Health Reform Update – Week of August 14, 2017

CONGRESS

Senate dramatically rejects attempts to repeal the Affordable Care Act

Surprise defections and parliamentarian rulings blocked Senate Republicans last month from passing any form of legislation to repeal key provisions of the Affordable Care Act (ACA).

The Senate initially rejected the Better Care Reconciliation Act (BCRA), their modified House-passed bill (H.R 1628) that sought to repeal key provisions of the ACA including the Medicaid expansion, allowed insurers to offer limited-benefit coverage, and offered less generous tax credits. In addition, it sought to convert Medicaid into a "block grant" program with per enrollee spending caps. Due to a 35 percent cut in Medicaid funding to states, the BCRA never had the support of key moderate Senators but also was opposed by several conservatives who believed it did not go far enough in repealing the ACA (see Update for Week of July 10th).

The Senate parliamentarian effectively doomed the BCRA when she blocked a dozen provisions from the budget reconciliation process, which needs only 50 votes to pass. These included some of the most popular provisions for conservatives, including waivers that would allow states to opt-out of consumer protections like essential health benefits and community rating (barring insurers from raising premiums due to pre-existing conditions). As a result of the rulings, the waivers and provisions allowing insurers to charge old consumers 500 percent or more than younger consumers needed a filibuster-proof majority to pass. The "lock-out" period preventing consumers from buying individual market coverage for six months if they have more than a 62-day lapse in coverage also would need 60 votes.

The BCRA ultimately came-up seven votes short of passage. However, Senate leaders were also unable to pass their primary alternative, which was to resurrect their 2015 reconciliation bill (vetoed by President Obama) that would have repealed the ACA's premium and cost-sharing subsidies, most ACA taxes, and the Medicaid expansion—all following a two-year "transition period" (see Update for Week of January 4, 2016). This "repeal and delay" path was favored by President Trump (see Update for Week of January 30th). However, five Senators largely agreed with insurers that it would immediately destabilize the ACA Marketplaces.

Senate leaders were consequently left with no option but to pursue a "skinny" repeal that eliminated only the ACA's individual mandate, delayed the employer mandate and tax on medical device manufacturers, and included no changes to Medicaid. The move was intended solely to get to a conference committee with House and Senate leaders from both parties in order to resolve differences between their bills.

Majority Leader Mitch McConnell (R-KY) received assurances from House Speaker Paul Ryan (R-WI) that the "skinny" repeal would not be passed by the House without a conference and thought he had the votes when he introduced it during a late-night session. However, in a rare legislative surprise, Senator John McCain (R-AZ) joined with Senators Susan Collins (R-ME) and Lisa Murkowski (R-AK) in opposing the "skinny" repeal, causing the legislation to fail by a single vote.

House and Senate eye bipartisan Marketplace stabilization measures

The current impasse over Affordable Care Act (ACA) repeal and replace legislation leaves both House and Senate leaders with little alternative but to pursue a bipartisan compromise bill that would stabilize the ACA Marketplaces in the short term.

Senate Republicans need the support of least eight Democrats to proceed with such an "ACA fix" and Democratic leaders have already outlined several improvements they would support. These include federal funds for states to create reinsurance programs that replace the extra compensation insurers received during the first three years of the ACA for extraordinary claims, which the Trump Administration has already approved for Alaska (see Update for Week of July 10th). Other changes likely to have bipartisan support include basing ACA tax credits on age as well as income, allowing the credits to be used to purchase certain types of non-Marketplace coverage, and guaranteeing the availability of the ACA's cost-sharing reductions (see Update for Week of July 10th).

Senate Finance Committee chair Orrin Hatch (R-UT) confirmed last week that his committee will hold a September hearing on a bipartisan marketplace stabilization plan—a departure from the "repeal and replace" strategy that moved forward without any hearings. Meanwhile, the leader of the conservative House Freedom Caucus Mark Meadows (R-NC) is negotiating a compromise plan with leading moderate Tom McArthur (R-NJ) that would guarantee insurers will continue to receive the ACA cost-sharing reduction funding in exchange for providing states with greater flexibility to opt-out of key ACA provisions under Section 1332 waivers (see below).

A survey released last week by the Kaiser Family Foundation found that 78 percent of Americans want Congress to focus on ACA fixes instead of repeal, including a majority (52 percent) of Republicans.

House conservatives seek to force vote on "skinny" ACA repeal bill

Members of the House Freedom Caucus remain determined to force the chamber to vote on the "skinny" repeal measure that failed last month in the Senate by a single vote.

The move would effectively let House members decide whether to pass the identical versions of the Affordable Care Act (ACA) repeal bill that passed the House in 2015 before being vetoed by President Obama (see Update for Week of January 4, 2016). That measure would have created a two-year transition period and eliminated the ACA individual and employer mandates, premium and cost-sharing subsidies, and Medicaid expansion.

Speaker Paul Ryan (R-WI) has thus far insisted that the House lacks the votes to pass the 2015 repeal bill, noting that it would need approval from all but 22 of the 240 House Republicans. He continues to insist that the Senate needs to first act on the American Health Care Act passed earlier this year by the House (H.R. 1628), which provides a different path to repealing key ACA provisions in addition to overhauling Medicaid (see above).

America's Health Insurance Plans (AHIP) and consumer advocate Community Catalyst both testified last week before the health insurance task force created by the National Conference on State Legislatures (NCSL) that such a "skinny" repeal would "immediately destabilize" the individual health insurance market, even with a two-year delay.

President threatens to let ACA "implode" if Congress fails to move forward on repeal

With Congressional efforts to repeal the Affordable Care Act (ACA) stalled, President Trump urged lawmakers this week to simply "let Obamacare implode" in an effort to force Democrats and reluctant Republicans to negotiate a replacement plan that can pass both chambers.

The President has remained adamant that Republicans must fulfill campaign promises to repeal the landmark health insurance reform law and hold another Senate vote when lawmakers return in September. However, Senate leaders have shown little appetite to do so, given that they face deadlines

next month to raise the debt limit, continue funding the government, and reauthorize the Children's Health Insurance Program (CHIP).

Absent Congressional action, President Trump repeatedly has threatened to "implode" the Marketplaces by terminating the cost-sharing reductions (CSRs) under the ACA, which are provided to those earning 100-250 percent of poverty. America's Health Insurance Plans (AHIP) and insurers have argued would send the ACA Marketplaces into a "death spiral". The Congressional Budget Office (CBO) did not go that far, but did predict this week that eliminating the CSRs would cause gross premiums to spike by 20 percent in 2018 and up to 25 percent by 2020, while increasing the federal deficit by $194 billion through 2026.

The Trump Administration had the option of ending the CSRs simply by dropping an Obama Administration appeal of a lower Federal court ruling last year that found they were never lawfully appropriated by a Republican-controlled Congress (see Update for Week of May 16, 2016). However, 17 state attorneys general from Democrat-led states (and the District of Columbia) successfully persuaded the appellate court early this month to let them intervene and continue the appeal if the Trump Administration elects not to do so.

Despite the ruling, the Office of Management and Budget (OMB) still retains the authority to cease CSR payments each month. Thus far, it has committed to funding the CSRs only on a month-to-month basis, creating a level of uncertainty for Marketplace insurers that continues to cause substantial premium increases (see below). Insurers in federal Marketplaces (and some state-based Marketplaces) have contractual provisions allowing them to exit Marketplaces mid-year if the CSRs are not paid.

FEDERAL AGENCIES

HHS delays deadline for federal Marketplace insurers to set premiums

The Trump Administration announced last week that insurers in the federally-facilitated Marketplaces (FFMs) operated pursuant to the Affordable Care Act (ACA) will have until September 5th to submit all proposed rate filings for 2018.

The Centers for Medicare and Medicaid Services (CMS) acknowledged that the three-week extension was needed to accommodate the uncertainty created by Congressional efforts to repeal and replace the ACA (see above). In their bulletin, the agency specifically recognized that state insurance commissioners were allowing insurers to submit multiple rates in order to account or the "uncompensated liability" that may result if the cost-sharing reductions (CSRs) under the ACA were eliminated (see Update for Weeks of June 12th and 19th).

CMS to move forward with ACA cuts to indigent care funding for hospitals

The Centers for Medicare and Medicaid Services (CMS) surprised many hospital groups last month when it issued proposed rules that would implement the Affordable Care Act (ACA) cuts to disproportionate share hospital (DSH) funding.

Under the ACA, the $18 billion in annual DSH funds that hospitals receive for uncompensated care (as of 2014) was scheduled to be phased-down by $43 billion over seven years, starting in fiscal year 2014. However, the DSH cuts were included in the ACA under the assumption that every state would expand Medicaid to those earning up to 138 percent of the federal poverty level.

Congress delayed the cuts until fiscal year 2018 (which begins October 1st) following the U.S. Supreme Court decision that made the Medicaid expansion optional for states (see Update for Week of June 25, 2012). As a result, 19 states have still not expanded Medicaid. America's Essential Hospitals,

the American Hospital Association, the National Rural Health Associate, and other hospital groups warned that the DSH cuts would be devastating to providers in those opt-out states and force them to either eliminate services or staffing.

Congressional proposals to repeal and replace the ACA recognized this dilemma by specifically seeking to restore DSH funding to pre-ACA levels (see above). As a result, hospital industry groups were "very disappointed that CMS is moving forward with these cuts" absent any legislative correction.

CMS officials note that the proposed rule was structured to help mitigate harsher impacts on opt-out states by imposing the largest cuts only on states with the lowest percentage of uninsured.

HHS seeks delay in final rule capping Section 340B drug payments to safety-net providers

The Department of Health and Human Services (HHS) proposed this week to delay implementation of rulemaking finalized by the Obama Administration that would set a ceiling price on drugs purchased through the federal Section 340B drug program.

The final rule was set to go into effect last March but had been delayed three prior times. The Trump Administration has now decided to postpone any implementation until at least July 2018, insisting that it would be "disruptive" for drugmakers "to make targeted and potentially costly changes to pricing systems and business procedures in order to comply with a rule that is under further consideration and for which substantive questions have been raised."

The Pharmaceutical Research and Manufacturers of America (PhRMA) had sought the delay in order to negotiate revisions to the final rule that were adopted over their objections.

CMS is moving forward with a separate proposed rule that would cut Medicare payments for Part B drugs purchased by 340B providers by 22.5 percent of the average sales price (see Update for Week of July 10th). An upcoming executive order on drug pricing from President Trump was rumored to include directives that the HHS Secretary further reduce the size of the 340B program, which the pharmaceutical industry contends has far exceeded its initial intent (see Update for Weeks of July 1 and 8, 2013). However, the American Hospital Association and America's Essential Hospitals both stated last month that the President is leaning against including 340B directives and instead leaving decisions on the direction of the program largely up to Congress (see Update for Week of July 10th).

Spending under the 340B program has more than tripled since 2005 and the number of safety-net providers receiving the discount drugs have more than doubled in the last five years. Drug sales under 340B reached $16.2 billion in 2016, a 34 percent spike from the year before. It now accounts for five percent of all prescription drug sales (see Update for Week of July 10th).

The dramatic growth has raised heightened scrutiny among lawmakers and federal regulators about whether the discounts are benefiting those in need and resulting in "windfall" profits for providers. A related Congressional hearing last month focused on ways that both Congress and HHS and improve oversight and transparency to ensure savings from the discounted drugs are being appropriately used.

Appeals court overturns order for HHS to reduce backlog of Medicare appeals in four years

The U.S. Court of Appeals for the District of Columbia has invalidated a December 2016 court order to would have required the Department of Health and Human Services (HHS) eliminate its backlog of pending Medicare reimbursement appeals in four years.

According to HHS, more than 500,000 appeals remained pending at the administrative law judge (ALJ) level. As of 2015, appeals were taking about 547 days to resolve compared to only 95 days in fiscal year 2009 (see Update for Week of May 4, 2015). The backlog is due largely due a record number

of appeals being submitted (more than 700,000 in fiscal year 2013) while claims appeal staff has remained constant. As a result, the office is no longer hearing new appeal cases.

The American Hospital Association (AHA) brought suit in 2014 seeking to reduce this backlog and successfully obtained an order from the D.C. Circuit requiring HHS to achieve a 30 percent reduction in the backlog by the end of 2017, a 60 percent reduction by the end of 2018, a 90 percent reduction by the end of 2019, and a full reduction by the end of 2020. However, two of the three judges hearing the appeal (including chief judge Merrick Garland whose nomination by President Obama to the U.S. Supreme Court was blocked by the Senate) remanded the case back to D.C. Circuit, suggesting that the ambitious timetable set by the lower court may be "impossible" to achieve. Judge Karen Henderson (appointed by President George H.W. Bush) dissented, insisting that remanding the case would "waste time and [punish] blameless Medicare providers."

STATES

Marketplace consumers buying silver plans will likely see "modest" rate hikes for 2018

The Kaiser Family Foundation released a limited analysis this week of proposed rate filings for 2018 showing that while Marketplace premiums are expected to vary dramatically across 21 major cities, average increases for most consumers are expected to be "modest".

The study focused only on premiums for "benchmark" silver tier plans, which are the plans on which the Affordable Care Act (ACA) premium tax credits are based and thus the choice of 71 percent of Marketplace consumers. It found that across the 21 cities, proposed monthly premiums for a 40 year old non-smoker range from $244 in Detroit, Michigan to $621 in Wilmington, Delaware (before tax credits are reflected). This would result in some consumers seeing premiums actually fall by as much as five percent (for Providence, Rhode Island) while others could face up to a 49 percent increase (for Wilmington). In about half of the 21 cities, premiums will increase by less than 15 percent on average. Benchmark plan consumers in Burlington, Vermont will see no change in their $491 average monthly premium.

When factoring in the premium tax credits, the overall impact of the rate hikes would be far more muted and actually result in a three percent average decline for a single adult earning $30,000 per year.

Kaiser notes that the proposed rate hikes have remained "modest" despite insurers adding up to 23 percent to their proposed premiums due to "uncertainty" caused by the potential loss of ACA cost-sharing reductions or repeal of other key ACA provisions. Researchers note that most insurers that were concerned about this "uncertainty" were choosing simply to exit the Marketplaces for 2018 (see below), as across the 20 states surveyed (in addition to the District of Columbia), an average of only 4.6 insurers per state committed to participating in Marketplaces next year (down from 5.1 in 2017 and 6.2 in 2016).

Only two counties currently have no ACA Marketplace options for 2018

Centene Corporation announced this week that it will offer Affordable Care Act (ACA) Marketplace plans for all of Nevada's 17 counties.

The move was a major victory for Governor Brian Sandoval (R), who had heavily lobbied Centene to expand its coverage to the 14 counties that were left without any coverage when Anthem exited the Marketplace last June and Aetna recently abandoned plans to cover those "bare" counties.

Centene previously agreed to cover nearly all of the "bare" counties in Missouri (see Update for Week of July 10th), as well as two counties in Indiana and Wisconsin that were also left without any Marketplace insurers for 2018 (Centene is expanding from 32 to 49 counties in Indiana). Centene officials have repeatedly emphasized that these counties represent a "strong business opportunity" for the

insurer, which has been very profitable operating as a Medicaid managed care insurer in Nevada, Missouri, and several other states.

According to the Kaiser Family Foundation, more than 60 counties were at one point this year left without any Marketplace options for 2018. However, as of August 15th only two rural counties in Ohio (see below) and Wisconsin remain "bare" for 2018 following Centene's aggressive expansion into unserved areas and the agreement of several insurers in Washington's Marketplace to expand their coverage areas (see Update for Week of July 10th). Optima Health also agreed to expand into 50 Virginia counties that were threatened to be left "bare" by the loss of Aetna and Anthem (just last week).

Despite the dramatic improvement, Kaiser emphasizes that more than 1,000 counties nationwide still will have only one Marketplace insurer in 2018, which could result in steep premium increases for those non-competitive areas.

Colorado

Marketplace insurers agree to return but are seeking hefty premium increases

The Division of Insurance released proposed rate filings last month for the seven insurers that have committed to continuing their participating in Connect for Health Colorado for 2018.

Retaining all seven insurers was a critical goal for the Division, as most have limited their coverage areas only to certain counties in the state. Of the 64 counties in the state, 14 are served only by Anthem Blue Cross and Blue Shield, while 53 have three or fewer Marketplace insurers.

However, the insurers are seeking a 27 percent average proposed rate hike for next year, due largely in part to the uncertainty and instability created by the Trump Administration's threats to terminate the cost-sharing reductions under the Affordable Care Act (ACA) or guarantee enforcement of the law's individual mandate (see above). Unlike federal Marketplaces, insurers in Connect for Health Colorado cannot exit the Marketplace mid-year if the CSRs are eliminated, causing dominant insurers like Anthem and CIGNA to increase rates by a dramatic average of 30.2 and 44.3 percent respectively.

A Kaiser Family Foundation analysis of the proposed rate filings found that for a 40-year-old non-smoker, the unsubsidized premiums for the "benchmark" silver plan (to which ACA premium tax credits are based) will be 12 percent higher in 2018 for those in the metro Denver area.

Insurance Commissioner Marguerite Salazar (D) emphasized that the Division has the authority to reduce rate proposals that are not "actuarially justified" but acknowledges that most of the increases may be granted due to the "dubious situation at the Federal level [that] has contributed to the premium increase requests."

The Commissioner has already tried to accommodate insurer risk pool concerns by extending the open enrollment period by four weeks (to January 12th). Open enrollment for federal Marketplaces will be cut this year to only six weeks (from November 1st through December 15th). However, Colorado is one of six state-based Marketplaces that have extended the enrollment deadlines beyond the federal minimum (see District of Columbia below).

District of Columbia

ACA Marketplace will retain all insurers, expand coverage options for 2018

DC Health Link has confirmed that it will retain all participating insurers for both the individual and small group versions of the Marketplace it created pursuant to the Affordable Care Act (ACA).

According to Kaiser Family Foundation, DC Health Link has been among the most successful of any state-based or federally-facilitated Marketplace in the nation, enrolling nearly three-quarters of all

eligible residents. Kaiser acknowledges that DC Health Link is aided by two unique factors. The first is that members of Congress and their staff are required to enroll in DC Health Link for their coverage. The second is that DC Health Link is the only ACA Marketplace besides Vermont Health Connect (see below) that does not allow off-Marketplace coverage for individuals. (However, researchers note that Vermont Health Connect has enrolled only about half of eligible residents.)

The success of DC Health Link has enabled the District of Columbia to attain the third lowest uninsured rate in the nation (at just 3.7 percent in 2016 according to the National Center for Health Statistics).

In an effort to continue to maximize enrollment, DC Health Link is also the only Marketplace in the country that has retained the three month open enrollment period from 2017 (running from November 1st through January 31st). Five other state-based Marketplaces have so far extended their open enrollment deadline from the six-week period that the Trump Administration has set for federally-facilitated Marketplaces (see Update for Week of July 10th) but none will remain open as long as DC.

The two insurers participating in DC Health Link's individual Marketplace will increase their plan options from 20 to 26 for next year but increase premiums by a steep average of just over 26 percent. This includes a nearly 40 percent increase for CareFirst Blue Cross and Blue Shield's HMO option. CareFirst proposed a nearly 20 percent hike for its PPO option, while Kaiser Permanente requested only a 13 percent increase.

For the small group market, plan options will increase from 151 to 158, while premium increases will be far more restrained (11.4 percent on average) among the four participating insurers (including CareFirst and Kaiser).

Florida

Marketplace insurers seeking 14 percent average rate hike for 2018

Six insurers will participate in the federally-facilitated Marketplace (FFM) for Florida in 2018, with Humana being the lone insurer choosing to exit.

Florida Blue will continue to be the only Marketplace insurer offering coverage in 49 of Florida's 67 counties, including most of the northern part of the state. They are seeking premium increases next year that range from nine to 24 percent (or six to 11 percent for the HMO Health Options plan), but have repeatedly warned that premiums will be increased across-the-board by 20 percent if the Trump Administration follows through on threats to eliminate the cost-sharing reductions under the Affordable Care Act (see above).

Centene has agreed to expand their coverage area for 2018, as they are doing nationwide (see above). They are seeking a 12.4 percent average increase, which is below the 17.8 percent average increase sought by all five insurers. The largest increases belong to Molina Health Plan and AvMed, which are seeking increases that range from 37 to 44 percent.

Nearly 1.8 million consumers enrolled in Florida's Marketplace during the 2017 open enrollment period, far surpassing totals for the next two closest states (California and Texas).

Iowa

Lone Marketplace insurer seeking 57 percent premium increase

The lone insurer agreeing to participate in the Affordable Care Act (ACA) Marketplace for Iowa has proposed a staggering 57 percent average increase in premiums for 2018.

The rate hike is 13 percent higher than previously estimated by Medica, which blamed the increase on "uncertainty" over whether the Trump Administration will continue the cost-sharing reductions under the ACA (see above). Roughly 34 percent of the 72,000 Marketplace enrollees receive the CSRs.

Medica became the lone insurer after Aetna and Wellmark Blue Cross and Blue Shield decided earlier this year to leave the Marketplace for 2018 (see Update for Week of May 8th).

The Division of Insurance will review whether the proposed rates are actuarially justified and issue a final determination this fall.

Massachusetts

ACA health insurance cooperative placed into receivership

The Department of Insurance announced this week that it had reached agreement with their counterparts in New Hampshire to place Minuteman Health into receivership.

Minuteman Health was one of only five surviving health insurance cooperatives created with Affordable Care Act (ACA) loans (see Update for Week of November 30, 2015). It had been very successful at recruiting consumers, enrolling 27,000 Marketplace consumers in New Hampshire, which exceeded the totals of dominant insurers Anthem Blue Cross and Harvard Pilgrim.

However, Minuteman Health relied on aggressive pricing to beat out its competitors, and consistently offered the lowest premiums in New Hampshire Marketplace. As with the majority of the other 18 failed cooperatives, shortfalls in federal risk corridor and reinsurance payments for exceptional claims caused the cooperative's financial condition to deteriorate in 2017, forcing it to file a lawsuit against the federal government in an effort to recover $16.7 million in unpaid funds (see Update for Week of August 15, 2016) and decide last June to exit the Marketplace for 2018. Its surplus has continued to fall to a point where the cooperative was at risk of not being able to pay all claims, thus triggering the receivership action in Massachusetts.

Regulators in both states insist that Minuteman Health still has adequate funding to meet all obligations to consumers through 2017 and that no current Marketplace policies will be cancelled.

New Hampshire

Three Marketplace insurers to remain for 2018

Three of the four 2017 insurers in New Hampshire's Affordable Care Act (ACA) Marketplace have confirmed that they will continue to participate for 2018.

Insurance Commissioner Roger Sevigny praised the news as "incredibly encouraging" given the "unprecedented instability [and] uncertainty coming from Washington D.C." Both Sevigny and Governor Chris Sununu (R) had heavily lobbied the state's largest insurer Anthem Blue Cross to remain in the Marketplace, following their decision to exit most of their other Marketplaces, most recently including Nevada and Virginia (see above).

Anthem, Harvard Pilgrim, and Ambetter will continue to offer coverage in both the Marketplace and the Premium Assistance Program, New Hampshire's version of the Medicaid expansion (see below). However, the leading insurer from last year, the non-profit cooperative Minuteman Health, failed in its effort to secure licensing approval for a new private company prior to this week's federal deadline. Due to deteriorating finances, it had already announced that the cooperative would not offer coverage in 2018 (see Massachusetts above).

Commissioner Sevigny has encouraged lawmakers to seek federal waivers for a state reinsurance program, similar to those created in Alaska and Minnesota (see Update for Week of July 10th), in order to mitigate premium increases of up to 40 percent from the three Marketplace insurers.

Medicaid expansion threatened by illegal hospital donations

The federal Centers for Medicare and Medicaid Services (CMS) notified Governor Chris Sununu (R) last week that a fund created in 2015 to pay for the state's share of their Medicaid expansion alternative under the Affordable Care Act (ACA) violates federal law and must be fixed by the end of fiscal year 2018.

The fund is partly supplemented by voluntary donations from hospitals. Although CMS approved the funding mechanism as part of the federal waiver allowing New Hampshire's Premium Assistance Program, the agency has now determined that the donations represent a "quid pro quo" since they effectively are being returned to hospitals via higher Medicaid revenue. According to CMS, "Medicaid expansion is [being[conditioned on the receipt of donations as articulated in New Hampshire legislation" and must be corrected for the expansion to continue.

According to the Kaiser Family Foundation, all states except Alaska rely on provider taxes and fees to fund at least part of the state share of Medicaid expansion costs (which increases to ten percent in 2020 and subsequent years). However, CMS distinguishes between mandatory provider taxes and voluntary donations, as the former are not paid on the expectation "that a provider will receive back in Medicaid reimbursements an amount equivalent or greater than the tax that was paid."

According to state officials, 52,000 New Hampshire residents are covered under the Medicaid expansion as of August 1st. The state currently receives more than $300 million in federal matching funds for covering new adults, which accounts for nearly one-third of all federal Medicaid funding for New Hampshire. As a result, Governor Sununu pledged this week that state officials would fix the funding formula instead of allowing that federal funding to end after fiscal year 2018.

<u>Ohio</u>

Insurers fill bare counties but seek dramatic premium increases

The Department of Insurance announced last week that five insurers including Molina Health Care of Ohio and Buckeye Health Plan have agreed to expand coverage through the Affordable Care Act (ACA) Marketplace in 19 of the 20 counties that had no Marketplace options for 2018.

The move makes Paulding County in rural northwestern Ohio the only county that remains unserved in the Marketplace. Department officials insisted that they would continue working with other Marketplace insurers to get that county covered before the September 27th deadline to sign contracts with the federally-facilitated Marketplace, as it remains one of only two bare counties nationwide (see above).

The Department is in the process of reviewing and finalizing proposed Marketplace premium increases for 2018, which have been substantially higher than last year due to "uncertainty" surrounding the potential Congressional repeal of key ACA provisions (see above). For example, Summa is proposing a 41 percent average rate hike for the most popular silver tier plans, while Care Source and Paramount Insurance Company are seeking 36 percent average increases across all plans. Molina, which has already exited the Utah and Wisconsin Marketplaces entirely, warned that it would be forced to add an extra 21.4 percent to the 24 percent average increase it already is seeking should the Trump Administration end the cost-sharing reductions under the ACA (see above).

Vermont

Marketplace board approves only single-digit premium increases for 2018

The Green Mountain Care Board announced last week that it has approved only single-digit premium increases for the two insurers participating in the Marketplace that Vermont created pursuant to the Affordable Care Act (ACA).

The Board reduced the 12.7 percent average increase sought by dominant carrier Blue Cross and Blue Shield (BCBS) of Vermont, allowing their rates to increase by only 9.2 percent. BCBS officials immediately expressed concern that the rate hike may not accommodate the higher costs that could result if the Trump Administration ends the cost-sharing reductions under the ACA or Congress repeals key provisions of the law (see above). They have the option to appeal the rate reduction but confirmed their intent to participate in 2018 even if such an appeal is denied. (BCBS has never appealed the board's rate modifications in the past.)

The Board also cut the rate proposal from MVP Health Care by nearly half (allowing only a 3.5 percent average increase instead of 6.7 percent). However, MVP only covers about 10,000 of the 80,000 Vermonters enrolled in Marketplace coverage.

Vermont is the only state (besides the District of Columbia) that made the Marketplace the lone source of individual market coverage for residents (see above). Despite this requirement, only about half of all eligible residents have enrolled in individual coverage through the Marketplace.