

Health Reform Update – Week of May 7, 2018

CONGRESS

Congressional Budget Office predicts higher premiums and less coverage due to Trump Administration policies

A new analysis released this week by the Congressional Budget Office (CBO) predicts that average premiums in Affordable Care Act (ACA) Marketplaces will increase by 15 percent next year, while enrollment will be one-third less than it previously estimated.

CBO “largely” attributes the higher premiums and coverage declines to two factors. This first is “short-term market uncertainty” by insurers about whether “certain subsidies that are currently available will continue to be provided”, leading to a decline in market competition. The second is the Congressional repeal of tax penalties under the individual mandate (see Update for Week of December 18th), which required individual consumers purchase minimum essential coverage they can afford. It also cited the Administration’s dramatic “reductions in federal advertising, outreach, and other enrollment efforts” as additional factors that limited overall enrollment in 2018 (see Update for Week of February 12th) and will continue to do so next year.

Researchers directly blamed the Trump Administration for making specific policy decisions to make the Marketplaces less functional and refuted Administration claims that the ACA was “imploding” on its own (see Update for Week of August 14th).

Initial rate filings released this week by Maryland and Virginia (see below) tended to support CBO’s conclusion, as several insurers sought staggering 64-91 percent increases in direct response to the expected skewing of their risk pools due to healthier and less costly consumers staying out of the Marketplaces.

With market stabilization measures dead, sponsors push CMS to expedite waivers, facilitate high-risk pools

The sponsors of legislation to stabilize Affordable Care Act (ACA) Marketplaces admitted this week that the measures will not advance this year and focused their attention on regulatory measures that can be taken in the interim by the Centers for Medicare and Medicaid Services (CMS).

The stabilization measures sought to restore funding for ACA cost-sharing reductions terminated by the Trump Administration (see Update for Week of November 6th), as well as a federal reinsurance program compensating insurers for extraordinary claims (i.e. those beyond a certain dollar threshold), comparable to the ACA reinsurance payments that expired after 2016. Since both measures appear dead, Senators Lamar Alexander (R-TN) and Susan Collins (R-ME) stated that they are working with CMS Administrator Seema Verma about steps CMS can take to speed the approval of State Innovation Waivers under Section 1332 of the ACA that let states opt-out of key ACA provisions in order to experiment with budget neutral reforms that promote equivalent coverage. Senator Alexander drafted bipartisan legislation along with Senator Patty Murray (D-WA) that not only relaxed this criteria, but would have let states receive expedited approvals for waiver requests that essentially copied another state’s approved waiver (see Update for Week of August 28th).

Three states have already used Section 1332 waivers to create their own reinsurance programs (see Update for Week of December 18th). Wisconsin’s request remains pending with CMS and roughly ten other states are considering submitting similar applications this year (see Update for Week of April 16th). Given the success of approved reinsurance programs in mitigating rate hikes, the Senators insist that speeding-up the approval process is critical to stabilizing Marketplaces for 2019.

Based on the experience in her home state, Senator Collins is also pushing CMS to create so-called “invisible” high-risk pools where insurers automatically receive extra compensation for enrollees that have certain diagnoses, without segregating those higher cost subscribers into their own marketplace.

Senator Collins had been promised a floor vote on her reinsurance bill by Senate Majority Leader Mitch McConnell (R-TN) in exchange for her support of the President’s tax reform bill that repealed tax penalties for the ACA’s individual mandate (see Update for Week of December 18th). However, conservative lawmakers remained adamantly opposed to any reinsurance program, which they previously labeled an “insurer bailout” (see Update for Week of December 15, 2014).

Senate sets second hearing on increasing oversight and transparency for 340B drug discounts

The Senate Health Education Labor and Pensions Committee announced last week that it will hold its second hearing about reforming the Section 340B drug discount program on May 15th.

Officials with the Inspector General for the Department of Health and Human Services (HHS) and Government Accountability Office (GAO) are set to testify. During the initial hearing (see Update for Week of March 19th), Chairman Lamar Alexander (R-TN) stated that the committee would like to follow-up on earlier audits from both entities that suggested 340B safety net hospitals may be reaping windfall profits from the drug discounts instead of passing them along to consumers as Congress intended (see Update for Weeks of July 1 and 8, 2013).

The House Energy and Commerce Committee has already released a report summarizing their two-year investigation that found that savings received by participating hospitals are not benefiting low-income, uninsured individuals (see Update for Week of January 8th). It called on Congress to clarify the intent of the 340B program, increase and standardize reporting and auditing requirements, and give the Health Resources and Services Administration (HRSA) greater authority and resources to conduct adequate oversight. This led to a flurry of House and Senate bills that would heighten reporting and transparency requirements for 340B providers (see Update for Week of March 19th).

HRSA is expected to testify at a third still unscheduled hearing that will focus on improving the agency’s program administration and oversight.

The second hearing was announced concurrent with HRSA notice that is seeking a fifth delay in the Obama Administration rule governing 340B ceiling prices and manufacturer penalties. That rule would now be effective July 1, 2019 instead of this July. However, because HRSA acknowledged that the delay was due to significant questions about “fact, law, and policy”, several commenters questioned whether HRSA would ever implement the rule. The delays were sought by the Pharmaceutical Research and Manufacturers of America (PhRMA), which insists that complying with the rule would be “disruptive” given the “substantive questions that have been raised” (see Update for Week of August 14th).

HRSA has already withdrawn proposed regulations that would have modified the Obama Administration’s modifications of how ceiling prices are calculated, as well as the definition of when drugmakers “knowingly and intentionally” overcharge 340B providers. However, the Trump Administration has not backed away from its 27 percent cut in Medicare Part B payments for 340B drugs that went into effect January 1st despite bipartisan opposition in Congress and a federal lawsuit from hospital groups (see Update for Week of January 8th).

FEDERAL AGENCIES

Trump drug pricing plan does not call for Medicare negotiation authority or drug importation

In a victory for the pharmaceutical industry, President Trump’s long-promised plan to “substantially” reduce prices for prescription drugs does not include giving Medicare Part D the authority to negotiate drug prices or allowing consumers to purchase lower-cost drugs from countries like Canada.

The President supported both provisions as a candidate and President-elect but has not mentioned them since assuming office (see Update for Week of January 9, 2017). Both are strongly opposed by the Pharmaceutical Research and Manufacturers of America (PhRMA).

Instead, President Trump adopted a decidedly more modest approach in the blueprint he released late this week that attempts to put most of the blame for “excessively high drug prices” on “foreign freeloading” that forces drugmakers to increase U.S. prices in order to cover research and development costs, a “rigged” system that “reward[s] list price increases”, and hospitals in the federal 340B drug discount program who fail to provide charity care (see above).

The broad proposals put forward by the President largely follow those laid out in his fiscal year 2019 budget plan (see Update for Week of February 12th) and include several changes to the Part D program, including:

- Allowing greater flexibility in benefit design, including adjusting the benefit design mid-year;
- Requiring plans to share drug rebates with subscribers;
- Offering free generic drugs to low-income subscribers;
- Discouraging plans from accelerating subscribers through the Part D coverage gap and into the catastrophic benefit with costly brand-name drugs;
- Setting a new out-of-pocket maximum to protect subscribers from catastrophic out-of-pocket costs while ensuring plans are incentivized to limit excessive costs.

Other reforms include:

- Limiting Medicare Part B payment for prescription drug price increases that are above inflation and cut incentives for physicians to write high-price prescriptions;
- Potentially paying for some Part B drugs under the Part D drug benefit;
- Ensuring that 340B participating providers paid under Part B spend more than one percent of patient costs on charity care in order to continue receiving 340B drug discounts (see above);
- Accelerating the approval of generic drugs by the Food and Drug Administration (FDA);
- Finalizing FDA policy in which each biosimilar for a given biologic gets its own billing code under Medicare Part B, in order to incentivize development of lower-cost biosimilars (see Update for Week of November 13th).
- Curbing abuse of FDA safety rules and the 180-day “first to file” exclusivity clock.

The 44-page blueprint identifies areas where the Administration might administratively encourage competitiveness or innovation but did not commit to specific regulatory actions, such as requiring drug manufacturers to discuss the price of their products in direct-to-consumer advertisements.

The blueprint does solicit comment on whether the use of copay coupons artificially inflates manufacturer drug prices and should be permitted for enrollees in public health insurance programs. However, it omits any reference to “pay-to-delay” patent litigation settlements between brand-name and generic drugmakers, which the Federal Trade Commission has long-sought to prohibit because they greatly delay the market introduction of lower-cost generics (see Update for Weeks of February 8 and 15, 2016).

CMS rejects lifetime limits for Medicaid, but approves even harsher Medicaid work requirements

The Centers for Medicare and Medicaid Services (CMS) announced this week that it has formally rejected the three-year lifetime limit on Medicaid enrollment sought by the Kansas Department of Health and Environment.

Kansas is one of five states (including Arizona, Maine, Utah, and Wisconsin) currently seeking to impose lifetime limits of 3-5 years through Section 1115 demonstration waivers (see Update for Week of February 12th). All five states would exempt children, pregnant women, and persons with disabilities.

CMS Administrator Seema Verma had previously refused to provide any indication of CMS' position on lifetime limits, in stark contrast to her very public encouragement for Medicaid expansion states to seek waivers that would impose work requirements on "able-bodied" adult Medicaid enrollees (see Update for Week of November 6, 2017). However, she had recently indicated that the agency had concerns about people being able to enroll in Medicaid when losing their employment-based health insurance, as well as likely legal challenges to imposing lifetime maximums.

Kansas' waiver had the most severe limit of three years. The agency wavered earlier in the week on issuing a full rejection, acknowledging that there was "internal disagreement" over the decision that needed additional time to resolve.

However, CMS at the same time made New Hampshire the fourth state with federal approval to impose work requirements on Medicaid enrollees made newly-eligible by the ACA expansion. Starting in 2019, working-age adults in New Hampshire will be required to work (or participate in school, job training, community service, substance abuse treatment, job skills development, etc.) for at least 100 hours per month in order to remain eligible for Medicaid. This is the highest threshold approved by CMS, which signed-off on an 80 hour per month requirement in other states—the same limit Senator John Kennedy (R-LA) has urged CMS to implement nationwide.

CMS has only approved work requirements for states that have expanded Medicaid. Administrator Verma did acknowledge at a press briefing that the agency has concerns about the non-expansion states seeking to impose work requirements (see Update for Week of February 26th), including Alabama, Florida, Kansas, Oklahoma, Tennessee, and Wisconsin. She encouraged these states to "figure out a pathway [or] bridge to self-sufficiency" for those caught in between very limited Medicaid eligibility (often below 30 percent of the federal poverty level) and the lower limit for Affordable Care Act (ACA) premium tax credits (at 100 percent of poverty), noting that they could face a "subsidy cliff...because there is no tax credit for them to move on to the exchanges, what happens to those individuals?"

CMS "working through legal issues" related to Massachusetts' request for closed Medicaid drug formulary

The Administrator for the Centers for Medicare and Medicaid Services (CMS) announced this week that the agency is still evaluating whether existing law would allow states to use restricted Medicaid drug formularies in an effort to gain leverage in negotiations with brand-name drug manufacturers.

The issue relates to the Medicaid drug rebate program, which requires brand-name manufacturers discount their drugs by 23 percent in order to have them covered by Medicaid. Massachusetts is the only state currently seeking federal permission to waive the requirement that states cover all drugs for which manufacturers offer the 23 percent rebate, however several states including Arizona are waiting for CMS to decide on the Massachusetts request before submitting their own waivers.

CMS was widely expected to reject the closed-formulary request, which is largely opposed by drug manufacturers and patient advocates. However, Administrator Seema Verma stated that the agency was "working through some of the legal issues" regarding the request, given that the "President's budget has proposed that we do some demonstrations with states on this."

Avalere study finds PSI charitable assistance cuts Medicare spending while increasing access to care

Avalere Health consultants issued a new report this week, which specifically found that charitable cost-sharing assistance furnished by Patient Services Inc. (PSI) reduces patient out-of-pocket costs for medication, improves medication adherence, and lowers total Medicare costs through reduced medical spending.

Avalere researchers used PSI-provide data and its proprietary Part D financial model to determine that the charitable foundation's assistance generated \$33.9 million in net federal Medicare savings in 2017 and nearly \$146 million in Medicare savings from 2013-2017.

According to Avalere, PSI helped more than 13,500 Medicare Part D enrollees in 2017 by providing \$70.9 million in cost-sharing assistance (and \$305 million over the last five years). Researchers found that every \$1,000 provided by PSI allowed Part D enrollees to fill an average of 3.5 additional prescriptions per year. Even when accounting for the additional costs to Medicare from greater medication adherence, the study concludes that every \$1 million in PSI assistance translates to nearly \$500,000 in savings for the entire Medicare program.

STATES

HHS settles Basic Health Plan lawsuit brought by New York and Minnesota

The U.S. District Court for the Southern District of New York has dismissed a lawsuit brought against the Department of Health and Human Services by both New York and Minnesota, after the agency agreed to pay the states \$170 million in Basic Health Plan (BHP) payments.

The two states were the only ones to exercise the BHP option under the Affordable Care Act (ACA), 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). The BHP payments that New York and Minnesota received from HHS thus previously equaled 95 percent of the ACA premium tax credits and cost-sharing reductions (CSRs) that BHP enrollees would have received had they remain in an ACA Marketplace plan. However, HHS notified both states on December 21st that the cost-sharing component of their BHP payments would no longer be made following President Trump's decision to terminate the ACA cost-sharing reductions paid to insurers (see Update for Week of November 6th).

As result, the attorneys general from both states sued HHS, insisting that the ACA statute itself requires the BHP payment include both the premium tax credit and CSR component (see Update for Week of January 22nd). They had asked the court to at least force HHS to simply revise the payment calculation so that the premium tax credit portion they receive from HHS accounts for "silver loading", which was how most state insurance commissioners compensated for the loss of CSRs (by increasing premiums solely on silver-tier plans)(see Update for Week of April 16th). BHP enrollees in both states would have faced higher silver-plan premiums had they remained in the Marketplace and thus higher premium tax credits.

Under the settlement, HHS will pay nearly \$152 million to New York and over \$17 million to Minnesota to resolve any amounts owed as the CSRs were eliminated (for nearly 800,000 BHP enrollees in both states). HHS also agreed to publish a revised BHP payment methodology by July 2nd.

California

Appropriations committee amends bill placing safeguards on third-party premium assistance

The Senate Appropriations Committee has amended legislation that would place safeguards on third-party premium assistance provided by non-profit organizations like PSI.

S.B. 1156 requires health insurers accept premium assistance payments made by the Ryan White HIV/AIDS Program and other federal and state health programs, as well as Native American tribes, consistent with federal regulations (see Update for Week of June 2, 2014). These entities do not need to meet the standards that the bill establishes for others providing third-party premium assistance.

S.B. 1156 was unanimously approved last month by the Health Committee (see update for Week of April 16th). However, the Appropriations Committee promptly changed the bill to so that it now applies solely to premium assistance instead of cost-sharing assistance. In addition, those receiving third-party assistance from a third-party entity no longer



must apply to Covered California, as under the original version. However, they still must first apply for and receive a denial from Medicare or Medicaid.

Other amendments to S.B. 1156 require the financial assistance to be “conditioned solely on income” and recipients notified annually of “all available health coverage options, including, but not limited to, Medicare, Medicaid, individual market plans, and employer plans.”

The bill also now requires health plans to accept third-party premium assistance from a member of an individual’s family (which includes a child, spouse, domestic partner, parent, grandparent, or sibling).

PSI Government Relations is submitting comments that object to the Committee conditioning assistance “solely on income”, which goes beyond federally-proposed safeguards and effectively prohibits charitable foundations from establishing disease-based programs. It is offering to work with the Committee to develop safeguards that address concerns about steering patients from private to public plans, which is not how independent bona-fide charities like PSI operate. PSI is urging the Committee to require insurers to accept premium assistance from charitable foundations that meet these new standards.

PSI also continues to back federal legislation (H.R. 3976) that would require Marketplace plans accept both third-party premium and cost-sharing assistance from non-profit charitable organizations, in addition to those already required by federal regulations, which includes safeguards proposed by CMS (see Update for Week of October 2nd). It now has at least 142 bipartisan cosponsors.

Colorado

Governor signs bill that would make catastrophic coverage available to all age groups

Governor John Hickenlooper (D) signed legislation this week that would require the Insurance Commissioner to evaluate whether to seek federal approval to remove the age limit on catastrophic health plans.

Sponsored by Senator Jim Smallwood (R), chair of the Health and Human Services committee, S.B. 132 would authorize the Insurance Commissioner to seek a federal Section 1332 waiver under the Affordable Care Act (ACA) if an actuarial analysis first demonstrates that removing the age limit would not increase average premiums or reduce the premium tax credits that Colorado subscribers receive under the ACA (see Update for Week of February 26th).

The ACA restricted the limited-benefit catastrophic plan option only to those under age 30 (or those meeting a hardship requirement).

The Virginia General Assembly passed similar legislation last month (S.B. 964), which is awaiting a decision from Governor Ralph Northam (D). That bill does not require a preliminary study.

Senate fails to act on bills creating reinsurance program, expanding premium assistance

Legislation that would make Colorado the latest state to create a federally-approved reinsurance program for high-cost conditions passed the House this week by a 40-23 margin but stalled in the Republican-controlled Senate before the end of the legislative session.

The *Individual Health Insurance Market Stabilization Act* (H.B. 1392) was sponsored and supported by both Democrats and Republicans (as well as the insurance commissioner), but faced strong opposition from the Colorado Chamber of Commerce, which insisted that it would actually increase premiums by \$100 or more per year for up to two million working Coloradans, while decreasing premiums by up to \$1,300 for roughly 124,000.

The plan would have provided additional payments to insurers whenever they incur an exceptional number of claims (\$25,000 to \$1 million per year), similar to models that the Trump Administration already approved for Alaska, Minnesota, and Oregon and waivers sought by several other states (see Update for Week of April 16th). However, H.B. 1392 would have funded the payments by imposing a two percent fee on premiums for all small and large group plans.

The Alaska reinsurance program has been so successful (reducing premium increases from 42 percent to seven percent) that Governor Bill Walker (I) is expected to sign legislation (S.B. 165) that will extend it another six years (until 2024).

The Senate also failed to act on two other House-passed measures that sought to make health insurance more affordable for Coloradans. The first, H.B. 1205, would have provided premium assistance to Coloradans earning 400-500 percent of the federal poverty level (or those just above the Affordable Care Act threshold for premium tax credits), so long as they spend more than 20 percent of their household income on health premiums. The second, H.B. 1384, would have required state agencies to assess the feasibility of a Medicaid buy-in option (see Update for Week of April 16th).

Connecticut

Governor to sign bill preserving ACA essential health benefits

Governor Dannel Malloy (D) is expected to sign legislation preserving the Affordable Care Act's essential health benefit packages after it overwhelmingly passed the House and Senate.

At least 13 states and the District of Columbia have already enacted a comparable measure, which would ensure most Connecticut health insurers continue to cover the ten categories of essential health benefits (including prescription drugs) mandated by the federal law even if they are weakened or repealed by the Trump Administration and Congress.

Hawaii

Legislature acts to preserve Affordable Care Act consumer protections

The legislature sent two bills to Governor David Ige (D) last week that seek to preserve key consumer protections established under the Affordable Care Act (ACA).

S.B. 2340 sponsored by Senator Rosalyn Baker (D) would ensure that state law prohibits health insurers from discriminating based on pre-existing conditions or varying premiums based on gender in the event these protections are repealed by Congress or weakened by the Trump Administration. In addition, the bill would ensure that adult children up to age 26 can remain on their parents' group health coverage, one of the most popular provisions of the ACA.

H.B. 1520 sponsored by Rep. Angus McKelvey (D) seeks to prevent insurers from taking advantage of the greater flexibility proposed by the Trump Administration to circumvent ACA protections by offering short-term health plans that expire in less than 365 days (see Update for Week of February 26th). Under the bill, short-term plans would be subject to the same protections against limited-benefit coverage that are already codified under state law. Similar legislation is being considered in several other states including California (S.B. 910).

Idaho

Medicaid expansion referendum submitted for ballot approval

An advocacy group named Reclaim Idaho announced last week that it has submitted more than the required signatures needed to place its Medicaid expansion initiative on the November ballot.

County clerks have until June 30th to verify the authenticity of the roughly 62,000 signatures, which exceeded the 56,192 signatures that were required to be collected by May 1st from all 44 counties and 35 legislative districts in Idaho. The Secretary of State would then certify the ballot referendum by July 6th.

If enacted, the ballot referendum would expand Medicaid coverage to an estimated 78,000 Idahoans earning up to 138 percent of the federal poverty level.

Maine is the only state where participating in the Medicaid expansion under the Affordable Care Act (ACA) was mandated by the voters (see below). However, advocacy groups have already collected enough signatures to place a comparable referendum on the November ballot and Utah (see Update for Week of April 16th) while a similar initiative is underway in Nebraska.

Outgoing Governor Butch Otter (R) has supported past efforts to expand Medicaid in Idaho following the recommendation of his Medicaid Redesign task force, which called expansion a “no brainer” (see Update for Week of January 12, 2015). However, conservative lawmakers remain staunchly opposed to any form of expansion, and Congressman Raul Labrador (R-ID) pledged this week that he would overturn any voter mandate to expand Medicaid if he is elected governor this fall.

Illinois

House passes bill creating independent board to reject unreasonable premium hikes

The House passed legislation last week that would create an independent quasi-judicial Health Insurance Rate Review Board to ensure premium increases are “reasonable and justified”.

The bill, sponsored last year by Health Insurance Committee chairperson Laura Fine (D), sets the procedures for board nominations and the process for review, modifying, or rejecting unreasonable rate hikes. It is being opposed by the Department of Insurance, which insists the measure is “duplicative” of their duties.

H.B. 2624 now moves onto the Senate Insurance Committee.

Maine

Patient advocates sue after Governor refuses to comply with voter mandate to expand Medicaid

The non-profit legal aid foundation Maine Equal Justice Partners filed suit this week on behalf of consumer and provider groups in Maine seeking to force the LePage Administration to comply with a voter mandate to expand Medicaid under the Affordable Care Act (ACA) by July 2nd.

Outgoing Governor Paul LePage (R) has staunchly opposed any form of Medicaid expansion in the state, vetoing six different expansion bills passed by the Democratically-controlled legislature during his two terms. After voters overwhelmingly made Maine the first state to instead expand Medicaid through a ballot referendum, LePage immediately refused to submit the required state plan amendment to the federal Centers for Medicare and Medicaid Services (CMS) by April 3rd unless the legislature appropriate double the \$30.5 million that Manatt Health predicted Maine would need to pay for the ten percent share of Medicaid expansion costs (see Update for Week of December 18th).

The plaintiffs (which include the Maine Primary Care Association and National Academy for State Health Policy based in Maine) have asked the Maine Superior Court for an expedited decision, giving that the federal filing deadline has already passed. They are also petitioning Maine Attorney General Janet Mills, a Democrat running to succeed Governor LePage in January, not to defend the lawsuit—a move that would allow the state to expand Medicaid coverage in July to roughly 80,000 Mainers earning up to 138 percent of the federal poverty level.

Governor LePage insists that the Medicaid expansion cannot be enacted since the legislature adjourned last month without making any appropriation. However, plaintiffs insist that the Medicaid program has enough budget reserves to fund the expansion through at least May 2019.

Governor lets prescription drug price transparency bill become law

Governor Paul LePage (R) allowed L.D. 1406 to become law this week without his signature, making Maine the seventh state to enact legislation requiring greater transparency in prescription drug pricing.

Under the new law, the Maine Health Data Organization must collect data from drug manufacturers by December 1st that identifies the 25 most frequently prescribed brand name and generic drugs in the state, as well as the 25 most costly drugs and 25 drugs with the highest year-over-year cost increases. The organization must also submit to the legislature by April 1st a plan and recommendations for further data collection.

The Maine drug price transparency law is much weaker than those enacted in California, Maryland, Oregon, or Vermont (see Update for Week of March 19th). California's law is considered the most comprehensive in the nation as it requires manufacturers to notify health insurers and government health plans at least 60 days before increases in drug wholesale acquisition costs (WAC) that exceed 16 percent over a two-year period (see Update for Week of November 6th). It applies to drugs with a WAC of \$40 or more.

Vermont enacted the first-in-the-nation drug price transparency law in 2016, which required the state to identify up to 15 prescription drugs for which the WAC has increased by 50 percent or more over the past five years and 15 percent or more over the past year (see Update for Week of June 20, 2016). At least two dozen states have or continue to consider comparable legislation. A bill that has cleared committee in Connecticut last month (H.B. 5384) would let insurers file complaints with the insurance commissioner whenever the cost of a prescription drug increases by at least 25 percent and causes subscriber premiums to rise by at least \$1.

New Hampshire

Governor to sign bill that will add work and managed care requirements to Medicaid expansion

The House approved S.B. 313 last week on a voice vote, which would reauthorize New Hampshire's popular Medicaid expansion alternative but add work requirements for newly-enrolled individuals, who would also be required to enroll in Medicaid managed care plans.

New Hampshire is one of eight states that received federal approval to use Affordable Care Act (ACA) matching funds for the Medicaid expansion to instead purchase private coverage in the ACA Marketplace for those that the law makes newly-eligible for Medicaid (see Update for Week of September 29, 2014). The Premium Assistance Program (PaP) has been very successful, enrolling more than 52,000 consumers since 2015 or roughly 42 percent of the entire individual market (see Update for Week of August 14th). However, Republican lawmakers had reauthorized the program only through the end of 2018 and created a legislative commission to recommend more conservative-favored reforms such as work requirements and eligibility verification measures that were disallowed by the Obama Administration (see Update for Week of November 13th).

S.B. 313 follows the commission's recommendations to require the newly-eligible population to obtain coverage through Medicaid managed care plans instead of the ACA Marketplace (see Update for Week of November 13th), based on a private study that found they were 26 percent more costly than non-Medicaid consumers and put upward pressure on premiums by being in the Marketplace risk pool (see Update for Week of August 28th). It also includes new work requirements on "able-bodied" adults that the Trump Administration has already approved for three states (see Update for Week of March 19th).

The House did make minor changes to the bill that passed the Senate earlier this year (see Update for Week of March 19th). This includes extending the reauthorization for five years but requiring a review at 2.5 years. The Senate is expected to either accept the changes or work out differences in conference committee before sending it on to Governor Chris Sununu (R) who has pledged his support.

North Dakota

Insurance commissioner proposes reinsurance program, invisible risk pool, and state-based health plans

Insurance Commissioner Jon Godfread (R) revealed this week that his office is commissioning a study to evaluate how the state can overhaul its individual health insurance market.

The study, which is due to the legislature by September, will specifically consider whether North Dakota should create a reinsurance program to compensate insurers for extraordinary claims, similar to those federally-approved for Alaska, Minnesota, and Oregon and sought by roughly ten other states including Louisiana, Maine, and Wisconsin (see Update for Week of April 16th). However, the waiver proposed would concurrently seek federal permission for North Dakota to significantly expand enrollment in its high-risk pool for those with costly conditions.

Commissioner Godfread acknowledges that the Trump Administration may not approve expansion of the existing high-risk pool, which imposes lifetime caps and waiting periods for applicants with pre-existing conditions, both of which remain prohibited under the Affordable Care Act (ACA). Premiums in the high-risk pool are also prohibitive for most enrollees, ranging from \$336 to more than \$1,500 per month. As a result, the Department is weighing whether to transition to an “invisible risk pool”, which subsidizes the costs of enrollees with a designated list of costly conditions while not moving them out of the general risk pool with healthier enrollees.

The Commissioner, an ardent opponent of the ACA, also seeks to pursue more controversial reforms to lower premiums for healthier subscribers, such as opting out of certain ACA mandates so that they can take advantage of skimpier but cheaper coverage options. He stated that the Department is considering the limited-benefit “state-based plans” that Idaho is trying to negotiate with the Trump Administration after its initial waiver was rejected for allowing lifetime caps, pre-existing conditional denials, and other practices prohibited by the ACA. However, unlike Idaho, the Commissioner insisted that North Dakota plans would continue to bar pre-existing condition discrimination and comply with the ACA essential health benefit packages and instead “would potentially allow for credits for healthy behavior or other health related factors.”

North Dakota insurers have yet to file 2019 rate requests, but the Department is expecting premium increases to jump substantially after Medica exited the ACA Marketplace following the Trump Administration’s elimination of ACA cost-sharing reductions (CSRs) (see Update for Week of November 13th). Their departure left North Dakota BlueCross BlueShield (BCBS) as the only real player in the Marketplace, since the lone competitor Sanford has less than 1,200 subscribers. BCBS received a 23 percent average premium increase for 2018 but was not allowed to re-file for higher premiums after the CSRs were lost, meaning the full impact of their elimination will likely be reflected in their 2019 filing.

Despite the rate hikes, North Dakota is one of only two federally-facilitated Marketplaces (including South Dakota) that increased enrollment each year since being created in 2014.

Vermont

Landmark drug re-importation bill sent to Governor

The House and Senate sent legislation this week to Governor Phil Scott (R) that would allow state residents to purchase cheaper prescription drugs from Canada.

The measure (S.175) would specifically create a wholesale importation program through which high-cost drugs could be purchased at lower cost from Canada through authorized wholesalers via an existing supply chain that includes local pharmacies (see Update for Week of February 26th). Details will be formulated by the Agency for Human Services (in consultation with stakeholders and the federal government) and submitted for legislative approval by January 1st.

Because drug importation continues to be illegal under federal law, the plan will require uncertain approval from the Trump Administration. President Trump expressed support for drug importation from Canada as a candidate but has been silent on the subject since assuming office and left it out of his blueprint to reduce drug prices (see above).

Governor Scott has also not yet indicated whether he will sign S. 175. However, the measure passed both chambers with only two dissenting votes, meaning any veto would likely be overridden.

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).

Drug importation measures have stalled or failed this year in several states including Colorado, Louisiana, New York, West Virginia, and Wyoming. A comparable measure in Utah (H.B. 163) sponsored by Rep. Norman Thurston (R) has passed the House and remains under Senate consideration. It would allow drugs to be purchased from Canada for in-state use if they are designated by the state to incur “substantial savings” for consumers (see Update for Week of February 26th).

Virginia

All Marketplace insurers will remain for 2019 but most are seeking substantial premium increases

The Bureau of Insurance confirmed this week that all seven insurers participating in the Affordable Care Act (ACA) Marketplace that the federal government operates for Virginia will remain for 2019.

Virginia had one of the healthiest Marketplaces in the country until the 2018 open enrollment period, when both Aetna and UnitedHealthcare decided to no longer participate and Anthem Blue Cross Blue Shield dramatically reduced their coverage area (remaining in only 68 counties). With Optima also limiting its coverage area, the result was that nearly half of the commonwealth’s counties were served by a single insurer (Anthem/HealthKeepers) for 2018, resulting in severe premium spikes for some rural areas. For example, a 40-year old earning above the ACA threshold for premium subsidies (at 400 percent of the federal poverty level) and purchasing silver-tier coverage faced a premium increase of nearly 235 percent (to \$1,012 per month), by far the highest in the nation, while non-subsidized Optima subscribers in the Charlottesville area paid premiums that were nearly three times higher than 2017, reaching up to \$1.048 per month for the same consumer.

The premium spikes likely contributed to a 2.6 percent decline in enrollment from 2017 to 2018, although the shorter enrollment period, 90 percent reduction in the federal advertising and outreach budget, and loss of ACA cost-sharing reductions were also to blame (see Update for Week of November 13th). However, Virginia is one of seven federally-facilitated Marketplaces (FFMs) where the state retains control over plan management functions, giving regulators greater ability to mitigate these adverse actions. As a result, Virginia’s decline was less than half the 5.3 percent average decline in FFM enrollment (see Update for Week of February 12th).

The Marketplace in Virginia will gain an additional insurer for 2019, however Virginia Premier plans to offer coverage only to about 4,000 consumers in the Richmond metro area. Rural counties in Virginia are still expected to have limited coverage options, even though Optima will expand into the Harrisonburg area.

Virginia has the earliest rate filing deadline in the country (all were due by May 4th) and those rate proposals that were already released by the Bureau show a wide range for 2019. Optima (with nearly 68,000 Marketplace consumers this year) is actually seeking a slight 1.9 percent average decrease, while much smaller insurers like Group Hospitalization and Medical Services and Piedmont Community Healthcare are seeking massive increases of 64.3 and 46.5 percent respectively.



Other major insurers like Kaiser Foundation Health Plan of the Mid-Atlantic, CareFirst BlueCross BlueShield, and Cigna are proposing average rate hikes of 32 percent, 26.6 percent and 15 percent respectively. However, each only serves limited coverage areas. Anthem is seeking a six percent average increase in the limited areas in which it remains.

Neighboring Maryland is the only other state that has released proposed rate filings. Dominant carrier CareFirst BlueCross Blue Shield is seeking a staggering 91.4 percent increase for its PPO option, which could increase premiums for a 40-year old purchasing silver-tier coverage up to \$1,334 per month. However, the bulk of CareFirst's 138,000 individual ACA Marketplace consumers are enrolled in HMO plans, for which it is seeking an average hike of only 18.5 percent.

Overall, the two insurers participating in the individual Marketplace (CareFirst and Kaiser) are seeking an average premium increase of 30 percent for 2019. Insurance Commissioner Al Redmer (R) stated that the rate proposals are evidence that the ACA Marketplace is in a "death spiral" and urged the Trump Administration to approve the state's request for a Section 1332 waiver under the ACA, which would make Maryland the fourth state with a federally-approved reinsurance program (see Update for Week of April 16th). CareFirst's chief executive officer estimated that the insurer's rate hikes would be 20-30 percent lower if insurers were compensated for extraordinary claims, as they were prior to the expiration of the temporary ACA reinsurance program after 2016.

Insurers in both Maryland and Virginia largely blame the sizeable premium increases on the Congressional repeal of the individual mandate penalties for 2019 (see Update for Week of December 18th) and the Trump Administration's allowance of short-term and association health plans (see Update for Week of March 19th). These changes are expected to cause a ten percent "morbidity deterioration" in the Marketplace risk pools as healthier and less costly consumers increasingly enroll in the skimpier low premium coverage outside of the Marketplace.

Governor Ralph Northam (D) has yet to decide whether to sign or veto legislation that would allow short-term health plans to be offered in the commonwealth (S.B. 844), contingent on the enactment of federal regulations expanding their use (see Update for Week of March 19th).