

Health Reform Update – Week of December 3, 2018

CONGRESS

New bipartisan bill would penalize manufacturers who misclassify brand-name drugs as generics

Senators Chuck Grassley (R-IA) and Ron Wyden (D-OR) introduced legislation last week that would let the federal government and states prevent drug manufacturers from boosting their Medicaid reimbursement by improperly classifying brand-name drugs and generics.

The Department of Health and Human Services (HHS) currently lacks the authority to either demand manufacturers reclassify their drugs or impose civil monetary penalties on those refusing to do so. The Senators insist that this “loophole” as allowed manufacturers to overcharge taxpayers hundreds of millions of dollars under the Medicaid drug rebate program and federal Section 340B drug discount program, citing Mylan’s 2016 settlement with the Department of Justice in which it agreed to repay \$465 million for falsely classifying its EpiPen treatment as a generic drug. (The HHS Office of Inspector General determined that taxpayers may have overpaid as much as \$1.27 billion for EpiPen over ten years).

The *Right Rebate Act* would not only give HHS and states the authority to impose capped CMPs and recoup rebates for misclassified drugs under the Medicare drug rebate program, it would let HHS correct any misclassification if the manufacturer fails to do so in a timely manner. It is expected to be voted in the House as early as next week as part of a larger package of bills.

Senator Grassley will chair the Finance Committee next year while Wyden will remain the ranking member.

Republican lawmakers balk at HHS plan to base Medicare Part B drug reimbursement on international prices

Republican lawmakers and conservative advocacy groups are pushing back against a recent proposal by the Trump Administration to alter Medicare Part B drug reimbursement based on international pricing.

Under the draft proposal released last month by the Department of Health and Human Services (HHS), the agency would create an International Pricing Index (IPI) payment model in order to more closely align payment for Medicare Part B drugs with drug prices in other countries (see Update for Week of November 12th). It would apply only to a randomly-selected half of the country and be used only for single-source and biologic drugs over the first two years.

The proposal weighs several alternatives to the current Average Sales Price (ASP) plus six percent add-on payment under Part B. Payment under the model would no longer be tied to drug prices and instead reimburse providers a set amount for storing and handling drugs.

The proposal caught stakeholders by surprise as it was not included as part of the President’s drug pricing “blueprint” released last spring (see Update for Week of May 7th) and goes further than the Obama Administration proposal to reform Medicare Part B drug pricing that simply reduced the mark-up received by physicians and hospitals. That proposed rule in 2016 drew intense opposition from drugmakers, providers, and bipartisan members of Congress and was quickly withdrawn.

HHS is accepting public comments through the end of the month and is scheduled to issue proposed regulations next spring. However, the plan has already drawn broad criticism from industry groups, who view it as “price controls”, while consumer groups are concerned about how it may restrict access to critical treatments (see Update for Week of November 12th). Senator Chuck Grassley (R-IA), who will assume chairmanship over the Senate Finance Committee next year, was among several Senators to express concerns last week about the plan, as did conservative House

members such as Rep. Larry Buchson (R-IN), a member of the GOP Doctors Caucus. In addition, conservative groups such as FreedomWorks and Americans for Tax Reform submitted a letter urging HHS to withdraw the entire proposal.

The measure does have some support from key Senators Lamar Alexander (R-TN), chairman of the Senate Health, Education, and Labor Committee, as well as Bill Cassidy (R-LA), a physician.

FEDERAL AGENCIES

Federal Marketplace enrollment continues to lag following dramatic cuts to marketing and outreach

Data released this week by the Centers for Medicare and Medicaid Services (CMS) shows that just over 2.4 million consumers have signed-up for coverage in federally-facilitated Marketplaces during the first five weeks of the 2019 open enrollment period.

The figure is 11 percent below enrollment at the same point last year, with an even greater decline found in states like Pennsylvania (25 percent), Missouri (25 percent), and Ohio (20 percent). New consumer sign-ups were down by 18 percent among all FFM states while 21 percent fewer consumers have visited the federal web portal.

Analysts were quick to blame the Trump Administration's decision to continue slashing funds for marketing and outreach for the dramatic drop-off, noting that nearly 800 counties within the 39 states defaulting to the FFM have no navigators or enrollment assisters helping consumers to sign-up for coverage. Data from state-based Marketplaces (SBMs) unaffected by the cuts would appear to support that claim, as four states have already reported enrollment that outpaces last year (an 11 percent increase in New York, six percent for Colorado, four percent in Massachusetts, and three percent for Washington).

The Government Accountability Office has previously blamed the Administration's 90 percent cut to the marketing and outreach budget for 2018 as the primary reason that total FFM enrollment fell by five percent last year (see Update for Week of August 27th). The Administration imposed another 72 percent cut for 2019, reducing total funding to only 16 percent of the initial \$63 million initially budgeted by the Obama Administration (see Update for Week of July 9th).

Democratic lawmakers also attributed the decline to final regulations from the Trump Administration expanding the use of short-term health plans that do not comply with the ACA (see Update for Week of August 13th). They cited a report released last week by the online insurance sales company eHealth reporting that through the first 25 days of open enrollment, roughly 70 percent of customers who had a choice between short-term plans and unsubsidized Marketplace plans selected the short-term option (a 56 percent increase from 2018). The report appears to validate earlier studies warning that a proliferation of lower-cost but limited-benefit coverage could siphon away significant numbers of younger and healthier Marketplace enrollees (see Update for Week of May 28th).

Navigator personnel disputed other concerns that Congress' repeal of the ACA's individual mandate penalties for 2019 was attributing to the decline (see Update for Week of December 18, 2017). A Kaiser Family Foundation (KFF) survey released last week found that at least a third of consumers surveyed were not even aware of the repeal.

The decline in enrollment comes even though average FFM premiums for the most popular "benchmark" plans are at least two percent lower than last year (see Update for Week of October 29th).

Enrollment for all FFMs ends on December 15th. However, several state-based Marketplaces have extended their enrollment deadlines, with California, the District of Columbia, and New York maintaining the full 12-week period (see Update for Week of July 23rd).

CMS will let states dramatically expand eligibility and use of ACA premium subsidies

The Centers for Medicare and Medicaid Services (CMS) issued new guidance this week giving states four additional ways to opt-out of the consumer protections mandated by the Affordable Care Act (ACA).

Since 2017, Section 1332 of the ACA has allowed states to seek federal waivers to implement their own health reforms so long as they were budget neutral, provide comparable levels of coverage to the parts of the ACA that they would supplant, and authorized by their legislatures. Eight states have already received approved State Innovation Waivers, with all but one using them to create reinsurance programs that compensate insurers with exceptional claims (see Update for Week of August 27th). At least 35 states have passed or are considering legislation authorizing Section 1332 waivers.

Recent guidance issued by the Departments of Health and Human Services (HHS) and Treasury relaxed or eliminated the guardrails placed on these waivers by the Obama Administration, so that state agencies can now pursue these waivers without authorizing legislation (see Update for Week of October 29th). In addition, states would be allowed to reduce or limit coverage to specific populations and offer coverage that does not comply with the ACA so long as ACA-compliant coverage remains available.

CMS Administrator Seema Verma followed-up on that guidance by announcing this week that the agency has created four examples of how states could use the re-branded State Relief and Empowerment Waivers.

The models proposed by CMS focus on broadening the use of the ACA premium tax credits, which are currently available to those earning 100-400 percent of the federal poverty level (FPL). CMS would now let consumers in approved states combine these subsidies with employer contributions to purchase employer-sponsored insurance or other types of lower-cost coverage that need not comply with the ACA, such as the association health plans and short-term coverage recently permitted by the Administration (see Update for Week of September 10th). Under the ACA statute, these subsidies currently can only be used to purchase qualified health plans in the ACA Marketplaces.

The Administrator insisted that CMS would not approve waivers that allowed ACA subsidies to be used to purchase plans that did not include the ACA's guaranteed issue mandate (requiring coverage be offered to everyone regardless of pre-existing conditions). However, the waivers specifically would let plans vary premiums based on pre-existing conditions, opt-out of the ACA's essential health benefits, and remove the ACA's annual out-of-pocket limits.

CMS is also proposing to let state governments make the premium tax credits available to those earning more than 400 percent of FPL and provide cash contributions that consumers could use towards premiums and out-of-pocket costs. States would also have the flexibility to adjust plan options, design their own premium assistance programs, and employ risk stabilization strategies (such as reinsurance programs or high-risk pools).

As with the earlier guidance, Democratic lawmakers joined with consumer and provider groups to criticize the new state flexibility as a further effort by the Administration to weaken or sabotage the ACA and make coverage more costly and inaccessible for high-cost consumers. Many expressed fears that prevalence of non-compliant plans would essentially segment the individual health insurance market into two different risk pools, with healthier and lower-cost consumers migrating into the lower-cost "junk" coverage while ACA-compliant plans are left to serve to sicker and higher-cost populations. This would translate into dramatically higher premiums for the latter.

The incoming chair of the House Energy and Commerce Committee, Rep. Frank Pallone (D-NJ), also insisted that the guardrails imposed by the ACA statute could not be waived and that HHS recent guidance would thus likely not survive court challenges. Rep. Richard Neal (D-MA), the incoming chair of the Ways and Means Committee also claimed that the HHS guidance violated the Administrative Procedures Act because it was not released for public comment.

Proposed CMS rule would create exceptions for six protected drug classes under Part D

The Centers for Medicare and Medicaid Services (CMS) issued proposed regulations last week that would give insurers the flexibility to exclude certain drugs from the “six protected classes” under Medicare Part D.

When Congress created Medicare Part D in 2003, it statutorily required plans to cover at least two drugs in each therapeutic class (which is a group of medications that are used to treat the same condition.) However, it recognized that patients receiving extensive or complicated treatments for certain conditions needed to be assured that their critical or life-saving treatment regimen for conditions like HIV, epilepsy, cancer, or organ transplantation would not be disrupted if they enrolled in a Part D plan. As a result, they created six protected classes where plans had to cover “substantially all” drugs on their formularies, regardless of price.

These protected classes are: (1) anticonvulsants, (2) antidepressants, (3) antineoplastics, (4) antipsychotics, (5) antiretrovirals, and (6) immunosuppressants. Based on recommendations from the influential Medicare Payment Advisory Commission (MedPAC), CMS had sought to eliminate antidepressants and immunosuppressants from this list in 2014, but was forced to scuttle those plans due to broad stakeholder opposition (see Update for Week of March 10, 2014).

The current proposed rule maintains all six classes but provides a far more extensive set of exceptions than the Obama Administration proposal. It specifically would allow drug formularies to be limited based on cost, as Part D plans could exclude drugs within the six classes whenever drugmakers raise prices faster than the rate of inflation or whenever they make new formulations of already-approved drugs. In addition, Part D plans would be able to impose prior authorization requirements within these classes as well as rely on step therapy, which would require patients first be treated with less-costly drugs even if their physician prescribes a costlier therapy (i.e. biosimilars in place of a higher-cost biologic).

The enhanced flexibility closely follows the drug pricing “blueprint” released earlier this year by the White House (see Update for Week of May 7th). However, CMS did not include the President’s proposal to require Part D plans share drug rebates at the point of sale, although it asked for comments on whether such a provision should be part of future rulemaking as early as 2020.

As they did in 2014, consumer groups led by The AIDS Institute and American Cancer Society were quick to denounce the proposed rule, warning that it would shift costs and disrupt care for the most vulnerable patients while ultimately raising Medicare spending for critical drugs.

GAO report finds flaws in FDA reviews for orphan drugs

A report issued last week by the Government Accountability Office (GAO) concludes that the Food and Drug Administration (FDA) is failing to ensure that its process for awarding rare disease status to orphan drugs is meeting the intent of the federal law that created the program.

Congress passed the *Orphan Drug Act* in 1983 to provide drug manufacturers with tax incentives and marketing exclusivity for developing treatments for rare disorders that afflicted fewer than 200,000 people. The incentives quickly became more valuable and coveted than anticipated, to the point where a third of all prescription drug spending by 2020 is expected to go towards orphan drugs.

However, critics have complained for decades that drug manufacturers have been able to “game” the process to gain approval of drug that are not always new or designed for orphan conditions. The GAO report appears to support some of these criticisms, revealing that 38.5 percent of orphan drug approvals from 2008 to 2017 were for drugs that had been previously approved either for mass-market or rare-disease use (such as the cholesterol drug Crestor, the cancer drug Herceptin, or the rheumatoid arthritis drug Humira). Only about 71 percent of the drugs given orphan status by the

FDA were actually intended to treat diseases affecting fewer than 200,000 people. In addition, more than 80 orphan drugs won FDA approval for more than one rare disease.

Researchers also uncovered inconsistent and often incomplete reviews early in the process of assigning orphan drug status. In some cases, they found that FDA reviewers failed to show they had verified how many patients could be treated by a drug under consideration for orphan status and simply trusted data furnished by the manufacturer. In nearly 60 percent of the 148 applications that GAO reviewed, it determined that FDA reviewers failed to capture basic regulatory history information such as the number of “adverse actions” from regulatory agencies. GAO identified 26 applications that were granted orphan status even though the initial FDA review had missing data.

FDA officials stated that they agreed with GAO’s recommendation to take “executive action” to “fix” the process and were “streamlining our processes.” However, it is not yet clear what specific actions the agency will undertake.

According to the GAO report, more than half of the drugs granted orphan status by the FDA from 2008-2017 were used to treat bleeding disorders or cancer.

New FDA commissioner Scott Gottlieb has pledged to modernize the orphan drug program which had a backlog of at least 138 applications that had been waiting more than four months when he assumed office last year (see Update for Week of July 10th).

Lower utilization of services curbed growth in health care spending for 2017

The growth rate in national health spending fell by nearly a full percent from 2016 to 2017 due in large part to the slowest reported rate of growth in prescription drug spending in five years.

Data from the Chief Actuary for the Centers for Medicare and Medicaid Services (CMS) revealed that total health spending grew by only 3.9 percent to \$3.5 trillion, down from the 4.8 percent increase from 2015-2016 and 5.5 percent from 2014-2015. However, the share of gross domestic product spent on health care dipped only slightly in 2017 from 18 percent to 17.9 percent.

Andy Slavitt, the former interim CMS Administrator under the Obama Administration credited the Affordable Care Act (ACA) for dramatically lowering spending growth from the 7.3 percent average from 1998-2007. In particular, he noted that the per capita growth rate in Medicaid spending is down to 0.9 percent (declining from 1.2 percent in 2016).

The CMS Actuary attributed much of the spending growth slowdown to a steep fall in retail prescription drug spending, which increased by only 0.4 percent in 2017 compared to 2.3 percent in 2016 and a staggering 8.9 percent in 2015. The report highlighted the much lower utilization rates for biologic drugs to treat high-cost conditions like Hepatitis C and well as opioids and other prescription painkillers.

By contrast, hospital spending outpaced all other categories, increasing by 4.6 percent in 2017. Although this was less than the 5.6 percent growth rate the year before, hospital prices went up by 0.5 percent during the year.

The growth in private health insurance spending also declined significantly (from 6.2 percent to 4.2 percent) as did household spending on out-of-pocket costs for medical care (3.8 percent compared to 4.8 percent). This was due largely to lower numbers of Americans enrolled in private health plans and lower utilization of services. Former Administrator Slavitt suggested that the lower utilization was due primarily to more cost-effective outpatient care and “better care management” as opposed to Americans increasingly forgoing needed care due to cost.

STATES

Rate of uninsured children increases for first time in a decade

A study released last week by the Georgetown University Center for Children and Families found that the number of uninsured children rose last year for the first time since the Affordable Care Act (ACA) was enacted.

The increase of 276,000 children was small statistically (raising the uninsured rate only from 4.7 percent to five percent). However, it was an unexpected reversal in the continued declines that had been brought by the ACA's coverage expansions, especially given that the national unemployment rate had hit its lowest level nearly half a century.

Because children tend to be covered when their parents are insured, researchers found that states still refusing to expand Medicaid under the ACA as of 2017 were partly to blame, as uninsured rates for children in the 17 states that had yet to expand were nearly three times as high as expansion states. The highest increases occurred South Dakota (up from 4.7 to 6.2 percent), Utah (up from six to 7.3 percent) and Texas (up from 9.8 to 10.7 percent). More than 20 percent of the nation's uninsured children live in Texas alone (roughly 835,000 children or nearly three times the amount in the largest state of California, which expanded Medicaid).

However, the study also cited the Trump Administration's anti-immigration policies as a factor causing many parents to fear enrolling children in health coverage for which they are eligible.

The uninsured rate for all ages remained unchanged in 2017 at 8.8 percent, also in contrast with prior years. This was consistent with Census Bureau data, which likewise showed overall uninsured rates increasing most precipitously in non-expansion states (see Update for Week of September 10th).

Florida

Medicaid program gets federal approval to limit retroactive eligibility to 30 days

Florida became the latest state last week to receive permission from the Trump Administration to limit retroactive coverage for Medicaid enrollees.

Federal law has traditionally allowed persons applying for Medicaid to be eligible for benefits for up to 90 days before the month of the application if the applicant met eligibility requirements at the earlier time. According to the Kaiser Family Foundation, this is "one of the long-standing safeguards built into the program" that helps those with unexpected hospital or nursing home admissions who are unable to immediately file an application.

The Centers for Medicare and Medicaid Services (CMS) approved Florida's request for a Section 1115 demonstration waiver to limit retroactive eligibility to only 30 days, starting February 1st. The change means that persons eligible for Medicaid would have to apply for it within the same calendar month that they received services from a provider. However, it would not apply to children or pregnant women.

CMS acknowledged that all of the public comments it received in response to Florida's requested waiver opposed limiting retroactive eligibility. Hospital, long-term care, and consumer groups all argued it would adversely impact access to care for poor, disabled, and elderly populations. However, CMS has already granted similar requests from Indiana, Iowa, Kentucky, and New Hampshire, although the Kentucky approval was blocked by a federal judge as part of his injunction prohibiting that state's Medicaid work requirement from going into effect (see Update for Week of June 25th).

In an effort to mitigate concerns about access to care, CMS officials emphasized that Florida would still be required to provide Medicaid coverage on the first day of the month in which an individual applies, as well as promote the change in retroactive eligibility on the state's website and materials sent to providers and enrollees.

The Florida Agency for Health Care Administration (AHCA) predicted the change would impact about 39,000 applicants and save the state nearly \$100 million. Arizona has a comparable waiver request pending with CMS.

Kentucky

CMS approves new Medicaid work requirement waiver without substantial changes

The Cabinet for Health and Family Services announced last week that the federal Centers of Medicare and Medicaid Services (CMS) has approved their revised waiver seeking to impose work requirements, double premiums, and lock-out periods on working-age and “able-bodied” adults enrolled in Medicaid.

Kentucky was the first state to receive CMS approval to impose work requirements on Medicaid enrollees. However, their Section 1115 demonstration waiver was voided by the U.S. District Court for the District of Columbia, when Judge James Boasberg ruled that the approval was “arbitrary” and “capricious” because it CMS “paid no attention” to the adverse impact of eliminating coverage for an estimated 95,000 Medicaid enrollees (or nearly 20 percent of the entire expansion population), nor did it address how the state would help find other coverage for those enrollees in accordance with their obligations under federal Medicaid law (see Update for Week of June 25th).

The revised five-year waiver, which would become effective as soon as April 1st, still made very few substantive changes. Kentucky Medicaid will still require most adults age 19-64 (except for pregnant women and the “medically frail”) to complete at least 80 hours per month of “community engagement” to keep their health benefits. This includes working, looking for a job, going to school, volunteering for community service or completing job training courses.

In response to the judge’s concerns, CMS insisted in their re-approval letter that it had considered all public comments received on the waiver had determined that Kentucky’s proposed was “consistent with the goals of the Medicaid program.” CMS did not specifically project or address how many enrollees were likely to lose coverage.

CMS issued the approval despite the urging of the Medicaid and CHIP Payment and Access Commission (MACPAC) to pause all waivers requests for Medicaid work requirements until the agency can develop adequate methods to evaluate whether those who lose coverage are able to obtain insurance from other sources (see Update for Week of October 29th).

Maine

Outgoing governor continues crusade against voter-mandated Medicaid expansion

The Kennebec County Superior Court ordered the Maine Department of Health and Human Services (HHS) this week to implement the voter-approved Medicaid expansion by February 1st despite continued protestations by outgoing Governor Paul LePage (R) that it will “bankrupt “ the state.

Under the original order issued last month by Justice Michaela Murphy, HHS is required to promulgate rules making Medicaid coverage for the newly-eligible population retroactive to July 2nd, the implementation date set by a ballot referendum overwhelmingly approved by voters last year (see Update for Week of November 6, 2017). Judge Murphy stated that the Governor “may not ignore the will of the people and refuse to take any action toward accomplishing the policy objectives of the Act.”

Governor LePage refused to let HHS submit the required State Plan Amendment paperwork to the Trump Administration by the referendum’s deadline and once forced to do so last fall by Maine’s Supreme Judicial Court, he urged the federal government to reject it (see Update for Week of September 10th). LePage has been a fervent opponent of the Affordable Care Act (ACA) and previously vetoed six attempts by the legislature to expand Medicaid under the ACA, including the \$60 million they appropriated last summer for the voter-approved expansion (see Update for Week of July 7th). He has repeatedly pledged to “go to jail” before implementing any form of Medicaid expansion and refused to let HHS promulgate the required regulations (see Update for Week of December 18, 2017).

The stand-off was ultimately resolved by the voters last month when they elected Attorney General Janet Mills (D) to be the next governor (see Update for Week of November 12th). Governor-elect Mills has pledged to immediately expand Medicaid upon her inauguration on January 2nd even though Judge Murphy agree to delay the implementation date until February 1st after LePage unsuccessfully sought a stay of her order.

Governor LePage, who could not run this cycle due to term limits, has threatened to run against Mills in four years should she follow through with her promise to expand Medicaid.

Michigan

New bills seek to strip power from incoming Democrats, expand short-term health plans

Republican lawmakers have introduced legislation attempting to shift many of the powers designated to the Governor and Attorney General to the Republican-controlled legislature following the election of Democrats to every statewide office (see Update for Week of November 12th).

Legislation sponsored by Rep. Robert VerHeulen (R) would specifically give both chambers the authority to intervene or withdraw from any legal proceeding involving the state, in a direct effort to prevent Attorney General-elect Dana Nessel (D) from removing Michigan from the federal lawsuit seeking to overturn the entire Affordable Care Act (see Update for Week of September 10th).

Current Attorney General Bill Schuette (R) had signed Michigan onto that litigation and intervened in nine other anti-ACA lawsuits during his eight-year tenure. Although he insisted that he would not terminate Michigan's Medicaid expansion if elected governor, Schuette had pledged to implement the work requirement for newly-eligible enrollees for which current Governor Rick Snyder (R) recently received federal approval.

However, Schuette was defeated by former Senate minority leader Gretchen Whitmer (D), a staunch ACA support who is expected to block the Medicaid work requirement. This led the original sponsor of the work requirement, Senator Mike Shirkey (R) to introduce legislation prohibiting her from doing so without legislative approval.

Senator Shirkey also introduced S.B. 1224 last week that would seek to remove Michigan's current restrictions on short-term health plans before the new governor is in place (a companion bill, H.B. 6538 was introduced in the House). Michigan currently restricts short-term plans (that need not comply with ACA consumer protections) to no more than 185 days and makes them non-renewable. However, S.B. 1224 would allow short-term plans to be offered for up to 364 days and annually renewable, consistent with federal regulations recently finalized by the Trump Administration (see Update for Week of August 13th). The bill specifically would allow insurers offering short-term plans to deny coverage based on pre-existing conditions and comply with only five of the ten essential health benefit packages mandated by the ACA.

Minnesota

Trump Administration cuts \$100 million from federal contributions to reinsurance program

Lawmakers were alarmed this week by a dramatic \$100 million reduction in the amount the federal government contributes to Minnesota's reinsurance program that compensates insurers with exceptional claims.

Following the lead of Alaska, Minnesota created its own state-funded reinsurance program last year in an effort to combat massive spikes in individual market premiums that occurred following the expiration of the three-year reinsurance payments under the Affordable Care Act (ACA) (see Update for Week of July 10, 2017). The program successfully reduced premiums that were spiking by 59 percent on average down to only single-digit increases and quickly won federal approval to continue as a combined federal-state program under a five-year waiver authorized through Section 1332 of the ACA.

Lawmakers had appropriated \$542 million from the state's budget surplus to fund the reinsurance program for the first two years and were expecting \$184 million from the federal government to continue the program into 2019. However, the state was informed by the federal Centers for Medicare and Medicaid Services (CMS) that it would likely receive only \$84 million of that amount.

Lawmakers were caught off-guard by the loss of funding. Senator Tony Lourey (D) conceded that while "some loss of federal support for our reinsurance program might have been expected" due to dramatically lower premiums, they were not informed of or expecting a cut "of this magnitude." Senator Michelle Benson (R), whose party will still control the Senate next year, noted that lawmakers were given no explanation by CMS for the reduction and insisted that "this change significantly impacts the conversation about reinsurance going forward." However, more than \$225 million in health fund savings from lower Medicaid enrollment and Medicaid managed care rates have helped to leave Minnesota with a \$1.5 billion budget surplus for fiscal years 2020 and 2021 for which it could fund the shortfall should the legislature elect to do so.

The reinsurance program was initially approved by a Republican-controlled legislature and outgoing Governor Mark Dayton (D). Democrats gained control of the House in last month's election, making Minnesota the only state that will have a divided legislature in 2019 (see Update for Week of November 12th). They also came within one seat of taking control in the Senate and will continue to control the governorship after the election of Congressman Tim Walz (D), who supports letting consumers above Medicaid eligibility buy-in to MinnesotaCare.

Wisconsin

Republicans pass bills to limit power of incoming Democrats to expand Medicaid, remove work requirements

The Republican-controlled Senate and Assembly passed legislation this week designed to prevent newly-elected Democrats from enacting their promised health reforms.

Republicans will lose control over every statewide office starting in January but heavily-gerrymandered districts allowed them to maintain majorities in both legislative chambers despite the Democratic sweep (see Update for Week of November 12th). Upon assuming office, Governor-elect Tony Evers (D) had pledged to remove the work requirements, lock-out periods, and higher premiums imposed on "able-bodied" Medicaid adults under a recently-approved federal waiver and take whatever administrative actions he could to expand Medicaid under the Affordable Care Act (ACA) (see Update for Week of October 29th). Attorney General-elect Josh Kaul (D) pledged to immediately remove Wisconsin as a lead plaintiff from a federal lawsuit backed by 17 other Republican attorneys general that seeks to overturn all of the ACA (see Update for Week of September 10th).

As a result, Republican lawmakers quickly passed three bills without public hearings during the lame-duck session (including S.B. 886) that would give the legislature oversight over any federal waivers, thereby preventing Governor-elect Evers from blocking the Medicaid work requirement without their consent. The bill would also require legislative committees to sign-off on withdrawing from federal lawsuits, and well as strip both offices of other powers including the ability to make appointments and oversee the rulemaking and election process.

Outgoing Governor Scott Walker (R) has signaled that he will sign the legislation, despite threats by the Governor-elect to seek injunctions barring its implementation. More than two dozen health industry groups including the Wisconsin Medical Society, Wisconsin Hospital Association, and America's Health Insurance Plans opposed the measures warning that they will limit the state's flexibility to make needed changes to the Medicaid program and negatively "impact health care delivery in Wisconsin."

Republican lawmakers in Michigan are considering similar legislation after they also lost every statewide office last month (see above), as are Republican lawmakers in North Carolina, who will lose supermajority status in January (see Update for Week of November 12th). A state court blocked initial efforts by North Carolina Republicans to strip

Governor Roy Cooper (D) of many of his powers when he assumed office two years ago. However, those bills did not impact Governor Cooper's authority over state health programs (see Update for Week of January 9, 2017).

Wyoming

Committee approves bills to consider reinsurance, Medicaid expansion

The interim Health and Labor Committee approved a series of bills last month seeking to reduce the exceptionally high cost of health insurance in the nation's least populated state.

Wyoming has the second highest health insurance premiums among the 39 states that currently default to the federally-facilitated Marketplace operated pursuant to the Affordable Care Act (ACA). The state's small and older population makes it highly susceptible to premium costs being driven-up by high-cost consumers.

The committee approved draft legislation that directs the Insurance Commissioner to develop a plan by 2021 to use a combination of state and federal funds to reimburse health insurance insurers for exceptional claims. The plan would be similar to reinsurance programs that the Trump Administration has already approved for eight states under Section 1332 waivers created by the ACA (see Update for Week of September 10th). Those reinsurance programs replaced the ACA's reinsurance payments that expired after 2016.

Chairman Scott (R) noted that Alaska and Minnesota have already demonstrated that premium increases could be substantially mitigated through reinsurance programs (see Update for Week of July 10, 2017). However, the chairman noted that reinsurance alone would not address the state's high hospital costs, which are at least ten percent above the national average and after years of opposition, the committee finally agreed to direct the commissioner to study whether Wyoming should expand Medicaid under the ACA—a move long-backed by the Wyoming Hospital Association and outgoing Governor Matt Mead (R) (see Update for Week of August 28, 2017).

Governor-elect Mark Gordon (R), the current state treasurer, opposed expanding Medicaid during the campaign but has hinted that he may support some alternative form "apart from the federal system." Successful Medicaid expansion voter referendums in neighboring Idaho, Utah, and Nebraska are all likely to put additional pressure on Wyoming to ultimately expand (see Update for Week of November 12th).

Governor Mead had commissioned a study by the Department of Health that concluded expanding Medicaid under the ACA would bring in at least \$268 million in federal funds and more than erase the Medicaid program's \$20 billion deficit (see Update for Weeks of January 11 and 18, 2016).