



Health Reform Update – Week of July 10, 2017

CONGRESS

Senate leaders push for quick vote on revised ACA repeal and replace bill

Senate Majority Leader Mitch McConnell (R-KY) released a revised version of the Better Care Reconciliation Act (BCRA) this week with the intent of holding a floor vote next week regardless of whether the bill is scored by the Congressional Budget Office (CBO).

Opposition from a dozen conservative and moderate Senators forced several changes to the initial draft of the BCRA (see Update for Weeks of June 12th and 19th), which amended the American Health Care Act (AHCA) passed last month by the House (see Update for Week of May 8th). The defections resulted from an initial CBO cost estimate that concluded the BCRA would not only strip coverage from 22 million consumers (including four million covered by employer plans) but also increase average silver plan premiums for Marketplace enrollees by 74 percent (from \$1,700 to \$6,500 for a 64 year old earning \$26,500 per year). Combined with dramatic increases in deductibles and other cost sharing, CBO predicted that “few low-income people would purchase any plan at all”. In particular, those losing Medicaid coverage under the BCRA (roughly 16 percent of those currently on Medicaid) could face deductibles that are nearly half their annual income.

Such staggering increases in consumer costs caused moderates like Susan Collins (R-ME), Dean Heller (R-NV), Lisa Murkowski (R-AK), and Shelley Moore Capito (R-WV) to come out strongly against the BCRA. They also cited additional concerns that the per capita spending cap would impose on nearly all Medicaid enrollees—a cap that was made even tighter under the Senate version, causing CBO to predict it would cut Medicaid funding to states by 35 percent over two decades.

However, the revised bill did not seek to mitigate those costs but instead tried to secure support from conservatives, who remained adamant that the bill does not go far enough in fulfilling their campaign promises to repeal the entire Affordable Care Act (ACA). As a result, the BCRA now includes an amendment from Senator Ted Cruz (R-TX) that would allow insurers to offer plans to do not comply with ACA consumer protections (including those barring discrimination based on pre-existing conditions and lifetime caps) so long as they offered at least one ACA-complaint plan at the silver and gold tier.

Both America's Health Insurance Plans (AHIP) and the Blue Cross and Blue Shield Association strongly opposed the amendment, warning it would lead to separate risk pools that would fracture and destabilize the Marketplaces. Kaiser Family Foundation (KFF) also claimed it would increase premiums for roughly 1.5 million of those with costly pre-existing conditions.

Despite additional opposition from nearly every other consumer and provider group (including AARP, the American Medical Association, and the American Hospital Association) and more than 61 percent of Americans surveyed by KFF, the amendment appears to have garnered support from some conservatives, including Senator Ron Johnson (R-WI), who now appears likely to vote in favor of a motion to proceed despite initial opposition.

The revised BCRA attempts to sway moderates by retaining three of the ACA taxes on wealthy Americans and using \$70 billion of that revenue to boost the stability fund for states to accommodate costlier patients. An amendment that would earmark a certain percentage of reinsurance payments (for insurers with exceptional claims) to the state with the highest health care costs (Alaska) appeared designed specifically to bring Senator Murkowski on board.



The Majority Leader has submitted two revised bills to CBO, one with the Cruz amendment and the other with limited changes that include a six-month waiting period for individual market consumers who do not maintain continuous coverage (i.e. no lapse of more than 62 days) and the higher funding. However, he also indicated that the Senate may move ahead a vote on the legislation without the score.

Neither bill modifies the planned phase-out of the Medicaid expansion in 2024 or the new per capita Medicaid spending caps, the major sticking point for moderates. However, only Collins announced she was still a “no” vote following the release of the revised BCRA.

Conservative Rand Paul (R-KY) has also remained opposed despite the changes. Republican leaders will be unable to move it through budget reconciliation (requiring only a bare majority) with three defections and are pressuring other reluctant Senators not to be the deciding vote against the measure.

Should the BCRA fail, an increasing number of conservatives are demanding a vote on repealing key ACA provisions and delaying decisions on any replacement. That strategy had been considered but rejected by Congressional leaders last winter due to concerns it would cause a mass exodus of insurers and send the Marketplaces into a “death spiral” (see Update for Week of January 30th).

House Democrats propose package of ACA fixes

A group of ten House Democrats led by Reps. Kurt Schrader (D-OR) and Peter Welch (D-VT) offered several proposals this week on ways that Congress could stabilize Affordable Care Act (ACA) Marketplaces with bipartisan support.

The package was released subsequent to the acknowledgement by Senate Majority Leader Mitch McConnell and moderates such as Bill Cassidy (R-LA) and Susan Collins (R-ME) that Republicans may need to pursue such a bipartisan plan if they are unable to pass current legislation to repeal and replace key provisions of the ACA through budget reconciliation (see above). However, it was not specifically backed by House Minority Leader Nancy Pelosi (D-CA), although her office did state that it “supported” the discussion.

The proposal focuses on areas where there is already some bipartisan agreement, namely the need for a permanent reinsurance program to compensate insurers with exceptional claims and assurances that cost-sharing reductions under the ACA will at least be available to insurers for the next two years. Other proposals would expand the ACA’s premium tax credits so that—similar to the Better Care Reconciliation Act (see above)—they are based on age (in addition to income and geography).

In addition, the proposal would broaden the availability of limited benefit catastrophic health plans for young adults under age 30 (which cannot be purchased with ACA tax credits), as well as restore resources for Marketplace advertising and outreach that were cut by the Trump Administration (see Update for Week of January 30th). It would also align the ACA’s annual open enrollment period with tax season in order to encourage sign-ups. Starting this fall, open enrollment will take place only from November 1st – December 15th (see Updated for Week of May 8th), a period when the Democratic group argues that consumers are most likely to be cash-strapped and forgo health insurance coverage.

The package includes other proposals that would be more contentious. This includes two Democratic favorites. The first would be to let consumers buy-in to Medicare prior to age 65, a move that could greatly mitigate the higher out-of-pocket costs that the current ACA repeal and replace bill would impose on those age 55-64. Democrats would also like to expand the greatly under-utilized Basic Health Plan (BHP) option under the ACA, which allows states to receive enhanced federal funding for covering those earning 138-200 percent of poverty in a lower-cost plan that provides coverage with no deductibles, limited copayments, and premiums of no more than \$20 per month.



To date, only New York and Minnesota have elected the BHP option (Oregon is considering it). This is largely because it dramatically cuts into Marketplace enrollment. For example, in New York, 40 percent of would-be Marketplace consumers are enrolled instead in the BHP (see Update for Weeks of May 29th and June 5th).

The package tries to incorporate two Republican-favored proposals. The first would create “bidding areas” in underserved Marketplaces to include a balanced pool of enrollees and improve competition in rural areas. It also calls for long-awaited federal guidance on Section 1333 of the ACA that would allow states to enter into Health Care Choice Compacts, which would allow insurers to sell across state lines in participating states, though not to the extent sought by Republicans.

One proposal that was debated but omitted from the Democratic plan involves increasing the penalty for the ACA individual mandate to better ensure a diverse risk pool of younger and older consumers (see below). However, retaining the individual mandate in any form remains a non-starter with most Republican lawmakers, as it remains the most unpopular ACA provision in public polling.

Two Senate Republicans offer “back-up” to ACA repeal and replace bill

Senators Bill Cassidy (R-LA) and Lindsey Graham (R-SC) released a “back-up” plan this week that could be voted upon should the Senate not have the votes to pass the Better Care Reconciliation Act (BCRA) in its current form (see above).

The proposal, which could also become an amendment to the BCRA, would retain the Affordable Care Act (ACA) taxes on wealthy Americans (as with the BCRA). However, states would receive block-grants from the \$110 billion raised by the taxes to use at their discretion for premium tax credits, cost sharing reductions, premiums for health savings accounts, or other healthcare spending.

The Cassidy-Graham plan would retain the ACA ban on discrimination based on pre-existing conditions. However, the individual and employer mandates would be repealed as with the BCRA.

The plan also retains the severe Medicaid cuts in the BCRA, which have been the major sticking point in negotiations between moderate and conservative Senators. As a result, Senator Susan Collins (R-ME) said she would not support it, even though she sponsored an earlier bill with Senator Cassidy that would have let states choose whether to opt-out of the ACA (see Update for Week of January 30th).

House spending bill blocks enforcement of ACA individual mandate

The Financial Services subcommittee for the Appropriations Committee has approved language in spending legislation that would deprive the Internal Revenue Service (IRS) of any funding to “implement or enforce” the individual mandate under the Affordable Care Act (ACA).

The IRS previously indicated that it would no longer reject federal tax returns that failed to disclose whether a filer was insured during the prior year, as required by the Obama Administration (see Update for Week of January 30th). That move created uncertainty among insurers as to whether the Trump Administration intended to fully enforce the mandate, which insurers insist is necessary to ensure sufficient numbers of younger and presumably less costly consumers enroll in coverage. As a result, insurers have increasingly sought dramatic rate hikes for 2018 to compensate for an expected skew of risk pools towards more costly consumers (see Update for Weeks of June 15th and 22nd).

If enacted by Congress, the ban on IRS funding for the individual mandate would further exacerbate rate hikes if not offset by other legislation. It would also prohibit the IRS from requiring that insurers and employers disclose the name and Social Security number of anyone to whom they provide health insurance coverage.



The Better Care Reconciliation Act (BCRA) currently being considered by the Senate (see above) would repeal the tax penalty for the individual mandate, though the mandate itself would remain law.

According to the most recent IRS figures, roughly 6.5 million taxpayers paid \$3 billion for not having minimum essential coverage in 2015. The average tax penalty (which is capped at \$2,000) was about \$470. The insurance industry (including the American Academy of Actuaries) has insisted that the penalty is “too weak” to compel adequate numbers of healthier consumers to enroll in coverage, citing far stiffer penalties under comparable universal coverage models in Massachusetts and countries like Germany, the Netherlands, and Switzerland.

House spending bill would bar funding for ACA Marketplaces and navigators

The House Appropriations Committee released its draft fiscal year 2018 funding bill this week for the department of Health and Human Services (HHS), which not only reduces funding for the Centers for Medicare and Medicaid Services (CMS) but specifically prohibits the agency from generating revenue that would fund the Affordable Care Act (ACA) Marketplaces.

CMS had expected to collect more than \$1.2 billion from the 3.5 percent user fee assessed on participating insurers in federally-facilitated Marketplaces (FFMs). Not only would the legislation prohibit these fees, it would also bar funding from being used for navigators or other assisters that help facilitate Marketplace enrollment.

The measure would similarly gut the Prevention and Public Health Fund created by the ACA to cover cost-sharing obligations for certain preventive services (like contraceptives and cancer screenings). Roughly \$840 million from that fund would instead go to fund the Centers for Disease Control and Prevention (CDC).

Consumer groups such as Families USA and the Center on Budget and Policy Priorities criticized the “destructive and gratuitous” cuts, insisting that they were yet another effort by Republican lawmakers to “sabotage the Affordable Care Act.”

The funding bill does ignore the President’s request to slash funding for the National Institutes of Health by \$7.5 billion. Instead, it provides a \$1.1 billion increase, largely at the urging of health subcommittee chair Tom Cole (R-OK), an advocate for biomedical research.

FEDERAL AGENCIES

Draft executive order would relax high-deductible health plan rules for chronic disease care

The White House released a draft version of an executive order last week that would allow patients enrolled in high-deductible health plans (HDHPs) to access care for chronic conditions before they meet their deductible.

Under existing Internal Revenue Service (IRS) rules, only preventive services, like mammograms and blood pressure screenings, are covered pre-deductible for those enrolled in HDHPs, in which the deductible is typically the maximum annual out-of-pocket limit under the Affordable Care Act (currently \$7,150 for individuals and \$14,300 for families). The IRS bars HDHPs from covering clinically-recommended services for people already diagnosed with a chronic illness until the deductible is met.

The draft executive order would instruct IRS to amend these rules so that healthcare services (including prescription drugs) that are used to manage chronic diseases would also be covered pre-deductible (the definition of which services relate to chronic diseases would be left up to the IRS).



According to industry/employer groups like the Smarter Health Care Coalition, this would remove cost barriers that cause consumers to delay care.

If enacted, the rule change would likely further boost the use of HDHPs, which have dramatically risen in recent years to roughly 29 percent of all workers in employer-sponsored coverage as employers increasingly view them as an effective means of shifting costs. (A 2016 survey by Mercer consulting found that HDHPs combined with a health-savings account cost employers an average of 22 percent less than a traditional preferred provider organization plan.)

Critics of the executive order warn that studies from RAND Corporation and other organizations have shown that HDHPs exacerbate the trend of consumers foregoing needed care due to high out-of-pocket costs. However, the change has bipartisan support in Congress as a bill introduced last year by Reps. Diane Black (R-TN) and Earl Blumenauer (D-OR) proposed a similar change and is expected to be reintroduced this year.

The Better Care Reconciliation Act (BCRA) currently being debated in the Senate (see above) would nearly double the amount that consumers can contribute tax-free to HSAs tied to HDHPs (from \$3,400 individuals to \$6,650).

CMS proposes cuts to Section 340B drug payments

The Centers for Medicare and Medicaid Services (CMS) is considering applying a 22.5 percent discount to the average sales price (ASP) for many drugs purchased through the federal Section 340B drug discount program, according to a proposed rule published this week for Medicare outpatient hospital payments.

Medicare had previously added a six percent premium to the ASP. According to the Secretary of Health and Human Services (HHS), the change would be intended to ensure that Medicare pays hospitals for 340B drugs "at a price more consistent with the actual cost hospitals and other providers pay to acquire those drugs." He insisted that it would reduce Medicare spending by roughly \$180 million per year, with "those savings passed on to [Medicare enrollees] in the form of lower copays."

The influential Medicare Payment Advisory Commission (MedPAC) has recommended last year that Medicare payments for Part B drugs purchased by 340B providers be cut by ten percent of ASP (see Update for Week of March 7, 2016)..

An upcoming executive order on drug pricing from President Trump was rumored to include directives that the HHS Secretary reduce the size of the 340B program, which the pharmaceutical industry contends has far exceeded its initial intent (see Update for Weeks of July 1 and 8, 2013). Drug sales under 340B reached \$16.2 billion in 2016, a 34 percent spike from the year before. It now accounts for five percent of all prescription drug sales.

However, the American Hospital Association and America's Essential Hospitals both stated this week that the White House is leaning against including 340B directives in the executive order and instead leaving decisions on the direction of the program largely up to Congress. The President's proposed budget for fiscal year 2018 did call for Congress to limit the program only to patient most in need.

New FDA plan would expedite the approval of orphan drugs

The Food and Drug Administration unveiled a new plan last week to more quickly approve orphan drug applications that have doubled from 2012-2016.



New FDA Commissioner Scott Gottlieb pledged to reduce to the current backlog of orphan drug designation requests, more than 200 of which have gone without an agency response for at least four months. The Office of Orphan Products Development received 568 new requests just in 2016.

Under the new plan, a “SWAT team” of experienced agency officials would be created to respond within 90 days to any request that has waited at least 120 days. In addition, the agency will develop an expedited review process that sets a “goal” of responding to all orphan drug designation requests within 90 days.

Sponsors of treatments that receive orphan drug designations are granted special benefits including tax credits and seven years of market exclusivity.

STATES

Insurer participation down 38 percent among federally-facilitated Marketplaces

Data released this week by the Centers for Medicare and Medicaid Service (CMS) revealed that 38 percent fewer health plans have applied to participate in the 39 Marketplaces that CMS operates pursuant to the Affordable Care Act (ACA).

The Secretary for the Department of Health and Human Services (HHS) used the decline from 227 insurers in 2017 to only 141 for next year as evidence that the Marketplaces were “failing”. However, a report concurrently released by the Kaiser Family Foundation concluded that insurer performance in the Marketplaces are actually improving, with “insurers on track to have the best year since the ACA began.”

The study found that average gross profit margins for Marketplace insurers were \$99 per enrollee in the first quarter of 2017 compared to only \$36 per enrollee at the same time in 2015. Average medical loss ratios (the percentage of premium revenues dedicated to medical care versus profits and overhead) also fell dramatically from 88 to 75 percent during the same period.

Kaiser’s findings largely follow those reached by Standard and Poors last spring, which found no evidence of any “death spiral” in the Marketplaces (see Update for Week of May 8th). Researchers instead pointed to the uncertainty over if and how Congress would repeal the ACA as the primary cause of insurer defections in 2018 (see Update for Weeks of June 15th and 22nd).

Alaska

Federal government approves first waiver request for state reinsurance program

The Centers for Medicare and Medicaid Services (CMS) announced this week that it has approved the federal reinsurance waiver that Alaska sought pursuant to Section 1332 of the Affordable Care Act (ACA).

Alaska became the first state last year to create a state-funded reinsurance program in order to mitigate premium increases in their ACA Marketplace that resulted from the expiration of the ACA reinsurance program at the end of 2016 (see Update for Week of July 18, 2016). The Alaska Reinsurance Program (ARP) used \$55 million in state funds to provide extra compensation to insurers for the entire plan year if subscribers are diagnosed with one of 33 medical conditions designated by the state as “high-cost”. It has been credited with keeping the lone Marketplace insurer (Premera Blue Cross and Blue Shield) in the Marketplace and reducing their average premium increase for 2017 from 42 percent to 7.3 percent (see Update for Week of December 5, 2016).

The legislation creating the ARP (H.B. 374) also authorized Alaska to seek a federal waiver seeking federal support for the program. Under the terms of the waiver, CMS will commit \$48 million to



the ARP for 2018 and up to \$323 million overall through 2022 (the waiver must be renewed thereafter). Alaska's share of the funding will fall from \$55 million to \$11 million.

Because lower premiums reduce the amount of ACA tax credits received by Marketplace enrollees, state officials predict that the ARP will save the federal government at least \$51 million.

Citing Alaska's success, CMS has encouraged other states to create similar ARPs, as did Minnesota earlier this year (see Update for Week of May 8th). Minnesota is the only other state to submit a federal waiver request for an ARP. However, legislatures in several states have authorized such a submission (see Update for Weeks of May 29th and June 4th).

California

Speaker nixes Senate-passed single-payer bill due to threat of ACA repeal

Assembly Speaker Anthony Rendon (D) scuttled The Healthy California Act (S.B. 562), this week, refusing to allow the single-payer health bill to move forward for 2017.

Despite being a single-payer advocate, Speaker Rendon insisted that the Assembly needed to focus on the "threat" from Congress' "cynical plan to repeal the Affordable Care Act" and leave millions of Californians without coverage. As a result, S.B. 562 will not get a hearing in the Rules Committee by the July 14th deadline, even though the Senate passed it earlier this month.

Senate sponsors pledged to resurrect the bill in 2018 and Speaker Rendon himself encouraged them to do so by provide more specifics about financing and cost controls. Two studies have recently estimated the costs of the single-payer model to be roughly \$367-400 billion (see Update for Weeks of May 15th and 22nd).

Law protecting consumers from surprise medical bills goes into effect

California became one of six states last week with a comprehensive law to protect consumers from "surprise" bills from ancillary out-of-network providers (such as pathologists, radiologists, or assistant surgeons) when they receive treatment at an in-network facility.

Governor Jerry Brown (D) signed A.B. 72 into law last fall, which went into effect on July 1st. It limits patient obligations only to in-network costs in such situations. According to Consumers Union surveys, at least one of every four Californians had been charged out-of-network rates at in-patient facilities from 2013-2015.

The new law applies to Californians with private plans regulated by the Department of Managed Health Care (DMHC) and the Department of Insurance. However, 5.7 million Californians covered by employer-sponsored insurance will not be protected.

Despite the loophole, Consumers Union and Families USA include California as one of six states that have now enacted a comprehensive approach to protecting consumers from "surprise" bills (including Connecticut, Florida, Illinois, Maryland, and New York). There are 15 other states that provide more limited protection for consumers under certain types of coverage or in specific settings.

Kentucky

Governor seeks stricter work requirements for Medicaid enrollees

Governor Matt Bevin (R) announced last week that his Administration has submitted an amended Medicaid waiver request to the Trump Administration that seeks a stricter work requirement than his Administration had originally requested and will accept public comments through August 2nd.



The initial Section 1115 waiver last August would have required that “able-bodied” adults without dependents work or participate in job training or community engagement programs for at least five hours per week, with a gradual increase to 20 hours per week after one year (see Update for Week of December 5th). Despite strong protests from consumer groups, the revised waiver would eliminate the phase-in period and immediately require 20 hours per week. In addition, it would lock-out enrollees for six months if they obtain a new job or higher salary and fail to promptly notify Medicaid.

The vast majority of 1,800 public comments received in response to the initial request were critical of the work requirement, pointing to analyses from groups like The Commonwealth Fund showing that such requirements directly result in mass coverage losses or treatment disruptions, which ultimately increase state costs. The Kentucky Center for Economic Policy warned last week that the lock-out period would be particularly harmful to low-income enrollees who frequently work in retail, restaurant, or construction jobs where hours and income frequently and greatly fluctuate depending on the time of year.

At least nine other states including Arizona, Arkansas, Indiana, Maine and Ohio are proposing similar work requirements, which had consistently been rejected by the Obama Administration but are now being encouraged by CMS (see Update for Week of January 30th). If implemented nationwide as Congress would do in the current legislation to repeal and replace the Affordable Care Act (see above), work requirements could ultimately be applied to 30 percent of all Medicaid enrollees.

Missouri

Centene will cover nearly all counties left without Marketplace insurers for 2018

Centene confirmed last week that it will start offering Affordable Care Act (ACA) Marketplace coverage in 39 Missouri counties for 2018, including 24 of the 25 counties that were left without any participating insurers after Blue Cross and Blue Shield of Kansas City elected in May to withdraw (see Update for Weeks of May 15th and 22nd).

The insurer previously announced its intent to fill the gaps in underserved areas, insisting that Marketplace defections are creating “lucrative” business opportunities for insurers that design and price their products appropriately. It nearly doubled its Marketplace enrollment last year, climbing to more than 1.2 million members by the end of the 2017 enrollment period, resulting in a 69 percent jump in revenue (see Update for Weeks of May 29th and June 5th). It already operates in eight Marketplaces and with its projected expansion into Missouri, Ohio, and Washington, Centene will become one the largest Marketplace insurers in the country.

Analysts credit Centene’s Marketplace success to its decision to focus on regions where it has already formed provider networks for its Medicaid managed care business and can better predict the annual costs for consumers.

Montana

Montana Health CO-OP lifts enrollment freeze

One of the five remaining Consumer Operated and Oriented Plans (CO-OPs) created with Affordable Care Act (ACA) loans announced late last month that it was lifting its 2017 enrollment freeze ahead of schedule and would begin accepting Marketplace enrollments in late July.

Montana Health CO-OP was forced to freeze enrollment last December in order to ensure it was able to pay its claims obligations. Low premiums offered by most of the 23 CO-OPs enabled them to become strong competitors to much larger Marketplace insurers. However, the unexpected shortfall in ACA reinsurance and risk corridor payments (for exceptional claims) forced all but a handful into liquidation as their claims obligations far outweighed premium revenue (see Update for Week of November 30, 2015).



Montana Health planned on resuming enrollment for the 2018 open enrollment period that starts November 1st. However, its improved fiscal condition has enabled it not only to resume enrollment ahead of schedule but seek only a four percent average premium increase for next year, by far the lowest of the three Marketplace carriers. (Dominant carrier Blue Cross and Blue Shield proposed a weighted average increase of 14.4 percent while PacifiSource sought a 7.4 percent average hike.) Final rates will be announced following public hearings in late July.

Montana elected a new insurance commissioner last fall to replace the term-limited Monica Lindeen (D). Unlike Lindeen, Commissioner Matt Rosendale (R) is a staunch opponent of the ACA and immediately sought federal approval to allow plans not compliant with the ACA to be sold within the Marketplace—similar to a Congressional proposal sought by Senator Ted Cruz (R-TX)(see above). He insists that the Montana Marketplace is in a “death spiral” even though it has the same three insurers since 2016 (serving more than 52,000 consumers) and rate hikes are well below national averages.

Ohio

Governor vetoes proposed freeze on Medicaid expansion

The Republican-controlled legislature failed last week to override the veto by Governor John Kasich (R) of their plan to freeze enrollment in the state’s Medicaid expansion under the Affordable Care Act (ACA).

After resisting initial calls from conservatives (see Update for Week of May 8th), Republican leaders inserted a late provision in the two-year budget bill that would have frozen enrollment starting in July 2018 and not allow those who drop out of the expansion program from re-enrolling. Governor Kasich insisted that it could result in more than 500,000 Medicaid enrollees in losing coverage and promptly used his line-item veto authority to remove the provision.

House Speaker Cliff Rosenberger (R) elected not to bring the override measure to a vote after signaling that the House remained one vote shy of the 60 needed to prevail. However, he did not rule out resurrecting the effort if a phase-out of the Medicaid expansion was enacted by Congress (see above).

More than 715,000 Ohioans enrolled in the Medicaid expansion after Governor Kasich circumvented the legislature to create the program with the approval of a state control board (see Update for Week of October 21, 2013). The move made him the first of 11 Republican governors to agree to participate in the expansion and has resulted in nearly annual showdowns with conservative lawmakers over its continuation.

The expansion population has far exceeded estimates, resulting in an aggregate cost of more than \$5 billion. The vast majority of the cost has thus far been borne by the federal government. However, the state share of that cost will increase to ten percent starting in 2020 and subsequent years if the ACA expansion remains in place.

Governor Kasich has been a staunch defender of the expansion and pointed out this week that it has brought Ohio more than \$300 million in new tax revenues.

Oregon

New reinsurance program limits 2018 premium increases

The Department of Commerce released preliminary approved premiums late last month for individual market insurers in and out of the Cover Oregon Marketplace created pursuant to the Affordable Care Act (ACA).

Final approved rates for 2018 are due to be released on July 20th but are expected to track closely to preliminary approvals, which will increase by a weighted average of 8.5 percent. Commerce



officials credited the reinsurance program enacted last month by the legislature (through the H.B. 2391 bill that became part of the budget package) with reducing average premiums in the individual market by an average of six percent.

Oregon is the third state (following Alaska and Minnesota) to use state funds to replace the reinsurance payments under the ACA that expired at the end of 2016 (see above). Alaska's reinsurance program (which compensates insurers for exceptional claims) reduced average premiums from 42 to 7.3 percent (see Update for Week of December 5th), and has been cited by the Trump Administration as an example that other states can follow (see Update for Week of May 8th).

The ACA repeal and replace legislation currently being debated in Congress would provide states with federal funding and increased flexibility (through federal waivers) to create similar reinsurance programs (see above). At least nine other states are considering legislation that would authorize a reinsurance program (see Update for Weeks of May 29th and June 5th).

Washington

Commissioner successfully pulls Marketplace insurers into unserved counties

Insurance Commissioner Mike Kreidler (D) announced this week that two insurers will offer Marketplace plans for consumers in Klickitat County in 2018.

The decision by Molina and BridgeSpan ensures that Marketplace plans will be available statewide, following last week's agreement by Premera Blue Cross to remain in Grays Harbor County (see Update for Weeks of June 12th and 19th). Consumers in both Grays Harbor and Klickitat were at risk of having no coverage options apart from the state's ongoing high-risk pool, after no insurers included them in their coverage areas following initial rate filings (see Update for Weeks of May 29th and June 5th). However, the Commissioner urged them to "re-evaluate their coverage areas and [think] seriously about the impact these decisions would have on consumers."

The Commissioner noted that more than 80 percent of Marketplace consumers in Klickitat County currently receive an average Affordable Care Act (ACA) premium tax credit of \$369.

Final rate decisions will be announced by the Commissioner in early fall.