

Health Reform Update – Week of July 23, 2018

CONGRESS

House-passed bills target two more ACA taxes, expand the use of health savings accounts

The House passed a series of bills this week that further roll-back specific provisions in the Affordable Care Act (ACA), while expanding the use of health savings accounts (HSAs).

The group of 11 bills was combined into two packages. The first (H.R. 6199), which 46 Democrats supported, would end the ACA's unpopular prohibition against using HSAs and flexible spending accounts (FSAs) to reimburse for over-the-counter (OTC) medications. Under the bill, HSA and FSA enrollees could include OTC drugs (as well as gym memberships and certain sports equipment) as qualified medical expenses (up to a limit of \$500 for individuals and \$1,000 for families).

The second package (H.R. 6311), which passed with the support of a dozen Democrats, increases the maximum annual HAS contribution to the maximum out-of-pocket limit under the ACA (which is \$6,650 for individuals in 2018, and \$13,300 for families). It also allows both spouses to make catch-up contributions to the same account, allows working seniors to contribute to HSAs, and FSA balances to be carried over from year-to-year.

Under H.R. 6311, bronze or catastrophic "copper" tier plans can qualify for an HSA. In addition, the bill would remove the age 30 limit on catastrophic coverage, a move recently enacted in Colorado (see Update for Week of May 7th) but vetoed by the Virginia governor (see Update for Week of May 28th).

H.R. 6311 further delays the ACA tax on insurers an additional two years (for 2020 and 2021). The House passed a separate bill would permanently repeal the 2.3 percent tax on medical devices (H.R. 184). The device tax initially went into effect in 2013 but was later suspended from 2016 through 2019. The House did not identify how the lost \$90 billion in revenue over ten years would be offset, which is certain to be a source of contention in the Senate.

The House also passed a separate fiscal year 2019 spending bill last week (H.R. 6147) with an amendment (H.Amdt. 948) that would prohibit the District of Columbia from creating their own alternative to the individual mandate under the ACA that Congress repealed starting next year (see Update for Week of December 18th). The DC Health Benefit Exchange Authority approved the individual mandate alternative earlier this year (see Update for Week of February 26th). New Jersey and Vermont were the only two states to do so (see Update for Week of May 7th).

Despite passing the Ways and Means Committee, House Majority Leader Kevin McCarthy (R-CA) elected not to allow a floor vote at this time on measures that would further delay the ACA's 40 percent excise tax on high-cost or "Cadillac" health plans (from 2020 to 2023) and retroactively repeal the employer mandate that has been enforced since 2015 (see Update for Week of July 9th).

The House-passed bills do not appear likely to be considered by the Senate before the mid-term elections. However, the Senate Health, Education, Labor and Pensions Committee did advance measures this week that would prohibit health insurers from using a "gag clause" to prevent pharmacists from informing patients whether it would be cheaper to pay cash for a prescription drug instead of using their insurance (S.2554), as well as reauthorize federal sickle cell research programs (S 2465).

House passes bill to reform FDA approval process for over-the-counter drugs

The House passed legislation last week that would bring about the first major changes to the regulatory system the Food and Drug Administration (FDA) created for over-the-counter (OTC) drugs back in 1972.

The *Over-the-Counter Monograph Safety, Innovation, and Reform Act of 2018* (H.R. 5333) was introduced this spring by Rep. Bob Latta (R-OH) and reported out of the House Energy and Commerce Committee in May. A similar version (S.2315) passed the Senate Health, Education, Labor, and Pensions Committee in April.

The Over-the-Counter (OTC) monograph system was created so that any OTC product that conforms to a monograph could be manufactured and sold without having to go through the costly and lengthy process to obtain FDA product approval. (A monograph is essentially a pre-determined checklist covering acceptable ingredients, doses, formulations and product labeling.)

However, the monograph system was never fully completed for all drug categories and relies on the rigid rulemaking process. As a result, critics argue that the process of determining the safety and efficacy of OTC drug ingredients is outdated, slow, and cumbersome. Because the process to simply update a product label with new safety information or improve new ingredients can take several years, they argue that it is hindering the approval of novel drugs based on scientific advancements.

Key provisions of H.R. 5333 would create a \$134 million user fee system similar to what is in place for prescription drugs to expand the FDA's \$8 million budget for OTC drug reviews (and add roughly 100 employees). The FDA would also be allowed to make expedited scientific determinations for OTC ingredients through an administrative order process instead of the much slower rulemaking process. Even though the administrative orders would still require a 45-day comment period and still be subject to judicial review, this is faster than the rulemaking process, which can typically take 3-6 months, and more easy to amend or supplement.

The most controversial provision of H.R. 5333 would reduce the 18-month exclusivity period given to manufacturers of innovative OTC drugs down to 12 months (the Senate bill allows for 24 months of exclusivity).

Both bills have bipartisan support (five of the eight House cosponsors are Democrats) as well as the backing of some health-related groups like the American Academy of Pediatrics, American Public Health Associations, Pew Charitable Trusts, and March of Dimes.

Democrats introduce bills to cap prescription drug costs, allow Medicare to negotiate drug prices

A group of Democratic lawmakers introduced legislation over the last two weeks that aim to lower prescription drug prices.

The first bill (S.3194) was introduced in the Senate by Senators Elizabeth Warren (D-MA) and Bill Nelson (D-FL) and in the House (H.R. 6340) by Rep. Jacky Rosen (D-NV). Called the *Capping Prescription Costs Act of 2018*, the measure would limit prescription drug copayments for group and individual health plan consumers at \$250 per month for individuals and \$500 per month for families. It is comparable to the caps enacted in eight other states including California (see Update for Weeks of May 18 and 25, 2015), and is supported by consumer groups such as Families USA and Community Catalyst.

The second bill (H.R. 6505) introduced by Rep. Lloyd Doggett (D-TX) would give the Medicare Part D program the authority to negotiate prescription drug prices. However, unlike Democratic efforts in previous years, this version would allow the Department of Health and Human Services (HHS) to pursue a lower-cost generic drug alternative by issuing a competitive license whenever a drug manufacturer refuses to offer a "reasonable" price, effectively allowing HHS to sidestep patents whenever it believes it is in the public interest to do so.

Both bills were largely viewed as election year posturing intended to draw a distinction from President Trump's drug pricing "blueprint" released earlier this year, which failed to include either cost-sharing caps or Medicare price negotiation authority (see Update for Week of May 7th).

FEDERAL AGENCIES

CMS resumes ACA risk adjustment payments to insurers after bipartisan pushback

The Centers for Medicare and Medicaid Services (CMS) released a final rule this week that restarts the risk adjustment payments under the Affordable Care Act (ACA) that were recently suspended by the agency.

The risk adjustment payments for insurers were one of the three premium-stabilization programs created under the ACA, but the only one that did not expire after 2016. The program spread the expense of high-cost enrollees across insurers within both the individual and small-group health insurance markets by forcing insurers with lower-risk enrollees to subsidize costs for insurers with higher-risk enrollees, based on a CMS formula.

Earlier this month, CMS Administrator Seema Verma had blamed a federal district court decision in New Mexico for forcing CMS to suspend all of the \$10.4 billion in risk adjustment payments due insurers for 2017-2018 (see Update for Week of July 9th). The suspension surprised insurers and other stakeholders as it came before CMS had even appealed the decision based on a contrary ruling in Massachusetts that upheld CMS' risk adjustment methodology. It caused Blue Cross and Blue Shield of Tennessee to promptly increase premiums by \$649 per enrollee while other major insurers threatened to reprice the proposed 2019 premiums if the payments were not resumed.

As a result, members of Congress from both parties, including House Ways and Means Committee chair Kevin Brady (R-TX), urged CMS to promptly reinstate the payments, which the agency did with the new regulations. Administrator Verma stressed that the final rule would "mitigate some of the uncertainty caused by the New Mexico litigation", which found that the CMS formula used to determine which insurers would receive payments was "arbitrary" and "unjustified". As result, the Administrator insisted that the final rule provides the additional explanation sought by the court and clarifies that it will use the same risk formula as applied for 2017.

CMS decided that the emergency created by the court's decision warranted issuing the final rule without the usual notice and comment period. However, it agreed to issue proposed regulations soliciting public comment on the risk adjustment formula for 2018 in the near future. The Administrator also noted that CMS already sought public comment on its decision to base the risk adjustment formula on the statewide average premium starting with the 2019 plan year, as part of the Notice of Benefit and Plan Parameters rule that was finalized last spring (see Update for Week of April 16th).

FDA working group considers allowing foreign importation of certain high-cost drugs

The Food and Drug Administration (FDA) revealed this week that it is forming a working group to examine if and how the agency could allow certain high-cost pharmaceuticals to be imported from other countries.

Drug importation remains against federal law, despite recent federal and state legislation attempting to allow it. Although President Trump supported allowing lower-cost drugs to be imported from Canada and other countries during his campaign, he failed to include drug importation as part of this recent "blueprint" to lower drug prices, with his Secretary for the Department of Health and Human Services (HHS) calling it a "gimmick" (see Update for Week of May 7th).

However, the announcement this week by both HHS and the FDA suggested that the Administration is considering allowing drug importation from abroad "in the event of a dramatic price increase for a drug produced by one manufacturer and not protected by patents or exclusivities." This exception would be "narrowly-focused" and "temporary" until adequate competition enters these categories."

As an example of a price increase for which this exception may apply, HHS Secretary Alex Azar cited the infamous example of the company once owned by recently imprisoned Martin Shkreli. Turing Pharmaceuticals had increased the price of Daraprim by more than 5,000 percent (see Update for Weeks of September 14 and 21, 2015). This drug had no patent protection and had been on the market for 62 years.

Key lawmakers like Senate Health, Education, Labor, and Pensions committee chair Lamar Alexander (R-TN) welcomed the move, noting that the FDA already approves “safe supply chains” for prescription drugs manufactured in overseas facilities. As a result, he said that “it makes sense to explore whether the FDA can do that in specific instances that increase competition and lower prices.”

However, the Pharmaceutical Research and Manufacturers of America (PhRMA) reiterated their opposition to any drug importation, insisting that it poses a “serious public health risk and jeopardiz[es] our secure medicine system.” Instead, it argued that the FDA should continue to increase patient access to lower-cost generic drugs.

The Trump Administration’s announcement may signal that it is prepared to approve a waiver that Vermont is preparing to submit to HHS in 2019, which would allow it to create a program whereby it could purchase the 10-15 most costly prescription drugs from Canada through authorized wholesalers (see Update for Week of February 26th). Vermont enacted legislation authorizing the importation program earlier this year (see Update for Week of May 28th). However, drug importation legislation stalled or failed in the seven other states that considered them.

CBO admits it underestimated Medicare Part D savings from mandatory discounts

Congressional Budget Office Director Keith Hall promised this week that the non-partisan budget scorekeeper would heighten oversight over its cost-estimate process after making a \$4 billion mistake regarding changes to the Medicare Part D coverage gap recently made by Congress.

CBO initially projected that the *Bipartisan Budget Act of 2018* would save the Part D prescription drug program \$7.7 billion over a decade, after Congress increased the amount of the discount that manufacturers must offer to enrollees within the coverage gap from 50 percent to 70 percent. However, the director notified Congress last week that CBO was not aware of “administrative data about the amount of the discounts provided under the coverage gap” at the time the provision was scored. As a result, CBO now concludes that the increase discounts will actually save \$11.8 billion over that time period.

The Biotechnology Innovation Organization and other stakeholders quickly used the mistake to launch a grassroots efforts to void the increased mandatory discounts, arguing the increased financial burden could reduce the number of products offered to Part D enrollees. Conservative lawmakers and commentators have also pounced on the mistake to support their claims that CBO was overestimating the costs of Republican bills last summer to repeal key provisions of the Affordable Care Act (ACA) (see Update for Week of July 10, 2017).

Federal appeal court rejects hospital effort to block Medicare payment cut for 340B drugs

A three-judge panel for the U.S. Court of Appeals for the District of Columbia has upheld a lower court opinion concluding that hospitals cannot challenge Medicare’s payment cut for drugs paid under the Section 340B program until it first pursues the proper appeals process through federal agencies.

The 27 percent cut in Medicare Part B payments for the discounted drugs that safety-net hospitals purchase through 340B went into effect on January 1st after a federal judge dismissed the “premature” lawsuit brought by the American Hospital Association and other hospital groups (see Update for Week of January 8th). 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. However, legislative fixes were ultimately not included in spending bills for fiscal year 2018 (see Update for Week of March 19th).

AHA and other plaintiffs have pledged to refile the lawsuit as soon as possible, which the lower court decision allowed (see Update for Week of January 8th).

STATES

Federal court dismisses lawsuit challenging loss of ACA cost-sharing reductions, but plaintiffs can refile

The U.S. District Court for the Northern District of California announced this week that it has dismissed the lawsuit filed by 18 state attorneys general who are challenging the Trump Administration's elimination of the cost-sharing reductions (CSRs) under the Affordable Care Act (ACA), but will allow the plaintiffs to refile their case should the Administration not let states "silver-load" premiums to compensate for the loss of the CSRs.

The federal Centers for Medicare and Medicaid Services (CMS) decided earlier this year not to block states from letting insurers hike premiums only for the silver-tier plans to which the CSRs are statutorily tied (see Update for Week of June 11th). However, they acknowledged that their decision was due solely to not being able to promulgate prohibitive regulations in time for the 2019 plan year, and that the agency would likely bar "silver-loading" starting with plan year 2020.

All but nine states relied on the practice of "silver-loading" to prevent insurers from taking massive losses after the CSRs were eliminated, even though insurers were still legally required to reduce cost-sharing for those earning 100-250 percent of the federal poverty level and enrolling in silver-tier coverage (See Update for Week of November 13th). However, the Congressional Budget Office (CBO) found that "silver-loading" caused the federal government to pay \$10 billion more in premium tax credits than anticipated (a 21 percent increase), since the amount of the credit was tied to the second lowest-cost silver plan (see Update for Week of April 16th). If allowed to continue, the federal government would have to pay up to \$44 billion more in premium tax credits over the next ten years.

The Democratic attorneys general from 18 states had been allowed to continue their lawsuit in California after House Republicans agreed to settle their initial lawsuit that caused a lower court in the District of Columbia to invalidate the CSRs pending appeal and led to the President's decision to ultimately terminate them (see Update for Week of December 18th). However, the attorneys general were subsequently forced to acknowledge that so long as "silver-loading" was a permissible workaround to adequately mitigate insurer losses "it is not clear that the public interest requires changing the status quo", rendering the lawsuit no longer ripe for dispute. The plaintiffs did not contest the dismissal.

California

Average premium increases will moderate to less than nine percent for 2019

Covered California officials announced this week that premiums for the individual Marketplace created pursuant to the Affordable Care Act (ACA) will increase next year by an average of 8.7 percent.

The average increase is far less than the premium spikes incurred by Covered California consumers this year, when several large insurers increased premiums by 30-40 percent to compensate for the loss of cost-sharing reduction (CSR) payments under the ACA and uncertainty about the ultimate fate of the law's consumer protections (see Update for Week of October 2nd). The overall premium increase for 2018 averaged 12.5 percent (before a 12.4 percent CSR surcharge was tacked on by regulators), following a 13.2 percent spike in 2017 caused by the expiration of the ACA's reinsurance payments for exceptional claims (see Update for Week of July 18, 2016). Prior to 2017, Covered California consumers enjoyed only a four percent average hike each year.

According to Covered California, premium increase should be fairly uniform across the state. Most of southern California and the San Francisco bay area will see rate hikes around nine percent, while Monterey, San Benito and Santa Cruz counties will face the highest increases of up to 16 percent on average.

The 8.7 percent average increase is less than 11 percent hike predicted by Covered California earlier this year (see Update for Week of May 28th). However, Covered California officials still emphasized that rates would only be increasing by an average of five percent for next year had Congress not repealed the tax penalties for the ACA's individual mandate (see Update for Week of December 18th), which is expected to cause roughly ten percent of individual plan subscribers to drop their coverage. Despite the expected adverse impact, California lawmakers failed to advance legislation that would create state alternative to the ACA's individual mandate (following the lead of New Jersey, the District of Columbia, and Vermont).

As with this year, the same 11 insurers in Covered California all plan to return for 2019. They are led by Kaiser Permanente and Blue Shield of California, which together control two-thirds of exchange enrollment (33 and 32 percent respectively). HealthNet is next at 14.4 percent.

Covered California was one of only three state-based Marketplaces (including DC and New York) that maintained a full 12-week open enrollment period for 2018 after the Trump Administration cut it down to six weeks for federally-facilitated Marketplaces (see Update for Week of October 2nd). It has decided to maintain the same 12-week period for 2019 but move the start date up from November 1st to October 15th (see Update for Week of March 19th).

Connecticut

New law makes Connecticut the second state to define pregnancy as a qualifying event

A bill that became law last month without the signature of Governor Dannel Malloy (D) makes Connecticut only the second state to create a special enrollment period (SEP) for pregnant women to purchase individual health insurance coverage that complies with the Affordable Care Act (ACA).

The measure (S.B. 206) does not apply to group coverage or to women who already have minimum essential coverage, as defined by the ACA. (It would not allow a women to upgrade her coverage once becoming pregnant). The SEP would be limited to 30 days from the time a woman is diagnosed as pregnant by a licensed health care provider.

Governor Malloy had expressed concerns about the bill's "potential to drive up premiums", especially for plans purchased in the ACA Marketplace. However, he allowed it to become law after it overwhelmingly passed both chambers with only ten dissenting votes.

New York was the first state to recognize pregnancy as a qualifying event allowing women to enroll outside of the annual open enrollment period (see Update for Week of January 4, 2016). However, the Obama Administration declined to impose a similar requirement for ACA coverage and no other state has followed suit. (California has only gone so far as to allow a SEP to be triggered if a women's primary care physician leaves her provider network during her pregnancy.)

Kentucky

Following court rejection, CMS reopens comment period on Kentucky Medicaid work requirement

The Centers for Medicare and Medicaid Services (CMS) announced this week that will open a new 30-day public comment period on Kentucky's proposed waiver to impose work requirements on "able-bodied" Medicaid enrollees following the decision by a federal court to strike down its prior approval last January.

Stakeholders expressed concern that simply reopening the comment period would not fully respond to the concerns expressed by U.S. District Court Judge James Boasberg, who concluded that CMS failed to consider how the work requirements (and additional premiums on higher-income enrollees) would eliminate coverage for an estimated 95,000 enrollees, as well as adequately respond to public comments that were overwhelmingly opposed to the waiver (see Update for Week of June 25th). That decision is currently being appealed.

CMS Administrator Seema Verma, who helped develop Kentucky's waiver proposal as a consultant prior to being nominated for her post, insisted that the work requirements would go forward in Kentucky and other states, despite the adverse court decision. CMS has already approved comparable work requirements in Arkansas, Indiana, and New Hampshire (see Update for Week of May 7th), with similar waiver request pending from states like Michigan and Wisconsin (see Update for Week of June 11th).

Kentucky Governor Matt Bevin (R) continues to threaten to terminate the entire Medicaid expansion (which covers 400,000 enrollees) enacted by his Democratic predecessor if the waiver is not ultimately approved after all legal avenues are exhausted (see Update for Week of February 12th). However, he reversed course this week and reinstated the dental and vision benefits for Medicaid enrollees that he eliminated following the court's rejection of Kentucky's waiver approval.

Maryland

Federal appeals court refuses to reconsider decision invalidating ban on prescription drug price-gouging

The full U.S. Fourth Circuit Court of Appeals has denied a request from Attorney General Brian Frosh (D) to reconsider the decision of a three-judge panel to strike down the state's unprecedented ban on price-gouging for essential prescription drugs.

Maryland was the only state in the nation to give its Attorney General authority to take legal action against drug manufacturers who dramatically increase the price of essential off-patent or generic drugs (see Update for Weeks of May 29 and June 5, 2017). Under H.B. 631, generic manufacturers or wholesale distributors were required to prove that an increase in price is not "unconscionable" or issue rebates to consumers. The health department would also notify the Attorney General whenever three or fewer manufacturers are actively manufacturing and marketing an essential off-patent drug, the wholesale acquisition cost (WAC) increases by 50 percent or more in one year, or if the WAC for a 30-day supply exceeds \$80.

The Association for Accessible Medicines (formerly the Generic Pharmaceutical Association) immediately sued to block the law from going into effect but was initially rebuffed the U.S. District Court for the District of Maryland (see Update for Week of October 2nd). However, in a 2-1 ruling, the appellate panel overturned the lower court's ruling and ordered it to grant the injunction sought by AAM, concluding that Maryland could not regulate out-of-state drug transactions under the Commerce Clause to the U.S. Constitution (see Update for Week of April 16th).

Attorney General Frosh had the option of petitioning to the full appellate court before appealing to the U.S. Supreme Court. His office has yet to announce whether it will now file that appeal.

Maryland remains the only state with a federal waiver allowing it to set prices for all hospital services (meaning all providers must charge the same rate)—a waiver that Governor Larry Hogan (R) recently received federal approval to expand. Maryland Citizens' Health Initiative, which backed the price-gouging law, is urging the Governor and General Assembly to pass legislation next session that would give the rate-setting commission authority to also set prices for brand-name and patented medications.

Several other states including Colorado, Illinois, Louisiana, and New Hampshire were considering price-gouging prohibitions modeled on the Maryland law (see Update for Week of February 26th). However, those may now be forestalled unless the U.S. Supreme Court reinstates Maryland's prohibition.

Reinsurance waiver accepted by CMS and released for public comment

The Maryland Health Benefit Exchange (MHBE) announced this week that it will hold a series of four public hearings through August 16th regarding the federal waiver they have sought to create a reinsurance program to compensate insurers for exceptional claims.

The Centers for Medicare and Medicaid Services (CMS) has already accepted the waiver application from MHBE, which was authorized by legislation enacted earlier this year (see Update for Week of April 16th). If approved, Maryland would become the fourth state behind Alaska, Minnesota, and Oregon to create reinsurance payments in place of those that expired under the Affordable Care Act (ACA) after 2016 (see Update for Week of December 18th).

The two MHBE insurers (CareFirst Blue Cross Blue Shield and Kaiser Permanente) are seeking some of the steepest premium increases in the nation, breaking 91 percent for Marketplace consumers in CareFirst's PPO option (which would raise their premiums to \$1,334 per month). MHBE officials are hoping that the reinsurance program is approved in time to apply payments for the 2019 plan year, as CareFirst predicts it would lower rate hikes by at least 20-30 percent (see Update for Week of April 16th).

Public comments on the waiver will be accepted through August 4th.

Minnesota

Marketplace consumers will again have ten-week open enrollment period for 2019

Consumers in the state-based Marketplace (SBM) that Minnesota created pursuant to the Affordable Care Act (ACA) will again have an additional four weeks with which to sign-up during the 2019 open enrollment period.

As one of 12 SBMs, the MNSure Marketplace has the discretion to go beyond the six-week open enrollment that the Trump Administration mandated for federally-facilitated Marketplaces (FFMs) (see Update for Week of November 13th). For the 2019 plan year, the enrollment period will run from November 1st to January 13th, the same ten-week period that MNSure applied for 2018.

Most SBMs elected to go beyond the December 15th cut-off for FFMs. However, only three handful (California, the District of Columbia, and New York) extended enrollment all the way to the full 12-week period that was applied for all ACA Marketplaces prior to last year. California will still use a 12-week period for 2019 but elected to move the start date up to October 15th (see Update for Week of March 19th).

Oregon

New reinsurance program credited with holding premium increases below eight percent for 2019

The Division of Financial Regulation released final approved rates this week for health plans offering coverage during the 2019 plan year in the individual and small group markets.

Seven individual market carriers initially sought a 10.5 percent weighted average increase. However, the Division lowered that average down to 7.8 percent. The largest reduction was applied to Health Net (from 16.3 percent to 10.1 percent), while average increases for both BridgeSpan and Kaiser Permanente were lowered by around five percent. Two insurers (Moda and PacificSource) saw no reduction while Regence BlueCross Blue Shield was not allowed any increase despite seeking a five percent average hike.

Insurance Commissioner Andrew Stolfi (D) credited the reinsurance program approved last year by the Trump Administration with decreasing 2019 rate hikes by 6.3 percent. Oregon is one of only three states with an approved federal waiver to create a reinsurance program (see Update for Week of December 18th), which compensates insurers for exceptional claims following the expiration of the Affordable Care Act (ACA) reinsurance payments after 2016.

The Division also stressed that rate increases for 2019 are due in large part to the Congressional repeal of the individual mandate penalties under the ACA (see Update for Week of December 18th) as well as the Trump Administration's decision to increase the user fee by a full percent for Oregon and the four other states that have state-based Marketplaces but rely on the federal web portal (see Update for Week of November 6th). Absent these two factors, the Division noted that individual market consumers would be seeing only a 1.7 percent average rate hike next year.

The commissioner stressed that Oregon will not be one of the states letting insurers refile their rate filings following the Trump Administration's suspension of ACA risk adjustment payments (see Update for Week of July 9th).

Because Oregon relies on the federal web portal, it must adhere to the six-week open enrollment period that the Trump Administration mandated for federally-facilitated Marketplaces (see Update for Week of October 2nd). As a result, open enrollment for 2019 will run from November 1st through December 15th.

Pennsylvania

Marketplace consumers to see negligible rate hikes for 2019 following two years of premium spikes

The Department of Insurance announced this week that all health insurers will offer individual market policies for 2019, with average premiums likely to increase by only 0.7 percent.

Insurance Commissioner Jessica Altman (D) attributed increased competition for much of the limited increases, as four of the five participating insurers are expanding their plan options for 2019 and a new insurer (Pennsylvania Health and Wellness, Inc.) has entered the market. As result, consumers in 31 of the state's 67 counties will see additional plan offerings next year. In some counties (such as Lehigh and Northampton), the number of plan offerings will nearly double. Only eight counties will be limited to only one participating insurer—down from 20 for this year.

Pennsylvania had experienced some of the nation's largest spike in premiums over the last two years, with increases averaging more than 30 percent due in large part to the Trump Administration's elimination of cost-sharing reductions under the ACA (see Update for Week of November 6th). However, insurers proposed only a five percent increase for 2019 as the previous rate hikes had greatly improved their bottom lines. In addition, the commissioner noted that insurers were largely able to maintain their same enrollment numbers as 2017 thanks largely to the decision by Governor Tom Wolf (D) to increase the state budget for marketing and outreach at a time when the Trump Administration slashed the outreach budget for federally-facilitated Marketplaces (like Pennsylvania's) by 90 percent (see Update for Week of June 11th). This enabled major insurers like Independence Blue Cross to actually sign-up ten percent more Marketplace consumers.

The Department reduced their proposed rates down to the 0.7 percent average following a review of their 2018 costs. However, final rates will not be approved until shortly before the open enrollment period starts on November 1st.

South Dakota

Voter referendum capping prescription drug prices removed from ballot

The Sixth Judicial Circuit in South Dakota has removed a statewide ballot initiative this fall that sought to limit prescription drug prices to those paid by the Department of Veterans Affairs (VA).

Similar measures have been soundly rejected in recent years by voters in California and Ohio, as even supporters of lowering drug prices have questioned the effectiveness of capping prices at VA levels (see Update for Week of November 6, 2017). They point out that not only are such measures difficult to implement, but many elements of VA contracts would remain confidential, and drugmakers would not be bound to sell at the discounted price offered to the VA.

These state initiatives have been backed largely by the AIDS Healthcare Foundation, which provided all of the \$50,000 to fund the signature drive in South Dakota. The South Dakota ballot initiative (Initiated Measure 26) survived an initial lawsuit from the Pharmaceutical Research and Manufacturers of America (PhRMA) challenging the wording of the ballot summary, with the state Supreme Court ruling last spring that the Attorney General's language was "fair, clear, and simple" enough to be understood by voters.



However, the director of South Dakota Biotech (the state affiliate for the Biotechnology Innovation Organization) filed subsequent litigation alleging that nearly 9,000 of the required signatures were invalid because they were from residents of other states. That challenge was upheld by the Sixth Judicial Circuit.

Earlier this year, PhRMA successfully blocked a similar measure from appearing on this fall's ballot in the District of Columbia, when the D.C. Election Board agreed with their complaint that it interfered with the local government's discretion over how to spend local funds.

Eight states (including California, Delaware, Louisiana, and Maryland) have already taken steps to impose a specific dollar cap on out-of-pocket costs for prescription drugs and Congressional Democrats recently introduced legislation that would set similar limits (see above).