



Health Reform Update – Week of January 30, 2017

CONGRESS

ACA repeal momentum stalls as Republican leaders shift focus to “repair”

Despite continued pressure from conservative groups to immediately repeal key provisions of the Affordable Care Act (ACA), Congressional leaders this week postponed their initial deadline and have pushed back plans for a “repeal and replacement” vote until at least March.

The delay was expected, as leading Republicans openly acknowledged in recent weeks that repealing substantial parts of the ACA without a definitive replacement would lead insurers to abandon the Marketplaces created by the ACA and collapse the individual market for health insurance. Aetna already announced this week that it would not return to the Marketplaces for 2018 and CIGNA stated that it may consider withdrawing if action was not taken to stem its substantial losses.

Congress had passed a budget resolution earlier this month directing committees to draft bills by January 27th that would repeal provisions of the ACA impacting the federal deficit through the reconciliation process that requires only a simple Senate majority (see Update for Week of January 9th). That bill would effectively cripple the ACA by terminating individual and employer mandate penalties, premium and cost-sharing subsidies, Medicaid expansion, and taxes on insurers, drug, and device makers (as well as wealthy Americans) that were used to fund the health insurance reforms.

However, Republican leaders have since increasingly concluded that such a bill would also cripple the Marketplaces as well as deprive replacement plans of the funding they would need to be enacted. Despite earlier invocations to repeal and replace the ACA within “weeks” (see Update for Week of January 9th), the Trump Administration now appears prepared to issue regulations that would stabilize the Marketplaces for at least two years while a comprehensive replacement plan is developed (see below). Rep. Chris Collins (R-NY) reiterated this week that the Administration is planning on a two-year transition period for any replacement, as insurers are presently formulating plan designs and premiums that must be submitted by May for the 2018 open enrollment period.

The delay has forced at least five leading Republicans including Senate Finance chair Orrin Hatch (R-UT), Senate HELP chair Lamar Alexander (R-TN), and House Speaker Paul Ryan (R-WI) to start using the term “repair” in an effort to rebrand and refocus their ACA efforts. Although several replacement plans were floated in the past two weeks (see below), none of garnered any consensus among Republicans, much less the eight Democrats that would be needed to break a Senate filibuster.

As a result, House Energy and Commerce Committee chair Greg Walden (R-OR) stated this week that his committee was likely to pursue piecemeal measures to “fix” parts of the ACA instead of one overall replacement plan for the entire law. The health subcommittee has already started to debate measures that would allow insurers to charge older subscribers up to 500 percent more (instead of just 300 percent under the ACA) and relax the ACA’s standards for essential health benefits. In addition, they would limit special enrollment periods and the ACA’s 90-day grace period for non-payment of premiums.

The conservative House Freedom Caucus and Heritage Foundation—which initially proposed the ACA model in 1989 and backed it until 2009—lamented this week that ACA repeal efforts were “murkier than ever” and headed in the “wrong direction”. They had demanded that repeal legislation be passed prior to Trump taking office and enacted before February 1st, even without an available replacement.



President issues executive order directing federal agencies to lessen ACA burdens

President Trump issued an executive order immediately upon assuming office that directs federal agencies to “waive, defer, grant exemptions from, or delay” any part of the Affordable Care Act (ACA) that imposes a financial or regulatory burden on those affected by it “to the maximum extent permitted by law.”

The practical impact of the order was unclear as it contained no explicit directions to federal agencies on what provisions of the ACA should be altered through regulation. Most legal commentators pointed out that federal law already directs agencies to reduce regulatory burdens, so the order was largely interpreted as a political signal that the President intends to following through on his promise to “repeal and replace” the ACA.

Because much of the ACA was implemented via regulation, there are concrete steps that federal agencies could take to nullify much of the health insurance reform law without Congress actually repealing statutory provisions. This includes refraining from enforcing either the individual or employer mandates administered by the Internal Revenue Service (the latter of which has already been delayed and yet to go into effect). In addition, the Department of Health and Human Services could end or limit premium and cost-sharing subsidies, redefine essential health benefit packages so that less comprehensive coverage could be offered, and relax requirements for federal waivers so that states could partly expand Medicaid or opt-out entirely from other key ACA provisions.

However, other changes sought by Republicans, such as eliminating the ACA’s taxes on providers, insurers, pharmaceuticals, and high-cost health plans could only be accomplished with an act of Congress. The same is true for repealing the controversial Medicare cost-cutting board, altering eligibility levels for ACA subsidies, or increasing age-rating bands so insurers would no longer be limited to charging older subscribers no more than 300 percent of the premiums charged to younger groups.

The executive order received cautious praise from Republican lawmakers trying to develop competing ACA replacement plans of their own, who have been increasingly concerned about the President’s promises of “coverage for everyone” that they may not be able to deliver (see Update for Week of January 9th). However, even conservative groups that strongly praised the order (such as the American Enterprise Institute) acknowledged its initial impact would be “minimal” without further guidance.

Several insurance commissioners (including those in Pennsylvania and Washington) warned that just the President’s confirmation of his intent to roll back key parts of the ACA could cause insurers to curtail plans to participate in the Marketplaces for 2018 (as Aetna already did last week). In addition, they pointed out that repealing the ACA could create tremendous confusion for the 46 states that implemented more than 175 laws and regulations to codify provisions of the ACA, most of which would have to be repealed or revised.

Latest ACA replacement bills receive little enthusiasm from either party

Senators Bill Cassidy (R-LA) and Susan Collins (R-ME) introduced legislation last week that would allow states to choose whether to remain with the current Affordable Care Act (ACA) model, opt-out and reject all federal assistance, or transition to a new program that will automatically enroll eligible individuals into a high-deductible health plan linked to a health savings account that enables them to purchase limited-benefit plans with federal tax credits

Giving states the option to stay with the ACA was intended to garner support from at least the eight Senate Democrats needed to overcome the 60-vote filibuster. However, Minority Leader Chuck Schumer (D-NY) immediately panned the bill for failing to provide consumers in non-ACA states with protection against insurance denials for pre-existing conditions, the single most popular provision of the ACA. In addition, the bill would convert Medicaid into a lump-sum block grant program, giving all states



only a fixed amount of Medicaid funding per year and forcing them to have to dramatically cut benefits or provider payments when enrollment surges during economic downturns.

Schumer also noted that allowing insurers to once again offer the “bare bones” coverage prohibited by the ACA would require fully-insured consumers to have to subsidize the uncompensated care of “bare bones” customers. Although the bill retains the ACA’s ban on lifetime caps, annual limits on out-of-pocket costs would disappear for consumers in those states that do not remain in the ACA model.

However, the *Patient Freedom Act of 2017* (S.191) failed to also engender enthusiasm among Republican leaders including Majority Leader Mitch McConnell (R-KY) and Senator Rand Paul (R-KY). Paul insisted that retaining the taxes imposed by the ACA on providers, pharmaceuticals, and insurers was a “non-starter” for at least half of Republicans, even if that was the only means of funding the bill.

Senator Paul issued a competing plan last week (S.222) that includes a \$5,000 tax credit for individuals to use as part of a health savings account to purchase health coverage. Although the tax credit is greater than that proposed under other ACA replacement plans, it would eliminate far more of the law’s consumer protections, including the popular requirement that parents could keep dependent children on their group plans until age 26.

A controversial provision of Paul’s bill would extend the ACA’s ban on pre-existing condition denials only for two years, after which time it would revert back to the pre-ACA standard allowing discrimination based on health status for those who do not maintain continuous coverage (i.e. a gap of not more than 62 days). Additionally, S.222 would remove restrictions on HSA’s so that individuals may make unlimited contributions, remove the requirement that HSAs be linked to a high-deductible health plan, and allow HSA contributions to be spent on premiums and prescription drugs.

CBO says individual market enrollment will remain steady for ten years if ACA left intact

A new analysis released this week by the Congressional Budget Office (CBO) lowers earlier projections for enrollment in Affordable Care Act (ACA) Marketplaces but predicts that enrollment will remain steady if left alone by Congress.

CBO now estimates that roughly ten million consumers will obtain Marketplace coverage in 2017. This figure is down substantially from the 15 million it projected for the decade in last year’s report though likely to be slightly below the actual total once state Marketplace enrollment is counted (see below).

CBO also now projects that only 13 million will purchase Marketplace coverage in 2027, down from the 18-19 million it previously forecast.

The non-partisan scorekeeper specifically refuted claims by Republican lawmakers that the ACA is causing a “death spiral” in the individual market, concluding that enrollment in non-group coverage would remain steady over the next decade (increasing from 18 million to 20 million) if Congress keeps the major provisions of the ACA intact.

A separate CBO report revealed that federal spending for Medicare grew by five percent last year due largely to continued spikes in prescription drug costs. However, the rate of growth in Medicare spending is expected to slow to 4.1 percent for 2017 as payments from enrollees increase.

The report showed that federal Medicaid spending also grew by five percent in 2016. However, this rate was far less than in previous years when states began participating in the Medicaid expansion under the ACA. Medicaid spending is expected to increase only slightly to 5.5 percent for 2017.



CBO also found that federal spending for premium subsidies under the ACA will increase by \$9 billion for 2017, due to an average increase in Marketplace premiums of more than 20 percent (see Update for Week of January 9th).

A CBO analysis released earlier this month found the budget resolution passed by the new Congress to repeal key provisions of the ACA through reconciliation (see Update for Week of January 9th) would increase the number of uninsured by 18 million in the first year and 32 million by 2026. Premiums in the individual market would also spike by 20-25 percent on average during the first year, up to 50 percent following the termination of the Medicaid expansion and ACA subsidies, and nearly 100 percent by 2026. The number of individual market consumers living in counties that would have no participating insurers would also dramatically increase from 50 percent in 2017 to 75 percent by 2026.

Republican lawmakers insisted the CBO analysis was premature because it does not account for offsetting effects of ACA replacement bills (see above) that would presumably be enacted concurrent with a repeal plan.

FEDERAL AGENCIES

White House blamed for “sabotaging” ACA Marketplace enrollment

Preliminary figures from the Department of Health and Human Services (HHS) show that only 9.2 million consumers used the 2017 open enrollment period to sign-up for coverage in one of the 39 states defaulting to the federally-facilitated Marketplace (FFM).

The total surprised analysts as the FFMs had experienced record enrollment through January 14th, with more than 8.8 million consumers enrolled (roughly 100,000 ahead of the pace in 2016). However, only 367,000 consumers signed-up during the last two weeks of the open enrollment period, when enrollment typically spikes (more than 700,000 signed up during the final week of 2016), causing the final tally to come in well below HHS projections. It was the first time that Marketplace enrollment failed to grow from the year prior.

The Obama Administration’s former chief executive officer for the federal web portal (www.healthcare.gov) blamed the White House’s order to cancel all “advertising and other outreach activities” for the last weeks of open enrollment, even though those advertisements had already been paid for through the end of the month. Because late sign-ups typically spike among young adult enrollees that are vital to spreading out costs evenly in the risk pools (and final HHS ads specifically target this group), he directly accused the Trump Administration of trying to “sabotage” the Marketplaces by deliberately depressing final enrollment numbers for this key demographic.

The directive did not impact the 12 state-based Marketplaces (SBMs) who continued outreach efforts. Unlike the FFM, several SBMs (including California, Colorado, and Minnesota) extended their deadline past January 31st in order to accommodate the typical enrollment surges they were experiencing. Initial numbers from the state of Washington showed a 13 percent jump in enrollment from 2016, the largest single year increase since the Marketplaces opened in 2013.

Final FFM and SBM totals will be issued by HHS in March.

Trump Administration will attempt to stabilize ACA Marketplaces that they want to repeal

The Department of Health and Human Services (HHS) requested final paperwork clearance this week from the Office of Management and Budget for a package of proposed rules that are intended to stabilize the health insurance Marketplaces created by the Affordable Care Act (ACA).



The rules are identified as "economically significant" meaning they are likely to have annual effect on the economy of at least \$100 million. However, the Administration offered no other details on their contents and there is no indication how soon they may be approved by OMB, which has 90 days to complete the review but frequently takes additional time.

HHS submitted the rules on the same day that the Senate Health, Education, Labor and Pensions Committee heard testimony from the insurance industry, who had been urging the Obama Administration to make several changes to the Marketplace that would help ensure greater numbers of healthier and less costly consumers. This includes limiting the use of special enrollment periods (SEPs) so that healthier consumers do not wait until they are sick or injured to enroll.

The Obama Administration had previously responded to insurer concerns by requiring verification of eligibility for SEPs before individuals were allowed to enroll (see Update for Weeks of February 8 and 15, 2016). The new rules from HHS are expected to further limit the number of available SEPs as well as curtail the 90-day grace period that the ACA allows for non-payment of premiums. In addition, conservative groups advising President Trump on health issues (such as the Heritage Foundation) are seeking to include new rules barring consumers from enrolling in Marketplace coverage if they owe money to another plan.

It is not clear if the Administration will guarantee insurers the full payment they are due under the ACA's risk corridors and reinsurance payments for 2016. Shortfalls in those programs have prevented insurers from receiving the full amounts they were due for exceptional claims in both 2014 and 2015, leading several large insurers to exit the Marketplaces for 2017 and the majority of non-profit insurance cooperatives created with ACA loans to collapse (see Update for Week of September 12th).

America's Health Insurance Plans, led by the former Administrator of the Centers for Medicare and Medicaid Services Marilyn Tavenner, is also asking Congress not to repeal the premium and cost-sharing subsidies under the ACA for at least 2-3 years and retain the law's individual mandate penalties for as long as the ACA bans discrimination based on pre-existing conditions. The rulemaking is expected to address whether the Trump Administration will continue to provide ACA subsidies and enforce the individual mandate, which for 2016 tax filers is expected to impose an average penalty of nearly \$1,000 on those who failed to purchase minimum essential coverage that they could afford.

Avalere confirms Marketplace consumers are paying more for less in 2017

A new report released last week by the Avalere Health consulting firm confirmed that consumer costs for coverage in Affordable Care Act (ACA) Marketplaces operated by the federal government rose sharply for 2017 even as provider networks and coverage options continued to narrow.

The analysis of government data showed that 71 percent of enrollees through December 24th selected silver-tier plans for which premiums increased by an average of 12 percent from 2016 (\$554 month compared to \$496 per month). However, premiums for the second-lowest cost silver-tier plans (to which the ACA premium tax credits are tied) jumped by more than double that amount (25 percent).

Monthly premiums for bronze and gold tier coverage rose by 16 and 18 percent respectively (to \$475 and \$712). However, the most generous platinum-tier plans saw premiums spike by a whopping 34.5 percent (to \$892 per month).

Average deductibles for silver plans (including state-based Marketplaces in California and New York) also jumped 20 percent during 2017 to \$3,703. However, bronze-tier deductibles only increased by five percent (to \$6,014), while deductibles for gold and platinum coverage actually dropped precipitously by nine and 39 percent respectively. The average deductible for gold coverage now stands at \$1,051 for gold coverage but just \$110 for platinum.



Consumers requiring specialty drugs will also face even greater out-of-pocket costs for 2017. Roughly 84 percent of silver-tier plans now require coinsurance for specialty drugs (up from 74 percent last year) and the coinsurance exceeds 30 percent for half of those plans. This is a substantial increase from only 36 percent last year.

However, perhaps the most dramatic change from 2016 is the number of regions with only one participating insurer (up to 36 percent in 2017 from only four percent last year). In addition, the number of preferred provider organization (PPO) options has dropped substantially, with only 31 percent of federally-facilitated Marketplace plans now offering PPO plans (that have wider provider networks), down from 52 percent in 2014 and 40 percent last year.

Republican leaders have used the spike in premiums and deductibles as evidence that the Marketplaces are “collapsing” and must ultimately be eliminated. However, other studies from Avalere, Standard and Poors, RAND Corporation, and the Urban Institute have concluded that the 2017 increases are expected to be a “one-time correction” to account for the termination of the ACA risk corridor and reinsurance programs that stabilized premiums in the first three years of full ACA implementation, as well as initial “underpricing” by several large insurers (see Update for Week of January 9th).

Federal judge halts CMS rule on third-party premium assistance

Federal judge Amos Mazzant (an appointee of President Obama) issued a temporary restraining order earlier this month barring last-minute regulations from the Obama Administration that would have required dialysis providers disclose to insurers any third-party premium assistance received by patients.

The judge from the U.S. District Court for the District of Texas issued the indefinite injunction based on the likelihood that the lawsuit filed by dialysis providers including Fresenius and DaVita would succeed on the merits. He found the interim final rule (IFR) issued by the Centers for Medicare and Medicaid Services (CMS) on December 12th to be “arbitrary and capricious” because the agency was “unable to identify any emergency that justified publishing a rule without notice and comment” in order to move the effective date of the rule up to January 15th (five days before the new Administration).

CMS had claimed that the emergency resulted from public comments it received to its request for information (RFI) last August, which solicited feedback on whether premium assistance from non-profit groups funded by dialysis providers were being used to steer patients with end-stage renal disease (ESRD) away from Medicare and Medicaid and into higher-paying private plans in Affordable Care Act Marketplaces (see Update for Week of September 12th). The agency claimed that these comments documented “concerning practices [in which] providers and suppliers influenc[ed] enrollment decisions in ways that put the financial interest of the supplier above the needs of patients,” despite acknowledging that more than 600 of the 829 comments also urged CMS to not let insurers refuse to accept premium assistance that can provide a critical lifeline to vulnerable patients, preserve patient choice, and avoid relying on taxpayer dollars (see Update for Week of October 24th).

A separate CMS fact sheet stated patients covered by Marketplace plans could “bring in as much as four times higher [reimbursement] than Medicare and Medicaid’s, adding up to a difference of \$100,000 to \$200,000 or more per patient per year.” CMS stressed that this differential “easily dwarfs the several thousand dollar cost of providing premium assistance.” Since CMS’ own data showed “large increases in the number of ESRD patients enrolled in individual market coverage” for some states, the agency concluded that “some dialysis facilities are aggressively steering vulnerable patients toward individual market coverage supported by premium assistance.”

CMS argues that this form of steering can harm ESRD patients as many Marketplace plans do not include coverage for transplants, rely on very narrow provider networks, and impose higher cost-sharing charges than Medicare or Medicaid.



The IFR created new standards for dialysis facilities that provide premium assistance for individual market health plans whether directly, through a parent organization, or through another non-profit entity (like the American Kidney Fund). These largely required that dialysis providers make their patients aware of coverage options (including Medicare and Medicaid), inform insurers which patients are receiving third-party assistance, and make sure the insurer agrees to accept the payments.

The latter requirements were bitterly opposed by dialysis providers, who feared insurers would use that information to discriminate against their patients. Since a 2014 CMS rule gave Marketplace insurers the discretion to refuse to accept third-party premium assistance from non-profits (see Update for Week of June 2, 2014), insurers in at least 38 states have done so in an effort to keep the highest-cost patients out of their risk pools and protect their bottom line (see Update for Week of June 20th).

The provider plaintiffs claimed that the rushed rulemaking was simply an attempt by CMS to ensure that insurers continue to participate in the Marketplaces, following the high-profile defection of several large players. Insurers like Aetna specifically cited third-party premium assistance as a factor for their decision to abandon most of their Marketplaces for 2017 (see Update for Week of August 15th).

The American Kidney Fund praised the ruling and stressed that they have proposed new safeguards to prevent the types of inappropriate steering cited by CMS. They supported CMS' goal of creating a more transparent process relating to the referral of patients to non-profit premium assistance but insisted that the IFR should not leave the decision up to insurers on whether to provide ACA coverage to patients requiring premium assistance.

The IFR does not relate to independent bona-fide charities like Patient Services Inc. that provide sliding-scale premium and copayment assistance under a model approved by the Office of Inspector General for the Department of Health and Human Services. PSI is backing Congressional legislation that would require Marketplace insurers accept premium assistance from charitable groups for all patients, the same as CMS requires that it accept such assistance from federal and state health programs (see Update for Week of October 24th). That legislation (H.R. 3742) had nearly 150 bipartisan cosponsors last session and a new House and Senate bill are expected to be introduced this session.

FDA issues long-awaited guidance on interchangeable biosimilar drugs

The Food and Drug Administration (FDA) issued its long-awaited guidance earlier this month that defines how biosimilar drugs can be deemed interchangeable with their brand-name biologic counterpart and thus freely substituted by a pharmacist without the physician's input.

When the Affordable Care Act (ACA) created a regulatory pathway for copies of biologic drugs, it created two tiers: (1) biosimilar drugs that are "highly similar [to the original product... [with] no clinically meaningful differences" and (2) interchangeable drugs that must "be expected to produce the same clinical result as the reference product in any given patient". While the FDA has already approved four biosimilar products under this pathway (see Update for Weeks of March 2 and 9, 2015), none have yet to meet the higher standard of interchangeability, where they could be switched back and forth with the name-brand biologic without any increased risk.

The guidance clarifies that the interchangeability standard must be met for all of the name-brand drug's FDA-approved uses and outlines the types of scientific data and studies that must be submitted by companies to obtain the designation. However, the agency is seeking public comments on unresolved issues about manufacturing changes or additional approved uses that occur after the interchangeable designation is granted.

The FDA issued guidance last month on guidance on how to name generic biosimilar copies of brand-name biologic drugs (see Update for Week of January 9th).



California

Marketplace ends bid to allow undocumented consumers to purchase coverage

At the request of state lawmakers, Covered California officials formally withdrew its request last week for a federal waiver that would have allowed the health insurance Marketplace to sell unsubsidized coverage to undocumented residents.

The Affordable Care Act (ACA) limits Marketplace eligibility only to U.S. citizens or permanent residents. California became the first state last summer to seek an exception to that requirement, shortly after S.B. 10 passed with bipartisan support and became law (see Update for Week of June 20th).

Covered California had sought such a waiver under Section 1332 of the ACA, which gave states the flexibility starting January 1st to opt-out of specific ACA provisions if their replacement plan provide comparable coverage at the same or lower cost. Hawaii became the first state to receive a Section 1332 waiver earlier this month (see Update for Week of January 9th).

Following the election of President Trump, the Obama Administration was expected to expedite its consideration of California's waiver request (though it gave no indication whether it would be approved). However, the sponsor of S.B. 10 Senator Ricardo Lara (D) urged Covered California to withdraw the request before Trump's inauguration, fearing that data from the application could be used to identify and deport undocumented residents (a campaign pledge of the President.)

Even if approved, Covered California did not expect more than 17,000 undocumented residents to enroll, as they still would have been ineligible for ACA premium tax credits and cost-sharing subsidies, making most plans financially prohibitive.

Governor Jerry Brown (D) did use his State of the State address this week to pledge to pursue whatever state legislation was necessary to preserve the consumer protections under the ACA for the 1.6 million consumers already enrolled in Covered California and nearly five million that would lose Marketplace or Medi-Cal coverage if the ACA were repealed (according to the Urban Institute). Despite the uncertainty over repeal, Covered California enrollment has continued to exceed its 2016 pace.

California previously became the first to extend full Medicaid benefits to children of undocumented residents (see Update for Weeks of October 5 and 12, 2015). Four others (including Minnesota earlier this month) have opened Medicaid coverage at least to those children brought to the United States by undocumented parents, who are currently protected from deportation by President Obama's Deferred Action for Childhood Arrivals (DACA) program. The Trump Administration has yet to decide whether to eliminate that program.

Connecticut

Marketplace board sets new rules for special enrollment, broker commissions

The board governing the health insurance Marketplace that Connecticut created pursuant to the Affordable Care Act (ACA) voted last week to tighten the rules for special enrollment periods (SEPs) and require participating insurers to brokers that facilitate sign-ups for 2018 open enrollment.

Under the new rules, consumers cannot get AccessHealth CT coverage through a SEP until they provide documentation verifying their eligibility. Current rules allowed coverage to begin before documentation was provided.



The move is in direct response to insurer complaints that consumers are often waiting until they get sick or injured to sign-up for coverage and mirrors a change in federal Marketplace rules that took place last year (see Update for Weeks of February 22 and 29, 2016). Insurers insisted that those who utilize special enrollment periods are “significantly costlier”, more likely to drop coverage during a plan year, and account for 6-10 percent of annual premium increases.

More than 500 consumers per month sign up for AccessHealth CT via SEPs. More than 80 percent of SEP consumers qualify due to a loss of minimum essential coverage.

The broker commission requirement was added after the dominant AccessHealth CT insurers (Anthem and ConnectiCare) stopped paying commissions for 2017, causing the percentage of consumers being assisted by brokers to fall from 50 to 25 percent. Both insurers insisted that the mandate would cause premiums to rise for 2018. ConnectiCare controls two-thirds of the Marketplace, while just under a third of consumers enroll through Anthem.

Hawaii

Committee approves measures to preserve key ACA consumer protections

The Senate Commerce, Consumer Protection, and Health Committee unanimously approved legislation this week that would preserve key consumer protections under the Affordable Care Act (ACA) in the event they are repealed by Congress (see above).

The committee chair Senator Rosalyn Baker (D) sponsored S.B. 403, which would ensure that the ACA’s ban on pre-existing condition denials remains in state law, as well as the law’s current prohibition on varying premiums based on gender. The bill would also continue to allow parents to keep their dependent children on their group health plans until age 26, one of the law’s most popular parts.

Companion legislation (H.B. 552) has yet to advance through committee.

New bill would establish advisory board for rare diseases

Senator Josh Green (D) introduced legislation this week that would create a rare disease advisory board within the health department. The panel would not only educate government agencies and medical professionals about rare diseases but encourage the funding of research to develop new treatments. It would be comprised of physicians, nurses, hospitals, insurers, drug manufacturers, consumer organizations, and rare disease patients and parents.

Senator Green is an emergency room physician who chairs the Senate Human Services Committee.

Indiana

Governor seeks federal approval to continue Vice President’s Medicaid expansion alternative

New Governor Eric Holcomb (R) announced this week that Indiana is seeking federal approval to extend its alternative to the Medicaid expansion under the Affordable Care Act (ACA) until 2021.

Before becoming Vice President, former Governor Mike Pence (R) made Indiana one of eight states to receive a federal waiver to operate a private-sector expansion alternative (see Update for Weeks of January 26 and February 2, 2015). The Healthy Indiana 2.0 model was based on a state-funded program that Indiana had operated under a federal waiver prior to the ACA, which requires beneficiaries to maintain health savings accounts that can be used to pay required premium and cost-sharing obligations, while coverage can be terminated for non-payment.



The model was created by health care consultant Seema Verma, who is expected to be confirmed as the next Administrator for the Centers for Medicare and Medicaid Services (CMS) (see Update for Week of January 9th). The waiver extension includes new elements such as incentives for job training and wellness behaviors that Verma has long proposed for conservative-leaning states and is expected to approve as CMS Administrator.

According to the waiver extension request, continuing the Medicaid expansion will cost Indiana \$1.5 billion but bring in \$8.6 billion in federal funding from 2018 to 2020. It pledges to continue Healthy Indiana 2.0 even if Congress converts Medicaid to a lump-sum block grant program, as leading Republican lawmakers have proposed (see Update for Week of January 9th). Both Governor Holcomb and Vice President Pence have encouraged Congress not to repeal the ACA's Medicaid expansion.

Kansas

Hospital association finds Republican support for Medicaid expansion

Representative Susan Concanon (R) introduced legislation last week crafted by the Kansas Hospital Association that would make Kansas the 32nd state to participate in the Medicaid expansion under the Affordable Care Act (ACA).

Kansas is one of 19 states that have opted-out of the ACA expansion after the U.S. Supreme Court gave them the flexibility to do so (see Update for Week of June 25, 2012). The legislature has consistently rejected all bills to expand Medicaid under the ACA, including through a "private sector" alternative enacted by eight states and favored by conservatives.

However, electoral gains last fall by pro-expansion Republicans has renewed interest in expansion proposed by KHA, which would fully expand Medicaid to those earning up to 138 percent of the federal poverty level (FPL), but add some elements from alternative expansion plans, such as a work referral requirement (see Update for Week of December 5th). In an effort to facilitate passage, H.B. 2064 drops the earlier requirement that all expansion enrollees pay premiums.

The Obama Administration routinely rejected work requirements and efforts to charge premiums on those earning below 100 percent of FPL (see Update for Weeks of August 6 and 13, 2012). However, the incoming Centers for Medicare and Medicaid Services Administrator favored such requirements when crafting federally-approved expansion alternatives in states like Indiana, Iowa, and Michigan and is expected to be more open to approving them (see Update for Week of January 9th).

Massachusetts

Republican Governor wants to restore employer mandate if ACA counterpart is repealed

Governor Charlie Baker (R), a former hospital executive, proposed last week to penalize employers if they fail to provide minimum employee health coverage.

Former Governor Mitt Romney (R) enacted Massachusetts' landmark health insurance reform law in 2006, which became the model for the Affordable Care Act (ACA). The 2006 law included an employer mandate that imposed a \$295 per worker fine on companies with more than 10 full-time employees that failed to comply. Massachusetts' employer mandate was eliminated in 2013 in order to be consistent with the employer mandate under the ACA. However, the ACA mandate was repeatedly delayed by Congress and is now widely expected to be repealed under the Trump Administration.

As a result, Governor Baker not only wants to restore the employer mandate, but impose a far higher penalty (\$2,000 per worker) and minimum standards. According to the draft of his fiscal year 2018 budget released last week, Massachusetts employers would be required to cover 60 percent of premium costs and 80 percent of employees must use the coverage.



Business groups pushed back immediately against the proposed mandate, insisting that it was “unfair” to impose unsustainable costs on small business due to the “deficiencies in the ACA.” However, Governor Baker insists the mandate is needed to provide a strong enough incentive to move those eligible for both subsidized Marketplace coverage and employer-sponsored coverage out of the Marketplaces. He points out that MassHealth spending has doubled since 2007 as enrollment increased by 70 percent with the coverage expansion caused by the ACA.

Governor Baker is proposing other changes including new payment caps for some providers, a moratorium on new insurance mandates, creating plan options in the ACA Marketplace, and increasing transparency tools. He is one of several Republican governors that oppose Congressional plans to convert Medicaid into a lump-sum block grant or per capita caps, which he warned members of Congress would cause states to “most likely make decisions based mainly on fiscal reasons rather than the health care needs of vulnerable populations.”

Minnesota

Governor signs emergency premium relief measure into law

Governor Mark Dayton (D) signed emergency legislation into law last week that will create a premium relief program for 2017.

The relief will come in the form of a 25 percent premium rebate and benefit roughly 120,000 Minnesotans who purchase health insurance in the individual market but are ineligible for Affordable Care Act (ACA) subsidies. Unlike prior versions of the bill, there is no income limit (see Update for Week of January 9th). However, recipients cannot be eligible for any government health care programs (like Medicare or Medicaid).

Although the bill was effective immediately (in order to spur Marketplace sign-ups before the January 31st open enrollment deadline), those eligible for relief will not receive the automatic premium reductions until they can be processed by insurers in 8-12 weeks. However, the reduction will be retroactive to January 1st and apply through the end of the year.

The measure (S.F. 1) was initially sponsored by Deputy Majority Leader Michelle Benson (R) as a way to protect unsubsidized Marketplace enrollees from a 59 percent average premium spike for 2017 (see Update for Week of January 9th). However, it was modified substantially to incorporate many provisions sought by the Governor, including allowing rebates to be received by those enrolled in individual coverage outside of the Marketplace. The rebates also will no longer be provided on a sliding scale, as the verification system required to do so would have taken too long to put in place.

Minnesota will most of its \$313 million budget surplus to fund the rebates. A remaining \$15 million it allocate to help consumers with acute or life-threatening conditions keep their physicians into 2017 even if the old network is no longer available.

S.F. 1 received wide bipartisan support despite several controversial provisions, most notably the change that would allow for-profit companies to operate as health maintenance organizations for the first time in decades. Republicans unanimously supported the provision, insisting that it would boost market competition. However, more than half of Senate Democrats voted against S.F. 1 due to that change.

The premium relief plan immediately resulted in another bonus for consumers, particularly those in rural areas, as Medica agreed to return to the individual market. The insurer had pulled out last November, which had left 62 counties with only one insurer following the departure of Blue Cross and Blue Shield of Minnesota last summer (see Update for Week of June 20th). The additional competition is expected to lower premiums in those areas.



Oregon

House bill would limit drug out-of-pocket costs by metal tier

The House Interim Committee on Health Care introduced legislation on January 17th that would cap consumer out-of-pocket costs for prescription drugs and require manufacturers reimburse insurers for the cost of drugs that exceed a certain threshold.

The measure (H.B. 2387) would require insurers to limit out-of-pocket costs for consumers filling or refilling a covered prescription drug to \$500 per plan year for those enrolled in bronze-tier coverage and \$250 per year for those enrolled in silver, gold, or platinum-tier coverage.

It also would impose new transparency requirements by forcing manufacturers to disclose all major costs associated with the development of a drug within 30 days of approval by the Food and Drug Administration, if the drug has an average wholesale price (AWP) of \$10,000 or more per year. The report must justify the introductory AWP and identify the cost of manufacturing the drug as well as the expected profit margin.

Manufacturers would also have to provide insurers with written notice of an increase in the AWP of a prescription drug that result in a cumulative increase of more than 3.4 percent in the drug's price over the preceding 12-month period. That notice must be issued within 60 days of the price increase.

Senate bill would limit prescription drug out-of-pocket costs to \$250 per retail encounter

Senator Elizabeth Steiner Hayward (D) introduced S.B. 399 last week, which would prohibit small employer, large group or individual health plans from requiring enrollees to incur more than \$250 in out-of-pocket costs for covered prescription drugs purchased during single retail encounter. It was immediately referred to the Senate Health Care Committee.