

## Health Reform Update – Week of February 26, 2018

### CONGRESS

#### ***Administration removes budget provision proposing to “fully fund” ACA risk corridor obligations***

The Trump Administration has removed a controversial provision from its proposed fiscal year 2019 budget that appeared to seek full funding for outstanding obligations to insurers under the expired Affordable Care Act (ACA) risk corridor program.

The proposal drew an immediate backlash from Senator Marco Rubio (R-FL) and other conservatives who had long-insisted that the risk corridor payments (which redistributed funds from better-performing insurers to those losing more than three percent of premium revenue) amounted to an “insurer bailout.” They successfully forced Democrats to agree to spending bills that barred the Centers for Medicare and Medicaid Services (CMS) from transferring funds to cover \$12.3 billion in outstanding obligations under the program, which ended after 2016 (see Update for Week of December 15, 2014).

A dozen Marketplace insurers are suing CMS to force payment for the outstanding risk corridor claims (see Update for Week of October 24, 2016) and at least two quickly pointed out that the President’s proposal contradicted court claims by Department of Justice (DOJ) lawyers that CMS is not obligated to make the payments. As a result, DOJ insisted that the President’s proposal was merely the result of an “accounting error” and removed it from a revised budget plan submitted last week.

### FEDERAL AGENCIES

#### ***Proposed rule would again allow short-term, limited benefit plans that do not comply with ACA***

The Department of Health and Human Services issued proposed regulations last week that would let individual consumers once again purchase short-term coverage for up to one year.

Short-term health plans do not need to comply with the consumer protections in the ACA and can offer limited benefits, impose annual and lifetime caps, and deny coverage to persons with pre-existing conditions or charge higher premiums based on health status. The Obama Administration had limited short-term plans to a duration of no more than three months (see Update for Week of June 20, 2016). However, under the Trump Administration, HHS is seeking to return to the pre-ACA limit of 364 days.

HHS emphasizes that short-term plans will be significantly cheaper for consumers, with premiums likely to average about \$124 per month instead of \$393 per month for an unsubsidized plan in the ACA Marketplaces. The agency insists that only 100,000-200,000 Marketplace consumers would enroll in short-term coverage and disputes claims by The Urban Institute (see below) and other researchers that allowing such non-compliant coverage to proliferate will effectively siphon away so many younger and healthier consumers that it will cause Marketplace premiums to dramatically increase. However, HHS acknowledges short-term plans will cause some increase in premiums, which will in turn cause the federal government to pay more for ACA premium subsidies and expand the federal budget deficit each year by \$96-168 million.

Senator Ron Wyden (D-OR) and other leading Democrats blasted the move as a return to “junk insurance” that creates a “green light to discriminate against Americans with pre-existing conditions [and] make quality health insurance more expensive and less accessible.”

***Urban Institute says premiums will spike 18 percent due to short-term plans, loss of individual mandate***

The Urban Institute released a new study this week predicting that Trump Administration efforts to eliminate Affordable Care Act (ACA) consumer protections and stability measures will cause premiums in most states to spike by more than 18 percent.

Researchers evaluated the impact of two specific actions: the proposed rule extending short-term health plans (see above) and the repeal of individual mandate penalties in 2019 (see Update for Week of December 18<sup>th</sup>). They found that in the 43 states that lack limits on non-ACA compliant plans, average monthly premiums for “traditional” health coverage will jump by 18.2 percent and 6.4 million people will become uninsured.

The study specifically projects that 4.2 million people will enroll in the new short-term health plans, exponentially above the 100,000-200,000 predicted by the Trump Administration (see above). The premium increase will also force federal government spending for ACA premium subsidies to increase by nine percent (or \$33 billion).

***Study finds proposed rule on association health plans will cut ACA enrollment, increase premiums***

A new study released this week by Avalere Health consultants concluded that roughly 3.2 million people will switch from Affordable Care Act (ACA) compliant coverage into non-compliant coverage that the Trump Administration wants to allow through association health plans (AHP).

The proposed rule issued earlier this year by the Department of Labor (DOL) seeks 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 (see Update for Week of January 8<sup>th</sup>). This would allow health plans sponsored by trade associations to sell policies across state lines that no longer need to comply with certain ACA consumer protections, like essential health benefits.

DOL estimated that up to 11 million Americans who are self-employed or work for small business could benefit under these AHPs (that would be organized by a geographic area or industry), far higher than the amount predicted by Avalere Health.

The agency attempted 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 (see Update for Week of January 8<sup>th</sup>). However, the plans specifically would no longer have to comply with the ACA’s essential health benefit packages or other consumer protections.

Avalere researchers confirmed that premiums for limited-benefit AHPs would be dramatically lower (nearly \$10,000 less costly than an ACA-compliant plan in the individual market). However, because AHP enrollment is likely to mostly constitute younger and healthier consumers who otherwise would be covered in the ACA Marketplace, premiums for Marketplace plans are likely to rise by at least 3.5 percent for individual coverage.

## **STATES**

***Republican Attorneys General file lawsuit to overturn entire ACA because of individual mandate repeal***

Republican Attorneys General from 20 states led by Texas and Wisconsin filed suit this week in the U.S. District Court for the Northern District of Texas claiming that the Affordable Care Act (ACA) is unconstitutional after the individual mandate was repealed by Congress (see Update for Week of December 18<sup>th</sup>).

Legal analysts largely mocked the lawsuit as a “jaw-dropping” political stunt, given that the U.S. Supreme Court already upheld the constitutionality of the individual mandate and the entire ACA (see Update for Week of June 25, 2012).

They note that repealing the entire ACA would effectively bring back the Medicare Part D coverage gap, terminate Medicaid or Marketplace coverage for up to 24 million Americans, and even undo Food and Drug Administration approvals for biosimilar drugs.

However, the case was assigned to Judge Reed O'Connor, an appointee of President George W. Bush who previously struck down Obama Administration regulations prohibiting transgender discrimination. A lower court ruling would also be appealed to the Fifth Circuit, widely considered the most conservative appellate court in the nation.

The Trump Administration has not yet indicated whether it will oppose the lawsuit, which names the Department of Health and Human Services as a defendant.

### ***Two states advance measures that would allow prescription drugs to be purchased from Canada***

Bills that would allow prescription drugs to be purchased from Canada have made significant progress in Utah and Vermont.

Drug importation continues to be illegal under federal law, although at least 15 states have considered measures since 2003 that would allow importation. Short-lived laws were enacted in both Rhode Island and Maine but failed in the face of opposition from the pharmaceutical industry and the Food and Drug Administration, as well as federal courts which overturned the law in Maine (see Update for Week of February 23, 2015). Congressional efforts have likewise been stymied (see Update for Week of December 16, 2013).

The latest measure in Utah (H.B. 163) was sponsored by a Republican (Rep. Norman Thurston) and cleared the full House chamber this month. It would specifically allow drugs to be purchased from Canada for in-state use if they are designated by the state to incur “substantial savings” for consumers.

A similar measure in Vermont (S.175) sponsored by Senator Tim Ashe (D) passed three Senate committees and is headed for the Senate floor. It would create a wholesale bulk purchasing program from Canada, but also require drug manufacturers to notify consumers before introducing new, high-cost drugs to the market. Health insurers would also be required to provide information on the impact of prescription drug spending on premium rates.

### ***States struggle to follow Maryland's lead in prohibiting prescription drug price-gouging***

At least ten states are considering legislation this session that would prohibit price-gouging for essential off-patent or generic, similar to the new law enacted last year in Maryland.

The Maryland law 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 (see Update for Weeks of May 29<sup>th</sup> and June 5<sup>th</sup>). However, comparable bills introduced in other states have yet to even advance through committee and were rejected in Mississippi (H.B. 137), New Hampshire (H.B. 1780), and Virginia (S.B. 223).

Legislation in New York (A.B. 5733/S.B. 2544) would set the reporting threshold at 100 percent instead of 50 percent set by Maryland and sought by other states. (S.B. 2402 in New York would let the courts decide whether the WAC increase was “unconscionably excessive”.)

S.B. 5995 in Washington did clear an initial committee but it would simply direct a state agency to study the issue and make recommendations to the legislature.

#### Alabama

***Medicaid seeks harshest work requirements in the nation***

The Alabama Medicaid Agency released a draft Section 1115 demonstration waiver request this week that would allow the state to impose the strictest work requirements in the nation on its Medicaid population.

Because Alabama is one of 18 states that have not expanded Medicaid under the Affordable Care Act (ACA), the work requirements would apply to roughly 75,000 Medicaid enrollees who are parents or caretakers of a child under age 19 and earn less than 18 percent of the federal poverty level (FPL) (or \$312 per month for a family of three). As a result, consumer groups like Alabama Arise questioned the motivation of such “cruel” requirements that would effectively eliminate coverage for this entire population, as someone working the mandated 20 hours per week would earn \$580 per month at minimum wage, well over the Medicaid eligibility limit.

Public comments on the waiver application will be accepted through April 2<sup>nd</sup>. A Senate committee is expected to shortly advance legislation (S.B. 140) that would authorize the application.

The Trump Administration has already approved waivers for two states seeking working requirements (Kentucky and Indiana) and several applications remaining pending (see Update for Week of February 12<sup>th</sup>). However, none are for states that have not expanded Medicaid under the ACA to include childless adults earning up to 138 percent of FPL.

#### Alaska

##### ***House and Senate bills would add Medicaid work requirements***

Conservative lawmakers in both the House and Senate are seeking to make Alaska the latest state to receive federal approval to require Medicaid enrollees work or seek job training for at least 20 hours per week.

The measures (S.B. 193, H.B. 356) were introduced by Senate President Pete Kelly (R) and Rep. Chuck Kopp (R). However, it is not clear if it would be approved by the Democratically-controlled House or signed by Governor Bill Walker (I), who stated earlier this year that he has no plans to add work requirements to the Medicaid program he expanded by executive order over conservative opposition (see Update for Week of July 13, 2015).

#### Colorado

##### ***New bill would remove age limit for catastrophic coverage offered in ACA Marketplace***

Legislation introduced by Senator Jim Smallwood (R), chair of the Health and Human Services committee, would authorize the Insurance Commissioner to seek a federal waiver that would remove the age limit for catastrophic health plans in the Affordable Care Act (ACA) Marketplace.

The ACA restricted the limited-benefit catastrophic plan option only to those under age 30 (or those meeting a hardship requirement). The bill (S.B. 132) seeks to remove that restriction so catastrophic plans would be available to any Colorado resident. It has already moved through the Health and Human Services committee.

Similar legislation in Virginia (S.B. 964) has already passed the Senate (see Update for Week of February 12<sup>th</sup>) and cleared its first House committee this week.

#### District of Columbia

##### ***Marketplace board proposes individual mandate, reinsurance program, enhanced premium subsidies***

The DC Health Benefit Exchange Authority (DCHBX) Executive Board unanimously adopted recommendations this week from its Affordable Care Act (ACA) Working Group that seek to improve the affordability and stability of the ACA Marketplace operated by the District of Columbia.

Mayor Muriel Bowser urged the ACA Working Group to propose an individual mandate requirement, comparable to the ACA requirement that individuals purchase minimum essential coverage they can afford. The recommendation would largely follow the ACA's individual mandate penalties, which were repealed by Congress starting in 2019 (see Update for Week of December 18<sup>th</sup>). At least nine other states including Hawaii (see below) are considering implementing their own individual mandate alternatives (see Update for Week of January 22<sup>nd</sup>).

The Working Group also recommended that the District follow the lead of states like Alaska, Minnesota, and Oregon and seek federal approval to create a reinsurance program that will compensate insurers for exceptional claims (see Update for Week of November 6<sup>th</sup>). Although premium increases under DC Health Link have been lower than national averages, they still spiked by more than 15 percent on average for 2018 and consumers would likely see similar jumps in subsequent years without the reinsurance payments that insurers received under the ACA prior to 2017.

The Working Group's recommendations would also provide supplemental premium subsidies to those provided under the ACA. However, only four percent of DC Health Link enrollees receive premium subsidies, compared to the 84 percent national average.

DC Health Link has been a very successful Marketplace, enrolling more than 74 percent of all eligible residents. This is by far the highest rate in the nation and due largely to the requirement that insurers are not allowed to offer individual plans outside of the Marketplace. (Vermont is the only other state with this requirement, but it has enrolled only 49 percent of eligible residents).

As a result, the District of Columbia's uninsured rate stands at a historic low of 3.7 percent, the third lowest level in the country.

In addition, the District of Columbia operates by far the largest small-group Marketplace in the country. More than 16 percent of enrollees are members of Congress and their staff, which are required to use it to purchase coverage instead of the Federal Employees Health Benefit Plan (FEHBP).

#### Florida

##### ***In apparent reversal, House approves Medicaid work requirements***

The House passed legislation this week that would authorize the Agency for Health Care Administration (AHCA) to seek a federal waiver that would allow the imposition of work requirements on Medicaid enrollees.

Passage of H.B. 751 appeared to contradict statements by House Speaker Richard Corcoran (R) at the outset of the legislative session indicating that the chamber was not likely to consider work requirements because Florida had not expanded Medicaid to include childless adults. However, it remains very unclear whether the measure will be taken up by the Senate, with the session set to end on March 9<sup>th</sup>.

H.B. 751 would impose the same work requirements on Medicaid managed care enrollees that it currently sets for the Temporary Cash Assistance Program, which mandates that single parents with children over age six work at least 30 hours per week. This would be more severe than the 20 hour per week requirement that the Trump Administration recently approved for Kentucky and Indiana, which is being sought by conservative lawmakers in roughly one dozen other states (see Update for Week of February 12<sup>th</sup>).

#### Hawaii

##### ***State alternative to ACA individual mandate advances in Senate***

The Senate Ways and Means Committee passed legislation this week that would create a tax penalty for persons who fail to maintain minimum essential health coverage they can afford.

The penalties under S.B. 2924 would be comparable to those under the individual mandate in the Affordable Care Act (ACA) that was repealed by Congress starting in 2019 (see Update for Week of December 18<sup>th</sup>). At least nine other states and the District of Columbia (see above) are considering enacting their own versions of the individual mandate (see Update for Week of January 22<sup>nd</sup>).

#### Iowa

##### ***House and Senate bills would certain health plans to charge more for pre-existing conditions***

Legislation advancing in both the House and Senate would allow plans operated by Wellmark Blue Cross Blue Shield for the Iowa Farm Bureau Federation to avoid Affordable Care Act (ACA) rules on pre-existing conditions.

The goal of H.F. 2364 and S.F. 2329 (which cleared their respective Commerce committees) is to offer Farm Bureau members low-cost options in the individual market that offer limited benefits. However, the plans would “be deemed to not be insurance” allowing it to skirt most state and federal regulations, including the ACA prohibition on charging higher premiums to those with costly pre-existing conditions. As a result, they would be purchased primarily for younger and healthier populations.

Critics charge that allowing the non-ACA compliant plans, even just for Farm Bureau members, would have the effect of siphoning the critical young adult demographic out of the ACA Marketplace, effectively driving up premiums for Marketplace consumers who will be left in a risk pool more skewed towards costlier consumers. Iowa’s Marketplace consumers already faced the highest premium spike in the nation this year (88 percent on average for “benchmark” silver plans) and a skewed risk pool could further upward pressure on premiums even as Wellmark returns to the Marketplace for 2019 (see Update for Week of February 12<sup>th</sup>).

Supporters note that the Farm Bureau in Tennessee has been allowed to sell similar non-compliant policies in that state, even though consumers who purchased those plans were forced to pay the ACA tax penalty for not maintaining essential health coverage they could afford. However, the ACA tax penalty has been repealed by Congress starting in 2019 (see Update for Week of December 18<sup>th</sup>).

Iowa Democrats pledge to ask the Secretary of the U.S. Department of Health and Human Services to intervene, if the legislation is enacted. However, he has yet to issue a determination about whether Idaho Blue Cross and Blue Shield can offer similarly non-compliant plans in that state (see Update for Week of February 12<sup>th</sup>).

#### Kansas

##### ***Medicaid expansion bill advances in Senate, though floor vote appears unlikely***

The Senate Public Health and Welfare Committee approved legislation this week that would expand Medicaid eligibility to 150,000 Kansans earning up to 138 percent of the federal poverty level.

S.B. 38 is the latest of several efforts by moderate Republicans in the Senate to make Kansas the 33<sup>rd</sup> state to expand Medicaid under the ACA, following a rash of rural hospital closures (see Update for Week of January 30, 2017). The Senate fell only two votes short of overriding last year’s veto of Medicaid expansion legislation by conservative Governor Sam Brownback (R) (see Update for Week of May 8<sup>th</sup>). However, new Governor Jeff Colyer (R) is just as stridently opposed to expansion, making Senate leaders reticent to bring S.B. 38 to a floor vote without a two-thirds majority.

Medicaid expansion proponents are trying to gain the Governor’s support by including provisions requiring “able-bodied” enrollees work at least 20 hours per week or participate in job training programs, similar to the waivers the Trump Administration approved last month for Kentucky and Indiana (see Update for Week of February 12<sup>th</sup>). A similar concession broke the Medicaid expansion impasse in Virginia (see Update for Week of February 12<sup>th</sup>), but appears

unlikely so far to persuade Governor Colyer, who was considered the “chief critic” of “Obamacare” when serving as Lt. Governor.

Fueling the debate over Medicaid expansion is new data released this week by the U.S. Department of Health and Human Services showing that during the first nine months of 2018, the adult uninsured rate in the 18 opt-out states is twice as high as for expansion states.

#### Kentucky

##### ***Governor countersues enrollees challenging Medicaid work requirements***

Governor Matt Bevin (R) filed an unusual lawsuit this week against the Medicaid enrollees who are challenging his implementation of work requirements and lock-out periods for “able-bodied” adults.

Earlier this year, the Governor made Kentucky the first state to impose such work requirements, a move that he estimates will terminate coverage for roughly 95,000 enrollees (see Update for Week of January 8<sup>th</sup>). Fifteen Medicaid enrollees promptly filed suit in the U.S. District Court for the District of Columbia, alleging that the Governor and the Centers for Medicare and Medicaid Services (CMS) lacked the authority to approve work requirements, which previous Administrations believed to violate federal Medicaid law (see Update for Week of January 22<sup>nd</sup>).

In response to the class-action lawsuit, Governor Bevin promptly issued an executive order threatening to terminate Kentucky’s entire Medicaid expansion under the ACA if the work requirements were not upheld by the Obama-appointed judge presiding over the case in the District of Columbia federal court (see Update for Week of February 12<sup>th</sup>). He had the option to intervene in that lawsuit in order to ensure Kentucky’s interests were upheld, but instead elected to file a countersuit in the U.S. District Court for the Eastern District of Kentucky, where all but one judge was appointed by Republican presidents.

The Trump Administration defended the Governor’s move and asked the District of Columbia court to simply transfer the case to the Eastern District of Kentucky.

The Governor’s own budget acknowledges that the administrative and technological changes needed to track work hours and other required documentation will cost \$187 million in the first six months alone. However, he insists that the vast majority of those costs will be paid by the federal government and that eliminating 95,000 Medicaid enrollees will ultimately save the state and federal government more than \$2 billion.

#### Maryland

##### ***Bills to curb how much insurers can pay for prescription drugs gains broad legislative support***

Legislation that would make Maryland a test case for prescription drug price controls has garnered broad legislative support and litigation threats from the pharmaceutical industry.

S.B. 1023 introduced this month by Senator Joan Carter Conway (D) (with the H.B. 1194 companion introduced by Del. Joseline A. Peña-Melnyk (D)) would create a Drug Cost Review Commission to decide the maximum amount that health plans, pharmacies and state programs could pay for the most expensive brand-name and patented medications. The model is similar to Maryland’s rate-setting commission that determines how much hospitals can charge for their services.

The House measure already has more than enough cosponsors to pass in that chamber and is only one shy of a Senate majority. Governor Larry Hogan (R), who is running for re-election, has not taken a position on the bills. However, he allowed Maryland’s unprecedented ban on price-gouging for essential and off-patent drugs to go into law without his signature last year, despite claiming it was “unconstitutional” and would be overturned (see Update for Weeks of May 29<sup>th</sup> and June 5<sup>th</sup>).

If enacted, S.B.1023 and H.B.1194 will also face promised legal challenges from drugmakers, who insist that it violates U.S. patent law. They point out that a 2005 District of Columbia law that allowed residents to sue drugmakers whose prices were at least 30 percent higher than in Australia, Canada, Germany and the United Kingdom was struck down by federal courts on that basis. However, Maryland Attorney General Brian Frosh (D) claims that these bills can survive patent challenges because they regulate “how much can be paid for medications—rather than how much can be charged.”

According to national Kaiser Family Foundation polls, 74 percent of Democrats and 71 percent of Republicans support the concept of prescription drug costs being regulated by an independent commission.

#### Minnesota

##### ***Governor proposes “public option” for ACA Marketplace***

Governor Mark Dayton (D) and several Democratic lawmakers are proposing to create a “buy-in” option that would allow roughly 100,000 Minnesotans who earn too much for Medicaid purchase coverage in the state-subsidized MinnesotaCare program.

MinnesotaCare has been operated by the state since 1992 and currently covers about 89,000 Minnesotans. Coverage is limited only to those earning up to 200 percent of the federal poverty level (FPL) who are ineligible for Medicaid, which covers up to 138 percent of FPL under the Affordable Care Act (ACA) expansion.

However, the Governor’s proposal would let Minnesotans earning more than 200 percent of FPL purchase MinnesotaCare coverage as an estimated cost of \$469 per month (or 13 percent lower than the average premium for individual market coverage). However, because the “buy-in” coverage would be offered as a “public option” within the MNSure Marketplace that the state created pursuant to the ACA, those eligible for ACA premium tax credits (if they earn less than 400 percent of FPL) could apply those credits towards MinnesotaCare coverage.

The prospects for legislative approval appear slim, as Republican lawmakers control both the House and Senate and strongly opposed a similar “buy-in” proposal last year. State hospital and physician groups also are not enthusiastic about the proposal, fearing that a “public option” would provide lower reimbursement.

A separate Democratic bill would merely extend the emergency premium relief program enacted last year that used the state’s budget surplus to give roughly 120,000 Minnesotans a 25 percent premium rebate if they purchased individual market coverage and were ineligible for Medicare, Medicaid, or ACA subsidies (see Update for Week of January 30, 2017). The measure (H.F. 2949) would authorize a comparable subsidy for 2018, although Republican lawmakers insist it is no longer necessary after the legislature later created one of four federally-approved reinsurance programs, which dramatically mitigated the 59 percent average premium spike faced by individual market consumers (see Update for Week of May 8<sup>th</sup>).

#### New Jersey

##### ***Senator renews efforts to limit cost-sharing for prescription drugs***

Former Senate Majority Leader Loretta Weinberg (D) introduced S.B. 1865 in the Senate Commerce committee this month, which is the latest incarnation of legislation that would limit consumer cost-sharing for prescription drugs.

The measure sets different limits depending on the coverage tier. For the lowest bronze-tier coverage, cost-sharing can be no more than \$200 per month for up to a 30-day supply of each prescription drug. Higher tiers must limit cost-sharing to no more than \$100 per month while catastrophic coverage remains exempt from any limits.

Senator Weinberg has introduced the nearly identical bill for the last two sessions (see Update for Week of October 10, 2016). It unanimously passed the Senate last year before stalling in the Assembly.

Wisconsin

***Legislature approves Governor's request to create reinsurance program for Marketplace insurers***

Governor Scott Walker (R) signed S.B. 770 into law this week after the legislature approved his plan to create a reinsurance program in order to mitigate rate hikes in the individual health insurance market.

S.B. 770 represents part of the "Health Care Stability Plan" that the Governor proposed in his State of the State address (see Update for Week of January 22<sup>nd</sup>). In addition to providing insurers with additional payments for exceptional claims, his plan codifies into law the Affordable Care Act (ACA) prohibition on insurance denials based on pre-existing conditions. It also authorizes the state to seek permanent federal approval for the SeniorCare program, which Governor Walker twice sought to dramatically scale back despite bipartisan opposition (see Update for Week of May 23, 2011). SeniorCare uses both federal and state funds to assist more than 92,000 residents age 65 or over with their out-of-pocket prescription drug costs under Medicare Part D.

S.B. 770 specifically authorizes state agencies to seek a federal waiver under which Wisconsin would receive \$120 million in federal reinsurance funds while the legislature would appropriate an additional \$80 million (see Update for Week of February 12<sup>th</sup>). The program would start in 2019 and provide additional payments to insurers for patients with claims between \$50,000 and \$250,000. It would be paid for with projected savings from cuts in the Medicaid program, which Wisconsin has not expanded under the ACA.

The reinsurance model is based on those that have already been approved by the Trump Administration for Alaska, Minnesota, and Oregon, which have dramatically reduced premium increases in those states (see Update for Week of November 13<sup>th</sup>). It replaces the temporary reinsurance program under the ACA that expired after 2016.

Although Democrats largely support the concept of reinsurance programs, most Democrats opposed S.B. 770 since Republicans slipped in a provision that would bar any future governor from expanding Medicaid under the ACA without legislative approval (should Governor Walker not be re-elected in the fall). They also objected to another provision directing the Governor to study whether to concurrently resurrect the Health Insurance Risk-Sharing Plan, which was the high-risk pool for persons with pre-existing conditions that the state operated prior to the ACA.

Democratic lawmakers instead have encouraged the Administration to expand Medicaid and use the ACA matching funds to fund the reinsurance programs. They note that the three other states with federal reinsurance waivers all participate in the Medicaid expansion.

Critics of the Governor's plan largely claim point out that his efforts "stabilize" the individual ACA Marketplace appear to contradict his approval of a federal lawsuit challenging the constitutionality of the ACA now that the individual mandate penalties have been repealed starting in 2019 (see Update for Week of December 18<sup>th</sup>). Wisconsin Attorney General Brad Schimel (R) has joined with the Texas Attorney General in leading the lawsuit on behalf of 18 other states (see above).