

Health Reform Update – Week of February 12, 2018

CONGRESS

Breakthrough on two-year budget deal satisfies health priorities for both parties

President Trump signed a temporary budget resolution last week that not only keeps the federal government operating through March 23rd but creates the framework for appropriators to fund a new two-year budget deal.

Republicans and Democrats had been unable to agree on any long-term spending bill following the September 30th end of the last fiscal year and relied on three short-term resolutions to provide emergency funding and prevent an extended government shutdown (see Update for Week of January 22nd). The Senate finally reached a compromise last week that was able to overcome opposition from House and Senate conservatives concerned about further spikes in the budget deficit, as well as House and Senate Democrats who unsuccessfully insisted on extended protections for children of undocumented immigrants.

The budget compromise satisfied priorities for Democrats, as it reauthorized the Children's Health Insurance Program (CHIP) for a full ten years (through 2028), instead of the six-year extension in the temporary spending bill signed last month by the President (see Update for Week of January 22nd). In addition to increased spending for the National Institutes of Health (NIH) and community health centers, the bill also closes the Medicare Part D coverage gap by 2019, one year earlier than scheduled under the ACA. This would increase the manufacturer discount for brand-name drugs in the so-called "doughnut hole" from 50 to 75 percent, meaning Part D enrollees would be responsible for the same 25 percent coinsurance in or outside of the gap.

However, the move also means Part D insurers would have their liability within the coverage gap limited to only five percent of spending in the coverage gap, down from 20 percent starting in 2020. This upset the Pharmaceutical Research and Manufacturers of America (PhRMA), who called it a "massive bailout for insurance companies."

The budget deal also increases income-related premiums for Part B and D enrollees who earn \$500,000 or more. Starting in 2019, they would pay 85 percent of costs (instead of 80 percent). It will also cover 100 percent of Medicaid costs for hurricane-devastated Puerto Rico over the next two years (at a cost of nearly \$5 billion).

Despite the concessions to Democrats, the compromise allowed Republican leaders to not only secure increases in defense spending and other party priorities, but make further inroads in their efforts to dismantle the ACA.

Most notably, the bill repeals the Independent Payment Advisory Board (IPAB), which was required to make automatic cuts in Medicare payments if spending exceeds pre-set targets. The panel has been controversial from the start and never assembled, with up to 76 Democrats agreeing with Republicans that it cedes too much authority away from Congress (see Update for Week of November 6th).

The budget deal also furthered delayed cuts in disproportionate share (DSH) payments for hospitals serving large numbers of indigent patients. Congress intended DSH payments to start phasing-down in 2014 once all states expanded Medicaid under the ACA. However, these cuts have been delayed several times after the U.S. Supreme Court made the Medicaid expansion optional (see Update for Week of June 25, 2012).

A provision of the budget deal that received far less attention requires makers of biosimilar drugs to offer the same discounts provided by brand-name biologics. Because such discounts do not count towards a Medicare enrollee's out-of-pocket costs under Part D, they actually are forced to remain in the coverage gap longer if they choose a biosimilar over the higher-cost reference product.

Republican leaders weigh including high-risk pools as part of market stabilization package

Senate leaders from both parties met again this week to negotiate a package of bills that would mitigate further premium spikes and insurer departures in the individual health insurance market.

In order to secure their support for the new tax reform law, several moderate Senators led by Senator Susan Collins (R-ME) had been promised a vote on bipartisan bills that would not only restore the Affordable Care Act (ACA) cost-sharing reductions (CSRs) terminated by President Trump but also provide funds for states to create their own reinsurance programs to compensate insurers for exceptional claims (see Update for Week of December 18th). However, the bills that were under consideration at that time have been stalled by opposition from the most conservative lawmakers, forcing negotiators to rework the proposals.

The latest iteration would still restore the CSR funding for two years, as under the bill introduced by Senators Lamar Alexander (R-TN) and Patty Murray (D-WA). However, instead of providing states with \$10.5 billion over two years to create reinsurance programs as proposed by Senators Collins and Bill Nelson (D-FL), Republican leaders are leaning towards the House conservative plan that would let states instead use the funds to resurrect high-risk pools, the severely underfunded pre-ACA model in which persons with costly pre-existing conditions were segregated into their own market.

It remains very unclear whether any approach that includes high-risk pools could secure the needed support from at least nine Senate Democrats, who staunchly oppose the approach. Insurance groups like the Blue Cross and Blue Shield Association also strongly favor the reinsurance model, which it predicts would lower silver-plan premiums by an average of 17 percent for 2019.

Senators Collins and Nelson are actively pushing Republican leaders to vote on the measure before insurers have to start setting 2019 rates this March, either as part of the two-year budget deal agreed to last week (see above) or as a separate package.

FEDERAL AGENCIES

Total Marketplace enrollment approaches 2017 total despite Affordable Care Act attacks

The Kaiser Family Foundation released a new analysis last week showing that total enrollment in Affordable Care Act (ACA) Marketplaces during the 2018 open enrollment period was 3.7 percent lower than the year before.

More than 11.7 million Americans signed-up for coverage, which far exceeded expectations following the Trump Administration's decision to cut the open enrollment period by half, slash the marketing and outreach budget by 90 percent, and eliminate cost-sharing reductions for insurers (which led to dramatic spikes in premiums) (see Update for Week of November 13th). According to Kaiser, these actions did have an adverse impact on federally-facilitated Marketplaces, where enrollment fell by 5.3 percent.

However, the 15 states (and the District of Columbia) that created their own Marketplaces (including those using the FFM web portal) were able to extend open enrollment beyond six weeks and fund their own marketing and outreach. As a result, total enrollment in those states actually increased slightly (by 0.2 percent).

The states with the highest increases from 2017 were Rhode Island (12.1 percent), Kentucky (10.4 percent), Washington (7.6 percent), and Minnesota (5.8 percent). All of these states created their own state-based Marketplaces (SBMs), although Kentucky decided last year to revert to the federal web portal. Furthermore, Rhode Island and Washington extended open enrollment beyond the December 15th deadline for FFMs.



The states with the largest decreases from 2017 were Louisiana (23.5 percent), West Virginia (19.5 percent), and Arizona (15.6 percent). All three are FFM states that suffered the full 90 percent cut in their marketing and outreach budget, as well as having the open enrollment period cut in half.

However, eight FFM states did exceed their 2017 enrollment total, led by Nebraska and Hawaii (at just over 4.5 percent).

The largest state-based Marketplace in California saw a slight decline of 2.3 percent from last year (or 35,000 enrollees) despite a three percent jump in first-time customers (see below). However, New York's enrollment increased by 4.2 percent. Both states extended open enrollment through the same January 31st deadline as 2017.

Florida's FFM continued to lead all Marketplaces with more than 1.7 million enrollees. However, that was a 2.5 percent decrease from 2017. The next largest FFM in Texas signed-up more than 1.1 million consumers, but that was a steep drop from last year of more than eight percent.

President's budget would repeal ACA, block-grant Medicaid, and make changes to 340B drug payments

President Trump submitted his budget request this week that laid out the Administration's legislative and regulatory priorities for fiscal year 2019.

Presidential budgets are always considered "wish lists" as they rarely are followed by Congress. That is likely to be even truer this year given the two-year budget compromise reached last week by the Senate (see above). However, the President's budget signaled his clear intent to continue pursuing a broad repeal of the Affordable Care Act (ACA) through the failed bill from Senators Lindsey Graham (R-SC) and Bill Cassidy (R-LA) that would have also converted Medicaid into a federal block grant program (see Update for Week of October 2nd).

However, the President's budget caught conservative lawmakers off-guard as it also called for stabilizing the ACA Marketplaces in the short-term by restoring the cost-sharing reductions for insurers that he terminated last fall (see Update for Week of November 6th), as well as "fully fund" the ACA's risk corridor funding that expired after 2016. The proposal as quickly shot down by Senator Marco Rubio (R-FL) and other conservatives who have insisted that the risk corridor payments (which redistributed funds from better-performing insurers to those losing more than three percent of premium revenue) amounted to an "insurer bailout" and barred the Centers for Medicare and Medicaid Services (CMS) from transferring funds to cover \$12.3 billion in outstanding obligations under the program (see Update for Week of December 15, 2014).

At least a dozen Marketplace insurers have filed a federal lawsuit seeking to force CMS to pay the outstanding risk corridor claims and attempts under the Obama Administration to settle the suit with an internal "judgment" fund were blocked by Senate Republicans (see Update for Week of October 24, 2016). President Trump did not clarify whether the nearly \$11.5 billion in risk corridor funding sought under his budget was intended to settle those lawsuits.

The remainder of the budget was largely the same as the President's fiscal year 2018 proposal as it would slash all non-defense discretionary spending by 42 percent. If the ACA were largely repealed as proposed, the net effect would be to cut Medicaid spending by more than 22 percent and Medicare spending by just over seven percent.

The President's proposal did specifically propose \$16 million in new user fees to help the Health Resources and Services Administration (HRSA) administer Section 340B drug discounts for safety net providers, which would more than double the agency's 340B budget and may be intended to act as an offset for expected changes to the quickly expanding programs. Apart from the user fees, the President's proposed changes track closely with those recommended by Congress and include creating greater oversight to better account for how providers are using 340B discounts (see Update for Week of January 8th). In addition, the President seeks to require 340B providers to provide a minimum level of

charity care in order to receive 340B payment adjustments. However, the budget did not address Congressional recommendations to move 340B jurisdiction from HRSA to CMS.

President proposes reducing Medicare drug costs by sharing rebates, expanding catastrophic benefit

The fiscal year 2019 budget plan submitted this week by President Trump includes a handful of narrow proposals to reduce Medicare prescription drug costs.

The primary recommendation would ensure that Medicare beneficiaries receive the benefit of discounts and rebates negotiated by pharmacy benefit managers (the middlemen between insurers and drugmakers). However, analysts were quick to point out that potential out-of-pocket savings could actually result in higher premiums charged by insurers who would no longer receive the discounts.

The budget plan would also eliminate Part D coinsurance for beneficiaries once they leave the “coverage gap”, which ends after they incur \$5,000 in out-of-pocket costs during the year. Currently, Part D pays 95 percent of costs at this “catastrophic” stage, but that would be increased to 100 percent under this proposal.

In addition, the President’s budget would move infusion drugs covered under the Part B outpatient hospital benefit into the Part D program, theoretically giving insurers greater ability to negotiate drug formularies.

The President’s budget makes no mention of giving Medicare the authority to negotiate Part D drug prices, a move the President supported as a candidate.

CMS gives states more than \$8 million to alter essential health benefits, enforce discrimination

The Centers for Medicare and Medicaid Services (CMS) announced last week that it was providing \$8.1 million in grants to support states in planning and implementing changes to the essential health benefits (EHB) packages required by the Affordable Care Act (ACA).

The grant funding comes as the Office of Management and Budget (OMB) is reviewing CMS’ final Notice of Benefit and Payment Parameters rule for 2019, which seeks to give states additional options for selecting “benchmark” plans under which the EHB packages are based (see Update for Week of November 6th). Although EHBs are the primary focus of the funding, the announcement states that it may also be used to help ensure guaranteed availability of coverage and renewability, as well as ensure that insurers “do not include discriminatory benefit designs that discourage people with potentially high-cost medical conditions from enrolling in those plans.”

CMS had found in 2015 that Marketplace insurers were engaging in practices that were potentially discriminatory under the ACA (see Update for Week of February 23, 2015). This included moving all drugs for a specific high-cost condition (like HIV/AIDS and Hepatitis C) into their highest cost-sharing tier (see Update for Week of June 2, 2014). However, it has since delegated identification and enforcement against these practices to state officials (see Update for Weeks of May 15 and 22, 2017).

Consumer advocates, insurers, and other provider groups largely opposed the weakening of EHB packages. At a minimum they urged CMS through public comment to delay the provision until 2020.

Interested states must send a letter of intent by February 26th and an application by April 5th. Each state (and the District of Columbia) will be eligible for a \$156,000 based grant with additional “workload” funding to be determined based on an unspecified formula. Funding will be available to recipients through June 5, 2020.

STATES

At least five states seek federal approval to put lifetime caps on Medicaid benefits

New U.S. Department of Health and Human Services (HHS) Secretary Alex Azar told members of Congress this week that the agency has not yet made a decision on whether it will approve waivers sought by five states that would cap the number of years enrollees receive Medicaid benefits.

The unprecedented request comes on the heels of HHS' first-ever approval of Medicaid work requirements for Kentucky (see Update for Week of January 22nd) and Indiana (see above), which are being sought by at least nine other states. Five of those states (Arizona, Maine, Kansas, Utah, and Wisconsin) are seeking to limit Medicaid eligibility to no more than 3-5 years and largely would apply to the same "able-bodied" and working-age population subject to the work requirements.

A long list of consumer groups have already urged HHS to reject the lifetime limits, as the agency did under the Obama Administration, which concluded both work requirements and lifetime caps were not allowed under federal Medicaid law. Critics have charged that both initiatives are simply efforts to discourage Medicaid enrollment and cause treatment for persons with life-threatening or chronic conditions to be disrupted and received only in the most costly settings.

Idaho

Blue Cross to start offering non-complaint ACA plans that increase premiums based on health status

Blue Cross of Idaho became the first insurer this week to take advantage of new rules issued by the Department of Insurance (see Update for Week of January 22nd) and offer individual market health plans that do not comply with the consumer protections in the Affordable Care Act (ACA).

Blue Cross will offer five non-compliant Freedom Blues plans starting next month which will return to pre-ACA standards that increase premiums based on medical status, offer limited benefits, impose \$1 million annual caps, and require a 12-month waiting period for coverage of pre-existing conditions if the consumer had a lapse in coverage of least 63 days. Consumers deemed the "healthiest" will be charged premiums that are 50 percent below standard rates while those deemed the least healthy will be charged 50 percent above standard rates.

Officials for Blue Cross stressed that the plans were intended to "bring the middle class back into the market", particularly those earning above 400 percent of the federal poverty level who are ineligible for ACA premium tax credits in the Marketplace. They point out that premiums for a healthy 45-year old could now be as low as \$195 per month compared to a 45-year old with pre-existing conditions who would pay \$526 per month.

Annual deductibles under the non-compliant Freedom Blues plans can also be dramatically higher than ACA plans, since subscribers will face a \$4,000 deductible for prescription drugs that is separate from the deductible for medical care.

Consumer groups and legal analysts have blasted the non-compliant plans, with a former U.S. Attorney calling them "crazy pants illegal" so long as the ACA consumer protections remain federal law. The new Secretary of the U.S. Department of Health and Human Services (HHS) has refused to say whether the agency would fine Idaho insurers who offer the non-compliant plans, despite acknowledging that HHS has a duty to enforce the ACA. (He did promise members of Congress that he would make a decision within 30 days.)

Other Idaho insurers told the *Wall Street Journal* this week that they have adopted a "wait and see" approach, opting to first evaluate whether the non-complaint plans can withstand expected legal challenges before deciding whether to enter the market. They also expressed concerns that the cheaper non-compliant plans would siphon away many

healthy consumers from the ACA-compliant plans that Idaho requires they continue to offer, meaning the ACA-compliant plans would effectively become a high-risk pool for sicker and more costly consumers.

Indiana

Indiana becomes second state allowed to slice Medicaid enrollment through work requirements, lockouts

Indiana became the second state last week to receive federal approval to terminate Medicaid coverage for working age and “able-bodied” adult enrollees who fail to prove they are working, volunteering, or going to school at least 20 hours per week.

Indiana’s approval follows a similar waiver that the Trump Administration granted last month for Kentucky (see Update for Week of January 22nd). However, it is considered somewhat more “lenient” in that it phases in the work requirements over 18 months. Both waivers allow the state to “lock-out” enrollees for extended periods of time. However, Indiana received approval to do so for only up to three months, compared to six months for Kentucky. Indiana also exempts adults starting at age 60, while Kentucky goes up to age 65.

The approval extends Indiana’s current federal demonstration waiver that allowed it to create a private-sector alternative to the Affordable Care Act (ACA) expansion of Medicaid (see Update for Weeks of January 26 and February 2, 2015). Under this Healthy Indiana program, more than 91,000 expansion enrollees have been terminated for failing to submit required paperwork under a similar lock-out period, and 25,000 were dropped for failing to timely pay premiums.

The director for the Georgetown University Center for Children and Families called the use of lock-out periods is “one of the worst policies to hit Medicaid in a long time”, pointing out that abruptly terminating coverage only causes chronic or life-threatening health conditions to worsen and become more costly to treat. Indiana officials insist that their purpose is not to simply cut Medicaid rolls, but “encourage better compliance”. However, they acknowledge the lock-out periods and work requirements will likely drop enrollment by one percent and slash state Medicaid spending by \$32 million next year.

Kentucky already faces a class-action lawsuit from Medicaid enrollees and consumer advocacy groups seeking to block the work requirements (see Update for Week of January 22nd). Even though similar legal challenges are likely, at least nine conservative-leaning states are considering work requirements (with new legislation recently introduced in Idaho and Iowa) and five of those (Alabama, Louisiana, Ohio, South Carolina, and South Dakota) are already crafting federal waiver applications.

Iowa

Wellmark to return to ACA Marketplace, citing less uncertainty over Congressional repeal

Wellmark Blue Cross and Blue Shield officials announced this week that it will resume selling health plans that comply with the Affordable Care Act (ACA) in 2019.

The state’s largest insurer elected last year to stop offering ACA plans in and out of the Marketplace in the wake of Congressional efforts to dismantle the entire ACA. It pledged to again sell Marketplace plans in all of Iowa’s 99 counties so long as “there aren’t any significant changes” to the ACA and acknowledged that the unexpectedly strong Marketplace enrollment for 2018 (see above) played a large role in its decision.

Wellmark’s entry should automatically mitigate premium spikes in Iowa, which were the highest in the nation (88 percent) in 2018 for the “benchmark” silver plans to which the ACA premium and cost-sharing subsidies were tied (see Update for Week of November 6th). Medica is the only insurer offering statewide Marketplace coverage this year as its lone competitor, Gunderson Health Plan, operates in only five counties.

Wellmark had lost \$90 billion in the individual ACA market after the temporary risk corridors and reinsurance payments under the ACA expired in 2016. As a result, they initially had demanded that the Trump Administration approve Iowa's request for a federal waiver to create their own reinsurance program as a condition for returning (see Update for Week of August 14th). That waiver also would have extended premium tax credits to those earning above the maximum threshold under the ACA (of 400 percent of the federal poverty level).

Even though Iowa's waiver was beset by procedural flaws and ultimately withdrawn (see Update for Week of November 6th), Wellmark officials nevertheless concluded that "we need to be back in" the Marketplace despite its imperfections. They expressed confidence that either Congress or state officials would take the necessary steps to stabilize Marketplace risk pools.

For his part, Insurance Commissioner Doug Ommen (R) stated this week that he had no plans to renew the reinsurance waiver, insisting that any solutions need to come from the federal level.

Maryland

Marketplace enrollment dips slightly though share of gold-tier consumers quadruples

Maryland Health Connection officials announced this week that more than 153,000 consumers signed-up for coverage during the 2018 open enrollment period that ended December 22nd.

The figure is roughly 2.7 percent below the final tally for 2017, which MHC attributes to the shorter open enrollment period. Maryland is one of 12 states and the District of Columbia that operate state-based Marketplaces under the Affordable Care Act (ACA), which had the discretion to extend the enrollment period beyond the December 15th deadline set by the Trump Administration for federally-facilitated Marketplaces (see Update for Week of November 13th). However, Maryland elected to push the deadline only until December 22nd, providing consumers with only seven weeks to sign-up for coverage instead of the 12-week period they had last year.

MHC officials insist that Marketplace enrollment remained "robust" despite the shorter deadline and premium spikes for silver-tier plans caused by the last-minute termination of ACA cost-sharing reductions (see Update for Week of November 6th). They note that average daily enrollment was up by 69 percent compared to 2017, while sign-ups among African-American and Latino consumers increased by 12 and ten percent respectively. Most importantly, they stressed that the share of younger and typically less-costly consumers in the critical age 18-34 demographic held constant at 30 percent, allowing insurer risk pools to remain balanced.

MHC officials did point out that the silver-tier premium spikes had the surprising effect of making more generous gold-tier plans affordable. As a result, 20 percent of all enrollees chose gold coverage, compared to only around five percent in prior years.

Nevada

Marketplace reverts back to state web portal due to rising user fees for federal platform

The Legislative Interim Finance Committee granted the Silver State Health Insurance Exchange (SSHIX) \$1 million in reserve funding to create and operate its own web portal.

Nevada was one of 15 states (and the District of Columbia) that created their own Marketplace pursuant to the Affordable Care Act (ACA). However, its web portal operated by Xerox was so beset with software glitches during the inaugural open enrollment period that it subsequently elected to default to the federal web portal while retaining control over other Marketplace functions (see Update for Week of June 2, 2014). Four other states subsequently elected this option, although Idaho has since reverted back to its own web portal.

The federal government initially did not charge states a user fee for defaulting to www.healthcare.gov. However, it starting imposing a 1.5 percent user fee in 2017 that increased to two percent for 2018 and is scheduled to jump to three percent for 2019 and beyond.

Because the three percent user fee will eat up most of the 3.15 percent premium currently charged by SSHIX and cost Nevada about \$12 million in 2019, lawmakers and state officials decided that it would be more cost-effective for the state to make another attempt at creating its own web portal, which it believes it can do with only a 1.5 percent premium (even lower than the 2.2 percent premium imposed by Idaho's state model). In addition, a state web portal would give SSHIX enhanced consumer data so than can better focus marketing and outreach efforts. Officials note that by using the federal web portal, SSHIX has "no insight into our consumers, who we are enrolling and where."

The committee instructed SSHIX to issue a Request for Proposal by the first week in March and a contract by August. SSHIX officials insist that they will only contract with a private vendor that can provide an "off the shelf" system that has already been successfully running for at least a year in another state. The web portal would then be tested for at least a full year in Nevada before being launched for the 2020 open enrollment period, in order to avoid a repeat of the technological issues in year one.

Despite defaulting to the federal portal with a shorter open enrollment period, SSHIX increased its enrollment by more than two percent during the 2018 open enrollment period, making Nevada one of only 16 states who increased their Marketplace enrollment from 2017 (see above).

Oregon

House Democrats pass ballot referendum on universal health care

The House voted along party lines this week to let Oregon voters decide whether the state Constitution should be amended to ensure every resident has "access to effective, medically appropriate and affordable health care."

The initiative attempts to seize on the momentum from last month's successful ballot referendum which made Oregon the first state where voters approved a funding mechanism for the Medicaid expansion under the Affordable Care Act (see Update for Week of January 22nd). However, passage in the Senate remains very unclear as even some progressive advocacy groups expressed concerns about obligating the state to a level of funding that may not be available during every budget cycle.

Both the bill's sponsor Rep. Mitch Greenlick (D) and prominent opponent Rep. Julie Parrish (R) have asked legislative counsel to provide a legal opinion on whether the proposed constitutional amendment would create an automatic funding obligation.

Utah

Public opposition scuttles bill requiring five years of state residency for Medicaid and CHIP

Senator Allen Christensen (R) announced this week that he is withdrawing his legislation that would require legal immigrants to reside at least five years in the state before qualifying for either Medicaid or the Children's Health Insurance Program (CHIP).

Senator Christensen, who chairs the Social Services Appropriations Committee, acknowledging that he lacked the "political support I need" to pursue S.B. 48, after polling from the University of Utah showed voters opposed it by a 53-40 percent margin. Christensen had insisted was a matter of "fairness" to other state residents and would prevent "creeping socialism" but consumer groups argued that it was a "mean-spirited attack" that would have immediately stripped coverage from nearly 500 legal immigrant children under CHIP.

Virginia

House Republicans open door to Medicaid expansion if work requirements are added

House Republicans included Medicaid expansion as part of their two-year budget plan this week (H.B. 30) but made it conditional upon Democrats accepting work requirements for “able-bodied” and working-age enrollees.

Rep. Terry Kilgore (R), chairman of the powerful Commerce and Labor Committee, had become the first House Republican earlier in the week to openly support expanding Medicaid under the Affordable Care Act (ACA), saying it was the “right thing to do” for the many uninsured constituents in his rural southwestern district. His announcement relaxed the staunch opposition to Medicaid expansion in the House, which had repeatedly blocked several efforts by more moderate Senate Republicans to find a compromise that would allow the expansion to be based on “conservative principles” (see Update for Week of December 7, 2015). It also followed the signal last month by House Speaker Kirkland Cox (R) that Republicans may be willing to support an expansion if Virginia receives federal approval to impose Medicaid work requirements (see Update for Week of January 22nd), similar to the federal waivers recently granted to Kentucky and Indiana (see above).

Medicaid expansion gained new momentum in Virginia after only a coin-flip prevented Republicans from losing House control in last fall’s elections. The Senate, which remains only narrowly under Republican control, unanimously approved a form of Medicaid expansion legislation this week (S.B. 915). However, it passed without any funding mechanism, meaning the final decision will have to be resolved next week by House and Senate committees ironing out competing budget bills.

The budget proposal submitted by outgoing Governor Terry McAuliffe (D) and supported by current Governor Ralph Northam (D) would accept nearly \$3.5 billion in ACA matching funds and fund the state’s ten percent share of costs through a hospital assessment McAuliffe negotiated with the state hospital association (see Update for Week of December 18th). However, that assessment was dropped from S.B. 915.

Senate approves bill to expand catastrophic coverage

The Senate unanimously approved legislation this week that would allow Virginia to offer catastrophic-only coverage created by the Affordable Care Act (ACA) to those age 30 or over.

The low-cost, high-deductible plans provide coverage to young adults for essential health benefits mandated by the ACA and at least three primary care visits per year. The ACA made this coverage tier available only to those under age 30 or who qualified for an affordability or hardship exemption. As a result, only about one percent of all Marketplace consumers are enrolled in this option.

S.B. 964 sponsored by Senator Glen Sturtevant (R) would require state officials to seek an ACA State Innovation Waiver that would give Virginia federal approval to offer this coverage regardless of age. It now moves over to the House Commerce and Labor Committee.

Washington

Senate passes bill to examine alternatives to individual mandate under the ACA

The Senate narrowly passed legislation last week that would direct the Insurance Commissioner to create a task force charged with recommending state alternatives to the individual mandate under the Affordable Care Act (ACA).

Penalties for the ACA’s mandate were set to zero by tax reform legislation that President Trump signed last month into law (see Update for Week of January 8th). However, at least nine state legislatures (including Hawaii and Maryland) are considering bills this session that would create either a state version of the ACA individual mandate or a

comparable mechanism to ensure insurance risk pools are sufficiently balanced between healthy and sicker populations (see Update for Week of January 22nd).

If passed by the House, S.B. 6084 would also direct the task force to study options for the state to enforce the minimum essential health benefit packages required by the ACA, in the event they are weakened by the Trump Administration. The report would be due by December 1st.

Wisconsin

Committee approves Governor's reinsurance plan, with a catch

The Joint Committee on Finance approved legislation this week that would create the reinsurance program proposed by Governor Scott Walker (R) in an effort to mitigate premium hikes in the individual market.

The Trump Administration has encouraged states to seek federal waivers allowing them to create their own reinsurance programs, replacing the temporary program under the Affordable Care Act (ACA) that expired after 2016. Alaska, Minnesota, and Oregon have already received federal approval to provide insurers with additional compensation whenever their claim costs exceed a pre-determined threshold (see Update for Week of November 13th). These payments have already resulted in dramatic reductions in rate hikes in those states, with most of the cost borne by the federal government.

Governor Walker used his State of the State address to urge the legislature authorize a federal waiver under which Wisconsin would receive \$150 million in federal reinsurance funds while the legislature would appropriate an additional \$50 million (see Update for Week of January 22nd). The program would start in 2019 and provide additional payments to insurers for patients with claims between \$50,000 and \$250,000. It would be paid for with projected savings from cuts in the Medicaid program, which Wisconsin has not expanded under the ACA.

The Joint Finance Committee revised the state share of the cost up to \$80 million under S.B. 770. However, the bill does not address how those costs would be paid after the non-partisan Legislative Fiscal Bureau questioned whether Medicaid cuts alone would offset them.

Although Democrats largely supported the concept of a reinsurance program, all but one committee Democrat opposed S.B. 770 since Republicans slipped in a provision that would bar any future governor from expanding Medicaid under the ACA without legislative approval (should Governor Walker not be re-elected in the fall). They also objected to another provision directing the Governor to study whether to concurrently resurrect the Health Insurance Risk-Sharing Plan, which was the high-risk pool for persons with pre-existing conditions that the state operated prior to the ACA.

Democratic lawmakers instead have encouraged the Administration to expand Medicaid under the ACA and use the ACA matching funds to fund the reinsurance programs. They note that the three other states with federal reinsurance waivers all participate in the Medicaid expansion.

S.B. 770 has the backing of the Wisconsin Association of Health Plans, the Wisconsin Medical Society, and the Wisconsin Hospital Association.