



Health Reform Update – Week of January 8, 2018

CONGRESS

Stopgap spending bill likely to include funding for CHIP but not market stabilization

Congress appears poised to pass another temporary spending bill next week in order to avoid a government shutdown when the current resolution expires on January 19th.

The measure is likely to at least include additional emergency Children's Health Insurance Program (CHIP) funds so that states can continue coverage while Congress debates a long-term extension. Congress unexpectedly let CHIP expire last fall while it debated whether to repeal key provisions of the Affordable Care Act (ACA) (see Update for Week of November 6th), forcing states to rely solely on unspent funds. The Centers for Medicare and Medicaid Services acknowledged this week that despite the \$2.85 billion in emergency CHIP allocated by the temporary spending resolution last month (see Update for Week of December 18th), several states will still run out of money by mid-January.

A bill to reauthorize CHIP did pass the House last fall but remains stalled in the Senate, where opposing parties could not agree how to offset the cost, with Democrats objecting to Republican plans to cut \$6.5 billion from the ACA's Prevention and Public Health Fund (see Update for Week of November 6th). However, that impasse appeared to be broken this week when the Congressional Budget Office concluded that because Congress repealed the ACA's individual mandate starting in 2019 (see Update for Week of December 18th), renewing CHIP would avoid the federal cost of increased ACA premium tax credits for these families (who would have to be moved to the ACA Marketplaces). As a result, there would be no additional cost to the federal government if Congress extended CHIP by at least six years and it could save up to \$6 billion with a ten-year extension.

Despite the CHIP progress, House conservatives remain opposed to including any of the bipartisan market stabilization bills proposed by the Senate. This includes the bill from Senators Lamar Alexander (R-TN) and Patty Murray (D-WA) that would restore the ACA cost-sharing reductions eliminated by the Trump Administration or the bill from Senators Susan Collins (R-ME) and Bill Nelson (D-FL) that would create a reinsurance or high-risk pool program over two years (see Update for Week of November 13th).

Senator Collins had insisted that Senate leaders pledged to pass both measures in exchange for her support of repealing the individual mandate under the ACA (see Update for Week of December 18th). She now claims that they will be enacted prior to insurers setting premiums for the 2019 open enrollment period and that Senate Majority Leader Mitch McConnell (R-TN) has agreed to boost funding under her bill to \$5 billion per year for 2019 and 2020.

Federal judge refuses to block dramatic cut in Medicare Part B payment for 340B drugs

The 27 percent cut in Medicare Part B payments for drugs that safety-net hospitals purchase through the Section 340B drug program went into effect on January 1st after a federal judge dismissed the "premature" lawsuit brought by the American Hospital Association and other hospital groups.

In dismissing this case for lack of standing, Judge Rudolph Contreras (appointed by President Obama) allowed the plaintiffs to renew their suit once the \$1.6 billion reimbursement cut was effective. The cut was part of the Centers for Medicare and Medicaid Services (CMS) final rule governing the Medicare outpatient prospective payment system (see Update for Week of November 13th).



The CMS action drew strong opposition from both sides of the aisle and House legislation (H.R. 4392) to overturn the cut quickly gained 174 cosponsors. A bipartisan group of Senators led by John Thune (R-SD) and Patty Murray (D-WA) are attempting to include a “fix” as part of a spending resolutions for fiscal year 2018. However, it is not likely to be included in the temporary resolution that must be passed by January 19th (see above).

The House Energy and Commerce Committee did release a report summarizing the two-year investigation by Republican members, which recommended greater scrutiny over how 340B discounts are used (although it did not address whether the 27 percent reimbursement cut should stand). The report concluded that savings received by participating safety-net hospitals are not benefiting low-income, uninsured individuals and called on Congress to clarify the intent of the 340B program and give the Health Resources and Services Administration greater authority and resources to conduct adequate oversight.

Energy and Commerce chairman Greg Walden (R-OR) is also seeking to increase and standardize reporting and audit requirements for participating hospitals, including the amount of uncompensated care each hospital provides.

The report emphasized that spending under the 340B program has more than tripled since 2005 and the number of safety-net providers receiving the discounted drugs have more than doubled in the last five years. Drug sales under 340B reached \$16.2 billion in 2016, a 34 percent spike from the year before. It now accounts for five percent of all prescription drug sales (see Update for Week of July 10th).

This dramatic growth had already heightened scrutiny among lawmakers and federal regulators, leading to previous reports from the Health and Human Services Office of Inspector General and Government Accountability Office suggesting that the discounts are not benefiting those in need and instead resulting in “windfall” profits for providers (see Update for Weeks of July 1 and 8, 2013).

FEDERAL AGENCIES

Profit outlook improves for Marketplace insurers despite ACA sabotage

Global credit rating organization A.M. Best revised their projection for Affordable Care Act (ACA) Marketplaces last week, predicting that they should remain “relatively stable” for 2018 despite efforts by Congress and the Trump Administration to undermine the ACA.

A.M. Best analysts had initially predicted a negative outlook for Marketplace insurers in 2018, assuming that a loss of ACA cost-sharing reductions and likely repeal of key ACA provisions would destabilize the Marketplaces and lead to dramatically higher premiums and insurer departures. While A.M. Best acknowledged that these factors did negatively impact insurers, they concluded that most were able to anticipate and adapt to these changes and actually benefit from the higher premiums and more limited competition that resulted.

However, the biggest factor working in favor of Marketplace insurers was a continued improvement in the composition of the risk pools between sicker and healthier consumers that started in 2016. Most insurers underestimated the number of sicker and more costly consumers in the initial years of the Marketplaces and underpriced their products as a result. The increase in healthier consumers and more accurate premium levels have improved insurer bottom lines across the board, and according to A.M. Best are likely to continue to do so through 2018.

The briefing report did note that the repeal of the ACA’s individual mandate had the potential to depress the enrollment of healthier and less costly consumers in 2019. However, the ultimate impact on insurer profits remains unclear as insurers will likely increase premiums to adjust to risk pools that will



may be more skewed towards costlier consumers. In addition, market stabilization packages being considered by Congress (see above) could offset some of the negative impact of the absence of the individual mandate.

Analysts at Goldman Sachs and S&P Global Ratings reached similar conclusions, noting that insurers such as Centene, Care Source, and Blue Cross Blue Shield plans that agreed to cover “bare” counties created by departing insurers were most likely to see profit gains this year. A.M. Best stressed that these insurers are typically “more comfortable, more stable, and [better] understand” the Marketplaces they are entering.

Labor department proposes rule implementing President's interstate health plan directive

The Department of Labor (DOL) issued proposed regulations last week that would facilitate the sale of association health plans across state lines that need not comply with the consumer protections in the Affordable Care Act (ACA).

The regulation stems directly from the executive order (EO) issued last fall by President Trump (see Update for Week of November 6th), which directed federal agencies to broaden the definition of employer under the federal Employment Retirement and Income Security Act (ERISA) law, which generally exempts large employer coverage from state regulation. It is part of several regulations that will be issued by DOL and the Department of Health and Human Services (HHS) to implement the EO.

In its proposed rule, DOL health plans sponsored by trade associations can gain enhanced status under ERISA. The agency predicts that up to 11 million Americans who are self-employed or work for small business could benefit under plans organized by a geographic area or industry.

DOL attempts to quell criticism of the plans by retaining the ACA's ban on pre-existing condition denials or charging higher premiums based on health status. However, the plans specifically would no longer have to comply with the ACA's essential health benefit packages or other consumer protections.

President Trump has long-touted the idea of selling association plans across state plans as a way to dramatically boost competition and lower premiums. However, the National Association of Insurance Commissioners, America's Health Insurance Plans, Blue Cross Blue Shield Association, and consumer groups have historically opposed the idea, arguing that it would segment the market so that healthier consumers would largely choose low-cost “junk” insurance while sicker consumers would be stuck in more comprehensive plans with significantly higher premiums due to the unbalanced risk pools (see Update for Week of October 2nd). Leading insurers like Blue Cross of California have previously attacked the idea as a “race to the bottom” (see Update for Week of January 30th).

Critics of the DOL rule also point out that several states including Georgia, Maine, and Wyoming have already passed laws allowing interstate association plans and were not able to draw any interest from insurers (see Update for Week of April 9, 2012). Last year's Congressional bill to allow association health plans (H.R. 1101) gained only 37 Republican cosponsors.

Insurance industry lawyers also note that because the DOL rule overturns years of DOL advisory opinions that narrowly interpreted the employer definition under ERISA, it would likely be subject to multiple legal challenges before being able to be implemented.

Premium rebates from ACA medical-loss ratios increased in 2016 despite years of declines

According to the Centers for Medicare and Medicaid Services (CMS), health insurers paid more than \$446 million in premium rebates to consumers in 2016 under the medical-loss ratios (MLRs) imposed by the Affordable Care Act (ACA).



Since 2011, the MLRs require that individual and small group insurance spend no more than 20 percent of premium revenue of profit and administrative expenses (or 15 percent for large group insurers). They must refund greater amounts to consumers every August.

Insurers initially paid more than \$1.1 billion in premium rebates for the 2011 plan year (see Update for Week of June 18, 2012). However, the amounts had steadily declined as insurers adjusted to the market. For example, insurers paid only \$332 million in rebates for 2014 (see Update for Weeks of October 5 and 12, 2015).

However, the \$446 million total for 2016 was higher than the \$397 million paid for 2015. (It works out to an average rebate of \$109-116 per consumer.)

Analysts largely predict that premium rebates will likely increase again for the 2018 plan year due to the tax bill signed last month by President Trump (see Update for Week of December 18th). This is because for most insurers the corporate tax cut will have the effect of lowering their MLR to the point where rebates will be required, unless they boost spending on quality initiatives or other qualifying expenses.

CMS has proposed to loosen the MLR thresholds as a part of their Notice of Benefit and Payment Parameters regulations for 2019, so that insurers could spend more on profit and administration (see Update for Week of November 6th).

STATES

States continue to pursue legislation preventing prescription drug price-gouging

Several states are considering legislation this session that would prohibit price-gouging for essential off-patent or generic drugs.

The bills are modeled after the law enacted last year in Maryland (see Update for Weeks of May 29th and June 5th). It required the health department to notify the Attorney General whenever three or fewer manufacturers are actively manufacturing and marketing the drug, the wholesale acquisition cost (WAC) increases by 50 percent or more in one year, or if the WAC for a 30-day supply exceeds \$80.

A nearly identical bill was pre-filed last month in New Hampshire (see Update for Week of December 18th) and several more were introduced by Democratic lawmakers last week at the outset of legislative sessions in other states. Some like H.B. 137 in Mississippi and S.B. 223 in Virginia are comparable to the Maryland law while others like S.B. 5995 in Washington and A.B. 5733/S.B. 2544 in New York set the reporting threshold at 100 percent instead of 50 percent. (S.B. 2402 in New York would let the courts decide whether the WAC increase was “unconscionably excessive”.)

Idaho

Governor lets insurers sell health plans that do not comply with ACA

Governor Butch Otter (R) issued an executive order last week directing the Department of Insurance to let health insurers sell state-created plans that do not comply with the consumer protections in the Affordable Care Act (ACA).

According to the Governor, the move is intended to give consumers the choice between ACA-compliant coverage and plans that cover fewer of the ACA’s essential health benefits but cost 30-50 percent less. While the Department has yet to define the new plans, Director Dean Cameron (R) insisted that they would incorporate most the essential benefit packages under the ACA with exceptions for specific services like maternity and mental health care that not every consumer would need.



Under the executive order, insurers would still be required to sell ACA-compliant plans. Consumers would only be able to eligible to use premium tax credits under the ACA for those ACA-complaint plans.

The executive order gives the Director the authority to seek any necessary federal waivers, though he claimed none would likely be necessary. Legal analysts largely expect any waiver of essential health benefit rules to be challenged in court, since they have not been repealed or altered by Congress.

Kentucky

Governor gets first waiver to impose work requirements, lockout periods on Medicaid enrollees

The Centers for Medicare and Medicaid Services (CMS) has made Kentucky the first state that can impose work requirements and lock-out periods on Medicaid enrollees.

Starting in July, “able-bodied” Medicaid enrollees between the ages of 18 and 65 must provide documentation proving they are employed or doing volunteer work at least 20 hours per week, or enrolled in job training programs. (Full-time students, pregnant women, and former foster youth will be exempt.)

In addition, the Section 1115 demonstration waiver will allow Kentucky to impose new premiums on enrollees that became eligible through the Medicaid expansion under the Affordable Care Act (ACA). Premiums are limited to \$15 per month, but Kentucky will can impose copayments for failure to make timely payments, or actually terminate coverage and force enrollees to remain uninsured for six months. Enrollees could also be locked out if they fail to report a change in income or miss paperwork deadlines.

Governor Matt Bevin (R) first submitted the waiver request last year (see Update for Week of July 25, 2016), shortly after being elected on a pledge to undo the state’s Medicaid expansion and state-based Marketplace under the ACA. Former Governor Steve Beshear (D) had made Kentucky the only southern state to participate in the Medicaid expansion and create their own Marketplace. Its subsequent 108 percent increase in Medicaid enrollment is the most nationwide enabling Kentucky to achieve the second steepest reduction in its uninsured rate after Arkansas (see Update for Week of January 4, 2016).

Governor Bevin promptly converted the state’s Marketplace to federal control but met with stiffer than expected opposition to eliminating the Medicaid expansion (see Update for Week of February 6, 2016). As a result, he has pursued alternative means to limit the number of expansion enrollees and admits that the new waiver will likely eliminate coverage for more than 95,000 working-age adults over the next five years (or roughly ten percent of the expansion population).

The vast majority of 1,800 public comments received in response to Governor Bevin’s request were critical of the work requirement, pointing to analyses from groups like The Commonwealth Fund showing that such requirements directly result in mass coverage losses or treatment disruptions, which ultimately increase state costs (see Update for Week of July 10th). The Kentucky Center for Economic Policy warned that the lock-out period would be particularly harmful to low-income enrollees who frequently work in retail, restaurant, or construction jobs where hours and income greatly fluctuate depending on the time of year.

Work requirements and lock-out periods have been part of federal waivers proposed by most conservative governors since 2014. Many of these waivers (including Kentucky’s) were crafted by new CMS Administrator Seema Verma, who has been highly critical of the Obama Administration for rejecting work requirements under the premise that they did not comply with federal Medicaid law (see Update for Week of November 6th). CMS’ legal counsel acknowledged last month that approving work requirements carried a “significant litigation risk going forward”. However, CMS put forward formal guidance this week indicating that the agency was likely to approve waivers similar to Kentucky’s that have already been filed by nine other states.



At least nine other states including Arizona, Arkansas, Indiana, Maine and Ohio are proposing similar work requirements, which had consistently been rejected by the Obama Administration but are now being encouraged by CMS (see Update for Week of January 30th). If implemented nationwide as Congress would do in the current legislation to repeal and replace the Affordable Care Act (see above), work requirements could ultimately be applied to 30 percent of all Medicaid enrollees.

Despite strong support from conservative governors, moderate Republican governors have been less enthusiastic. For example, Governor Charlie Baker (R) in Massachusetts stated this week that he would not pursue work requirements for Medicaid.

Maryland

Senate Democrats prepare to introduce alternative to individual mandate under ACA

Senators Brian Feldman (D) and James Rosapepe (D) released a draft bill this week that would let Maryland create their own alternative to the individual mandate under the Affordable Care Act (ACA).

President Trump signed legislation last month that will eliminate tax penalties for the ACA's individual mandate, starting with the 2019 plan year (see Update for Week of December 18th). Several democratically-controlled states immediately responded with proposals for an alternative mandate, including Massachusetts, which had an individual mandate prior to 2014 upon which the ACA version was based.

Maryland appears to be the first state prepared to introduce legislation as early as next week that will similarly penalize those who fail to purchase minimum essential coverage they can afford. However, instead of a tax penalty, consumers would be levied a fine that would go to the Maryland Health Exchange (created by the ACA), which would use it as a down-payment to automatically enroll the consumer in a health plan. If the consumer opts out, the fine would be used to stabilize the individual market.

Even if the legislation is passed by the Democratically-controlled legislature, it is not clear if it would be signed by Governor Larry Hogan (R). The Governor opposed Congressional bills last summer that sought to repeal key ACA provisions including the individual mandate. However, he has not commented on alternative proposed by Democrats.

Nevada

Marketplace sees record enrollment for 2018

Nevada Health Link officials announced last week that more than 91,000 consumers signed-up for coverage during the 2018 open enrollment period that ended December 15th.

The figure surpasses the Marketplace's previous high of 89,000 enrollees despite the enrollment period being cut in half. Nevada is one of only five states that created their own Marketplace but were forced to use the federal web portal due to persistent software glitches (see Update for Week of January 25, 2016). As a result, they were unable to keep enrollment open beyond the December 15th deadline for federally-facilitated Marketplaces (FFMs).

However, unlike FFMs, Nevada was able to maintain their own marketing and outreach budget and was not impacted by the 90 percent cut imposed by the Trump Administration (see Update for Week of November 6th). State officials credit Nevada's extensive advertising and enrollment assistance for the record number of sign-ups, which nearly tripled the enrollment during the first year of the Marketplace.

Nevada's success came despite being the only state to allow consumers to enroll in off-Marketplace plans year round without a qualifying event (albeit with a three-month waiting period). In



addition, consumers faced dramatic premium increases averaging 36.8 percent from Health Plan of Nevada (UnitedHealthcare), which offers Marketplace coverage only in the most populous counties. Silver Summit, which entered the Marketplace in 2018 in order to ensure no counties were “bare”, also offered only four plans statewide.

Final 2018 numbers are likely to further climb as Nevada Health Link created a special enrollment period until March 1st for Marketplace consumers who belonged to Anthem Blue Cross and Blue Shield or Prominence, which exited the Marketplace in 2017.

New Jersey

New Governor brings renewed efforts to create ACA Marketplace and Basic Health Plan

Senator Nia Gill (D), formerly the Senate President pro tempore, reintroduced legislation this week that would make New Jersey the 13th state (including the District of Columbia) to create their own health insurance Marketplace pursuant to the Affordable Care Act (ACA).

Outgoing Governor Chris Christie (R) was one of only 11 Republican governors who agreed to expand Medicaid under the ACA. However, Governor Christie elected to default to the federally-facilitated Marketplace and refused repeat attempts by Democratic lawmakers to convert the Marketplace to state control.

However, next week’s inauguration of Governor-elect Phil Murphy (D) has given the Democratically-controlled legislature new impetus to not only operate their own Marketplace, but become only the third state to use the Basic Health Plan (BHP). Neighboring New York is the only state besides Minnesota that elected this option, in which the federal government pays 95 percent of the costs for states to cover those earning 138-200 percent of poverty in a lower-cost plan than the Marketplace that comes with no deductibles, limited copayments, and premiums of no more than \$20 per month (see Update for Week of July 10th).

Gill’s legislation (S.551) would create the both an individual and small business Marketplace as part of the Department of Banking and Insurance, with a ten-member board of directors appointed by the House and Senate, at least one of whom should have an expertise in consumer health advocacy. The board can take whatever actions necessary to exercise the BHP option, or elect not to do so if the BHP threatens to siphon critical numbers of healthier and less-costly consumers away from the Marketplace (the reason most states did not pursue the BHP).

Additional legislation by Senator Gill (S.561) would make New Jersey the only state to create a public health insurance option within the Marketplace, similar to the public option that was proposed by Congressional Democrats drafting the ACA, but was stripped out prior to the law’s enactment. She also filed a bill seeking to preserve the minimum essential health benefits packages that are required by the ACA (S.562).

Governor Murphy has not taken a position of the legislation but has pledged to do whatever is necessary to “preserve health insurance coverage” for all residents should Congress repeal all or part of the ACA. This includes comparable emergency regulations to those taken by Governor Andrew Cuomo (D-NY) last year that required all private insurers to cover the ten essential health benefit categories required by the ACA and blocking any insurers that withdrew from New York’s state-based Marketplace from participating in Medicaid or the Children’s Health Insurance Plan (see Update for Weeks of May 29th and June 5th).

Rhode Island

Marketplace enrollment is 12 percent beyond 2017 totals with additional sign-ups expected



Officials with HealthSourceRI announced this week that more than 33,000 consumers signed up for Marketplace coverage during the 2018 open enrollment period.

As a state-based Marketplace, HealthSourceRI was able to extend their deadline until December 31st, compared to December 15th for federally-facilitated Marketplaces. In addition, HealthSourceRI will allow individuals who selected a plan but did not complete the enrollment process to continue to do so until January 23rd. As a result, the final tally is expected to add several hundred more enrollees. However, HealthSourceRI sign-ups are already five percent away from their record high in 2016 (of 34,670 enrollees) and 12 percent beyond last year's figures, despite the Trump Administration shortening the open enrollment period, eliminating Affordable Care Act cost-sharing reductions, and cutting Marketplace advertising and outreach budgets by 90 percent (see Update for Week of November 6th).

Washington

Insurance commissioner proposes reinsurance program to stabilize premiums

Insurance Commissioner Mike Kreidler (D) proposed legislation this week that aims to stabilize health insurance premiums for more than 300,000 consumers in the individual market by creating a reinsurance program for insurers.

The reinsurance program would provide insurers with partial reimbursement for high-cost medical claims that exceed a certain threshold. It would be comparable to the temporary reinsurance payments provided under the ACA through 2016 and subsequently implemented with federal approval in Alaska, Minnesota, and Oregon (see Update for Week of November 13th). Based on the positive results in those states, the Commissioner projects that the program would lower average rate hikes by roughly ten percent while expanding the number of plan options available to consumers.

Commissioner Kreidler's proposed bills (H.B. 2355 and S.B. 6062) were promptly cosponsored by the health committee chairs in both the House and Senate. Rep. Eileen Cody (D) insisted that the reinsurance program would help protect consumers from further federal efforts to undermine the ACA, following the repeal of the law's individual mandate (see Update for Week of December 18th), elimination of cost-sharing reductions, and slashing of the open enrollment period and outreach budget for the Marketplaces (see Update for Week of November 6th).

As with Alaska, Minnesota, and Oregon, creating of reinsurance program would require Washington to request a waiver from the Trump Administration in order for the costs to be partly subsidized by the federal government. The bills estimate that the program will cost \$200 million per year and project that roughly one-fourth of that amount would be federally-paid. The remainder would be funded largely through a state assessment on health insurers and plan administrators.

The Commissioner stressed that the need for a reinsurance program was evident by the number of insurers that left the ACA Marketplace in 2018, leaving nine counties with only one participating insurer. Washington nearly had two "bare" counties with no insurers before the Commissioner was able to persuade three insurers to fill in the gap (see Update for Week of July 10th). However, the limited options resulted in a record 24 percent average increase in Marketplace premiums, which was more than double the 11 percent increase in 2017 and single-digit increases in 2015 and 2016 (see Update for Week of October 2nd).

Roughly a dozen states are already considering similar reinsurance bills next session. A bipartisan Congressional bill from Senators Susan Collins (R-ME) and Bill Nelson (D-FL) would provide \$5 billion in reinsurance payments for two years. However, it has been stalled by conservative opposition despite the Majority Leader's assurance that it would implemented concurrent with the repeal of the ACA's individual mandate (see Update for Week of December 18th).