



Health Reform Update – Weeks of May 29 and June 5, 2017

CONGRESS

Senate eyes late June vote on secret ACA repeal bill that is attracting moderate support

Several moderate Republican Senators came out in favor this week of a bill being drafted behind closed doors that would repeal key provisions of the Affordable Care Act (ACA), while maintaining the law's cost-sharing reductions (CSRs) and protections against insurer discrimination based on pre-existing conditions.

The Senate version of the American Health Care Act (AHCA) bill passed earlier this month by the House (see Update for Week of May 8th) was placed on the fast-track calendar this week by Majority Leader Mitch McConnell (R-KY), even though it has not been shared with Senators outside the working group and most provisions have yet to be cleared by the parliamentarian for reconciliation (meaning they directly impact the budget deficit and can pass with only 51 votes instead of the 60 votes needed to break a filibuster). If submitted as planned next week for a Congressional Budget Office (CBO) score, the full Senate could vote on the bill (H.R. 1628) as early as June 28th without holding a single committee hearing—a stark contrast to the Senate Finance mark-up of the ACA that approved 160 amendments from the opposing party and was the longest in 22 years.

Key moderates including Senators Bill Cassidy (R-LA) and Rob Portman (R-OH) had been reluctant to support AHCA provisions that not only terminated the CSRs but would allow states to opt-out of the ACA's community rating requirements, which bar insurers from increasing premiums based on medical history. Senator Portman also insisted that Congress needed to “immediately” commit to providing CSR funding through 2018, noting that the “uncertainty” created by the Trump Administration's refusal to take a position on the CSR's caused Anthem Blue Cross to pull out of the Ohio Marketplace this week, leaving 20 counties in his state with any Marketplace option for next year (see below).

The decision to preserve the CSRs may prove critical to bill's chances of passing the Senate. According to the Kaiser Family Foundation, a total of 47 counties across three states now have zero Marketplace options for 2018 due to the ACA uncertainty and seven states (Alabama, Alaska, Delaware, Oklahoma, Nebraska, South Carolina and Wyoming) will have only one Marketplace insurer.

However, the key to recruiting moderates may well be the revised bill's proposed compromise on the Medicaid expansion, which the AHCA sought to end starting in 2020. At least seven Republican Senators from expansion states had pledged to vote against any bill that terminated the expansion. However, the additional seven-year phase out (until 2027) appears to have brought at least three moderate Senators on board (Portman along with Shelly Moore-Capito (R-WV), and Dean Heller (R-NV)).

The changes to the AHCA were immediately opposed by conservative Senators led by Rand Paul (R-KY) and Ted Cruz (R-TX), who have insisted that they would not support a measure that continues either the Medicaid expansion or CSRs. However, the working group is seeking to maintain the AHCA's waivers that would allow states to opt-out of the ACA's essential health benefit packages and limits on varying premiums based on age, both of which are strongly favored by conservatives.

The parliamentarian's ruling on whether those provisions could be part of reconciliation may prove crucial to whether conservatives will support the bill, as will her ultimate decision on whether the controversial prohibition on tax credits being used to purchase coverage with abortion services must be passed separately.



Senators Cassidy and John Thune (R-SD) are continuing to work on a redesign of the premium tax credits proposed by the AHCA, which were intended to replace the ACA's tax credits but be based on age instead of income. However, the working group is trying to blunt the impact of last month's CBO score on the House-passed bill, which found that low-income consumers aged 50-64 face premiums exceeding half their income (see Update for Weeks of May 15th and 22nd). As a result, the Senators are reportedly considering proposals that would let tax credits be both age and income-based for those below 250 percent of poverty and increase far beyond the \$4,000 annual maximum in the AHCA.

Ways and Means Committee approves three bills relating to AHCA tax credits

The House Ways and Means Committee voted largely along party lines this week to advance three narrowly-focused bills that are part of the overall Republican strategy to repeal and replace the Affordable Care Act (ACA). They are expected to receive a full floor vote next week.

The first bill (H.R. 2372) would amend the American Health Care Act (AHCA) passed last month by the House (see Update for Week of May 8th) to allow veterans eligible for but not enrolled in Department of Veterans Affairs coverage to be eligible for AHCA premium tax credits in the existing Affordable Care Act (ACA) Marketplaces.

The second bill (H.R. 2579) would permit AHCA tax credits to be also used for purchasing COBRA continuation coverage while the third (H.R. 2581) would require confirmation of eligibility and residency status by the Social Security Administration or Department of Homeland Security for individuals seeking premium tax credits.

H.R. 2579 was the only bill to receive any Democratic support (from Rep. Kind (D-WI)).

Committee chair Kevin Brady (R-TX) more forcefully reiterated his earlier insistence that Congress fully-fund the separate cost-sharing subsidies under the ACA through 2018, acknowledging that "insurers have made clear the lack of certainty is causing 2018 proposed premiums to rise significantly" (see below).

FEDERAL AGENCIES

Supreme Court speeds approval of biosimilar drugs

The U.S. Supreme Court unanimously overturned an appeals court decision this week that had prevented Novartis from selling its biosimilar version of Amgen's Neupogen drug for 180 days following approval from the Food and Drug Administration (FDA).

Under the new regulatory pathway created by the Affordable Care Act (ACA), the FDA has approved four biosimilar products, with not more than one competitor for a single product (see Update for Weeks of March 2 and 9, 2015). The statute requires biosimilar manufacturers to provide the brand-name manufacturer with a 180-day notice before launching their competing product.

Novartis' Zarxio (which treats a common side effect of chemotherapy) was the first biosimilar to win approval. However, two lower courts agreed with Amgen that the 180-day notice requirement should not start until FDA approval, a decision that Novartis claimed would effectively give Amgen an extra six months of exclusivity on top of the 12 years prescribed by law.

The Supreme Court agreed that under the "plain meaning of the statute" Congress never intended to grant brand-name drugmakers extended exclusivity nor did they dictate whether the notice must be given before or after FDA approval.



Congressional leaders have insisted that they will keep the biosimilar approval pathway intact if other key provisions of the ACA are repealed (see Update for Week of December 5, 2016). Thus far, it has not been part of the ACA repeal bills being considered in the House or Senate (see above).

HHS solicits comments on ways to reduce regulatory burdens for insurers

The Department of Health and Human Services (HHS) issued a Request for Information (RFI) last week seeking stakeholder feedback on ways to re-design insurance regulations that may inhibit job creation or regulatory burdens on businesses.

The notice piggybacks on the first executive order issued by the Trump Administration, which directed 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 (see Update for Week of January 30th).

The RFI specifically seek comments within 30 days on four agency objectives: (1) improving consumer choice, (2) stabilizing the ACA Marketplaces, (3) increasing plan affordability, and (4) affirming the states’ “traditional authority” over health insurance. In particular, HHS wants suggestions on how to “increase the number of younger and healthier consumers purchasing plans”, which is critical to ensuring health plans remain profitable enough that they continue to participate in the Marketplaces.

The Marketplace Access Coalition created by PSI will submit comments in response to the RFI regarding the burden placed on Marketplace consumers with costly conditions whose charitable premium assistance is not accepted by insurers. A recent letter signed by 184 members of Congress from both parties is urging HHS to fix an interim final rule that allowed insurers to discriminate in this manner and more than 70 plans in 41 states have subsequently done so (see Update for Weeks of May 15th and 22nd).

STATES

Centene to expand presence into regions with no Marketplace insurers

Centene announced that it will enter three new Affordable Care Act (ACA) Marketplaces for 2018 and expand its presence in existing Marketplaces to cover counties left with zero insurers.

Centene currently offers Marketplace plans in Arizona, Arkansas, Florida, Georgia, Indiana, Mississippi, Ohio, Texas, and Washington. The insurer nearly doubled its Marketplace enrollment last year, climbing to 1.2 million members through the end of the 2017 open enrollment period, resulting in a 69 percent jump in revenues from the first quarter of 2016. Centene (which took over HealthNet last year) has profited largely by targeting regions that are underserved as a result of insurers leaving the Marketplace, and is currently the lone insurer for most Mississippi counties and the Phoenix and Tucson metro area in Arizona.

Centene officials believe these underserved areas represent a “lucrative” business opportunity and are now eyeing some of the 25 counties left without an insurer in Missouri (see Update for Weeks of May 15th and 22nd), 20 in Ohio (see below), and two in Washington (see below). It is not yet known which counties they will enter, as Centene will evaluate each to determine if their risk pools will be roughly comparable to those in other regions in which Center participates.

Major insurers are no longer losing money on Marketplace plans

The nation’s five biggest for-profit insurers (Aetna, Anthem, Cigna, Humana and UnitedHealth Group), the nation’s five biggest for-profit insurers earned \$4.5 billion in collective profits from Affordable



Care Act (ACA) Marketplace business over the first three months of 2017, according to an analysis of new insurer filings prepared by *Axios*.

The total is the highest of any first quarter since Marketplace implementation in 2014. They confirm reports from Standard and Poors, Avalare Heath, and other consultants that the Marketplace are not in the “death spiral” alleged by ACA opponents, but that the dramatic premium increases for plan year 2017 were indeed a “one-time correction” that enabled insurers to adjust to the loss of risk corridor and reinsurance payments for exceptional claims at the end of 2016 (see Update for Week of May 8th).

Those top five insurers have already dropped most of their Marketplace business or announced plans to do so either to huge losses incurred in 2015-2016 or the uncertainty created by the potential repeal of key ACA provisions (see Update for Weeks of May 15th and 22nd). However, *Axios* stressed that non-profit Blue Cross and Blue Shield (BCBS) plans are also showing a dramatic turnaround from 2016. For example, Health Care Service Corp., the parent company for BCBS in Illinois, Montana, New Mexico, Oklahoma and Texas went from a \$442 million loss to an \$869 million profit (a \$1.4 billion swing).

BCBS plans are often the lone Marketplace insurer in certain states and their reversal of fortune has been most pronounced in those areas. For example, BCBS Alabama the lone insurer in that state, went from a \$50 million loss to an \$81 million profit, BCBS South Carolina went from a \$14 million loss to an \$39 million profit, Premera Blue Cross of Alaska went from a \$36 million loss to a \$27 million profit, and profits from BCBS Wyoming increased from \$3 million to \$12 million.

BCBS Arizona also showed a dramatic increase from only a \$5 million profit during the first quarter of 2016 to a \$56 million profit during the first quarter of 2017, while BCBS North Carolina went all the way from \$38 million to \$298 million. Each covers most Marketplace consumers in their state.

Both BCBS Alabama and Health Service Corp. announced plans to return to the Marketplaces in 2018, as has Florida Blue, which has the lowest medical-loss ratio of any BCBS plan (see Update for Week of May 8th). Florida Blue continues to be among the most profitable of any Marketplace insurer, with a profit of nearly \$1 billion in 2016, compared to \$471 million in 2015. Despite being the lone insurer in nearly all of Florida’s rural counties, Florida Blue warned this week that they would immediately increase premiums by nearly 20 percent if the cost-sharing reductions under the ACA were not fully-funded for the full plan year (see Update for Weeks of May 15th and 22nd).

States weigh reinsurance programs in efforts to retain Marketplace insurers

At least nine states are pursuing legislation that would follow the lead of Alaska and Minnesota in creating a state-funded reinsurance program for insurers in Affordable Care Act (ACA) Marketplaces.

The Trump Administration sent a letter to governors last April urging them to “pursue waiver proposals that include high-risk pool/state-operated reinsurance programs” to accommodate Marketplace enrollees with high-cost conditions (see Update for Week of May 8th). The letter specifically cited the experience of Alaska, who created their own state-funded reinsurance program last year in order to mitigate rate hikes caused by the Marketplace exit of a key insurer (leaving only one to serve the state). That program is credited with reducing average premium increases in 2017 from 42 percent to seven percent, just by reimbursing insurers for exceptional claims costs (see Update for Week of December 5th).

The letter represented a reversal in position since 2014, when Republicans in Congress led by Senator Rubio blocked funding for the three-year reinsurance program created by the ACA, calling it an insurer “bailout”. That caused a \$2.5 billion shortfall which led to the failures of all but six of the 23 CO-OPs. It also caused several major insurers like UHC, Humana, and Aetna, to incur such substantial losses that they largely left the Marketplaces (see Update for Week of August 15th). However, Republicans have supported reinsurance programs in the past, such as the permanent reinsurance fund they created for Medicare Part D in 2003.



The success of Alaska's reinsurance program appears to have created a realization that insurers will not participate in the Marketplaces without one. As a result, the Republican legislature in Minnesota quickly passed legislation in March to create a state-funded reinsurance program that would stabilize a Marketplace where average premiums jumped by 59 percent due to insurer departure and Republican Congressional leaders then specifically allocated \$130B as part of the market stabilization fund under the American Health Care Act (AHCA) to be used for state high-risk pools or reinsurance programs (see Update for Week of May 8th).

This realization has caused a flurry of state bills from both parties authorizing their respective agencies to seek the federal Section 1332 waiver under the ACA to create/restart a high-risk pool or reinsurance program. These include the following nine states.

Colorado (S.B. 300 signed by Governor this week)
Maine (L.D. 659 signed by Governor last week, which would restart previous reinsurance program under the state's Dirigo Health coverage)
Montana (H.B. 652, which was vetoed by the Governor last month)
New Hampshire (H.B. 469, which remains pending)
North Carolina (H.B. 913, which remains pending)
Oklahoma (H.B. 2406, see above)
Oregon (pending as part of large tax bill)
Rhode Island (H.6156, S. 831, which remains pending)
Texas (S.B. 2087, which was signed by Governor this week)

Alaska implemented its program before Section 1332 waivers could be granted starting last January. Its application remaining pending with the Trump Administration, as does Minnesota. The other states still need to submit waiver applications.

Arkansas

Marketplace insurers will remain for 2018, submit multiple rates

The three insurers participating in the state partnership Marketplace that Arkansas operates pursuant to the Affordable Care Act (ACA) have elected to continue participating in 2018.

The Department of Insurance will allow the three carriers (Arkansas Blue Cross Blue Shield, QualChoice, and Centene/Ambetter) to file two sets of proposed premiums by the July 14th deadline. The first set will be based on the assumption that the ACA cost-sharing reductions (CSRs) will remain in place for the full plan year. The second set will be a contingency plan in the event the Trump Administration follows through on earlier threats to eliminate the CSRs (see Update for Weeks of May 15th and 22nd).

Insurance commissioners in California and New Mexico are similarly allowing insurers to submit multiple rates (see Update for Week of May 8th), while Connecticut has delayed their deadline for 2018 rate filing until September to let insurers adjust rates due to uncertainty.

California

Covered California will use higher rate filings if ACA subsidy uncertainty not resolved by August

The communications director for Covered California announced this week that the Marketplace will wait no longer than mid-August for the Trump Administration or Congress to commit to funding the cost-sharing reductions under the Affordable Care Act (ACA) through 2018.

Covered California is allowing insurers to submit two sets of rate filings prior to the June 30th deadline. The first assumes that Congress will make no major changes to the ACA for 2018, while the



second set of “Trump rates” accounts for the termination of the cost-sharing reductions and the lack of enforcement for the individual mandate (see Update for Week of May 8th).

Covered California officials warn that silver-plan premiums will increase by an average of 16.6 percent if the CSRs are eliminated, on top of premium increases already being sought by insurers to account for medical inflation or a sicker than expected mix of subscribers. However, it insists that after mid-August it will have to “presume [the CSRs] will not be funded and use the higher rates for 2018” in order to finalize premiums by the October 1st deadline.

The Trump Administration delayed a decision last month on whether to appeal a federal court decision invalidating the CSRs for 90 days, meaning the case will not be heard until late September at the earliest (see Update for Weeks of May 15th and 22nd). However, several key members of Congress are seeking to “immediately” providing funding in order to resolve the uncertainty that is causing Marketplace insurers to either increase premiums or leave altogether (see above).

Senate passes renewed prescription drug cost transparency bill

The Senate passed legislation this week that would require drug manufacturers to publicly justify treatment costs and price hikes.

The measure (S.B. 17) is similar to legislation that also cleared the Senate last year before the sponsoring Senator Ed Hernandez (D) withdrew it, claiming that the amendment had been so “watered down” that it could no longer accomplish its goal of “shedding light on the reasons precipitating skyrocketing drug prices” (see Update for Week of December 5th). It is backed by most consumer groups and large insurers but strongly opposed by the pharmaceutical and biotechnology industries.

S.B. 17 currently would require that manufacturers give state purchasers (such as MediCal or CalPERS) a 90-day advance notice anytime the wholesale acquisition cost (WAC) of a drug increases by at least 25 percent over a three calendar year period if the WAC is below the Medicare Part D specialty drug threshold, or ten percent or more if the WAC is above that threshold. This notice must detail the factors justifying the increase and requires agencies post it online in a manner that allows consumers to access it on a per-drug basis and shows the overall impact of a the drug cost on plan premiums.

Drug manufacturers would also be required to notify agencies within three days of Food and Drug Administration (FDA) approval of any drug if the WAC exceeds the Medicare Part D specialty drug threshold. Within 30 days of this notice, the manufacturer would have to provide details about their pricing plans and marketing budget for the drug, including amounts budgeted for patient assistance programs and the estimated patient population for the drug.

Starting October 1, 2018, health plans and insurers in both the large and small group markets would be required to annually notify state agencies about the 25 most frequently prescribed drugs, the 25 most costly drugs, and the 25 drugs with the higher year-over-year increase in annual spending. Regulators would again be required to report this information online.

California is one of 25 states (and Puerto Rico) that considered drug price transparency laws this session. Opponents objected that its bill goes much further than the transparency law enacted last year in Vermont, which required that 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). Maryland recently enacted the first “price gouging” law in the nation that seeks to prevent WAC increases of 50 percent or more for “essential” generic or off-patent drugs (see below) while a new Colorado law only requires that certain providers make a single document available to the public listing direct pay prices and cost-sharing obligations for their most common health care services (see Update for Week of May 8th). The Louisiana governor signed a bill this week (H.B. 436) that would require drug manufacturers to report wholesale acquisition costs on a quarterly basis.



Maine

Harvard Pilgrim seeks unprecedented rate hike due to ACA uncertainty

Harvard Pilgrim Health Care announced this week that it is seeking a 39.7 percent average increase in premiums next year for consumers in the federally-facilitated Marketplace operated in Maine pursuant to the Affordable Care Act (ACA).

The hike is the most ever sought by a Marketplace insurer in Maine and nearly double the 21.1 percent increase that Harvard Pilgrim was granted by state regulators for 2017. Harvard Pilgrim blames the increase on the uncertainty about whether the Trump Administration will enforce the individual mandate under the ACA, or if it will be repealed by Congress (see above). The insurer warned that it would exit the Marketplace entirely if the cost-sharing reductions (CSRs) under the ACA were not fully-funded for 2018 (see above).

Anthem Blue Cross and Blue Shield, which chose to exit the Ohio Marketplace this week for the same reasons (see below), is seeking a far lower average rate hike of 21.2 percent. The third insurer expected to participate again for 2018 is Community Health Options (CHO), which is one of only five of the remaining non-profit insurance cooperatives created with ACA loans.

CHO, which participates in the Maine and New Hampshire Marketplaces, has yet to release its proposed hike for next year, but previously received a 25.5 percent average increase in Maine in order to help it stay afloat following major losses. Low premiums helped it dominate early Marketplace enrollment, controlling 80 percent of the Marketplace in 2015 (see Update for Week of December 7, 2015). However, it also attracted a far sicker and more costly risk pool and was unable to pay all claims obligations, forcing the Bureau of Insurance to freeze enrollment for 2016 and shift some consumers to competing carriers.

CHO still controls half the Maine Marketplace and recently reported a \$3.7 million surplus resulting from an improved case-mix. It is the only one of the five surviving cooperatives that received an ACA risk corridor payout from the federal government.

Maryland

Governor allows landmark drug price-gouging legislation to become law

Governor Larry Hogan (R) made Maryland the first state to protect consumers from price-gouging for prescription drugs, when he allowed H.B. 631 to become law on May 26th without his signature despite insisting that it was “unconstitutional” and being “not convinced [that the law] is truly a solution to ensuring that Marylanders have access to essential prescription drugs.”

The measure would apply only to sales of essential off-patent or generic drugs and give the Attorney General authority to demand that generic manufacturers or wholesale distributors produce documentation proving that an increase in price is not “unconscionable” and issue rebates to consumers.

Under the bill, “essential” drugs are those designated by the Department of Health and Mental Hygiene or found under the Model List of Essential Medicines published by the World Health Organization. “Unconscionable” is defined as an increase not justified by the cost of producing or expanding access to the drug, or an increase that results in consumers having no meaningful choice about whether to purchase the drug.

H.B. 631 specifically requires the Medicaid program to notify the Attorney General of any increase in an essential off-patient generic drug whenever three or fewer manufacturers are actively manufacturing and marketing the drug, the wholesale acquisition cost (WAC) increases by 50 percent or more in one year, or if the WAC for a 30-day supply exceeds \$80.



The measure was strongly supported by the Attorney General and consumer groups like the Maryland's Citizen's Health Initiative. However, it faced opposition from groups representing generic drug manufacturers like the Association for Accessible Medicines, which insisted that it would cause a host of "unintended consequences" and actually restrict competition, without lowering drug prices for consumers. As a result, H.B. 631 was "watered down" from initial versions by complaints that it went much further than the drug transparency law enacted last year in Vermont (see Update for Week of June 20th).

Similar legislation has been considered this session in Connecticut and Rhode Island and filed last week in Maine (see Update for Weeks of May 15th and 22nd). At least 20 state attorneys general (including Maryland) have already filed suit against six drug manufacturers alleging price-fixing schemes to artificially inflate prices for generic drugs.

Nevada

Legislature passes bill that would allow all residents to purchase Medicaid coverage

The House and Senate sent a bill this week to Governor Brian Sandoval (R) that would let any resident purchase Medicaid-equivalent coverage through the Silver State Health Insurance Exchange, including those receiving premium and cost-sharing subsidies under the Affordable Care Act (ACA).

The Governor has not indicated whether he would sign A.B. 374, which would require a federal waiver from the Trump Administration. It would effectively define the Nevada Care Plan as a "qualified health plan" and allow it to be offered by the Exchange that Nevada created pursuant the ACA to those otherwise ineligible for Medicaid. Benefits under the Nevada Care Plan coverage would be the same of those available to Medicaid enrollees, except for non-emergency transportation services.

Governor Sandoval is considering whether to sign A.B. 408, which would codify some of the most popular provisions of the ACA into state law in the event they are repealed by Congress (see above). This includes requirements that insurers cover everyone regardless of health status, not vary premiums based on health status, and allow young adults up to age 26 to remain on their parents' group coverage.

Governor vetoes bill that would have required drug price transparency

Governor Brian Sandoval (R) vetoed S.B. 265 this week, which sought to make Nevada the latest state to make prescription drug costs more transparent (see above).

The primary provisions of the bill required state agencies to compile and publicly display the wholesale acquisition costs of drugs that are determined to be "essential" for treating diabetes. However, a specific section would also have required "a nonprofit organization that advocates for patients or funds medical research in this State to [submit] certain information concerning payments, donations and anything else of value that the organization receives from manufacturers of prescription drugs, certain third parties or pharmacy benefit managers or trade or advocacy groups for such entities."

The Governor vetoed S.B. 265 largely because it was a Democratic-sponsored bill. His office has indicated that he would likely sign a comparable Republican-sponsored measure (S.B. 539) that was amended this week to include the same reporting requirement for non-profits. The primary difference between S.B. 265 and S.B. 539 is that the latter drops the 90-day notification requirement for price changes in diabetes drugs.

New York

Emergency rule bars insurers from Medicaid and SCHIP business if they leave ACA Marketplace

Governor Andrew Cuomo (D) announced new emergency regulations this week would require insurers to participate in the NY State of Health Marketplace created pursuant to the Affordable Care Act



(ACA) if they also want to offer coverage to Medicaid, State Children Health Insurance Plan (SCHIP), or Essential Plan enrollees.

The Department of Financial Services rule is intended to stem the tide of departures that have occurred in other ACA Marketplaces as Congress continues to wrestle with if and how to repeal key ACA provisions. Although New York has one of the healthiest Marketplaces in the nation with 14 competing insurers, several including Anthem (see Ohio below), Oscar Health Plan, and UnitedHealth Care have threatened to not to participate for 2018 if the Trump Administration does not ensure the ACA cost-sharing subsidies will be available for the entire plan year (see Update for Weeks of May 15th and 22nd).

The emergency rule specifically would require that plans participating in NY State of Health continue to cover all ten essential benefit categories mandated by the ACA, as well as offer coverage regardless of pre-existing conditions, even if these provisions are repealed by Congress (New York was one of five states that already banned pre-existing condition discrimination prior to the ACA). However, it is the link to Medicaid, SCHIP, or Essential Plan coverage that is likely to have the greatest impact on insurers as these plans tend to be more lucrative than Marketplace business.

New York is one of only two states (besides Minnesota) that elected the Essential Plan option (Oregon is weighing the option for next year). The Essential Plan is the basic health plan (BHP) option created by the ACA, which provides New York with extra federal funding for covering those earning up 138-200 percent of the federal poverty level in a lower-cost option. More than 665,000 New Yorkers are enrolled in the Essential Plan instead of Marketplace coverage, which provides coverage with no deductibles, limited copayments, and premiums of no more than \$20 per month. This represents 40 percent of all Marketplace consumers.

New York becomes first state to cap annual spending on prescription drugs

Increased scrutiny over prescription drug costs is expected to result in additional manufacturer discounts under new Medicaid rules that were part of the state budget enacted in April.

Medicaid officials now have the authority to impose multiple layers of review over manufacturer profit margins and drug effectiveness if manufacturers do not voluntarily make additional rebates whenever drug spending exceeds certain targets. They make New York the first state to impose pre-set caps on drug spending, which are intended to limit annual payments to no more than five percent above medical inflation.

The pharmaceutical industry strongly opposed the new caps, insisting that it would have a “chilling effect...on New York’s economy.” In addition, they argued that provisions allowing manufacturers to avoid additional scrutiny by boosting their rebates are “unclear [and] prone to abuse.”

However, state officials argued that they were needed to reign in Medicaid drug costs that have increased by an average of eight percent per year since 2014, thanks largely to spending on new “cures” for Hepatitis C. Drug spending currently accounts for more than five percent of the Medicaid budget.

Under the new rules, Medicaid officials can refer specific drugs to the state’s Drug Utilization Review Board whenever spending exceeds the caps. The Board would then recommend a target rebate. Manufacturers would refuse to agree to at least 75 percent of that amount could face “sanctions” that include prior authorization, cost-effectiveness reviews for the drug, or disclosure of its average profit margin and charges over a five-year period. Medicaid could also exclude certain drugs entirely.

Ohio

Anthem exit leaves 20 counties with no Marketplace insurer



Anthem Blue Cross announced this week that it would not participate in the Affordable Care Act (ACA) Marketplace for Ohio next year, a move that will leave 20 of Ohio's 88 counties without any participating insurers if other carriers do not expand their coverage areas.

Anthem, which currently covers 67,000 Marketplace consumers (or 28 percent of the entire Marketplace), insisted that it was not able to accurately plan and price its Marketplace plans for 2018 because of "continual changes in federal operations, rules and guidance." It specifically cited the uncertainty over whether the Trump Administration would continue the cost-sharing reductions (CSRs) offered by the ACA as its primary reason for staying out of the Marketplace next year (see Update for Weeks of May 15th and 22nd).

Anthem's decision was not based on finances as it expects to show a profit from ACA business in 2017 after more than \$300 million in losses the prior year. Ohio also has a very competitive Marketplace compared to other states and average benchmark premiums increased by only two percent for 2017 compared to the double-digit increases in less competitive states.

Humana is the only other insurer to previously pull out of the Ohio Marketplace for 2018. The remaining nine Marketplace insurers from 2017 all submitted the required filings by the June 5th deadline in order to participate next year. However, they all cautioned that their decision is contingent upon the availability of the CSRs, as their contracts allow them to leave mid-year if the CSRs are terminated.

Anthem had previously threatened to stop selling plans in all of 14 Marketplaces if the Administration did not provide greater certainty about the CSRs, a move that could also leave counties in Colorado, Kentucky, and Missouri without participating Marketplace insurers (see Update for Week of May 8th). However, so far it has filed proposed 2018 rates in Connecticut, Maine, and Virginia and is leaning towards participating in Colorado. It is also likely to file in Nevada as exiting the Marketplace would require also dropping their Medicaid managed care business in that state. A similar emergency measure in New York may force Anthem to remain in that Marketplace as well (see above).

To date, the Trump Administration has only committed to funding the CSRs a month at a time and asked a federal appeals court for a 90-day extension to decide whether to drop an Obama Administration appeal of a lower court ruling that would terminate them (see Update for Weeks of May 15th and 22nd).

Oklahoma

Governor to consider legislation to create high-risk pool or reinsurance program

Governor Mary Fallin (R) signed H.B. 2406 this week, which authorizes the state to seek a federal waiver to stabilize individual market premiums through either a high-risk pool or reinsurance program.

If signed into law, the program would be operated by a non-profit legal entity with operational support from the Insurance Department. It would use a combination of federal funds and insurer assessments to either return to a high-risk pool that segregates costlier patients into their own market or follow the example of Alaska and Minnesota and supplement costs for insurers with exceptional claims, both of which have been encouraged by the Trump Administration (see Update for Week of May 8th).

H.B. 2406 was based upon the report last March from the Section 1332 waiver task force created by the Department of Health and Human Services (see Update for Week of May 8th). Their recommendations included making Oklahoma only the second Republican-controlled state (after Idaho) to shift from the federally-facilitated Marketplace to a state-based model. In addition, they proposed that Oklahoma get federal waivers to eliminate the metal tiers under the Affordable Care Act (ACA), change the eligibility for ACA premium subsidies from 100-400 percent of the poverty to 0-300 percent, narrow the essential health benefits package under the ACA, and broaden the ACA's age rating band from 3:1 to 5:1 (meaning insurers could charge older subscribers 500 percent more than younger ones).



The report also recommended Oklahoma seek federal waivers allowing it assume responsibility for modifying or rejecting plan premiums in the individual and small group markets. It was one of only three states (with Texas and Wyoming) for which the federal government still assumes control over rate review (see Update for Week of July 18th).

Starting in 2017, the ACA allows state to experiment with their own alternatives to the ACA so long as they cover a comparable number of residents at the same or lower cost. Hawaii received the first Section 1332 waiver earlier this year (see Update for Week of February 27th). However, the Section 1332 authority is expected to greatly broadened by the Trump Administration.

Oregon

Insurers who exited the Marketplace will be allowed to return in less than five years

Governor Kate Brown (D) signed legislation this week (H.B. 2340) that would allow the Department of Consumer and Business Services to insurers who previously discontinued coverage in a service area return prior to the expiration of the five-year waiting period mandate by state law. The bill would apply to individual and group coverage and is intended to ensure Cover Oregon remains competitive as insurers weigh whether to exit due to uncertain over if and when key Affordable Care Act (ACA) provisions will be repealed (see above).

Washington

Two counties left with no Marketplace insurers for 2018 due to ACA uncertainty

The Office of the Insurance Commissioner (OIG) announced this week that eight insurers submitted filings to participate in the Washington Healthplanfinder for 2018.

Commissioner Mike Kreidler (D) stated that he was “deeply troubled” and “disappointed” by the loss of two insurers in the Marketplace, most notably Kaiser Foundation Health Plan of Washington, who elected not to participate due to the “uncertainty” over whether the Trump Administration would fund the cost-sharing reductions under the Affordable Care Act (ACA) and enforce the individual mandate while Congress decides whether or how to repeal and replace key ACA provisions. The Commissioner specifically blamed the Trump Administration for delaying any decision on the CSRs for at least 90 days (see Update for Weeks of May 15th and 22nd), insisting that it was “sabotaging the process.”

As a result of the insurer departures, nearly 3,500 Marketplace consumers in two counties (Grays Harbor and Klickitat) currently have no plan options from which to choose. The Commissioner stressed that the lack of insurers in Grays Harbor could be particularly harmful as consumers in that county received an average of \$408 in ACA premium tax credits to help purchase 2017 coverage, the third-highest average in the state.

Commissioner Kreidler pledged to reach out to the departing insurers to “strongly encourage them to reconsider their participation in the two counties”. He also promised to “look for whatever options are available at the state level to protect the stability” of the Marketplace if no insurers fill the void.

The insurers submitted proposed premiums by the June 7th deadline. However, OIC will not release any premium data until later this month.