Health Reform Update – Week of September 18, 2017

CONGRESS

Senators resurrect ACA repeal effort but face major obstacles to passage

Senators Bill Cassidy (R-LA) and Lindsey Graham (R-SC) introduced a last-ditch effort last week to repeal key provisions of the Affordable Care Act (ACA) before the authority to use the budget reconciliation process expires on the September 30th end of the federal fiscal year.

The Cassidy-Graham bill is similar to the Better Care Reconciliation Act (BCRA) that failed to pass last summer (see Update for Week of August 14th). It would likewise repeal the ACA individual and employer mandates, as well as several of the taxes that fund the law, and convert Medicaid to per capita spending caps. However, it would substitute a federal block grant for ACA funding that provides states with resources for the Medicaid expansion, as well as the law's premium and cost-sharing subsidies. In exchange, the bill gives states the flexibility to decide how to use that funding. It would also largely dismantle the insurance Marketplaces created by the ACA, a major departure from previous repeal bills.

The Congressional Budget Office (CBO) said this week that it would be able to only offer a "preliminary assessment" of the legislation before the September 30th deadline and that a full analysis of its impact on the deficit, premiums, and health insurance coverage would take "several weeks" to complete. However, that did not stop Majority Leader Mitch McConnell (R-KY) from scheduling a floor vote next week, prior to any score being received.

Republican leaders feared that an adverse CBO score would stall momentum for the legislation, as occurred with prior versions (see Update for Week of July 10th). Because estimates from non-profit groups including Avalere Health, Kaiser Family Foundation, and the Brookings Institute projected dramatic losses in federal funding for as many as 34 states (roughly $713 billion less through 2026), Republican leaders clearly felt that chances of passage would be greater prior to any CBO score.

The bill still also needs to clear the Senate parliamentarian. She previously ruled that similar provisions in the BRCA that allowed states to opt-out of ACA consumer protections like essential health benefits and community rating (preventing insurers from increasing rates based on health status) would not directly impact the budget deficit and thus not be allowed to pass through reconciliation (see Update for Week of August 14th). Provisions that are not cleared for reconciliation would require 60 votes to pass instead of just 50 votes (with the Vice President breaking the tie).

Senate leadership appeared to have 48 votes already in hand this week. However, Senator Rand Paul (R-KY), a supporter of previous repeal bills, came out immediately in opposition to Graham-Cassidy, insisting that it did not go far enough in repealing the ACA. He was joined later in the week by Senator John McCain (R-AZ), who cast the deciding vote against the "skinny" repeal bill last July. As a result, that leaves the fate of the bill largely up to Senators Susan Collins (R-ME) and Lisa Murkowski (R-AK), both of whom voted against all of the previous repeal bills (see Update for Week of August 14th) and both of whom expressed significant reservations about the Graham-Cassidy bill.

Senator leaders are attempting to bring Murkowski on board by essentially allowing Alaska to keep the Medicaid expansion and ACA subsidies in place. However, similar efforts to provide enhanced funding for Alaska failed to persuade Murkowski to support the repeal bills last summer and an analysis released this week by the Alaska Department of Health may give her further pause, as it shows Graham Cassidy would cut 25 percent of federal health care funding for Alaska by 2026. Furthermore, an analysis

by AARP predicted that the Graham-Cassidy bill would increase premiums by $31,790 for a 60-year-old Alaskan earning $25,000 (and $22,074 more for the same individual in Arizona).

Because similar efforts by bill sponsors to increase funding for Arizona and Maine do not appear likely to bring either Senators McCain or Collins on board, the Graham-Cassidy bill faces very long odds of passing by the September 30th deadline, even with the parliamentarian's approval. These odds further increased when Senator Ted Cruz (R-TX), one of the staunchest Senate advocates for repealing the ACA, joined with Senator Paul in insisting on further changes to the legislation.

Bipartisan plan to stabilize ACA marketplaces shelved in favor of ACA repeal

The chairman of the Senate Health Education Labor and Pensions Committee announced this week that negotiations with Democratic lawmakers on limited measures to stabilize the Affordable Care Act (ACA) have hit an impasse and will no longer be pursued.

The move by Senator Lamar Alexander (R-TN) was widely viewed as deference to the decision by Majority Leader Mitch McConnell (R-KY) to hold a vote next week on the latest Senate Republican bill to repeal key provisions of the ACA (see above). The chairman and ranking member Patty Murray (D-WA) had made progress on a deal that would indefinitely extend cost-sharing reductions (CSRs) under the ACA in exchange for the greater flexibility for State Innovation Waivers sought by Republican leaders.

Democrats have lobbied heavily for Congress to provide insurers with some certainty on CSR funding prior to the September 27th deadline for insurers to decide on participating and premiums in the federally-facilitated Marketplace. The Trump Administration has only been making CSR payments on a month-to-month basis and threatened on several occasions to terminate the payments and "let Obamacare implode" (see Update for Week of August 14th). Insurers have cited the "uncertainty" over the CSR payments as the primary factor in decisions to increase 2018 premiums by 20 percent or more (see Update for Week of August 28th).

However, Senators Alexander and Murray have been unable to reach agreement over exactly how much flexibility states should be afforded. Section 1332 of the ACA allowed them to seek waivers starting last January to opt-out of key ACA provisions in favor of reforms that provided comparable coverage and did not increase the federal deficit. Senator Alexander insisted that these "guardrails" were preventing states from experimenting with any reforms that did not offer ACA marketplace plans and the ten essential benefit categories they are required to cover. Senator Murray, despite agreeing to give states significantly greater flexibility, was adamant that any experimental reforms not dramatically increase out-of-pocket costs for consumers.

Senator Murray and other Democrats were also dismayed that the chairman has refused to consider including federal reinsurance payments to insurers for exceptional claims as part of the stabilization package (see Update for Week of August 28th). The Trump Administration has already approved a Section 1332 for Alaska to operate such a reinsurance program and encourage other states to do so (see Update for Week of July 10th). However, Senator Alexander insisted that these payments would amount to an insurer bailout.

Senator Murray issued a letter this week urging Senator Alexander to resume negotiations on the stabilization package should the latest ACA repeal bill fail to pass next week.

Bipartisan agreement to reauthorize CHIP could be threatened by ACA repeal

The Senate Finance Committee introduced their bipartisan bill this week that would renew funding for the Children's Health Insurance Program for five years, prior to the September 30th expiration of the latest reauthorization.

The legislation (S.1827) would also maintain for two years a 23 percentage point enhanced federal match given to states in previous reauthorizations. States would receive only an 11.5 percent bump for fiscal 2020 before the matching rate returns to traditional level in fiscal 2021.

Chairman Orrin Hatch (R-UT) and ranking member Ron Wyden (D-OR) were able to agree on including a critical requirement under the Affordable Care Act (ACA) that required states to maintain current eligibility levels through fiscal 2019, or fiscal 2022 for children in families earning less than 300 percent of the federal poverty level. Nineteen states that cover kids above that income threshold could adjust eligibility starting in fiscal 2020.

Consumer advocacy groups widely praised the bipartisan compromise. However, the latest Senate effort to repeal key provisions of the ACA (see above) could threaten to undo the agreement or push passage beyond the September 30th deadline. The Finance Committee still has not marked up the bill and no hearings have been scheduled for next week due to the repeal push.

More than nine million children are currently covered through CHIP.

FEDERAL AGENCIES

CBO predicts Marketplace enrollment will fall due to ACA uncertainty, outreach cuts

The Congressional Budget Office (CBO) warned last week that dramatic cuts in advertising and outreach could restrict enrollment in Affordable Care Act (ACA) Marketplaces for 2018, even though it still projects that 11 million consumers will sign-up for coverage next year.

The Centers for Medicare and Medicaid Services (CMS) announced last month that the 2018 budget for Marketplace advertising and outreach would be slashed by 90 percent (to only $10 million) ahead of the November 1st start of the open enrollment period (see Update for Week of August 28th). As a result, CBO predicts at least one million fewer consumers will sign-up next year and 7-10 million fewer consumers will enroll in Marketplace coverage over the next eight years.

However, CBO also pointed out that higher premium costs resulting from “uncertainty” over whether the Trump Administration will continue the ACA’s cost-sharing reductions (CSRs) will also contribute to this decline in Marketplace enrollment. Researchers estimate that the average premium for benchmark plans (i.e. the second lowest-cost silver plan on which ACA premium tax credits are based) will increase by roughly 15 percent just due to this “uncertainty about federal funding of CSR payments.”

Latest OIG study finds Medicare Part B would save $1.8B by requiring drug rebates

A new report released last week by the Department of Health and Human Services (HHS) Office of Inspector General (OIG) found that requiring drug manufacturers issue Medicare Part B rebates whenever drug prices rise faster than inflation would have saved the program up to $1.8 billion in 2016.

Currently, rebates are only required under the Medicaid program and not for Medicare. Drugmakers pay both standard rebates and inflation-indexed rebates. However, the OIG report requested by Rep. Sander Levin (D-MI) estimated potential savings only from those that were inflation-indexed. The study relied on a subset of drugs that account for roughly 81 percent of all Part B expenditures.

The report follows similar conclusions from prior OIG studies, which showed that Medicare could have saved $2.7 billion in both basic and inflation-indexed rebates for 60 high-expenditure Part B drugs.

New FDA commissioner seeks to protect against abuse of orphan drug program

New Food and Drug Administration (FDA) Commissioner Scott Gottlieb announced last week that the agency would change how it approves orphan drugs, accusing drugmakers of abusing the law intended to help patients with rare diseases.

The Commissioner stated that the agency would ensure financial incentives are granted "in a way that's consistent with the manner Congress intended" when the Orphan Drug Act was first passed in 1983. That legislation gave drugmakers a package of incentives, including tax credits, user fee waivers and seven years of market exclusivity for developing drugs used to treat conditions affecting fewer than 200,000 Americans or would not be profitable within seven years of approval.

However, a Kaiser Health News investigation earlier this year revealed that more 70 of the roughly 450 drugs that have won orphan drug approval had been already approved by the FDA for mass-market use. Those include cholesterol the world's best-selling drug Humira, used largely for rheumatoid arthritis. The Government Accountability Office (GAO) has subsequently agreed to a Congressional request for an investigation.

As a result, the Commissioner stated that the FDA would seek to close a loophole that allows manufacturers to skip pediatric testing requirements when developing a drug already approved for common use in adults for orphan use in children. The agency will also require that drugmakers prove their medicine is "clinically superior" before getting the market exclusivity that comes with being an orphan drug. He also indicated that the FDA is weighing "bigger" changes due to "scientific advances" such as biosimilar copies of high-cost biologics.

The agency has seen a boom in orphan drug applications, with nearly half of all drugs approved by the FDA now designated for rare diseases.

HEALTH CARE COSTS

Kaiser study shows "remarkable slowdown" in premiums for employer-sponsored coverage

Family premiums for employer-sponsored insurance (ESI) rose by an average of three percent for 2017, according to the annual survey released this week by the Kaiser Family Foundation.

Researchers concluded that the poll of more than 2,100 employers confirmed the "remarkable slowdown" in premium growth, emphasizing that family premiums have grown by only 19 percent since 2012, compared to 30 percent from 2008-2012 and 51 percent from 2002-2007. However, they stress that the premium growth still far outpaces increases in wages, which grew by only 2.3 percent in 2017 and were largely stagnant since the 2007-2009 recession, causing more than 30 percent of ESI subscribers surveyed to report difficulty paying medical bills.

Researchers called the premium slowdown "health care's greatest mystery" and suggested it may be due to workers bearing an increasing share of health insurance costs. They noted that worker costs have increased by 32 percent per year since 2012, compared to only 14 percent for the employer share of costs. Employer-sponsored family coverage now costs an average of $18,800 per year with workers shouldering an average of $5,700 of that amount (or roughly 30 percent).

However, researchers also emphasized the growth in deductibles for ESI did moderate in 2017, increasing by only $27 on average. This is in stark contrast to average increases of more than $100 in prior years and dramatic spikes in deductibles now occurring in the individual market.

The survey also pointed out that small business workers continue to pay a much higher share of health insurance costs than for large employers (with family plan deductibles for small businesses averaging $6,800 compared to only $5,300 for large employers). Furthermore, just half of companies with 50 or fewer employees offered coverage in 2017, down from 59 percent in 2012.

The share of all employers offering coverage remained statistically unchanged from 2016 (at 53 percent) as did the share of all workers covered (at 62 percent).

STATES

Arizona

State Supreme Court to hear Republican lawmakers challenge to Medicaid expansion

The Arizona Supreme Court has agreed to hear a legal challenge to the state's Medicaid expansion under the Affordable Care Act (ACA).

The expansion was part of a budget package proposed by Governor Jan Brewer (R) and enacted with a bare majority over the objections of conservative lawmakers only after she began following through on her threat to veto all other legislation (see Update for Week of June 10, 2013). Three dozen Republican lawmakers immediately filed suit to block the expansion, arguing that the hospital assessment used to fund the state's share violated state law requiring a two-thirds majority in order to enact a tax increase.

The Maricopa County Superior Court initially dismissed the case for lack of standing before the Supreme Court ordered a decision on the merits (see Update for Week of March 16, 2015). The county court ultimately concluded the assessment was not a tax requiring a supermajority, because the Medicaid Director had the authority "establish, administer, and collect" such a levy. That decision was upheld last March by the Court of Appeals.

An adverse Supreme Court ruling could jeopardize Medicaid coverage for nearly 400,000 Arizonans that have benefited from the expansion.

California

Legislature sends two prescription drug cost bills to Governor

The legislature overwhelmingly approved legislation this week that would become the nation's most comprehensive prescription drug cost transparency law if signed by Governor Jerry Brown (D).

S.B. 17 was strongly opposed by the pharmaceutical industry but passed with only 17 dissenting votes across both chambers. It would require pharmaceutical companies to notify health insurers and government health plans like Medi-Cal and CalPERS at least 60 days before increases in drug wholesale acquisition costs (WAC) that would exceed 16 percent over a two-year period. These thresholds were lowered from the version that passed the Senate last May, which required a 90-day notice for price increases of at least 25 percent (see Update for Weeks of May 29th and June 5th).

The measure also forces drug companies to explain the reasons behind those increases and post them online in a manner that allows consumers to access it on a per-drug basis and shows the overall impact of a the drug cost on plan premiums.

Other provisions would set new disclosure requirements for health insurers in both the large and small group markets, who would be required (starting in October 2018) to annually notify state agencies about the 25 most frequently prescribed drugs, the 25 most costly drugs, and the 25 drugs with the

highest year-over-year increase in annual spending. Regulators would again be required to report this information online.

Passage of the bill represents a major victory for Senate Health Committee chair Ed Hernandez (D), who was forced to withdraw a similar version last year after intense industry lobbying forced amendments that he felt so "watered down" the measure that it could no longer accomplish its goal of "shedding light on the reasons for precipitating skyrocketing drug prices" (see Update for Week of December 5th). He and the lead Assembly sponsor acknowledged that the bill by itself would not dramatically alter drug pricing but insisted that it brought California "one step closer to lifting the veil on soaring drug prices and identifying meaningful strategies to ensure access to life-saving treatments."

Fearing that S.B. 17 would become a national model, the Pharmaceutical Research and Manufacturers of America invested heavily in opposing the bill, insisting that "it won't help Californians access needed medicine or make their costs at the pharmacy counter any lower." The trade group noted that the bill "won't even paint a complete picture of prescription drug spending since it only calls for information on list prices rather than the final cost after discounts and rebates."

California is one of 25 states (and Puerto Rico) that considered drug price transparency laws this year. S.B. 17 does go further than the previous drug transparency law enacted last year in Vermont, which required that state to identify up to 15 prescription drugs for which the WAC has increased by 50 percent or more over the past five years and 15 percent or more over the past year (see Update for Week of June 20, 2016). Maryland recently enacted the first "price gouging" law in the nation that seeks to prevent WAC increases of 50 percent or more for "essential" generic or off-patent drugs (see Update for Weeks of May 29th and June 5th) while a new Colorado law only requires that certain providers make a single document available to the public listing direct pay prices and cost-sharing obligations for their most common health care services (see Update for Week of May 8th).

The legislature also passed a related and heavily-amended bill sponsored by Assemblyman Jim Wood (D) that would prohibit drug manufacturers from offering discounts for brand-name drugs, if a less-expensive equivalent brand is available. It specifically exempts patient assistance provided by independent bona-fide charities like PSI (see Update for Weeks of May 15th and 22nd).

Governor Brown has until October 15th to decide whether to sign or veto both bills.

Anthem blames drug costs for 35 percent rate hike on individual market consumers

As justification for seeking to hike individual market premiums by an average of 35 percent, Anthem Blue Cross claimed this week that prescription drug costs in California were likely to climb by 30 percent or more for 2018.

Critics are urging the Department of Managed Health Care to reject or modify the substantial increase, pointing out that figures from non-profit groups like Altarum show prescription drug costs climbed by only 6.1 percent nationwide over the 12 months ending in July, which was a drop from 12.9 percent in 2014, when prices spiked following the introduction of new drugs to "cure" Hepatitis C. Advocacy groups like Consumers Union have also pointed out that Anthem projected only an 11.4 percent increase in 2018 drug costs for Colorado and that their proposed rate hike far exceeds the 15-16 percent drug cost increases forecast by leading competitors Health Net and Blue Shield of California.

In addition, Anthem's proposed rate hike assumes that the cost-sharing reductions (CSRs) under the Affordable Care Act (ACA) will be paid for the full plan year. Company officials have repeatedly insisted that they would have to hike rates by an average of 20 percent or leave Marketplaces altogether if the CSRs were terminated (see Update for Week of May 8th).

Anthem insists that its higher projection of drug costs is needed to account for "growing market volatility" and specifically the "uncertainty" over how efforts by Congress to repeal the ACA could impact the individual market next year. Fearing that a drop in enrollees would lead to a sicker than expected risk pool, Anthem has already elected to withdraw from the individual market for about half of California's counties next year. It has dramatically scaled back its Marketplace coverage nationwide, choosing to remain in only a handful of states (see below).

Colorado

Marketplace insurers will all return, but with a 26 percent average premium increase

The seven insurers that participated in the Affordable Care Act (ACA) Marketplace for 2017 largely received the premium increases they sought in exchange for agreeing to return next year.

Final Marketplace premiums published by the Division of Insurance were reduced only slightly from an average increase of 26.96 percent to 26.7 percent. CIGNA was the lone Marketplace insurer whose rate filing was significantly modified by state regulators (receiving a 30.9 percent average increase instead of the 41.2 percent they proposed). Dominant insurers Anthem Blue Cross and Blue Shield and Kaiser Permanente received the exact rate hikes they requested (30.2 and 24 percent respectively).

All of the premiums were approved under the assumption that the Trump Administration would continue to fund the ACA cost-sharing reductions (CSRs)(see Update for Week of August 28th). The Division notes that rates would have been at least 14 percent higher if insurers knew before filing that the CSRs would be eliminated during the plan year.

The Division was forced to approve higher than expected premiums for the Marketplace because Colorado is one of only a handful of Marketplaces whose insurers are not contractually-allowed to exit the Marketplace mid-year or adjust premiums if the CSRs are terminated. (All federally-facilitated Marketplaces have this option).

Despite having more participating Marketplace insurers than most states, the dominant insurers have largely limited their coverage only to certain counties. As a result, 14 of the 64 counties in the state will have only one participating insurer (Anthem) while 53 counties will have three or fewer insurers.

Connecticut

Both Marketplace insurers agree to return so long as ACA cost-sharing reductions are paid

Premiums for the two remaining insurers participating in Access Health CT will increase next year by an average of 29.3 percent, according to final rates released last week by the Insurance Department.

State regulators approved such exceptional increases based on the assumption that the Trump Administration will not continue the cost-sharing reductions (CSRs) under the Affordable Care Act (ACA) for the full plan year (see Update for Week of August 28th). The Administration announced this week that it would pay the CSRs to insurers for September but provided no guarantee beyond that.

Anthem Blue Cross Blue Shield received a 31.7 average increase, which was significantly lower than the 41 percent they requested. However, ConnectiCare actually received a much higher average increase than they sought (27.7 percent compared to 17.5 percent). The Department stressed that it based its decision on actual enrollment experience and rejected ConnectiCare's prediction that silver-tier plan consumers would simply migrate to other metal tier plans if the CSRs were eliminated (CSRs are available only for silver-tier plans.)

Roughly 43,000 Access Health CT consumers currently receive CSRs (because they earn 138-250 percent of the federal poverty level). However, ConnectiCare has far more CSR consumers than Anthem, meaning the impact of losing CSRs would fall more heavily upon them. As a result,

ConnectiCare has already warned Access Health CT officials that it will leave the Marketplace mid-year if the CSRs are not continued.

Anthem has already left most of its Marketplaces for 2018 due to the "uncertainty" over whether CSRs would be fully-funded (see Update for Week of August 14th). However, in addition to Connecticut it has decided to remain in the Marketplaces for Colorado, Maine, Missouri, New Hampshire, and Virginia given that its withdrawal would cause numerous counties in those states to be left without any Marketplace insurer (see below).

Although Access Health CT is a state-based Marketplace under the ACA, it has decided to follow the open enrollment period for the federally-facilitated Marketplace, which has been cut in half for 2018 to only six weeks (ending on December 15th). Most other state-based Marketplaces have extended this deadline (see Update for Week of August 28th).

Louisiana

Final Marketplace premiums assume that ACA cost-sharing reductions will disappear

The Department of Insurance approved final 2018 premiums for the Affordable Care Act (ACA) Marketplace last week, which were nearly identical to the rate hikes sought by the three participating insurers.

Marketplace insurers received a weighted average increase of 21.4 percent based on the assumption that the cost-sharing reductions (CSR) under the Affordable Care Act (ACA) would be eliminated during the plan year (see Update for Week of August 14th). Without the corresponding increase, the Department estimates that average premiums would have increased by only 7.2 percent for 2018.

HMO Louisiana holds the largest share of the Marketplace, with nearly 54,500 consumers. However, its average premium increase of 14.87 percent was far less than the 31-35 percent average increases approved for the Marketplace options offered by Blue Cross and Blue Shield (BCBS) of Louisiana. BCBS had served more than 59,000 Marketplace consumers as recently as 2016 but that number fell to less than 22,000 last year.

Vantage Health Plan, which serves only 16,000 Marketplace subscribers, received a 28.46 percent average rate hike.

State regulators emphasized that if the CSR reductions are fully-funded through 2018, the premium overcharges will be refunded to consumers in 2019 via the medical-loss ratio rebates mandated by the ACA.

Maine

Anthem files Marketplace rates but will exit if ACA cost-sharing reductions terminated

The Bureau of Insurance finalized premiums last week for the three insurers participating in the Affordable Care Act (ACA) Marketplace for 2018.

Insurers were allowed to submit two different rate proposals last June, which varied according to whether the Trump Administration ensured that the cost-sharing reductions provided by the ACA would continue throughout the plan year. However, the Bureau ultimately decided to require insurers refile their proposals last month under the assumption that CSRs would be fully funded for 2018 and granted them a 20 percent weighted average increase in premiums.

The Bureau modified the proposed premiums filed by Anthem Blue Cross and Blue Shield, deeming its 21.2 percent average rate hike "excessive" and reducing it to 18 percent. Anthem left most of

its ACA Marketplaces due to the uncertainty over whether CSRs will continue (see Update for Week of August 14th) and insists it will exit the Maine Marketplace entirely if they are eliminated. In such an event, Anthem would also only offer one gold-tier plan to individual consumers outside the Marketplace and boost their average premium increase from 18 to 25 percent.

Community Health Options (CHO), one of only five remaining non-profit cooperatives created with ACA loans, actually holds the largest market share in the Marketplace and received a 17.5 percent average premium increase (reduced from the 19.6 percent average it requested). Despite financial struggles that forced it to freeze enrollment in 2016 (see Update for Weeks of May 29th and June 5th), CHO actually expects a nearly 18 percent jump in enrollment for 2018 (to more than 39,000 enrollees) due to an improved mix of healthier and sicker consumers.

Harvard Pilgrim has the fewest enrollees of the three Marketplace insurers (nearly 21,000) but received the highest average premium increase of 27.1 percent. Their requested 39.7 percent average increase had been the highest ever sought by a Marketplace insurer in Maine (see Update for Weeks of May 29th and June 5th).

Both CHO and Harvard Pilgrim would be allowed to increase silver-tier premiums by an average of 50 and 46 percent respectively) should the CSRs be eliminated during the plan year.

Minnesota

Governor seeks Congressional help to prevent loss of Basic Health Plan funding

Governor Mark Dayton (D) criticized the Trump Administration this week for a "nightmarish" reversal on its pledge to approve a federal waiver that it would allow to continue operating a reinsurance program for exceptional insurer costs without any loss in federal funds.

Section 1332 of the Affordable Care Act (ACA) allowed states to seek State Innovation waivers opting out of key ACA provisions starting January 1st, so long as they implemented alternative reforms that were budget neutral and provided comparable levels of coverage. Hawaii received the first such waiver (to opt-out of the small group Marketplace)(see Update for Week of January 9th). Alaska received the second, which provided federal funding for the state to continue the reinsurance program it created last year (see Update for Week of May 8th).

Department of Health and Human Services (HHS) Secretary Tom Price encouraged other states last spring to follow the lead of Alaska and Minnesota created a similar program (see Update for Week of May 8th). It submitted a complete waiver application in June and according to Governor Dayton was assured it would be approved by this August without any loss in other federal funds.

However, HHS notified Governor Dayton last week that in exchange for the $208 million in new federal funding for the Section 1332 reinsurance waiver, Minnesota would no longer receive the $369 million that the federal government currently provides the state for its Basic Health Plan (BHP). Minnesota is the only state besides New York that elected the BHP option under the ACA, in which the federal government pays 95 percent of the costs for states to cover those earning 138-200 percent of poverty in a lower-cost plan than the Marketplace comes with no deductibles, limited copayments, and premiums of no more than $20 per month (see Update for Week of July 10th). (Roughly 100,000 Minnesotans are covered through the BHP.)

The surprise decision to eliminate BHP funding would mean that Minnesota would lose $161 million overall if it continued its reinsurance program, which was expected to reduce premium increases in the MNSure Marketplace by up to 20 percent.

Governor Dayton has enlisted the help of both Democratic and Republican members of the Minnesota Congressional delegation to lobby against the funding cut. He insists that HHS' decision and

failure to timely approve the waiver is “jeopardizing the credibility and integrity of the entire MNsure program.”

Virginia

Anthem returns to ACA Marketplace but will dramatically increase premiums

Anthem Blue Cross and Blue Shield announced last week that it will return to the Affordable Care Act (ACA) Marketplace for Virginia in order to ensure that every county has at least one participating insurer for 2018.

The insurance giant had decided last month to withdraw from the Marketplace in Virginia, citing the uncertainty over whether the Trump Administration would fully under the ACA cost-sharing reductions or enforce the individual mandate. Anthem had elected to exit most of its ACA Marketplaces for 2018 (including Ohio, Missouri, and Nevada) but made a similar decision to cover “bare” Missouri counties last month (see Update for Week of August 28th) and elected to stay in the Marketplaces in Colorado, Maine (see above), and New Hampshire where their exit would have left large numbers of counties without participating insurers (see Update for Week of August 14th).

Anthem was heavily pressured by both the Democratic governor of Virginia and its Republican Assembly Speaker to re-enter the Marketplace following the decision by Optima Health earlier this month to limit coverage only areas served by Sentara Healthcare, its corporate parents. As a result, 58 counties in Virginia risked being left “bare” for 2018.

Anthem officials agreed to not only cover those “bare” counties but also offer Marketplace coverage in the ten counties that had only one other participating insurer. However, as it did in Missouri, Anthem’s change of heart came with the condition that it could dramatically increase premiums. It promptly amended its earlier rate filing with the Bureau of Insurance (that had sought increases of 35-55 percent) in order to hike rates by 42-64 percent for all individual plans it will offer in and out of the Marketplace.