Health Reform Update – Week of November 6, 2017

CONGRESS

Bipartisan compromise to extend ACA cost-sharing subsidies stalls in Senate

Senators Lamar Alexander (R-TN) and Patty Murray (D-WA) announced last month that they reached agreement on a short-term package that could stabilize premiums in Affordable Care Act (ACA) Marketplaces for the next two years.

Uncertainty over whether the Trump Administration would fully fund the ACA's cost-sharing reductions (ACA) for the full plan year had already led Marketplace insurers to dramatically increase premiums for 2018 by up to 50 percent. The CSRs are written into law, meaning eligible consumers will continue receive them from insurers for 2018 (which can limit their out-of-pocket share to only six percent of coverage costs). However, President Trump's decision last month to immediately stop compensating insurers for their CSR costs (see below) is likely to further spike premiums or cause insurers to exit Marketplaces altogether.

In an effort to mitigate these spikes and exits, Senator Alexander, who chairs the Senate Health, Labor, Education, and Pensions (HELP) Committee and ranking member Murray had been working on a compromise plan that would extend CSRs through 2019 in exchange for giving states greater flexibility to seek waivers allowing them to opt-out of key ACA provisions (see Update for Week of September 18th). Their draft legislation would streamline the process by which states can get these State Innovation Waivers under Section 1332 of the ACA, cutting the wait time from 180 to 90 days and voiding the need for states to first pass authorizing legislation. In addition, states could get fast-track approvals for waivers modeled on another state's approved waiver and the lifetime of waivers would be extended to six years.

The package surprisingly includes funding for state reinsurance programs, which had initially been ruled out by Chairman Alexander (see Update for Week of August 28th). These payments would compensate insurers for extraordinary claims, similar to the temporary ACA reinsurance program whose 2016 expiration led to premium spikes last year. The Trump Administration has already approved Section 1332 waivers allowing Alaska and Minnesota to create reinsurance programs with federal funding (see Update for Week of September 18th) and Avalere Health has predicted that even just a $15 billion reinsurance fund through the end of 2018 could reduce Marketplace premiums by 17 percent (if CSRs are restored). However, the Alexander-Murray bill would only allow their provision to go into effect if cost estimates from the Congressional Budget Office (CBO) show their entire bill would have sufficient cost savings available for reinsurance funding.

Other measures included in an effort to garner conservative support include the creation of a "copper" tier plan that would essentially offer catastrophic-only coverage at a lower cost than "bronze" plans and apply the maximum deductible allowed by the ACA. It would be similar to the catastrophic-only option now offered only to those under age 30, but the age limitation would be removed.

In addition, the legislation would force HHS to finally issue regulations implementing provisions of the ACA that would allow insurers to sell coverage across state lines while complying only with the regulations of their home state. Such a provision has long been sought by conservatives and was part of the President's recent executive order allowing for the return of limited benefit plans that do not include ACA consumer protections (see below).

In an effort to secure full backing from Democrats, the measure would restore $106 million of the funding for Marketplace advertising and outreach that was cut by the Trump Administration for 2018 (see Update for Week of August 28th).

The Alexander-Murray bill quickly drew enough bipartisan support to break a 60-vote filibuster and clear the Senate. However, passage in the House is far less certain, where roughly 40 members of the ultra-conservative House Freedom Caucus remain staunchly opposed to measures that "fix" instead of repeal the ACA. As a result, both Senator Ron Johnson (R-WI) and President Trump himself have called for the Senate bill to be amended to include provisions that would "rollback" key parts of the ACA, such as standards for essential health benefits and the individual and employer mandates. However, such provisions would likely siphon away the Democratic support needed to assure House passage.

As a result, many analysts predict that the best chances for the Alexander-Murray compromise to be enacted may be as part of a larger bill that Congress must pass by the end of year, such as the federal budget bill for fiscal year 2018. However, it will not impact premiums for 2018 since it was not passed prior to the November 1st start of the open enrollment period.

House to vote on tax reform bill that eliminate medical expense deduction, orphan drug tax credits

House Republicans are slated to hold a floor vote this week on sweeping new legislation (H.R. 1) that would slash the nation's corporate tax rate while expanding standard deductions.

Despite Republican majorities in both the House and Senate, passage through both chambers remains far from certain given that Republicans must use the budget reconciliation process to avoid the 60-vote threshold needed to break a Senate filibuster. As a result, the cost of the tax reforms cannot add to the deficit beyond the ten-year budget window, and H.R. 1 is currently at least $74 billion above that amount according to the Joint Committee on Taxation (JCT).

As a result, conservative lawmakers and the White House are pushing Republican leaders to repeal the controversial individual mandate under the Affordable Care Act (ACA) as part of H.R. 1. The Congressional Budget Office (CBO) estimated this week that such a repeal would reduce the deficit by $338 billion over ten years. This would give Republicans the budget savings they need to pass their legislation with only 50 Senate votes (the Vice President would break the tie). However, CBO stressed that it would also dramatically increase the number of uninsured by four million in 2019 and 13 million by 2027, in addition to causing premiums to further spike by an average of 20 percent as insurers compensate for the loss of healthier and less-costly subscribers in their risk pools.

Fearing these negative impacts and the prior difficulties in passing any ACA repeal legislation last summer (see Update for Week of October 2nd), Republican leaders have thus far left the individual mandate repeal out of either H.R. 1 or the Senate draft of tax reform legislation. However, Senator Tom Cotton (R-AR) among others have pledged to seek its addition to any Senate bill.

Other provisions of H.R. 1 may also complicate its prospects for passage. These include several health-related provisions including a repeal of the orphan drug tax credit. The National Organization for Rare Disorders and Biotechnology Innovation Organization (BIO) both slammed this "wholly unacceptable" proposal, citing a 2015 study by the EY consulting firm which warned that eliminating the critical tax incentive would likely cut orphan drug approvals by at least one-third over the next decade.

House Republicans estimate that repealing the orphan drug tax credits will save $54 billion over ten years. The Senate plan would not repeal the tax credit but would impose limits that would result in $30 billing in savings over that time period.

H.R. 1 would also repeal the medical expense deduction that is used by more than 8.8 million mostly middle-class consumers whose medical expenses exceed ten percent of their adjusted gross income in a given year. Many analysts were surprised that Republicans targeted this provision given that they protested the increase in the threshold from 7.5 percent to ten percent under the ACA and had sought to restore the earlier threshold under initial versions of their ACA repeal and replace bills.

More than 40 consumer groups led by AARP have protested the elimination of the medical expense deduction and Senate Republicans have thus far left it out of their version of H.R. 1.

House votes to repeal controversial Medicare cost-cutting board under ACA

The House voted last week to pass legislation that would repeal the controversial Medicare cost-cutting board under the Affordable Care Act (ACA).

The Independent Payment Advisory Board (IPAB), which has never gone into effect, was designed to make recommendations on Medicare spending cuts whenever costs exceeded pre-determined targets. These recommendations would automatically be implemented if Congress failed to pass equivalent cuts.

The IPAB has drawn opposition from both Republicans and significant numbers of Democrats who fear it would cede authority away from Congress and into the hands of "unelected bureaucrats" (see Update for Week of December 1, 2014). As a result, the House repeatedly passed individual measures to repeal the ACA (see Update for Week of June 22, 2015) and its elimination was consistently part of larger bills to repeal and replace the ACA (see Update for Week of October 2nd). The latest IPAB repeal bill (H.R. 849)—the first under the Trump Administration—received the support of 76 House Democrats.

Despite the bipartisan support, the measure is not expected to receive a floor vote in the Senate by the end of year given the lack of urgency. Neither President Obama nor Trump have appointed any of the 15 members to the panel and its recommendations are not expected to be triggered until 2021 at the earliest. In addition, disputes over how to offset the $17 billion cost of repealing the IPAB (over ten years) are likely to prevent it from receiving the 60 votes needed to pass the Senate as a stand-alone bill.

FEDERAL AGENCIES

President ends ACA cost-sharing subsidies just before start of 2018 open enrollment

President Trump announced last month that the Department of Health and Human Services would immediately stop compensating insurers for the cost-sharing reductions (CSRs) they are required to make pursuant to the Affordable Care Act (ACA).

The CSRs are mandated by the ACA statute so cannot be repealed without Congressional action, even though they were not appropriated by the Republican-controlled Congress. As a result, the 58 percent of Marketplace consumers earning from 100-250 percent of the federal poverty level (FPL) will still receive the CSRs, which can limit their deductibles, coinsurance, and copayments to only 6-27 percent of their income if they purchase silver-tier plans in the ACA Marketplaces. However, insurers will now be on the hook for the difference, which will be have the greatest impact in southern states like Alabama, Florida, and Mississippi where more than 73 percent of Marketplace consumers received CSRs in the 2017 plan year.

Because the President had been threatening to discontinue the CSRs since taking office in January, most state insurance commissioners allowed states to factor in the potential loss of CSRs into their 2018 rates and others have allow insurers to seek higher premium increases subsequent to the decision. As a result, premiums have spiked across all plans within both federal and state Marketplaces,

with the 38 federally-facilitated Marketplaces reporting a nearly 38 percent average increase for silver-plan premiums (see below).

The President insisted that his decision was based solely on the "illegality" of the CSRs. House Republicans had successfully obtained a federal court decision ruling that HHS was unlawfully funding the CSRs from other accounts after the Republican-controlled Congress refused to appropriate funds in 2014 (see Update for Week of May 16, 2016). That decision had been stayed pending an appeal by the Obama Administration—an appeal which the President has now dropped.

However, the U.S. Court of Appeals for the District of Columbia previously allowed 18 attorneys general from Democratically-controlled states to intervene in the lawsuit (see Update for Week of August 14th). As a result, it is now up to the appellate court whether to allow those states to continue the appeal and potentially overturn the lower court ruling.

The 18 states (which includes the District of Columbia) failed in their effort to obtain a preliminary injunction from the United States District Court for the Northern District of California that would have forced the Trump Administration to make the CSR payments that were due on October 20th. The judge in that case ruled that no irreparable harm would result because states had already accounted for the loss of CSRs in the higher premiums they were allowed to charge. However, insurers may be able to seek legal recourse in the U.S. Court of Federal Claims if the appellate court in the District of Columbia finds they are entitled to the CSRs under the ACA statute.

The Congressional Budget Office (CBO) predicted as late as August that eliminating the CSRs would "increase the federal deficit, on net, by $194 billion from 2017 through 2026" because the dramatically higher premiums would force the federal government to pay higher premium tax credits for those earning 100-400 percent of FPL (see Update for Week of August 28th). As a result, significant numbers of Republican lawmakers are urging the President to support a bipartisan market stabilization package that would extend the CSRs through 2019 (see above).

Executive order expands use of limited-benefit plans that do not comply with ACA

President Trump signed an Executive Order (EO) on September 12th directing executive department agencies to broaden the definition of ERISA (which governs large group coverage) so that small employers so that they can band together through trade groups to offer coverage under "association health plans" across state lines that need not comply with the consumer protections in the Affordable Care Act (ACA).

The EO also urges agencies to expand the definition of short-term limited duration insurance plans, which also are exempt from the ACA. The Obama Administration had limited such plans to a duration of not more than three months (starting April 1, 2017). The President insists that such coverage would cost two-thirds less than ACA-compliant coverage and still provide "broad provider networks and high coverage limits."

The EO did not specify whether either form of coverage (association or short-term plans) would be defined as "minimum essential coverage" and satisfy the individual mandate penalty under the ACA. It specifically would allow each to circumvent ACA rules on minimum essential benefits, but insists that association plans would not be able to vary premiums based on health status.

Because federal regulations would need to be reinterpreted and rewritten, any impact from the EO is not likely to result until the 2019 open enrollment period. America's Health Insurance Plans (AHIP) acknowledged that it was not clear what, if any, impact the EO would have on plan availability or premiums given the lack of interest insurers previously have shown in offering association health plans or other limited-benefit coverage.

The National Conference of State Legislatures issued a report concurrent with the EO showing that of the six states that have already enacted laws allowing health plans sales across state lines "no state was known to actually offer or sell such policies." State insurance commissioners from both parties had pre-emptively criticized the President's EO, noting that the 2011 interstate health plan law passed in Georgia attracted zero insurers, similar to other failed efforts in Maine and Wyoming, while insurers like Blue Shield of California insisted that allowing such limited-benefit coverage would create a "race to the bottom" (see Update for Week of October 2, 2017).

The American Academy of Actuaries warned that a plethora of non-ACA complaint coverage would "deteriorate the risk pool, lead to increased premiums, more instability and potentially make insurers have to make decisions on whether they're going to continue to participate." Though AHIP stopped short of opposing the EO, it urged the Trump Administration to focus on reforms that "stabilize the individual market."

IRS will reject tax returns that fail to identify whether filers complied with ACA individual mandate

The Internal Revenue Service (IRS) announced last month that it will reject electronic tax returns for 2017 that do not include confirmation of whether the filer had minimum essential health coverage.

This policy was initially put into place late in the Obama Administration. However, the IRS elected immediately after the inauguration of President Trump to not enforce this policy (see Update for Week of February 27th) under the apparent assumption that the individual mandate under the Affordable Care Act (ACA) would be shortly repealed.

The individual mandate requires that consumers purchase minimum essential coverage that they can afford or pay a tax penalty in 2017 of $695 per adult of 2.5 percent of income (capped at $2,085). Less than two percent of all tax filers paid this penalty in the first two years of the mandate (when the penalty was lower) however polling consistently ranks it as the single most unpopular ACA provision.

IRS officials claim that the reversal is based on "a review of our process and discussions with the National Taxpayer Advocate [that concluded] it is more burdensome for taxpayers to allow them to file an incomplete tax return and then have to manage follow-up letters and potentially amend their return." However, the insurance industry has also strongly urged the Administration to enforce the mandate in the short-term, as 2018 premiums were largely based on the assumption that it would remain in place for the next plan year. Without it, insurers insist that they would need to raise premiums by an average of 20 percent, on top of premium spikes already caused the Administration's elimination of ACA cost-sharing subsidies (see above).

CMS will allow work requirements for Medicaid enrollees, fast-tracked waiver requests

The Administrator for the Centers for Medicare and Medicaid Services (CMS) confirmed this week that her agency will allow states for the first time to impose work requirements for non-disabled adult Medicaid enrollees.

Work requirements were long-sought by conservatives as part of Section 1115 demonstration waivers approved by CMS, but consistently rejected by the Obama Administration, which insisted they do not comply with federal Medicaid law (see Update for Week of December 5th). The Obama Administration instead allowed states to require enrollees participate in job search or training programs.

CMS Administrator Seema Verma made the announcement in an appearance before the nation's Medicaid directors. However, her controversial assertion that the Obama Administration engaged in "soft bigotry" by arguing that the work requirements "do not support or promote the objectives of Medicaid" angered several directors, particularly New York's Jason Helgerson who claimed the accusation could create an adversarial "us vs. them" relationship between CMS and certain state Medicaid officials. In

addition, several Medicaid directors criticized the Administrator's claims that they were focused only on ways to "expand access [to Medicaid]" and not on "helping people move up, move on and move out."

Eight states (Arizona, Arkansas, Indiana, Kentucky, Maine, New Hampshire, Utah and Wisconsin) have already submitted waiver requests to CMS that would require non-disabled Medicaid adults to either work or provide community service. However, the work requirements vary by state. For example, Arizona requires enrollees to be either working or enrolled in school or job training programs for at least 20 hours per week. However, New Hampshire would increase that threshold up to 30 hours for those enrolled in Medicaid for more than two years.

The legal director for the National Health Law Program suggested that the work requirements were very likely to be challenged in court, emphasizing that CMS does not have the legal authority to use Section 1115 waivers to curtail eligibility.

According to the Kaiser Family Foundation, roughly 59 percent of non-disabled Medicaid adults under age 65 are currently employed in some capacity.

New Marketplace standards would make it harder for individuals to qualify for premium subsidies

The Department of Health and Human Services (HHS) published their proposed Notice of Benefit and Payment Parameters for 2019 on October 27th, which set the annual standards for Affordable Care Act (ACA) Marketplaces.

The proposed rule makes many very detailed changes, but broadly seeks to "reduce regulatory burdens" relating to ACA mandates and give federal and state agencies greater flexibility in their enforcement, consistent with the President's first executive order (see Update for Week of January 30th). However, it also specifically seeks to make it harder for consumers in states that did not expand Medicaid under the ACA to qualify for premium tax credits to purchase Marketplace coverage.

Because the ACA initially required all states expand Medicaid for everyone earning up to 138 percent of the federal poverty level (FPL), Congress set the lower threshold for premium tax credits at only 100 percent of FPL. The U.S. Supreme Court subsequently made the Medicaid expansion optional (see Update for Week of June 25, 2012), leaving consumers in 19 opt-out states caught in a "coverage gap" between extremely low Medicaid eligibility levels and the minimum threshold for tax credits.

Under the Obama Administration, HHS had "generally" accepted an individual's attestation of their income if it conflicted with data on file with the Internal Revenue Service (IRS) and the Social Security Administration (SSA). However, in instances where an individual is claiming income higher than IRS or SSA have on file, and that income would make them eligible for premium tax credits, HHS is now proposing to require that individual be ineligible for the credits until additional proof of income is provided.

Consumer advocates warn that individuals who income often fluctuates would be bounced on and off Marketplace coverage if this policy goes into effect and HHS routinely flags reported income data that is below the tax credit threshold.

HHS notably makes no mention in the NBPP of whether it will require Marketplace insurers to accept third-party premium and copayment assistance from charitable organizations (like PSI), the same as they required of federal and state health care programs under a 2014 interim final rule (see Update for Week of June 2, 2014). Under the Obama Administration, the agency had agreed in prior NBPP rules to consider making such a change, following numerous letters from Congress urging them to do so. However, HHS' failure to move forward on this issue under either the Obama or Trump Administration led Rep. Kevin Cramer (R-ND) to reintroduce legislation last month (H.R. 3976) that would force HHS to ensure the availability of charitable assistance (see Update for Week of October 2nd).

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STATES

Marketplace enrollment on record pace despite cuts to marketing, outreach, and subsidies

Open enrollment for all Affordable Care Act (ACA) Marketplaces started on November 1st and sign-ups are outpacing 2017 figures despite efforts by the Trump Administration to depress enrollment.

Consumer advocates feared much lower numbers than usual after the open enrollment period was slashed in half to only six weeks for the 38 Marketplaces operated by the federal government and marketing and outreach budgets slashed by 90 percent (see Update for Week of August 28th). The President's decision to terminate the ACA's cost-sharing reductions effective October 20th led to severe premium spikes (see below), further heightening fears that only sicker and more costly consumers would obtain coverage.

However, early data from the Centers for Medicare and Medicaid Services (CMS) showed that nearly 601,000 enrollees signed-up for federally-facilitated Marketplace (FFM) coverage during the first five days, a record figure that is nearly 80 percent above the total for the same period last year. More than 34,000 consumers were signing-up per day, well above the 26,000 per day pace in 2017. (About 77 percent enrollees are returning customers, same as one year ago.)

The limited data from state-based Marketplaces (SBMs) show similar enrollment surges. Enrollment in in Covered California, which actually increased its marketing and outreach budget by 11 percent, is running about 25 percent higher than last year. Marketplace enrollment in Connecticut is up by 15 percent, Maryland and Washington have seen about a 50 percent increase, and Rhode Island sign-ups are 500 percent higher thanks to its auto-renewal system that forces consumers to actively opt-out if they no longer want coverage.

The 2018 open enrollment period will end December 15th for all FFMs. Idaho, Maryland, and Vermont are the only SBMs that will adhere to that federal deadline. California, the District of Columbia, and New York will allow enrollment to continue until January 31st (same as last year), while Colorado, Minnesota, Washington, and Massachusetts will end enrollment on January 12th, 14th, 15th, and 23rd respectively. December 22nd is the final day for open enrollment in Connecticut, while Rhode Island will allow sign-ups through December 31st.

Loss of cost-sharing subsidies cause premium spikes, but not for those with premium tax credits

The U.S. Department of Health and Human Services (HHS) and the Kaiser Family Foundation released reports coincident with the start of the 2018 open enrollment period showing how premium spikes are likely to impact consumers in Affordable Care Act (ACA) Marketplaces.

According to HHS data, average premiums for the second lowest-cost silver-tier plans will jump by more than 37 percent for federally-facilitated Marketplaces (FFM) in 2018 (increasing from $300 to $411). Consumers in Iowa will face the steepest increase (88 percent) while Alaska will actually see a 22 percent decrease due to a federally-approved reinsurance program they created to compensate insurers for extraordinary losses (see Update for Week of July 10th). These are the "benchmark" plans upon which the amount of ACA premium tax credits are based.

Most states allowed insurers to assume that the Trump Administration would not fully-fund the cost-sharing reductions (CSRs) under the ACA for the entire plan year and HHS allowed insurers in other states to refile rates once the CSRs were official eliminated last month (see above). As a result, the loss of the CSRs is already factored into premium increases for 2018.

Because CSRs were available only to those enrolled in silver-tier plans, 30 states (either FFM or state-based Marketplaces) applied all of the premium increase due to the loss of CSRs to silver-tier plans. This allowed increases in other tiers to stay below 20 percent, which according to the Kaiser study, will actually have the perverse effect of making other tier plans far more affordable for those with premium tax credits, as the amount of their credit will rise concurrent with the spike in their premiums.

The increase in premium tax credits will force the federal government to pay more than $194 billion more over ten years, according to the Congressional Budget Office. However, Kaiser found that it could also lower premiums for 54 percent or 5.9 million the 10.7 million who are uninsured and eligible for Marketplace coverage. Of that 5.9 million, 4.5 million (or 42 percent of the total) will now be able to purchase less-comprehensive bronze-tier coverage with zero premium (or roughly half of all Marketplace enrollees in states like Maine). Furthermore, depending where they live, more comprehensive gold-tier coverage could suddenly cost the same or nearly the same as their silver-tier coverage.

For example, a 40-year old earning just over 200 percent of poverty ($25,000 per year) will see their average premiums decline across all metal tiers, due to the size of their subsidy (falling 75 percent for bronze, 12 percent for silver, and 21 percent for gold). That same 40-year old earning 332 percent of poverty ($40,000 per year) will have zero increase for silver plans, but a 28 percent decrease for bronze and eight percent decrease for gold.

As a result, for Marketplace consumers in a states like Kansas, New Mexico, Pennsylvania, or Wyoming, the more comprehensive gold-tier coverage will actually be cheaper in the vast majority of cases for those receiving premium tax credits. In other states like Florida, the gold plans will only be slightly more costly (in Orange County the gold premium would be $83 per month versus $469 for silver, a difference of only about three percent).

However, the situation is very different for those earning above 400 percent of poverty who are ineligible for ACA premium tax credits. This group will bear the full brunt of the premium spikes for 2018,

Because insurer participation in the Marketplaces is declining by more about 21 percent for next year, those in rural areas dominated by only one insurer will be exceptionally hard hit. For example, 40 year old earning above this threshold in Albemarle County, Virginia will face a premium increase of nearly 235 percent (to $1,012 per month). In Glades County in Florida, that individual will pay 71 percent more ($779 per month) even though the same person in Hillsborough County (Tampa) will pay only $428 per month (a 40 percent increase).

According to the Kaiser study, roughly 29 percent of all Marketplace enrollees will reside in counties with only one Marketplace insurer next year, including those in eight entire states (Alaska, Delaware, Iowa, Mississippi, Nebraska, Oklahoma, South Carolina, and Wyoming.)

California

Governor signs nation's broadest prescription drug price transparency law

Governor Jerry Brown (D) signed the nation's most comprehensive drug pricing transparency initiative into law on October 10th over the strong objections of the pharmaceutical industry who had spent nearly $17 million to defeat it.

S.B. 17 requires drug manufacturers to notify health insurers and government health plans at least 60 days before increases in drug wholesale acquisition costs (WAC) that would exceed 16 percent over a two-year period (see Update for Week of September 18th). It applies to drugs with a WAC of $40 or more. In addition, manufacturers must explain the reasons behind those increases and post them online in a manner that allows consumers to access it on a per-drug basis and shows the overall impact of the drug cost on plan premiums.

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

Senate Health Committee chair Ed Hernandez (D) was forced to withdraw a similar version last year in face of intense industry lobbying (see Update for Week of December 5th). He and the lead Assembly sponsor acknowledge that S.B. 17 will not dramatically alter drug pricing but insisted that it brought California "one step closer to lifting the veil on soaring drug prices and identifying meaningful strategies to ensure access to life-saving treatments."

California is one of 25 states (and Puerto Rico) that considered drug price transparency laws this year. S.B. 17 does go further than the previous drug transparency law enacted last year in Vermont, which required that 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 (see Update for Week of June 20, 2016). Maryland recently enacted the first "price gouging" law in the nation that seeks to prevent WAC increases of 50 percent or more for "essential" generic or off-patent drugs (see Update for Weeks of May 29th and June 5th) while a new Colorado law only requires that certain providers make a single document available to the public listing direct pay prices and cost-sharing obligations for their most common health care services (see Update for Week of May 8th).

Governor signs bill limiting manufacturer discounts for brand-name drugs

Governor Jerry Brown (D) signed A.B. 265 into law on October 10th, which prohibits prescription drug manufacturers from offering discounts (including product vouchers or copayment coupons) in an individual's cost-sharing expenses for brand-name drugs, if a less-expensive and therapeutically-equivalent brand-name or generic drug is available.

Assemblyman Jim Wood (D) introduced the bill earlier this year, insisting that the use of copayment coupons and other discounting strategies "appear to help the consumer" but could actually push overall costs higher by leading patients into expensive brands instead of less-costly generic options.

Similar concerns led Massachusetts to prohibit copayment coupons (see Update for Week of July 16, 2012) and New Jersey is considering a similar proposal.

As with the drug pricing transparency law also signed into law (see above), the Pharmaceutical Research and Manufacturers of America (PhRMA) strongly opposed the legislation, arguing that it will not ensure that patients who need name-brand products over a generic alternative will have access to that drug, despite exceptions in the law for brand-name drugs that receive prior authorization.

A.B. 265 was previously amended to specifically exempt the type of premium and copayment assistance provided by independent bona-fide charities like PSI, which are operated in compliance with OIG advisory opinions (see Update for Weeks of May 15th and 22nd).

State scrutiny forces Marketplace insurers to scale back premium increases

Several of the 11 insurers participating in Covered California for 2018 have voluntarily agreed to reduce their premium increases following adverse findings by the Department of Managed Health Care (DMHC) and Insurance Commissioner David Jones (D).

California regulators lack the authority to modify or reject rate hikes but can evaluate them to determine if they are not reflective of increases in medical costs. DMHC specifically concluded that the 40.3 percent average rate hike sought by the nation's second largest insurer Anthem Blue Cross was "excessive" because it was based on a projection that pharmacy costs would jump by 30 percent, which

far exceeds national trends and is more than double the rate estimated by other insurers (see Update for Week of September 18th). As a result, Anthem decreased its rate hike by three percent on average.

Another large insurer, HealthNet, agreed to reduce premium hikes by nearly 50 percent following the Commissioner's review and will now increase premiums by only 12.1 percent on average. L.A. Health Care Plan cut their premium increase by nine percent to an average of 21.7 percent.

Anthem's 37.3 percent rate hike is exceeded only by Molina Healthcare, which received a 44.7 percent average increase. However, they are retreating from all but three of the state's 19 rating areas for 2018 (see Update for Week of September 18th). Blue Shield of California, which serves the most Covered California enrollees, will hike rates by an average of 22.8 percent, while Kaiser Permanente and Valley Health Plan will see increases of 11.6 and 9.8 percent respectively.

All Covered California insurers were required to submit two sets of rate filings for 2018 in the event the Trump Administration eliminated the cost-sharing reductions under the ACA (see Update for Week of May 8th). The final approved rates for 2018 reflect the 12.4 percent surcharge that Covered California tacked onto silver-tier plans to compensate for the loss of the CSRs, as well as the average rate hike of 12.5 percent that insurers sought across all plans after assuming CSRs would not be paid (see Update for Week of October 2nd).

Maine

Governor defies voter mandate to expand Medicaid under the ACA

Governor Paul LePage (R) refused this week to expand Medicaid during the remainder of his term, despite voters overwhelmingly approving a ballot initiative mandating that he do so.

Nearly 60 percent of voters supported Question 2, the binding referendum requiring that Maine become the 32nd state to participate in the Medicaid expansion under the Affordable Care Act (ACA). However, Governor LePage, who vetoed six bipartisan expansion bills over the past five years (see Update for Week of April 18, 2016), remains adamant that such an expansion would "bankrupt" the state, citing higher costs following a Medicaid expansion in 2002.

The LePage Administration has dramatically scaled back Medicaid eligibility since 2011, eliminating coverage for childless adults and parents with minor children who earned 100-200 percent of the federal poverty level (see Update for Week of December 1, 2014). As a result, the ACA expansion would benefit nearly 80,000 Mainers earning up to 138 percent of poverty, who currently lack coverage.

The Governor insists that he will only expand Medicaid if the Legislature authorizes the $276 million that he predicts the expansion will cost Maine over the next four years. However, the state's nonpartisan Legislative Office of Fiscal and Policy Analysis estimates that the expansion will actually cost Maine only $128 million over that time, based on offsetting budgetary savings that have been realized in other expansion states In addition, they note that data from the federal Centers for Medicare and Medicaid Services shows that the cost for expanding Medicaid coverage to childless adults is the same or less than previously-eligible adults, despite LePage's claims that they will be twice as expensive to cover.

Although the referendum is binding, analysts concede the Governor may be able to delay implementation until he leaves office after 2018, meaning that the expansion may not go into effect until a new administration takes over. As a result, House Speaker Sara Gideon (D) immediately pledged that the legislature would "swiftly" fund the expansion and that any efforts to "illegally delay or subvert this law will not be tolerated and will be fought with every recourse at our disposal."

The vote made Maine the first state to expand Medicaid via the ballot box. Expansion advocates in Idaho and Utah have already started gathering signatures to put the issue before voters in their states next year. State Senator Adam Morfeld (D) pledged to introduce a resolution in the Nebraska legislature

that would place a comparable referendum on the 2018 ballot if 30 of 49 Senators approve. Florida and Missouri are among the other non-expansion states where such a ballot referendum would be allowed.

Massachusetts

Senate-passed bill would impose new drug price transparency requirements, hospital penalties

The Senate passed sweeping legislation this week that seeks to impose greater state scrutiny over prescription drug prices.

The 100-page bill (S.B.2202) is referred to as "Part 2" of the landmark 2012 law that required hospital and physicians to cut their rate of cost growth by nearly half (down to 3.6 percent per year)(see Update for Weeks of July 23 and 30, 2012). It specifically calls for imposing greater pricing transparency on the pharmaceutical industry and would require drug manufacturers submit data on changes in wholesale acquisition costs, average profit margins, and other pricing data to the Health Policy Commission created by the 2012 law (Chapter 224).

The bill also would for the first time impose penalties on hospitals who fail to meet the 3.6 percent benchmark. Chapter 224 had given the Commission discretion to levy such penalties, but it had yet to do so. However, the Commission's own annual report last year acknowledged that hospitals were failing to meet the benchmark while insurers were successfully doing so, despite a 10.1 percent increase in prescription drug costs (see Update for Week of September 12, 2016). This report provided critics of the spending caps with greater justification to call the lack of penalties the "Achille's Heel" of the 2012 law (see Update for Weeks of July 23 and 30, 2012).

S.B. 2022 also include an optional Medicaid buy-in for employers but notably does omits the proposal from Governor Charlie Baker (R), a former health insurance executive, to move more than 140,000 Medicaid enrollees into subsidized plans in the Affordable Care Act (ACA) Marketplace.

Senate minority leader Bruce Tarr (R) insisted that such a comprehensive measure was ill-timed given the uncertainty over if and how the ACA will be repealed and replaced by Congress. Leadership in the Democratically-controlled House appeared to acknowledge these concerns by stating that they would take a "wait and see" approach to moving the legislation in response to a "very defined problem." State hospital, insurer, and biotech groups have already lined up in opposition to the bill.

North Carolina

Average rate hike for Blue Cross Blue Shield jumps from zero to 14 percent after loss of CSRs

The dominant insurer in the Affordable Care Act (ACA) Marketplace for North Carolina has agreed to lower its average premium increase in 2018 to 14.1 percent, down from the nearly 23 percent increase in initially sought when Congress was debating repealing key provisions of the ACA.

Blue Cross and Blue Shield of North Carolina, which will be the lone insurer in 95 of the state's 100 counties, blamed the entire 14.1 percent increase on the Trump Administration's decision to eliminate the cost-sharing reductions (CSRs) under the ACA just before the November 1st start of open enrollment (see above). Without the loss of the CSRs, BCBS officials insist that there 2018 increases would have been "near zero" given the fact that Congressional repeal efforts have stalled.

BCBS serves more than 502,000 consumers in the ACA Marketplace, roughly 66 percent of whom received the CSRs during the 2017 plan year. CIGNA, which serves only about 22,000 Marketplace consumers in five counties around Raleigh-Durham, will receive a 24.61 percent average premium increase, but only about five percent of that amount is attributable to the loss of CSRs.

BCBS anticipates some higher costs due to nearly 50,000 customers transitioning from their grandfathered plans that were not ACA-complaint. The insurer has elected to terminate these plans for 2018 (which at one time covered more than 330,000 enrollees).

Ohio

Voters overwhelmingly reject caps on prescription drug pricing

A ballot initiative that sought to cap prescription drug costs paid by state agencies at the discount prices offered to the Department of Veteran's Affairs (VA) failed to garner more than 20 percent of the vote this week.

The defeat was the largest in state history for a voter referendum and is likely to stall momentum for comparable initiatives slated for the November 2018 ballot in South Dakota and the District of Columbia. The measure, which was largely funded by $16 million from the AIDS Healthcare Foundation, likewise failed last year in California, though by a much slimmer margin (see Update for Week of November 14, 2016).

The Ohio measure was to be placed on the ballot for 2016 but was delayed after a successful push by Governor John Kasich (R) to invalidate thousands of signatures had to be resolved by the state Supreme Court (see Update for Week of January 4, 2016).

The Pharmaceutical Research and Manufacturers of America spent nearly $60 million to defeat Drug Price Relief Act (Issue 2) in Ohio, after pouring in more than $100 million against the California initiative, making the referendums the most costly in the history of both states. Voters largely attributed the plethora of negative ads and confusion over the actual impact of the caps for their decision to vote no.

The non-partisan Office of Budget and Management in Ohio acknowledged that cost savings from the initiative would be "unclear." A similar finding by the Legislative Analyst Office in California appeared to likewise doom their initiative, along with the opposition from some advocacy groups representing HIV and Hepatitis C patients (such as Project Inform and the Treatment Action Group) who suggested that it took the "wrong approach" to reducing drug costs and would actually cause manufacturers to respond to the new caps by simply raising the prices they charge the VA (see Update for Week of July 25, 2016).

Oregon

Oregon becomes third state with federal approval to create state reinsurance program

The Centers for Medicare and Medicaid Services has approved Oregon's request for a federal waiver allowing it to create a state reinsurance program that will mitigate premium increase in the individual health insurance market.

Starting January 1st of this year, Section 1332 of the Affordable Care Act (ACA) allowed states to seek waivers of certain ACA mandates in order to experiment with alternative deficit-neutral reforms that provide comparable coverage. The Trump Administration specifically encouraged states last spring to use this waiver authority to create reinsurance programs that compensate insurers for exceptional costs, following the expiration of the ACA's temporary reinsurance payments at the end of 2016 (see Update for Week of May 8th).

CMS approved the first two waiver requests, allowing Alaska and Minnesota to create such a reinsurance program (see Update for Week of July 10th), but then failed to timely act on applications from Oklahoma and Iowa, forcing state officials to withdraw them (see Update for Week of October 2nd). At least eight other states are considering reinsurance waivers, most recently Washington whose insurance commissioner directed consulting firms this week to develop actuarial analyses of their premium impact.

Oregon's request to waive the ACA's single risk pool requirement in order to create the reinsurance program partly funded through a state tax on health insurers was approved by CMS without any caveats. That was not the case for Minnesota, whose approval was contingent upon the state losing funding for its Basic Health Plan program created through the ACA, which that state's governor has continued to protest (see Update for Week of September 18th).

West Virginia

CHIP board votes to stop enrollment if Congress fails to reauthorize funding

The board of directors for the Children's Health Insurance Program in West Virginia voted this week to cease enrollment on February 28, 2018 if Congress does not reauthorize funding by that date.

Congress failed to reauthorize CHIP funding by the end of the federal fiscal year on September 30th due to the debate over the latest effort to repeal and replace the Affordable Care Act (see Update for Week of October 2nd). The House finally passed a reauthorization bill last week (H.R. 3922) but it faces resistance from at least 22 Senate Democrats as it seeks to offset the costs by slashing nearly $6.5 billion from the Prevention and Public Health Fund under the ACA that ensures certain preventive services are available without consumer cost-sharing.

State officials acknowledge that they will run out of fiscal year 2017 CHIP funding during March and have no alternative but to stop enrollment before that time.