Health Reform Update – Week of June 25, 2018

CONGRESS

Senate subcommittee unanimously approves omnibus bill that boosts non-ACA related health spending

The Senate Appropriations Health and Human Services subcommittee unanimously approved a fiscal year 2019 omnibus spending bill this week that would increase funding for most health agencies while blocking funds for Affordable Care Act (ACA) programs.

Under the measure (H.R. 5895), the Department of Health and Human Services would receive a $2.3 billion increase while funding would be boosted for the National Institutes of Health and Centers for Disease Control and Prevention by slightly lower amounts. The increases are a sharp contrast to the dramatic 20 percent funding cut for NIH sought by the President (see Update for Week of May 8, 2017) and are expected to be approved by the full Appropriations Committee after the holiday recess.

A notable provision in the legislation would specifically deny the reimbursement of any outstanding funds due to insurers under the ACA temporary risk corridors program that expired after 2016. The U.S. Court of Appeals for the Federal Circuit recently ruled that the Trump Administration is not obligated to pay these amounts (which were intended to compensate insurers for exceptional claims) even though they were provided by statute (see Update for Week of June 11th). At least 20 insurers have filed lawsuits trying to force the outstanding funds to be paid (see Update for Week of August 15, 2016).

HRSA asks Congress for greater 340B oversight in final Senate hearing

The Senate Health Education Labor and Pensions Committee held its third and final hearing last week regarding reforms to the Section 340B drug discount program.

The head of the 340B program under the Health Resources and Services Administration (HRSA) provided an overview of how HRSA has already heeded recommendations from Congress and the Office of the Inspector General (OIG) for the Department of Health and Human Services (HHS) to create greater oversight over whether the discounts are properly benefiting low-income, uninsured individuals or being used by participating safety net providers to reap “windfall” profits, as audits from both the OIG and Government Accountability Office have suggested (see Update for Weeks of July 1 and 8, 2013). Director Kristen Pedley also outlined steps Congress could take to the give the agency the needed authority to conduct adequate oversight and enforcement.

The House Energy and Commerce Committee released its report earlier this year concluding that 340B savings are not properly being passed on to consumers and calling on Congress to increase and standardize reporting and audit requirements and provide HRSA with enhanced authority and resources (see Update for Week of January 8th). This led to a flurry of House and Senate bills that would heighten reporting and transparency requirements for 340B providers (see Update for Week of March 19th). However, during the hearing Senate HELP chair Lamar Alexander (R-TN) downplayed the likelihood of any legislation being advanced this year.

FEDERAL AGENCIES

Trump Administration finalizes rule allowing for association health plans

The Department of Labor (DOL) finalized regulations last week that will expand the ability of employers to band together to create association health plans (AHPs) that need not comply with specific consumer protections in the Affordable Care Act (ACA).

The final rule, which applies only to employer-sponsored health insurance, would allow employers to join together as a single group to purchase insurance in the large group market if they (1) are in the same trade, industry, line of business, or profession; or (2) have a principal place of business within a region that does not exceed the boundaries of the same state or the same metropolitan area. Sole proprietors and other self-employed individuals could also join AHPs.

The Trump Administration has promoted AHPs as a means to expand consumer choice and lower premiums by allowing employers to offer more limited coverage to healthier consumers (see Update for Week of January 8th). However, opponents quickly pointed out that siphoning away younger and less-costly consumers into limited-benefit plans would cause premiums to spike in ACA-compliant coverage whose risk pools will consequently be skewed towards sicker and more-costly subscribers.

In an effort to mitigate these concerns, both the proposed and final regulations retained many of the ACA non-discrimination provisions, including prohibitions on insurer denials based on pre-existing conditions and varying premiums based on health status. However, AHP plans would be allowed to increase premiums based on non-health factors such as age and geography, subject to state regulations.

The final rule largely mirrors the proposed rule. However, in response to public comments, DOL did add a requirement that AHPs have at least one business purpose other than providing insurance coverage. DOL also elected to stagger the effective date of the rule. While all associations (new or existing) can begin to offer fully-insured AHPs on September 1st, the rule will not be effective until January 1st for self-funded AHPs that are in an existing association that has previously offered insurance. Self-funded AHPs that are offering insurance for the first time cannot be established until after April 1st.

Several supporters, including the National Restaurant Association (which has already created an AHP), were upset that the final rule did not make any changes to the regulatory structure of fully-insured AHPs, which will continue to be jointly overseen by federal and state officials (see Update for Week of June 11th). NRA also unsuccessfully sought to create an exemption from state regulation for self-insured products.

Business groups remain divided on the rule, with the U.S Chamber of Commerce applauding the greater "relief and flexibility" they would provide employers while the Small Business Majority insisted that AHPs would cause the "market for small businesses to split in two, leading to major spikes in premiums for small firms that remain in the small group market."

America's Health Insurance Plans (AHIP) and the Blue Cross Blue Shield Association continued to express concern that "broadly expanding the use of AHPs may lead to higher premiums for consumers who depend on the individual or small group market" and puts "consumers at greater risk of fraudulent actors entering this market."

The Democratic attorneys general from Massachusetts and New York promptly announced that they would file suit to block the final rule from going into effect, insisting that expanding AHPs will "invite fraud, mismanagement and deception."

Critics of the DOL rule have repeatedly pointed out that several states including Georgia, Maine, Oklahoma, and Wyoming already passed laws allowing interstate AHPs and were not able to draw any interest from insurers (see Update for Week of April 9, 2012). Last year's Congressional bill to allow AHPs (H.R. 1101) gained only 37 Republican cosponsors.

Trump Administration asks for more time to respond to insurer lawsuit demanding CSR payments

The Department of Justice (DOJ) has asked the U.S. Court of Federal Claims to extend the deadline for it to respond to Blue Cross Blue Shield (BCBS) of Vermont's lawsuit over the Trump Administration's failure to pay Affordable Care Act (ACA) cost-sharing reductions since the last quarter of 2017.

The President terminated the CSRs shortly before the start of the 2018 open enrollment period after they were invalidated by a lower court ruling in 2016 (see Update for Week of November 6th). DOJ subsequently agreed to vacate that ruling as part of a settlement with 18 Democratic state attorneys general whose appeal threatened to overturn it (see Update for Week of December 18th).

However, BCBS Vermont had filed suit in March claiming that the Administration's termination of CSRs was an unlawful taking under the U.S. Constitution because it violated an implied contract where insurers reduced consumer cost-sharing under the statutory agreement that they would be later compensated by the Administration for those reductions. BCBS Vermont insists that it incurred at least $4.6 million in lost reimbursement from the unreimbursed CSRs, because Vermont was one of two states that did not allow insurers to mitigate CSR losses by hiking rate on the silver-tier plans to which the CSRs are tied. Vermont subsequently changed their policy for next year (see Update for Week of March 19th).

DOJ is asked for a 30-day extension to respond to the lawsuit due to a separate ruling by the U.S. Court of Appeals for the Federal Circuit overturning a decision from the Court of Federal Claims that denied insurers reimbursement for amounts owed under the ACA's temporary risk corridor program that expired after 2016 (see Update for Week of June 11th). DOJ claims that the appellate courts' ruling in that case may impact whether insurers are due outstanding CSR payments, not only in the BCBS Vermont case but by similar lawsuits filed by a dozen other insurers.

STATES

California

New budget will expand Medi-Cal coverage to more than 2,000 enrollees with Hepatitis C

Governor Jerry Brown (D) signed a revised budget bill this week that will make available an additional $176 million to expand Medi-Cal coverage for persons with the Hepatitis C virus (HCV).

Following the lead of Oregon and Illinois, Medicaid programs in California and at least 33 other states took steps to ration the availability of emerging HCV "cures" over 2014 and 2015 (see Update for Week of January 4, 2016). The National Association of Medicaid Directors insisted that states had no alternative given that the cost covering those drugs for every Medicaid enrollee with HCV was more than 300 percent of the total pharmacy budget in several states.

However, the Centers for Medicaid Services (CMS) warned Medicaid agencies in 2015 that such rationing of care violates federal Medicaid law and at least one federal court concurred, forcing them to be rescinded in Washington (see Update for Week of June 20, 2016). As a result, most states have started to voluntarily relax their restrictions, most recently Colorado, which made HCV coverage available to all Medicaid enrollees late last year (see Update for Week of December 18th). Currently, coverage is limited to HCV enrollees with liver scarring or HIV, women of childbearing age, active injection-drug users, and patients who fall into other high-risk categories—limitations that are not nearly as severe as those imposed by other states.

The Department of Health Care Services expects that the broader restrictions will expand coverage to roughly 2,090 Medi-Cal enrollees with HCV over the next fiscal year. About 7,800 Medi-Cal enrollees with HCV can access their medications under the current policy.

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Assembly and Senate resurrect efforts to expand Medicaid to undocumented immigrants

The Assembly and Senate health committees approved legislation this week that would expand Medi-Cal coverage to undocumented immigrants under age 26 and over age 65.

The measures (A.B. 2965 and S.B. 974) passed their chambers of origin last month and now move on to the Appropriations Committee in the opposing chambers before heading to a floor vote. The expanded coverage would cost the state roughly $3 billion for fiscal year 2019, according to the Legislative Analyst's Office.

California became the first state in the nation in 2016 to extend full Medi-Cal benefits to children of undocumented residents who are under age 19 (see Update for Weeks of October 5 and 12, 2015). Washington, New York, Illinois and Massachusetts have since implemented similar policies.

Governor Brown subsequently signed legislation that would have allowed undocumented immigrants to purchase coverage in Covered California (see Update for Week of June 20, 2016). The Governor sought the required federal waiver, which was needed since the Affordable Care Act (ACA) limits Marketplace eligibility to citizens or permanent residents. The Obama Administration was expected to approve the waiver before leaving office, but the bill's sponsor Ricardo Lara (D) quickly withdrew the waiver following the inauguration of President Trump for fears that his Administration would use data collected from the application to identify and deport undocumented immigrants (see Update for Week of January 30, 2017).

Delaware

Senate resolution aims to study whether consumers can buy into Medicaid

The Senate and House passed a concurrent resolution this week with no dissenting votes that directs the General Assembly to create a Medicaid Buy-In Study Group to recommend by January 31st if and how the state should allow consumers earning above Medicaid eligibility limits purchase Medicaid coverage.

Under S.C.R. 70 sponsored by Senator Margaret Rose Henry (D), the Study Group would be composed of lawmakers and the heads of applicable state agencies. However, it would also require that the group include at least two representatives each from insurers, physicians, and hospitals, while three representatives from consumer groups would be named by the governor.

Delaware is one of 34 states that have expanded Medicaid under the Affordable Care Act (ACA) to include everyone earning up to 138 percent of the federal poverty level. The proposed buy-in would allow consumers above that threshold to pay sliding-scale premiums to purchase Medicaid coverage.

Medicaid buy-in legislation has been considered in several states with Democratically-controlled legislatures but struggled to gain traction. Nevada Governor Brian Sandoval (R) vetoed the only Medicaid buy-in measure that cleared a legislature last year (see Update for Weeks of June 12 and 19, 2017) while the New Mexico legislature created a comparable study group to the one proposed in Delaware (see Update for Week of January 22nd). Other bills have been introduced in Colorado (see Update for Week of April 16th), Illinois, Iowa, Massachusetts (see Update for Week of November 6th), Minnesota (see Update for Week of February 26th), Missouri, New Jersey, and Washington.

A Congressional measure to create a Medicaid buy-in program for all states was introduced last year by Rep. Brian Schatz (D-HI) but gained little support (see Update for Week of August 28th).

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Florida
Marketplace consumers will see single-digit rate hikes, additional competition

The Office of Insurance Regulation (OIR) revealed this week that all six of the insurers participating in Florida's Affordable Care Act (ACA) Marketplace will return for 2019 and be joined by new entrant Oscar Health (which is also expanding into Arizona and Michigan).

Although proposed rates for each insurer have yet to be released, OIR did disclose that the average premium increase sought by the insurers is 8.8 percent. This is a dramatic reduction from 17.8 percent average hike they sought for 2018 and the 44.7 percent average increase that OIR ultimately approved based on the assumption that Trump Administration would eliminate the cost-sharing reductions under the ACA (see Update for Week of October 2nd). (OIR blamed at least 31 percent of that increase on the CSR termination).

Despite having robust competition in major metropolitan areas, Florida Blue was the only insurer in 2018 that offered Marketplace coverage in all 67 counties. OIR has not yet revealed whether they will continue to be the only statewide player for 2019.

Florida's federally-facilitated Marketplace (FFM) enrolled more than 1.7 million consumers during the 2018 open enrollment period, by far the highest of any federal or state-controlled Marketplace (see Update for Week of February 12th). Enrollment slipped by 2.5 percent from 2017 due largely to the shorter open enrollment period and 90 percent cut in the advertising outreach budget. However, that was only half the average drop for FFMs.

Illinois
Legislature passes bills to protect consumers from efforts to weaken Affordable Care Act

The Democratically-controlled legislature has sent Governor Bruce Rauner (R) two bills that intend to preserve consumer protections in the Affordable Care Act (ACA) and limit the use of non-compliant short-term coverage sought by the Trump Administration.

The first measure (H.B. 4165) would specifically bar state agencies from applying for any federal waiver that would "reduce or eliminate any protection or coverage" provided by the ACA without the approval of the General Assembly, including the minimum essential health benefits packages required by the law and the prohibitions on insurer denials for pre-existing conditions. The bill also specifically would prohibit any state agencies from applying for a federal waiver that would result in more restrictive standards, methodologies, or procedures for the Medicaid program.

The second measure (H.B. 2624) would require any short-term health plan that expires in less than 365 days to explicitly notify potential subscribers in writing that the plan does not comply with the consumer protections in the ACA, including essential health benefit packages or protections against discrimination based on pre-existing conditions. The Trump Administration has proposed to allow the issue of such short-term coverage starting next year (see Update for Week of February 26th).

It is not clear that Governor Rauner, who is in a tough re-election battle, will sign either bill.

Kentucky
Federal judge blocks work requirements for Medicaid adults

A federal court has invalidated the Trump Administration's approval of a federal waiver that would have allowed Kentucky to impose work requirements on most adult Medicaid enrollees, double Medicaid premiums beyond what is allowed under federal law, and lock-out Medicaid enrollees for not timely complying with reporting requirements.

Governor Matt Bevin (R) made Kentucky the first state to impose the work requirements on all "able-bodied" adults of working age, a move that he acknowledged would end coverage for roughly 95,000 enrollees or nearly 20 percent of the entire Medicaid expansion population (see Update for Week of January 8th). Three consumer groups led by the National Health Law Program promptly filed suit in the District of Columbia federal court on behalf of 16 Kentucky Medicaid enrollees, alleging that the Centers for Medicare and Medicaid Services (CMS) lacked the authority to approve the work requirements and higher premiums, which previous Administrations believed to violate federal Medicaid law (see Update for Week of January 22nd).

When the case was appointed to Judge James Boasberg, an Obama-appointee, Governor Bevin unsuccessfully tried to transfer the case to the Eastern District of Kentucky, where all but one judge is a Republican appointee, before filing a countersuit against the D.C. plaintiffs in that jurisdiction (see Update for Week of February 26th). The Governor also issued an executive order threatening to terminate the state's entire Medicaid expansion under the ACA (which was enacted by his Democratic predecessor) if the federal courts struck down the work requirements (see Update for Week of February 12th).

Judge Boasberg's opinion focused on the 95.000 adults who would lose Medicaid coverage, stating that CMS "paid no attention to that deprivation" or addressed how Kentucky would otherwise help furnish medical assistance to those enrollees in accordance with their obligations under federal Medicaid law. As a result, the Judge found that "this single omission renders [the CMS] determination arbitrary and capricious" and blocked its July 1st implementation, concluding that even a temporary implementation could "cause serious harm".

Governor Bevin had previously promised to appeal any adverse lower court decision and his executive order specifically does not terminate the Medicaid expansion until "all judicial appeals have been exhausted" or six months have passed. However, Boasberg's decision could stall the waiver requests for Medicaid work requirements that remain pending with CMS and threaten to undo the comparable waivers that CMS subsequently approved for Arkansas, Indiana, and New Hampshire.

Although the judge's ruling dealt primarily with the work requirements, it also invalidated the premiums the waiver sought to apply on higher-income enrollees (that would have gone up to four percent of income) as well as the lock-out requirements that CMS approved for other states.

Maine

Supreme Court lets Governor delay compliance with voter mandate to expand Medicaid

The Maine Supreme Judicial Court has granted the request by Governor Paul LePage (R) to stay a lower court order forcing him to expand Medicaid under the Affordable Care Act (ACA) until his appeal his heard.

The Superior Court had directed the Governor to submit a state plan amendment (SPA) to the federal government by June 11th after he had refused to comply with the mandate passed by the voters last fall to expand Medicaid (see Update for Week of June 11th). Under the voter referendum, the Governor was required to submit the SPA by April 3rd and promulgate necessary regulations by July 3rd. However, Governor LePage refused to do so unless the legislature appropriated double the $30.5 million that Manatt Health predicted Maine would need to pay for the ten percent share of Medicaid expansion costs (see Update for Week of December 18th).

Maine Equal Justice Partners and other consumer and providers groups filed suit in the Superior Court after the legislature ended its regular session without making any appropriation (see Update for Week of May 7th). The court agreed with the plaintiffs that Maine had more than enough budget reserves to fund the expansion through at least May 2019 and could enter into a binding contract with the Trump Administration to expand Medicaid without any appropriation (see Update for Week of June 11th).

The legislature did pass a bill last week appropriating $55 million for the first year of the Medicaid expansion (L.D. 837), which would appear to void the Governor's basis for appeal. However, Governor LePage could choose to veto the measure, as he has done with six other bills the Democratically-controlled legislature passed to expand Medicaid (see Update for Week of April 18, 2016).

The Supreme Court will not hear oral arguments on the Governor's appeal until July 18th.

Massachusetts

CMS refuses to grant waiver for closed Medicaid drug formulary, Medicaid expansion rollback

The federal Centers for Medicare and Medicaid Services (CMS) announced this week that they will not allow Massachusetts to create a closed prescription drug formulary for Medicaid enrollees.

Under federal law, Medicaid programs must cover any drug approved by the Food and Drug Administration (FDA). In return, drug manufacturers must provide rebates to states based on a set formula that typically results in at least a 23 percent rebate on the brand-name price and a 13 percent for generic drugs. States can negotiate for additional rebates if they agree not to attach restrictions to new prescription drugs.

Massachusetts became the first state last fall to seek the Trump Administration's approval to refuse Medicaid coverage for certain drugs, arguing that covering all FDA-approved therapies creates an incentive for patients to enroll in Medicaid even when employer-sponsored coverage may be available to them (see Update for Week of December 18th). In order to prevent this, Massachusetts tried to use a Section 1115 federal demonstration waiver to exclude coverage for those drugs it determines do not have a significant, clinically meaningful, therapeutic advantage in terms of safety, effectiveness, or clinical outcome over another drug on the state's formulary, so long as at least one medicine for every "therapeutic class" or group of medications designed to treat specific conditions (such as HIV or hepatitis C).

The request is modeled after Medicare Part D and the Veterans Health Administration, which both used closed formularies (although Part D requires at least two drugs be covered for each "therapeutic class"). Arizona sought a similar waiver but followed the Part D model, while Massachusetts' proposal was more restrictive (see Update for Week of December 18th).

The waivers were strongly opposed by the Pharmaceutical Research and Manufacturers of America (PhRMA) as well as some consumer groups like the American Cancer Society. However, CMS said that the waiver was rejected because Massachusetts sought to continue receiving rebates through the Medicaid Drug Rebate Program, which it could not do if a closed formulary were applied.

CMS also refused Massachusetts request to roll back its participation in the Medicaid expansion under the Affordable Care Act (ACA), which requires state coverage everyone earning up to 138 percent of the federal poverty level (FPL) in order to received ACA matching funds. Massachusetts had sought to limit coverage only to those earning up to 100 percent of FPL, a threshold that several conservative-led states had sought under the Obama Administration but were consistently denied (see Update for Week of November 30, 2015).

The agency did approve a request from Oklahoma allowing that state to negotiate supplemental drug rebates with drug manufacturers involving value-based purchasing. The move would allow the state to receive additional rebates whenever certain clinical outcomes are not achieved.

CMS also reiterated that all Medicaid programs must cover drugs approved with a lower standard of evidence that the accelerated approval program created by the federal Food and Drug Administration.

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Despite the denial of Massachusetts' proposal, the President has proposed a comparable plan as part of his fiscal year 2019 budget that would allow up to five states to opt-out of the Medicaid Drug Rebate Program, impose closed drug formularies, and negotiate their own rebates from drug manufacturers.

Montana
Premium increases will remain modest for 2019

Initial rate filings released this week by Insurance Commissioner Matt Rosedale (R) showed that all three participating insurers in Montana's Affordable Care Act (ACA) Marketplace will remain for 2019 and are seeking premium increases of only six percent on average.

The highest average increase of 10.6 percent belongs to Montana Health CO-OP, one of only four remaining non-profit Consumer Operated and Oriented Plans (CO-OPs) created with ACA loans. Despite its financial struggles, Montana Health CO-OP has successful enrolled more consumers (23,300) than either Blue Cross and Blue Shield (BCBS) of Montana (18,500 members) or PacificSource (12,700). PacificSource is seeking a 6.2 percent average rate hikes while BCBS will not increase premiums at all for 2019.

The modest increases surprised analysts as the Insurance Commissioner had allowed all three insurers to increase silver-plan premiums to accommodate the loss of the cost-sharing reductions under the ACA (as they did for 2018)(see Update for Week of November 13th). The insurers pointed out that increases likely would have been flat or reduced had the Trump Administration not eliminated the individual mandate tax penalty for 2019 or allowed for the proliferation of limited-benefit coverage that does not comply with the ACA (see Update for Week of May 28th).

The Republican-controlled legislature had passed legislation last year that would have allowed Montana to seek federal approval to mitigate rate hikes by creating a reinsurance program to compensate insurers for exceptional claims, similar to the ones the Trump Administration has approved for Alaska, Minnesota, and Oregon (see Update for Week of December 18th). However, Governor Steven Bullock (D) vetoed the legislation (H.B. 652) because it gave Commissioner Rosedale, an ardent ACA critic, the discretion to instead segregate consumers with costly pre-existing conditions into a high-risk pool (see Update for Weeks of May 29 and June 5, 2017).

Ohio
Marketplace premiums to moderate for 2019 as coverage expands

The Department of Insurance released preliminary rate filing data this week showing that insurers in the Affordable Care Act (ACA) Marketplace that the federal government operates in Ohio are seeking an average premium increase of 8.2 percent for 2019.

The increase is less than half of the 20 percent average the Department approved last year for Marketplace insurers, after initial rate filings showed that insurers had pulled out entirely from 20 counties (see Update for Week of August 28th). Those "bare" counties were eventually filled for 2018 and the Department stressed this week that every county will be served in 2019.

The Department credits the increased competition for moderating 2019 premium increases, noting that only sixteen counties will have one insurer next year, while 33 counties will have at least two insurers. The remaining counties will all have from 3-6 competing insurers.

Final premiums will not be released until September. However, the average Marketplace premium sought by insurers is $6,274 per month.

Oklahoma
Blue Cross Blue Shield will no longer be sole insurer for ACA Marketplace

The Department of Insurance announced this month that Medica will enter the Affordable Care Act (ACA) Marketplace for 2019, giving consumers a choice of insurers for this first time in three years.

Oklahoma was one of eight states with only one participating Marketplace insurer for 2018. They will join Blue Cross Blue Shield (BCBS) of Oklahoma, according to initial rate filings.

Unitedhealthcare had tried to compete with BCBS statewide but was unable to dent the 95 percent of the Marketplace that BCBS controlled and exited after 2016. This lead to dramatic premium spikes of more than 70 percent for 2017. However BCBS increased premiums by only a 7.8 percent average for this year.

It is not clear what impact, if any, Medica's entry will have upon 2019 premiums, which will not be released until August 1st. Oklahoma remains one of only three states (besides Texas and Wyoming) where rate review is handled entirely by the federal government, which has reduced proposed premiums sought by Oklahoma insurers only modestly in prior years (see Update for Week of October 24, 2016).

Governor Mary Fallin (R) had applied for a waiver under Section 1332 of the Affordable Care Act (ACA) that would have made Oklahoma that fourth state with a federally-approved reinsurance program to compensate insurers for exceptional claims (see Update for Week of May 29 and June 5, 2017). The reinsurance program was projected to reduced premiums by an average of 34 percent for 2018. However, it was withdrawn after the Trump Administration would not approve it in time for the 2018 open enrollment period (see Update for Week of October 2nd).

The legislature did pass S.B. 1162 last spring, which authorizes a new waiver application that would not only create the reinsurance program, but allow Oklahoma to opt-out the ACA's essential health benefit package and age-rating limits, as well as base ACA premium tax credits on age instead of income. The waiver would also seek to shift control of the ACA Marketplace from the federal government to the Insure Oklahoma web portal that provides state subsidies for small business to provide health coverage for their employees.

The Oklahoma Health Care Authority, which administers Medicaid, has also urged the governor to make Oklahoma the ninth state with a federally-approved alternative to the Medicaid expansion under the ACA. The Authority's plan would let those made newly-eligible for Medicaid (everyone earning up to 138 percent of the federal poverty level) instead purchase coverage through Insurance Oklahoma (see Update for Week of April 16th.)

Oregon
Preliminary rate approvals show only modest increases for 2019 due to reinsurance program

The Department of Consumer and Business Services (DCBS) released their preliminary rate decisions showing individual market consumers will face only a 7.8 percent average increase in 2019 premiums thanks to the Oregon Reinsurance Program.

The Department reduced proposed rate hikes for four of the seven insurers participating in the individual market next year. The highest average increase will be faced by consumers of Providence Health Plan (10.6 percent). However, PacificSource Health Plans consumers will actually see an average decrease of 9.6 percent while those enrolled in Regence Blue Cross and Blue Shield will incur no increase.

Regulators emphasized that premiums were reduced on average by 6.3 percent due to federal approval of a reinsurance program to compensate insurers for exceptional claims, similar to the temporary reinsurance payments made under the Affordable Care Act (ACA) through 2016. Oregon was the third state after Alaska and Minnesota to receive a Section 1332 ACA waiver to create a reinsurance program (see Update for Week of December 18th).

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Based on the preliminary decisions, Silver Standard Plan premiums for a 40-year-old in Portland would range from $414 to $486 per month.

Regulators also stressed that the average increase would have been only 1.7 percent if not for the additional rate hikes insurers were granted to reflect sicker risk pools due to the Trump Administration's elimination of ACA individual mandate tax penalties (see Update for Week of December 18th) and their allowance for limited-benefit plans that do not comply with the ACA (see Update for Week of February 26th).

Preliminary rates may still be adjusted following public hearing to be held in the coming weeks. Final rates will be announced on July 20th.