



## Health Reform Update – Weeks of May 15 and 22, 2017

### CONGRESS

#### ***Administration delays decision on ACA cost-sharing subsidies for 90 days***

The Trump administration and House of Representatives were granted a 90-day extension this week by a federal appellate court to decide whether to drop the appeal of the House lawsuit seeking to invalidate the cost-sharing reductions (CSRs) provided by the Affordable Care Act (ACA).

A federal judge appointed by President George W. Bush had given House Republicans a temporary victory by ruling that the Obama Administration illegally continued to pay CSRs even after Congress refused to appropriate funds for them in 2014 (see Update for Week of May 16, 2016). That decision was stayed pending their appeal.

The Trump Administration had asked the court for a delay until May 22<sup>nd</sup> to decide whether to end the Obama Administration's appeal and effectively terminate the CSRs (see Update for Week of February 27<sup>th</sup>). His director for the Office of Management and Budget (OMB) had pledged only to continue the CSRs through this month, creating tremendous uncertainty for insurers who have to decide by June 21<sup>st</sup> whether to participate in ACA Marketplaces for 2018.

Under their contracts with the Centers for Medicare and Medicaid Services (CMS), Marketplace insurers can exit during the plan years if the CSRs are not provided and Florida Blue and Molina are among two prominent insurers that have pledged to do so (see Update for Week of May 8<sup>th</sup>). Other insurers such as Anthem and Oscar Health Plan have stated that they would be forced to immediately hike premiums by at least 20 percent, while at least four major insurers have already withdrawn for 2018, citing the lack of certainty about the CSRs.

Although Republican leaders in both the House and Senate insist that the CSRs will be funded through at least 2018 (See Update for Week of May 8<sup>th</sup>), President Trump has repeatedly threatened to terminate them if Democrats did not come to the table on an ACA replacement. His new CMS Administrator Seema Verma is currently fending off similar allegations by the *Los Angeles Times*, which reported last week that she told insurance officials the agency would only fund the CSRs if the industry backed the American Health Care Act (AHCA).

According to *POLITICO*, President Trump's own advisers are urging him to continue the CSRs and avoid throwing the Marketplaces into "chaos". A broad industry coalition is also lobbying Senate leaders to provide some clarity regarding the fate of the CSRs, including the National Association of Insurance Commissioners, America's Health Insurance Plans, the American Medical Association, the American Hospital Association, and the U.S. Chamber of Commerce.

In addition, the Attorneys General from at 15 Democratically-controlled states and the District of Columbia asked the U.S. Court of Appeals for permission to intervene in the House lawsuit, in an effort to preserve the CSRs. They argue that the executive branch is "not adequately defending its authority to make the payments and does not represent their interests."

#### ***CBO confirms AHCA will dramatically increase costs for those with pre-existing conditions***

The Congressional Budget Office (CBO) released its new cost estimate this week for the amended version of the American Health Care Act (AHCA) that recently passed the House, warning that



the bill could de-stabilize the individual health insurance markets in certain states while causing those with pre-existing conditions to pay “substantially higher premiums.”

The non-partisan scorekeeper had initially predicted that the proposed repeal and replacement of key Affordable Care Act (ACA) provisions would eliminate coverage for up to 24 million Americans by 2026 (including 14 million next year) while dramatically increasing premium and out-of-pocket costs for those with aged 50-64 with low-incomes. The political backlash from that projection had forced House leaders to pull the bill from the floor and vote on an amended version prior to obtaining a new CBO score (see Update for Week of May 8<sup>th</sup>).

However, the ultra-conservative Freedom Caucus forced changes to the AHCA that actually worsened CBO’s projected impact on older and less healthy consumers. This includes allowing states to waive key consumer protections in the ACA such as essential health benefit standards, age rating, and community rating (see Update for Week of May 8<sup>th</sup>).

CBO predicted that these waivers would cause individual market “instability” in likely opt-out states where one-sixth of the American population lives, causing premiums for comprehensive ACA-equivalent coverage to be “unaffordable” for those with pre-existing conditions. For example, in a state where insurers would be allowed to once again offer “junk” coverage, hike premiums based on medical status, and charge older consumers 500 percent or more than younger consumers, CBO projected that premiums for someone aged 50-64 earning below 200 percent of the federal poverty level (roughly \$26,500) could increase by 847 percent to just over \$16,000 per year (well over half their annual income).

The CBO score continued to project substantial coverage losses from elimination of the ACA’s Medicaid expansion, premium and cost-sharing subsidies, and individual and employer mandates. As with its earlier estimate, it predicts that 14 million Americans would lose coverage during the first year. It now predicts that 23 million Americans would lose coverage by 2026.

The coverage losses and adverse impact on those with pre-existing conditions drew immediate concern from Republican Senators in Democratically-leaning states such as Susan Collins of Maine and Dean Heller of Nevada. However, conservative Senators were equally upset that the revised AHCA would offers substantially lower cost-savings than the earlier version (\$119 billion over ten years compared to the initial \$150 billion estimate).

Senate leaders had already pledged to draft their own ACA repeal and replacement legislation (see Update for Week of May 8<sup>th</sup>). However, leaks from closed-door negotiations suggested that they were working on a plan that would continue to allow insurers to charge more for those with pre-existing conditions so that premiums could be lowered for younger and presumably healthier groups who could buy “skinny” coverage. CBO did find that the current AHCA would reduce premiums for younger adults by an average of four percent (followed by an initial 20 percent premium spike).

The outcome of Senate negotiations is likely to depend largely on whether conservative Senators demanding an immediate elimination of the Medicaid expansion can reach a compromise with those from expansion states who do not want to forgo billions of dollars in ACA matching funds. Majority Leader Mitch McConnell (R-KY) acknowledged this week that the Senate does not yet have enough votes as at least eight pro-expansion Senators are already against the current AHCA bill, which cannot pass through budget reconciliation with the opposition of more than two Republicans.

### ***CBO score pushes Senators to consider doubling premium tax credits under AHCA***

A group of Senate Republicans led by Bill Cassidy (R-LA), Bob Corker (R-TN), Susan Collins (R-ME), John Hoeven (R-ND), and John Thune (R-SD) are proposing to boost the premium tax credits available under the American Health Care Act (AHCA).



The AHCA bill that recently passed the House (H.R. 1628) would eliminate all premium and cost-sharing subsidies under the Affordable Care Act (ACA) and replace them with a tax credit ranging from \$2,000 to \$4,000 that is based on age instead of income (see Update for Week of May 8<sup>th</sup>). The tax credits would start to phase down from those earning above \$75,000 per year and no longer be available for those earning above \$90,000 (or \$115,000 for those age 60 and older).

However, Senators working behind closed doors on an ACA replacement are reportedly seeking to restructure the AHCA credits to make them “enough so that lower-income, middle-income people have the ability to actually purchase healthcare,” according to Senator Corker. He and several other Senators acknowledge that cost estimates provided by the CBO show those aged 50-64 earning less than \$26,500 would face premiums exceeding half their income (see above).

Senator Hoeven hinted that the Senate version of the AHCA could not only double the amount of tax credits available (\$4,000-\$8,000), but link them to income, similar to the ACA. Senator Cassidy indicated that the enhanced credits would also be focused on “older folks.”

However, higher subsidy levels would face likely opposition from the most conservative members of the Senate such as Ted Cruz (R-TX), who has insisted that they are a “new entitlement” that should be eliminated entirely.

President Trump tweeted that Congress “should add more dollars to Healthcare”, potentially indicating that he would support either the higher subsidies or increasing funding for the high-risk pools and reinsurance payments authorized by H.R. 1628 (see Update for Week of May 8<sup>th</sup>).

### ***House members urge HHS Secretary to ensure availability of non-profit premium assistance***

A total of 181 House members from both parties have signed on to a Dear Colleague letter urging the new Secretary of the Department of Health and Human Services to ensure the availability of third-party premium and cost-sharing assistance from charitable groups like Patient Services Inc. (PSI).

The letter was written by Reps. Kevin Cramer (R-ND) and Doris Matsui (D-CA). Cramer was the lead sponsor for the Access to Marketplace Insurance Act (H.R. 3742) that garnered nearly 150 bipartisan cosponsors last year and is expected to be reintroduced this session.

Since 2014, the Centers for Medicare and Medicaid Services (CMS) has given Marketplace insurers the discretion to refuse third-party assistance from non-profit organizations (see Update for Week of June 2, 2014) and more than 70 plans in 41 states have done so. The agency has ignored several requests from Congress to provide data justifying insurer concerns that allowing such assistance would “skew the risk pools” towards sicker and more costly subscribers (see Update for Week of August 15<sup>th</sup>).

The latest Dear Colleague letter urges the Trump Administration to reverse this policy and require Marketplace insurers accept third-party assistance from non-profits, the same as they are required to do from state and federal health programs.

More than 20 consumer groups that are part of the Marketplace Access Coalition founded by PSI have argued that CMS’ policy allows Marketplace insurers to effectively skirt the ACA ban on pre-existing condition denials by making plans as unaffordable as possible for those with costly illnesses. CMS previously agreed that similar practices (such as moving all drugs for a costly illness into the highest cost-sharing tier) did constitute unlawful discrimination (see Update for Week of February 23, 2015) and is directing states to take action as part of the plan certification process (see below). It agreed last year to “consider” whether the practice of refusing third-party assistance was likewise discriminatory but has thus far refused to act (see Update for Week of September 12<sup>th</sup>).



### ***CMS will let federal Marketplace states decide whether drug tiers are discriminatory***

Consumer advocates are protesting the last month's decision by the Centers for Medicare and Medicaid Services (CMS) to stop reviewing drug formularies as part of the Qualified Health Plan (QHP) certification process for federally-facilitated Marketplaces (FFMs).

The CMS guidance cites the executive order issued by President Trump upon entering office, which directs agencies to find ways to provide "greater flexibility" to states in administering the Affordable Care Act (ACA). It will allow FFM states that conduct their own plan management to assume responsibility for determining if drug formulary and cost-sharing designs violate the non-discrimination provisions of the ACA. (CMS will continue this role for states that do not conduct plan management).

CMS began reviewing drug formulary and cost-sharing designs following a civil rights complaint filed by The AIDS Institute that showed Marketplace insurers were moving all drugs for certain costly conditions like HIV/AIDS or Hepatitis C into their highest cost-sharing tier (see Update for Week of June 2, 2014). The AIDS Institute argued that deliberately making a plan as unaffordable as possible for persons with costly conditions constituted unlawful discrimination under the ACA and insurance commissioners in states like Florida and Illinois have subsequently cracked down on the practice (see Update for Week of March 23, 2015). However, a recent civil rights complaint from Harvard Law School targeted seven insurers in eight states that were continuing to engage in similar discrimination (see Update for Week of October 24, 2016).

CMS agreed that such practices were potentially discriminatory and sought to identify them through the plan certification process each year (see Update for Week of February 23, 2015). The agency specifically looked for plans with co-payments or co-insurance that were outliers compared to other plans.

The AIDS Institute, the Epilepsy Foundation, and other consumer groups have sought to meet with CMS to stress that states currently "do not have the laws and regulations in place to protect patients against [such] bad practices" and assigning them this role only two months before plans must submit 2018 rate filings provides them with inadequate time to implement them. They also criticized CMS for failing to provide any advance opportunity for public comment.

### ***Federal Marketplace consumers no longer have to finish enrollment on HealthCare.Gov***

The Centers for Medicare and Medicaid Services (CMS) announced this week that websites facilitating enrollment in the federally-facilitated Marketplaces will no longer be required to direct consumers to HealthCare.gov at the end of the process.

The new guidance will allow consumers who start their application process on third-party websites to complete it there, in response to many consumer complaints that the final step made it difficult to finish. Third-party web brokers like eHealth strongly backed the change, insisting that the process of "bouncing back and forth between our web site and healthcare.gov to get a tax credit" was "ridiculous".

### ***CMS will no longer operate small group Marketplaces***

The Centers for Medicare and Medicaid Services (CMS) announced this week that HealthCare.gov will no longer handle enrollment functions for the Small Business Health Options Program (SHOP), starting in 2018.



Eligibility for the small employer tax credit will continue to be determined by HealthCare.gov, the web portal for the federally-facilitated Marketplaces (FFMs). However, CMS will shortly issue a proposed rule that will allow both small employers and their works to enroll in SHOP plans directly through agent or broker (or through a SHOP Marketplace created by states).

According to CMS, roughly 27,000 small employers had active coverage through federal or state SHOP Marketplaces through January 2017, covering approximately 230,000 workers. These numbers are well short of Congressional Budget Office (CBO) projections of four million workers being covered by SHOP Marketplaces in 2017 and CMS expects future enrollment to remain well below expectations.

As a result, CMS is proposing this “more efficient” method to make SHOP enrollment easier for employers, while maintaining access to the Small Business Health Care Tax Credit offered by the ACA, assuming it is not repealed by Congress (see above).

## STATES

### California

#### ***Citing healthiest risk pool in the nation, Covered California will not cut open enrollment***

Covered California officials announced this week that it will maintain the same three-month open enrollment for 2018, despite the Trump Administration’s plan to cut open enrollment by half for federally-facilitated Marketplaces (FFMs).

The 2018 enrollment period will again run from November 15<sup>th</sup>-January 31<sup>st</sup> compared to the FFM period which will only be open from November 1<sup>st</sup> to December 15<sup>th</sup> (see Update for Week of February 27<sup>th</sup>). Covered California cited an analysis from its own actuaries showing that its risk pool had a better mix of healthy and sicker consumers than any Marketplace in the nation as justification for its decision, noting that a narrower open enrollment period would likely depress enrollment of the younger and typically less-costly enrollees that are so critical for insurer profitability and participation.

The latest Covered California data also showed strong competition among participating insurers. Blue Shield of California continued to have the largest market share with more than 31 percent of all Marketplace enrollees. Although it widened its margin from its nearest competitors during 2017, it was far from dominant as Anthem Blue Cross still signed-up more than 25 percent of enrollees while Kaiser Permanente enrolled 24 percent.

#### ***Appropriations committee approves bill to limit prescription drug discounts***

The Assembly Appropriations Committee voted 11-4 this week to advance legislation that would prohibit drug manufacturers from offering discounts or other reductions in an individual’s insurance cost-sharing expenses (including product vouchers or copay coupons) if a lower-cost brand or generic drug is covered under the individual’s health plan on a lower cost-sharing tier that is designated to be therapeutically equivalent by the Food and Drug Administration (FDA).

A.B. 265 had passed the Assembly Health Committee last month but was subsequently amended by the Appropriations Committee (see Update for Week of May 8<sup>th</sup>). It specifically exempts patient assistance provided by independent bona-fide charities like Patient Services Inc. (PSI).

#### ***Single-payer health care cost would exceed the state general fund budget***

A committee report issued this week is likely to throw cold water on renewed legislation to create a single-payer health care system in California.



The analysis of S.B. 562 prepared by the Senate Appropriations Committee predicted that providing state coverage for all 39 million Californians would likely cost roughly \$400 billion per year, or more than double the general fund budget for the state. Only about half of that cost would be funded by a new payroll tax on workers and employers.

The estimated price tag is likely be a “non-starter” and force substantial changes to the legislation. The measure currently would create a system that not only supplants coverage for all employer-based insurance, but also those enrolled in Medicare or Medicaid. In addition, S.B. 562 also would extend coverage to state residents regardless of immigration status.

Supporters of the bill note that the \$400 billion projection is roughly in line with the \$367 billion in public and private spending for health care in 2016, citing figures from the UCLA Center for Health Policy Research. In addition, employers and employees in California now spend roughly \$100-150 billion a year on health insurance and medical care, meaning that “total new spending required under the bill would be between \$50 billion and \$100 billion per year.”

However, the committee analysis acknowledges that S.B. 562 would likely require a significant number of new taxes on top of the 15 percent payroll tax it seeks to impose—taxes that could require ballot referendums under California law and greatly complicate implementation. In addition, a single-payer system would require a federal waiver under Section 1332 of the Affordable Care Act (ACA), which may not be granted by the Trump Administration.

Senator Ricardo Lara (D), the bill sponsor, stressed that the total cost projection does not account for the “big premium savings for employers and individuals” or the savings from creating a single government plan that can wield significant “bargaining power” and eliminate the administrative overhead under private insurers. However, Appropriations members acknowledge that it was premature to vote on S.B. 562 given the amount of uncertainty created by the analysis and postponed any vote this week (it initially cleared the Health Committee last month).

## Georgia

### ***Dominant insurer plans to stay in ACA Marketplace for 2018***

Blue Cross and Blue Shield (BCBS) of Georgia announced last week that it will participate in the Affordable Care Act (ACA) Marketplace for all counties in the state.

The move came as a relief to state insurance officials, who had openly worried that consumers in many rural areas would be left with no participating insurers for 2018 after BCBS officials stated that they would “re-evaluate” whether to participate if the cost-sharing reductions under the ACA were terminated (see above). BCBS is the lone insurer for 96 of 159 counties in Georgia, following the exit of Aetna and UnitedHealthcare last year.

Kaiser Permanent, Ambetter, and Alliant will also return to the Marketplace for 2018, although they primarily serve northern parts of Georgia (including Atlanta). As a result, southern counties served only by BCBS are likely to see dramatically higher premiums as confirmed by a recent study from The Urban Institute, which found that consumers with only one insurer face average rate hikes of nearly 30 percent (with median monthly premiums of \$451) compared to the 12 percent average hike in regions with 3-5 insurers (whose median premium is \$317). Regions with only one insurer are typically found in southern FFM states like Georgia and 98 percent of them are served by a BCBS carrier.

Georgia’s federally-facilitated Marketplace has struggled with enrollment throughout its existence, signing-up only about 494,000 consumers in 2017—a significant 16 percent decline from the year before. According to the Kaiser Family Foundation, only about 41 percent of eligible Marketplace consumers have actually enrolled in Georgia.



Illinois

***House and Senate pass measure to protect from pre-existing condition exclusions***

Both the House and Senate have passed H.B. 2959, which mirrors the Affordable Care Act (ACA) prohibition on pre-existing condition exclusions in the event it is repealed by Congress.

The American Health Care Act (AHCA) that Congress is currently considering does not eliminate the pre-existing condition prohibition under the ACA. However, it does allow states to procure federal waivers that would allow insurers to again charge dramatically higher premiums for those with costly pre-existing conditions (see above).

Kansas

***Dominant Marketplace insurer likely to continue Marketplace participation***

Blue Cross Blue Shield (BCBS) of Kansas announced this week that it made a “preliminary decision” to continue participating in the Affordable Care Act (ACA) Marketplace that the federal government currently operates for Kansas.

The insurer filed initial paperwork with the Department of Insurance but does not have to file proposed rates until July or make a final decision until September. However, a company spokesperson indicated that the decision will ultimately rest on whether Congress continues to fund the cost-sharing reductions under the ACA (see Update for Week of May 8<sup>th</sup>).

BCBS’ participation is critical to the Kansas Marketplace, as its only competition is from Medica, which capped enrollment at 10,000 (compared to over 90,000 for BCBS). Medica has also already indicated that it may exit the Marketplace in neighboring Iowa next year (see Update for Week of May 8<sup>th</sup>) and has yet to make “any decision about Kansas.”

BCBS of Kansas operates in every county except Wyandotte and Johnson. Those counties are covered by BCBS of Kansas City, which elected this week to exit all Marketplaces for 2018 (see below). For the time being, each county will be served only by Medica.

Maine

***Senator files legislation to prohibit price-gouging for “essential” drugs***

Senator Eloise Vitelli (D) introduced L.D. 1605 last week, which would seek to prohibit price-gouging in the sale of essential off-patent or generic drugs.

The measure is similar to the price-gouging prohibition that the Maryland General Assembly recently sent to Governor Larry Hogan (R), and bills considered in the legislatures for Connecticut and Rhode Island (see Update for Week of May 8<sup>th</sup>). It would specifically require the Maine Health Data Organization, upon the request of the Attorney General, to annually identify prescription drugs on which the State spends significant amounts of money and for which the manufacturer’s list price for the drug has increased by 50 percent or more over the past five years or 15 percent or more over the past 12 months.

In addition, cited manufacturers must provide the Attorney General by March 1<sup>st</sup> of each year with a description of all manufacturer-sponsored assistance programs for that drug in the previous year, including the total amount of financial assistance provided to residents and the average amount of assistance per resident.

Manufacturers must respond to requests from the Attorney General to provide data justifying the price increase within 20 days or face civil penalties.



As with the Maryland bill, “essential drugs” would be defined as those found under the Model List of Essential Medicines published by the World Health Organization and for which all exclusive marketing rights have expired.

#### Missouri

##### ***BCBS exit leaves 25 counties with no Marketplace insurers***

Blue Cross Blue Shield of Kansas City (Blue KC) announced this week that it will not offer plans in Affordable Care Act (ACA) Marketplaces for next year due to more than \$100 million in losses through 2016 and the “current uncertainty” of the future of the Marketplaces.

Although Blue KC participated in the Marketplaces for 32 counties in both Kansas and Missouri, its departure will have the steepest impact in Missouri, where it was the lone participating insurer for 25 counties in the western part of the state. As a result, about 19,000 current enrollees will have no Marketplace coverage options for 2018 unless another insurer steps in.

In response, U.S. Senator Claire McCaskill (D-MO) filed legislation this week (S.1201) that would allow Marketplace consumers in counties with no participating insurers to purchase coverage from the Marketplace for the District of Columbia, the same Marketplace that serves federal employees including members of Congress and their local staff.

Blue KC’s medical-loss ratio (MLR) had improved for each year it participated in the Marketplaces, falling for the first time below 100 percent during 2016 (meaning it took in more premiums than it paid out in claims). However, Blue KC officials insisted that that number needed to be closer to 90 percent instead of 98 percent in order to ensure profitability and that the potential loss of cost-sharing reductions under the ACA would prevent it from doing so (see above).

Humana has already left the Marketplace for Missouri and CIGNA has yet to decide whether to do so. Blue Cross and Blue Shield of Kansas plans to stay in the Marketplace for Kansas in 2018 (see above), despite having a worse MLR than Blue KC.

#### New Hampshire

##### ***Governor and Insurance Commissioner support waivers to opt-out of ACA protections***

Governor Chris Sununu (R) and Insurance Commissioner Roger Seigny (R) endorsed legislation this week that give them the authority to opt-out of key provisions of the Affordable Care Act (ACA), including those that prohibit premiums from being increased due to pre-existing conditions.

The amendment to H.B. 469 would let either individual seek federal waivers from ACA restrictions if necessary to keep health insurance affordable and available to state residents, contingent on Congress passing the American Health Care Act (AHCA). The ACA currently grants Section 1332 waivers to states that wish to experiment with their own reforms, so long as they are budget neutral and ensure coverage is not narrowed from ACA levels (see Update for Week of January 9<sup>th</sup>). However, provisions of the AHCA would remove those restrictions and allow states to opt-out of essential health benefit standards and community rating limits, thereby allowing “junk” coverage that lowers premiums for young adults while dramatically increasing costs for older consumers (see above).

Commissioner Seigny stressed that the waivers were needed to combat premium hikes in the ACA Marketplace, which a recent report in the *New Hampshire Sunday News* claims could approach 44 percent for 2018. The Commissioner’s own data shows that insurers lost \$43 million in the individual market last year (losing ten cents for every premium dollar collected). Only one of the four insurers participating in the Marketplace made a profit last year (Ambetter).



Both the Governor and Insurance Commissioner stressed that H.B. 469 would resurrect the state high-risk pool that New Hampshire operated prior to the ACA. It would also give the state the discretion to create a reinsurance program to compensate insurers for exceptional claims, similar to the reinsurance program that the ACA offered from 2014-2016 and which Alaska and Minnesota have already created (see Update for Week of May 8<sup>th</sup>).

#### New Mexico

##### ***New study shows ACA repeal and replace bill would adversely impact New Mexicans***

An analysis released earlier this month by the Robert Wood Johnson Center for Health Policy at the University of New Mexico projects that federal funding reductions resulting from the current version of the American Health Care Act (AHCA) in Congress would dramatically increase uncompensated care costs, while slashing jobs, wages, and tax revenues.

The study showed that the AHCA's phase-out of the Medicaid expansion under the Affordable Care Act (ACA) and the imposition of per capita spending caps for the Medicaid program would shift \$427 million of Medicaid costs to New Mexico from 2020 through 2026 and cost the state nearly \$11.5 billion in federal funds. These cuts would also cost New Mexico roughly 31,800 jobs, \$1.6 billion in wages and salaries, and \$759 million in state tax revenues.

More than 265,000 New Mexicans have enrolled in Medicaid as a result of the ACA expansion or nearly a third of all 900,000 Medicaid enrollees.

#### North Carolina

##### ***BCBS blames 60 percent of rate hike on uncertainty about ACA cost-sharing subsidies***

Proposed Marketplace premiums filed this week by Blue Cross and Blue Shield (BCBS) of North Carolina show that consumers will likely face an average rate increase of nearly 23 percent for 2018, unless the Trump Administration provides greater certainty about the availability of cost-sharing reductions (CSRs) under the Affordable Care Act (ACA).

The dominant carrier in North Carolina's federally-facilitated Marketplace (FFM) publicly blamed 60 percent of their proposed increase on the delay in the Administration's decision whether to terminate the CSRs (see above). BCBS officials stressed that their average 2018 increase would be only 8.8 percent if the CSRs were certain to be available for the entire plan year, the lowest increase they have sought since the Marketplaces opened and almost a third of the average 24.3 percent increase they received for 2017.

BCBS will control almost all of the Marketplace next year following the departures of Aetna, UnitedHealthcare, and Humana. CIGNA remains the only significant competitor in five counties but their continued participation for 2018 remains uncertain.

#### Oregon

##### ***Marketplace insurers scale back coverage, hike rates in response to ACA repeal threat***

The six participating insurers in Cover Oregon have agreed to participate for 2018, but are reducing their coverage areas seeking to increase premiums by nearly 20 percent in large part due to the uncertainty over if and how the Affordable Care Act (ACA) will be repealed and replaced.

The Department of Consumer and Business Services (DCBS) had allowed insurers to delay their 2018 rate filings for two weeks (until May 15<sup>th</sup>) in order to recalculate premiums following passage of the American Health Care Act (AHCA) earlier this month (see above).



Providence Health Plan is the only Cover Oregon carrier offering statewide coverage for 2018. However, they are seeking a 20.7 percent average rate hike due to expected “market volatility and weakening of the [ACA] individual mandate [which will cause a] market contraction where healthier individuals are more likely to forego coverage.”

Providence expects that it will have roughly 42 percent fewer Marketplace enrollees in 2018, while BridgeSpan is projecting that sign-ups will drop by nearly a third. Although BridgeSpan offered statewide coverage in 2017, they are responding by dramatically limiting 2018 coverage only to three large counties and hiking premiums by more than 17 percent on average.

Atrio is seeking the largest increase of 21.8 percent and is likewise reducing coverage from six counties to only two. Two insurers that already reduced their coverage areas for 2017 (Moda Health and PacificSource) proposed much lower average rate hikes (about 13 and seven percent respectively).

Kaiser Permanente is the only Cover Oregon insurer predicting a slight increase in enrollment, which it attributes to increasingly competitive rates.

As a result of the more limited coverage, three counties (Lane, Lincoln, and Tillamook) will now be served by only one Marketplace insurer in 2018 (Providence).

The House passed H.B. 2342 last week, which would give DCBS the authority to take emergency actions necessary to stabilize the individual market if Congress passes the AHCA (see above).