

Health Reform Update – Week of March 19, 2018

CONGRESS

Insurers threaten dramatic premium spikes after Congress fails to act on Marketplace stabilization bills

The House and Senate passed a two-year \$1.3 trillion omnibus spending bill this week that imposes additional oversight mandates on Affordable Care Act (ACA) Marketplaces but failed to include any of the ACA stabilization measures sought by insurers.

The bill signed by the President (H.R. 1625) was hastily passed by the March 23rd deadline to avoid a third government shutdown this year. Despite bipartisan support for the \$30 billion three-year reinsurance pool and restoration of ACA cost-sharing reductions (CSRs), partisan infighting over Republican demands for auto-renewal of short-term plans and abortion restrictions on the CSRs prevented negotiators from reaching agreement on either proposal.

Trade groups representing health insurers were “deeply” disappointed at the failure to include the stabilization measures, which had been proposed as separate stand-alone bills but were instead expected to be part of the omnibus bill. Senate leaders have promised a vote on the measures, which were intended to give insurers some certainty about how to price Marketplace products for 2019, when tax penalties for the individual mandate will be repealed (see Update for Week of December 18th). Insurers must make these pricing decisions before filing rates in May and several including the Blue Cross and Blue Shield Association (whose plans are the dominant player in most Marketplaces) indicated this week that absent Congressional action on a stand-alone stabilization package, they will have to either dramatically increase premiums by double-digits or sit-out of the Marketplaces next year until they can better assess whether the loss of the individual mandate and influx of new short-term health plans will cause large numbers of healthier and less costly consumers to leave the Marketplace risk pools.

The loss of the reinsurance program was especially critical to insurers, who would have been paid for exceptional claims similar to the temporary ACA reinsurance program that expired after 2016. The Congressional Budget Office (CBO) had estimated that the reinsurance program combined with restoring the CSRs that were terminated last fall by the Trump Administration (see Update for Week of November 13th) would have reduced 2019 premiums by ten percent and 20 percent in subsequent years. The Milliman consulting firm had predicted a 40 percent drop in premiums from the reinsurance program (and additional waiver flexibility for states), based on the experience from Alaska and Minnesota, which created their own reinsurance programs last year (see Update for Week of December 18th). The Urban Institute found that Minnesota’s program has already cut certain silver-tier premiums by 15 percent (see below).

Despite failing to adopt the stabilization measures, the spending bill mandates that the Centers for Medicare and Medicaid Services (CMS) provide Congress with advance notice before releasing any ACA-related data or funding opportunities to the public. CMS must now “publish ACA-related spending by category since its inception,” and make public the number of employees, contractors and activities that implement, administer or enforce any ACA provisions.

More notably, the bill extends Congress’ 2014 prohibition on CMS making any of the outstanding payments owed to insurers under the risk corridor program that expired after 2016 (see Update for Week of December 15, 2014). A dozen Marketplace insurers are suing CMS to force payment for these claims, which redistributed funds from better-performing insurers to those losing more than three percent of premium revenue (see Update for Week of October 24, 2016). President Trump had proposed to fully-fund these obligations in his budget plan for next year but it was quickly withdrawn after a backlash from conservatives led by Senator Marco Rubio (R-FL) (see Update for Week of February 26th).

Senate committee considers new reporting and transparency requirements for 340B drug discounts

A hearing held last week by the Senate Health, Education, Labor and Pensions Committee revealed that key Republicans are planning to join House leaders in imposing new reporting requirements on safety net providers benefiting from discounted drugs under the federal Section 340B program.

Chairman Lamar Alexander (R-TN) stated that his committee would focus on how participating providers are using the discounts. In particular, they want to follow-up on studies by the Government Accountability Office, Health and Human Services Inspector General, and others that suggested providers may be reaping windfalls from the savings instead of passing them along to consumers as Congress intended (see Update for Weeks of July 1 and 8, 2013).

The House Energy and Commerce Committee has already released a report summarizing their two-year investigation that found that savings received by participating hospitals are not benefiting low-income, uninsured individuals (see Update for Week of January 8th). It called on Congress to clarify the intent of the 340B program, increase and standardize reporting and auditing requirements, and give the Health Resources and Services Administration greater authority and resources to conduct adequate oversight.

The report emphasized that spending under the 340B program has more than tripled since 2005 and the number of safety-net providers receiving the discounted 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).

Despite the flurry of subsequent House legislation (and two Senate bills) that would heighten reporting and transparency requirements for 340B hospitals, the HELP hearing was the first concrete sign that Senate leaders are likely to delve into the issue. However, Democrats in both the House and Senate have largely sided with hospitals, trying to instead focus blame on dramatic increases in prescription drug prices. Senator Maggie Hassan (D-NH) echoed a number of Democratic arguments in stating that pharmaceutical industry should accept the same transparency for prescription drug prices that they want Republican leaders to impose on the 340B program.

FEDERAL AGENCIES

FDA commissioner blames rebate agreements for stifling biosimilar competition

Food and Drug Administration (FDA) Commissioner Scott Gottlieb urged insurers last week to cease making deals with manufacturers of biologic drugs that are intended to stifle competition for less costly biosimilar products.

The agency has approved nine biosimilars under the new regulatory pathway created by the Affordable Care Act (ACA) (see Update for Weeks of March 2 and 9, 2015), three of which are already on the market. However, the Commissioner lamented that the emerging biosimilars have not been able to generate the expected level of competition because insurers have thus far been largely reluctant to cover them.

Gottlieb blamed “opaque” rebate arrangements between insurers and brand-name manufacturers for part of this reluctance. These arrangements offer rebates in exchange for agreements to cover a drug. He acknowledged that such practices exist for most drugs but insisted that they are especially problematic for biologics, which can cost several thousands of dollars per month, because they “encourage large list price increases” that inflate the amounts patients must pay out-of-pocket, often making the drugs inaccessible.

The commissioner also noted that biosimilars are only about 15-20 percent less costly than brand-name biologics, compared to the 50 percent price drop-off for traditional generic drugs. This means that an insurance plan would have to “switch all of their patients over to the biosimilar” in order to recoup the cost of the lost rebates. This produces a financial incentive to limit biosimilar use and “continue the flow of large rebate payments.”

As a potential solution, the commissioner praised UnitedHealthcare's announcement last week that it would pass along its negotiated rebates to its customers instead of using them to offset premiums or pad profit margins.

Insurers responded to Gottlieb's criticism by placing the blame on biologic manufacturers, who they insist "hike the prices of brand name biotech drugs before generic competition arrives", thus forcing biosimilar companies to "set their prices higher." America's Health Insurance Plans (AHIP) cited Humira as an example, whose price increased by 73 percent over the three years that a biosimilar neared approval.

AHIP also argued that since drugmakers typically only offer rebates once competitors hit the market and because biosimilars do not have the rebates that brand-name biologics do, passing on rebates to consumers would essentially encourage more use of the brand-name product. The association also pointed out that because of existing patents, biosimilar competitors can actually be forced to wait years to reach the market following FDA approval, as is the case with Humira whose patent does not expire until 2022.

STATES

Arkansas

CMS approves Medicaid work requirements but defers decision on partial Medicaid expansion

The Trump Administration has approved Arkansas' request to impose work requirements on "able-bodied" Medicaid adults but punted on its request to roll back its Medicaid expansion under the Affordable Care Act (ACA).

Kentucky and Indiana had already received federal approval for comparable work requirements, however Arkansas' would start in June for adults under age 50, making it the first to go into effect. Nine other conservative-leaning states have already submitted similar waiver requests (see Update for Week of February 12th).

Arkansas' waiver request concurrently sought to cut more than 300,000 adult enrollees from its Medicaid expansion program. Under the Obama Administration, Arkansas became the first state in the nation to receive federal approval for a "private sector alternative" to the ACA expansion and was allowed to use ACA matching funds to instead purchase Marketplace coverage for newly-eligible Medicaid enrollees so long as they expanded coverage for everyone earning up to 138 percent of the federal poverty level (FPL), as the ACA required (see Update for Week of September 25, 2013).

Despite its success, Arkansas' expansion has been under constant attack once the governorship and legislature transferred to Republican control (see Update for Weeks of February 8 and 15, 2015). Its latest effort would scale back the expansion threshold to only 100 percent of FPL, instead of 138 percent of FPL. Republican lawmakers argue that since eligibility for ACA premium tax credits starts at 100 percent of FPL, those earning from 100-138 percent of FPL use the tax credits to purchase Marketplace coverage instead of the state having to expand ACA matching funds for the identical coverage.

The Obama Administration had consistently refused to approve such partial expansion requests, including those in Utah and Wisconsin (see Update for Weeks of October 5 and 12, 2015). However, CMS Administrator Seema Verma had pledged to grants states more flexibility on such requests (see Update for Week of November 6, 2017). She did not offer any explanation for why CMS deferred its decision on Arkansas' partial expansion.

Administrator Verma had recused herself from decisions involving Kentucky and Indiana, since she helped design their waiver requests as a health care consultant. She played a similar role in crafting Arkansas' expansion waiver (and proposed work requirements), and drew the ire of Congressional Democrats for refusing to similarly recuse herself without explanation.

Oklahoma and Tennessee, which have not expanded Medicaid, became the latest states last week to start developing a plan to add Medicaid work requirements. To date, CMS has only approved work requirements for states that expanded Medicaid under the ACA. However, several non-expansion states including Alabama and Florida (see Update for Week of February 26th) are now seeking to apply work requirements to those with exceptionally low incomes. The Wyoming House refused this week to advance a Senate-passed measure that added work requirements after the Wyoming Hospital Association opposed it on the basis that it largely targeted single mothers because the state had not expanded Medicaid to include childless adults.

California

Covered California moves open enrollment start date up to October 15th

Covered California officials have confirmed that pursuant to state legislation enacted late last year (A.B. 156), the open enrollment period for 2019 coverage will run from October 15th through January 15th.

The Trump Administration had cut the open enrollment period for federally-facilitated Affordable Care Act (ACA) Marketplaces in half for 2018 (down from 12 weeks to six weeks). However, state-based Marketplaces were able to extend that period and California was one of only three (including the District of Columbia and New York) that elected to keep the same period ending on January 31st (see Update for Week of November 13th).

California will still have a 90-day open enrollment period for 2019 but will move the start date two weeks earlier than any other Marketplace. Open enrollment for non-Marketplace plans will also use the same window.

In order to make this change, Covered California will technically have to create special open enrollment periods from October 15th to November 1st and December 15th to January 15th. This is because federal regulations now designate November 1st to December 15th as the official open enrollment period.

Committee approves bill outlawing short-term health coverage that evades Affordable Care Act

The Senate Health Committee unanimously passed legislation last week that would prohibit insurers from offering short-term health insurance coverage lasting less than 12 months in duration.

S.B. 910 was introduced by chairman Ed Hernandez, O.D. (D) in direct response to proposed federal regulations that would allow insurers to evade the consumer protections in the Affordable Care Act (ACA) by simply limiting coverage to 364 days (see Update for Week of February 26th). (The Obama Administration had limited the use of short-term coverage to only 90 days).

Senator Hernandez insisted that the measure was needed to prevent the influx of “junk insurance” that would “destabilize” the individual health insurance market.

Covered California predicts that some state will see “catastrophic” rate hikes for ACA plans

An actuarial analysis released this week by Covered California predicted that without federal action to stabilize the individual health insurance market, every state will likely see premiums increase 12-32 percent for 2019 and have a cumulative premium-increase totaling 35-94 percent by 2021.

The study was prepared by researchers at the University of California-Los Angeles, University of California-San Diego, and Harvard University, with modeling done by the Milliman consulting firm. It put most the blame for the increases on Congress’ decision to repeal penalties for the individual mandate under the Affordable Care Act (ACA), starting next January (see Update for Week of December 18th). Researchers concluded that the repeal alone will increase premiums next year by at least 7-15 percent and by up to ten percent in each following year. Other contributing factors include the Trump Administration’s decision to slash marketing and outreach budgets for Marketplaces, shorten

the enrollment period time, and allow healthier consumers to enroll in association health plans as well as short-term limited-benefit health plans—both of which can avoid ACA consumer protections (see Update for Week of February 26th).

According to the analysis, every state is at risk of cumulative premium increases of at least 35 percent over the next three years. However, 17 conservative-leaning states in the south and midwest that are not likely to implement measures to preserve ACA protections are likely to face “catastrophic” rate hikes of more than 90 percent. Another 19 states are expected to see rates spike by at least 50 percent over that time.

The authors stress that a good portion of the rate increases could be mitigated by federal or state efforts to stabilize the Marketplaces, primarily through reinsurance programs that compensate insurers for exceptional claims (see Update for Week of November 6th). The expiration of the ACA’s three-year reinsurance program was largely to blame for premium spikes in 2017 and the study concludes that “a nationwide reinsurance program with annual funding of \$15 billion could result in average premium reductions of 16 to 18 percent.” Previous Covered California analyses have shown that because reinsurance programs result in lower premiums and thus more limited expenditures for premium subsidies, a program funded with \$15 billion would only have a net cost to the federal government of \$5 billion.

Other stabilization measures recommended by the authors include restoring the ACA cost-sharing reductions terminated last fall by the Trump Administration, as well as the marketing and outreach budgets that the Administration slashed by 90 percent (see Update for Week of November 13th).

Congress considered each of these measures as part of the omnibus spending bill that was passed this week, but ultimately failed to include any of them (see above).

Connecticut

Committee shelves two bills that would create state alternative to individual mandate under the ACA

The House Insurance and Real Estate Committee shelved competing measures this week that would have created a state alternative to the individual mandate under the Affordable Care Act (ACA).

Connecticut is one of ten Democratic-leaning states that have considered implementing their own individual mandate after tax penalties for the ACA’s individual mandate when repealed by Congress starting in 2019 (see Update for Week of December 18, 2017). Most of these states are seeking to pass an individual mandate with comparable tax penalties to the ACA, which for this year stood at \$695 or 2.5 percent of income (whichever is greater) for those who failed to maintain minimum essential coverage (MEC) they could afford (with a cap set at the national average Marketplace premium for family coverage at the bronze tier level).

However, the two bills in Connecticut have not followed this path. The first bill proposed by Governor Dannel Malloy (D) (H.B 5039) sought to create an individual mandate that had a lower penalty of \$500 or two percent of income, or 1/12 of that amount for each month the consumer fails to maintain MEC. However, committee leaders introduced their own version of the mandate (H.B. 5379) that imposed a dramatically higher penalty of 9.66 percent of income (capped at \$10,000), based on research from the Yale University School of Management concluding that this was the amount that sufficiently compelled younger and healthier consumers to purchase coverage and ensured risk pools were adequately balanced between healthier and sicker enrollees.

Critics of the individual mandate has long-insisted that the ACA version was “too weak”, noting that the Massachusetts model upon which the ACA mandate is based imposes far higher penalties, which are equal to roughly half of the least costly insurance premium in the Marketplace (although the penalty varies further by age and income). Committee leaders largely favored the higher penalty approach, pointing out that only 60,000 Connecticut residents actually paid the ACA penalty in 2016.

However, committee leaders were unable to agree on an appropriate penalty level prior to the committee deadline forcing chairman Sean Scanlon (D) to hold the measures for a later date. Senate President pro tem Martin Looney (D) has already pledged to try and attach some form of individual mandate this session as an amendment to other legislation.

District of Columbia

Marketplace board warns that association health plans could spike premiums and uninsured rates

The DC Health Benefit Exchange Authority (DCHBX) submitted public comments last week urging the U.S. Department of Labor (DOL) to withdraw its controversial proposed rule on association health plans (AHPs).

The proposed rule would allow health plans sponsored by trade associations to sell policies across state lines that no longer need to comply with certain ACA consumer protections, like essential health benefits or prohibitions on raising premiums based on gender or health status. DOL estimated that up to 11 million Americans who are self-employed or work for small business could benefit under these AHPs (that would be organized by a geographic area or industry), although Avalere Health consultants later forecast that only 3.2 million would actually enroll (see Update for Week of February 26th). However, Avalere warned that would still cause Marketplace premiums to rise by 3.5 percent as those enrolling in AHPs would largely be younger and healthier consumers needed to balance the costs of older and often sicker enrollees.

According to DCHBX, which is headed by former Maine Insurance Commissioner Mila Kofman, the “proposed regulation essentially repeals the Affordable Care Act without Congress” by allowing insurers to “cherry pick” these healthier consumers while leaving the most costly enrollees in ACA-compliant coverage. They cited an analysis prepared by Oliver Wyman actuaries warning of even more adverse impacts. For example, it predicted that allowing limited-benefit AHPs to be exempt from key ACA consumer protections would cause nearly three percent of those with individual coverage and 2.4 percent of those under small group coverage to become uninsured, all while increasing premiums for those in ACA-compliant plans by nearly 11 percent for individuals and 26 percent for small groups.

Idaho

Trump Administration rejects Governor’s request to sell “junk” plans that do not comply with ACA

The Centers for Medicare and Medicaid Services (CMS) announced last week that it has rejected Idaho’s proposal to allow insurers to sell limited-benefit plans that do not meet the consumer protections required under the Affordable Care Act (ACA).

The letter from CMS Administrator Seema Verma stated that although the Trump Administration opposes the ACA, it was required to uphold its provisions so long as the law remains on the books. However, the Administrator pledged to give Idaho “as much flexibility as permissible under the law” and encouraged the state to instead focus on offering short-term health plans that the Administration’s proposed regulations would allow to evade ACA standards so long as they expire within 364 days (see Update for Week of February 26th).

The Department of Insurance had issued regulations earlier this year, pursuant to an executive order from Governor Butch Otter (R) authorizing the agency to create limited benefit plans that cost 30-50 percent less (see Update for Week of January 8th). Director Dean Cameron (R) insisted that the lower-cost plans were necessary to mitigate premium spikes by giving consumers the option to purchase only those benefits they need, instead of plans that mandate the coverage of all essential health benefits under the ACA, including mental health, maternity care, and prescription drugs. He stressed that insurers would still have to concurrently offer ACA-compliant options in the individual market (see Update for Week of January 22nd).

Blue Cross of Idaho promptly agreed to offer Freedom Blue Standard products that increase premiums based on medical status, offer limited benefits, impose \$1 million annual caps and dramatically higher deductibles, and require a 12-month waiting period for coverage of pre-existing conditions if the consumer had a lapse in coverage of least 63 days (see

Update for Week of February 12th). Consumers deemed the “healthiest” would be charged premiums that are 50 percent below standard rates while those deemed the least healthy would be charged 50 percent above standard rates.

Despite Blue Cross’ lead, other Idaho insurers had elected to take a “wait and see” approach to find out if the plans would first survive expected legal challenges (see Update for Week of February 12th). PacificSource also expressed concern that the non-compliant plans would siphon away younger and healthier consumers from the ACA Marketplace, which would trigger “considerable market instability and risk.”

Governor Otter and Director Cameron insisted they would not back away from the non-compliant plans and consider CMS’ letter to be an “invitation” and not a rejection. Following a meeting this week with CMS and White House officials, Director Cameron announced that his department would make several modifications to their regulations on non-compliant plans in order to clear up “misunderstandings with our guidance and misunderstandings with our position.” He would not disclose the specific modifications, but commentators largely expect them to revolve around the ACA prohibition on increasing premiums based on health status, which was the primary objection that CMS articulated in its letter.

House refuses for a second time to vote on Governor’s Medicaid expansion plan

For the second time this year, Republican leaders in the House refused to hold a floor vote this week on legislation proposed by Governor Butch Otter (R) that would provide a limited expansion of the Medicaid program.

The measure (H.464) would not expand Medicaid under the Affordable Care Act (ACA), a move staunchly opposed by conservative lawmakers for six consecutive sessions despite the urging of the Governor’s own task force (see Update for Week of November 12, 2012). However, it would allow more than half of the 78,000 Idahoans caught in the coverage gap between Medicaid eligibility and the threshold for ACA premium tax credits to have access to those tax credits and purchase coverage in the Marketplace that Idaho operates pursuant to the ACA. In addition, it would lower Marketplace premiums by transferring up to 3,500 of the most costly Marketplace consumers into traditional Medicaid.

In an effort to attract conservative support, H.464 would also impose work requirements on “able-bodied” adults, similar to provisions the Trump Administration has already approved for three states (see Arkansas above).

H.B. 464 currently has the support all Democrats and four House Republicans (including Reps. Christy Perry and Eric Redman). As a result, it was able to twice clear the House Health and Welfare Committee. However, on each occasion House leaders have sent the bill back to committee without a vote, insisting that it does not have enough support to clear the chamber.

The rejection is generating further momentum for consumer advocates to place a referendum on this fall’s ballot that would leave the decision up to the voters (see Update for Week of December 18th). Medicaid for Idaho, which is sponsoring the initiative, insists that it already has nearly double the required 56,192 signatures that it needs before May. If the signature drive succeeds, the referendum is expected to pass based on the 2017 Idaho Public Policy Survey that showed it was supported by more than 70 percent of voters polled. However, the Deputy Attorney General has warned that the referendum may be subject to legal challenges because it requires an “immediate” expansion.

Maine became the first state last fall to pass a voter referendum forcing their state to participating in the Medicaid expansion under the ACA (see Update for Week of November 6th).

Michigan

Governor signs law regulating biosimilar substitution

Governor Rick Snyder (R) signed H.B. 4472 into law last week, making Michigan the latest state to allow pharmacists to substitute biosimilar drugs designated by the Food and Drug and Administration (FDA) as “interchangeable” for brand-name biologics.

The measure passed the legislature with broad bipartisan support and was backed by the Biotechnology Innovation Organization (BIO). It specifically would let a pharmacist who receives a prescription for a brand-name biologic drug dispense a lower cost but “interchangeable” biosimilar product. However, it requires the pharmacist to notify both the prescribing physician and patient of the substitution and does not allow for substitution if the physician states that the prescription must be dispensed as written.

The Affordable Care Act (ACA) created the first regulatory pathway for approval of biosimilar drugs (see Update for Weeks of March 2 and 9, 2015) and three FDA-approved biosimilars are already on the market (with six more about to launch). However, none has yet to meet FDA standards for interchangeability under guidance released last year, where they could be switched back and forth with the name-brand biologic without any increased risk (see Update for Week of January 30, 2017).

Although the FDA is in charge of determining whether a biosimilar is “interchangeable”, it is up to states to judge whether one product may be substituted in place of a physician prescription and whether a pharmacist must inform patients or physicians if they make a substitution. At least two dozen states have passed legislation similar to Michigan’s, which are based on model legislation proposed by BIO (see Update for Week of January 9, 2017).

Minnesota

New study confirms reinsurance payments have dramatically reduced monthly premiums

Researchers with the Urban Institute have concluded that the reinsurance program created by Minnesota in 2017 has slashed average premiums by up to 15 percent.

Minnesota became the second state after Alaska to enact their own reinsurance program, after the temporary payments under the Affordable Care Act (ACA) expired at the end of 2016. By using a state budget surplus to compensate insurers for exceptional claims, Minnesota was able to dramatically reduce the average 59 percent rate hike that consumers were facing for that year (see Update for Week of May 8th).

Minnesota’s program is one of three for which the Trump Administration subsequently approved and agreed to largely fund (see Update for Week of December 18th). The Urban Institute study credits it with reducing average monthly premiums this year for a 40-year old nonsmoker buying the lowest-priced silver-tier plan to \$365, well below the \$444 average nationwide (which increased by nearly one-third for 2018).

The study points out that average premiums for comparable coverage are increasing in most states. Even in Rhode Island, which has the lowest average of \$287 per month, rates increased 13 percent in 2018. The hike was even steeper (74 percent) in Wyoming, which now has the highest national average of \$860 per month.

The findings are likely to only bolster efforts by roughly a dozen states to create their own reinsurance programs, following the lead of the approved federal waivers for Alaska, Minnesota, and Oregon.

New Hampshire

Senate votes to reauthorize Medicaid expansion alternative if enrollees are moved into managed care

The Senate voted 17-7 last week to approve legislation that would reauthorize New Hampshire’s Medicaid expansion for five years but convert it to a purely managed care model.

New Hampshire is one of eight states that received federal approval to use Affordable Care Act (ACA) matching funds for the Medicaid expansion to instead purchase private coverage in the ACA Marketplace for those that the law makes newly-eligible for Medicaid (see Update for Week of September 29, 2014). The Premium Assistance Program (PaP) has been very successful, enrolling more than 52,000 consumers since 2015 or roughly 42 percent of the entire

individual market (see Update for Week of August 14th). However, Republican lawmakers have reauthorized the program only through the end of 2018 and created a legislative commission to recommend more conservative-favored reforms such as work requirements and eligibility verification measures that were disallowed by the Obama Administration (see Update for Week of November 13th).

S.B. 313 follows the commission's recommendations to require the newly-eligible population to obtain coverage through Medicaid managed care plans instead of the ACA Marketplace (see Update for Week of November 13th). The Commission cited a private study commissioned by the Insurance Department that found this group was 26 percent more costly than non-Medicaid consumers and thus puts upward pressure on premiums by being in the Marketplace risk pool (see Update for Week of August 28th).

The bill includes new work requirements on "able-bodied" adults that the Trump Administration has approved for three states and are being sought by roughly another dozen conservative-leaning states (see Update for Week of February 26th). However, it still received the support of all ten Senate Democrats (seven Republicans voted no).

If the measure passes the House, it is likely to be signed by Governor Chris Sununu (R) who has pledged his support.

Oregon

Governor signs prescription drug price transparency bill

Governor Kate Brown (D) signed H.B. 4005 into law this week, making Oregon the sixth state to establish new standards to increase the consumer transparency for prescription drug prices.

Under the new law, drug manufacturers must compile a report on each prescription drug that costs \$100 or more for a one-month supply (or for a course of treatment lasting less than one month) or for which the net price jumps by ten percent or more. For each of the drugs, the manufacturer must provide data demonstrating the "factors that contributed to the price increase," research and development costs, and the direct costs incurred to manufacture, market and distribute the drug. In addition, the manufacturer must list the "10 highest prices paid for the prescription drug during the previous calendar year in any country other than the United States."

California enacted a drug price transparency law last year that is still considered the most comprehensive in the nation, as it requires manufacturers to notify health insurers and government health plans at least 60 days before increases in drug wholesale acquisition costs (WAC) that exceed 16 percent over a two-year period (see Update for Week of November 6th). It applies to drugs with a WAC of \$40 or more.

Utah

Legislature approves partial Medicaid expansion, despite lack of federal approval

The House and Senate sent legislation Governor Gary Herbert (R) last week that would partially expand Medicaid while imposing work requirements on those newly-eligible.

Under H.B. 472, Medicaid would cover those earning up to 95 percent of the federal poverty level (or roughly 70,000 additional enrollees). It is not yet clear if the Governor will approve the legislation, which differs dramatically from the full expansion up to 138 percent of the FPL (or 146,000 new enrollees) that he negotiated with the Obama Administration before being rejected by the legislature (see Update for Week of July 25, 2016).

It likewise is not clear if the Trump Administration will approve the necessary waiver for a partial expansion. The Obama Administration had consistently made Medicaid expansion an "all or nothing" proposition, refusing to release ACA matching funds to states that sought only to partially expand (see Update for Weeks of October 5 and 12, 2015). The

Trump Administration has promised greater flexibility on the issue (see Update for Week of January 30, 2017), but deferred any decision on the partial expansion waiver sought by Arkansas (see above).

Vermont

Governor signs bill allowing insurers to load costs of ACA cost-sharing subsidies onto silver plans

Governor Phil Scott (R) signed legislation last month allowing individual health plan insurers to reflect lost cost-sharing subsidies under the Affordable Care Act (ACA) into 2019 premiums for silver-tier Marketplace plans.

Vermont was one of only three states (including North Dakota and the District of Columbia) who were not allowed to increase 2018 premiums in order to account for the ACA cost-sharing reductions (CSRs) that the Trump Administration terminated last fall (see Update for Week of November 6th). This forced insurers to take a loss (estimated at \$12 million for the year in Vermont), since consumers were statutorily entitled to the CSRs under the ACA statute, which has not been repealed.

Vermont and the District of Columbia did not allow offsetting premium increases because they previously were the only two states that require Marketplace and non-Marketplace plans to be identical for the individual market. The new law (S.19) corrects that restriction by allowing differential pricing in and out of the Marketplace. As a result, insurers within Vermont Health Connect (the ACA Marketplace) can add the cost of lost CSRs to silver plans for 2019, while silver plans outside the Marketplace will not have the lost CSR costs reflected.

House passes state-alternative to repealed individual mandate under the ACA

The House passed legislation last week (H.696) that would require state residents maintained minimum essential health coverage they can afford.

The bill would go into effect on January 1, 2019, the same date that penalties for the comparable individual mandate under the ACA are slated to be repealed by Congress (see Update for Week of December 18th). This would ensure a seamless transition to Vermont's alternative. However, the measure leaves decisions on the penalty amounts and enforcement up to a working group that would be formed if the legislation is enacted.

Vermont is one of ten Democratic-leaning states that are considering measures that would establish some form of individual mandate (see Update for Week of February 26th). A Hawaii bill that would establish a mandate with comparable penalties to the ACA version (S. 2924) has already passed the Senate and two House committees, while similar measures have passed the Maryland House (H.B. 1782) and two Senate committees in New Jersey (S.1877). However, two bills that would create very different individual mandate penalties in Connecticut were rejected this week in committee (see above).

Virginia

Governor calls special session to resolve Medicaid expansion impasse

Governor Ralph Northam (R) announced this week that he will call the General Assembly into a special session starting April 11th in order to resolve the impasse over Medicaid expansion that impeded passage of a state budget.

The House of Delegates passed a budget plan last month that for the first time agreed to participate in the Medicaid expansion under the Affordable Care Act (ACA) (see Update for Week of February 12th). In order to gain support from holdout conservatives, the plan included work requirements for "able-bodied" Medicaid enrollees, similar to those the Trump Administration has already approved for Kentucky and Indiana (see Update for Week of February 26th).

However, the work requirements have not been enough to persuade Republicans who narrowly control the Senate, even though the ACA expansion would bring in nearly \$3.5 billion federal funding that would give the

commonwealth a large budget surplus over the two-year budget cycle. Under the House plan, the commonwealth's share of costs would be funded through a hospital assessment. Thus far, the Senate has only proposed form of Medicaid expansion that lacks any funding mechanism (see Update for Week of February 12th).

In order to help facilitate passage, Governor Northam submitted a new budget plan this week that was the same as his predecessor's but would reserve the projected surplus from Medicaid expansion into a rainy day fund instead of spending it. It was immediately rejected by Senate Majority Leader Tommy Norment (R).

Both chambers must pass a budget by June 30th or risk another government shutdown, such as the one that occurred in 2014 when the House refused to go along with a Senate-passed alternative to the ACA expansion (see Update for Week of September 15, 2014).

Governor considers bill that would make catastrophic health plans available to full individual market

The House and Senate transmitted legislation this week to Governor Ralph Northam (D) that seeks to make catastrophic health plans available to all consumers in the individual market.

The Affordable Care Act (ACA) created the high-deductible, limited-benefit plans only for Marketplace consumers under the age of 30, or for those who meets exemptions for hardship or affordability. They provide coverage for all essential health benefits but limit consumers to only three primary care visits per year.

Under S.B. 964, the Insurance Commissioner would be authorized to seek a federal waiver allowing Virginia to remove the age limit, so that any individual market consumer has access to the catastrophic tier option. The waiver would also remove the requirement that insurers must offer the catastrophic option in every locality in which it offers another health benefit plan.

Similar legislation in Colorado (S.B. 132) passed their Senate earlier this month (see Update for Week of February 26th).

Washington

Marketplace announces record enrollment for 2018 despite premium spike, shorter enrollment period

Officials with the Washington Health Benefit Exchange announced this week that a record 209,802 consumers used the Washington Healthplanfinder Marketplace created pursuant to the Affordable Care Act (ACA) to purchase coverage during the 2018 open enrollment period.

This final tally is nearly three percent higher than for 2017 and 50 percent higher than the number of enrollees following the inaugural open enrollment period in 2014. Officials were pleased that more than 36 percent of sign-ups were new enrollees, which enabled the Marketplace to exceed expectations despite efforts by Congress and the Trump Administration to depress enrollment (see Update for Week of November 13th). Although federal regulations cut the open enrollment in half (to only 45 days), Washington exercised their discretion as a state-based Marketplace to extend open enrollment an extra 30 days (through January 15th). However, in the end, 95 percent of all consumers signed-up before the December 15th deadline the Administration set for federally-facilitated Marketplaces.

The Administration's decision to terminate the ACA's cost-sharing reduction payments for insurers only days before the start of open enrollment caused a \$66 per month spike in average monthly premiums. However, this spike dramatically inflated the amount of premium tax credits received by consumers (see Update for Week of November 13th). In Washington, this resulted in each subsidy-eligible consumer receiving an average of \$263 in tax credits per month, compared to only \$75 last year. As a result, more comprehensive coverage suddenly became more affordable for most consumers resulting in an 82 percent increase in those selecting gold-tier coverage.