



## Health Reform Update – Week of August 28, 2017

### CONGRESS

#### ***Senate HELP committee plans four hearings on bipartisan market stabilization plans***

The chairman of the Senate Health, Education, Labor, and Pensions (HELP) committee announced this week that his committee will hold two additional market stabilization hearings next month on top of the two hearings already slated for next week (see Update for Week of August 14<sup>th</sup>).

Chairman Lamar Alexander (R-TN) is pushing Republican Senators to work with Democrats on a bipartisan plan to mitigate premium increases and insurer departures within the Affordable Care Act (ACA) Marketplaces. He insisted this week that a plan would be ready by September 27<sup>th</sup> even though only 12 legislative days are scheduled for this month, during which time Senators must pass legislation raising the debt ceiling, funding the government past the September 30<sup>th</sup> end of the fiscal year, and reauthorizing the Children's Health Insurance Program (CHIP).

Chairman Alexander acknowledged that passage of a stabilization plan would be "difficult" given pressure from more conservative members and President Trump to resurrect failed efforts to repeal and replace the ACA (see Update for Week of August 14<sup>th</sup>). However, the Senate parliamentarian narrowed the window for the Senate to pass repeal measures through budget reconciliation (requiring only 50 votes) by ruling this week that the reconciliation authorization contained in the fiscal year 2017 budget bill would also expire on September 30<sup>th</sup> and both House and Senate leaders have thus far shown little appetite for renewing the repeal effort.

There appears to be broad bipartisan agreement that any market stabilization bill will continue funding for the ACA's cost-sharing reductions (CSRs), as insurers have largely cited "uncertainty" over whether the CSRs will continue as the primary factor in 2018 premium increases (see Update for Week of August 14<sup>th</sup>). Ranking member Senator Patty Murray (D-WA) insisted this week that continued CSR funding was critical to securing any bipartisan support but would not state for what length of time Democrats would demand they be funded.

Republican lawmakers are largely demanding that any market stabilization bill include increased flexibility for states to secure Section 1332 waivers allowing them to opt-out of key ACA provisions to experiment with alternative reforms (see below). However, extending the ACA's reinsurance payments to cover insurer's exceptional claims costs is currently not on the table according to senior committee aides, even though it is a critical component in the stabilization plan sought by a bipartisan group of governors and strongly supported by the Trump Administration (see below).

#### ***Governors release their market stabilization plan***

Governors John Hickenlooper (D-CO) and John Kasich (R-OH) released a list of immediate actions Congress should take to stabilize and strengthen the individual health insurance market.

Their letter was joined by Democratic governors in Louisiana, Montana, Pennsylvania, and Virginia, as well as the Republican governor in Nevada and independent governor in Alaska. It was intended to create a blueprint for Congress to follow in advance of Senate hearings scheduled next week on potential market stabilization legislation (see above), one of which will feature the Colorado and Montana governors as witnesses.



The governors stressed the continued “uncertainty [regarding the] direction of federal policy” has led to dramatic premium increases and limited competition in nearly 1,500 counties nationwide (see below).

The “immediate federal action” sought by the governors was headlined by their demand that Congress guarantee it will fund the cost-sharing reductions (CSRs) under the ACA through at least 2019. Major insurers have cited the Administration’s unwillingness to fund CSRs on more than a month-to-month basis as the primary factor causing them to increase premiums by an average of 20 percent or more for 2018 (see Update for Week of August 14<sup>th</sup>).

The letter also urges Congress to create a \$15 billion fund that states can use to create a reinsurance program (or similar initiatives to reduce individual market premiums). The Trump Administration has already agreed to federally-fund the reinsurance program that Alaska created last year, which dramatically reduced rate hikes by compensating insurers for exceptional claims, as the ACA did from 2014-16 (see Update for Week of July 10<sup>th</sup>). Minnesota has created a similar reinsurance program and at least ten other states are considering bills that would authorize one (see Update for Weeks of May 29<sup>th</sup> and June 5<sup>th</sup>). Senate Democrats have already introduced legislation (S.1354) that would restore the ACA’s reinsurance payments and make them permanent (see Update for Weeks of June 12<sup>th</sup> and 19<sup>th</sup>).

The governors also propose that Congress foster greater Marketplace competition in rural areas by exempting insurers from the ACA’s annual excise tax if they are in one of the nearly 1,500 counties that currently have only one participating insurer for 2018.

The letter strongly encourages Congress to leave the individual mandate under the ACA in place until Congress can enact a “credible replacement.” The Trump Administration’s unwillingness to state whether the mandate will continue to be enforced by the Internal Revenue Service has also been identified by insurers as a primary factor in 2018 rate hikes (see Update for Weeks of June 12<sup>th</sup> and 19<sup>th</sup>).

The recommendations also include an admonition for the Trump Administration to promote “appropriate enrollment” in the ACA Marketplaces and restore funding for outreach and enrollment efforts, especially towards the critical young adult demographic (age 18-34) that are so critical to maintaining balanced risk pools. The Department of Health and Human Services (HHS) was heavily criticized this week for slashing 2018 funding advertising and outreach efforts by 90 percent (see below).

The list also includes recommendations long-favored by more conservative lawmakers, including stronger verification of consumer eligibility for special enrollment periods, shorter grace periods for non-payment of premiums, and giving states greater flexibility to choose benchmark plans for the ten essential health benefit categories mandated by the ACA.

A critical recommendation would also let HHS streamline the process for granting Section 1332 waivers under the ACA, which lets states opt-out of key ACA provisions and experiment with alternative reforms that are deficit neutral and provide equivalent coverage levels. The letter does not specifically seek the statutory removal of these two requirements (as Republican governors have sought) but would let states build upon previously-approved waivers granted to other states. Hawaii and Alaska are the only two states to receive approved Section 1332 waivers since they became an option on January 1<sup>st</sup> (see Update for Week of August 14<sup>th</sup>). Minnesota and Iowa (see below) are awaiting decisions from HHS.

The governors insist that Congressional reforms “should not shift costs to states or fail to provide the necessary resources to ensure that the working poor or those suffering from mental illness, chronic illness or addiction can get the care they need.” Moderate Republicans who opposed recent Congressional efforts to repeal and replace the ACA cited concerns that block-granting Medicaid, limiting the amount of premium and cost-sharing subsidies, and increasing the share of insurance costs to be borne by consumers all failed to comply with these standards (see Update for Week of August 14<sup>th</sup>).



Consumer groups such as the National Organization for Rare Disorders (NORD) also submitted market stabilization proposals that included similar elements but also urged Congress to limit cost-sharing for specialty tier drugs and ensure the availability of premium assistance from charitable non-profits like PSI. However, the NORD letter specifically warned Congress about letting states use increased flexibility under Section 1332 waivers to effectively discriminate against persons with costly pre-existing conditions.

### ***Senate Democrat proposes Medicaid buy-in***

Senator Brian Schatz (D-HI) revealed last week that he is preparing new legislation to give states the option of allowing residents buy into Medicaid if they earn just above current eligibility levels.

A similar bill was passed earlier in the year by the Nevada legislature but vetoed by Governor Brian Sandoval (R) (see Update for Weeks of June 12<sup>th</sup> and 19<sup>th</sup>). It would let Marketplace consumers receiving premium tax credits under the Affordable Care Act (ACA) use those credits to purchase Medicaid coverage, effectively making Medicaid the “public option” that Congressional Democrats initially sought to include in the ACA.

The bill is likely to be staunchly opposed by the most conservative members of Congress, who vigorously fought against the “public option” in the early ACA drafts. It remains unclear how much support it would have among more moderate Republicans, who have supported proposals to allow ACA tax credits to be used to purchase other private non-Marketplace coverage (see Update for Weeks of May 29<sup>th</sup> and June 5<sup>th</sup>).

In an effort to encourage support from providers, Senator Schatz plans to also propose increasing Medicaid reimbursement rates to Medicare levels, as the ACA temporarily did for two years. Medicaid currently pays about 72 percent of Medicare rates on average.

Senator Schatz acknowledges that those buying-in to the Medicaid program would require a different benefit package than traditional Medicaid enrollees. However, he insists that the buy-in benefit package would include all ten of the essential health benefit categories mandated by the ACA. He also notes that Medicaid buy-in enrollees would have a far broader provider network under Medicaid than under potential Marketplace plans.

## **FEDERAL AGENCIES**

### ***CMS slashes funding for Marketplace advertising, outreach, and enrollment assistance***

The Centers for Medicare and Medicaid Services (CMS) announced this week that fiscal year 2018 funding for federally-facilitated Marketplaces (FFM) will be dramatically slashed by 72 percent.

The budget for advertising and outreach will total only \$10 million next year (down 90 percent from \$100 million in 2017). This is but a small fraction of the \$111.5 million that the Covered California Marketplace spends on advertising and outreach for just its state.

CMS will further cut funding for navigators and other enrollment assisters by an expected 43 percent (or \$23 million) by allocating revenue from FFM user fees based on the ability of navigators “to meet their enrollment goals during the previous year.” Navigators attaining 100 percent of their 2017 enrollment target will receive the same funding as last year, while those enrolling 70 percent of their target will receive only 70 percent of 2017’s funding.

CMS officials argued that advertising and outreach efforts were “no longer needed” as most Americans now know about the Affordable Care Act (ACA). The move engendered swift criticism from



consumer advocates, who argued that it was further evidence of the Trump Administration's stated effort to "let Obamacare implode."

CMS previously terminated previously-paid advertising and outreach during the last ten days of the 2017 open enrollment period, a move that consumer advocates insist depressed FFM enrollment by at least one million sign-ups (see Update for Week of January 30<sup>th</sup>). In addition, CMS has already cut the 2018 open enrollment period for the 39 FFMs in half, which is further expected to limit Marketplace enrollment next year.

### ***Uninsured rate hits another record low during first quarter of 2017***

More Americans had health insurance during the first three months of 2017 than ever before, according to new data released this week by the National Center for Health Statistics within the Centers for Disease Control and Prevention (CDC).

The uninsured fell to 8.8 percent in their latest survey, slightly below the 9.0 percent recorded by the National Health Interview Survey for all of 2016. The data shows that 20.5 million Americans have now gained health insurance coverage since the Affordable Care Act (ACA) was enacted in 2010. The biggest gains have been among Latinos, for whom the uninsured rate fell from a high of 40.6 percent in early 2013 to 24.1 percent during the first quarter of 2017.

However, the survey also shows that coverage gains are resulting largely from a dramatic increase in the number of high-deductible plans or those defined by the CDC as having an annual deductible of at least \$1,300 for individuals or \$2,600 for families. Enrollment in these plans has jumped from 25.3 million in 2010 to 42.3 million by 2017.

## **STATES**

### Alabama

#### ***BCBS will no longer be the lone Marketplace insurer in 2018***

The Department of Insurance confirmed this week that Bright Health will offer Affordable Care Act (ACA) Marketplace coverage in the Birmingham metropolitan area for 2018.

The move means that Blue Cross and Blue Shield (BCBS) of Alabama will no longer be the lone Marketplace insurer for consumers in that region, although the dominant insurer continues to be the sole option for the rest of the state. BCBS is seeking a 15.7 percent average premium increase for 2018, based on assumptions that the federal government will not fund the ACA's cost-sharing reductions for the full plan year or continue to enforce the law's individual mandate.

Bright Health's entry means that only six entire states still have only one insurer for 2018. However, this represents 23 percent of all Marketplace enrollees according to Bloomberg Health. Another 27 percent will have at least two insurers while 32 percent will have four or more.

### Iowa

#### ***Proposed federal waiver would redistribute ACA subsidies to help more "healthy folks" enroll***

Insurance Commissioner Doug Ommen (R) confirmed last week that the Insurance Division has formally submitted its request for a federal waiver that would allow it to dramatically increase out-of-pocket costs on lower-income in order to make premiums more affordable to those who are lower-cost and higher-income.



Section 1332 of the Affordable Care Act (ACA) allowed states starting January 1<sup>st</sup> of this year to seek permission to opt-out of key ACA provisions and experiment with alternative reforms that provide equivalent coverage yet are budget neutral (see above). Although these are statutory criteria that can only be eliminated by Congress, the Trump Administration has indicated that it will seek to “broaden” these restrictions to give states as much flexibility as possible to opt-out of the ACA.

The first part of the Iowa Stopgap Measure would create a reinsurance program to compensate insurers for exceptional claims, similar to the ACA program that expired at the end of 2016 (see above). It would use federal and state funding to cover 85 percent of claims that cost from \$100,000 to \$3 million. The Trump Administration has already approved a similar program for Alaska (see Update for Week of August 14<sup>th</sup>), which reduced Marketplace premium increases by 35 percent, and the Division projects that reinsurance payments will reduce insurer claims costs and similarly mitigate premium increases for Iowa.

The reinsurance portion of the waiver request has broad support, as Marketplace consumers are currently facing a 56 percent average premium increase for 2018 from the lone insurer willing to participate (Medica). The state’s dominant insurer, Wellmark Blue Cross and Blue Shield, has already committed to returning to the Marketplace should the reinsurance program be created.

However, the second part of the Iowa Stopgap Measure has generated intense opposition from consumer groups as it would abolish the cost-sharing reductions (CSRs) under the ACA that dramatically reduce deductibles and out-of-pocket costs for those earning 100-250 percent of the federal poverty level (FPL). The savings would be used to make the ACA’s premium tax credits available to those beyond the statutory cap at 400 percent of FPL. These would also vary based on age, instead of just income.

Consumer groups pointed out that eliminating the CSRs for nearly 28,000 Iowans could effectively increase annual deductibles for this group from as low as \$20 up to the maximum of \$7,350 (for individuals) set by the ACA. This is because all participating Marketplace insurers would only be allowed to offer one standardized silver-tier plan under the proposed waiver and not be able to offer deductibles lower than the \$7,350 maximum (or \$14,700 for families).

Another proposed change would limit eligibility for special enrollment periods (such as those triggered by marriage, divorce, birth, adoption, or a permanent move) only to those who have not had a gap in coverage or more than 60 days during the preceding 12 months.

Governor Kim Reynolds (R) and Commissioner Ommen insist that the waiver is needed because the Iowa Marketplace is “clearly in collapse” due to premiums that are unaffordable to healthier but higher-income residents who are consequently unable to balance the risk pools for insurers. The Commissioner argued that Iowa needed to do “what was necessary and appropriate to maximize participation at all income levels [because the Marketplace is] not sustainable without healthy folks.” If the waiver is not approved, Ommen predicts that roughly 20,000 of the 72,000 “healthier” Marketplace enrollees will face annual premiums of nearly \$40,000 and be forced to drop coverage for next year, further pushing premiums upward.

However, the Kaiser Family Foundation and other consumer groups were quick to point out that the Division’s analysis rests on the assumption that lower-income groups who tend to be “less healthy” will purchase coverage at the same rate despite dramatically higher out-of-pocket costs (from a \$7,350 annual deductible on top of copayments of up to \$300 for prescription drugs.) Health Affairs contributor Timothy Jost insisted that it “doesn’t make sense” that those earning only \$15,000 per year would still be able to purchase Marketplace coverage with a \$7,350 deductible, even with premium tax credits.

Critics also noted that Iowa’s decision to allow the sale of “grandmothered” short-term or limited-benefit plans that are not compliant with the ACA has contributed to a skewing of their Marketplace risk pool towards sicker and lower-income subscribers, as roughly 85,000 typically healthier Iowans continue to be enrolled in these ACA-deficient plans instead of joining the Marketplace. (A Robert Wood Johnson



Foundation study released last week showed that every state that allowed such “grandmothered” plans experienced adverse impacts on their risk pools.) Commissioner Ommen acknowledged this dilemma during public hearings on the waiver request but insisted that it would be “unfair” to force those enrolled in ACA-deficient to suddenly pay much higher premiums for Marketplace coverage.

Despite the greater leeway promised by the Trump Administration, federal approval of the Iowa Stopgap Measure faces several procedural hurdles. For example, the Governor has asked the Trump Administration to approve the waiver on an “emergency basis” because the legislature has yet to pass the required legislation authorizing the Insurance Division to submit a Section 1332 waiver request. Furthermore, the ACA does not allow states opt-out of the guaranteed issue mandate under any circumstance and thus Iowa’s proposal to allow coverage denials for those with a 60-day gap in coverage may be ineligible for the waiver.

#### Missouri

#### ***Anthem will not exit Marketplace counties in which it is the lone participating insurer***

Anthem Blue Cross and Blue Shield announced this week that it will continue to offer Marketplace coverage next year in the 68 Missouri counties in which it is the lone participating insurer, even though it will scale back coverage from the 85 counties where it participated for 2017.

The nation’s second largest insurer still participate in 14 Marketplaces nationwide although it has dramatically reduced its participation for 2018. It exited the Marketplaces in Nevada and Virginia earlier this month (see Update for Week of August 14<sup>th</sup>) and previously withdrew from Indiana, Ohio, Wisconsin, and half of its participating counties in Georgia (see Update for Weeks of June 12<sup>th</sup> and 19<sup>th</sup>).

Anthem operates in all Missouri counties except for 30 counties in the western part of the state where Blue Cross and Blue Shield of Kansas City is licensed to operate. Blue KC’s decision to exit the Missouri and Kansas Marketplaces for 2018 temporarily left 25 of these counties without any participating Marketplace insurer until Centene agreed to fill the void last month (see Update for Week of July 10<sup>th</sup>).

#### New Hampshire

#### ***New study shows Medicaid expansion enrollees are younger but more costly than anticipated***

A new report commissioned by the Insurance Department revealed this week that initial enrollees in New Hampshire’s federally-approved alternative to the Medicaid expansion under the Affordable Care Act (ACA) were younger but also more expensive than projected by the state.

The findings by Gorman Actuarial are likely to be hotly debated when the Commission to Evaluate the Effectiveness and Future of the Premium Assistance Program holds its September 6<sup>th</sup> hearing on whether to continue the program beyond its scheduled expiration at the end of 2018. The authors testified this week that claims costs for those enrolling in the Premium Assistance Program (PaP) were 26 percent higher than other individual market enrollees, even the proportion of enrollees age 19-29 was higher (19 percent compared to 14 percent).

The authors emphasized that additional studies were needed to identify the factors causing PaP enrollees to be more costly but suggested that allowing consumers to sign-up on a “rolling basis” throughout the year may be one cause, as it may make them more likely to wait for a costly health emergency to enroll.

New Hampshire is one of eight states that have received a federal Section 1115 demonstration waiver allowing it to use matching funds for the ACA Medicaid expansion to instead cover the newly-eligible population in private Medicaid managed care plans or the state partnership Marketplace that New Hampshire operates pursuant to the ACA (see Update for Week of September 29, 2014). The PaP has



been very successful, enrolling more than 52,000 residents as of August 1<sup>st</sup> or roughly 42 percent of the entire individual market (see Update for Week of August 14<sup>th</sup>).

The PaP was initially set to expire at the end of 2016 but reauthorized for an additional two years even though the Obama Administration stripped out work requirements and other eligibility verification measures sought by conservative lawmakers (see Update for Week of December 5<sup>th</sup>). However, the funding mechanism must be altered by lawmakers before the end of 2018 after the Trump Administration determined that the Medicaid expansion was unlawfully being conditioned on the receipt of voluntary donations from hospitals (see Update for Week of August 14<sup>th</sup>).

## Ohio

### ***Last “bare” county in nation gets Marketplace insurer for 2018***

Nonprofit health insurer CareSource announced last week that it will offer Affordable Care Act (ACA) Marketplace coverage to consumer in Paulding County for 2018.

The Dayton-based non-profit health insurer had already agreed to cover eight other counties in Ohio that faced the prospects of having no participating Marketplace insurers following the withdrawal of Anthem Blue Cross and Blue Shield earlier this year (see Update for Week of August 14<sup>th</sup>). CareSource is the second-largest Ohio health insurer by revenue and is an experienced Medicaid managed care insurer, serving Medicaid enrollees in Ohio, Kentucky, Indiana, and West Virginia (and Georgia starting next year).

Paulding County had only 334 Marketplace enrollees last year. However, CareSource’s decision to offer coverage to them was significant because it was last of roughly 60 counties that were at risk of having no Marketplace insurers for 2018 (see Update for Week of August 14<sup>th</sup>). Department of Insurance Director Jillian Froment (R) praised the news but urged Congress to pass measures to stabilize the Marketplaces, citing figures from the federal Centers for Medicare and Medicaid Services showing that 1,476 counties nationwide currently will be served by only one Marketplace insurer next year, including the 20 “bare” counties in Ohio that five insurers have now agreed to fill.

CareSource insisted that its decision was based upon its “commitment to the Marketplace and serving those who are in need of health care coverage.” However, it is seeking to increase premiums across all plans by an average of 36 percent next year in order to accommodate the risk created by the “uncertainty” over whether the ACA cost-sharing reductions will be paid for the full plan year (see Update for Week of August 14<sup>th</sup>).

## Wyoming

### ***Republican governor dismayed at lack of Medicaid expansion, Marketplace rate hikes***

Governor Matt Mead (R) blamed “uncertainty” over Congressional efforts to repeal and replace the Affordable Care Act (ACA) for lack of any legislative interest in expanding Medicaid and the nearly 50 percent rate hike that Wyoming consumers will face in the ACA Marketplace.

The Governor has made several unsuccessful efforts to expand Medicaid and acknowledged he is unlikely to be able to do so before being term-limited next year. Republican lawmakers have rejected all forms of Medicaid expansion despite a Department of Health study showing that it would bring in more than \$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). Senate leaders have already ruled out any consideration of the Medicaid expansion next session, noting that federal repeal efforts make it even more likely the ACA matching funds will not be available in the long-term.

Governor Mead, who did not support efforts to repeal the entire ACA, noted that the mostly rural hospitals in the state are struggling with uncompensated care costs (including some operating only on “60



days cash”) and would have greatly benefit from the expansion funds. He acknowledged that “the idea that we did not accept Medicaid expansion and things are going to be good just hasn’t turned out.”

The Governor also expressed concern that the “uncertainty” over whether the Trump Administration would continue the cost-sharing reductions under the ACA (see above) caused the state’s only Marketplace insurer to raise premiums for 2018 by a staggering average of 48 percent. Wyoming Blue Cross and Blue Shield has been the lone insurer since 2015 but sought only a 7.4 percent average rate hike last year and six percent in 2016 (see Update for Week of July 25, 2016).