to advance in Maryland but remain pending in Connecticut.

House seeks to impose premiums and work requirements on existing Medicaid population

The House failed to act this week on controversial legislation that would have required "able-bodied" Medicaid enrollees to prove they are employed, actively seeking work, or enrolled in a job-training program, or be locked out of coverage for one year.



According to legislative staff, the requirements would have applied to roughly 385,000 enrollees (while exempting the disabled, children, and those in long-term care). However, the analysis acknowledged that "an indeterminate number of enrollees may be dis-enrolled" due to the requirements, leading to "an increase in hospital charity care."

Initial proposals to impose \$10-15 monthly premiums/copays were stripped from the broader House-passed Medicaid managed care bill (H.B. 7117). However, it still would impose a one-year lockout on those enrollees that failed to meet with the work requirement within a 60-day grace period.

The requirements, which were proposed by Health and Human Services chair Travis Cummings (R), are also being considered in other conservative-led states like Wisconsin. However, even if enacted, they would require federal waivers. The Obama Administration had consistently rejected proposals to impose work requirements or lock-out periods on Medicaid enrollees, as well as premiums on those earning below the federal poverty level. However the new Secretary for the U.S. Department of Health and Human Services has already signaled that the Trump Administration is likely to allow for "reasonable [and] enforceable" premiums, as well as "innovations that build on the human dignity that comes with training, employment and independence" (see above).

Democratic opponents of the requirements, such as Rep. Lori Berman (D), insist that they are so "onerous" that they would "make it more difficult to escape poverty", noting that Florida already has one of the most restrictive Medicaid programs in the nation. The director of the Georgetown Center for Children and Families went even further, stating that "this bill...is one of the worst pieces of legislation I've seen in a long time", noting that premiums or copayments of even \$5-10 per month on those below poverty were sufficient to cause mass disenrollment of Medicaid enrollees in states like Oregon. As a result, they could cost the state money long-term as the disenrolled turn to emergency rooms for uncompensated care.

Iowa

Aetna and Wellmark abandon Marketplace due to ACA repeal uncertainty

Aetna announced late last month that they will withdraw next year from the Affordable Care Act (ACA) Marketplace that the federal government operates in Iowa, following the decision by dominant carrier Wellmark Blue Cross and Blue Shield to pull out of the individual market entirely.

Both plans blamed "financial risk and an uncertain outlook" created by uncertainty over if and how Congress will repeal and replace the ACA (see above) for their decision not to participate in 2018. They specifically wanted clarity regarding the availability of federal cost-sharing subsidies, which could be terminated at any time if the Trump Administration drops the Obama Administration's appeal of a lower court ruling invalidating them (see above).

Wellmark, which only started offering Iowa Marketplace plans in 2017, claims it lost \$90 million in three years on ACA-compliant plans for Iowa and South Dakota and pulled out of the individual market for South Dakota earlier this year. (It never participated in their Marketplace.) Despite its individual market dominance, it offered only narrow network Marketplace plans in 40 of Iowa's 99 counties.

Their withdrawal leaves the Iowa Marketplace with only two participating insurers, Medica and Gundersen. However, Gundersen operates only in four counties, leaving Medica as the only statewide insurer. The remaining two plans have until June 21st to decide whether to likewise withdraw and Medica strongly hinted this week that it would not participate without help from state or federal officials.

UnitedHealthcare previously withdrew from the Iowa Marketplace at the end of 2016 (see Update for Week of April 18, 2016). It had offered coverage for 71 of the state's 99 counties and their departure had forced Wellmark to seek (and receive) a 42.6 percent average rate hike for their bronze and silver plans selected by 2017 Marketplace enrollees.



Kansas

Legislature fails to override Governor's veto of Medicaid expansion legislation

The House fell three votes short last month of making Kansas the 32nd state to participate in the Medicaid expansion under the Affordable Care Act (ACA).

A rash of rural hospital closures (with 31 other hospitals on the brink of collapse) created momentum for the Medicaid expansion plan backed by the Kansas Hospital Association (KHA) and election losses by key expansion opponents last fall paved the way for the bill to pass both chambers by sizeable margins, even in a Republican-dominated legislature (see Update for Week of January 30th). Only five of 165 stakeholders testifying at committee hearings opposed the measure (see Update for Week of February 27th).

However, the most conservative members of the legislature ultimately sided with Governor Sam Brownback (R), who insisted that the expansion would impose “unrestrainable” costs on a state facing a \$1 billion budget shortfall and complained that the bill no longer included the work requirement sought by other conservative-leaning states (see above). Brownback remains very unpopular among his own party for tax and spending cuts that are largely blamed for the shortfall and expansion proponents pledged to renew their efforts next session during a year in which he is up for re-election, citing the likely closures of several hospitals in the coming months including St. Francis Health in Topeka, whose uncompensated care costs have more than doubled since 2012.

Maine

Medicaid seeks unprecedented premiums, cost-sharing, and work requirements

The Department of Health and Human Services released its draft Section 1115 waiver application for public comment on April 25th, which seek to impose premiums on the lowest-income Medicaid enrollees, lock-out those who fail to pay, penalize those who miss physician appointments, and require all “able-bodied” adults to be working or attaining education for an average of at least 20 hours per week.

The dramatic changes would require the Trump Administration’s approval of a five-year waiver and are similar though somewhat more extreme than those already been sought by Wisconsin and debated in Florida (see above), all of whom have not expanded Medicaid under the Affordable Care Act. However, they seek changes that the Centers for Medicare and Medicaid Services has never allowed.

Maine’s waiver specifically seeks to waive current federal caps on premiums and cost-sharing for Medicaid enrollees. It wants to charge those earning less than 150 percent of poverty premiums that can exceed two percent of household income and lock-out those below 100 percent who fail to pay premiums on time. Under their proposal, premiums could climb all the way to \$66 per month for those at or above 200 percent. In addition, emergency room cost-sharing could exceed five percent of income.

Maryland

Legislature passes bill to prohibit price-gouging for essential generic drugs

The General Assembly sent a measure to the desk of Governor Hogan (R) last month that would make Maryland the first state in the nation to prohibit price-gouging for prescription drugs.

The Governor has yet to indicate whether he will sign H.B. 631, although it passed both chambers with only a handful of dissenting votes. The measure would apply to sales of essential off-patent or generic drugs and give the Attorney General authority to demand that generic manufacturers or wholesale distributors produce documentation proving that an increase in price is not “unconscionable”.

Under the bill, “essential” drugs are those designated by the Department of Health and Mental Hygiene or found under the Model List of Essential Medicines published by the World Health



Organization. “Unconsonable” is defined as an increase not justified by the cost of producing or expanding access to the drug, or an increase that results in consumers having no meaningful choice about whether to purchase the drug.

H.B. 631 specifically requires the Medicaid program to notify the Attorney General of any increase in an essential off-patient generic drug 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.

The measure was actually “watered down” after industry lobbyists complained that it went much further than the drug transparency law enacted last year in Vermont (see Update for Week of June 20th). That law (Act 65) required the state to identify up to 15 prescription drugs for which the WAC has increased by 50 percent or more over the past five years and 15 percent or more over the past year. The first report mandated by the law found that of the more than 87,000 drugs evaluated, nearly 9.5 percent had price increase of 50 percent or more over the past five years and more than 4.5 percent increased by at least 15 percent over the past year.

At least 20 state attorneys general (including Maryland) have already filed suit against six drugmakers alleging price-fixing schemes to artificially inflate prices for generic drugs. Both Connecticut and Rhode Island considered similar price gouging measures this session, while 25 state legislatures including Colorado (see below), Florida (where a measure passed both chambers), and New York are considering legislation this session that would impose new drug pricing transparency requirements.

Minnesota

Governor allows individual market reinsurance program to become law

Governor Mark Dayton (D) allowed H.F. 5 to become law last month without his signature, effectively creating a state reinsurance program for individual market insurers with extraordinary costs.

The Minnesota Premium Security Plan (MPSP) was narrowly-passed by Republican lawmakers, who control both the House and Senate. Although the Governor had proposed and backed the creation of such a program in order to mitigate premium increase for 2017 that averaged nearly 59 percent (see Update for Week of January 9th), he opposed the decision by Republican lawmakers to fund the \$542 million costs (over fiscal 2018 and 2019) from the existing Health Care Access Fund and other state accounts instead of through a new assessment on providers. However, the Governor was able to secure a 30 percent federal match from the Trump Administration and did not want to veto the bill.

H.F. 5 requires the Minnesota Comprehensive Health Association to determine the payment parameters for the program, but sets the claims threshold for receiving payments at \$50,000 and a cap on payments at \$250,000.

Minnesota becomes the second state after Alaska to create their own reinsurance program following the expiration last December 31st of the three-year risk corridor and reinsurance program under the Affordable Care Act (ACA) (see Update for Week of December 5th). The new secretary of the U.S. Department of Health and Human Services has urged other states to follow their approach, citing Alaska’s success in reducing 2017 premium increases from 42 to seven percent (see above).

Governor Dayton previously signed temporary premium rebates into law for this year (see Update for Week of January 30th). That measure (S.F. 1) had wide bipartisan support and successfully encourage Medica to return to the Marketplace. However, H.F. 5 faced significant opposition from Democratic lawmakers who favored a public option for Marketplace consumers, similar to the model that was stripped out of early versions of the ACA. Democrats also opposed giving insurers a \$542 million “subsidy” without any assurances that the funds would be used to cut premiums or out-of-pocket costs.



Nevada

Democrats, patient advocates renew legislation to prohibit surprise medical bills

Democratic leaders and patient advocates renewed efforts this session to limit surprise bills for out-of-network charges incurred at in-network facilities.

Similar measures have already been enacted in several other states including California, Florida, and New York (see Update for Week of October 31st) and are being debated this session in many others including Connecticut, Georgia and Montana (see Update for Week of February 27th). However, current Governor Brian Sandoval (R) has already vetoed the previous effort by lawmakers to limit surprise medical bills, stating in 2011 that dictating the prices consumers could be charged in such situations would improperly interfere in the contracts that hospitals negotiate with insurers.

The current measure (A.B. 382) sponsored by Assemblywoman Maggie Carlton (D) would cap out-of-network costs at that of the average contract agreement or 125 percent of the average Medicare reimbursement rate for the same services in the region of the facility where treatment is provided. Hospital association lobbyists indicated last week that hospitals would support legislation that does not cap out-of-network costs at or below their contractual prices.

The governor's office did not immediately oppose the measure, noting that health insurance market has greatly changed in Nevada since his 2011 veto due to the Medicaid expansion (enacted by Sandoval) and other provisions of the Affordable Care Act. As a result, his office suggested that he would "wait to weigh in until the Legislature has thoroughly debated and vetted the issue."

A.B. 382 passed the Health committee last month and is currently pending in Ways and Means.

North Carolina

Four Republicans sponsor Medicaid expansion alternative

Four House Republicans sponsored legislation last month that would make North Carolina the 32nd state to participate in the Medicaid expansion under the Affordable Care Act (ACA).

The measure (H.B. 662) is the first expansion initiative to be backed by Republicans and would follow the alternative model federally-approved two years ago for Indiana (see Update for Weeks of January 26 and February 2, 2015), in which those made newly-eligible would be required to pay premiums (of up to two percent of income) and be "engaged in activities that promote employment."

The lead sponsor of the Carolina Care plan, Rep. Donny Lambeth, is a former hospital administrator. Two other sponsors, Reps. Greg Murphy and Donna White, are a physician and nurse. They insisted that the measure made pragmatic sense because it would save North Carolina more than \$45 million per year in traditional Medicaid expenses.

However, the bill met immediate resistance from Republican leaders in both chambers who have blocked all Democratic efforts to expand Medicaid, including the temporary injunction they were granted against efforts by new Governor Roy Cooper (D) to enact a traditional Medicaid expansion through his executive authority (see Update for Week of January 30th). The General Assembly enacted legislation in 2013 that they insist prohibits the governor from expanding Medicaid without legislative approval.

House Speaker Tim Moore (R) remains opposed to any form of Medicaid expansion, insisting that the "best thing to do for the working poor is to continue to grow the economy." He also noted that the bill sponsors have yet to get the support of the North Carolina Hospital Association for the hospital assessment that would largely fund the state share of costs under the expansion.



Ohio

House Republicans abandon plans to freeze Medicaid expansion enrollment

Republican House leaders rebuffed efforts by the most conservative members to freeze enrollment in the Medicaid expansion under the Affordable Care Act (ACA) but not before agreeing to increase legislative control over expansion expenditures, adding work requirements, and erasing the word “expansion” from the approved two-year budget plan.

House Finance Committee chair Ryan Smith (R) objected to the proposed freeze on new enrollees, arguing that it would quickly be challenged in court “because we’d be treating the same class of people differently.” However, Republicans in control of the House did require approval from the state Controlling Board before any new expenditures can be issued.

Governor John Kasich (R) made the controversial decision to participate in the ACA Medicaid expansion without legislative approval (see Update for Week of October 21, 2013). He instead relied upon the approval of the Controlling Board while session was out, which are a bipartisan group of lawmakers headed by a gubernatorial appointee.

Conservative lawmakers remain angered over the decision and have continued to seek changes to scale back the expansion, which covers roughly 715,000 Ohioans. Even though 43 percent of this group are working poor, conservatives succeeded in making Board approval for new expenditures contingent on the Trump Administration letting Ohio impose premiums and work requirements for the expansion population. Similar requirements have been proposed in Arkansas (see above), Maine (see above), and Wisconsin after the Trump Administration signaled that they would be more receptive to them than the Obama Administration (see above).

The budget also directs the Joint Medicaid Oversight Committee to study whether Ohio should segregate the most costly individual market consumers into a high-risk pool, if Congress passes legislation making federal funds available for that purpose (see above).

Oklahoma

Health department seeks federal waiver from several ACA requirements

The state Department of Health and Human Services proposed last month to make Oklahoma only the second state to receive a federal Section 1332 waiver allowing it to opt-out of key provisions of the Affordable Care Act (ACA).

Starting in 2017, the ACA allows state to experiment with their own alternatives to the ACA so long as they cover a comparable number of residents at the same or lower cost. Hawaii received the first Section 1332 waiver earlier this year (see Update for Week of February 27th).

The centerpiece of the draft recommendations would make Oklahoma only the second Republican-controlled state (after Idaho) to shift from the federally-facilitated Marketplace to a state-based model. Starting with the 2019 plan year, Insure Oklahoma would operate the web portal for Marketplace consumers (instead of www.healthcare.gov), much as it already does for those covered under the state-subsidized program for low-income residents.

The waiver would also allow state officials to assume regulatory control in 2018 for approving or modifying premiums sought by individual and small group premiums. Oklahoma had remained one of only a handful of states still defaulting to the federal government for rate review.

Another provision would end the ACA’s metal tier designations for plans (bronze, silver, etc.) and replace it with two standardized benefit designs. The first would be a “robust” traditional plan while the alternative would be a high-deductible health plan that works in conjunction with health savings accounts.



However, state officials are seeking approval to “re-evaluate and reduce” the scope of essential health benefits that plans must cover under the ACA, leaving the definition of “robust” very unclear.

The Secretary is also seeking approval to let insurers vary premiums for older consumers by 500 percent instead of the 300 percent limit under the ACA—the same change included by Congress in the American Health Care Act (see above). Oklahoma would base premium subsidies on age as well as income, so that older consumers presumably would receive a higher level of assistance. However, eligibility would also be shifted down to those earning 0-300 percent of the federal poverty level (instead of 100-400 percent under the ACA).

The waiver proposal notes that nearly 40 percent of Oklahoma’s uninsured population earns less than 100 percent of FPL and currently cannot access the ACA subsidies. However, the waiver makes no mention of the fact that Oklahoma is one of 19 states who have refused to expand Medicaid for this population and does not propose any changes to Medicaid eligibility.

Oregon

New bills seek to extend Medicaid coverage to undocumented children

House and Senate bills that would extend Medicaid coverage to undocumented children under age 19 have passed their respective health care committees with little opposition.

The “Cover All Kids” initiatives would allow roughly 17,600 undocumented children from families earning up to 300 percent of the federal poverty level (or about \$73,000 for a family of four) enroll in the Oregon Health Plan at a cost of \$55 million over the next two-year budget cycle that starts July 1st. It would not apply to undocumented adults in the same household.

The bills have broad support from Governor Kate Brown (D) and House Speaker Tina Kotek (D), as well as several Republicans (including Rep. John Huffman) and hospital and provider associations. Similar policies are already in effect in California, Illinois, Massachusetts, New York, and Washington.

However, passage is far from certain given the state’s \$1.8 billion budget gap. Oregon must pay the entire share of Medicaid costs for undocumented individuals compared to only a share of the costs for the other one million Medicaid enrollees. Supporters stress that covering undocumented children would actually save money in the long-term as they are able to access preventive health care.

Despite being considered a progressive-leaning state, Oregon voters have also largely resisted policies favoring undocumented immigrants. A 2014 ballot referendum that would have granted them short-term driving licenses failed by a 2-to-1 margin. As a result, both bills (S. 558 and H.B. 2726) contain “emergency clauses” making them effective upon enactment and barring any referral to voters.

Health committee approves bill that would require rebates for high drug costs

The House Health Care Committee passed legislation by one vote last month that would require drug manufacturers to issue rebates insurers whenever the cost of a prescription drug exceeds a specified threshold.

The rebates would be governed by a new Oregon Premium Protection Program created in the Department of Consumer and Business Services. The measure (H.B. 2387) also would require manufacturers to provide a 60-day advance notice whenever prescription drug cost increases exceed 3.4 percent over a 12-month period.

Puerto Rico

Federal “bailout” of Medicaid program not enough to prevent bankruptcy



The fiscal year 2017 omnibus spending bill passed last week by Congress (see above) provides Puerto Rico with nearly \$296 million in immediate relief for their collapsing Medicaid program.

A massive fiscal crisis put Puerto Rico \$70 billion into debt and forced it to file last week for the only type of bankruptcy allowed under federal law applying to territories. With a 45 percent poverty rate and unemployment running double the U.S. average, the entire public health system is nearly insolvent.

The crisis caused a mass emigration that decimated the territory's population and dramatically limited the number of doctors and medical providers available to those who remained. However, it is the expiration of the one-time pool of money provided to U.S. territories under the Affordable Care Act (ACA) at the end of 2017 that threatens to push Puerto Rico into an even deeper crisis as it would no longer be able to fund its \$2.76 billion Medicaid budget. This Medicaid "cliff" could force Puerto Rico to eliminate Medicaid coverage altogether for at least 900,000 enrollees. (Territories receiving the ACA funding because they receive far less in federal Medicaid matching funds than do states).

The record exodus of Puerto Rico Medicaid enrollees to the U.S. has already increased Medicaid spending this year by \$25.6 billion across 25 states (including \$6.3 billion in Florida alone). More than half of these costs are financed by federal matching funds.

The \$296 million, which was sought by House Minority Leader Nancy Pelosi (D-CA), was intended to minimize this burden on other states and enable Puerto Rico to enter into new contracts with Medicaid managed care plans for fiscal year 2018 (which starts July 1st). However, Department of Health Secretary Rafael Rodriguez-Mercado insists that the emergency funds are still nearly \$300 million short of what Puerto Rico needs to fund its Medicaid budget next year.

President Trump and conservative lawmakers opposed the relief insisting it was a "bailout" and noting that it caused an increase in the federal deficit (per the Congressional Budget Office). However, both Florida Senators Marco Rubio (R) and Bill Nelson (D) spearhead the relief and are continuing to push for further assistance to Puerto Rico through the reauthorization of the Children's Health Insurance Program that must be passed by September 30th.

Texas

Senate passes bill that would authorize high-risk pool or reinsurance program

The Senate unanimously passed legislation on April 26th that would authorize Texas to create a high-risk pool or reinsurance program if funded by the federal government prior to the next legislative session in 2019.

The American Health Care Act (ACA) that passed the U.S. House of Representatives last week specifically provides states with \$130 billion to stabilize premiums in the individual market once key parts of the Affordable Care Act (ACA) are repealed (see above). An additional \$8 billion would be available for those again allowed to be charged higher premiums based on medical history if they have a lapse in coverage. It gives states the flexibility whether to segregate patients with costly conditions into high-risk pools or make additional payments available to insurers with exceptional claims as Alaska and Minnesota have already done (see above).

S.B. 2087 would put a plan in place to let the Department of Insurance use that funding. Texas was one of 33 states that previously operated a high-risk pool but it was dissolved when the ACA was implemented. Another of those states, North Carolina, is considering a measure (H.B. 913) that would re-establish their high-risk pool.