



## Health Reform Update – Week of December 5, 2016

### CONGRESS

#### ***Compromise on 21<sup>st</sup> Century Cures Act easily clears House and Senate***

The House and Senate overwhelmingly passed a revised \$6.3 billion package of biomedical innovation bills this week that are intended to facilitate faster development of breakthrough drugs for rare disorders by removing regulatory obstacles and boosting available funds.

President Obama stated that he would promptly sign the latest version of the *21<sup>st</sup> Century Cures Act* (H.R. 34). It passed the House by an even broader margin than last year with only 26 dissenting votes (see Update for Weeks of July 26 and August 2, 2015) and only five Senators opposed it. Senator Lamar Alexander (R-TN), who chairs the committee that revised the measure last year, referred to the rare bipartisan consensus as a “Christmas miracle.”

However, the landmark legislation was not without controversy. One its early authors, Senator Elizabeth Warren (D-MA) insisted that it has now been “hijacked by Big Pharma and big Republican donors” who went “too far” with incentives for drugmakers. Other Senators also had residual concerns over how to offset the enhanced funding for the National Institutes of Health (NIH) and Food and Drug Administration (FDA), which had resulted in the Senate amendments to the previous House-passed version (see Update for Week of October 10<sup>th</sup>).

H.R. 34 does contain significant differences from the original legislation (H.R. 6). The most prominent change removes the mandatory funding stream in place of “innovation” funds that will be set aside and require annual legislative appropriations for withdrawals.

Several House and Senate Democrats remained opposed to this move including Rep. Jim McGovern (D-MA), Assistant Senate Minority Leader Dick Durbin (D-IL), and Senator Warren, as it effectively authorizes only a quarter of the original funding for NIH, FDA, the President’s Precision Medicine initiative, and the Vice President’s cancer “moonshot” initiative, with “no guarantee that the appropriations will follow through with the funding each year.” The conservative Heritage Foundation objects to the funding stream on different grounds, insisting that it is a “gimmick” as it does not count towards the annual spending caps created by the *Budget Control Act of 2011* (see August 1, 2011).

Overall, the bill will provide \$872 million in fiscal year 2017 funding, \$300 million of which will be allocated by the continuing spending resolution that Congress is expected to pass before leaving town, which would expire in April. The costs will be fully offset. However, several Democrats were angered that the bill does so by cutting another \$3.5 billion (or 30 percent) from the Prevention and Public Health Fund that the Affordable Care Act (ACA) created to cover cost-sharing obligations for certain preventive services like contraception, mammograms, and immunizations. Republicans have repeatedly stripped funds from this account in previous deficit reduction deals, insisting that they are nothing more than a “slush fund” for insurers (see Update for Week of April 15, 2013). The fund is likely to be included as part of their initial ACA repeal bill in January (see below).

According to *The Washington Post*, groups of health researchers are criticizing what they view as a contradictory effort to speed-up drug reviews by cutting down on disease prevention initiatives. The National Center for Health Research warned that relaxing the standards for clinical trial data will compromise patient safety.



At least one former Centers for Medicare and Medicaid Services (CMS) official also cautioned that a new provision in the *21<sup>st</sup> Century Cures Act* would erode quality under private Medicare Advantage plans, as it would prevent CMS from terminating poorly-performing plans through 2018 (i.e. those receiving less than three stars at least once in three years)(see Update for Weeks of October 6 and 13, 2014). However, other commenters noted that only about one percent of Medicare Advantage enrollees are currently enrolled in such low-quality plans.

Consumer groups like Public Citizen are also objecting to a provision requiring the FDA to develop a program allowing pharmaceutical companies to re-purpose older drugs for new conditions. However, Public Citizen praised the House for removing provisions that would have allowed drugmakers to extend the patent exclusivity for rare disease drugs as well as weaken part of the Physician Payment Sunshine Act that was incorporated into the ACA.

### ***House Republicans reverse course on barring ACA cost-sharing subsidies***

House Republican leaders successfully asked the U.S. Court of Appeals for the District of Columbia this week to temporarily suspend their lawsuit against the Obama Administration, which sought to block the payment of \$175 billion worth of cost-sharing subsidies under the Affordable Care Act (ACA).

Former Speaker John Boehner (R-OH) initially filed the lawsuit in 2014, alleging that the Department of Health and Human Services (HHS) could not use alternate funding sources to pay the cost-sharing subsidies once House Republicans refused to authorize an appropriation (see Update for Week of July 28, 2014). Judge Rosemary Collyer (appointed by President George W. Bush) ruled in favor of the Speaker last year but agreed to stay her ruling pending the Obama Administration's appeal (see Update for Week of May 16<sup>th</sup>). The Obama Administration not only insisted that it has the authority to pay the cost-sharing subsidies but also that Congress should not have been granted "unprecedented" standing to litigate a legislative dispute (see Update for Weeks of August 31 and September 7, 2015).

However, the election of a Republican President earlier this month has put House Republicans in an unexpected predicament, as the Trump Administration would be forced to immediately terminate cost-sharing subsidies if Judge Collyer's decision is upheld. Terminating cost-sharing subsidies could make health insurance unaffordable to millions of younger and healthier enrollees. (For example, Health Access California noted this week that 1.2 million Covered California consumers receiving subsidies would lose an average of \$309 per month.) The potential loss of such large numbers of less-costly subscribers would cause a mass exodus of insurers ACA Marketplaces, a result that may no longer be politically favorable to Republicans.

AHIP warned Congress this week that even the uncertainty over whether subsidies would remain available could cause most insurers to decide to exit Marketplaces even before the May deadline to decide on 2018 participation. A separate letter from the American Academy of Actuaries pointed out that contract provisions with Marketplace insurers would allow them drop out at any time if cost-sharing subsidies are not paid.

House Republicans were already aware of these concerns and asked the court for additional time after the inauguration for the Trump Administration to weigh how to proceed. The three-judge panel set a February 21<sup>st</sup> deadline for the Administration to reach a decision.

### ***Republicans vow swift repeal of ACA, but remain divided on replacement***

Senate Majority Leader Mitch McConnell (R-KY) and other Republican leaders reiterated this week that repealing key provision of the Affordable Care Act (ACA) through the budget reconciliation process would be the first order of business when the new Congress is seated in early January.



Leadership has been under intense pressure to follow through on eight years of promises to “repeal every word of the ACA” after President-elect Trump initially signaled a reluctance to get rid of the health insurance reform law’s most popular provisions and suggested that amending and improving upon the ACA may be an option for lawmakers (see Update for Week of November 14<sup>th</sup>). However, Vice President-elect Mike Pence assured conservative groups like the Heritage Foundation last week that an ACA repeal remains the incoming Administration’s top priority.

The plan is for the House to immediately advance a budget resolution that includes instructions to repeal specific provisions of the ACA that impact the federal deficit. These can be done through budget reconciliation with only a simple majority of the House and Senate, without requiring a 60-vote majority to break a Senate filibuster.

The bill is likely to resemble the reconciliation bill that both chambers passed last year (H.R. 3762), which would have repealed the penalties for the individual and employer mandates, as well as a revenue-raising provisions like the medical device tax, insurer and pharmaceutical tax, and 40 percent excise tax on “Cadillac” health plans (see Update for Week of January 4<sup>th</sup>). That bill, which was vetoed by President Obama, also would have eliminated the ACA’s premium and cost-sharing subsidies and Medicaid expansion. However, Republican leaders have not decided whether to include either provision in next year’s repeal bill as both insurers and Republican governors have urged them not to do so.

Leading Republicans also continue to differ on whether to include a “transition period” that would delay the actual repeal until a replacement plan is enacted. Conservative lawmakers from the House Freedom Caucus are demanding that the repeal take effect in less than two years. However, Senate Health Education Labor and Pensions Committee chairman Lamar Alexander (R-TN) and Senate Finance Committee chair Orrin Hatch (R-UT) insist that the “consensus” among Senate Republicans is for even slower “replace then repeal” approach, one that could at least three years and put the effective date of the repeal past the 2018 midterm elections. This would also give Republicans time to marshal the 60 Senate votes they need for an ACA replacement plan.

The outgoing Republican Insurance Commissioner in Iowa has been among the leading voices warning Congress about the chaos in the individual market that would result from repealing the ACA without an adequate replacement (see Update for Week of November 14<sup>th</sup>). Without some certainty that the risk pools will not be skewed towards costlier subscribers, Marketplace insurers facing a May deadline to decide on 2018 participation would likely opt not to participate. They could also leave the Marketplaces in the middle of the 2017 plan year if Congress eliminates ACA subsidies (see above).

A new study from the Urban Institute affirmed those concerns this week. It concluded that repealing major ACA provisions without simultaneously providing insurers and consumers with a “clear replacement” could “upend the health insurance market” and cause an additional 7.3 million to lose health insurance, on top of the 22.5 million that would lose coverage directly from the loss of ACA subsidies and Medicaid expansion. A Dobson DeVano and Associates commissioned by the American Hospital Association and Federation of American Hospitals found that hospitals would lose \$500 billion from repealing the ACA without a comparable replacement.

Also complicating ACA replacement plans is the fact that Republicans may now have to provide insurers during the transition period with the same reinsurance funding for extraordinary claims that they have previously railed against (see Update for Week of November 14<sup>th</sup>). The temporary ACA reinsurance program expires at the end of this month and insurers already losing millions of dollars are not likely to remain in the Marketplaces without the possibility of additional funding.

Furthermore, Republicans would be unable to finance the same level of reinsurance payments without keeping two of the biggest sources of revenue under the ACA. However, both the net investment income tax and the surcharge on earnings are targeted at those earning above \$250,000, which



Republicans are under pressure from conservative groups to repeal. According to the Congressional Budget Office, eliminating just those two revenue sources would cost \$346 billion.

House Majority Leader Kevin McCarthy (R-CA) along with chairs of various House committees dealing with health care sent a letter this week soliciting “input and recommendations” on ACA replacement plans from governors and state insurance commissioners, including the return to high-risk pools that both Speaker Ryan and Rep. Price have endorsed (see below).

### ***Public support for ACA repeal dramatically falls after election***

The latest survey data from the Kaiser Family Foundation revealed this week that support for repealing the Affordable Care Act (ACA) among Republican voters has collapsed after Republicans gained a clear path to do so (see Update for Week of November 14<sup>th</sup>).

Only a slight majority of Republican voters polled by KFF now favor a repeal, a 22 percent drop since the most recent survey just prior to the Presidential election. Furthermore, the number of Republicans that favor improving upon the ACA more than doubled from 11 percent to 24 percent.

Overall, only 26 percent of voters surveyed want Congress to repeal the ACA while 30 percent want to see the law expanded and 19 percent want it implemented as is.

### ***Republican leaders back-off from Medicare privatization, but not Medicaid block grants***

Leading Republicans quickly retreated this week from plans to convert Medicare into the premium support system long-advocated by House Speaker Paul Ryan (R-WI).

The proposed nomination last week of Rep. Tom Price (R-GA) to head the Department of Health and Human Services (HHS) (see below) immediately raised fears that Republicans would use their unified control over the Presidency and Congress to advance Ryan’s premium support plan that has previously-passed the House (see Update for Week of April 7, 2014). Rep. Price and other committee chairs had indicated in the days following the election that they intended to use budget reconciliation to fast-track the premium support plan as early as next summer (see Update for Week of November 14<sup>th</sup>), which energized both the AARP and Democratic lawmakers to start raising funds and holding press conferences to defend against plans to “destroy Medicare”.

In response to what Speaker Ryan termed “Medi-scare tactics”, both Vice President-elect Pence and Senate health committee chair Lamar Alexander (R-TN) promptly announced this week that any plans to privatize or overhaul Medicare (including raising the Medicare eligibility age to 67) are “off-the-table” until Republicans can reach a consensus on how to repeal and replace the ACA (see above).

However, both suggested that proposals to convert Medicaid into lump-sum block grants remain very much in play (see below). A report released last month by Fitch Ratings warned that such a block grant proposal could have devastating consequence on state Medicaid budgets and effectively ration care to Medicaid enrollees nationwide. Both the Commonwealth Fund and Center for Budget and Policy Priorities have issued similar analyses, concluding that the block grant proposal backed by Price and Ryan would actually limit state flexibility by cutting funding by up to 23 percent (according to the Congressional Budget Office). This would force states to dramatically scale back on benefits and provider reimbursement rates in order to avoid major budget deficits.

### ***Senator Cassidy insists biosimilar pathway will not be part of ACA repeal***

Senator Bill Cassidy (R-LA), one of 19 physicians in Congress, assured attendees of a policy briefing this week that Republicans have no intention of terminating the new regulatory pathway for biosimilar drugs that was created by the Affordable Care Act (ACA).



A repeal of the full ACA would automatically terminate the pathway, which the Food and Drug Administration (FDA) first used last year to approve lower-cost copies of brand-name biologic drugs (see Update for Weeks of March 2 and 9, 2015). It also would roll-back the *Physician Payment Sunshine Act*, which was also incorporated into the ACA in an effort to make financial relationships between physicians and drug and device manufacturers more transparent (see Update for Week of September 29, 2014). However, Republican lawmakers have thus far sought to avoid repealing either provision.

The Solicitor General did ask the U.S. Supreme Court this week to hear the case involving the first FDA biosimilar approval of a copy of Amgen's Neupogen, which treats a common side effect of chemotherapy. Sandoz had appealed a lower court ruling that as a biosimilar applicant it must wait for FDA approval before sending the brand-name drugmaker the 180-day notice of intent to market, arguing that the delay effectively gives the reference product six additional months of market exclusivity.

### ***Report finds Congressional scrutiny slowed drug prices***

A new report released this week by the QuintilesIMS Institute for Healthcare Informatics concludes that increased Congressional scrutiny over prescription drug pricing likely cut the rate of dramatic price increases by about half for 2016.

Researchers attributed the “notable slowing of list price increases” to “congressional inquiries and media exposure” following outrage over \$1,000 per pill pricing for new hepatitis C “cures” and increases of up to 4,000 percent on other life-saving drugs (see Update for Weeks of September 14 and 21, 2015). They found that drug costs grew by only 6-7 percent in 2016, down from 12 percent the year prior.

In response to the Congressional scrutiny Novo Nordisk announced this week that it would limit price increases to no more than ten percent per year and will increase patient assistance and copayment support programs. Allergan made a similar commitment earlier this fall.

The report predicts that major drug pricing reforms are unlikely in the short-term, including allowing Medicare to negotiate prices for Part D drugs, a change long-sought by Congressional Democrats. Pharmaceutical stocks had driven a rally in the stock market since the election, largely driven on the same assumption that President-elect Trump would not pursue the same drug pricing reforms sought by his opponent, which included a \$250 cap on specialty drugs (see Update for Weeks of September 14 and 21, 2015).

However, those same stocks dropped precipitously this week as President-elect Trump used an interview this week with *TIME* magazine to reiterate his campaign pledge to “bring down drug prices.” Trump did not provide any details but has previously supported giving Medicare authority to negotiate drug prices, as well as allowing lower-cost prescription drugs to be imported from Canada and other countries. The pharmaceutical industry had successfully negotiated both provisions out of the Affordable Care Act (ACA) and remains strongly opposed to them.

## **FEDERAL AGENCIES**

### ***Nominee for HHS secretary wants to quickly repeal ACA, overhaul Medicare and Medicaid***

President-elect Trump confirmed this week that he will nominate one of the leading Congressional opponents of the Affordable Care Act (ACA) to serve as the next Secretary for the Department of Health and Human Services (HHS).

Rep. Tom Price (R-GA) is an orthopedic surgeon who currently chairs the House Budget Committee and has repeatedly sought to block funding for key provisions of the ACA (such as premium



tax credits and insurer compensation for extraordinary claims). He is best-known as the author of the first Republican bill to repeal the ACA and replace it with a traditional set of piecemeal reforms long-favored by conservatives. Price also steered the vetoed reconciliation bill through the House last year (H.R. 3762) that sought to repeal some of the law's most critical deficit-related provisions (see above).

While Price's plan shares many of the concepts advanced by Speaker Paul Ryan (R-WI), it is the only replacement proposal put into legislative form and thus offers far more details into the direction the new Administration may pursue. His *Empowering Patients First Act of 2015* (H.R. 2300) (first introduced in 2013 and again last year) largely focuses on replacing ACA premium tax credits with a tax credit of \$900-\$3,000 that would vary based on age instead of income. Individuals in public health programs or employer-sponsored plans could opt-out and use the credit for individual coverage.

Both Price and Ryan would retain the guaranteed issue requirement under the ACA but return to segregating patients with costly conditions in state high-risk pools. However, Price's proposal is far less generous, offering only \$3 billion over three years to fund the pools, compared to the \$25 billion over a decade proposed by Ryan.

Rep. Price would also offer a \$1,000 tax credit for individuals who maintain health savings accounts. However, he would for the first time cap the tax exclusion for employer-sponsored insurance at only \$8,000 (far lower than other Republican proposals), a move long-sought by health economists but considered politically untenable.

Price endorses the sale of interstate health plans, the one specific health reform that President-elect Trump heralded during his campaign. This would allow insurers to comply only with the regulations in the state they choose to make their primary place of business. However, heads of insurers like Blue Shield of California have largely dismissed this plan, claiming it would create a "race to the bottom" and a similar 2011 law passed in Georgia attracted zero insurers (see Update for Week of April 9, 2012).

Several prominent Senate Democrats including new Minority Leader Chuck Schumer (D-NY), Senate Finance ranking member Ron Wyden (D-OR), and Elizabeth Warren (D-MA) were quick to criticize Price's nomination, citing his opposition to reauthorizing the State Children's Health Insurance Program (SCHIP), which expires in September. In addition, they oppose his support of Speaker Ryan's plan to privatize Medicare and convert Medicaid into lump-sum block grants (see above).

As a result, consumer groups were predictably wary of Price's nomination, with the executive director for Families USA calling it "extremism at its worst". However, physician groups were divided, with the American Medical Association (AMA) supporting his nomination while the National Physician Alliance (NPA) came out strongly in opposition.

Senior AMA staffers acknowledged that there was dissension among some "rank and file members" who were upset that the AMA endorsed Price, given the association's prior support of the Affordable Care Act (ACA). According to *Politico*, senior AMA officials anonymously defended the endorsement, insisting that Price was a known-quantity with whom the association could work and was preferable to some of the other less experienced choices being floated. Board chair Patrice Harris stressed that "the AMA remains committed to improving health insurance coverage" and would fight any HHS proposal that "cause[s] individuals currently covered to become uninsured."

### ***Nominee for CMS Administrator likely to give states greatly flexibility on Medicaid expansion***

President-elect Trump announced this week that he will nominate a former consultant for Vice President-elect Mike Pence to be Administrator of the Centers for Medicare and Medicaid Services (CMS).



Seema Verma heads a consulting firm called SVC Inc. through which she helped Governor Pence craft his federal waiver request that allowed Indiana to become one of eight conservative-leaning states allowed to use ACA matching funds to create a “private sector” alternative to the Medicaid expansion. She previously worked for the Health and Hospital Corporation of Marion County (Indiana) and the Association of State and Territorial Health Officials.

The eleven Republican governors that have expanded Medicaid under the ACA (including Pence) have lobbied the Trump Administration to retain the expansion but grant them more flexibility to experiment with alternatives. Although House Republicans have not indicated whether they will again include the Medicaid expansion in their repeal bill (see above), Verma’s nomination suggests that the Administration is leaning towards the governors’ approach.

Alternative plans that Verma’s firm crafted for other conservative-leaning states like Iowa, Kentucky, and Michigan have sought to impose work requirements on those made newly-eligible for Medicaid, as well as unprecedented premiums for those under the poverty level and lock-out periods for those who fail to pay on time. These are requirements that the Obama Administration largely rejected but may now be permitted by CMS.

Some consumer groups were concerned how far Verma may go to force Medicare and Medicaid enrollees to “have some skin in the game” and create barriers to coverage. For example, the Georgetown Center for Children and Families found that roughly one-third of those eligible the Indiana Medicaid expansion alternative that Verma created never enrolled in the program because the premiums were unaffordable.

Democratic lawmakers like Senator Sherrod Brown (D-OH) also criticized her for an apparent conflict of interest as her consulting firm did work for Hewlett Packard, who was one of the major vendors for the Indiana Medicaid expansion program that she crafted.

However, Verma’s selection was largely praised by insurer and provider groups, who were encouraged by her emphasis on flexibility and likelihood that she would favor modifying but not repealing key ACA provisions like the Medicaid expansion. In addition, her confirmation could pave the way for states to only partly expand Medicaid and still receive ACA matching funds.

The Obama Administration had consistently made Medicaid expansion an “all or nothing proposition” by releasing matching funds only to those states that expanded eligibility all the way to those earning up to 138 percent of the federal poverty level (see Update for Weeks of August 6 and 13, 2012). They had expressed a willingness to consider partial expansions beginning in 2017, when the federal match for the Medicaid expansion population starts to phase-down from 100 percent to 90 percent starting in 2020 (see Update for Weeks of December 3 and 10, 2012).

States like Wisconsin (see Update for Week of November 11, 2013) and South Dakota (see Update for Week of December 7<sup>th</sup>) have already unsuccessfully sought approval to partially expand to cover those caught in the “coverage gap” between their existing Medicaid eligibility limits and the ACA threshold for premium subsidies (which starts at 100 percent of FPL.) However, while Verma may be willing to approve those plans, it is not clear that state like Utah will finally get approval for its “bare bones” expansion that would cover only 11,000 residents earning up to 55 percent of FPL (see Update for Week of July 25<sup>th</sup>).

### ***Marketplace enrollment tops 2.1 million, with most in plans costing less than \$75 per month***

The biweekly Marketplace enrollment snapshot released this week by the Centers for Medicare and Medicaid Services (CMS) shows that more than 2.1 million individuals have now enrolled in coverage through the federal Marketplace web portal (at [www.healthcare.gov](http://www.healthcare.gov)) since the November 1<sup>st</sup> start of open enrollment.



Total enrollment now exceeds last year's pace by over 97,000 consumers. More than 1.1 million have signed-up for coverage in the last two weeks despite promises by Republican lawmakers to repeal the Affordable Care Act (ACA) as soon as the new Congress is seated in January (see above).

More than 1.6 million of the 2.1 million total are renewing their Marketplace coverage from last year. CMS insists that most enrollees were able to purchase coverage for \$75 or less per month, due to ACA subsidies that would be terminated under the repeal bill that House Republicans intend to pursue.

### ***Health care spending ticks upward as more Americans became insured***

The latest data from the actuary for the Centers for Medicare and Medicaid Services (CMS) shows that national health care spending picked-up during 2015 due to the expanded coverage under the Affordable Care Act (ACA) and continued increases in prescription drug prices.

The 5.8 percent rate of growth for 2015 exceeded the 5.3 percent jump in 2014, the first year of full ACA implementation. National health spending had seen historically low rates of growth from 2009-2013 following the deep recession in 2007-2008. However, the actuary stressed that the uptick in 2014 and 2015 are still well below the annual spending spikes that occurred prior to the recession.

The data did show that prescription drug spending tapered-off slightly in 2015. However, it still grew faster than any other category at more than nine percent (or \$324.6 billion) and far exceeds the 2.3 percent growth rate as recently as 2013. The actuary attributed continued high rates of prescription drug spending to exceptionally-costly new drugs for conditions like hepatitis C and cancer.

Total spending for physician and clinical services was the second-highest cost driver (increasing by 6.3 percent to \$634.9 billion) as those becoming newly-insured under the ACA typically used more health care services than other populations. Medicaid spending jumped by nearly ten percent due to additional states expanded eligibility pursuant to the ACA. However, this growth rate was actually below the 11.6 percent spike in 2014, the first year of the Medicaid expansion.

The growth rate for out-of-pocket spending nearly doubled in 2015 (from 1.4 percent to 2.6 percent), which the CMS Actuary attributed to increasing consumer reliance on high-deductible health plans. However the Actuary stressed that the rate of growth is still a full two percent below the 4.6 percent annual growth rate from 200-2009. Out-of-pocket spending now accounts for 11 percent of all total spending.

Overall, national health spending totaled \$3.2 trillion in 2015 or \$9,990 per person (up from roughly \$3 trillion and \$9,515 per person in 2014.) This represented 17.8 percent of the gross domestic product (up from 17.4 percent in 2014.)

The national uninsured rate reached an all-time low of 9.1 percent in 2015 (down from 11.2 percent the year before) (see Update for Week of September 12<sup>th</sup>).

### ***CDC survey shows fewer Americans struggle to pay medical bills***

Fewer Americans having problems paying medical bills. That's according to new estimates from the National Health Interview Survey, which found that 43.8 million Americans in the first half of 2016 were in families that had problems paying their medical bills, down from 56.5 million Americans in 2011.

While the gains were concentrated among Americans who were uninsured or had public coverage, those with private insurance also benefited. Nearly 15 percent of Americans under age 65 with private coverage were in families having problems paying medical bills in 2011, but that number fell to 12.6 percent in the first 6 months of 2016.



An 11-country survey from The Commonwealth Fund finds that adults in the United States are far more likely than those in 10 other high-income nations to go without needed health care because of costs and to struggle to afford basic necessities such as housing and healthy food. The survey findings, published by Health Affairs, also indicate Americans are sicker than people in other countries and experience high levels of emotional distress.

## STATES

### Alaska

#### ***Insurance division releases draft waiver for successful reinsurance program***

The Division of Insurance posted a draft late last month of its Section 1332 State Innovation waiver that it plans to submit to the Obama Administration for approval of the new Alaska Reinsurance Program (ARP).

Governor Bill Walker (I) signed legislation creating the reinsurance program (H.B. 374) last summer, which seeks to stabilize health insurance premiums in the individual market through a reinsurance program for high-cost enrollees that is funded by an existing tax on all health insurers (see Update for Week of July 18<sup>th</sup>). The measure was prompted by Moda Health Plan's decision to exit the individual market for 2017, leaving Premera Blue Cross as the only remaining insurer and raising fears that premiums would consequently spike by at least 42 percent (see Update for Week of January 25<sup>th</sup> and February 1<sup>st</sup>).

As a result of the \$55 million the legislature appropriated for reinsurance program in 2017, the Division notes that the ARP has reduced premium increases in the individual market to only seven percent, increased individual plan enrollment by nearly 1,650 subscribers, and will save the federal government roughly \$51.6 million in Affordable Care Act (ACA) premium tax credits for 2018.

However, the ARP still requires federal approval through the flexibility that Section 1332 of the ACA gives states to experiment with their own innovation measures that would ensure the same level of coverage as the ACA. If granted, the ARP would be approved for five years, with an option to renew for an additional ten years.

H.B. 374 made additional legislative appropriations for the ARP contingent upon federal approval of the Section 1332 waiver.

The Division states that the waiver is part of Governor Walker's continued efforts to build-upon the "success of the ACA". The Governor used his executive authority to expand Medicaid under the ACA last year despite the opposition of the Republican-controlled legislature (see Update for Weeks of August 31 and September 7, 2015). Nearly 20,000 Alaskans have since enrolled in the expansion program.

### Arkansas

#### ***Governor gets federal approval to revise Medicaid expansion***

Governor Asa Hutchinson (R) announced this week that his proposed changes to the Private Option Medicaid expansion program have received federal approval, with some modifications.

Under previous Governor Mike Beebe (D), Arkansas became the first state in the nation to receive federal approval for a private sector alternative to the Medicaid expansion under the ACA (see Update for Week of September 25, 2013). More than 300,000 Arkansans have since enrolled in the Private Option, which uses ACA matching funds for the expansion to instead purchase private Marketplace coverage for those made newly-eligible for Medicaid.



However, the waiver has met with stiff opposition from conservative lawmakers that subsequently gained control of the governorship and legislature. It requires annual renewal, which it managed by only one vote last year and conservatives insisted that it would not be reauthorized this year if reforms were not implemented that would increase enrollee cost-sharing, impose “work encouragement” requirements, move lower-income enrollees into traditional Medicaid, and terminate those that fail to pay premiums (see Update for Weeks of January 26 and February 4, 2015).

Governor Hutchinson called a special session earlier this year to secure legislative approval for the changes that initially received conceptual approval from the Obama Administration (see Update for Weeks of February 8<sup>th</sup> and 15<sup>th</sup>). However, some of the most conservative lawmakers continued to try and terminate the Private Option by refusing to approve a Medicaid budget that funded it, forcing the Governor to back a budget plan with the termination provision in order to use his line-item veto to strip it out and then signed the bill allowing the Private Option to continue (see Update for Week of April 18<sup>th</sup>).

The Governor is one of 11 Republican governors that are urging the incoming Trump Administration not to repeal the Medicaid expansion, but rather gives states more flexibility to incorporate some of the conservative principles that the Obama Administration refused to approve (see Update for Week of November 30, 2015). Hutchinson also favors the plan advanced by U.S. House Speaker Paul Ryan (R-WI) that would convert Medicaid into lump-sum block grants with few strings attached (see above).

Governor Hutchinson was able to get the Obama Administration to allow Arkansas to require that unemployed Private Option enrollees be referred to voluntary work training, impose small copayments, and stop making coverage retroactive for up to 90 days.

#### California

#### ***Health committee chair renews push for drug price transparency***

The chair of the Senate Committee on Health is reintroducing legislation that he pulled last summer, which would have required drug manufacturers to justify treatment costs and price hikes,

S.B. 17 is largely the same as S.B. 1010, which had cleared the Senate and appeared poised to pass the Assembly before Senator Ed Hernandez (D) withdrew it, claiming that the amendment had been so “watered down” that it could no longer accomplish its goal of “shedding light on the reasons precipitating skyrocketing drug prices” and “making sure drug companies played by the same rules as everyone else in the health care industry (see Update for Week of August 15<sup>th</sup>).

The initial bill would have required that drug manufacturers provide state agencies and health insurers a justification for increasing the wholesale acquisition cost (WAC) of the drug by more than ten percent or \$10,000 for brand-name drugs (within a 12 month period). The same justification would be required for price increases on generic drugs of at least \$100 per month or more than 25 percent.

Drug manufacturers would have to provide at least a 60-day notification of any such price increase (similar to existing state requirements on individual and small group insurers) and issue an actuarial justification within 30 days of that notification.

However, the House Appropriations Committee raised the reporting threshold for brand-name drugs to the same 25 percent threshold as for generic drugs. The panel also removed the requirement that drug manufacturers provide justification for price increases and delayed by one year the effective date for the 60-day notification requirement.

The measure continues to face strong opposition from the pharmaceutical industry. However, Senator Hernandez insists that it is even more important to pursue after last month’s election which



reduced the likelihood of federal action on drug transparency (given the full Republican control) but provided Democrats with supermajorities in both chambers in California (see Update for Week of November 14<sup>th</sup>).

California was one of 16 states that considered drug price transparency measures last session. However, only Vermont has enacted such legislation (see Update for Week of June 20<sup>th</sup>). According to the National Conference of State Legislatures, lawmakers in Virginia are also likely to resurrect their transparency legislation next year.

#### Colorado

##### ***Marketplace enrollment outpaces last year***

Connect for Health Colorado officials announced this week that enrollment in the state-based Marketplace created pursuant to the Affordable Care Act (ACA) exceeded last year's pace by roughly 23 percent. Nearly 38,000 individuals have selected qualified health plan coverage through the Marketplace, which is more than a 19 percent jump compared to the first month of open enrollment in 2015, despite higher premiums.

#### District of Columbia

##### ***Committee approves legislation capping specialty tier drug cost-sharing***

The subcommittee on Consumer Affairs for the Committee of the Whole unanimously passed legislation last month that would limit copayment and coinsurance obligations for specialty tier drugs to no more than \$150 for a 30-day supply or \$300 for a 90-day supply. Both limits will be annually adjusted based on the Consumer Price Index for the region that is set by the U.S. Department of Labor.

The *Specialty Drug Copayment Limitation Act of 2015* (B21-0032) was initially introduced in the Committee on Business, Consumer, and Regulatory Affairs in January 2015, which held an October 2015 public hearing at which numerous consumer groups including PSI testified in support (see Update for Week of November 30, 2015). It was re-referred to the subcommittee last September, which added the limit on a 90-day supply based on comments received at the hearing indicating that 90-day prescriptions are "common" and "usually less than simply three times the 30-day cost."

The subcommittee also delayed the effective date by one year until January 1, 2018 to provide ample time for the measure to be debated by the full Council of the District of Columbia.

#### Kansas

##### ***State hospital association will continue to pursue Medicaid expansion despite repeal threat***

The Kansas Hospital Association (KHA) announced this week that it will still propose legislation next session that will expand Medicaid under the Affordable Care Act (ACA), despite pledges by Congressional Republicans to make repealing the ACA their first order of business in January (see Update for Week of November 14<sup>th</sup>).

The eleven Republican governors that have already expanded Medicaid in their states have urged Congress to retain the expansion, citing the enormous budget deficits and uncompensated care costs that would result from an immediate repeal. However, Republican leaders in most of the 19 states that have yet to expand Medicaid under the ACA declared expansion efforts dead as a result of the impending repeal vote in Congress.

Nevertheless, KHA remained undeterred in pursuit of Medicaid expansion, citing the number of pre-expansion Republicans and Democrats that won their state legislative races last month. Lieutenant Governor Jeff Colyer (R) has also indicated that Governor Sam Brownback (R) may be willing to work out a "Kansas solution" with the hospital association, which appeared to be a nod towards some form of the



conservative-favored alternatives to the ACA expansion that are expected to be approved by the incoming CMS Administrator (see above).

KHA will likely resurrect its proposal from last year that was modeled after the Medicaid expansion alternative that was federally-approved for Indiana, which allowed ACA matching funds to be used for health-savings accounts from which newly-eligible enrollees could pay for coverage in Medicaid managed care plans (see Update for Weeks of January 26 and February 2, 2015).

#### New Hampshire

##### ***CMS rejects new work and eligibility requirements for Medicaid expansion population...for now***

The Centers for Medicare and Medicaid Services (CMS) notified the New Hampshire Department of Health and Human Services last month that it will not approve its August 2016 request to impose new work requirements and eligibility verification measures on the population made newly-eligible under the Affordable Care Act (ACA).

New Hampshire is one of eight states that have received a federal Section 1115 demonstration waiver allowing it to use matching funds for the ACA Medicaid expansion to instead cover the newly-eligible population in private Medicaid managed care plans or the state partnership Marketplace that New Hampshire operates pursuant to the ACA (see Update for Week of September 29, 2014). Despite enrolling more than 45,000 previously uninsured residents, Republicans sought to impose several conservative-favored elements to the program since assuming control of both legislative chambers (see Update for Week of March 16, 2015). This includes making the most recent two-year reauthorization conditional on the Department seeking federal approval to impose copayments on non-urgent emergency room use, require newly-eligible “able-bodied” adults without children to work at least 30 hours per week, and prove U.S. citizenship with at least two forms of identification (see Update for Week of March 7<sup>th</sup>).

CMS permitted small copayments for inappropriate emergency room use (\$8 for the first offense, \$25 thereafter). However, the agency rejected the latter two requirements, insisting that they would “undermine access, efficiency, and quality of care provided to Medicaid beneficiaries.”

CMS has consistently stripped out analogous provisions sought by other conservative-leaning states (see Update for Week of November 30, 2015). However, the nominee for CMS Administrator personally crafted these provisions while serving as consultant for several of the eight states with Medicaid expansion waivers. As a result, CMS is expected to start approving such requests once she is confirmed (see above).

#### New Jersey

##### ***One in ten adults would become uninsured if the ACA Medicaid expansion is repealed***

A new report released last week by the non-partisan non-profit New Jersey Policy Perspective projects that more than ten percent of the state’s adult population (roughly 500,000 people) will become uninsured if the Medicaid expansion under the Affordable Care Act (ACA) is repealed (see above). As a result of the repeal, New Jersey would have to forgo \$3 billion in ACA funds for 2018 and more than \$11 billion by 2021.

Governor Chris Christie (R) was among the first of 11 Republican governors to expand Medicaid under the ACA. He is a former member of President-elect Trump’s transition team and has urged Trump not to support a repeal of the expansion.

#### Washington

##### ***Consultant recommends no changes to successful Marketplace despite ACA repeal threat***



A new report from Wakely Consulting Group recommends that Washington continue to operate a state-based Marketplace (SBM) pursuant to the Affordable Care Act (ACA), citing the dramatic progress the state has made in expanding the number of enrollees and plan options while holding down premiums.

The Washington Healthplanfinder has consistently been among the best-performing of all ACA Marketplaces (see Update for Week of April 21, 2014). It ranked fourth in overall enrollment after the inaugural open enrollment period and has boosted its total number of qualified health plan enrollees from roughly 133,000 in 2014 to nearly 164,000 for 2016.

Participation in the Healthplanfinder has remained steady, with eight insurers participating for all of the first three years of operation. During that time, the number of statewide plan offerings have nearly tripled from 46 in 2014 to 138 by 2016. Although the number of plan offerings for less-populated counties is falling for 2017, the number of statewide options (98) still remains more than twice as high as in 2014.

The report also found that there is now a more even distribution of market share within the Healthplanfinder. The dominant carrier, Premera Blue Cross, now controls only 30 percent of the Marketplace, down from a high of 47 percent in 2014, with the remaining market share being distributed equally among competing insurers.

Although the average annual rate of growth in premiums jumped dramatically in 2016 (to 11.4 percent from only 3.6 percent in 2015), Wakely researchers found that the average increase remained far below the increases experienced in other states and did not result in the use of "ultra-narrow" provider networks by Healthplanfinder insurers. However, Wakely did note that insurers were increasingly relying on narrow networks in order to limit rate hikes.

The report was issued after the Presidential election gave Republicans a clear path to repeal the ACA (see Update for Week of November 14<sup>th</sup>). However, Wakely recommends that given the stability of the Healthplanfinder, Washington make no changes to its Marketplace in the short-term, in order to limit the uncertainty for participating insurers and enrollees. It also urged the state not to make any changes to its healthy individual market and retain the requirement that carriers offering non-Marketplace bronze tier coverage also offer gold and silver tier coverage outside the Marketplace. Researchers found no evidence that this requirement has destabilized the market and concluded that it could help equalize market conditions in the future.